

Select Committee on Mental Health

Mental Health Services in New South Wales

Final Report

Ordered to be printed according to the Resolution of the
House

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Terms of Reference

1. That a Select Committee be appointed to inquire into and report on mental health services in New South Wales and in particular:
 - (a) the changes which have taken place since the adoption of the Richmond Report,
 - (b) the impact of changes in psychiatric hospitalisation and/or asylum,
 - (c) levels and methods of funding of mental health services in NSW, including comparisons with other jurisdictions,
 - (d) community participation in, and integration of, mental health services,
 - (e) quality control of mental health services,
 - (f) staffing levels in NSW mental health services, including comparisons with other jurisdictions,
 - (g) the availability and mix of mental health services in NSW,
 - (h) data collection and outcome measures.
2. That the Committee table an interim report by 3 September 2002.
3. That, notwithstanding anything to the contrary in the Standing Orders, the Committee consist of the following members:
 - i) 2 Government members nominated in writing to the Clerk of the House by the Leader of the Government,
 - ii) Dr Pezzutti and Mr Moppett,
 - iii) Dr Chesterfield Evans and Mr Breen.
4. That the Committee have leave to sit during any adjournment of the House to adjourn from place to place, to make visits of inspection within New South Wales, and other States and Territories of Australia with the approval of the President, and have power to take evidence and to send for persons, papers, records and things, and to report from time to time.
5. That should the House stand adjourned and the Committee agree to any report before the House resumes sitting:
 - (a) the Committee have leave to send any such report, minutes of proceedings and evidence taken before it to the Clerk of the House,
 - (b) the document be printed and published and the Clerk forthwith take such action as is necessary to give effect to the order of the House,
 - (c) the document be laid on the Table of the House at its next sitting.
6. That on receipt of a request from the Committee for funding, the Government immediately provide the Legislative Council with such additional funds that the Committee considers necessary for the conduct of its inquiry.

Legislative Council, Minutes of Proceedings, 11 December 2001, pp 1357-1358.

Committee Membership



The Hon Dr Brian Pezzutti RFD MLC

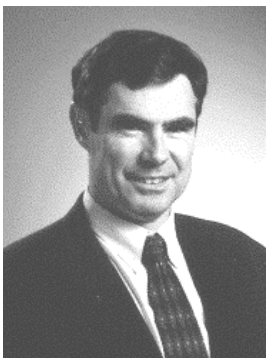
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Reform the Legal System



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The Hon Amanda Fazio MLC

Australian Labor Party



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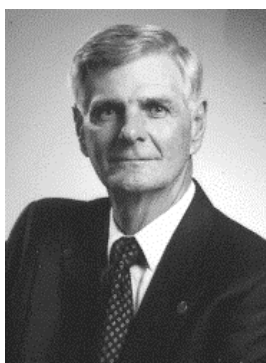
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Liberal Party of Australia

(Appointed to Committee 20 June 2002)



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Chair's Foreword

In 1846, a Legislative Council Select Committee conducted the first inquiry into mental health services in NSW. This Legislative Council Select Committee on Mental Health is the first NSW Parliamentary inquiry since 1877 to look specifically into mental health. The report coincides with the 20th Anniversary of the release of the Richmond Report.

The Select Committee is made up of six members, two Liberal, two Labor, one Australian Democrats and one Independent. The Committee has approached the questions and challenges before the inquiry in a sensitive and bi-partisan manner.

Since the inquiry was announced in December 2001, we received 303 submissions from private citizens, mental health professionals, and non-government and government organisations. The Committee heard evidence from 91 witnesses. I was almost overwhelmed by the detail and quality of the submissions and the high calibre of the witnesses, particularly the highly personalised and invaluable insights provided by the speakers at the Committee's public forum.

The objectives of the Richmond Report and the deinstitutionalisation process have been undermined by practical problems arising during implementation. Consequently, NSW has a community mental health sector with a large responsibility for mental health care, but not the necessary resources. The weight of evidence presented to the Committee highlights that mental health services in NSW need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment.

There are some good models of supported care in NSW. The best of these work better because of greater coordination at a local level. They draw together the care, support, housing, and social contacts people need to be part of their community. Many acute patients, however, are beyond such a model and many more, including those with both a mental illness and substance abuse problem, are slipping through the gaps in the system. The report recommends that an Office of Mental Health be established within the Premier's Department to coordinate government agencies, improve interagency communication, cut through the bureaucratic process and close the gaps in services.

Much debate in 2002 concerned the fate of Rozelle Hospital, part of Callan Park. Since 1876, people with a long-term mental illness have received treatment and care at Callan Park. The recent debate over the site, however, has been predominately concerned with public green space, and not mental health services. There are ample grounds at Callan Park for residents, the public, sporting fields and dog exercise areas away from Rozelle Hospital. In a city like Sydney, which is bursting at the seams, it is important for people with mental illness to have a place to go to take time out to recover. In this State 20% of us will suffer a mental condition during the next year, and 40% of us will have a major mental illness some time in our lives. Places to which we can go to get better are vital.

The Committee is not suggesting that Rozelle Hospital be isolated or 'walled' from the community, rather, involvement must be on the patients' terms. This is an important distinction.

This report discusses the long term care of people with a mental illness. In 1961, around the time of the Royal Commission into Callan Park, there were some 1,750 patients in residence. It was a case of the residents needing asylum from the Asylum. This report recommends that the concept of a place of sanctuary become a reality for people with a mental illness. The report does not recommend a return to the former 'institutions'. The unfortunate conditions that prevailed in many of these places must not re-

occur. The rate of homelessness and imprisonment of people with a mental illness, however, must not be allowed to continue either. Government and the community must not be indifferent to the treatment and care of people with a mental illness. Many serious mental illnesses are chronic and relapsing in spite of best care, just like diabetes and asthma, yet they do not get the same priority. **Mental health is everyone's business;** it is as important as physical health and deserves equal priority.

There cannot be a 'one size fits all' approach to mental health services. Based on evidence presented to the Committee, a sanctuary, a place of respite, retreat and safety, is beneficial to many people with a mental illness. The disability of a mental illness in some situations means that many people become dependent on family, friends or carers. Understandably, for some families and carers, the burden becomes too much. Unfortunately, as the Committee heard regularly throughout the inquiry, many people with a mental illness do not have any support base to depend upon.

I acknowledge that NSW has increased its funding to mental health services. In April 2000, the NSW Government increased mental health funding by \$107.5 million and was spent over three years. This is a positive development, but the Committee has heard repeatedly that it is not enough. Only a small fraction has been allocated for non-government organisations to provide community care.

In addition to the adequacy of funding, the Committee also examined the allocation of funding. The allocation of funding for mental health is not a population based model, as it is for other health services. A number of key stakeholders have also expressed their concern that money allocated to mental health services cannot be 'quarantined'. Once it goes out to Area Health Services, it is almost impossible to track its allocation. There is widespread concern that mental health money ends up being spent elsewhere.

A concern of many stakeholders was that the policies of the Centre for Mental Health are not being implemented. Service delivery guidelines have been developed, but colour brochures do not compensate for inadequate service provision. Implementation of mental health service policies by some Area Health Services remains poor. The Minister for Health must ensure that these Area Health Services are committed to mental health service provision through actions not words.

I am particularly concerned with the incarceration of forensic patients. Forensic patients are those found not guilty by reason of mental illness, those unfit to plead and those imprisoned who are later found to have a mental illness and are transferred to a hospital for treatment. Unfortunately, in NSW there is no secure forensic hospital outside a prison. Consequently, many of those found not guilty or unfit to plead by reason of mental illness are sent to gaol anyway. They are subject to the terms and conditions of Corrective Services and locked in their cell for eleven hours a day. NSW is the only mainland State to incarcerate forensic patients and, as far as the Committee can determine, only one of a few in the Western World. Present and past Governments in NSW have neglected to address this issue, which is a breach of the *United Nations Declaration of Human Rights 1948* and the *NSW Mental Health Act 1990*.

Another issue, which has impacted on services, is the shortage of nurses in mental health. The nursing shortage is preventing the opening of new beds and placing strain on a sector already operating on limited resources. Further career opportunities must be developed and encouraged for nurses, with appropriate remuneration. Mental health nurses and workers in general, are historically a team-orientated workforce. Assisting people to get well again can be a tremendously satisfying occupation. Unfortunately, the episodic and short-term care of people with a mental illness, with its 'revolving door' outcomes, has diminished job satisfaction. Improving facilities and services, funding more long-term

beds and increase lengths of rehabilitation, may not only improve the patients' recovery, but also provide incentives for people to work in the sector and many of the dissatisfied to return.

The Committee also looked at the issues effecting older and young people and multicultural and indigenous issues.

The mental health services sector in NSW is capable of revolutionary reform. Based on evidence put before the Committee, the sector is in fact seeking it. Such a complex, diverse and important area needs sufficiently empowered advocates or champions, to ensure the necessary reform occurs and succeeds. Two champions, united in their commitment, with the necessary resources, could ensure this reform - the Premier of NSW and the Minister for Health. After chairing this inquiry, I am convinced that no other issue in my 14 years as a Member of Parliament is more important. People with a mental illness who seek services must not encounter service discrimination. There must be **'no wrong door'** when people with a mental illness attempt to access health services.

I take this opportunity to thank my fellow Committee Members for their valuable input to this complex and challenging inquiry. The bipartisan approach adopted by Members enabled the Committee to conduct a comprehensive inquiry, which is reflected in this report.

Acknowledgement must also go to the Secretariat, for their comprehensive, sensitive and accomplished organisational and research skills. This report is indicative of the commitment of the Legislative Council's Committee Secretariat staff. The Committee is indebted to the Secretariat for their ability to successfully pull together and distil a vast volume of information and represent it in a considered and accurate form. Special mention must go the Senior Project Officer, Mr Bayne McKissock, for his comprehensive understanding of the subject matter, intellectual leadership and considerable report writing skills during a long and arduous inquiry. I would like to acknowledge the Committee Director, Mr Rob Stefanic for combining his Committee experience with coordination, editing and strategic direction. I would also like to thank the Project Officer, Ms Julia Martin, for her dedicated research and report writing skills. Finally, I wish to note the work of the Committee Officers, Ms Cathy Nunn and Mrs Annie Marshall, whose administrative support and meticulous proof reading skills ensured the quality of this report.

Finally, I would like, once more, to pay tribute to the Hon Doug Moppett MLC, who was a member of this Committee until 14 June 2002 and passed away on 18 June 2002. Since Doug passed away, tributes to his commitment to country NSW, parliamentary democracy and social issues have been many and varied and every political persuasion has acknowledged a great man. Sadly missed, we remember Doug as an inspiring and remarkable gentleman.

Hon Dr Brian Pezzutti RFD MLC

Chair

Summary of Recommendations

Recommendation 1

Page 35

That the Premier of New South Wales establish an Office of Mental Health in the NSW Premier's Department.

The Office of Mental Health should provide integrated government advice and coordination of mental health services in NSW, to effectively coordinate the:

- NSW Department of Housing
- NSW Department of Ageing, Disability and Home Care
- NSW Health
- NSW Police
- Attorney General's Department
- non-government organisations and community service providers.

Recommendation 2

Page 35

That the proposed Office of Mental Health be adequately funded and resourced for a period of 5 years. At the end of this period its functions, objectives and continuation should be reviewed.

Recommendation 3

Page 41

That the Minister for Health commission an independent inquiry into the incidence and circumstances of suicide among people with a mental illness who were:

- under the care of NSW Health or
- refused admission to a public hospital or psychiatric unit within a week prior to their suicide.

The inquiry should review cases from the previous two years, and report to Parliament within 12 months.

Recommendation 4

Page 46

That the Minister for Health introduce data collection on readmissions to psychiatric units at three, six and twelve month intervals (in addition to the 28 day data already collected), to assist in the planning of services with a relapse prevention focus. This information should be made available publicly.

Recommendation 5

Page 53

That the Minister for Health utilise sections 127, 129, and 130 of the *Health Services Act 1997* to ensure that all NSW Health mental health policies, programs and service delivery guidelines are implemented by Area Health Services.

Recommendation 6

Page 55

That the Minister for Health ensure additional resources are made available for community crisis teams and the adequate case management of people with a mental illness in the community.

Recommendation 7**Page 55**

That NSW Health develop a program of assertive case management for the sustainable long-term management of people with a mental illness in the community and that the Minister for Health provide long term recurrent funding to support such a program. Such a model should be based on the Assertive Community Treatment program developed in the USA, and include:

- a multidisciplinary team of psychiatric inpatient staff, including case managers, a psychiatrist, several nurses, social workers, vocational specialists and substance abuse treatment specialists, operating a 24 hour, 7 days per week service
- comprehensive treatment planning, ongoing responsibility, staff continuity and small case loads, most commonly with 1 staff member for every 10 clients and
- targeting individuals with the greatest need to ensure cost efficiency, particularly those with multiple hospitalisations.

Recommendation 8**Page 59**

That the Minister for Health introduce a needs assessment in all mental health related areas to identify the gaps in services and that an expert advisory committee be established to oversee the assessment.

The committee should consist of eminent people with knowledge of successful rehabilitation models operating throughout the world. The committee should be allocated recurrent funding as a guarantee, in order to:

- plan a comprehensive range of services and
- continue as a monitoring and evaluation group once the model is operational.

Recommendation 9**Page 63**

That the Minister for Health recognise the need and demand for rehabilitation services and facilities for people with a mental illness and retain and establish more medium to long-term managed psychiatric beds within designated facilities for people with a mental illness.

Recommendation 10**Page 63**

That NSW Health establish Rozelle Hospital as an asylum for the mentally ill, in the true meaning of the concept. The facility should be gazetted under the *Mental Health Act 1990* and provide medium to long-term rehabilitation services for people with a mental illness. The hospital grounds must be clearly recognised as a health facility and not considered public space.

Recommendation 11**Page 63**

That NSW Health increase the number of long term rehabilitation facilities in appropriate settings for people with a mental illness.

Recommendation 12**Page 64**

That NSW Health undertake to clearly and adequately define the roles of the public and private mental health sectors within the mental health system for treatment, care and general service provision and ensure that these roles and funding streams be transparent.

Recommendation 13**Page 64**

That the proposed Office of Mental Health assume responsibility for ensuring that the roles and funding streams within the mental health system are transparent at all times.

Recommendation 14**Page 64**

That the Minister for Health, in supporting the establishment of an Office of Mental Health within the NSW Premier's Department, require Area Health Services to provide monthly incidence and outcome reports to the Office of Mental Health.

Recommendation 15**Page 66**

That the Minister for Health ensure carers are assessed for their capacity to support people with a mental illness, are included in the planning of care programs and assisted to access support for themselves.

Recommendation 16**Page 66**

That NSW Health ensure that carers are included in discussions for determining assertive care plans and Community Treatment Orders.

Recommendation 17**Page 71**

That the Minister for Health develop a proposal for consideration by the Commonwealth Ministers for Health and Education, that outlines the need for national undergraduate nursing courses to contain an assessable mandatory mental health training component, including practical training. The proposal should indicate the NSW Government's support for the following recommendations by the Senate Community Affairs Committee Inquiry into Nursing:

- that the Commonwealth fund scholarships for psychiatric/mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course (Recommendation 76)
- that funding be provided for the development of advanced practice courses in mental health nursing (Recommendation 78).

Recommendation 18**Page 71**

That the Minister for Health develop and initiate a targeted campaign to improve the status and image of mental health nursing, in accordance with Recommendation 77 of the Senate Community Affairs Committee Report on the Inquiry into Nursing:

- that a targeted campaign be undertaken to improve the status and image of mental health nursing.

Recommendation 19**Page 73**

That the Minister for Health immediately appoint authorised Nurse Practitioners and that positions with in-principle approval be considered for appointment as a matter of urgency, particularly within mental health.

Recommendation 20**Page 73**

That the Minister for Health appoint an eminent clinician as a specialist advisor to:

- review the Nurse Practitioner implementation policy, evaluate the role and effectiveness of Area Health Services in the process and
- ensure medical groups participate in the process of appointing Nurse Practitioners, particularly within mental health.

Recommendation 21**Page 75**

That, in addition to increasing and better targeting funding for respite and support programs run by non-government organisations, NSW Health develop, fund and coordinate the establishment of a central support program for the carers of people with a mental illness, including respite care services.

Recommendation 22**Page 79**

That the position of the Principal Official Visitor:

- be located within the proposed Office of Mental Health in the NSW Premier's Department and
- be either designated as a full-time position, or that the Principal Official Visitor establish an adequate consultation period for Official Visitors during office hours.

Recommendation 23**Page 86**

That the Minister for Health utilise the authority of the *Health Services Act 1997* to ensure that mental health funds are being allocated and expended by Area Health Services in accordance with NSW Health policies.

Recommendation 24**Page 90**

That the Centre for Mental Health consider and determine the funding allocation for statewide programs run by non-government organisations.

Recommendation 25**Page 95**

That the Minister for Health immediately initiate and support a formal process where Area Health Service mental health directors report directly to the Chief Executive Officer of the relevant Area Health Service for the purposes of monitoring program movements and allocations.

Recommendation 26**Page 95**

That each Area Health Service publish in its annual report, detailed and transparent information regarding mental health funding allocations and direct mental health expenditure.

Recommendation 27**Page 96**

That the Minister for Health work with the Auditor-General to develop and initiate the following audit programs:

- a performance audit of mental health budget allocation and expenditure from July 2003 to 30 June 2004 in NSW, and that the performance audit report be tabled in Parliament
- an audit plan designed for the annual audit of Area Health Services and service providers (hospitals and affiliated health organisations), that includes disclosure of mental health funding allocation and expenditure. Expenditure of mental health funding on non-mental health programs should be reported.
- an on-going audit program to include both the current financial audit, as well as a physical audit of hospitals and other mental health service providers, to ensure that staffing, infrastructure and auxiliary budget costs are directly hypothecated.

Recommendation 28**Page 96**

That NSW Health develop and implement a set of Key Performance Indicators for inpatient mental health services in public hospitals, and that these Key Performance Indicators be linked to service performance agreements and funding allocation. The performance against these Key Performance Indicators should be reported in each Area Health Service annual report.

Recommendation 29**Page 96**

That the Minister for Health establish a Mental Health Quality Care Committee within each Area Health Service. The functions of the Mental Health Quality Care Committee should include:

- reporting to the Area Health Service Board and the Centre for Mental Health
- developing a means by which the quality of clinical and secondary care to consumers within the Area can be defined, measured, monitored, reported and improved and
- collecting, collating and analysing Area Key Performance Indicator data and reporting findings to the Area Board and the Centre for Mental Health.

Recommendation 30**Page 104**

That the Minister for Health and the Attorney General review the *Guardianship Act 1987* with respect to people who suffer severe and/or episodic mental illnesses during which they are not capable of making informed consent. This review should include the possibility of enduring guardianship.

Recommendation 31**Page 104**

That the Centre for Mental Health and the Office of the Public Guardian work together to develop an information package for mental health professionals that:

- outlines their obligations as well as the rights of families and carers under relevant mental health, privacy and guardianship legislation, and
- clarifies the existing definitions of ‘consent’ and ‘substitute decision-making’ in mental health settings and communicate this clarification to mental health professionals.

Recommendation 32**Page 104**

That the Minister for Health prepare a proposal for consideration by the Minister for Education to ensure that students in undergraduate and postgraduate health programs receive training regarding:

- their obligations to seek information from and disclose information to consumers, families, guardians, carers and other service providers, and
- the rights of consumers, families and carers under the relevant mental health, privacy and guardianship legislation.

Recommendation 33**Page 108**

That the Minister for Health seek to amend the NSW *Mental Health Act 1990* to allow limited disclosure of confidential information about clients of mental health services without the consent of the client. These exceptions to confidentiality would allow information to be disclosed in the following circumstances:

- to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client and the person who is receiving the information will be involved in providing the care and
- where it is required in connection with the further treatment of a client.

Recommendation 34**Page 108**

That, prior to the operation of the *Health Records Information Privacy Act 2002* in 2003, NSW Health and the NSW Privacy Commission ensure that public and non-public health care service providers, be provided with adequate information and training about consent and substitute decision-making laws in NSW.

Recommendation 35**Page 108**

That the Minister for Health allocate funds for the training of public health employees on the requirements of the *Health Records Information Privacy Act 2002*.

Recommendation 36**Page 110**

That the Centre for Mental Health prepare guidelines on limited disclosures under the *Health Records and Information Privacy Act 2002* and ensure these guidelines are:

- incorporated into a privacy protocol within the Memorandum of Understanding between NSW Health and the NSW Police Service and
- communicated to all mental health workers and police across NSW.

Recommendation 37**Page 110**

That NSW Health ensure that the NSW Police Service has access to mental health services on a 24 hour basis for support and urgent advice.

Recommendation 38**Page 111**

That the Minister for Health seek a further amendment to the NSW *Mental Health Act 1990* to enable guardians, family and primary carers to obtain an interim court order for:

- the release of confidential information from a health care provider or
- an urgent assessment of an individual's mental health, where it can be established there is a reasonable belief that there is:
 - a serious and imminent threat to the life, health or safety of the individual or another person or
 - a serious threat to public health or public safety.

Recommendation 39**Page 116**

That the Minister for Health ensure, through a process of monitoring and review, that the Mental Health Outcomes Assessment Tools do not have an adverse impact on clinical service provision.

Recommendation 40**Page 127**

That the Minister for Health increase the number of supported accommodation places for people with mental disorders in NSW from 1,635 to 2,635 over the next two years, and that an average of 12 adult beds per 100,000 are available for 24-hour per day high level supported residential services.

Recommendation 41**Page 127**

That NSW Health match the level of funding provided by the NSW Department of Ageing, Disability and Home Care for 24 hour supported accommodation packages for people with psychiatric disabilities.

Recommendation 42**Page 132**

That NSW Health inquire into and report publicly on the shortfall in support and case management services for people with a mental illness who are accommodated in public housing, and allocate adequate resources to meet the identified shortfalls.

Recommendation 43**Page 133**

That the proposed Office of Mental Health oversee the implementation of effective, coordinated support services for people with a mental illness living in public housing. This will require monitoring service agreements at state and local level between the NSW Departments of Housing, Health, Community Services and Ageing, Disability and Home Care.

Recommendation 44**Page 133**

That NSW Health and the NSW Department of Housing establish a clustered housing (intensive, managed) project for people with a mental illness who have had difficulty maintaining public housing tenancies.

Recommendation 45**Page 135**

That NSW Health, the NSW Department of Community Services, the NSW Department of Ageing, Disability and Home Care and the NSW Department of Housing, cooperate to conduct an assertive outreach campaign that includes raising the awareness of boarding house residents and landlords about residents' rights to health care, mental health care, legal services and other services relevant to their needs.

Recommendation 46**Page 135**

That the NSW Government fund the continuation and expansion of the Boarding House Reform Strategy.

Recommendation 47**Page 139**

That NSW Health publish a report on the outcomes of the *Framework for Housing Accommodation Support for People with Mental Health Problems and Disorders* within 6 months and then annually. The reports should include information from Area Health Services on:

- consumer satisfaction indicators
- waiting list numbers for supported accommodation places and public housing and
- indicators of unmet need at all local area levels.

Recommendation 48**Page 144**

That the NSW Departments for Housing, Community Services, Health, Ageing Disability and Home Care and Attorney General, coordinate to immediately initiate a specialist supervised and supported accommodation or 'bail hostel' program across NSW, for homeless people with a mental illness who have been charged with an offence.

Recommendation 49**Page 144**

That the Attorney General propose amendments to the NSW *Bail Act 1978* to legislate for the provision of supervised and supported bail hostels for people with a mental illness.

Recommendation 50**Page 147**

That NSW Health evaluate the success of existing pilot programs for homeless people with a mental illness and:

- discontinue programs shown not to be effectively and efficiently achieving their planned outcomes
- expand funding to programs identified as effectively and efficiently achieving planned outcomes.

Recommendation 51**Page 149**

That the Partnerships Against Homeless initiative be expanded to include key non-government agencies that deliver services to homeless people.

Recommendation 52**Page 150**

That the participating agencies in Partnerships Against Homelessness, in collaboration with Supported Accommodation Assistance Program services, establish coordinated referral systems between participating agencies.

Recommendation 53**Page 150**

That the participating agencies in Partnerships Against Homelessness, fund assertive outreach services among homeless people in areas where the incidence of homelessness is identified as particularly high.

Recommendation 54**Page 150**

That the NSW Department for Housing and NSW Health develop a simple Housing Risk Identification Tool, which can serve as a proactive measure for managing an individual's housing risks. This should be incorporated into an 'Early Intervention Manual for People with Mental Illnesses at Risk of Homelessness'.

Recommendation 55**Page 150**

That NSW Health and the NSW Department of Housing adopt a housing strategy for people with a mental illness similar to the 'Joined Up Initiatives' program in Victoria where:

- the NSW Department of Housing allocates suitable housing stock for mentally ill people with complex needs and
- NSW Health funds non-government organisations to manage residential rehabilitation programs using the allocated housing stock.

This strategy should be developed and implemented within 6 months and allocation of housing stock commenced within 12 months of the strategy implementation.

Recommendation 56**Page 156**

That NSW Health and the Centre for Mental Health develop information packages or 'care kits' for consumers that will enhance access to information facilitating self-care. Kits should contain information such as:

- contact details from the Health Care Interpreter Service and the Telephone Interpreter Service
- contact details and locations of 24 hour crisis services and
- rehabilitation options available, such as case management and multidisciplinary care as well as contact details for access to such services.

Recommendation 57**Page 156**

That NSW Health develop and conduct a consumer and carer perception survey for people from culturally and linguistically diverse backgrounds to:

- identify satisfaction with the manner and attitudes of mental health professionals in delivering services, and
- assist in development of staff training programs designed to improve focus on individual care and flexibility in providing treatment suitable to the patient's needs.

Recommendation 58**Page 157**

That NSW Health provide, in accordance with its *Caring for Mental Health in a Multicultural Society* policy, a strategy to improve access to appropriately trained health care interpreters and services for people from culturally and linguistically diverse backgrounds, including:

- adequate funding so that bilingual crisis services are provided 24 hours per day
- recruitment of more interpreters and bilingual mental health workers in a broad range of language groups and
- education for mental health professionals about effective use of interpreters in clinical settings and referral of consumers and carers to the Health Care Interpreter Service and the Telephone Interpreter Service.

Recommendation 59**Page 157**

That NSW Health work with the Transcultural Mental Health Centre to develop and implement a cultural training program that requires:

- the participation of all mental health professionals and staff and
- ongoing cultural sensitivity training relative to the client group they support.

Recommendation 60**Page 157**

That NSW Health develop and initiate a program tailored for General Practitioners to inform them of the full range of public mental health service options available to people from culturally and linguistically diverse backgrounds.

Recommendation 61**Page 157**

That NSW Health investigate and implement support initiatives for carers of mental health consumers from culturally and linguistically diverse backgrounds, including counselling services with bilingual interpreters.

Recommendation 62**Page 164**

That as part of its review of any Aboriginal Mental Health Policy, NSW Health should:

- review Aboriginal Mental Health Worker numbers and their distribution in NSW
- assess obstacles and incentives to recruit and retain Aboriginal Mental Health Workers in NSW and
- integrate review findings into the new Aboriginal Mental Health Policy.

Recommendation 63**Page 165**

That NSW Health, as part of any new Aboriginal Mental Health Policy, develop a strategy for recruiting and adequately resourcing Aboriginal Mental Health Workers throughout NSW.

Recommendation 64**Page 165**

That NSW Health continue to work towards partnerships between mainstream mental health services and Aboriginal community-based mental health services, including trial partnerships between local general practitioners and Aboriginal Mental Health Teams.

Recommendation 65**Page 165**

That the Minister for Health develop a proposal to the Commonwealth Ministers for Health and Education to initiate a post-graduate module in Aboriginal Mental Health for nursing and health related courses.

Recommendation 66**Page 165**

That the Minister for Health provide at least three fully funded scholarships for psychiatric nurses undertaking the proposed post-graduate module in Aboriginal Mental Health on an annual basis.

Recommendation 67**Page 166**

That NSW Health implement a policy that requires the Aboriginal and Torres Strait Islander Medical Service be involved, with the consent of the patient, once an Aboriginal and Torres Strait Islander 0person is admitted to hospital for psychiatric care and later when discharged.

Recommendation 68**Page 186**

That the Minister for Health provide additional funding to the Centre for Mental Health for the purposes of reintroducing an integrated service program for people with a mental illness and substance use disorder.

Recommendation 69**Page 186**

That the Centre for Mental Health develop and conduct a training program for drug and alcohol workers designed to increase the awareness and knowledge of mental illnesses and mental health practices.

Recommendation 70**Page 197**

That NSW Health and the NSW Department of Ageing, Disability and Home Care collaborate to develop policies and structures to enable intellectually and physically disabled people with mental health needs, to access appropriate mental health services, particularly where residents in institutions move into the community. This would include:

- inter-departmental ‘Service Agreements’ across NSW that require regular meetings between area mental health and disability teams to facilitate a collaborative approach to exchange of information and recommendations
- initiating a professional development program for disability and mental health sector professionals to better understand dual diagnosis and protocols and procedures necessary to provide appropriate services to people with dual diagnosis.

Recommendation 71**Page 197**

That the Minister for Health include a module on intellectual disability, for inclusion in the proposal suggested at Recommendation 17, regarding national undergraduate nursing courses.

Recommendation 72**Page 197**

That NSW Health liaise with general practitioner and specialist representatives to develop and implement a continuing medical education program designed to improve the knowledge and understanding of intellectual disability and dual diagnosis.

Recommendation 73**Page 197**

That the Centre for Mental Health support and promote further research into the identification and diagnosis of intellectually disabled people with mental health needs, with a view to:

- reviewing current intake and support protocols for mental health services
- to promote interagency cooperation, including non-government service providers
- providing consistent quantitative and qualitative information which can be used to develop more effective service provision and evaluate treatment outcomes.

Recommendation 74**Page 198**

That NSW Health and the NSW Police Service revise section 11.5 of the *Memorandum of Understanding between NSW Police and NSW Health* to:

- recognise dual diagnosis (mental illness/intellectual disability) as separate but frequently overlapping special needs groups
- require that local dual diagnosis protocols between police, mental health services, drug and alcohol services, and ageing and disability services include quarterly review meetings between local service partners.

Recommendation 75**Page 198**

That NSW Health, in consultation with mental health services, the NSW Police Service, and other stakeholders, develop a service protocol for people with an intellectual disability and behavioural disorder who are frequently presented to mental health facilities for assessment but not admitted.

Recommendation 76**Page 198**

That NSW Health consider intellectual disability within the court liaison program for people with suspected or confirmed intellectual disability and mental illness.

Recommendation 77**Page 203**

That the *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* be revised to include guidelines recommending a range of social and diversionary activities to assist with the treatment of symptoms of depression.

Recommendation 78**Page 203**

That NSW Health develop and implement strategies for improving referral rates of older people to psychiatrists, and that referral rates be monitored to identify whether or not more older people are referred as a result of the *Consensus Guidelines for the Assessment and Management of Depression in the Elderly*.

Recommendation 79**Page 205**

That NSW Health develop systems to ensure access for older people in residential facilities to Aged Care Mental Health Teams.

Recommendation 80**Page 207**

That NSW Health ensure that its new mental health care strategy for the aged and accompanying service plan for the aged in NSW includes:

- consultations with stakeholders, funders and providers
- defined roles and responsibilities for stakeholders, funders and providers in implementing and delivering the plan
- regional population projections as part of service planning and infrastructure provision
- clarification of intergovernmental responsibilities for dementia and co-existing mental health problems
- clarification of the role of community health teams and services in relation to private or non-government organisations residential settings and
- timelines for achievements with annual reporting requirements.

Recommendation 81**Page 213**

That the Minister for Health collaborate with the non-government and private sectors to establish and fund the following facilities across metropolitan and regional NSW:

- purpose built high quality psychogeriatric nursing homes and
- purpose built acute care psychogeriatric units in hospitals.

The Minister for Health should seek Commonwealth funding assistance for this purpose, although establishment of facilities should not be contingent on Commonwealth funds.

Recommendation 82**Page 213**

That NSW Health should, when a sufficient number of psychogeriatric nursing homes and acute care psychogeriatric units are operational:

- develop individual service plans for existing Confused and Disturbed Elderly (CADE) unit residents guaranteeing ongoing treatment and accommodation
- transfer all CADE unit residents to high quality psychogeriatric facilities and then
- close or redevelop the nine CADE units currently operating in NSW.

Recommendation 83**Page 214**

That NSW Health conduct an awareness program for mental health professionals to:

- assess the level of care required for a person with a mental illness in conjunction with the age and physical condition of the carer
- where necessary, refer the carer to information about alternative care and guardianship arrangements and
- seek respite care services for people with a mental illness and their elderly carers.

Recommendation 84**Page 223**

That NSW Health urgently establish and recruit staff for child and adolescent acute units in each major region of NSW, with bed numbers based on a population distribution formula.

Recommendation 85**Page 223**

That the Minister for Health immediately implement procedures to eliminate or minimise the incidence of adolescents being placed in adult psychiatric wards.

Recommendation 86**Page 224**

That the Minister for Health direct that, where no psychiatric facilities are available for young people in a hospital, specialist staff should be assigned to adolescent beds in paediatric wards for the duration of all adolescent admissions.

Recommendation 87**Page 224**

That the Minister for Health, in relation to people who have attempted suicide and been admitted to hospital as mentally disordered:

- propose the *Mental Health Act 1990* be amended to require a post-discharge assessment appointment
- the appointment be allocated and the patient informed of the appointment and
- the assessment be conducted within 5 days of discharge.

Recommendation 88**Page 224**

That NSW Health ensure that discharge plans are created for all young people admitted to an acute care facility to ensure continuous post-discharge care. The discharge plan must include an appointed case manager.

Recommendation 89**Page 227**

That NSW Health ensure that when young people in early psychosis programs are discharged, where required, individual service plans should include medium to long-term rehabilitation and supported accommodation.

Recommendation 90**Page 227**

That NSW Health fund and provide support for adequate places in medium to long-term rehabilitation and supported accommodation for young people requiring such support following their first episode of psychosis.

Recommendation 91**Page 228**

That NSW Health publish a progress report on the implementation of *Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales* within six months.

Recommendation 92**Page 228**

That NSW Health cooperate with other mental health service providers in NSW, to produce a service framework for accommodation and rehabilitation for young people following acute episodes of mental illness.

Recommendation 93**Page 228**

That the NSW Department of Education and Training, in consultation with NSW Health and non-government service providers, develop and provide specialist, supported and task-focused vocational and employment training programs for young people with a mental illness. The programs should focus on young people with varying degrees of cognitive, social or communication difficulties secondary to mental illness who may not succeed in mainstream training programs or paid employment.

Recommendation 94**Page 230**

That NSW Health investigate and evaluate pilot programs to manage young people with a mental illness and substance abuse problem while addressing the following objectives:

- expansion of such programs across metropolitan, rural and regional NSW
- to inform further local area mental health planning.

Recommendation 95**Page 232**

That NSW Health initiate a program to encourage general practitioners to utilise Telepsychiatry services in child and adolescent mental health, to improve the availability of specialist psychiatric services.

Recommendation 96**Page 232**

That NSW Health fund support services on a statewide basis to children and young people with parents with a mental illness.

Recommendation 97**Page 238**

That the Minister for Health seek to amend section 22 of the *Mental Health Act 1990*, to incorporate criteria with which medical practitioners must comply before they can request police escort of mental health patients under Section 22 (1) (a).

Recommendation 98**Page 238**

That NSW Health initiate and maintain a mental health patient transfer service for the transport of people with a mental illness that includes:

- vehicles staffed by appropriately trained mental health professionals
- all inter-hospital transfers including, from emergency departments to mental health facilities
- return of missing patients (non-violent) and
- breaches of community treatment and community counselling orders.

Recommendation 99**Page 245**

That the Minister for Health and the Minister for Police initiate a mandatory comprehensive training program to provide all police officers with training to better respond to mental health problems in the community. The training program should be funded by NSW Health and include training in:

- recognition of common and significant psychiatric problems
- techniques to deal with people with a mental illness and
- understanding of the relevant legislation and associated legal issues.

Recommendation 100**Page 245**

That the most recent Memorandum of Understanding between NSW Health and NSW Police include as signatories, nursing, general practice and medical specialist area representative groups.

Recommendation 101**Page 246**

That the proposed Office of Mental Health within the NSW Premier's Department should, after 12 months operation of the Memorandum of Understanding Revision 2002:

- conduct a review of the instrument's operation
- amend the instrument as required and
- seek to amend the *Mental Health Act 1990* to incorporate key components of the Memorandum of Understanding.

Recommendation 102**Page 246**

That NSW Health require all Area Health Services to introduce or improve security arrangements at public hospitals and mental health units in NSW for the purposes of monitoring and managing mental health patients.

Recommendation 103**Page 246**

That NSW Health require all Area Health Services to monitor and report publicly on the incidence of the 'absence without leave' (AWOL) of mental health patients from public hospitals and mental health units. These reports should include:

- the incidence of AWOL from the hospital or unit
- a record of all reasonable attempts made to locate the missing patient and
- the incidence of requests by hospitals for police assistance in locating and returning of missing mental health patients.

Recommendation 104**Page 246**

That the Minister for Health provide funding to NSW Health to increase specialist mental health staff so that hospitals can manage the detention and care of a person presented by police under sections 21, 22 and 24 of the *Mental Health Act 1990*.

Recommendation 105**Page 246**

That the proposed Office of Mental Health (see Recommendation 1), when established, should initiate and oversee the coordination of an inter-agency specialised program for the care of persons with a mental disorder not currently recognised under the *Mental Health Act 1990*.

Recommendation 106**Page 248**

That the Minister for Health ensure that the contracts for employment of consultant psychiatrists with Corrections Health Service require them to only address patient treatment related needs.

Recommendation 107**Page 248**

That the Minister for Health increase funding to employ additional psychiatrists to meet the increased forensic mental health assessment, consultation and treatment needs.

Recommendation 108**Page 250**

That the Minister for Health implement a formal agreement with the Mental Health Review Tribunal for the supervision and management of released forensic patients, including:

- clarification of the responsibility of clinical services in the monitoring and reporting of clinical supervision, including the role of the Mental Health Review Tribunal in monitoring progress and
- clarification of formal procedures for managing breaches of release conditions.

Recommendation 109**Page 256**

That as a matter of urgency the Minister for Health finalise plans, allocate funding and provide all other support necessary to construct a secure forensic mental health unit outside the perimeter of Long Bay Correctional Complex and that the facility be staffed by health professionals and non-corrections personnel.

Recommendation 110**Page 256**

That the Minister for Health allocate funding for the development of plans to construct further maximum and medium security forensic mental health units in NSW, in order to meet the projected needs of the increasing population.

Recommendation 111**Page 256**

That the Minister for Health ensure that there is sufficient minimum security accommodation to avoid undue detention of patients in medium security units.

Recommendation 112**Page 256**

That the Minister for Health and the Minister for Corrective Services immediately act to exempt forensic patients from wearing prison attire.

Recommendation 113**Page 258**

That NSW Health allocate additional resources to the receptions screening program, including adequate funding and staffing to ensure that remand inmates with a mental health problem are identified.

Recommendation 114**Page 262**

That the Minister for Health and Minister for Corrective Services ensure that, in relation to the current review of conditions of the Mum Shirl Unit, Mulawa Correctional Centre:

- the Chair of the review committee is provided with adequate funding and administrative resources to expedite the review and
- recommendations of the review committee be implemented without delay.

Recommendation 115**Page 262**

That the Minister for Health fund a secure forensic mental health facility for women.

Recommendation 116**Page 263**

That NSW Health provide the Governor of Mulawa Correctional Centre with funding to improve the facilities for the treatment of women with a mental illness or disorder. The funding allocation should cover the following:

- comprehensive occupational health and safety review by an independent WorkCover accredited consultant and
- implementation of the occupational health and safety review recommendations.

Recommendation 117**Page 263**

That the Minister for Health and the Minister for Corrective Services ensure that any future maximum and medium security forensic hospital built in NSW should incorporate segregated accommodation suitable to male and female patients.

Recommendation 118**Page 265**

That NSW Health continue to extend the Court Liaison Service to all regions, including enhanced funding and resources for existing services.

Recommendation 119**Page 271**

That the Attorney General and the Minister for Health cooperate to expedite the establishment of a State Institute of Forensic Science, and include forensic mental health within its responsibilities. Features relating to forensic mental health to be incorporated within the State Institute of Forensic Science include:

- provision of forensic mental health services, including court liaison services and court reports
- responsibility as a provider for all forensic psychiatric services in NSW
- a Board of Management to oversee operations and
- a State Forensic Mental Health Service located within the State Institute of Forensic Science which reports through the State Institute of Forensic Science Board to the Director General of NSW Health.

Recommendation 120**Page 271**

That NSW Health evaluate the model and structure of mental health services provided by Forensicare at the Thomas Embling Hospital in Victoria with a view to implementing this model for any planned forensic hospital facility in NSW.

Glossary

Acquired brain injury	A loss of brain function incurred some time after birth, caused by a blow to the head, drug and alcohol use, poisoning, stroke, brain tumours, lack of oxygen, infections or other diseases or conditions. Long and short term effects can be cognitive, behavioural, physical or social in nature.
Acute	Recent onset of severe clinical symptoms of mental illness.
Advocate	Person who intercedes for and acts on behalf of a client when the client is unable to do so.
Affective disorder	Also known as mood disorder. A range of conditions that includes depression, bipolar disorder (manic depressive illness) and mania.
Anxiety disorder	An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal defined according to clinically derived standards of psychiatric diagnostic criteria.
Area Health Service	The area health service system was first established under the <i>Area Health Services Act 1986</i> . However, that system was restricted to certain metropolitan areas of the State. The system of area health services established by the <i>Health Services Act 1997</i> extends throughout the whole of the State.
Asylum	A place of refuge, retreat, safety or sanctuary. Hospital specifically set up to treat mentally ill patients
ADHD	Attention Deficit Hyperactivity Disorder. A disorder typified by persistent inattention, hyperactivity, and or impulsive behaviour in almost all settings.
AVO	Apprehended Violence Order. An order made by a court restricting the behaviour of the person the order is taken out against. The purpose of an AVO is to protect the person taking out the order from violence, harassment or intimidation in the future.
Bed	A means of measuring how many consumers can be adequately housed, supported or treated in a given facility per night.
Bipolar disorder	A mental illness characterised by alternating periods of mania, hypermania and depression, usually with an intervening period of normal function. Also known as bipolar affective disorder, bipolar mood disorder, manic depression.
CADE unit	Confused and Disturbed Elderly Unit. Specialist hospital unit providing care for older people who have a primary diagnosis of dementia or psychogeriatric diagnosis with onset of dementia.
Capable	Where a person is determined to be able to make informed, rational decisions.
Carer	A person whose life is affected by virtue of a close relationship and a caring role with a consumer.
Case management	The mechanism for ensuring continuity of care across inpatient and community settings, for access to and co-ordination of the range of services necessary to meet the individual and identified needs of a person within and outside the mental health service.
Chronic	Of lengthy duration or recurring frequently, often with progressive seriousness.

Comorbidity	The co-occurrence of two or more disorders.
Consent	Where the client provides permission for a specific treatment to occur based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission and their knowledge of available alternative treatments.
Consumer	A person utilising, or who has utilised, a mental health service.
Criminal insanity	A legal description of a person labouring under such a defect of reason from mental illness as not to know what they are doing, or, if they did know, they did not know they were doing it, or they did not know they were doing what was wrong.
CTO	Community Treatment Order. Authorises psychiatric treatment that has been prescribed by a medical practitioner. A patient who is subject to a Treatment Order is required to undergo the authorised treatment, even if they do not want to. A Treatment Order can only be made in relation to a person with a mental illness. There are set criteria in the law that must be met before a Treatment Order can be made.
Deinstitutionalisation	The transition from institution to community. Since the 1950s the term has been associated with the closure of large state ‘asylums’ and the dispersion of their former patients into the community.
Dementia	A chronic or persistent disorder of the mental processes due to organic brain disease. It is marked by short term memory loss, changes in personality, deterioration in personal care, impaired reasoning ability, and disorientation.
Depression	A sustained sad mood or lack of pleasure defined according to standard diagnostic criteria.
Disability	A condition that makes a person unable to perform in a usual manner.
Diversion	The practice of referring people entering or at risk of entering the criminal justice system into programs in which they can develop personal skills and avoid future imprisonment.
DSM-IV	The Diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association to assist in the accurate identification of mental disorders. The fourth edition (IV) is current.
Dual diagnosis	A diagnostic description of a person suffering from the combined effects of mental illness and intellectual disability.
Duty of care	Duty of care requires everything reasonably practical to be done to protect the health and safety of a person in one’s care.
ECT	Electroconvulsive therapy. A treatment for severe depression and sometimes for schizophrenia and mania. A convulsion is produced by passing an electric current through the brain. Use of ECT is restricted by the <i>NSW Mental Health Act 1990</i> .
Forensic patient	A person unfit to plead on a criminal offence because of mental illness, or not guilty by reason of mental illness, or a person on remand in a prison hospital and waiting for psychiatric assessment.
Intellectual disability	A disability caused by significantly sub-average general intellectual functioning that is accompanied by limitations in functioning in at least two of the following skills areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, health and safety, leisure, and work.

Involuntary patient	Also known as a scheduled patient. A person who is mentally unwell, fails to recognise they are unwell and is admitted to hospital for compulsory treatment. Involuntary patients cannot discharge themselves from hospital.
Mental health	A dynamic process in which a person's physical, cognitive, affective, behavioural and social dimensions interact functionally with one another and with the environment.
Mental Health Act 1990	The <i>Mental Health Act 1990</i> governs the care of people with severe mental illness in NSW. The Act provides for involuntary admission and treatment of a person who is considered to be a danger to themselves or others.
Mental health problem	A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.
MISA	Mental Illness Substance Abuse comorbidity. Where a person has a coexisting mental illness and drug and alcohol abuse problem.
Mental illness	According to the <i>NSW Mental Health Act 1990</i> , a mental illness is a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (a) delusions, (b) hallucinations, (c) serious disorder of thought form, (d) a severe disturbance of mood, (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)-(d).
Mentally disordered	A state in which someone is not mentally ill but is temporarily irrational or a danger to themselves or others.
MH-OAT	Mental Health Outcomes and Assessment Tools. See Chapter 6 of this report for a full description.
Mood disorder	See affective disorder.
Neurotic (non-psychotic) illnesses	A mental illness in which insight is retained but there is a maladaptive way of behaving or thinking that causes suffering. For example, depression, anxiety, phobias or obsessions.
Occupational therapy	A form of therapy in which clients are encouraged to perform useful tasks and develop interests that may either re-establish old skills and knowledge or initiate new ones. The aim is to reach the maximum level of function and independence in all aspects of daily life.
Official visitor	Official Visitors act under the <i>NSW Mental Health Act 1990</i> . They inspect hospitals or health care agencies and make such inquiries as they think necessary as to the care, treatment and control of informal patients and the patients or persons detained in the hospital or subject to a community counselling order or community treatment order and being treated by the health care agency.
Outcome	A measurable change in the health of an individual, or a group of people or population, which is attributable to an intervention or series of interventions.
Paranoia	Individuals afflicted with this disorder assume, with little or no concrete evidence to support the assumption, that others plan to exploit, harm, or deceive them.
Parkinsonism	A disorder that mimics the symptoms of Parkinson's disease, such as slowed movement, expressionless face, shuffling gait, and severe motor tremors.

Personality disorder	A disorder with deeply ingrained and maladaptive patterns of behaviour, persisting through many years, usually commencing in adolescence. The abnormality of the behaviour must be sufficiently severe that it causes suffering, either to the patient or to other people or both.
PTSD	Post-Traumatic Stress Disorder. A disorder that follows a traumatic event such as major disaster, rape, torture or accidents. Involves re-living the event and withdrawal from the external world.
Prevention	Interventions that occur before the initial onset of a disorder. (Commonwealth Department of Aged Care 2000).
Psychiatrist	A licensed physician who treats the biological, psychological, and social components of mental illness simultaneously. They can investigate whether symptoms of mental disorders have physical causes, such as a hormone imbalance or an adverse reaction to medication, or whether psychological symptoms are contributing to physical conditions. Psychiatrists, unlike psychologists and psychiatric social workers, can prescribe medication. They are also able to admit patients to hospital.
Psychogeriatric	A component of the mental health service which targets older people with mental illness who require both specialised mental health and aged care expertise.
Psychologist	A professional who has undertaken scientific study of the human mind and its functions, usually at university level, and has completed the required training to be registered with the relevant state registration body. Psychologists cannot prescribe medication. Some psychologists specialise in particular fields, for example, forensic psychology.
Psychosis	A severe mental derangement, especially when resulting in delusions and loss of contact with external reality. There is often a lack of insight, although memory and intellect tend to remain intact.
Psychotherapy	Psychological methods for the treatment of mental disorders and psychological problems, eg psychoanalysis, family therapy, group therapy.
Psychotropic	A term applied specifically to drugs used to treat mental illness, eg., antidepressants, stimulants, tranquillisers.
Rehabilitation	The process of facilitating an individual's restoration to an optimal level of independent functioning in the community.
SAAP	Supported Accommodation Assistance Program. A partnership approach by Federal and State and Territory governments to address Australian homelessness.
Schedule 5 Hospital	Hospital created under Schedule 5 of the <i>Public Hospitals Act 1929</i> , repealed by the <i>Health Services Act 1997</i> . Originally combined the care of people with mental illness, drug and alcohol problems, developmental disabilities and psych-geriatric problems.
Schedule hospital	A hospital designed to accommodate patients scheduled under sections 21-27 of the <i>Mental Health Act 1990</i> and approved by the Minister
Scheduling	Signing a patient into hospital against their will, under sections 21-27 of the <i>Mental Health Act 1990</i> (see also involuntary patient).
Schizophrenia	A severe mental illness characterised by a disintegration of the process of thinking, of contact with reality, and of emotional responsiveness. Delusions and hallucinations (especially of voices) are usual features, and the person may feel that thoughts, sensations and actions are controlled by or shared with others. The person may become socially withdrawn and lose energy. No single cause of the disease is known. There are strong genetic factors in the causation and environmental stress can precipitate illness.

SSRIs	Selective Serotonin Re-uptake Inhibitors. Medications that inhibit the reuptake of the neurotransmitter serotonin. Used as a treatment for major depression, they have fewer negative side effects than other anti-depressant medications previously widely prescribed.
Stigma	A sign of disgrace or shame associated with an illness.
Supported accommodation	Housing which incorporates any type of tailored service plan for the inhabitant(s). This can range from weekly home visits to 24-hour in-house support staff.
Treatment plan	A plan that states: (a) in general terms, an outline of proposed treatment, counselling, management, rehabilitation and other services to be provided, and (b) in specified terms, the method by which, the frequency with which, and the place at which, the services would be provided, to implement a community counselling order or a community treatment order.
Voluntary patient	A person who is mentally ill, recognises they are unwell, and consents to be admitted to hospital to receive treatment. Unlike involuntary patients, they may discharge themselves from care.

Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AHS	Area Health Services
AMA	Australian Medical Association
ANCD	Australian National Council on Drugs
ARAFMI	Association for Relatives and Friends of the Mentally Ill
ASMOF	Australian Salaried Medical Officers Federation
ATSI	Aboriginal and Torres Strait Islander
AVO	Apprehended Violence Order
B. Miles	B. Miles Women's Housing Scheme
BCP	Bilingual Counsellor Program
CADE unit	Confused and Disturbed Elderly unit
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Services
CAP	Crisis Accommodation Program
CARE	Counselling and Retraining For Employment
CASA	Coalition for Appropriate Supported Accommodation
CASP	Comprehensive Area Service Psychiatrists
CAT	Community Assessment Team
CHS	Corrections Health Service
CTO	Community Treatment Order
DADHC	NSW Department of Ageing, Disability and Home Care
DOCS	NSW Department of Community Services
DSM-IV	The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
ECT	Electroconvulsive Therapy.

ED	Emergency Department
GP	General Practitioner
HACC	Home and Community Care program.
HCCC	Health Care Complaints Commission
HCIS	Health Care Interpreter Service
HREOC	Human Rights and Equal Opportunity Commission
JGOS	Joint Guarantee of Service (for people with a mental illness)
JSDU	Joint Services Development Unit
MDAA	Multicultural Disability Advocacy Association of NSW
MHA	Mental Health Association of NSW
MHCC	Mental Health Co-ordinating Council
MHCCP	Mental Health-Clinical Care and Prevention Model
MHIRC	Men's Health Information and Resource Centre
MH-OAT	Mental Health Outcomes and Assessment Tools
MHQP	Mental Health Quality Portfolio
MHRT	Mental Health Review Tribunal
MHSOP	Mental Health Service for Older People
MISA	Mental Health and Substance Abuse comorbidity
MNCAHS	Mid North Coast Area Health Service
MOU	Memorandum of Understanding
NAPP	National Association of Practising Psychiatrists
NCOSS	Council of Social Service of New South Wales
NGO	Non-Government Organisation
NMHRC	National Health and Medical Research Council
NSMHW	<i>National Survey of Mental Health and Wellbeing (Australia)</i>
NSW CAG	NSW Consumer and Advisory Group

NSW CID	NSW Council for Intellectual Disability
OMNI	Older Men New Ideas
OPC	Office of the Protective Commissioner
OPG	Office of the Public Guardian
PTSD	Post Traumatic Stress Disorder
PWD NSW	People with Disabilities NSW
RACGP	Royal Australian College of General Practitioners
RCP	Regional Coordination Program
SAAP	Supported Accommodation Assistance Program
SCIPP	Select Committee on the Increase in Prisoner Population
SIFS	State Institute for Forensic Science
SSRIs	Selective Serotonin Re-uptake Inhibitors
SWFMHS	Statewide Forensic Mental Health Service
TCF	Triple Care Farm
TIS	Telephone Interpreter Service
TMHC	Transcultural Mental Health Centre
WHO	World Health Organisation
YPPI	Young People and Early Psychosis Intervention

Chapter 1 Background to the inquiry

Terms of reference

- 1.1** On 11 December 2001, the Legislative Council resolved that a Select Committee be appointed to inquire into and report on mental health services in NSW and in particular:
- (a) the changes which have taken place since the adoption of the Richmond Report
 - (b) the impact of changes in psychiatric hospitalisation and/or asylum
 - (c) levels and methods of funding of mental health services in NSW, including comparisons with other jurisdictions
 - (d) community participation in, and integration of, mental health services
 - (e) quality control of mental health services
 - (f) staffing levels in NSW mental health services, including comparisons with other jurisdictions
 - (g) the availability and mix of mental health services in NSW
 - (h) data collection and outcome measures
- 1.2** The Committee was required to table an interim report by 3 September 2002.¹ As a result of a prorogation of Parliament on 20 February 2002, the Legislative Council reinstated the Committee and the inquiry on Wednesday 13 March 2002.² The motion for the terms of reference was originally moved by the Hon Dr Arthur Chesterfield-Evans MLC. Debate on the motion is recorded in the Legislative Council Hansard which may be viewed at the Parliament's website: www.parliament.nsw.gov.au. A link to the debate is provided at the Select Committee on Mental Health homepage.

Conduct of this inquiry

- 1.3** In conducting this public inquiry the Committee endeavoured to:
- facilitate broad and diverse public participation
 - generate public and stakeholder discussion and
 - achieve the above aims in a cost effective and accountable manner.
- 1.4** The Committee applied five mechanisms to achieve these aims.

¹ Legislative Council, *Minutes of Proceedings*, 11 December 2001, pp 1357-1358

² Legislative Council, *Minutes of Proceedings*, 13 March 2002, p 50

- 1.5 Firstly, following receipt of the terms of reference, the Committee issued a media release announcing the inquiry into mental health services in NSW. The intent of the media release was to specifically communicate the following points to the community:

The inquiry will examine how mental health services are now being delivered in New South Wales and the changes which have taken place since the adoption of the Richmond Report in 1983. Issues for particular examination include the impact of changes in psychiatric hospitalisation, community participation in mental health services, the availability and mix of services and the levels and methods of funding.³

- 1.6 The media release was circulated to all major newsprint and electronic media sources. Communication of these media releases to the public is dependent on media interest.

- 1.7 Secondly, the Committee advertised its terms of reference inviting public submissions in the major metropolitan and regional print media delivering to all areas of NSW. Advertisements were placed in the following newspapers during the period 2 February 2002 to 7 February 2002.

Table 1.1 Publications, position and date of advertising of Committee's terms of reference

Publication	Position	Display date	Circulation
Metropolitan⁴			
The Sydney Morning Herald	Early General News	2 February 2002	249,438
The Daily Telegraph	Early General News	2 February 2002	411,790
Major Regionals⁵			
The Land	Early General News	7 February 2002	51,915
Albury Wodonga Border Mail	Early General News	2 February 2002	37,000
Goulburn Post	Early General News	4 February 2002	4,129
Grafton Daily Examiner	Early General News	2 February 2002	7,080
Tweed Daily News	Early General News	2 February 2002	7,418
Wagga Daily Advertiser	Early General News	2 February 2002	20,300
Orange Central Western Daily	Early General News	2 February 2002	7,817
Tamworth Northern Daily Leader	Early General News	2 February 2002	9,428
Illawarra Mercury	Early General News	2 February 2002	52,000
Bathurst Western Advocate	Early General News	2 February 2002	6,102
Broken Hill Truth	Early General News	2 February 2002	7,665
Coffs Harbour Advocate	Early General News	2 February 2002	20,807
Griffith Area News	Early General News	5 February 2002	4,900
Lismore Northern Star	Early General News	2 February 2002	19,500
Maitland Mercury	Early General News	2 February 2002	5,977
Newcastle Herald	Early General News	2 February 2002	77,425
Dubbo Daily Liberal	Early General News	2 February 2002	9,761

³ Select Committee on Mental Health, Media Release, Monday 4 February 2002

⁴ Circulation source: Media Monitors, *Mediadirectory*, July 2001, Vol 17, No 5

⁵ Circulation source: Government Advertising Agency, *Media Rate List*, July 2001 to June 2002

- 1.8 The combined print media circulation for the Committee's terms of reference was 1,010,452 at a cost of \$11,577.56.
- 1.9 Thirdly, the Committee utilised the Parliament of New South Wales' web site (www.parliament.nsw.gov.au) to create a homepage to enable visitors to generate and forward electronic submissions.
- 1.10 Fourthly, the Committee wrote to 174 stakeholder groups informing them of the Committee's inquiry into mental health services in NSW and inviting them to make submissions.
- 1.11 Finally, the Committee disseminated details of scheduling of its public hearings to numerous media outlets across NSW. Media releases were distributed to print, television and radio media in an effort to inform as widely as possible. Information on public hearings was also posted on the Committee homepage.
- 1.12 At the time of preparing this report, the Committee had received 302 submissions for the inquiry. The following table outlines the submissions by respondent type.

Table 1.2 Number and percentage of submissions by organisation type

Respondent Type	No of Submissions	Percentage of total
Private citizen	160	53.0
Private organisation/interest group (includes university research centres and local government)	126	41.7
State/ Federal Government agency (includes Area Health Services)	16	5.3
Total	302	100

- 1.13 The Committee conducted 12 hearings at Parliament House, Sydney with 91 witnesses attending these hearings (see Appendix 3). The Committee made travel arrangements for a number of witnesses attending from rural and regional areas.
- 1.14 On 7 August 2002, the Committee held a public forum to provide private citizens with an opportunity to describe their experiences with the NSW mental health system. Approximately 80 people attended the forum, and 27 people were chosen by ballot to present their views and suggestions to the Committee. The list of speakers at the forum appears at Appendix 4.
- 1.15 The Committee received a significant number of submissions from consumers, carers and family members of people with a mental illness. The forum was an opportunity to gain first-hand accounts of the experiences of consumers, families and carers. The Committee thanks the people who appeared at the forum for their courage in speaking about often very painful experiences. Through their stories, the Committee gained a direct knowledge of the needs of those who use mental health services and the problems that exist.
- 1.16 Common experiences and concerns among speakers included:
- the lack of, and restrictions on, access to mental health services

- the many ‘gaps’ which exist in the mental health system
- the emotional and financial costs to families with a member who has a mental illness
- the lack of supported accommodation and rehabilitation options for people with chronic disability due to mental illness
- the need for carers to be able to give and receive information about the person they care for.

1.17 The Committee incorporated these and other issues raised at the forum into this report and its recommendations.

1.18 On 29 July 2002, the Committee conducted two site visits to correctional facilities – Long Bay Hospital at Long Bay Correctional Complex, and the Metropolitan Remand and Reception Centre (MRRC) and Mulawa Correctional Centre at the Silverwater Complex. The Chief Executive Officer of Corrections Health Service, Dr Richard Matthews, escorted the Committee through each complex and provided a briefing session to the Committee. During the site visit the Committee discussed corrections health related matters with the nursing managers of each ward at Long Bay Hospital, as well as with the senior management of the Mulawa and MRRC complexes.

1.19 The Committee conducted an information gathering visit to Victoria between 8 October and 9 October 2002 to examine aspects of Victoria’s forensic mental health system and supported accommodation initiatives.

1.20 On 9 October 2002, the Committee visited the Thomas Embling Hospital, a modern-maximum security forensic hospital. The hospital is operated by Forensicare, which is the trading name of the Victorian Institute of Forensic Medicine. During the site visit, the Committee met with Mr Michael Burt, Chief Executive Officer, Forensicare, and Prof Paul Mullen, Clinical Director, Forensicare. The Committee discussed a variety of issues relating to forensic patients and specifically, the model of care and environment provided at the newly established hospital. (see Chapter 14 for further discussion). Following this meeting, the Committee met with the Deputy Chief Psychiatrist, Department of Human Services, Victoria, for a general discussion on forensic mental health.

1.21 In respect of Supported Accommodation initiatives, the Committee met with Ms Jennifer Westacott, Director, Housing, Department of Human Services, Victoria. Ms Westacott informed the Committee of current housing programs in Victoria, and initiatives specifically related to supported accommodation for people with a mental illness (see Chapter 7 for further discussion).

1.22 The Committee tabled an interim report on 3 September 2002. The interim report primarily outlined issues raised with the Committee through submissions, public hearings, site visits and the public forum. Its aim was to provide stakeholders of the mental health system with a statement of direction for this final report. The interim report can be accessed at the Parliament website: www.parliament.nsw.gov.au.

- 1.23** The Committee considered the Chair's draft report at its meeting on 26 November 2002. The report was adopted on 26 November 2002.

Previous inquiries into mental health services

- 1.24** The Committee is aware of a number of previous state parliamentary inquiries and commissions of inquiry relating to mental health services in NSW. These are:

- Legislative Council Select Committee on the Lunatic Asylum, Tarban Creek, 1846
- Commission of Inquiry on the Lunatic Asylums of New South Wales, 1855
- Select Committee on the benevolent asylum, Sydney, 1861-1862
- Select Committee on the present state and management of lunatic asylums, 1863-1864
- Commission on lunatic asylums, 1867-1869
- Randwick Asylum Board of Inquiry, 1876
- Select Committee on the Lunatic Asylum, Parramatta, 1876-1877
- Government asylums inquiry board, 1887
- Royal Commission on the administration of the mental hospitals and the reception house for the insane at Darlinghurst, 1913
- Royal Commission on lunacy law and administration, 1922-1923
- Committee for legislation in regard to mental defectives, 1959-1960
- Royal Commission on matters affecting Callan Park Mental Hospital, 1961-1962
- Royal Commission into Deep Sleep Therapy, 1990
- Legislative Council General Purpose Standing Committee No 2, Inquiry into Rural and Regional New South Wales Health Services: rural doctors, aged care and mental health, 1999.

Scope and nature of this report

- 1.25** This report addresses issues raised with the Committee through submissions, public hearings, site visits and the public forum. It provides an analysis of mental health services in NSW and addresses specific recommendations to the Government where the Committee has identified issues of concern.

- 1.26** **Chapter 2** of this report provides background information on previous inquiries conducted into mental health services in NSW, as well as government policies and initiatives.
- 1.27** **Chapter 3** provides an overview of the mental health sector in NSW, including government, non-government, private and community organisations.
- 1.28** **Chapter 4** discusses the provision of services within the mental health sector in NSW. There is also consideration of services which provide support to the mental health sector.
- 1.29** **Chapter 5** focuses on the funding of mental health services in NSW.
- 1.30** **Chapter 6** considers the issue of privacy and the provision of effective mental health services.
- 1.31** **Chapter 7** examines the housing needs of people with a mental illness and the ability at present to address those needs. There is also consideration of homelessness and mental illness.
- 1.32** **Chapter 8** examines the special needs of culturally and linguistically diverse populations in NSW.
- 1.33** **Chapter 9** examines the special needs of Aboriginal and Torres Strait Islander people in NSW.
- 1.34** **Chapter 10** provides analysis of the particular difficulties of people with both mental illness and substance abuse disorders in accessing mental health services.
- 1.35** **Chapter 11** considers the issue of dual diagnosis, with a focus on the funding of mental health and disability services and on the coordination of these services.
- 1.36** **Chapter 12** provides an overview of the particular mental health needs of people aged over 65, and the mix of funding available to address those needs from the Commonwealth and NSW governments.
- 1.37** **Chapter 13** addresses the mental health needs of people aged under 25, in particular the provision of appropriate services.
- 1.38** **Chapter 14** examines the overrepresentation of people with a mental illness within the criminal justice system, and the management of interactions between the criminal justice and health systems.
- 1.39** Every effort has been made to ensure the currency of the information presented in this report.

Issues not discussed

- 1.40** The Committee has attempted to produce a comprehensive and wide ranging report on mental health services in NSW. The Committee is nevertheless mindful that there are

issues that have not been considered in detail either due to limited evidence received or identified issues are beyond the scope of the present inquiry.

- 1.41** Rural and regional issues are significant and have been incorporated within the general context of service delivery. As a result, no chapter has focussed specifically on rural and regional issues. Improving access and integration of services is necessary in both metropolitan and regional areas. NSW Health must determine the level of service that is required in regional areas to ensure equity throughout the State.
- 1.42** The incidence of suicide among mental health patients was a critical issue for many people who made submissions and who spoke at the public forum. Of major concern to the Committee was the incidence of suicide among those who had presented at a hospital but were not admitted, and the incidence of suicide while people with mental illnesses were in the care of NSW Health. The Committee determined these issues were beyond the scope of the present inquiry. The Committee considers that this issue requires the immediate attention of the Minister for Health and urges the Minister to commission an independent inquiry into the incidence and circumstances of suicide among mental health patients. (see Recommendation 3).

Chapter 2 Historical context

As the Committee detailed in its interim report⁶, the current inquiry into mental health services is the first parliamentary inquiry on mental health services in NSW since 1877⁷.

The Legislative Council Select Committee on the Lunatic Asylum, Tarban Creek, conducted the first parliamentary inquiry into mental health services in NSW, reporting to Parliament on 21 October 1846⁸. Following that inquiry, a Commission of Inquiry on the Lunatic Asylums of New South Wales reported to the Legislative Council in 1855⁹. The most prominent inquiries and reports that were subsequently initiated included two Royal Commissions in 1923¹⁰ and 1961¹¹, the Richmond Report in 1983¹², the Barclay Report in 1988¹³ and the Burdekin Report in 1993.¹⁴

These reports, among others, have commented on and made recommendations for improving mental health services in NSW. The reports that have had the most influence on mental health services in NSW over the last twenty years were the Richmond Report and the Burdekin Report. A brief background on these reports has been reproduced from the Committee's interim report.

Richmond Report

2.1 In 1982, the Minister for Health established an Inquiry into the Provision of Mental Health Services for the Psychiatrically Ill and the Developmentally Disabled. The inquiry was established to examine funding of alternatives to institutional care. The essence of the recommendations in the Report were to:

- decrease the size and number of mental hospitals
- expand integrated community networks
- maintain clients in the community
- separate developmental disability services from mental health services and
- change funding arrangements.

⁶ Legislative Council, Select Committee on Mental Health, *Inquiry into mental health services in New South Wales – Interim Report*, September 2002

⁷ Legislative Council, Select Committee on Lunatic Asylum, Parramatta, 1877

⁸ Legislative Council, *Report from the Select Committee on the Lunatic Asylum, Tarban Creek*, 21 October 1846

⁹ Legislative Council, *Report from the Commissioners of Inquiry on the Lunatic Asylums of New South Wales*, 6 June 1855

¹⁰ Royal Commission on Lunacy Law and Administration, 1923

¹¹ Royal Commission on Matters affecting Callan Park Mental Hospital, 1961

¹² D T Richmond, (Chair), *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled*, 1983 [Hereafter referred to as the “Richmond Report”]

¹³ W Barclay, (Chair), *Report to the Minister for Health*, Ministerial Implementation Committee on Mental Health and Development Disability, 1988 [Hereafter referred to as the ‘Barclay Report’]

¹⁴ Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into Human Rights of People with a Mental Illness*, 1993 [Hereafter referred to as the “Burdekin Report”]

2.2 The Richmond Report is often associated with initiating the deinstitutionalisation process in NSW, that is, devolving long-term care from institutions to community based arrangements. Many submissions received by this Committee and evidence heard before it have supported this assumption. The NSW Parliamentary Library Research Service Briefing Paper, *Mental Health in NSW: Current Issues in Policy and Legislation* (1996),¹⁵ however, concluded that the process in reality dates from the 1960s and had largely been accomplished by the late 1970s:

For example, in the Report into Callan Park Mental Hospital (1961), the Royal Commissioner suggested that the hospital should be geared to therapy and not custody, and that efforts should be made to reduce the number of patients and an active treatment programme towards rehabilitation introduced.

It has been observed that relative to the changes between 1960 and 1978, very few patients were directly affected by the recommendations of the Richmond Report itself. The deinstitutionalisation of the 1980's mainly concerned staff and facilities.¹⁶

2.3 While a move away from institutionalisation was already occurring, the Richmond Report provided the framework from which to consolidate and plan developments. The NSW Parliamentary Library Briefing Paper noted that:

The key recommendation of this Report was that services be delivered primarily on the basis of a system of integrated community based networks, that the highest priority in mental health services be the community based care and rehabilitation of the seriously mentally ill. The two prime operational objectives therefore were to provide services which maintain clients in their normal community environment and to progressively reduce the size and number of Fifth Schedule hospitals. In addition, the Report endorsed a number of principles of service delivery. These included *inter alia* the integration of community and hospital services to provide a comprehensive service, the adoption of a multi-disciplinary approach, and emphasis on continuity of care. Acute admission services would be relocated to general public hospitals, leaving psychiatric hospitals to become more specialised, emphasising habilitation and rehabilitation.¹⁷

2.4 The Richmond Report recommendations were adopted as government policy and implementation commenced in 1984. The objectives of the Report and deinstitutionalisation process, however, appear to have been undermined by practical problems arising during implementation. This final report examines the extent to which the Richmond Report was implemented and evaluates the success of initiatives introduced pursuant to its recommendations.

2.5 In 1988, opinion about hospital care for the mentally ill was being reconsidered. This led some commentators, including Dr William Barclay, to conclude that the Richmond Program had seen the erosion of the psychiatric hospital system before the development of appropriate community services.

¹⁵ NSW Parliamentary Library Research Service, *Mental Health in NSW: Current Issues in Policy and Legislation*, Briefing Paper No 21/96, 1996

¹⁶ *ibid*, p 9

¹⁷ *ibid*, pp 9-10

Barclay Report

2.6 In November 1988, the Ministerial Implementation Committee on Mental Health and Developmental Disability chaired by Dr William Barclay, produced a *Report to the Minister for Health* (Barclay Report)¹⁸. The Report essentially supported the policy of providing community care for patients while recommending modification in other respects. The Barclay Committee explained what it considered to be the fundamental difference in approach from the Richmond Report:

this report advocates a balance between hospital and community care; that balance being a dynamic one which is arrived at by a process of evolution rather than the wholesale closure of mental hospitals and the decanting of large numbers of patients in a short period of time into the community.¹⁹

2.7 The Report concludes:

Although the literature indicates that the majority of patients can be cared for in the community, the success of this depends on the quality, intensity, comprehensiveness and continuity of care provided to them as well as the amount of funds allocated. However, the deinstitutionalisation of severely disabled, difficult to manage, chronic patients who need long term accommodation with very high staff/patient ratios is very expensive and does not appear to be cost effective in community settings. Such patients could probably be more cost effectively catered for in long stay wards of hospitals. Hospital beds are also required for patients with acute episodes when needed and appropriate and to provide respite for overburdened relatives. The total number of such beds would appear to depend on the care and other facilities provided in the community.²⁰

2.8 The Greiner Government's plan of action (*Blueprint for Health* 1988)²¹, based on the Barclay Report, contained four distinct components:

- upgrading of State Psychiatric Hospitals to accreditation standards
- establishment of new services or expansion of existing services for the admission and assessment of patients in public hospitals
- provision of special purpose built units for the elderly and
- expansion of community based services.²²

2.9 Three years after the *Blueprint for Health*, the NSW Health issued its policy document, *Leading the Way: A Framework for NSW Mental Health Services 1991-2001*. The Framework set out the direction for mental health services:

¹⁸ Ministerial Implementation Committee on Mental Health and Development Disability, *Report to the Minister for Health*, W Barclay, (Chair), November 1988

¹⁹ Barclay Report, p 165, and NSW Parliamentary Briefing Paper 1996, p 14

²⁰ *ibid*

²¹ NSW Government, *Blueprint for Health – A New Direction in Mental Health Services*, 1988

²² NSW Parliamentary Library Briefing Paper, 1996, p 14

Mental health services today emphasise early intervention and assistance to individuals in their own environments, thus minimising the need for protracted periods of hospitalisation resorted to in the past...Proposed models strongly emphasise the requirement for services to be client-centred, integrated and closely aligned with mainstream health and social services.²³

- 2.10** The policy of ‘mainstreaming’ is to co-locate mental health services with general health services, while retaining the internal integration of specialised services to ensure continuity and clinical management.²⁴

Burdekin Report

- 2.11** In June 1990, the Human Rights and Equal Opportunity Commission (HREOC) announced a *National Inquiry into Human Rights of People with a Mental Illness*, producing a final report in 1993 (the Burdekin Report).

- 2.12** In 1993, the Burdekin Report noted that there was a significant proportion of people with a mental illness who had never actually been admitted to a psychiatric institution.²⁵ Affiliated with this trend has been the advent of specialised treatment facilities, specifically for drug and alcohol disorders, adolescents and aged care.²⁶ The continued development and improvement of pharmaceuticals also enabled many people with a mental illness to remain in the community.²⁷ Against this backdrop, the 1996 NSW Parliamentary Library Briefing Paper noted that:

Despite these developments, people suffering mental illness are still considered to be amongst the most vulnerable and disadvantaged in the community. The conclusion of the Burdekin Report was that the level of ignorance and discrimination still associated with mental illness and psychiatric disability in the 1990s is completely unacceptable.²⁸

- 2.13** The Burdekin Report was ambivalent about the value of mainstreaming:

The success of this radical policy shift to mainstreaming and of the National Mental Health Plan remains to be demonstrated in practice. The debate about distinctions in policy has tended to divert attention away from the endemic underresourcing that has characterised mental health services. Lack of resources has bedevilled community based care in much the same way that inappropriately allocated resources contributed to the ineptly executed demise of the large institutions.²⁹

²³ NSW Department of Health, *Leading the Way: A Framework for NSW Mental Health Services 1991-2001*, 1991, pp 5-6.

²⁴ NSW Parliamentary Library Research Service, *The Burdekin Report – Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, Briefing Paper No. 004\93, 1993, p 11

²⁵ Burdekin Report, p 298

²⁶ NSW Parliamentary Library Briefing Paper, 1996, p 6

²⁷ *ibid*

²⁸ *ibid*, p 7

²⁹ Burdekin Report, p 142, NSW Parliamentary Library Briefing Paper, 1996, p 8

- 2.14** The issue of forensic patients (those deemed to be not guilty, or unfit to stand trial by reason of mental illness) was not addressed in the recommendations of the Richmond Report, but was identified in the Burdekin Report:

Mentally ill people detained by the criminal justice system are frequently denied the health care and human rights protection to which they are entitled.³⁰

- 2.15** The Burdekin Report stated that distinctions between mental illness and criminal behaviour need to be made and the protection of the rights of forensic patients guaranteed across all jurisdictions.³¹

- 2.16** While the Burdekin Report highlighted insufficient funding of community care and lack of trained staff to care for patients after discharge, of greater concern was the analysis of the government's implementation of mental health reform. The Burdekin Report identified not only inefficient planning and organisational arrangements to integrate services within hospitals, but also a lack of procedures to involve families in the community treatment process. It was considered that these issues had not been adequately addressed. Evidence received by this Select Committee indicates that in NSW these issues still require further attention.

Post-Barclay Report

- 2.17** In its submission to this Committee, NSW Health outlined policy developments since the Barclay Report:

In 1992 all Australian Health Ministers adopted the National Mental Health Strategy, which provided, and continues to provide, a national framework for dealing with mental health issues. The Strategy now comprises the Mental Health Statement of Rights and Responsibilities (1991), the National Mental Health Policy (1992), the first National Mental Health Plan (1993-98), the Commonwealth/State healthcare agreements, and the Second National Mental Health Plan (1998-current).³²

- 2.18** Following the publication of the Burdekin Report in 1993, the NSW Health *Annual Report 1994-1995* identified that continued development of community based services and strengthening the role of the non-government sector in service provision, were priorities in the mental health area for NSW. The Annual Report identified that areas such as services for people of indigenous and non-English speaking backgrounds, people living in public housing and prisoners, were to be specifically targeted.³³

³⁰ Burdekin Report, p 940

³¹ NSW Parliamentary Library Research Service, *The Burdekin Report – Human Rights and Mental Illness Report of the National Inquiry into the Human Rights of People with Mental Illness*, Briefing Paper No. 004\93, 1993, p 41

³² Submission 267, NSW Health, p i

³³ NSW Health *Annual Report 1994-1995*, p. 41. Also cited in NSW Parliamentary Library Briefing Paper, 1996, p 15.

2.19 In 1998, NSW Health produced *Caring for Mental Health – A Framework for Mental Health Care in NSW*³⁴ and a Charter for Mental Health Care. In its submission, NSW Health states that these policies:

Support the strategic direction of the National Mental Health Strategy. It is a lifespan approach that takes into account the special needs of population groups and groups with special needs.³⁵

2.20 The *Mental Health Act 1990* was the first Act in NSW to define mental illness in legislation. The basis of the definition was symptoms and signs, rather than a delineation between functional and organic disorders. The Act made significant steps forward from the *Mental Health Act 1958* (which had replaced the *Lunacy Act 1898*) through the following:

- alternatives to compulsory hospital treatment such as community counselling orders and community treatment orders
- a distinct preference for community care
- the principle of ‘least restrictive care’ and
- an extensive statement of the legal rights of people thought to be mentally ill or disordered.

2.21 The *Mental Health Act 1990* was reviewed in 1992 by the Mental Health Act Implementation Monitoring Committee and found to be an effective, humane piece of legislation.³⁶ The Act was further reviewed in 1994 and 1997.

Select Committee on Mental Health - inquiry into mental health services in NSW

2.22 The Richmond, Barclay and Burdekin Reports were prepared, as well as the subsequent policy and legislative changes made, in a decade of increasing recognition of civil liberties and at a time when the powers to schedule (involuntarily admit) patients to psychiatric hospitals were being restricted. The Committee received evidence from the Society of St Vincent de Paul, which indicated that this process may have gone too far:

The strict criteria used to ascertain whether someone should be hospitalised means sufferers and their carers are left to deal with extremely difficult episodes on their own. While the civil liberties of all people should be respected, an extreme libertarian view can lead to an abjuration of responsibility by those responsible for mental health services.³⁷

2.23 Since the Richmond Report, governments have attempted to formulate, among numerous competing factors, the most efficient, considerate and strategic framework and infrastructure for the provision of mental health services in NSW.

³⁴ NSW Health Department, *Caring for Mental Health – A Framework for Mental Health Care in NSW*, 1998.

³⁵ Submission 267, NSW Health, p i

³⁶ NSW Parliamentary Library Research Service (1996), *Mental Health in NSW: Current Issues in Policy and Legislation*, Briefing Paper No 21/96, p 18

³⁷ Submission 143, Society of St Vincent de Paul, *A Long Road to Recovery: a social justice statement on mental health*, p 5

- 2.24** The historical context for this current inquiry highlighted recurring themes and endemic problems in the provision of mental health services. This Final Report identifies the main issues and problems facing mental health services in NSW.
- 2.25** The proposed changes range from 'housekeeping' measures to fundamental or revolutionary reform.

Chapter 3 **Mental health sector in NSW – organisation and policy**

Given the episodic nature of mental illness, it is not uncommon for a consumer (person with a mental illness) to spend time in the NSW system, some other time in the Federal system, and a lot of time in the regions covered by neither.³⁸
[NSW Consumer Advisory Group]

The Committee received a significant number of comprehensive submissions from government and non-government mental health service providers and from families and carers in NSW. This chapter provides a snapshot of the mental health sector in NSW, as presented to the Committee.

Background

- 3.1** Debate ensued for much of the 1980s and 1990s regarding whether non-government organisations (NGOs) or public mental health services were best placed to provide psychiatric treatment, care and rehabilitation. There was however, little research or evidence supporting the various assertions made. The move towards deinstitutionalisation in various forms was by then an international phenomenon.
- 3.2** In NSW, deinstitutionalisation coincided with removing the responsibility for drug and alcohol and disability services from the mental health budget. Various changes in government and professional policy positions resulted in the mental health sector becoming an amalgam of public and private hospital care, NGO services and community care. Evidence before this inquiry suggests that the police, charities and support groups, carers and families, have been left attempting to support deficiencies or ‘gaps’ in the system.

Implications of the Richmond Report

- 3.3** Mr Phillip Scott, Court Liaison Clinician, commented on the lasting effect of the Richmond Report on the mental health sector in NSW:

Closely associated with the Richmond Report is the deliberate dismantling of the Schedule 5 Hospital system. The Schedule 5 system combined the care of people with mental illness, drug and alcohol problems, developmental disabilities and psycho-geriatric problems. The Richmond Report effectively saw the dividing of service responsibilities into separate departments, Mental Health Services, Drug and Alcohol Service, psycho-geriatrics under Aged Care and developmentally disabled under Department of Community Services. All these separate departments require individual administrative structures and duplication of associated costs to run and house each service adequately. In addition to this we are now seeing non-government organisations taking over the traditional government roles adding another tier of structural management.³⁹

³⁸ Submission 162, NSW Consumer Advisory Group, p 18

³⁹ Submission 67, Mr Phillip Scott, Court Liaison Clinician, p 2

- 3.4** In its submission to the Committee, NSW Health quoted the *World Health Report 2001*, which outlined a preferred direction for health services:

governments should move away from large mental institutions and towards community health care, and integrate mental health care into primary health care and the general health care system.⁴⁰

- 3.5** Evidence received by the Committee suggests that the devolution of responsibilities to separate departments and the increasing role of the NGO sector has not been planned, coordinated, or managed appropriately. For example, UnitingCare declares that “there seems to be very poor integration of services for people with mental health disorders”.⁴¹

- 3.6** While supporting the process of deinstitutionalisation, and the premise that where care is required, it should be provided on a ‘least restrictive basis’, UnitingCare remains critical of the lack of ‘fiscal follow-through’ for mental health services:

Direct mental health services, in hospital and community-based settings, are resource-constrained. Just as importantly, key agencies that assist people with mental health issues (such as non-profit non-government organizations in the disability, youth and family support fields) are not recognised and supported by government funding.⁴²

- 3.7** Ms Helena O'Connell, Executive Officer of the NSW Council for Intellectual Disability, also expressed concern over the lack of resources accompanying people with a mental illness into community care:

At the moment it focuses on finding accommodation for people to live in. While there is a recognition, I am concerned there is not enough work and resources going into community services for these people. Many people coming out of institutions will have a psychiatric disability and others will have, even if it is short term, some kind of post-traumatic stress disorder. They are used to living with 30 people, and we might not think that is a good thing, but change it to something else and people experience some loss. There needs to be a lot of support in place for people in those circumstances.⁴³

Government sector

- 3.8** The submission from St John of God Health Services stated the basic difference between public and private providers of mental health services:

In essence the major difference between public and private providers, is the mix of diagnostic groups. A large component of the workload for public mental health services is caring for those with chronic and severe psychotic illnesses. The major component of the private system is treating those with affective disorders.⁴⁴

⁴⁰ World Health Organisation (2001): *The World Health Report 2001: “New Understanding, New Hope”* Press Release WHO/42, 28 September 2001, cited in NSW Health, Submission 276, introduction

⁴¹ Submission 78, UnitingCare, p 13

⁴² *ibid*, p ii

⁴³ Ms Helena O'Connell, Executive Officer, NSW Council for Intellectual Disability, Evidence 28 May 2002, p 16

⁴⁴ Submission 182, St John of God Health Services, p 6

- 3.9** Public sector mental health service providers are identified below and discussed briefly. Detailed discussion on these providers will occur in the following chapters.

Centre for Mental Health

- 3.10** The Centre for Mental Health is a branch of NSW Health with a role to provide leadership in the improvement of mental health services in NSW through the development of planning, policies, programs and service models.⁴⁵ Its functions are:

- population based planning to meet mental health needs across the life span and across NSW
- continuous development of the evaluation of clinical services and their outcomes including the implementation of outcomes based evaluation methodologies across NSW
- development of promotion and prevention programs to improve the mental health of the NSW population
- development of evidence based clinical policies and strategic partnerships, including partnerships with other agencies and NGOs, to support the development of high quality services
- review, support, maintain and oversee Departmental and Ministerial responsibilities under the Mental Health Act and associated legislation
- development of investment plans, funding policy and performance measurement to support the achievement of the NSW Health goals and
- participate in national and international developments to advance policy and practice in the delivery of mental health services.⁴⁶

- 3.11** At the time of publication of this report, the Centre for Mental Health indicated that its current work priorities were:

- implementation of the 2002-2003 enhancement to mental health services, including the additional \$20 million recurrent funding in respect of the accelerated mental health bed program to open 300 additional mental health beds by June 2003
- implementation of Child and Adolescent and Adult Mental Health Service Networks
- development and implementation of an effective recruitment strategy for clinical mental health staff
- implementation of a mental health information strategy and outcomes assessment
- ongoing development and implementation of evidence based clinical policies and strategic partnerships.⁴⁷

⁴⁵ Correspondence from NSW Health to the Committee, 11 September 2002

⁴⁶ *ibid*

3.12 The Centre for Mental Health also identified what it prioritised as contentious issues within its domain:

- poor access for some Areas to tertiary mental health services
- problems in accessing acute psychiatric beds, underdeveloped child and adolescent mental health services and
- other issues including suicide rates, violence in the health workplace and difficulties in recruiting mental health clinical staff.⁴⁸

Area Health Services

3.13 Area Health Services (AHS) are divisions of NSW Health, and are constituted under section 17 of the *Health Services Act 1997*. AHS facilitate the conduct of public hospitals and health institutions and are principally concerned with the provision of health services for residents within their geographic area. The *Health Services Act 1997* states that, among other functions, the AHS must:

- achieve and maintain adequate standards of primary care and services
- ensure the efficient and economic operation of its health services and health support services and use of its resources and
- administer funding for recognised establishments and recognised services of affiliated health organisations.⁴⁹

3.14 The AHS are responsible for carrying out the policies and services delivery guidelines of the Centre for Mental Health, and provide both inpatient and outpatient services.

Corrections Health Service

3.15 Corrections Health Service (CHS) is a statutory health corporation under the *NSW Health Services Act 1997*, caring for a health community that is unique in NSW – almost 7,800 inmates in 25 correctional centres, ten periodic detention centres and six police and court cell complexes.⁵⁰ (See also Chapter 14)

3.16 Mental health services is one of five major clinical service programs provided by CHS. Services provided include:

- area administration (Long Bay Correctional Complex)
- inpatient services

⁴⁷ ibid

⁴⁸ Correspondence from NSW Health to the Committee, 11 September 2002

⁴⁹ *Health Services Act 1997* sections 10 (d), (e) and section 129

⁵⁰ Correspondence from NSW Health to the Committee, 10 September 2002

- specialist tertiary referral outpatient services (Metropolitan Medical Transient Centre)
- inpatient detoxification services
- Mental Health Court Liaison Services and
- general outpatient services provided at each NSW correctional centre.⁵¹

3.17 Mental health services for inmates provided by CHS include visiting psychiatrists, registered psychiatric nurses and crisis and multi-disciplinary risk intervention teams. Inmates with a psychiatric illness are transferred to Long Bay Hospital when their conditions cannot be managed locally. Forensic mental health services provide:

- inmates with mental disorders requiring secure inpatient hospital treatment
- inmates with mental disorders requiring ambulatory assessment and management in a correctional centre
- persons detained after being found unfit to plead
- persons detained after being found guilty by reason of mental illness
- offenders or alleged offenders referred by courts for mental assessment, and
- persons who are deemed 'forensic patients' in terms of the *Mental Health Act 1990*, being those found not guilty by reason of mental illness, those found unfit to plead and those imprisoned who are later found to be mentally ill and are transferred to hospital for treatment.⁵²

3.18 The Committee notes that many challenges face CHS, and include the remote location of some clinics, the high turnover and frequent relocation of patients and the need to develop and provide appropriate services for long and very short-term inmates. Dr Richard Matthews, Chief Executive Officer of CHS, commented on the average length of stay for inmates:

There are some misconceptions about how long people stay in prison. Not everyone is there for life. Of the roughly 16,000 annual receptions, about 70 per cent come on remand and 30 per cent are sentenced; of the total, 27 per cent remain with us for less than eight days; another 17 per cent between eight and 30 days, so almost half the total is there for less than one month; 56 per cent remain longer than 30 days.⁵³

3.19 Based on the average length of stay of inmates, CHS has a limited time to implement health interventions that might improve the health status of individuals and the Committee acknowledges that this time frame affects how CHS delivers its services.

⁵¹ ibid

⁵² Submission 267, NSW Health, p A 21

⁵³ Dr R Matthews Chief Executive Officer, Corrections Health Service, Evidence 30 May 2002, p 17

- 3.20** In *Crime Prevention through Social Support - Second Report* the Legislative Council Standing Committee on Law and Justice reported that forensic patients are often under the care of CHS by default. The report noted that a local magistrate had:

sent people to jail because it was the only place they could receive proper treatment programs for the mental illness which was greatly contributing to their offending. At a conference, the same magistrate also spoke of having to wait 9 weeks for a psychiatric assessment, leading to defendants with a mental illness being held on remand because of lack of alternative facilities.⁵⁴

- 3.21** Concern about the high prevalence of mental illness in correctional centres has resulted in the development of court diversionary programs to divert offenders with a mental illness from the criminal justice system to community mental health services.⁵⁵

- 3.22** The role of court diversion programs, CHS, and forensic issues in general, are discussed in detail in Chapter 14.

Community care

- 3.23** Community mental health services manage acute care with outreach and crisis services and acute assessment and treatment. They include partnerships with other government and non-government agencies and general practitioners. A strong emphasis is increasingly being placed on effective rehabilitation programs aimed at achieving a return to education and work where this is possible, and case management for care, particularly assertive community treatment for those severely affected.⁵⁶ (See also Chapter 4)

Housing service sector

- 3.24** Following the deinstitutionalisation process, housing has become an essential component of the mental health sector. While the Commonwealth provides funding for public housing in NSW, housing allocation for people with a mental illness is split between NSW Health, the NSW Department of Housing (including the Office of Community Housing), the NSW Department of Ageing, Disability and Home Care (a new department which brings together the Ageing & Disability Department with the Disability Services from the Department of Community Services and the Home Care Service of NSW).

- 3.25** Shelter NSW, a community-based peak housing body, commented on the volume of tenants with a mental illness living in, or seeking, public housing:

At present, there are over 96,000 households on the NSW Department of Housing's waiting list. A significant number of current applicants (though we cannot produce exact figures since the applicants do not have to divulge information about any specific illness if they do not want to) would have a mental illness. Further to this, a significant number of sitting Department of Housing

⁵⁴ NSW Legislative Council, Standing Committee on Law and Justice, *Crime Prevention through Social Support – Second Report*, August 2000, pp 84-85

⁵⁵ Submission 267, NSW Health, p A 26

⁵⁶ *ibid*, p ii

tenants would also have a mental illness. The same is true of community housing tenants.⁵⁷

- 3.26** The NSW and Commonwealth Governments are both signatories to the Supported Accommodation Assistance Program (SAAP), which provides transitional, supported accommodation to people who are homeless or at risk of becoming homeless. The NSW Department of Housing has a Crisis Accommodation Program and is part of the interagency Partnerships Against Homelessness. The Office of Community Housing has established five mental health projects in partnership with various Area Mental Health Services providing 19 units of accommodation, 12 of which are in non-metropolitan or rural areas.⁵⁸
- 3.27** The funding for SAAP is allocated to more than 400 services provided by non-government organisations.⁵⁹ SAAP services provide support such as outreach, advocacy and living skills development. They also link people to other services such as health and aged care. Agencies on the SAAP committee include the Departments of Housing, NSW Health, Ageing and Disability, Fair Trading, Corrective Services, Women, Juvenile Justice, and Department of Community Services.⁶⁰
- 3.28** The Directors-General of the NSW Department of Housing and NSW Health signed the Joint Guarantee of Service for People with a Mental Illness (JGOS) in September 1997. NSW Health stated that the JGOS was developed in response to concerns about the lack of coordination between health and housing services:
- The JGOS defines the roles and responsibilities of both Departments and outlines the processes and procedures for the Departments to follow to enable them to work together cooperatively. In particular, confidential protocols were developed to permit the exchange of necessary information and to support cooperative planning around joint programs and practice models.⁶¹
- 3.29** NSW Health has indicated that a project is under way to expand the JGOS partnership to include the NSW Department of Community Services (DOCS), SAAP program and services, the Office of Community Housing, the Aboriginal Housing Office and other services providers.⁶²
- 3.30** Shelter NSW, however, raised some concerns over the coordination and management of public and community housing for the mentally ill:

The Department of Housing was unable to answer our inquiries about (a) the number of clients who indicated they were receiving treatment for mental illness or (b) the number of clients covered by Joint Service Agreements. The central office did not have access to statistics.

⁵⁷ Submission 198, Shelter NSW, p 4

⁵⁸ NSW Department of Housing, *Annual Report 2000-2001*, p 32

⁵⁹ 'SAAP Services: Supporting People in Need,' Factsheet, NSW Department of Community Services, p 1

⁶⁰ *ibid*, p 2

⁶¹ Submission 267, NSW Health, p G 41

⁶² *ibid*

There are Joint Service Agreements (where local Department of Housing offices and other agencies co-operate and agree to provide support for clients) in place. These work well in some areas, depending on local circumstances, and often, the commitment or competency of key individuals. However, application of these policies is patchy across NSW. Shelter NSW's constituents who work in the field continually tell us that although the policies exist on paper, the situation as it really is, does not match up with the rhetoric of integrated support, because the level of support required is either not available at all in some areas, or is poorly supplied.⁶³

- 3.31** Submissions to the inquiry also described other housing options for people with a mental illness, including various supported accommodation models and boarding houses.⁶⁴ (See also Chapter 7, Housing and homelessness)

Commonwealth agencies

- 3.32** The Commonwealth Government monitors and coordinates the National Mental Health Strategy, which provides a national framework for dealing with mental health issues. The Strategy currently comprises the Mental Health Statement of Rights and Responsibilities (1991), the National Mental Health Policy (1992), the first National Mental Health Plan (1993-98), the Commonwealth/State healthcare agreements, and the Second National Mental Health Plan (1998-current).⁶⁵
- 3.33** In addition to program grants to NSW, the Commonwealth provides direct expenditure, funds the Pharmaceutical Benefits Scheme, and also provides Medical Benefits Schedule items for general practitioners to undertake multidisciplinary care plans and multidisciplinary case conferencing for people with chronic conditions.
- 3.34** Management of health and ageing issues are reliant on intergovernmental cooperation between the Commonwealth and the State. Submissions to the Committee however, have described a number of problems caused by this division of responsibilities and funding.

Non-government organisations

- 3.35** According to NSW Health, the role of non-government organisations (NGOs) in the provision of mental health services in NSW broadly includes:
- disability support – services of organisations such as Aftercare, Richmond Fellowship and the Psychiatric Rehabilitation Association, including accommodation support, residential services, outreach, respite, rehabilitation, non-clinical case management/co-ordination, supported employment, social/recreational
 - self help/mutual support, usually through consumer and/or carer support groups and

⁶³ Submission 198, NSW Shelter, p 40

⁶⁴ Submission 172, Coalition for Appropriate Supported Accommodation (CASA); Submission 78, UnitingCare NSW

⁶⁵ Submission 267, NSW Health, p i

- advocacy/information/education services. This may be the organisation's primary role, such as the Mental Health Association of NSW, or a secondary role.⁶⁶

3.36 Submissions from NGOs highlighted that they provide considerable core services in the mental health sector in NSW. For example, the Northern Rivers Area Mental Health Council noted the trend to outsource government services and contended that the most notable shift of services has been to the NGO sector:

In particular, the NGO sector has been prevailed upon to pick up a large share of previously core mental health business. This includes the receipt and provision for sub acute clients, emergency and long-term accommodation, community rehabilitation and vocational planning. Some of these and other services provided by NGOs are no longer seen as "core mental health business".⁶⁷

3.37 NSW Health acknowledged the expanding role of NGOs and indicated support for formalising NGO partnerships through policies, procedures, protocols and funding:

The NSW Government has identified increased involvement in health care provision by NGOs as a key policy commitment. The Mental Health Implementation Group is currently developing a Framework for NGOs and Mental Health to formalise and progress partnerships.

Through the NSW Health NGO Grant Program, 350 grants totalling \$14.7 million were allocated across 271 NGOs in 2000.⁶⁸

3.38 NSW Health did not, however, indicate the level of funding allocated to NGOs in the mental health sector, which would exemplify its level of commitment. The Committee has repeatedly been informed by NGOs throughout the inquiry that such 'commitment' to NGO funding and support has been limited.⁶⁹ According to the *National Mental Health Report 2002*, NSW allocates the least amount of proportional funding for NGO programs in the mental sector out of all the states and territories in Australia:

New South Wales' relatively low level of funding to non government organisations, accounting for 1.5% of total services expenditure, distinguishes it from other jurisdictions. Per capita funding to non government agencies in 1999-00 was 69% below the national average, the lowest of the jurisdictions.⁷⁰

3.39 Funding issues are discussed in more detail in Chapter 5.

3.40 A common issue raised in submissions is the allocation of funding for NGO programs. The Committee was informed by a number of NGOs that they must apply for funding to the Area Health Service in which their respective head office is located. Statewide NGOs are currently restricted in implementing comprehensive statewide programs. Consequently,

⁶⁶ Submission 267, NSW Health, p G 28

⁶⁷ Submission 76, Northern Rivers Area Health Mental Health Council, p 2

⁶⁸ Submission 267, NSW Health, p G 28

⁶⁹ Mental Health Association (NSW), Evidence 23 May 2002, p 41; Society of St Vincent de Paul, Evidence 23 May 2002, p 15; NSW Council for Intellectual Disability, Evidence 28 May 2002, p 18; and Mental Health Co-ordinating Council, Evidence 28 May 2002, p 26

⁷⁰ Commonwealth Department of Health and Aged Care, *National Mental Health Report 2002*

locally oriented NGOs are forced to compete for funding with organisations which are far better prepared and experienced in seeking funding, though not necessarily more proficient at providing the required service in a specific area.⁷¹

Registered charities

- 3.41** Registered charities have always been an auxiliary service to primary government services. Evidence suggests, however, that they may also be supplementing core services in the mental health sector in NSW. The Committee received evidence from a number of registered charities, expressing concern that they are becoming a veiled second tier of the mental health sector. NSW Health does not collect information in relation to persons with a mental illness cared for by NSW registered charities, so it is difficult to ascertain the significance of output levels. NSW Health stated that:

While grants are provided to non-government organisations there is no requirement for these agencies to report on the number of 'patients' they care for. There is no consistent national data regarding this, nor agreed definitions.⁷²

- 3.42** The Committee understands that NSW Health is currently involved in the preparation of the third National Mental Health Plan and that reporting requirements on mental health outputs for non-government organisations are being developed for the Plan. In order for NSW Health to allocate appropriate funding and determine the average provision of acute psychiatric beds in NSW, it is the Committee's view that NSW Health should develop a transparent and up-to-date method of calculating the number of mental health 'patients' in care throughout the mental health sector in NSW.

General Practitioners

- 3.43** There are more than 7,000 General Practitioners (GPs) in NSW providing health assessments to 80% of the Australian community each year. GPs provide mental health interventions to 27% of people attending their practices.⁷³
- 3.44** The NSW Transcultural Mental Health Centre noted that the vast majority of those receiving care for mental disorders receive it from GPs. Consequently, consideration needs to be given to the provision of such care by GPs, mental health services, private psychiatrists and the linkages and service delivery partnerships between these service providers.⁷⁴
- 3.45** In its submission, the Alliance of NSW Divisions, a Commonwealth funded, State based organisation representing GPs, stated that:

Relationships between General Practitioners and public mental health services are historically poor. With de-institutionalisation of mental health inpatient units, the

⁷¹ Submission 103, Association of Relatives and Friends of the Mentally Ill in NSW (ARAFMI); Ramjan, Schizophrenia Fellowship, Evidence, 8 August 2002, p 21, 30; Walker, Evidence, 8 August, 2002, p 31

⁷² Submission 267, NSW Health, p A 27

⁷³ *ibid*, p G 27

⁷⁴ Submission 228, NSW Transcultural Mental Health Centre, p 4

development of community mental health services largely happened independently of primary health care in general practice.

In spite of the fact that some 80% of mental health problems present to the GP, detection and management is inadequate. The resources available to general practice for referral and support are very limited.⁷⁵

- 3.46** The Alliance of NSW Divisions advocated that best patient outcomes can be achieved if Area Mental Health Services and GPs work together in the provision of primary mental health care:

The incidence of physical health problems amongst MH (mental health) consumers is significant with 40% suffering a chronic illness that is often neglected. Whilst the primary role for most GPs will be to look after the MH consumer's physical wellbeing, there is a role for sharing the care of mental health problems. Many GPs will provide this service if they feel confident and know the support is there.⁷⁶

- 3.47** The Port Macquarie Division of General Practice expressed concern that existing services in the Hastings area are inadequate for most mental health patients. The Division is concerned that GPs may have to provide the intervention for those patients who will not meet the criteria for 'entry' into the public mental health service:

much time, effort and many words have been and are being spent across Australia in up-skilling GPs to be more effective in delivering mental health care. However no amount of up-skilling or financial inducement will address the fact that there are some tasks that GPs will never be in a position to perform eg a long home visit to encourage a patient to attend a therapy group. Thus the question remains who will provide this care?⁷⁷

Carers and family

- 3.48** The Committee received over 160 individual submissions from carers and families of people with a mental illness. A common theme of these submissions was frustration with service provision and, more specifically, the fragmented structure of the mental health sector in NSW. Importantly, the majority of these submissions were not necessarily critical of individual workers, organisations or programs. Many were unmistakably "enraged" and "angry" with a sector that seemed to duplicate service delivery in some areas, while having no presence in others.⁷⁸

⁷⁵ Submission 279, Alliance of NSW Divisions, *Partnerships in Urban Divisions between GPs and the Area Mental Health Services*, p 3

⁷⁶ *ibid*

⁷⁷ Submission 149, Port Macquarie Division of General Practice, p 8

⁷⁸ Public forum, NSW Parliament House, 7 August 2002

- 3.49** The South West Sydney Area Carer Network argued that families should be an integral part of the treatment team, though should not be a substitute for the mental health system:

The mental health system should support, never supplant families...In no case should the presence of a loving and caring family be allowed to be used as a substitute for a delivery system that provides for all of the person's treatment and rehabilitation needs.⁷⁹

- 3.50** The NSW Consumer Advisory Group (NSW CAG) highlighted the significant role of carers and family in the care of people with a mental illness.⁸⁰ The submission referred to a wide-ranging consultation of carers throughout Australia by the Mental Health Council of Australia, which found that "individual carers on average contribute 104 hours per week caring for a person with a mental illness".⁸¹

- 3.51** The role of carers and family in the mental health sector is considerable. At the same time however, the Committee notes the consistent frustration expressed through submissions and, in particular, during evidence at the Committee's public forum on 7 August 2002, over the lack of critical information available to carers and family.⁸²

- 3.52** The Committee understands that there are privacy and confidentiality restrictions placed on health professionals and administrators. The Committee nevertheless also understands the frustration expressed by carers and families regarding the difficulties these restrictions often cause in their endeavour to ensure a patient's safety and care. Unfortunately, it remains an underlying tension between carers and family, the patient, and the health system. Chapter 6, Privacy, confidentiality and information, discusses this issue in more detail.

Office of the Protective Commissioner (NSW)

- 3.53** The Office of the Protective Commissioner (OPC) is part of the NSW Attorney General's Department Human Rights program, and manages the affairs of people with impaired decision-making ability in NSW. The OPC provides its services following a financial management order made under the *Protected Estates Act 1983* or *Guardianship Act 1987*.⁸³

- 3.54** The major client group of the OPC are people with a brain injury, dementia and intellectual, neurological or psychiatric disability. There are currently 3,718 clients of the OPC with a psychiatric disability.⁸⁴

⁷⁹ Submission 187, South West Sydney Area Carer Network, p 5

⁸⁰ Submission 162, NSW Consumer Advisory Group, p 28

⁸¹ Mental Health Council of Australia, *Carers of People with Mental Illness Project*, Final Report, 2000

⁸² Submission 162, NSW Consumer Advisory Group; Speakers, public forum, Parliament House, 7 August 2002

⁸³ Submission 219, Office of the Protective Commissioner (NSW), p 1

⁸⁴ *ibid*, p 2

- 3.55** The OPC has a specialised unit, the Client Services Centre (CSC) that assists clients with high support needs. The OPC stated that the CSC fills a gap in the mental health sector in NSW:

Clients at this centre require cash allowances, are often itinerant, isolated, ad hoc users of support services and present with challenging behaviours. Of the 295 clients assisted by the CSC approximately 80% have a psychiatric disability as their primary disability. The extent of support required by these clients from OPC is indicative of a demand for such needs to be met and highlights gaps in service provision in the community.⁸⁵

Office of the NSW Public Guardian

- 3.56** The NSW Public Guardian can be appointed by the Guardianship Tribunal to be the legal substitute decision maker for a person with a disability, which can include a person with a mental illness.⁸⁶
- 3.57** The Public Guardian is currently the guardian for approximately 1,680 people with disabilities who reside across NSW. Over the past two and a half years the number of people under guardianship with a primary diagnosis of mental illness has been approximately 12%. A significant number may also have both a mental illness and another disability, such as a developmental or intellectual disability.⁸⁷
- 3.58** The Office of the NSW Public Guardian detailed its role in representing a person under guardianship:

the Public Guardian has frequent contact with services and professionals in the mental health sector. This contact arises in the context of seeking reports and opinions from mental health staff, client assessments, negotiating admission or discharge, or patient/outpatient care and consenting to medical treatment. The Public Guardian may raise issues of individual or systemic nature with the Minister for Health and the Director General of NSW Health.⁸⁸

- 3.59** The Committee notes that decisions relating to the appointment of guardians (including enduring guardians) can now be reviewed by the Administrative Appeals Tribunal under *The Guardianship and Protected Estates Legislation Amendment Act 2002*. This legislation will further protect the rights of people with a mental illness wishing to appoint guardians. (See Recommendation 30)

De facto mental health services – NSW Police

- 3.60** When the Committee embarked on this inquiry it did not anticipate that it would be making reference to the NSW Police Service in the context of mental health service provision. The Committee was alarmed by the significant role the NSW Police Service is

⁸⁵ Submission 219, Office of the Protective Commissioner (NSW), p 2

⁸⁶ Submission 255, Office of the NSW Public Guardian, p 2

⁸⁷ *ibid*

⁸⁸ *ibid*

required to fulfil within the mental health sector. There was virtually unanimous praise for the role and conduct of the police when dealing with people with a mental illness in evidence presented to the inquiry. The police are, however, being called upon to provide services that are designated core health services.

3.61 Section 24 of the NSW *Mental Health Act 1990* outlines police responsibilities with respect to mentally ill persons:

If a member of the Police Force finds a person in any place who appears to be mentally disturbed and the member of the Police Force has reasonable grounds for believing:

- (a) that the person is committing or has recently committed an offence and that it would be dealt with in accordance with this Act rather than otherwise in accordance with law, or
- (b) that the person has recently attempted to kill himself or herself or attempted to cause serious bodily harm to himself or herself,

the member of the Police Force may apprehend the person and take the person to a hospital (other than an authorised hospital).

3.62 The Police Association of NSW and the NSW Police Service were concerned that police are becoming a de facto after-hours mental health service.⁸⁹ The Association acknowledged that there is clearly a role for police in ensuring public and individual safety, although it is concerned that the role of the police has expanded by default:

A contradiction arises, however, because the police feel that their job is to step in only when action is deemed necessary, usually when someone is in danger or breaking the law. Police do not feel, and rightly so, that it is their role to provide psychotherapy, counselling or aid and comfort for the lonely and confused. This is the job of mental health professionals, a group whom police see to some extent, as abdicating their responsibilities. Police see the responsibilities thrust upon them as they are – they are being asked to shoulder duties no one else wants or can manage.⁹⁰

3.63 The Police Association also referred to the significant impact that deinstitutionalisation had on the rate of homelessness and, in turn, law enforcement:

Living on the street further complicates matters by making it difficult for mentally ill persons to receive follow-up services. Without this and ongoing care, individuals often stop taking their medication and sooner or later, end up having a run in with local law enforcement. It is at this point, what was once the institution's mental health problem now becomes a police problem.⁹¹

⁸⁹ Submission 286, NSW Police Service, p 3; Submission 254, Police Association of NSW, p 4

⁹⁰ Submission 254, Police Association of NSW, p 4

⁹¹ *ibid*, p 3

- 3.64** The Police Association expressed resignation at their assumed role:
- police have little choice but to continue to carry the burden of a lack of effective government policy and lack of funding in mental health services.⁹²
- 3.65** Police are increasingly the first point of contact for those suffering a mental illness. The growing levels of community based mental health services and the contemporary prominence of a diverse range of illicit drugs has compounded this trend.⁹³ The increasing proportion of patients presented by police under section 24 of the *Mental Health Act 1990* between 1991-2000 is alarming.
- 3.66** Chapter 14 examines forensic issues and the respective role of police in the delivery of mental health services in NSW.

Coordination of mental health services

Centre for Mental Health perspective

- 3.67** NSW Health advised the Committee that the Centre for Mental Health coordinates the Mental Health Quality Portfolio (MHQP). The MHQP was intended to implement a “comprehensive quality strategy” developed in response to two NSW Health policy and planning documents, *Caring for Mental Health*, October 1998 and *A Framework for Managing the Quality of Health Services in New South Wales*, February 1999.⁹⁴ NSW Health explained that issues associated with the day-to-day delivery of mental health services in NSW have also been incorporated into the portfolio:
- The implementation of this quality agenda has involved, and will continue to involve, close cooperation between the Centre for Mental Health and area health services as well as partnerships between these bodies and a wide range of non-government organisations and other government agencies.⁹⁵
- 3.68** NSW Health also advises that “public sector mental health services are building upon emerging service networks” and referred to a statement in the World Health Organisation’s (WHO) *World Health Report 2001*:
- WHO’s message is that every country, no matter what its resource constraints, can do something to improve the mental health of its people. What it requires is the courage and the commitment to take the necessary steps.⁹⁶

⁹² *ibid*, p 4

⁹³ Submission 254, Police Association of NSW, p 2

⁹⁴ Submission 267, NSW Health, p E 2

⁹⁵ *ibid*

⁹⁶ World Health Organisation, the *World Health Report 2001*, Press Release WHO/42, 28 September 2001, cited in Submission 267, NSW Health, introduction

Mental health service consumers' perspective

3.69 The NSW mental health sector comprises a diverse range of organisations providing an equally diverse range of services. Such organisations often compete for service delivery and struggle to provide a service that may not be adequately funded or staffed. Many patients are falling through the gaps within a system requiring greater oversight and regulation.

3.70 The NSW CAG commented on the fragmented and uncoordinated composition of the provision of mental health services:

Given the episodic nature of mental illness, it is not uncommon for a consumer (person with a mental illness) to spend time in the NSW system, some other time in the Federal system, and a lot of time in the regions covered by neither.⁹⁷

3.71 The submission from the Office of the Protective Commissioner called for improved service coordination:

Area based government mental health services and an apparent lack of workable whole of government approach to providing a service to people with dual or multiple disabilities, including psychiatric disabilities, pose significant barriers to continuity of service for people with a psychiatric disability. Rather than being provided with a service which meets their individual needs these people often end up receiving no service whatsoever as the presentation of their disabilities is such that no service provider on their own feels resourced to support them appropriately, or the service defines them out of service eligibility.⁹⁸

3.72 The NSW CAG argued that underlying many problems in the mental health system is the question of appropriate management:

Being a psychiatrist does not automatically mean that one has the skills to manage a complex, multi-million dollar organisation with vast competing demands. NSW CAG supports a professional approach in both management and clinical practice.

...So many of the problems of the mental health system today are about resource allocation and integrated systemic approaches to problems. These problems are the bread and butter of the professional manager but not necessarily of the clinician.⁹⁹

Conclusions

3.73 Based on the submissions, detailed expert evidence and supplementary briefings the Committee has received, the Committee considers that the mental health sector in NSW lacks the funding levels to allow adequate coordination and implementation of service programs. The mental health sector in NSW has more than adequate 'courage and commitment'. Rather than mission statements, the sector requires adequate and transparent

⁹⁷ Submission 162, NSW Consumer Advisory Group, p 18

⁹⁸ Submission 219, Office of the Protective Commissioner (NSW), p 11

⁹⁹ Submission 162, NSW Consumer Advisory Group, p 51

funding supported by well planned, coordinated and managed policy implementation and service programs.

- 3.74** NCOSS expressed concerns about the gaps in the mental health system, highlighting that health consumers and community organisations have repeatedly identified that closer and more consistent integration between mental health services and other government agencies and services is required:

This points to the need for a ‘whole of government’ approach to be applied to the provision of community mental health services. Such an approach should address relationships between mental health services and the broader health service, as well as the links between mental health and other government agencies such as Housing, Education, Corrective Services, Juvenile Justice, Police and Transport.¹⁰⁰

- 3.75** In a review of whole of government activities in the NSW Public Sector, commissioned by the NSW Premier’s Department in 1998, an analysis of 19 case studies revealed a number of characteristics which are common to many whole of government initiatives, including:

a focus on better services for customers; collaboration between all relevant agencies and levels of government; community participation; tailored responses to regional and local needs; more cost effective use of resources; and questioning and redesign of the way services are traditionally delivered to make them reflect people’s needs rather than bureaucratic structures.¹⁰¹

- 3.76** In an informed and passionate address to the Committee, Sister Myree Harris, Society of St Vincent de Paul, supported a coordinated government response to the inadequacies in the mental health sector in NSW. Sister Harris concluded, “there is no continuity of care”¹⁰² and offered the following recommendation in response to this concern:

Our big recommendation is for an office of mental health separate to NSW Health, located as part of the Premier’s Department and Cabinet. This is because mental health is different from mental illness. Mental illness requires medication. Mental health is integration back into the community as a fully functioning person. It is a holistic thing. We want experts from all government departments and from non-government agencies to be working together to plan a service delivery.¹⁰³

- 3.77** An Office of Mental Health in the NSW Premier’s Department should provide the necessary service coordination and whole of government response that mental health services in NSW require, coordinating:

- NSW Department of Housing
- NSW Department of Ageing, Disability and Home Care

¹⁰⁰ Submission 192, NCOSS, p 12

¹⁰¹ I Vincent, *Collaboration and Integrated Services in the NSW Public Sector*, Australian Journal of Public Administration, Vol 58, no 3, September 1999, p 50

¹⁰² Sr M Harris, Society of St Vincent de Paul, Evidence 23 May 2002, p 10

¹⁰³ *ibid*

- NSW Health
- NSW Police Service
- Attorney General's Department and
- the various NGOs and community care groups.

3.78 A precedent for this unit was established when the current NSW Government established the Office of Children and Young People (1997), and the NSW Office of Drug Policy (1999) within The Cabinet Office. These were established in recognition of the need for a coordinated government approach to the relevant issue.

3.79 The Committee supports the establishment of an Office of Mental Health in the NSW Premier's Department, in order to reflect the magnitude of the issues and to provide the support and coordination required to improve the services provided by both the government and non-government sectors.

3.80 The Committee is not critical of the policy development by NSW Health, and does not see the Office of Mental Health as a policy unit. The establishment of this unit in the NSW Premier's Department is primarily to assist in the coordination of service delivery and to ensure an inter-agency channel of communication. The Committee cites the Strategic Projects Division of the NSW Premier's Department, in managing the Regional Coordination Program (RCP) as precedent in this regard. The RCP aimed to:

enhance Government services by coordinating service delivery in ways that better meet the needs of regional communities and make best use of government resources.¹⁰⁴

3.81 A case study of the RCP published in *Working Together – Integrated Governance* (March 2002) concluded:

The program gives effect to NSW Government policy priorities which recognise that many of the significant pressures on communities require a corporate and holistic response from government and its agencies.¹⁰⁵

3.82 Substituting '[regional] communities' with 'mental health consumers and carers' in the above statements would make such statements relevant to the objectives of the proposed Office of Mental Health. The Committee contends that the improved coordination of service delivery in the mental health sector would improve efficiency in administration and government resources.

¹⁰⁴ Institute of Public Administration Australia (IPAA), *Working Together – Integrated Governance*, March 2002, p 38

¹⁰⁵ *ibid*

Recommendation 1

That the Premier of New South Wales establish an Office of Mental Health in the NSW Premier's Department.

The Office of Mental Health should provide integrated government advice and coordination of mental health services in NSW, to effectively coordinate the:

- NSW Department of Housing
- NSW Department of Ageing, Disability and Home Care
- NSW Health
- NSW Police
- Attorney General's Department
- non-government organisations and community service providers.

Recommendation 2

That the proposed Office of Mental Health be adequately funded and resourced for a period of 5 years. At the end of this period its functions, objectives and continuation should be reviewed.

Chapter 4 Service provision, treatment and care

For the purposes of this inquiry, ‘mental health services’ have been defined broadly to not only include both public and private mental health services, but also the many and varied related services that support the mental health sector. This chapter will discuss service provision by the mental health sector in NSW, including the ability of the sector to treat and care for the mentally ill and staffing issues. Importantly, the Committee was interested to identify a basis for the following statement:

At a time when the medications available and the treatment for mental illness have vastly improved, the health of the mentally ill is deteriorating.¹⁰⁶
[Society of St Vincent de Paul]

Defining mental health services

- 4.1** Public mental health services are provided by NSW Health, and include crisis teams, case managers and public hospitals, as well as other government-provided community care. Private mental health services include non-government organisations (NGOs), registered charities, General Practitioners (GPs), carers and families. Services that support the mental health sector are associated either through legislation or by default and include the housing sector, NSW Police, Office of the Protective Commissioner of NSW, Office of the Public Guardian and the justice system. The mental health sector and its associated services as a whole, present as a complex and diverse ‘service’. The interrelationship of these services is discussed in this chapter.
- 4.2** NSW Health advises that in accordance with the Second National Mental Health Plan, it is developing public-private partnerships to provide complementary and integrated public and private sector services. These partnerships involve consumers, carers, NGOs, GPs and other agencies including NSW Police and NSW Department of Housing.

Policy foundation – the Population Health Model

- 4.3** NSW Health informed the Committee of a list of extensive clinical and service policies it has initiated, some in conjunction with Commonwealth initiatives. According to NSW Health, mental health service planning is based on the Population Health Model for Mental Health¹⁰⁷, a nationally accepted framework under the National Mental Health Strategy:

This model identifies the patterns of morbidity and mortality in the population in terms of both population surveys and data from health service utilisation statistics. It also takes into account: the influence of social context; socio-economic and demographic patterns; risk and protective influences; and the service systems in terms of both public health and direct clinical personal health care.¹⁰⁸

¹⁰⁶ Submission 143, Society of St Vincent de Paul, attachment, *A Long Road to Recovery – a social justice statement on mental health*, p 16

¹⁰⁷ Submission 267, NSW Health, Attachment - B Raphael, *The Development of a Population Health Model for the Provision of Mental Health Care*, Centre for Mental Health, NSW Health Department, 2000, p G 1

¹⁰⁸ Submission 267, NSW Health, p G 1

- 4.4 The model is intended to recognize the different levels of service delivery - primary, secondary and tertiary systems, as well as health and mental health needs across a person's lifespan. The model is also designed to identify mental health care requirements and priorities for service delivery at different levels of need:

It is supported by an emphasis on the resources necessary to support service delivery and care that will achieve improved mental health outcomes; measure and evaluate these outcomes for individuals and in relation to the service systems that have delivered them; the effectiveness and efficiency of the programs delivered; and the nature, skills and resources for the workforce that will contribute to care.¹⁰⁹

- 4.5 Significantly however, NSW Health does not fund mental health using a population-based model. With the exception of mental health, funds for other health services are distributed from NSW Health to Area Health Services in proportion to population need using a formula called the Resource Distribution Formula (RDF). (See Chapter 5)

- 4.6 The Council of Social Service of New South Wales (NCOSS) indicated that it considers NSW and Commonwealth policy frameworks to be essential elements of an effective policy response to mental illness. NCOSS was one of various organisations, however, which argued that effective implementation of the framework to provide adequate care is not occurring:

Of concern to NCOSS is the extent which these principles, and the broader policy directions outlined in these frameworks, are effectively implemented. Evidence available to NCOSS indicates that many people with a mental illness are receiving wholly inadequate treatment and support, with disastrous consequences.¹¹⁰

- 4.7 Specific policies were examined to identify whether or not policy development has evolved into service provision.

Policy - Mainstreaming

- 4.8 'Mainstreaming' is a policy concept that aims to co-locate mental health services with general health services, while retaining integrated specialised services to ensure continuity and clinical management.¹¹¹ According to NSW Health, the mainstreaming of mental health care is important because of:

- the complex nature of mental illnesses with the involvement of brain and physical health pathology
- the high comorbidity of major physical and mental health problems that are not adequately dealt with in stand alone psychiatric hospitals

¹⁰⁹ Submission 267, NSW Health, p G 1

¹¹⁰ Submission 192, NCOSS, p 5

¹¹¹ NSW Parliamentary Library Research Service, *The Burdekin Report – Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, Briefing Paper No 004\93, 1993, p 11

- the need for complex investigations in the diagnosis and treatment of mental illnesses.¹¹²

4.9 The negative impacts of mainstreaming or centralisation of mental health services have been compounded with the centralisation of public health services in general. St John of God Health Services argued that the centralisation of public health services is exacerbated by geographical clusters of services:

To compound the problem of centralisation of public health services, there is a substantial over-supply of hospital beds in the Eastern suburbs of Sydney, moving hospitals further from the communities they treat! Mental health hospitals have traditionally been much more distant than physical health facilities. This distribution of resources is inconsistent with the need to treat people with mental health problems in the community in which they live (Murthy 2001).¹¹³

Acute care

4.10 According to NSW Health the National, State and Area mental health policies advocate that clinical care and rehabilitation, disability and accommodation support and other services should be delivered to the individual in their home “in the least restrictive manner”.¹¹⁴ Many people with a mental illness however, only receive treatment and care when they present to an emergency department at a public hospital. The nature of episodic care administered at public hospitals and the subsequent discharge or absconding from care by a patient, means that the current principle of caring for a person in the least restrictive manner may not work as intended.

4.11 The proclamation of the *Mental Health Act 1990* and the adoption of the *National Mental Health Plan 1992*, initiated a significant increase of community-based services in the 1990s. During this period, NSW downsized psychiatric hospitals and transferred resources to general hospital services and the community.¹¹⁵ Psychiatric inpatient units were purpose built at general hospitals and integration of services became a major focus of the first National Mental Health Plan.¹¹⁶ NSW Health explained that inpatient services are delivered in a number of settings and frameworks:

A range of community and inpatient care models exist, including ‘Hospital in the Home’ and community care units. Inpatient services sit on a spectrum with both community based pre-hospital programs or diversion, and discharge, follow-up and continuing care.

There has been considerable debate in the community about the degree to which community based care can replace inpatient services. Both in Australia and internationally there is an agreed need to have an adequate balance of both sets of services and a spectrum of care within each, plus appropriate supported

¹¹² Submission 267, NSW Health, p D 3

¹¹³ Submission 182, St John of God Health Services, p 13

¹¹⁴ Submission 267, NSW Health, p G 39

¹¹⁵ D Meadows & B Singh, et al (eds), *Mental Health in Australia – Collaborative Community Practice*, Chapter 6, p 72

¹¹⁶ *ibid*

accommodation options. The emphasis is on integration of care between inpatient and community services and continuity of care for the individual who is ill.¹¹⁷

- 4.12** The Committee was provided with significant examples where this balance, integration and continuity of care are not functioning adequately. The Health Care Complaints Commission informed the Committee of a number of case studies that illustrated gaps in services, a lack of continuity of care as well as medium and long-term care. For example:

B, a young man, had tried to commit suicide on several occasions. He was admitted to hospital after performing life-threatening self-mutilation. While in hospital, he underwent an operation and was assessed by the Community Mental Health Team. During the assessment, B's mother provided the team member with B's mental health history. B was discharged less than 24 hours after admission. The hospital advised his family that there had been a meeting arranged for B with the Community Mental Health Team the next morning. After discharge, B and his father contacted the Team to be informed that no meeting had been arranged and that the earliest available appointment was in 6 days' time. Four days later after B's discharge, he committed suicide.¹¹⁸

- 4.13** The Australian Association of Social Workers (NSW) highlighted that this breakdown in B's discharge plan was not an isolated case:

The relationship between inpatient and community care providers remains poor, discharge plans are generally developed in isolation, often the consumer and carer is left to find their own way to community supports and at times also required to provide their own referral information.¹¹⁹

- 4.14** While B's situation may identify a failure of treatment procedure, the Australian Salaried Medical Officers Federation indicated that, when health services are underfunded and staff are struggling to cope on a daily basis, then adverse events are inevitable:

The blame for any such problems is then rapidly apportioned to the clinician at the coal face despite the fact that the event is the culmination of inadequate resources rather than any negligence or incompetence.¹²⁰

- 4.15** According to the NSW Nurses' Association, while the NSW Health policy of assessment and admission of mental health patients via emergency departments is "philosophically optimal", its success is dependent on the availability and skills in the triage of mental health patients and mental health assessment. The Association informed the Committee that the facilities and staffing mix in general hospitals in many instances are not appropriate for the safe management of acute and possibly violent patients, which can lead to staff errors:

these factors are not present in many hospital emergency departments leading to triage and assessment errors and delays in transporting the patient to a mental unit/facility that can cater for their mental health needs.

¹¹⁷ Submission, NSW Health, p A 13

¹¹⁸ Submission 120, Health Care Complaints Commission, p 2

¹¹⁹ Submission 130, Australian Association of Social Workers (NSW), p 2

¹²⁰ Submission 91, Australian Salaried Medical Officers Federation, p 3

...The result of the lack of available skilled personnel, potential errors and delays, is the increased risk of violence and harm to patients and staff. Other adverse outcomes include the associated risks of prosecution by WorkCover NSW, litigation by patients or their families, and poor public image of the NSW Health care system.¹²¹

- 4.16** The Committee acknowledges that sometimes anecdotes may represent isolated or atypical instances of a breakdown in the system, rather than representing any systemic problems. The number of similar incidents detailed to the Committee, however, raises real concerns about the provision of inpatient and community services in NSW. Based on the evidence received by the Committee, NSW Health needs to better coordinate policy development with service provision for both community and inpatient care.
- 4.17** The Committee notes that the Sentinel Review Committee, chaired by Prof Peter Baume, is reviewing this issue. The Minister for Health may satisfy Recommendation 3 by extending the Sentinel Review Committee's terms of reference.

Recommendation 3

That the Minister for Health commission an independent inquiry into the incidence and circumstances of suicide among people with a mental illness who were:

- under the care of NSW Health or
- refused admission to a public hospital or psychiatric unit within a week prior to their suicide.

The inquiry should review cases from the previous two years, and report to Parliament within 12 months.

Psychiatric beds

Availability

- 4.18** In 1995, the *Australian and New Zealand Journal of Psychiatry* presented evidence suggesting that average provision of acute psychiatric beds in NSW approximates the lowest levels internationally.¹²² The National Association of Practising Psychiatrists (NAPP) criticised the closure of psychiatric beds in NSW, and highlighted the continued shortage:

Today, 11 out of 17 NSW Area Health Services, with a population of 2,714,613 adults, do not provide non-acute psychiatric beds and total psychiatric beds in NSW have declined from 12,000 in 1970 to approximately 2,100 currently.¹²³

¹²¹ Submission 212, NSW Nurses' Association, p 6

¹²² Rosenman, *Australian and New Zealand Journal of Psychiatry*, 1995, 29, pp 238-247.

¹²³ Submission 189, National Association of Practising Psychiatrists, p 5

- 4.19** NSW Health advised the Committee that the changes in the way psychiatric services are provided, and the associated decrease in the number of specialist psychiatric beds in NSW, are reflective of international trends.¹²⁴ The NSW Health submission cited a number of World Health Organisation (WHO) reports. With regard to psychiatric beds, the *World Health Report 2001* is quoted:

[Provision of] mental hospitals with a large number of beds is not desirable... inpatient places should be moved from mental hospitals to general hospitals and community rehabilitation services.¹²⁵

- 4.20** In its submission to the Committee, the NAPP referred to a draft report from NSW Health dated June 2001. In that document NSW Health clearly recognises the shortage of beds:

The pendulum has swung too far and...the number of beds, particularly non-acute beds, may not be sufficient to meet current needs.¹²⁶

- 4.21** Prof Beverley Raphael, Director of the Centre for Mental Health, explained that the document referred to by the NAPP was a draft document and quite different from the final version.¹²⁷ The statement above nevertheless reflects the concerns of many submissions received by the Committee. It also supports the concerns of some health workers that the pressure to discharge patients prematurely is extreme.¹²⁸

- 4.22** Prof Raphael indicated that more acute and secondary beds were presently required while detailing plans to increase bed numbers over the next year:

We have a large number of new beds opening in the accelerated program over the next 12 months. In addition we have supported accommodation beds set up in partnership with the areas and non-government agencies. The staffing issues for the inpatient beds will require extensive education and training and recruitment strategies, and some of those are currently under way.¹²⁹

- 4.23** The Australian Salaried Medical Officers' Federation wrote to the Minister for Health in June 2000 arguing that the number of beds does not correlate with the increasing demand:

It is often the case that patients are discharged from hospital in a state of health which ten years ago would have resulted in their admission to hospital.¹³⁰

- 4.24** Numerous submissions and witnesses to the Committee identified a changing demand in mental health services in recent years that suggest a need for more beds.¹³¹ The NAPP

¹²⁴ Submission 267, NSW Health, A.12

¹²⁵ *ibid*, citing *WHO Report*, 2001, A.13

¹²⁶ Submission 189, National Association of Practising Psychiatrists, p 9, citing NSW Health, *Mental Health Non-Acute Inpatient Services Plan 2001 (Draft)*, p 6

¹²⁷ Prof Beverley Raphael, Interview, *4 Corners*, Australian Broadcasting Corporation, 9 September 2002

¹²⁸ Submission 275, Australian Psychological Society, pp 2, 7; Submission 261, Lithgow Family & Community Mental Health Support Group, p 1

¹²⁹ Prof B Raphael, Director of the Centre for Mental Health, Evidence 12 August 2002, p 4

¹³⁰ Submission 91, Australian Salaried Medical Officers' Federation, Attachment A

¹³¹ Ms Leanne Elsworthy, Coordinator, B. Miles Women's Housing Scheme, Evidence 29 May 2002, p1 and Submission.98, p 5; Dr Jean Lennane, Psychiatrist, Evidence 31 May 2002, pp 22-23; Dr Brian Boettcher, Forensic Psychiatrist, Evidence

informed the Committee that there is more violence, more suicide, as well as more and different drug use, which has led to an increase in the incidence of increasingly difficult patients.¹³² The NAPP submission, among numerous other submissions, commented on the lack of available acute beds to accommodate this trend:

There is a large and recurrent difficulty in getting people with acute psychiatric illnesses admitted to hospital. On many days there are no free acute beds in NSW. By acute beds we mean secure bed facilities where there are *trained staff in adequate numbers* so patients can be closely observed, adequately treated, kept safe from absconding or harm, and kept safe until such time as their illness is controlled.¹³³

- 4.25 The Comprehensive Area Service Psychiatrists (CASP) outlined that inadequate funding, and the subsequent diversion of community and secondary resources to acute inpatient services to cope with the increasing acuity and violence, creates a vicious circle:

When budgets are shrinking, the only areas that can be cut are community and longer-term care services, as acute assessment and in-patient services cannot be reduced. This leads to a restricted “illness” rather than recovery oriented service, and the increasing relapses put further pressure on acute beds.¹³⁴

- 4.26 The Committee acknowledges that NSW Health has increased ambulatory direct care services and recently announced 300 additional beds,¹³⁵ however, the Committee also notes the weight of evidence critical of the lack of adequate acute and non-acute beds in NSW.

Management of beds

- 4.27 The demand for bed numbers is estimated using a ‘theoretical’ or ‘average’ provisions formula. Theoretical or average provisions provide an overall guide for health planners. The average provision of beds does not account for problems of equitable distribution. In response to a question from the Committee on the adequate distribution of beds Mr Ted Campbell, Director of Mental Health at Port Macquarie Base Hospital, stated that the distribution pattern has become important for local needs:

Logically, from my point of view, the nearer the carers, relatives, support personnel and services are located, the more efficient the operation. So when we aggregate positions into particular localities we gain some benefits, but we also have some discrepancies. For example, one of the issues that is constantly being raised with me by my community advisory committee is the question of whether or not Port Macquarie should have a gazetted unit. That is a complex issue that involves many questions. Leaving aside those questions and looking at it from the point of equity, if it is going to be the pattern that base hospitals look like having a

8 August 2002, p 39; Dr Michael Giuffrida, Forensic Psychiatrist, Evidence 8 August 2002, p 49; Ms Trish Butrej, Professional Officer (OH&S), NSW Nurses’ Association, Evidence 30 July 2002, p 45; Mr Ted Campbell, Director, Mental Health, Port Macquarie Base Hospital, 1 August 2002, p 22; Prof Beverley Raphael, Director, Centre for Mental Health, NSW Health, Evidence 12 August 2002, p 2

¹³² Submission 189, National Association of Practising Psychiatrists, p 7

¹³³ *ibid*

¹³⁴ Submission 209, Comprehensive Area Service Psychiatrists, p 3

¹³⁵ NSW Minister for Health, *press release*, 4 June 2002

mental health unit with gazetted components, then logic would suggest that would occur at Port Macquarie.¹³⁶

- 4.28** An estimate based on an 'average' may not adequately indicate needs when the occupancy and demand for long stay and rehabilitation beds are above average or there is no hospital accommodation available on a statewide basis. Mr Campbell said that, although the number of gazetted beds has increased, the total number remains insufficient:

The long-term rehabilitation services are few and far between. Mr Scott alluded to that in his comments about the schedule 5 hospitals being wound down. The difficulty we have is not that the number of people in our area who need this intensive amount of support is great, it is the amount of resource demand that these people bring with them. We are not able to provide them with the level of intensity of rehabilitative support that they require if they are going to be able to live a semi-independent life back in the community.¹³⁷

- 4.29** According to the NAPP, the pressure on beds means that it is not possible to keep patients in hospital long enough to ensure that their illness has stabilised. The NAPP outlines a common theme expressed in submissions from consumers, carers and health professionals:

Because of the enormous pressure to discharge quickly, there is no time to reflect on acute and long-term management plans, often large doses of medications are used to achieve rapid changes, and there is next to nothing in the way of psychological therapies. What is worrying this patient, what pressures have they been under, who are they, what about their families? No one asks, there's no time.¹³⁸

- 4.30** The NAPP also asserted that:

Early discharge of patients in the acute phase of psychotic illness is now routine. Many patients are now discharged at a level of illness that once constituted criteria for admission.¹³⁹

- 4.31** In its submission to the Committee, St John of God Health Services stated that it is a lack of prevention services that is responsible for the pressure on acute beds:

Acute beds are central to tertiary treatment programs, and necessary in treating severe episodes of mental health programs. Secondary programs are needed to assist people to live with their illnesses. That is, there is an excessive load of tertiary services due to the lack of secondary prevention services. Thus, those in need of tertiary services appear to be getting slow and/or inadequate treatment. Residential services, as previously indicated, have the potential to minimise the misuse of acute beds and other acute services increasing the resources available to those in crisis. Thus the pressure on hospital beds may not be due to the lack of beds but to the lack of appropriate community based secondary prevention services.¹⁴⁰

¹³⁶ Mr Ted Campbell, Director of Mental Health, Port Macquarie Base Hospital, Evidence, 1 August 2002, p 20

¹³⁷ *ibid*

¹³⁸ Submission 189, National Association of Practising Psychiatrists, p 8

¹³⁹ *ibid*, p 9

¹⁴⁰ Submission 182, St John of God Health Services, p 28

- 4.32** Dr William Barclay, psychiatrist, noted that in some Area Health Services the pressure to provide acute services has overshadowed the need to provide rehabilitation and extended care services. Dr Barclay reasoned that:

From a consumer and carer point of view an acute admission to hospital is but one phase of what may be a lifetime of mental disorder. The burden on families begins when the index patient is diagnosed and may or may not be admitted to hospital for the first time but does not end when the patient is discharged. From the viewpoint of the nation it is chronic disability that carries the greatest social and economic cost.¹⁴¹

- 4.33** Based on the weight of submissions, the unfortunate result of inadequate resources allocated for secondary mental health services, such as rehabilitation and supported accommodation, is that people with a mental illness are regularly readmitted into acute care. Described as a ‘revolving door’ syndrome¹⁴², many people with a mental illness will then once again become reliant on a secondary care tier that is not adequately resourced to ensure rehabilitation. Consequently, these people may deteriorate psychologically and become socially degraded in inappropriate accommodation, or become homeless.

- 4.34** The Mental Health Co-ordinating Council (MHCC) suggested a possible course of action which may allow NSW Health to address the revolving door problem:

Currently mental health services are required to collect statistics on readmissions within 28 days of discharge. A number of mental health services examined why readmission was required, with a particular focus on the adequacy of the discharge plan. While these data are useful and should form standard reporting in all services, the availability of readmission data at three, six and 12 month intervals would enable NSW Health and the NGO sector to assess more fully the extent of the ‘revolving door’ syndrome. Analysis of these data would assist health planners to identify factors, interventions or services that could prevent readmission. These readmission figures are currently not reported but could be accessed from clients’ records.¹⁴³

- 4.35** The Centre for Health Service Development, University of Wollongong, argued that the mental health sector has a history of poor bed management and that better community support services is required to relieve the pressure on inpatient beds:

The best way to manage beds is not to open more beds. It is through providing better community services both before and after an admission and to stop an admission occurring. One goal is clear and fundamental to resolving the ‘mental health crisis’ in NSW – the goal of any change recommended by the Committee should reduce readmission rates. Unless this occurs, the system will remain in a perceived crisis.¹⁴⁴

- 4.36** The Committee shares community concerns that the mainstreaming of mental health services delivers episodic care without adequate secondary care and is creating a revolving

¹⁴¹ Submission 263, Dr William Barclay, p 3

¹⁴² Submission 218, Mental Health Co-ordinating Council, p 4

¹⁴³ *ibid*

¹⁴⁴ Submission 268, The Centre for Health Service Development, University of Wollongong, p 8

door system for some people with a mental illness. The Committee supports the extended collection of readmission statistics as requested by the MHCC.

Conclusion

- 4.37** NSW Health has significantly reduced the length of stay for patients in hospitals, which has been generally considered to be a positive clinical, budgetary and service initiative.¹⁴⁵ This performance measure is inappropriate for mental health patients who require longer periods of managed care. It takes several days for someone who is acutely unwell to stabilise and start responding to medication and up to 14 days for it to then take effect.¹⁴⁶ Clearly mental health care cannot be completely integrated with general inpatient care without adequate and responsive secondary care services.

Recommendation 4

That the Minister for Health introduce data collection on readmissions to psychiatric units at three, six and twelve month intervals (in addition to the 28 day data already collected), to assist in the planning of services with a relapse prevention focus. This information should be made available publicly.

Acute care to secondary care – service linkages

- 4.38** For those severely affected by a mental illness NSW Health advocates a ‘strong emphasis’ on rehabilitation and case management, particularly assertive community treatment. NSW Health advised that community mental health services deal with acute care through a range of models, including ‘Hospital in the Home’ and community care units. Services available between inpatient and community care include community based pre-hospital programs or diversion, discharge follow up, continuing care, outreach and crisis services.¹⁴⁷ NSW Health also referred to extensive partnerships with other agencies, such as housing, NGOs and GPs in the delivery of community services.¹⁴⁸ The role of the GP, case manager and community services are vital in the rehabilitation phase for people recovering from an acute episode.

- 4.39** In its submission, NSW Health outlined treatment management from inpatient to community care:

A continuum from inpatient to varying levels of community residential care and supported accommodation are also essential components of an integrated service framework. Furthermore, non-government organisations play a vital role in disability support, rehabilitation and other aspects of non-acute care and specific

¹⁴⁵ NSW Legislative Council, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, p 36

¹⁴⁶ Submission 189, National Association of Practicing Psychiatrists, p 9

¹⁴⁷ Submission 267, NSW Health, A.13 & A.19

¹⁴⁸ *ibid*, A.19

strategy to promote partnerships between NGOs and mental health services is being implemented.¹⁴⁹

- 4.40** Although NSW Health outlined extensive continuing care programs, the Committee received overwhelming evidence about the lack of continuity of care. In a submission to the Committee, St John of God Health Services referred to the poor integration of service provision:

There is also an effect of the separate service silo, in that each service has the opportunity to say this person is receiving care from over there, and thus we don't need to do anything. Experience within St John of God Health Services is that several people who have received services from us have not been able to get services from the community mental health teams because they are perceived to have another source of help. There is a need for greater integration of the public and private sectors, removing some of the boundaries so that people get the services they need.¹⁵⁰

- 4.41** The impact of service 'silos' for people with mental health problems is that access to a range of services becomes difficult and permits health services to transfer responsibility to others.¹⁵¹ The existence of silos, due to the poor integration of services, was noted in the mid-term review of the Second National Mental Health Plan by the Commonwealth Department of Health and Ageing:

Financial and service silos exist where seamless systems are needed for mental health, housing, education, disability, geriatricians, child and family services.¹⁵²

Intervention through community care/crisis teams

- 4.42** The Legal Aid Commission stated that it regularly sees a failure to recognise the seriousness of a situation and a lack of assertive intervention. According to the Commission, this failure highlights poor quality service at the critical early assessment phase, which can subsequently lead to quite dramatic outcomes.¹⁵³
- 4.43** Mr Fred Pateman's son had schizophrenia and was killed by a close friend also suffering chronic schizophrenia. Mr Pateman's submission to the Committee included a copy of a letter he sent to the Minister for Health, which stated:

There is a lot of talk about early intervention in the system, but we are always told that unless someone is a danger to himself or others nothing can be done. By the time they have reached that stage they have either been shot by police or have committed suicide.¹⁵⁴

¹⁴⁹ Submission 267, NSW Health, A.19

¹⁵⁰ Submission 182, St John of God Health Services, p 15

¹⁵¹ *ibid*

¹⁵² G Thornicroft & V Betts, *International mid-term review of the Second National Mental Health Plan*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Ageing, 2002 (Canberra), p 15

¹⁵³ Submission 216, Legal Aid Commission, p 4

¹⁵⁴ Submission 247, Mr & Mrs Pateman, attachment, letter to Mr Craig Knowles, Minister for Health

- 4.44** The limitations of case management places significant reliance and pressure on community crisis teams. The importance of crisis teams as intervention and ambulatory service providers was repeatedly expressed to the Committee. For example, Prof John Snowdon, made a personal submission to the Committee in which he stated:

My impression (from knowledge of working patterns in various locations, and from the opinions of consumers, carers, professionals and non-government organisations) is that attempts have been made, in the last 19 years in NSW, to develop community teams that can respond to calls for help, and which can help mentally ill people to stay out of hospital. However, funding cuts have led to a reduction in the size of such teams and somewhat patchy availability of staff to provide support.¹⁵⁵

- 4.45** The Gethsemane Community submission referred to the burden of work facing many community mental health teams, stating they are overstressed and overworked:

In the Inner Western Sydney area I know, one team member has a case-load of 30. He is also on the Crisis team for 3 out of 5 days and does intake for 4hrs on another day. Other team members have 50-60 clients.¹⁵⁶

- 4.46** Later, in reference to new clinical reporting requirements and the consequent additional administrative burdens, the Gethsemane Community added:

Consequently, team members are being advised to offload clients to GPs. Is this an indication of the encroachment of a Managed Care (US style) approach to Mental Health services here? A lot of information may be gathered, but this is of limited use if the services are not there. Also, all the information from clients offloaded to GPs will be lost. It is possible that many offloaded clients will regress because few GPs have the interest and skills to follow up such patients.¹⁵⁷

- 4.47** In rural areas, the situation is far worse, with some major centres having no psychiatrist at all:

There is usually no Crisis Team. Even if one exists, it operates only during working hours Monday to Friday. In Mudgee, the President of St Vincent de Paul conference often received phone calls from the police late at night, trying to place a homeless person, who often had a mental illness.¹⁵⁸

- 4.48** Another St Vincent de Paul member reported:

We called a number for the mental health crisis team for the Riverina and our call was diverted to Melbourne. This was because we rang on the weekend and the local mental health team doesn't operate on the weekend. What's the use of an emergency service located over 500kms away?¹⁵⁹

¹⁵⁵ Submission 273, Prof John Snowdon, p 2

¹⁵⁶ Submission 75, Gethsemane Community, p 2

¹⁵⁷ *ibid*

¹⁵⁸ *ibid*, p 3

¹⁵⁹ Society of St Vincent de Paul, *A Long Road to Recovery: a social justice statement on mental health*, July 2002, p 16

- 4.49** Submissions from the NGO sector indicate that there are considerable problems between the communicated urgency of referrals by community carers and support organisations and the interpretation and subsequent responses of acute care teams. Ms Leanne Elsworthy, Co-ordinator of the B. Miles Women's Housing Scheme, expressed frustration with the assessment of urgency by crisis teams, particularly when the case manager cannot be contacted:

That is where the systems can break down as well. Because the case managers are very hard to get we can actually have trouble getting the crisis team to come if there is a case manager around and we cannot get on to that case manager, because the crisis team wants to talk to the case manager. We have had situations where the case manager has just not been there and they will not listen to us. That is extremely frustrating.¹⁶⁰

- 4.50** Ms Elsworthy explained that there have been times when the crisis team assumed that, as the worker contacting them is not a health employee, they may not know the full clinical details of the person concerned. Ms Elsworthy provided a case example where such an assumption, without proper assessment, could have had devastating consequences:

I had a client try to burn the house down. We were ringing the crisis team and they were telling us it was not an emergency. This was the day before Easter and we were not going to be there for the next five days. It took hours.

...[the client] ended up being admitted for about three months and was one of the most ill patients Prince of Wales apparently ever had.¹⁶¹

- 4.51** While Ms Elsworthy added that this case was some time ago, and did not believe that such demarcation would occur now, she concluded that:

Because we are not in the health system, we are not health employees, there can be a lack of respect about our knowledge. Because we are not clinicians we can be downgraded in terms of how we are viewed. But, believe me, I know psychosis when I see it.¹⁶²

- 4.52** The Committee understands the increasing presentation of violent and difficult patients, often under the influence of amphetamines, has made the ability of crisis teams to perform their duties very difficult¹⁶³ (see Chapter 10, MISA). This trend has seen police increasingly called on to function as a first response team, often in the place of crisis teams. The NSW Police Service acknowledged the valuable role mental health teams fulfil, and stressed that in many areas effective partnerships are in place. It was noted however that there are also many instances where mental health workers do not respond to situations at all:

There appears to be a view held by some mental health workers that police will substitute for them and attend premises to schedule persons under section 24 of the Act. This is not the case as police powers under this section relate only to

¹⁶⁰ L Elsworthy, Evidence, 29 May 2002, p 5

¹⁶¹ *ibid*, pp 5-6

¹⁶² *ibid*, p 5

¹⁶³ Submission 189, NAPP, p 15; R Matthews, Evidence, 30 May 2002, p 27

commission of offences and suicide attempts. On many occasions, police feel as though they are being asked to be de-facto mental health workers.¹⁶⁴

4.53 See Chapter 14 for further detail on police and mental health services.

General Practitioners

4.54 Both the MHCC and NCOSS contend that episodic care in public health services effectively means that ongoing case management is replaced by a referral to a GP once the case manager considers the patient has 'stabilised'.¹⁶⁵ Apart from the fact that GPs are not specifically experienced, trained or funded to act as an adequate case manager, many GPs may be unwilling or unable to provide adequate case management services. Mental health services must be able to go to the patient.

4.55 NSW Health informed the Committee that a number of projects and strategies have been introduced in Area Health Services to support GPs in providing mental health services:

These have provided the flexibility to trial locally generated solutions for improving mental health services. Most trials are in a two-year phase with final evaluation reports due in November 2002. Examples include improved liaison and support services for general practitioner consultation in the Illawarra Area following the establishment of a telephone support network to general practitioners seeking support on guidance and advice with managing patients with mental illness; increased training and secondary consultation activity and the provision of support to general practitioners and remote health service staff in the Far West and a project to improve networks for consumers and carers in the Hunter Area Health Service.¹⁶⁶

4.56 NSW Health also informed the Committee that it has developed partnerships with GPs to complement the care of people with mental health problems and disorders:

This is an active partnership program aimed at bringing service systems closer together. It builds on shared care developments, but extends beyond them to better recognise the special contributions of general practice.¹⁶⁷

4.57 Dr Margo Hoekstra, a GP advisor on partnership issues appointed by the Alliance of General Divisions (NSW), argued that 'partnerships' with GPs are essentially a unilateral push by public health services:

The use of words like 'partnership' or 'primary care' are not part of the language of general practice...Essentially GPs are used to working alone and have not developed skills to work in a team.¹⁶⁸

¹⁶⁴ Submission 286, NSW Police Service, p 7

¹⁶⁵ Submission 218, MHCC, p 14; Submission 192, NCOSS, p 6

¹⁶⁶ Submission 267, NSW Health, p G 26

¹⁶⁷ *ibid*

¹⁶⁸ Submission 279, Dr Hoekstra, Alliance of General Divisions (NSW), p 7

4.58 Dr Hoekstra expressed doubt that partnership programs would succeed:

On the whole GPs have a remote interest in working at partnerships with mental health services. A focus on building partnerships is not a GP strength. GP thinking can be elitist and intolerant of other's world views...GPs tend to be somewhat obsessive by nature and as they operate in a culture of personal responsibility they have created an environment where the problem has to be fixed now...

...At the level of Area Mental Health Service the time lines are longer, and need to be more flexible – a lot more work needs to go into relationships, negotiation and renegotiation and then if there is a change of staff you have to start all over again. That's how the real world functions.¹⁶⁹

4.59 GPs are an important segment of mental health services in NSW. Their value should however, be recognition and referral rather than as de facto mental health case managers. The NSW health system should not rely on GPs to provide the necessary secondary care for people with a mental illness.¹⁷⁰ The Hon Frank Walker, QC, President, Schizophrenia Fellowship, referred to the need for GPs to have a greater understanding of mental illness, and when to refer clients to a specialist:

We need to run campaigns and most of all we need to convince GPs that they should know something about mental illness because a great many of them know absolutely nothing. They do a six-month course at university and most of them are so out of date that they are not much use at all.

They know nothing about the medications. When they prescribe medications they are the wrong ones or the old-fashioned ones dating back 20 years. I am not saying it is everyone because some are very good but our experience is that GPs need to be educated greatly. That is probably one of the great problems about mental illness, early intervention is vital with schizophrenia and there are not many GPs who have the first idea how to diagnose it, to see the signs and to get people to specialists quickly so that they might intervene, thereby saving a great deal of time and trouble.¹⁷¹

Non-government sector

4.60 Core public mental health services are increasingly under pressure from a lack of resources, beds and in certain areas, expertise. The MHCC asserts that the private sector and, in particular, NGOs are being increasingly called upon to fill the gaps in these services:

For example numerous NGOs have reported to MHCC the difficulties in obtaining a timely response from Extended Hours Teams or other emergency psychiatric services providing after hours cover. This has meant that NGOs have had to continue to provide a service in the interim. The other main area where

¹⁶⁹ Submission 279, Dr Hoekstra, Alliance of General Divisions (NSW), p 7

¹⁷⁰ Submission 75, Gethsemane Community, p 2

¹⁷¹ F Walker, Evidence, 8 August 2002, p 32; The Hon Frank Walker QC, career includes: MHR (ALP) Robertson NSW - 1990-96 Fed Minr Admin Services 1994-96, Special Minr State, V-Pres Exec Council 1993-94; NSW MLA (ALP) Georges River - Minr Arts 1986-88, Housing 1983-88, Youth and Community Services 1983-88, Aboriginal Affairs 1981-84, Attorney-General 1976-83

mental health NGOs are feeling pressure to fill the gap is in case management or outreach support services, given that provision by public mental health services is becoming more scarce. A number of NGOs already provide case management services but are neither recognised nor funded as providers of these services.¹⁷²

4.61 Mental health NGOs are not-for-profit community managed organisations that receive government funding to provide community support services for people with a mental illness. NSW Health states that the role of NGOs in the provision of mental health services in NSW broadly includes:

- peak/statewide representation of members
- disability support, including accommodation support, residential services, outreach, respite, rehabilitation, non-clinical case management/co-ordination, supported employment, social/recreational
- self help/mutual support, usually consumer and/or carer driven peer support groups. In recent years there has been an increased focus on NGO based psycho-social rehabilitation services with the emergence of the Clubhouse model and supported employment services and
- advocacy/information/education services. This may be the organisation's primary role, such as the Mental Health Association of NSW, or a secondary role. NSW Health expressed that the NSW Government has identified increased involvement in health care provision by NGOs as a key policy commitment.¹⁷³

4.62 The Committee has consistently heard that NGOs, registered charities, GPs, families and carers are poorly resourced to cope with the burden from the public sector shift. The level of resources allocated by government to the community sector has been consistently criticised by NGOs and carers. NSW Shelter, for example, informed the Committee that accommodation for people coming out of boarding houses and funded by the NSW Department of Ageing, Disability and Home Care (DADHC) is costed on the basis of the person's support needs taken as a moment in time, and assuming this to be constant. Chair of Shelter NSW, Mr Phillip French argued:

That is not effective for people with mental illness because this week the person may require four hours assistance, next week the person may require 60 hours if the condition deteriorates. Part of the problem is planning effective support services for people with mental illnesses. The system has to recognise that the level of assistance required is not static, it needs to be able to flow in a much more flexible way to people. That means funding infrastructure rather than individuals.¹⁷⁴

4.63 The MHCC raised concerns over what it sees as an apparent change in direction of mental health services in the treatment of people with a mental illness. In its submission to the Committee the MHCC stated that services for people with continuing and severe mental

¹⁷² Submission 218, Mental Health Co-ordinating Council, p 13

¹⁷³ Submission 276, NSW Health, p G.28

¹⁷⁴ Mr Phillip French, Chair, Shelter NSW, Evidence, 29 May 2002, p 54

illnesses have been downgraded as the focus has turned to health promotion and early intervention.¹⁷⁵ More specifically, the MHCC asserted that:

there appears to be a much greater focus in the public sector on treating depression and anxiety rather than psychosis....The NSW Health mental health policy documents released in the last five years reflect this change in direction.¹⁷⁶

- 4.64** The MHCC expressed concern that the NGO sector was not consulted about the change in direction, stating that it has had a direct impact on NGO services:

The non-government sector is under increasing pressure to support the most disabled clients with psychotic illnesses in the community with inadequate resources and inadequate clinical back up from the public sector.¹⁷⁷

- 4.65** In its submission to the Committee NSW Health explained that it was developing partnerships with the NGO sector. The NSW Consumer Advisory Group (NSW CAG) stated however, that this initiative is not yet effective:

Despite the rhetoric, the concept of partnership is still embryonic. With further effort and real commitment partnerships could reduce duplication of services, enhance access to services and ensure better outcomes.¹⁷⁸

- 4.66** Clearly, policies developed by NSW Health need improved implementation programs and service integration.

Recommendation 5

That the Minister for Health utilise sections 127, 129, and 130¹⁷⁹ of the *Health Services Act 1997* to ensure that all NSW Health mental health policies, programs and service delivery guidelines are implemented by Area Health Services.

Assertive case management

- 4.67** A number of submissions and witnesses informed the Committee that assertive case management has been found to improve the continuity of care for an individual. For example, a mental health worker responsible for engaging a client in care and organising

¹⁷⁵ Submission 218, Mental Health Co-ordinating Council, p 2

¹⁷⁶ *ibid*

¹⁷⁷ *ibid*, p 3

¹⁷⁸ Submission 162, NSW Consumer Advisory Group, p 47

¹⁷⁹ Section 127 refers to the determination of subsidies, specifically 127 (4) The Minister may attach to the payment of any subsidy such conditions as the Minister thinks fit. Section 129 refers to funding of recognised establishments and recognised services of affiliated health organisations. The Minister may delegate to any area health service the function of determining: (a) the subsidy (if any) to be received by any affiliated health organisation for its recognised establishments and recognised services, and (b) the conditions (if any) that should attach to that subsidy. Section 130 refers to performance agreements between area health services and affiliated health organisations they subsidise, including 130 (1) An area health service exercising a function delegated under section 129 in respect of an affiliated health organisation may enter into a performance agreement with the affiliated health organisation in respect of its recognised establishments and recognised services.

the care required, would also engage in cross agency liaison necessary to acquire the best services for the client.¹⁸⁰

- 4.68** The primary purpose of case management is to ensure continuity and integration of services for the benefit of consumers. The lack of adequate case management, according to the NAPP, returns additional pressure to acute care services:

After discharge most patients with a mental illness get no treatment to speak of, perhaps occasional monitoring of their medication, and suffer from “revolving door” breakdowns needing readmission to hospital. This creates enormous strain in families, on the patient themselves and on the health system generally.¹⁸¹

- 4.69** NSW Health currently funds community case management programs in NSW; however, as the Committee has heard, it is not uncommon for case managers to have carriage of between 50-60 clients.¹⁸² In response to a question from the Committee regarding episodic care and whether or not there was a lack of systematic case management, Ms Jenna Bateman, Executive Officer of the MHCC stated:

that is something that is increasingly evident in the way that case management services just stop after a certain amount of time and people are left without that support in the community. We would want to see those people, after that intensive case management, then refer to NGO outreach services, for example, so that there is someone keeping an eye on them so that when their household gets a bit hectic or they are beginning to isolate, there is someone who is aware of it and who can link them back or connect them with the community.¹⁸³

- 4.70** NSW Health should encapsulate the intention of assertive case management to dismantle the ‘silo’ effect. A more comprehensive assertive intervention program is the Assertive Community Treatment program developed in the USA. The Program of Assertive Community Treatment originated in Wisconsin in the late 1970s, where a multidisciplinary team of psychiatric inpatient staff adapted its role, prompted by the process of deinstitutionalisation, to patients in the community. The program adopts an intensive approach to the treatment and care of people with a serious mental illness, where a team including case managers, a psychiatrist, several nurses and social workers, vocational specialists, and substance abuse treatment specialists operate a service, 24-hours, 7 days per week.¹⁸⁴

- 4.71** Central to the program is comprehensive treatment planning, ongoing responsibility, staff continuity and small case loads, most commonly with 1 staff member for every 10 clients. The cost of operating such an intensive program is considerable, and is recognised as most cost effective when targeted towards individuals with the greatest need, particularly those with multiple hospitalisations.¹⁸⁵

¹⁸⁰ Submission 182, St John of God Health Services, p 15

¹⁸¹ Submission 189, National Association of Practising Psychiatrists, p 10

¹⁸² Submission 75, the Gethsemane Community, p 2

¹⁸³ Ms Jenna Bateman, Executive Officer, MHCC, Evidence, 28 May 2002, p 38

¹⁸⁴ US Public Health Service, *Mental Health: A Report of the Surgeon General*, Chapter 4

¹⁸⁵ *ibid*

- 4.72** Clearly the functioning of case management programs requires review in NSW. St John of God Health Services supports more intensive case management and community treatment, though it identified that:

Assertive case management requires a shift in culture and funding. A major requirement of the funding is to fully fund an assertive treatment program.¹⁸⁶

- 4.73** The involvement of carers in case management is further discussed in Chapter 6.

Recommendation 6

That the Minister for Health ensure additional resources are made available for community crisis teams and the adequate case management of people with a mental illness in the community.

Recommendation 7

That NSW Health develop a program of assertive case management for the sustainable long-term management of people with a mental illness in the community and that the Minister for Health provide long term recurrent funding to support such a program. Such a model should be based on the Assertive Community Treatment program developed in the USA, and include:

- a multidisciplinary team of psychiatric inpatient staff, including case managers, a psychiatrist, several nurses, social workers, vocational specialists and substance abuse treatment specialists, operating a 24 hour, 7 days per week service
 - comprehensive treatment planning, ongoing responsibility, staff continuity and small case loads, most commonly with 1 staff member for every 10 clients and
 - targeting individuals with the greatest need to ensure cost efficiency, particularly those with multiple hospitalisations.
-

Long-term care and rehabilitation

- 4.74** Places of long-term institutionalised care for people with a mental illness were once referred to as ‘asylums’. The term asylum appropriately means a place of refuge, retreat, safety or sanctuary. It has unfortunately become stigmatised through association with historically poor management of psychiatric institutions. Attitudes towards ‘institutionalised’ care vary considerably among the many submissions received and witnesses heard during the inquiry.

¹⁸⁶ Submission 182, St John of God Health Services, p 15

The debate on institutionalised care

- 4.75** Evidence provided by witnesses such as Mr Ian Ball, President of the Police Association of NSW, and Ms Gillian Church, of the Mental Health Association, commented on the previous horrific conditions within some areas of institutionalised care. Ms Church said that the Mental Health Association was opposed to institutionalised care:

We say quite clearly that we are strongly in support of care in the community, and I must say at this stage that we are implacably opposed to either reopening the old institutions or to building new ones. For example, there is a proposal in the air that has been put by the Opposition to build a new 400 bed hospital on the grounds of Rozelle. I am not sure if that is one building or several buildings. It does not matter to us.¹⁸⁷

- 4.76** By way of contrast, the Committee received evidence from consumers and carers advocating the need for long-term rehabilitation and care facilities for people with chronic mental illness. Sister Myree Harris, Society of St Vincent de Paul, contended that:

We think there is a need for some kind of asylum, not the old psychiatric institution, but we need a longer stay in hospital or in some kind of therapeutic community outside of hospital, some kind of supported accommodation where people can get well enough.¹⁸⁸

- 4.77** Ms Maureen Doyle, primary carer for her 34 year old disabled daughter diagnosed with dual disabilities, called for a retreat for some people with a mental illness:

There are some people in our world that are unable to cope in our society and I feel that there needs to be a place of retreat where they can live with dignity and quality of care without outside pressures that only execrate their condition.¹⁸⁹

- 4.78** Sister Mary Trainor, Chairperson of Bloomfield Hospital, referred to the need for such retreats or designated rehabilitation units:

There is a growing recognition that not all patients are able to be rehabilitated to the point of being able to function in the outside community. This highlights the need for "asylum". A safe and secure unit needs to be provided for the protection, care and management of these people.¹⁹⁰

- 4.79** A distinction must therefore be made between the previous management of psychiatric institutions and the concept of institutionalised care. The inquiry received numerous submissions from former patients who referred positively to the benefits and rehabilitation attributes of 'institutions'.¹⁹¹

¹⁸⁷ Ms Gillian Church, Mental Health Association, Evidence, 23 May 2002, p 38

¹⁸⁸ Sr M Harris, Evidence, 23 May 2002, p 6

¹⁸⁹ Submission 155, Ms Maureen Doyle, p 2

¹⁹⁰ Submission 140, Sister Mary Trainor, Bloomfield Hospital, p 4

¹⁹¹ Submission 117, Ms Geraldine Simpson; Submission 28, Mr John Liebmann; Ms Patricia Webster, public forum, 7 August 2002

- 4.80** The Richmond and Burdekin reports were both compiled during domestic and international campaigning by civil libertarians. An aspect of this campaigning concerned the independence of people suffering a mental illness, which was considered a priority. Dr Giuffrida informed the Committee, however, that it has become apparent that the shift away from some areas of managed care has not necessarily been in the best interests of some patients:

Twenty years ago people believed somehow, naively, that we could prevent people going on to develop chronic forms of schizophrenia with all of the disability and chronicity that one would see with chronic cases. But that was not to be so. There are still people who develop very virulent forms of schizophrenia who require long stay rehabilitation services of the kind that are now only available in a few fifth schedule hospitals that still stand. And some of those are in danger of being closed.¹⁹²

Shortage of long-term care

- 4.81** Dr Michael Giuffrida, Director of Forensic Psychiatry, Westmead-Cumberland Hospital, explained to the Committee that secondary care units are required to relieve the congestion in acute care units:

Otherwise the acute units simply get blocked with long-stay patients waiting for a rehabilitation bed in a hospital far away. At any one time a unit might have three, four or five such people who might stay there for months on end.¹⁹³

- 4.82** The CASP submission expressed a similar view and stated that there is an apparent shortage of acute inpatient places “due to blocking of acute beds by long-term patients waiting interminably for placements in constipated psychiatric hospitals”.¹⁹⁴

- 4.83** Dr Giuffrida noted the systematic reduction of rehabilitation services within scheduled hospitals:

Over the last 18 years we have seen the devolution of the fifth schedule hospitals. They did provide for a continuity of care in the sense that they had acute unit beds and then various ranges of accommodation on the hospital campus with rehabilitation facilities and ultimately cottage-type beds and a more domestic arrangement. We argued that when I was a member of the Barclay Committee from 1988 to early 1990. The Health Department at the time provided for a whole range of accommodation in those fifth schedule hospitals. They have now become the core of the rehabilitation beds still available in New South Wales. But there are simply not enough to provide for the new chronic patients.¹⁹⁵

¹⁹² Dr Michael Giuffrida, Forensic Psychiatrist, Evidence, 8 August 2002, p 51

¹⁹³ *ibid*

¹⁹⁴ Submission 233, CASP, p 1

¹⁹⁵ M Giuffrida Evidence, 8 August 2002, p 51

- 4.84** The Chair of Shelter NSW, Mr Phillip French, informed the Committee that the lack of rehabilitation services is a major problem in mental health services in NSW:

One of the biggest problems in the health system is that not only most of the money goes into acute services, although to some extent they remain insufficient in some areas of the State, but that we do not have a clearly articulated system that says that a person with a mental illness—taking their human service trajectory—will need services that relate to their acute health care needs and services that relate to their rehabilitation and services that relate to the community care needs, which are non-acute but which relate to domestic assistance because of a lack of skill.¹⁹⁶

- 4.85** Mr French also argued that the lack of a systematic approach to planning is compounded by the territory disputes between the NSW Department of Ageing, Disability and Home Care and NSW Health about who is responsible for various areas. Mr French stated:

Health says that it is responsible for acute health care needs, that is putting it at the extreme. What it does not do is effectively invest in community-based rehabilitation services. DADHC is saying that this is a new population group for it, why should it have to stretch its dollar to this new group of people.¹⁹⁷

- 4.86** The submission from Gethsemane Community, a community house for a small group of people who have a mental illness, expressed concern that there is currently a lack of a planned, coherent approach to psychiatric rehabilitation:

There seems never to have been a systematic, planned, developed approach to rehabilitation services. A senior Mental Health advisor stated categorically: “Clubhouses don’t work”. When challenged with eminently successful models such as the specifically targeted range of clubhouses in Columbia, South Carolina, he hadn’t heard of them. He said the system had to continue operating the present activity centres, though they were of limited usefulness, because some people liked them.¹⁹⁸

- 4.87** The Gethsemane Community called for a needs assessment in all mental health related areas to establish the gaps in services and suggested that an expert advisory committee be established, comprising eminent people with knowledge of successful rehabilitation models operating throughout the world, to plan a comprehensive range of services. This advisory committee would continue as a monitoring and evaluation group once the model is operational. The submission states that recurrent funding must be allocated as a guarantee.¹⁹⁹

¹⁹⁶ P French, Evidence, 29 May 2002, p 54

¹⁹⁷ *ibid*, p 55

¹⁹⁸ Submission 75, Gethsemane Community, p 2

¹⁹⁹ *ibid*

Recommendation 8

That the Minister for Health introduce a needs assessment in all mental health related areas to identify the gaps in services and that an expert advisory committee be established to oversee the assessment.

The committee should consist of eminent people with knowledge of successful rehabilitation models operating throughout the world. The committee should be allocated recurrent funding as a guarantee, in order to:

- plan a comprehensive range of services and
- continue as a monitoring and evaluation group once the model is operational.

Rozelle Hospital – a place of asylum

- 4.88** The Committee acknowledges that some stakeholders are concerned that the reintroduction of institutionalised care conflicts with the concept of encouraging independence as part of rehabilitation programs for people with a mental illness. The Committee has determined, after considering the evidence presented during the inquiry, that it is important that properly managed places of asylum for the chronically mentally ill be available as one option among other rehabilitation and care services.
- 4.89** Rozelle Hospital was formed in 1976 from the amalgamation of the psychiatric hospitals, Callan Park and Broughton Hall. It provides services for patients under the:
- *Mental Health Act 1990* (both voluntary and involuntary provisions)
 - *Guardianship Act 1987*
 - *Inebriate Act 1912* and
 - the forensic provisions of the *Mental Health (Criminal Procedures) Act 1990* and the *Mental Health Act 1990*.
- 4.90** The 61 hectares of Callan Park remain hospital grounds, consisting of inpatient and rehabilitation services, drug and alcohol unit, psychogeriatric services, and training facilities for mental health education and research.
- 4.91** Rehabilitation services consist of 40 beds, providing programs for people with serious mental illness who have symptoms requiring longer-term specialist mental health care. The service is designed to improve quality of life and promote optimum functioning in the community. Rehabilitation services at the hospital also contain graded accommodation ranging from high levels of support to independent living.
- 4.92** The NSW Government recently withdrew plans to sell 8 hectares of the Rozelle Hospital site for a housing development, which were intended to raise an estimated \$43 million to relocate the hospital and patients to a new psychiatric unit being built as part of the

redevelopment of Concord Hospital. Funding of the Concord Hospital redevelopment will now come from consolidated revenue.²⁰⁰

4.93 As part of the change in plans, the Hon Sandra Nori MP, Member for Port Jackson, introduced the *Callan Park (Special Provisions) Bill* to Parliament on 24 October 2002. During the second reading speech on the Bill, Ms Nori stated:

There are five objects of the bill, which will ensure continued public ownership of, and access to, Callan Park. As the objects state, the bill will ensure the preservation of open space at Callan Park. It will allow public access to that open space, including the harbour foreshore. It will allow public access for both active and passive recreation. The bill will preserve the heritage significance of Callan Park and will impose appropriate controls on future development. Clause 5 of the bill guarantees that all of Callan Park will remain in public ownership.²⁰¹

4.94 Earlier in the year, the NSW Liberal/National Party Coalition announced a policy platform for mental health services that includes establishing a Centre of Excellence for Mental Health on the site of Rozelle Hospital at Callan Park.²⁰² The Coalition proposed that the Centre would provide a holistic approach to mental health care and include:

- up to 400 extra beds for psychiatric care, including psychogeriatric, adolescent, extended care and long-term rehabilitation
- teaching and clinical research opportunities, to be developed in consultation with the Commonwealth Government and the National Mental Health Council
- multi-disciplinary health care for patients with dual diagnosis such as drug related psychosis
- purpose built outpatient facilities
- a base for the Mental Health Co-ordinating Council, representing non-Government Organisations and other relevant industry groups and
- support services for those caring for people with mental illness, including respite care and co-located retirement and nursing home residential care.²⁰³

4.95 In 1873, the Sir Henry Parkes Government bought the Callan Park Estate with the intention of building a 'Hospital for the Insane'.²⁰⁴ It was not until 1884 that the Colonial Architect, Mr James Barnet, reported that building work on Callan Park was complete.²⁰⁵

²⁰⁰ Sydney Morning Herald, *Housing plan axed in Callan Park backflip*, 21 October 2002; and www.cs.nsw.gov.au/facilities/, 24 September 2002

²⁰¹ The Hon Sandra Nori MP, *Callan Park (Special Provisions) Bill*, Second Reading, Hansard, 24 October 2002 p 6

²⁰² Mr John Brogden MP, NSW Liberal Leader, Press Release, 9 April 2002

²⁰³ *ibid*

²⁰⁴ Ms Sue Zelinka, 'Out of mind, out of sight: public works and psychiatry in New South Wales, 1810-1911', Chapter 5, in Dr Lenore Coltheart (Ed), *Significant Sites – History and public works in New South Wales*, Public Works Department, NSW (Hale & Iremonger, Sydney, 1989), p 113

²⁰⁵ *ibid*, p 115

Ms Sue Zelinka wrote in *Significant Sites – History and public works in New South Wales* that Mr Barnet had built “a humane and modern institution for its time, having selected such a suitable site and persuading Premier Sir Henry Parkes to buy it”.²⁰⁶ Ms Zelinka reported that:

For the first time in Australian institutional history, there was enough room to allow for the classification of patients and separate pavilions housed different groups of inmates.²⁰⁷

4.96 Ms Zelinka nevertheless noted that:

When finally pressured into some positive action like commissioning a new asylum [governments] begrudged further demands for funds for maintenance and improvement.²⁰⁸

4.97 The significance of the Callan Park site and the reason for its existence should not be forgotten during the debate over public land use. As Ms Zelinka wrote:

The recognition of psychiatric asylums or hospitals as public works requiring architectural features specific to the needs of those who would live and work there was the legacy of the first 100 years of housing the mentally ill in New South Wales and the foundation on which modern design standards were developed.²⁰⁹

4.98 Although Central Sydney Area Health Service states that Rozelle Hospital provides rehabilitation services for people who have serious mental illnesses, Rozelle Hospital patients share the grounds with members of the public who access the grounds for sporting and leisure pursuits such as walking domestic pets.

4.99 Some buildings on the Hospital site are currently leased to government and community organisations, such as the Rozelle Childcare Centre, the Sydney College of the Arts and the Writers’ Centre. At present users of the facilities such as the Writers’ Centre are advised:

Hirers should realise that Rozelle is a working hospital and should confine their activities to the grounds immediately around the NSW Writers’ Centre building.²¹⁰

4.100 The current public campaign over the Rozelle Hospital site appears primarily focussed over the use of public land, rather than the provision of mental health services. Callan Park is an area that residents consider, to a large extent, to be a public park. This includes a sign authorised by Leichhardt Council at the entry stating, “Save Callan Park – we invite you to explore this wonderful public asset”.

²⁰⁶ Ms Sue Zelinka, *Significant Sites – History and public works in New South Wales*, p 115

²⁰⁷ *ibid*

²⁰⁸ *ibid*, p 120

²⁰⁹ *ibid*

²¹⁰ NSW Writers Centre, website: www.nswwriterscentre.org.au/hire.html, accessed 24/09/02

- 4.101** In April 2002, during the debate on mental health services in the Legislative Assembly, the Minister for Health acknowledged the recreational use of the Hospital grounds:

For the past 100-odd years it has been a mental hospital site where people have jogged and walked their dogs in the grounds. We will make it a park and release the funds tied up in this old health asset to build a new health asset at Concord Hospital, linked to a brand new hospital which has been endorsed by every leading mental health clinician in this State.²¹¹

- 4.102** In the same debate the Minister opposed the proposal by the Coalition, inferring that the proposed mental hospital would be a privately operated facility. The Minister stated that:

a private operator will not let the 40-something dads like me jog through that area with their three-wheel tricycles and their little babies because there is a funny thing called public liability. There will be no more walking Fifi down those wonderful dog trails. They will be off that site forever.²¹²

- 4.103** Considering that a large percentage of Callan Park is a gazetted psychiatric hospital under the *Mental Health Act 1990*, the Committee considers that it is totally inappropriate for patients to share mental health grounds with the general public, whether the hospital is public or privately operated, especially taking into account public liability laws.

- 4.104** Leichhardt Council residents, for example, are more than adequately provided with facilities for recreation and dog exercise, both on and off-leash. Since 1998 Leichhardt Council has offered seven off-leash areas.²¹³

- 4.105** The Committee makes no determination regarding the Government's plans to relocate mental health inpatient services to Concord Hospital, as long as services are improved. The President of the Schizophrenia Fellowship, the Hon Frank Walker, QC, expressed concern over the State Opposition leader's proposal for Rozelle Hospital:

We are a little concerned about some aspects of his plan to recreate the large psychiatric hospital at Rozelle and hope to see him soon to explain why we think parts of that plan may not be a good idea...We would prefer to see units far smaller than the 400 patients proposed.²¹⁴

- 4.106** The *World Health Report 2001* recommended that custodial mental health hospitals be closed gradually and services integrated with mainstream services and community care.²¹⁵ The Report also stated, however, that:

Furthermore, hospitals need to be converted into centres for active treatment and rehabilitation.²¹⁶

²¹¹ The Hon Craig Knowles MP, Minister for Health, Legislative Assembly, Hansard 10 April 2002, p 1315

²¹² *ibid*

²¹³ source: members.ozemail.com.au/~crocomut/InnerWestParks.htm, accessed 24/09/02

²¹⁴ The Hon Frank Walker QC, *The Quest for Justice with Dignity 2*, tabled document, 8 August 2002, p 7

²¹⁵ World Health Organisation, *World Health Report 2001*, p 87

²¹⁶ *ibid*

- 4.107** The Committee considers that NSW Health urgently needs to increase the number of mental health secondary prevention and care services, including the number of medium to long-term rehabilitation beds. Based on strong evidence from consumers, family, carers and mental health sector workers, the Committee determines that there is a need for a segment of such services to be provided within places of asylum, and managed by health services.
- 4.108** The Committee supports the conversion of Rozelle Hospital, with improved facilities, to an asylum for the mentally ill in the true historical meaning of the concept - as a place of sanctuary, refuge or retreat. The term 'asylum' must be reclaimed and dissociated from the negative connotations that resulted from past management practices. The Committee is not advocating a return to the past. While the philosophy of deinstitutionalisation is a progressive move for the vast majority of people with a mental illness, some form of institutionalised care for those without the necessary independence or support structures is required.
- 4.109** Rehabilitation services for the mentally ill at Rozelle Hospital could be provided under clause 7 of the *Callan Park (Special Provisions) Bill*, introduced by the Hon Sandra Nori MP, which allows for the provision of health care facilities, aged care facilities, educational facilities and community facilities.²¹⁷ In addition, the Committee has recommended assessable mandatory mental health training, including practical training, be introduced as a component of undergraduate nursing courses (see Recommendation 17 of this chapter). Hence, under clause 7 of the Bill, the Committee considers that NSW Health could employ Rozelle Hospital as a training hospital for undergraduate mental health nursing students.

Recommendation 9

That the Minister for Health recognise the need and demand for rehabilitation services and facilities for people with a mental illness and retain and establish more medium to long-term managed psychiatric beds within designated facilities for people with a mental illness.

Recommendation 10

That NSW Health establish Rozelle Hospital as an asylum for the mentally ill, in the true meaning of the concept. The facility should be gazetted under the *Mental Health Act 1990* and provide medium to long-term rehabilitation services for people with a mental illness. The hospital grounds must be clearly recognised as a health facility and not considered public space.

Recommendation 11

That NSW Health increase the number of long term rehabilitation facilities in appropriate settings for people with a mental illness.

²¹⁷ The Hon Sandra Nori MP, *Callan Park (Special Provisions) Bill*, Second Reading, Hansard, 24 October 2002 p 6

Conclusion

- 4.110** Reducing readmission rates should be a priority for NSW Health. If mental health services are to be reliant on the private (GPs) or the community sector, case management programs and crisis teams must be adequately resourced to ensure the required level of care is provided. Case managers must be responsible for engaging a client in care and organising the care required. Currently this role requires cross agency liaison in NSW, where managers often face agency demarcation over responsibility. The Committee has received evidence, such as that from the Office of the Public Guardian, which highlights that this liaison is not occurring.²¹⁸ The Committee acknowledges that such cross agency liaison can be an unnecessary burden on case managers and remains an impediment to services. Mental health services must be less inward looking and will require greater cooperation if case managers are to function in the manner required.
- 4.111** The roles and responsibilities of all segments of the mental health sector must be clarified and clearly delineated. Support services must be accessible to ensure that case managers are able to acquire the best services for the client. To ensure this occurs, the Committee encourages NSW Health to support the establishment of an Office of Mental Health within the NSW Premier's Department. The Committee determines that Area Health Services should be required to provide monthly incidence and outcome reports to the proposed Office of Mental Health, which would maintain a review function to ensure that a coordinated government approach to mental health services is realised.

Recommendation 12

That NSW Health undertake to clearly and adequately define the roles of the public and private mental health sectors within the mental health system for treatment, care and general service provision and ensure that these roles and funding streams be transparent.

Recommendation 13

That the proposed Office of Mental Health assume responsibility for ensuring that the roles and funding streams within the mental health system are transparent at all times.

Recommendation 14

That the Minister for Health, in supporting the establishment of an Office of Mental Health within the NSW Premier's Department, require Area Health Services to provide monthly incidence and outcome reports to the Office of Mental Health.

Family and carers

- 4.112** A substantial proportion of submissions received during the inquiry were from consumers, family members and carers that detailed personal experiences of mental health service

²¹⁸ Submission 255, Office of the Public Guardian, p 5

provision in NSW. Many submissions from consumers and carers referred to the St Vincent de Paul Society's publication, *A Long Road to Recovery*, which highlights "the fact that NSW fails to provide adequate care and support for many people with a mental disorder".²¹⁹ The Public Forum at Parliament House, 7 August 2002, provided many of these people with the opportunity to address the Committee on their perceptions of mental health service provision in NSW.²²⁰

4.113 Chapter 3 outlined the mental health sector in NSW and referred to the frustration expressed by carers and families in their endeavour to ensure adequate care is provided to a person with a mental illness. During the public forum the Committee heard how frustration turned to anger after the various barriers and restrictions on service delivery were repeatedly experienced. Consumers, carers and families expressed their scepticism of policy statements by NSW Health and the commitment of government to implement change.

4.114 Mr Patrick Connoley, father of a daughter with schizophrenia, made the following comment which was a common view among forum participants:

The mental health system is a disgrace. We recognise mental health illness is a highly complex, confronting and disturbing topic which still carries an awful social stigma. This general reluctance to face mental health is compounded by the fact that politically speaking, mental illness, as an issue and a platform, is about as unsexy and unappealing as it gets.²²¹

4.115 Mr Fred Pateman expressed in a submission to the Committee his anger towards the mental health system and government's apathetic management of the sector. Mr Pateman posed four questions that outlined the plight of his son:

- (1) Why did Glen [son] have to die at the young age of thirty when it was preventable?
- (2) Why wasn't help available for the person who killed him when asked for?
- (3) Do we have to wait for other deaths before something can be done?
- (4) Why aren't friends and relatives being listened to when they say something is wrong?²²²

4.116 Mr Pateman expressed feelings similar to many submissions received by the Committee, when referring to the death of his son:

As a father I am angry. Not angry at the mental health workers, not angry at the man who killed him, but angry at a system where you can't get help when someone is crying out for help.²²³

4.117 More funding does not appear to be the answer to all the perceived problems with the mental health system in NSW. The system is diverse and fragmented where the only available and comprehensive record of a patient's history is often the family or carer.

²¹⁹ St Vincent de Paul Society, *A Long Road to Recovery: a social justice statement on mental health*, July 2001, p 5

²²⁰ Public forum, 7 August 2002, NSW Parliament House

²²¹ Patrick Connoley and Elizabeth Brennan, public forum, 7 August 2002

²²² Submission 247, Mr & Mrs Pateman, attachment: *To Politicians, Lawyers, Mental Health Workers, Carers and Friends*, p 2

²²³ *ibid*, p 1

Mental health services must possess a broader perspective of all services available to apply available resources more effectively. The knowledge and commitment of family and carers should be included in the determination of appropriate services. The MHCC recommended that carers be incorporated in the care of people with a mental illness:

It is recommended that carers of people with mental illnesses be assessed for their capacity to support consumers, be included in the planning of care programs and assisted to access support for themselves.²²⁴

- 4.118** The Committee concludes that the mental health service sector must acknowledge the role of family and carers in the management and care of people with a mental illness. Acknowledgement must include incorporating family and carers in intervention planning and in the determination for improving access to services. Any issues of privacy must be interpreted in a constructive manner so as to ensure the information needs of consumers, carers and families are met. (see Chapter 6)

Recommendation 15

That the Minister for Health ensure carers are assessed for their capacity to support people with a mental illness, are included in the planning of care programs and assisted to access support for themselves.

Recommendation 16

That NSW Health ensure that carers are included in discussions for determining assertive care plans and Community Treatment Orders.

Staffing

- 4.119** NSW Health states that defining and counting the mental health workforce is difficult as there are presently shortages across Australia for mental health nursing. This is compounded by an ageing workforce and serious difficulties with recruitment and retention.²²⁵ The nursing shortage has been accompanied by a decline in psychiatrists, particularly in public sector mental health, over the last decade.²²⁶
- 4.120** Submissions generally praised the work done by mental health workers given that they operate within an under-resourced system. The NSW CAG, however, reported that a common complaint of consumers is the lack of respect shown by health workers in the system.²²⁷ This may be seen as an indicator of the lack of adequate resources and management within the mental health system. Mental health workers operate under pressure in an environment that is increasingly hazardous for staff, patients and carers. Comorbidity issues such as mental illness and substance abuse (MISA) have added another

²²⁴ Submission 218, MHCC, p i

²²⁵ Submission 267, NSW Health, p F 1

²²⁶ *ibid*, p F 6

²²⁷ Submission 162, NSW Consumer Advisory Group, p 37

dimension to care, in the treatment required for people with a mental illness, as well as the correlative changes in provision of services. Staffing levels, however have not increased to reflect the increased intensity of care. The NSW Nurses' Association stated:

Resource restrictions translate to mental health nurses and other workers only being able to provide crisis intervention and ongoing maintenance to people with chronic mental illness. Other people and subsequent services are falling through the gaps in the system. People with dual diagnosis or multiple chronic disabilities, for instance, are disadvantaged and are not receiving adequate service in the community.²²⁸

- 4.121** This view is supported by the NAPP, who also added that the lack of supervision and opportunities for staff to discuss patients and issues, so they can review their work, has had a negative effect on the level of care that can be provided.²²⁹
- 4.122** NSW Health must improve and increase the resources made available to mental health workers, including greater supervision, support staff and respite services where staff can receive physical and emotional relief and assistance.

Nursing

- 4.123** As with general nursing, there is a considerable shortage of nurses in mental health. The recent Commonwealth Senate Community Affairs Committee report, *The Patient Profession: Time for Action – Report on the Inquiry into Nursing* (July 2002), identified the main areas impacting on retention of mental health nurses:

Working conditions are often poor, with heavy workloads and lack of resources which adds to the stress of nursing staff. There is a lack of pay parity with other health professions. There is a high level of WorkCover claims in the mental health sector. There is a lack of career pathways which has resulted in low morale, lack of job satisfaction, and poor status. Mental health nurses, as with other specialist nursing groups, lack professional development opportunities and employer educational assistance schemes. All of these issues undermine the attractiveness of mental health nursing for new graduates and encourage professional stagnation of those already practicing.²³⁰

- 4.124** The Australian Salaried Medical Officers Federation (ASMOF) also indicated that the shortage of nurses has led to high demand and has created a cycle where nurses leave the public system for the wages and flexibility offered by private agency work. According to the ASMOF, this has been a major factor in the overrun of mental health budgets.²³¹
- 4.125** Prof Beverley Raphael, Director of the Centre for Mental Health, indicated that the shortage of nurses has led to a delay in opening new beds:

²²⁸ Submission 212, NSW Nurses' Association, p 5

²²⁹ Submission.189, National Association of Practising Psychiatrists, p 11

²³⁰ Senate Community Affairs Committee (Parliament of Australia), *The Patient Profession: Time for Action – Report on the Inquiry into Nursing*, July 2002, p 163

²³¹ Submission 91, Australian Salaried Medical Officers Federation, p 4

The Centre for Mental Health is supporting the areas to do everything we can to recruit nurses, including overseas recruitment. But that is the key issue that will delay the opening of beds. I cannot guarantee that this will happen to the fullest extent by the end of that time because of nursing issues.²³²

- 4.126** This was supported by Dr Olav Nielssen, Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists:

Other units have been unable to keep beds open because of the shortage of trained staff...increase in staff numbers has not been maintained...²³³

- 4.127** While initiatives are being undertaken, the recruitment problems facing NSW Health were made quite apparent by Prof Raphael when referring to the delay in opening new beds in the Northern Rivers area. Prof Raphael identified that NSW Health was exhausting recruitment avenues:

It was intended that it should be opened. Recruitment as a local Area health Service level is critical because funds are there...[to the Committee] If you have any helpful suggestions about how we can assist recruiting at local level, because we cannot recruit to those areas.

...Some of the areas have quite a pool of nurses who are being re-recruited and who are already in place. We are part of the overseas initiative to try to recruit overseas nurses, and there are number of mental health nurses in that. Centrally we have put funding into local regional universities to work with areas to try to recruit nurses, but I agree that this is a problem. I do not know what extra you would like to suggest that I could do about it.²³⁴

- 4.128** Ms Judith Meppem, the then Chief Nursing Officer, informed the Committee that the number of registered nurses does not reflect the availability of nurses:

We have 92,000 registered enrolled nurses who are registered with the Nurses Registration Board. Theoretically one could argue that they might be available to work, but of those approximately 55,000 are working in either the public or private sector. As I said many people...never intended to nurse again. They have used those qualifications to move on to other occupations.²³⁵

- 4.129** Ms Meppem also informed the Committee that mental health nurses are an ageing workforce which is beginning to lose its high skill mix:

Nursing is still predominantly female, although not in mental health. Our mental health nursing is predominantly male and is an ageing nursing work force...We have an ageing nursing work force and this is particularly an issue in mental health where the average age of mental health nurses is above 45.

There are more inexperienced nurses now in the work force and there are some skill mix issues around experienced nurses and inexperienced nurses, particularly

²³² B Raphael, Evidence, 12 August 2002, p 13

²³³ Submission 22, Dr Olav Nielssen, Royal Australian and New Zealand College of Psychiatrists, p 2

²³⁴ B Raphael, Evidence, 12 August 2002, pp 13-14

²³⁵ Ms Judith Meppem, Chief Nursing Officer, NSW Health, Evidence 31 July 2002, p 18

in regard to the new models of care that are emerging. We have issues around the power structures and relationships, particularly owing to the fact that the health system is generally a medical model. Mental health is that particular area where there are new models of care emerging where nurses could take a lead.²³⁶

4.130 The NAPP was critical that “psychiatric nurse training was effectively abolished with the shift to university-based qualifications”.²³⁷ The Senate report noted that students in general undergraduate courses have inadequate exposure to mental health nursing during their studies and therefore do not consider it as a career path.²³⁸ The NAPP recommend that postgraduate qualifications for psychiatric nursing need to be appropriately remunerated.²³⁹

4.131 To address the lack of mental health nurses, NSW Health outlined workforce planning strategies that have been initiated, including a Mental Health Nursing Working Group, a joint initiative between the Centre for Mental Health and the Office of the Chief Nursing Officer.²⁴⁰ The planning includes:

- support for mental health clinical placements for about 2,500 undergraduate nursing students
- scholarships and clinical support for about 350 registered and enrolled nurses
- mental health nursing introductory courses in a range of general hospital settings,
- mental health refresher programs for registered and enrolled nurses who either wish to re-enter the mental health workforce or to change their nursing specialty.²⁴¹

4.132 The NSW Nurses’ Association expressed concern that more and more general nurses are working in de facto psychiatric units, as mainstreaming delivers more psychiatric patients to emergency departments:

Most nurses in the general hospital system receive little or no education on the ways to interact and respond to people with a mental illness. Many people with an acute mental illness have their entry into the health system via the emergency department. However the staff are often ill equipped to deal with them, and this can result in the escalation of their symptoms.²⁴²

4.133 To address this concern, Prof Raphael advised the Committee that the Centre for Mental Health has established a program of mental health nurses in emergency departments and has provided a handbook to increase skills.²⁴³

²³⁶ *ibid*, p 21

²³⁷ Submission 189, NAPP, p 13

²³⁸ Senate Community Affairs Committee (Parliament of Australia), *The Patient Profession: Time for Action – Report on the Inquiry into Nursing*, July 2002, p 162

²³⁹ Submission 189, National Association of Practising Psychiatrists, p 11

²⁴⁰ Submission 267, NSW Health, p F 2

²⁴¹ *ibid*

²⁴² Submission 212, NSW Nurses’ Association, p 6

²⁴³ B Raphael Evidence, 12 August 2002, p 9

4.134 While applauding the employment of mental health nurses in emergency departments, the NSW Nurses' Association stated:

Unfortunately the services are usually not extended to cover after hours services, which we all know is an extremely busy time in most city emergency departments. Also many rural emergency departments do not have a mental health nurse in their employment.²⁴⁴

4.135 The Committee recognises the limited placement of mental health nurses in emergency departments. As there is a shortage of psychiatric nurses in general, the Committee is concerned that the provision of a handbook is not sufficient to prepare non-psychiatric trained General Registered Nurses for the specific demands of mental health care.

4.136 NSW Health urgently needs to address the critical shortage in mental health nursing. NSW Health advised that undergraduate and postgraduate funding supported the Mental Health Nursing Working Group. Funding has also been provided to all NSW Colleges and Universities providing nursing education to develop a range of mental health education modules.²⁴⁵

4.137 The long-term sustainability of mental health nursing requires further Commonwealth support. The educational opportunities for nurses need to improve and the generic undergraduate nursing programs need to incorporate a mandatory mental health component. The Committee supports the Senate Community Affairs Committee Recommendations 76, 77 and 78, which state:

- *Recommendation 76* – that the Commonwealth fund scholarships for mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course
- *Recommendation 77* – that a targeted campaign be undertaken to improve the status and image of mental health nursing
- *Recommendation 78* - that funding be provided for the development of advanced practice courses in mental health nursing.²⁴⁶

²⁴⁴ Submission 212, NSW Nurses' Association, p 6

²⁴⁵ Submission 267, NSW Health, p F 5

²⁴⁶ Senate Community Affairs Committee (Parliament of Australia), *The Patient Profession: Time for Action – Report on the Inquiry into Nursing*, July 2002, p 166

Recommendation 17

That the Minister for Health develop a proposal for consideration by the Commonwealth Ministers for Health and Education, that outlines the need for national undergraduate nursing courses to contain an assessable mandatory mental health training component, including practical training. The proposal should indicate the NSW Government's support for the following recommendations by the Senate Community Affairs Committee Inquiry into Nursing:

- that the Commonwealth fund scholarships for psychiatric/mental health nursing for graduate year students wanting to specialise in the area, and for already qualified nurses wishing to undertake a mental health nursing course (Recommendation 76)
- that funding be provided for the development of advanced practice courses in mental health nursing (Recommendation 78).

Recommendation 18

That the Minister for Health develop and initiate a targeted campaign to improve the status and image of mental health nursing, in accordance with Recommendation 77 of the Senate Community Affairs Committee Report on the Inquiry into Nursing:

- that a targeted campaign be undertaken to improve the status and image of mental health nursing.

Nurse practitioners

4.138 In October 1999, the Minister for Health stated that the *Nurses Amendment (Nurse Practitioners) Act 1998*²⁴⁷ “would allow highly specialised registered nurses to provide advanced levels of care in rural and regional communities.”²⁴⁸ In the same press release, the Minister announced:

“In principle” approval has already been given to seven Nurse Practitioner positions – four in the Far West and three in the Mid West regions.

It is expected that up to 40 Nurse Practitioner positions will be appointed to country areas by July 2000.²⁴⁹

4.139 The NSW Nurses Registration Board did not authorise the first two Nurse Practitioners until 12 December 2000. On 11 May 2001, the first nurse was appointed to a Nurse Practitioner position in NSW.²⁵⁰ The then Chief Nursing Officer, Ms Judith Meppem,

²⁴⁷ Nurse Practitioners are now provided for under the *Nurses Act 1991*

²⁴⁸ NSW Minister for Health, The Hon Craig Knowles, *press release*, 29 October 1999

²⁴⁹ *ibid*

²⁵⁰ NSW Minister for Health, The Hon Craig Knowles, *press release*, 11 May 2001

informed the Committee that only nine Nurse Practitioners, two in mental health, were authorised as of 31 July 2002.²⁵¹ At this time, Ms Meppem advised the Committee that there was still only one practicing Nurse Practitioner in NSW, stating that, “after 12 years we are still only at this point”²⁵²:

We have had very slow progress to date. To date there have been only seven nurse practitioner positions given full approval...I am often asked why there are not more positions. The reasons include the difficulties that our area health services are having in getting medical groups to participate in the process and the hoops that the area health services have to go through in the negotiated implementation policy.²⁵³

4.140 Ms Meppem further explained to the Committee the difficulties nurses face in pursuing professional development:

Why are not more nurses applying? Feedback identifies that the reasons include: there are no positions in the city and not many positions yet in rural towns, the hoops nurses have to go through to get authorised; and negative pressure from medical colleagues in country towns when they do put up their hand. I have a very good example in one country town where the doctor who was servicing that town withdrew his services when he realised that we were about to approve the nurse practitioner position. Fortunately, the town has been able to get another medical practitioner to take up the service.²⁵⁴

4.141 The Minister for Health announced the most recent Nurse Practitioner appointments on 5 September 2002, one in the Emergency Department at the Children’s Hospital at Westmead, and one other at Hill End Community Health Service.²⁵⁵

4.142 After setting a target of 40 Nurse Practitioners to be working in country areas by July 2000, only three positions have been established. Two positions are located in country NSW, one of those on 5 September 2002. The third position is located at the Children’s Hospital, Westmead, one of the biggest and best resourced hospitals in NSW.

4.143 Ms Meppem concluded that the reason the program of Nurse Practitioners has not been as successful in NSW as it has in New Zealand is mainly due to the attitude of doctors.²⁵⁶ Ms Meppem expressed that it has been a fact of life that mental health nurses theoretically already function as nurse practitioners and referred to the Menadue and Sinclair reports, which recommended the progress of the nurse practitioner services.²⁵⁷

4.144 The Committee has heard how the role and requirements of nursing in general have developed to become more intensive, although pharmaceuticals and treatments have also

²⁵¹ J Meppem, Evidence, 31 July 2002, p 25

²⁵² *ibid*

²⁵³ *ibid*

²⁵⁴ *ibid*

²⁵⁵ NSW Minister for Health, The Hon Craig Knowles, *press release*, 5 September 2002

²⁵⁶ J Meppem, Evidence, 31 July 2002, p 25

²⁵⁷ *ibid*, p 26

improved. Ms Meppem stated that mental health nurses are making excellent case managers and team leaders, within multidisciplinary teams. According to Ms Meppem:

That is where I see the nurse practitioner project being very valuable. So you will find that there will be a mix of people who like to move between the two, and there are some people who only like to work in community mental health services, and some people who only like to work in institutional services.²⁵⁸

- 4.145** While this could be seen as an avenue for mental health nurse outflow from inpatient services, the Committee considers that the creation of greater career pathways for mental health nurses would effectively increase rather than decrease numbers. Improved status and remuneration must be a part of such initiatives. It is this Committee's view that the Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP) and the Doctor's Reform Society are well placed to foster the expanded role for highly qualified nursing professionals and that they should support the Nurse Practitioner Program, particularly within the mental health sector. The health system must begin to appreciate and reward the various skill levels within nursing.

Recommendation 19

That the Minister for Health immediately appoint authorised Nurse Practitioners and that positions with in-principle approval be considered for appointment as a matter of urgency, particularly within mental health.

Recommendation 20

That the Minister for Health appoint an eminent clinician as a specialist advisor to:

- review the Nurse Practitioner implementation policy, evaluate the role and effectiveness of Area Health Services in the process and
 - ensure medical groups participate in the process of appointing Nurse Practitioners, particularly within mental health.
-

Caring for carers

- 4.146** The focus of the public mental health system on acute treatment services has shifted an increasing responsibility to the community sector. Adequate support services for family and carers have not accompanied this shift.
- 4.147** The public forum conducted by the Committee on 7 August 2002 for consumers, carers and families provided the Committee with a harrowing, but valuable account of the difficulties and anguish which carers and family often experience. The Committee heard how, despite their commitment, they often felt isolated from the mental health system and support services. Mr Fred Pateman summed up the feelings of many at the forum:

²⁵⁸ J Meppem, Evidence, 31 July 2002, p 30

I could talk about not enough money for mental illness, not enough beds in psychiatric hospitals, psychiatrists not wanting to go to country areas, the number of people who suffer mental illness in gaols...we've heard that all day today...police wanting to deal with criminals not illness, all the glossy books...and I hope this [inquiry] goes further than glossy books. I could talk and write about all the suggestions you have on your call for submissions...but you have more qualified people than me to do that.

I would like to talk about something lifetime experience has made me qualified to comment on; since the death of our son...I have been approached by many friends, carers and relations, all of whom have the same problems, the problems coming through today. When they call on the mental health system they are told nothing can be done until their sons and daughters have become a danger to themselves and others. It's about time the family and friends were taken notice of. They see the person with their mental illness most of the time doctors only see them occasionally.²⁵⁹

4.148 In *A Long Road to Recovery*, one young carer aged 12 said:

I've never been to a school camp. I used to lie and tell them that we didn't have enough money, but it was really because Mum was too sick. I just couldn't leave her. If I wasn't around, she would have nobody.²⁶⁰

4.149 The Centre for Mental Health stated it provides \$1 million each year to fund programs designed to support carers of people with a mental illness. The programs include a focus on providing personal and emotional support and training, targeting children of parents with a mental illness, support for self-help groups and information services.²⁶¹

4.150 The nature of the submissions from family and carers however, suggested that this funding was entirely inadequate and that access to such services is poor. Ms Lexie Lord, Parents and Carers Mental Health Group, Casino, expressed that:

Virtually we are a support group among ourselves because there is nothing much out there for carers. We save the Government a fortune but there is not the mental health staff to also take into consideration the parents who are particularly traumatised.²⁶²

4.151 The sentiments expressed by family and carers was supported by the NSW Nurses' Association, which stated that:

It is our contention that very little funding has been allocated in NSW for consumers and carer run programs or consumer support groups.²⁶³

²⁵⁹ Mr Fred Patemen, speaker, public forum, NSW Parliament House, 7 August 2002

²⁶⁰ Submission 143, Society of St Vincent de Paul, attachment, *A Long Road to Recovery – a social justice statement on mental health*, p 18

²⁶¹ Submission 267, NSW Health, p G 36-37

²⁶² Ms Lexie Lord, Parents and Carers Mental Health Group, Casino, Evidence 31 July 2002, pp 12-13

²⁶³ Submission 212, NSW Nurses' Association, p 7

- 4.152** According to the NSW Nurses' Association, the inability for carers to access support services could be attributed to the lack of Consumer Advisors, not yet employed by health services, despite recommendations and guidelines from the Centre for Mental Health. The Association summed up by stating: "consumer participation is tokenistic in far too many Area Health Services".²⁶⁴
- 4.153** A government program that provides respite care and other supports for those people looking after people with a mental illness is required. These support services would recognise the significant role of carers and family, which was previously the responsibility of the public system.

Recommendation 21

That, in addition to increasing and better targeting funding for respite and support programs run by non-government organisations, NSW Health develop, fund and coordinate the establishment of a central support program for the carers of people with a mental illness, including respite care services.

Official Visitors

- 4.154** The role of an Official Visitor is to inspect and report on the conditions of mental health care, treatment and control of patients. The role and requirements of Official Visitors, as legislated in the *Mental Health Act 1990*, are an important component of the Minister's management of public mental health facilities and services in NSW. The Principal Official Visitor is therefore in a significant position to independently advise the Minister on the running of NSW mental health facilities.
- 4.155** According to Chapter 8, Part 2 of the *Mental Health Act 1990*, the Principal Official Visitor oversees the Official Visitor program. Section 227 of the Act outlines the functions of the Principal Official Visitor:
- The Principal Official Visitor:
- (a) must assist in the exercise by Official Visitors of the functions conferred or imposed on them by or under this Act, and
 - (b) may, in relation to any hospital or health care agency, exercise any such function, and
 - (c) must, in accordance with such directions as are given by the Minister, report to the Minister as to the exercise of the functions of the Principal Official Visitor and of Official Visitors.
- 4.156** In relation to the inspection of hospitals, Section 230 of the Act requires that at least two Official Visitors, one being a medical practitioner, 'must visit':

²⁶⁴ Submission 212, NSW Nurses' Association, p 7

- (a) each hospital under their control of the area health service concerned, and each authorised hospital situated in the area of the area health service, at least once a month, and
- (b) each health care agency under the control of the area health service concerned, and each other health care agency situated in the area of the area health service, at least once every 6 months

with or without any previous notice, at such time of time of the day or night and for such length of time as they think fit.

4.157 The Act further states that the Official Visitor ‘must, so far as practical’, inspect every part of the hospital at least once each visit, inquire into the care, treatment and control of patients and informal patients and report to the Principal Official Visitor as soon as practical after each visit.²⁶⁵

4.158 NSW Health considers the role of the Principal Official Visitor (a part-time position) to undertake advocacy on behalf of consumers, act as a resource person to Official Visitors with respect to current issues and developments in the mental health field and to refer appropriately matters of significance.²⁶⁶ NSW Health outlined the activities involved and an estimate of the resources required in the role of the Principal Official Visitor:

- read all Official Visitors’ monthly reports with the assistance of the designated officer in the Centre for Mental Health and decide what matters should be further investigated. Follow up matters not satisfactorily resolved (6 hours/week)
- report on those matters (in anonymous format) referred to the Health Care Complaints Commission (varies, but average 2 hours/week)
- compile quarterly report to the Minister on the Official Visitor program (5 days per quarter)
- report immediately to the Minister on matters of grave concern (variable)
- be available for consultation by all Official Visitors (“on-call” for office hours)
- be responsible for conducting the Annual Official Visitor Conference and Training Program for newly appointed Official Visitors (10 days for each, spread over 2 months for each, with conference once per year, training twice every 3 years)
- chair the Official Visitor Advisory Committee and prepare/edit material as required (2 hours/week)
- prepare quarterly News Bulletin for distribution to all Official Visitors (2 hours/week)

²⁶⁵ *Mental Health Act 1990*, Part 2, section 230

²⁶⁶ Correspondence from NSW Health to Committee, 14 October 2002, p 1

- responsible for recruitment and assisting in development of Official Visitors (Varies, 8 days work twice every 2 years, may involve recruitment between terms upon retirement of an Official Visitor).²⁶⁷

4.159 In 1846, the Select Committee on the Lunatic Asylum, Tarban Creek, noted that reports by Official Visitors, commissioned to inspect and report on the conditions of mental health care, were not being accorded appropriate recognition. Mr Charles Cowper Esq, Committee Chairman, reported:

That the present mode of inspection is a comparative failure, the Council will have already seen is the opinion of the Committee; and the only plan which they feel safe in suggesting in lieu of the present is, that the English system be adhered to closely as possible.²⁶⁸

4.160 The problems encountered by Official Visitors in 1846 appear similar to those present now. Dr Peter Harvey, retired Cardiologist, now an Official Visitor of mental health facilities operated by NSW Health, raised serious questions over the true value of the Official Visitor program as it currently functions. Dr Harvey referred to the demand that is placed on the Official Visitor:

as I see it, a visit is a pretty arduous ordeal; you are there for about four hours... and in that...you are supposed to cover: from hospital services, from the amount of drugs used, from the way the records are written, talking to individual patients—and you can imagine how far you get talking to five very certifiable people and sorting out the truth from fantasy and hallucinations. We do all this, and a whole lot more.²⁶⁹

4.161 Dr Harvey stated that many Official Visitors are well established and have good working relationships with the hospital, but to come into the system currently is a daunting experience, citing the complex nature of the *Mental Health Act 1990* and the strenuous requirements.²⁷⁰

4.162 While Dr Harvey described the duties of the Official Visitor, he informed the Committee that he was not provided with training, nor was he invited to attend an induction program when he became an Official Visitor:

when I came into the system it was out of sync with the training program and I was given no training. I am a cardiologist.

Some months later after I repeatedly pointed this out I was given three weeks notice to say that a special training day had been arranged for me to go through all this material...[which Dr Harvey couldn't attend due to prior engagement]...They did not even consult me as to when to have it, so they cancelled it and I have never had any training. I have just sort of read the Act and tried to talk to the Principal Official Visitor.²⁷¹

²⁶⁷ Correspondence from NSW Health to Committee, 14 October 2002, pp 1-2

²⁶⁸ Legislative Council, *Report from the Select Committee on the Lunatic Asylum, Tarban Creek*, 21 October 1846, p 4

²⁶⁹ Dr Peter Harvey, Official Visitor, NSW Health, Evidence, 8 October 2002, p 2

²⁷⁰ *ibid*, p 5

²⁷¹ *ibid*, p 4

- 4.163** According to Dr Harvey, there are often not enough visitors available to visit the hospitals each month, as required under the Act. Dr Harvey informed the Committee that the lack of training and demands for Official Visitors, who more often than not are retired health workers, places undue pressure on them:

One of my complaints is that it is putting an awful lot on—I am a retired cardiologist and chest physician and one of my colleagues was a Deputy Vice-chancellor of the University of NSW, another was a nursing administrator, another was a social worker and we are asked to consider such things as, "Do you consider excessive amounts of medication are being prescribed?" You walk into a unit with 30 or 40 people, some of them talking to the walls, some of them prancing up and down shouting for the nurses and you are supposed to look at this.²⁷²

- 4.164** In addition to fulfilling these roles, Dr Harvey stated that the Official Visitor must complete a monthly report to the Principal Official Visitor, which involves filling in a quite extensive form. Dr Harvey expressed concern however, that once the report is filed, no feedback is relayed to the Official Visitor:

We get no feedback. Occasionally if you refer a matter to the Principal Official Visitor you will get a report back from one of her underlings—never from the organ grinder, always from an underling. Often, the issues that require following up are totally ignored. At least we are not informed of any action.²⁷³

- 4.165** As Official Visitors are meant to receive a feedback report every three months, Dr Harvey was concerned that the information, diligently gathered by Official Visitors, was not being fully utilised:

I have been attending for 20 months and I have not seen a report yet. Going back with my colleagues, the last one I can find was January 1998. There may have been others but there certainly have not been any since March 2001. So we collect all this information and it is valuable and it is hard to gather and we feed it into a system and we get no feedback. This is one of my complaints.²⁷⁴

- 4.166** In referring to the Annual Official Visitor Conference and Training Program, Dr Harvey was complementary of some of the addresses by psychiatrists and police. Dr Harvey was, however, critical of the lack of feedback on the action taken following Official Visitor reports:

The Principal Official Visitor was supposed to give us a report, the title of which was "What happens to your reports when we get them?" Her formula was to list all the reports, subdivide them, so many about "food", about "the toilets", about "not seeing enough of the patients", that "it was dirty". She just went through all the complaints. She did not ever tell us what she did with them or what happened to all this information that we feed in. So that is the official meeting, and then you might meet a couple of other people but there is really no question time. It is all didactic and instructive. There is not enough question time.²⁷⁵

²⁷² P Harvey, Evidence, 8 October 2002, p 3

²⁷³ *ibid*

²⁷⁴ *ibid*

²⁷⁵ *ibid*, p 4-5

- 4.167** In response to a question from the Committee regarding additional efforts he may have made to obtain feedback on issues, Dr Harvey stated that he had previously attempted to contact the Principal Official Visitor but person was never available on the telephone, never answered the paging system, and did not return his calls.²⁷⁶
- 4.168** The Committee expects that the majority of Official Visitors receive adequate training and that the Principal Official Visitor intends to function as effectively as possible. The Principal Official Visitor is responsible, however, for visiting 58 hospitals and 70 agencies and addressing every matter that is raised. The Committee cannot ignore the evidence presented by Dr Harvey, given the apparent frustration he has experienced:
- The system is not run efficiently. That is why I am here. I feel that I have done my best. I do not know how much longer I will have the energy to do this. I am thinking strongly of just giving it up but I thought I would like to see your Committee perhaps do something before I drop out of the system.²⁷⁷
- 4.169** Following Dr Harvey's appearance before the Committee, NSW Health advised that a selection of Official Visitors to rural areas for the next three-year term had been completed and that training for this group was planned for 2-3 December 2002.²⁷⁸ NSW Health indicated that Dr Harvey would be invited to attend this training.
- 4.170** Given the value of the Official Visitor program, the Committee considers that the program might be best served by locating the Principal Official Visitor within the proposed Office of Mental Health within the NSW Premier's Department. To improve accessibility of Official Visitors to the Principal Official Visitor, the Committee considers that the position of the Principal Official Visitor must either be designated as a full-time position, or that the Principal Official Visitor establish allocated and adequate consultation periods during office hours for Official Visitors.

Recommendation 22

That the position of the Principal Official Visitor:

- be located within the proposed Office of Mental Health in the NSW Premier's Department and
 - be either designated as a full-time position, or that the Principal Official Visitor establish an adequate consultation period for Official Visitors during office hours.
-

²⁷⁶ P Harvey, Evidence, 8 October 2002, p 7

²⁷⁷ *ibid*, p 17

²⁷⁸ Correspondence from NSW Health to Committee, 10 October 2002

Chapter 5 Funding - the need for transparency

We are also extremely concerned about accountability for the spending of those funds and at present we have very little information about where those funds actually go, which does not create a great deal of confidence that they are going to the right place.²⁷⁹

[Ms Roslyn Bragg, Deputy Director, Policy, NCOSS]

This report focuses on mental health service provision rather than funding of mental health services. Funding is nevertheless a component of health service provision and will be discussed in that context to provide an overview of funding allocations. This chapter will not provide detailed analysis of funding criteria or dissect the mental health budget in NSW in any great detail. The funding of health services by Commonwealth and State governments is often quite complex and shrouded in multiple interwoven initiatives. Mental health funding is indicative of the complex nature of health funding.

NSW funding model

- 5.1 The NSW funding model is a two-tiered system. With the exception of mental health, funds are distributed from NSW Health to Area Health Services in proportion to population need using a formula called the 'Resource Distribution Formula' (RDF). With the exception of mental health, it is recognised that NSW has done well in achieving population equity.²⁸⁰ NSW Health data suggests that all Areas will be within 2% of their RDF share by 2003.²⁸¹
- 5.2 The Centre for Health Service Development, University of Wollongong, stated that the Centre for Mental Health has historically resisted the introduction of formula-based funding, preferring a submission-based approach instead.
- 5.3 NSW Health informed the Committee that it has been developing an RDF for mental health, which specifically reflects mental health needs. In developing a draft RDF, NSW Health indicated that the formula would be used to guide the allocation of new resources, rather than be used to redistribute existing resources.²⁸²
- 5.4 NSW Health stated that the draft mental health RDF has been used to guide additional enhancement funding allocations to general acute funding for area health services, but not in relation to the allocation of funds for specialist statewide and non-acute services.²⁸³

²⁷⁹ Ms Roslyn Bragg, Deputy Director, Policy, NCOSS, Evidence 31 July 2002, p 38

²⁸⁰ Centre for Health Service Development, Submission 268 p 4

²⁸¹ *ibid*

²⁸² NSW Health, Submission 267, p C.8

²⁸³ *ibid*

Funding comparisons

- 5.5** According to the study *Mental Health in Australia Collaborative Community Practice*, NSW is the second lowest spending state per capita in Australia on mental health.²⁸⁴ For the 2000-2001 financial year, approximately 8% of the NSW Health budget (\$7.77 Billion) was spent on mental health.²⁸⁵ By international comparisons, the United States of America commits approximately 19% of its health budget to mental health, the Netherlands 23.3% and Great Britain 22%.²⁸⁶

Table 5.1 Selected key indicators of mental health services, NSW²⁸⁷

Indicator				National Avg.
	1992-1993	1997-1998	1999-2000	1999-2000
State Government Expenditure				
State spending on mental health services	\$388.7M	\$445.4M	\$495.1M	
State spending per capita	\$64.94	\$70.70	\$76.92	\$81.76
Service Mix				
% total service exp. – community services	29.9%	41.0%	44.5%	49.2%
% total service exp. – sep. psych hospitals	43.6%	32.4%	28.1%	23.3%
% total service exp. – colocated hospitals	26.5%	26.7%	27.3%	27.5%
Community Services (NGOs)				
% total service exp.	1.3%	1.7%	1.5%	5.4%
Per capita exp.	\$0.87	\$1.23	\$1.20	\$4.42

Source: *National Mental Health Report 2002*, Australian Department of Health and Ageing

- 5.6** Recent changes in the structure and mix of NSW public mental health services have seen an increase in community care and parallel reductions in inpatient services.²⁸⁸ By 1997-1998, 41% of expenditure was directed to community services compared with 30% in 1992-1993. By 1999-2000, 45% of mental health expenditure was directed to community services and spending on stand-alone hospitals had reduced to 28% of total service expenditure. Per capita spending on community services and general hospital units increased by 12% (\$46 million) between 1998-2000, taking the total increase in these services to \$132 million or 58% above 1992-1993 levels.²⁸⁹

²⁸⁴ W Weir & A Rosen, in G Meadows & B Singh (eds), *Mental Health in Australia Collaborative Community Practice*, Oxford University Press (Melbourne), 2001, pp 70-72

²⁸⁵ NSW Health, *Annual Report 2000-2001*

²⁸⁶ R S Murthy et al, *The World Health Report 2001 - Mental Health: New understanding, New Hope*, World Health Organisation (Geneva, Switzerland), 2001; Submission 182, St John of God Health Services, p 11

²⁸⁷ The Committee did not seek data earlier than 1992. The introduction of accrual accounting in all departments from 1990 to 1991 would make comparisons difficult with financial reports earlier than this period.

²⁸⁸ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

²⁸⁹ *ibid*

- 5.7** Section 129 of the *Health Services Act 1997* delegates the administration of funding for recognised establishments and recognised services of affiliated health organisations to the Area Health Services. In turn, section 130 provides the AHS with powers to set operational performance targets for the organisation, under a performance agreement. Section 127 refers to the determination of subsidies to be paid to AHS.
- 5.8** While this establishes the legislative role of the AHS in the determination of funding allocations, and hence service delivery, section 127 (4) of the *Health Services Act 1997* determines that “the Minister may attach to the payment of any subsidy such conditions as the Minister thinks fit”.

Table 5.2 Expenditure on mental health programs by Area

	1995/1996			1996/1997			1997/1998			1998/1999			1999/2000			2000/2001		
	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend
Central Sydney AHS	623,703	54,887	8.80	643,592	58,413	9.08	727,436	59,423	8.17	783,026	65,989	8.43	776,049	65,068	8.38	777,863	65,124	8.37
Northern Sydney AHS	525,005	57,535	10.96	547,296	55,711	10.18	611,574	60,446	9.88	631,301	67,221	10.65	689,030	77,398	11.27	704,922	74,477	10.57
Western Sydney AHS	607,185	54,706	9.01	567,332	50,156	8.84	688,138	51,870	7.76	717,954	55,620	7.75	766,647	58,648	7.65	812,583	76,433	9.41
Wentworth AHS	186,110	8,864	4.76	217,292	6,130	2.82	217,837	11,132	5.11	267,827	15,026	5.61	289,228	16,246	5.62	302,69	17,079	5.64
South Western Sydney AHS	414,308	18,810	4.54	427,226	21,466	5.02	564,103	25,284	4.48	615,190	29,727	4.83	645,729	32,633	5.05	673,844	34,858	5.17
Central Coast AHS	167,320	7,088	4.24	172,307	9,869	5.73	220,871	12,722	5.76	249,389	18,711	7.50	263,609	17,065	6.47	273,469	13,791	5.04
Hunter AHS	459,696	37,692	8.20	480,004	40,866	8.51	535,021	50,328	9.41	578,189	54,080	9.35	601,851	58,088	9.32	613,006	57,884	9.44
Illawarra AHS	205,904	13,132	6.38	216,816	16,345	7.56	275,569	19,254	6.99	303,103	19,509	6.44	315,065	26,073	8.28	345,844	28,965	8.38
South Eastern Sydney AHS	920,850	42,931	4.66	837,982	41,111	4.91	923,849	43,647	4.72	1,028,641	51,042	4.96	1,032,138	47,578	4.61	1,069,096	52,814	4.94
Northern Rivers	186,378	7,833	4.20	191,966	9,689	5.05	222,433	11,213	5.04	235,305	11,521	4.90	243,024	12,482	5.14	281,954	14,139	5.01
Mid North Coast	159,399	7,764	4.90	163,292	8,796	5.39	187,122	10,171	5.44	222,508	11,797	5.30	243,625	12,782	5.25	251,810	16,180	6.43
New England	153,965	6,558	4.26	159,110	7,326	4.60	176,149	9,121	5.18	197,599	9,520	4.82	203,234	9,764	4.80	209,236	11,716	5.60
Macquarie	98,626	2,556	2.59	99,471	2,900	2.92	115,626	3,241	2.80	123,675	4,034	3.26	132,507	4,372	3.30	137,779	4,638	3.37
Mid West	164,090	19,119	11.65	166,692	20,916	12.55	185,202	20,506	11.07	219,684	24,280	11.06	231,050	25,512	11.05	227,792	25,322	11.12
Far West	53,803	1,388	2.58	60,168	1,650	2.74	63,456	2,487	3.92	76,594	3,280	4.28	78,905	5,436	6.89	90,232	3,943	4.37
Greater Murray	209,146	5,285	2.53	232,219	5,911	2.55	231,808	8,878	3.83	249,934	9,826	3.93	253,187	9,523	3.76	290,546	10,705	3.68
Southern	132,354	18,561	14.02	130,584	16,858	12.91	146,293	18,671	12.76	167,606	24,762	14.77	175,081	24,023	13.72	229,653	22,961	10.00
New Children Hospital	135,930		0.00	150,960		0.00	165,008	325	0.20	176,568	350	0.20	177,763	872	0.49	185,810	1,559	0.84
Corrections	21,098	7,120	33.75	25,834	8,795	34.04	27,168	10,067	37.05	30,004	10,467	34.89	33,779	10,723	31.74	39,301	13,475	34.29
	5,423,870	371,829	6.86	5,489,459	382,908	6.98	6,264,663	428,786	6.84	6,874,077	486,772	7.08	7,149,501	512,296	7.17	7,517,430	546,083	7.26
NSW Department of Health Annual Report	6,013,513	375,327	6.24	5,973,131	384,604	6.44	6,493,604	428,736	6.60	6,978,379	479,877	6.88	7,193,294	509,996	7.09	7,506,070	549,692	7.32

- 5.9** Table 5.2 shows that between 1995-2001, while expenditure on mental health increased, there remains little change as a percentage of total health expenditure. As the cost of delivering services has increased, allowing for CPI increases, mental health expenditure may have actually decreased during this period.
- 5.10** The six National Mental Health Reports published to date have provided funding data under the National Mental Health Strategy, which monitors the progress of NSW in key policy areas. The *National Mental Health Report 2002* reported that NSW spent \$106 million more in real terms on mental health in 1999-2000 than in 1992-1993, representing a 27% increase or equivalent to a 18% per capita increase.²⁹⁰ Despite the significant growth, NSW investment in mental health remains lower than the national average over the course of the Strategy.²⁹¹ Per capita spending in NSW in 1999-2000 was 5.9% less than the national average.²⁹²
- 5.11** In April 2000, the NSW Government announced a mental health enhancement funding package totalling \$107.5 million to be delivered as recurrent funding over three years, up to the 2002-2003 financial year. NSW Health provided the following table to show how additional funding will be provided over the three-year period.

Table 5.3 Summary of Increases in Mental Health Funding 2000-2001 to 2002-2003

Year	Cost Escalation \$M	Enhanced Services \$M	Total Increase \$M
2000-2001	12.5	24.0	36.5
2001-2002	9.7	18.7	28.4
2002-2003	10.3	32.3	42.6
Total increase in annual allocation for Mental Health Services	32.5	75.0	107.5

Source: NSW Health, Submission 267, p C 6

- 5.12** As table 5.3 shows, the package comprises two parts: Cost Escalation of \$32.5 million and new real recurrent growth funding totalling \$75 million. \$28 million of this latter amount, however, is to support the operating costs associated with NSW Health's capital program.²⁹³ NSW Health explained the funding allocation:

The general enhancement funds for 2001-2002 and 2002-2003 have been allocated to area health services to enable them to develop their non-inpatient mental health services in priority areas. The area plans for 2000-2001 and 2001-2002 indicate that \$6 million in recurrent funds was allocated to specialist child and adolescent mental health services; \$17.2 million to adult mental health services; and \$2.5 million to mental health services for older people. A further \$2.5 million is being

²⁹⁰ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

²⁹¹ *ibid*

²⁹² *ibid*

²⁹³ Submission 267, NSW Health, p C 5

allocated by the areas from their enhancement funds to develop mental health services provided through non-Government organisations.²⁹⁴

- 5.13** The National Association of Practising Psychiatrists (NAPP) questioned the veracity of the additional funding and anticipated a lack of impact or improvement to services as a result:

Where has all the other mental health money gone over the last 13 years? Where has the injection of \$150 million disappeared to? NAPP believes that the short answer is that the AHS have subsumed it – a crucial issue for the Committee to address.²⁹⁵

- 5.14** The NAPP further queried whether or not NSW should return to centralised funding for mental health services. Referring to the fragmentation of responsibilities, notably alcohol and other drug services, and services for people with a developmental disability, the NAPP questioned whether or not these services should be reintegrated with mental health.²⁹⁶ (see Chapter 9, MISA)

- 5.15** While NSW Health contends that it is enhancing the accountability of the Area Health Services, the Director of the Centre for Mental Health, Prof Beverley Raphael, nevertheless acknowledged the practical difficulties:

The Areas are responsible for the delivery of services. That is their legislated brief. I cannot control that delivery of services.²⁹⁷

- 5.16** Prof Raphael stated, however:

I re-emphasise the fact that we recognise there is a need to do better. We are working actively with the area health services to deliver services to ensure this happens, but we will be very much looking for your recommendations to support our processes.²⁹⁸

- 5.17** With the 1999-2000 increase in per capita spending in NSW averaging 4.3%, by national and international standards, mental health funding in NSW does not reflect the demand currently being placed on services.

Recommendation 23

That the Minister for Health utilise the authority of the *Health Services Act 1997* to ensure that mental health funds are being allocated and expended by Area Health Services in accordance with NSW Health policies.

²⁹⁴ Submission 267, NSW Health, p C 7

²⁹⁵ Submission 189, National Association of Practising Psychiatrists, p 16

²⁹⁶ *ibid*

²⁹⁷ B Raphael, Evidence, 12 August 2002, p 18

²⁹⁸ *ibid*, p 4

Funding of community based services

- 5.18** Community based mental health services are managed by both the AHS and community or non-government organisations (NGOs). Community based services are the main method of mental health services delivery in NSW. Developments over the last twenty years have seen the decrease in inpatient services and an increased reliance on community based care.²⁹⁹ NSW CAG argue that the interaction between those with a mental illness and the hospital system is currently quite limited:

At any one time, a small percentage of those with a mental illness are in hospital. Yet the budgets for mental health do not reflect this.

NSW CAG's concern is not solely about not having enough beds in this state, (although there is no doubt that this is an important issue for acute and sub acute services), for most consumers are not in hospital. It is about the lack of funding for community-based services.³⁰⁰

- 5.19** In its submission to the Committee, the Mental Health Co-ordinating Council referred to the *National Mental Health Report 2000*, which detailed NGO funding data comparing 1992-1993 with the 1997-1998 financial year.

Table 5.4 Expenditure on community based mental health services per capita (ambulatory, residential and NGO) 1992-1993 and 1997-1998

	1992-1993		1997-1998	
	% of total mental health expenditure on mental health NGOs	Per capita expenditure on mental health NGOs (\$)	% of total mental health expenditure on mental health NGOs	Per capita expenditure on mental health NGOs (\$)
NSW	1.3	0.82	1.7	1.16
Vic	2.9	2.24	9.6	7.49
Qld	1.3	0.67	5.2	3.47
WA	2.4	1.55	5.6	4.86
SA	1.6	1.11	2.0	1.64
Tas	3.0	1.96	3.5	2.73
ACT	2.5	1.32	5.9	1.60
NT	1.0	0.54	5.1	3.78
Nat Avg	1.8	NA	5.0	3.66

Source: MHCC, Submission 218, p5 and Submission 192, NCOSS, p 6.

- 5.20** Table 5.4 shows that for these periods NSW allocated a significantly lower proportion of its total mental health expenditure, and a lower per capita expenditure, on mental health NGO services than most other states in 1992-1993 and the lowest in 1997-1998. Between

²⁹⁹ Submission 218, Mental Health Co-ordinating Council, p 6; Submission 192, NCOSS, p 5

³⁰⁰ Submission 162, NSW Consumer Advisory Group, p 35

1993 and 1998, the *National Mental Health Report 2000* notes that while grants to mental health NGOs in NSW increased by 48%, the average national growth was 201%.³⁰¹ It is apparent from the table that Victoria, Queensland, Western Australia and the Northern Territory have all significantly increased their expenditure on mental health NGO services between the two periods.

5.21 The MHCC noted in its submission to the Committee, that NSW Health reported an increase in funding to mental health NGOs in 2000-2001 of 2.1%. As the Consumer Price Index (CPI) for 2000-2001 was 2.5%, the mental health NGO sector sustained a cut in funding in real terms.³⁰²

5.22 The *National Mental Health Report 2002* noted:

Allocations to non-government organisations and spending on community based residential services showed little change when adjustments are made to account for the broader definition of residential services used in 1999-00.³⁰³

...NSW allocated a significantly lower proportion of its total mental health expenditure, and a lower per capita expenditure, on mental health NGO services than most other states in 1992-93 and the lowest in 1997-98.³⁰⁴

5.23 In contrast, the *National Mental Health Report 2002* noted that Victoria, which had the highest expenditure on NGOs:

continued as the leading State in the extent of structural reform, with resource distribution greater than all other jurisdictions combined. [There was a] 128% increase in expenditure on community based services since 1992-1993...[The] reduction in inpatient beds was more than offset by the development of alternative community based residential units.³⁰⁵

5.24 While acknowledging a lack of sufficient funding for NGO programs, the Committee is mindful that any increase in funding needs to be well coordinated and targeted. As Mr Robert Ramjan, Executive Director, Richmond Fellowship, stated:

there is no question that funding to NGOs should be increased in the mental health area, but if there is a sudden influx of money to the non-government sector, that would probably destroy a number of organisations. They would not have the infrastructure nor the expertise.³⁰⁶

³⁰¹ Commonwealth Department of Health and Aged Care (DHAC), *National Mental Health Report 2000*, p 51

³⁰² Submission 218, Mental Health Co-ordinating Council, p 6

³⁰³ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

³⁰⁴ *ibid*

³⁰⁵ *ibid*, p 58

³⁰⁶ R Ramjan, Evidence, 8 August 2002, p 21

Resource allocation between Area Health Services and NGOs

- 5.25** The Committee questioned Prof Beverley Raphael on whether or not NGOs in NSW are getting 68% less funding than the national average. Prof Raphael responded that this was attributable to various factors that increased the national average. For example, the national average for Victoria is particularly high because of the way NGO funding programs are structured:

There is no agreed national definition of what NGO charging is in the national survey data. So a range of different things come under NGOs. One of the things Victoria does, all its disability support comes under NGOs. We believe that NGOs have a major role in disability support, and our rehabilitation program identifies that. What we are trying to do now is look at where areas are providing that disability support which might be more properly provided by NGOs, as well as funding some of the strategies within NGOs...much of the work that Victoria identifies as NGO funding is being done by our Area Health Services.³⁰⁷

- 5.26** The Macksville Positive Living Skills Centre, currently under the Mid North Coast AHS (MNCAHS) expressed concern that their services are to be detached from the AHS and funded under the auspices of an NGO.³⁰⁸ This would indicate a shift towards a similar division of service to that of Victoria. The submission by the Macksville Positive Living Skills Centre continued:

Mental health services are currently provided by the MNCAHS, the expertise, knowledge base, experience and resources provided by the MNCAHS are crucial to the provision of high level of quality care. It is essential for Macksville Positive Living Skills to have good access to these services provided by the MNCAHS. Moreover, the shifting of responsibilities out of our region would certainly result in a deterioration of service provision. Therefore, it is essential that the provision of Positive Living Skills service remain a responsibility of the MNCAHS.³⁰⁹

- 5.27** The additional \$107.5 million for mental health announced in April 2000 was to include additional funding for the NGO sector. The MHCC informed the Committee that it had not been able to ascertain how the additional funds would be allocated, particularly for mental health NGOs. The Council of Social Service New South Wales (NCOSS) states that, despite assurances from both the Centre for Mental Health and a representative of the Minister for Health, it has seen no indication that NGOs were involved in a structured, participatory planning process for the rollout of the \$107.5 million.³¹⁰ In April 2002, the MHCC also informed the Committee that it was only aware of three NGO programs receiving funding, totalling around \$450,000 (0.4%).³¹¹

- 5.28** According to the MHCC, of particular concern to the mental health NGO sector is a perceived conflict of interest where AHS are both purchasers and providers of services:

³⁰⁷ B Raphael, Evidence, 12 August 2002, p 8

³⁰⁸ Submission 218, Mental Health Co-ordinating Council, p 6

³⁰⁹ Submission 64, Macksville Positive Living Skills Centre, p 2

³¹⁰ Submission 192, NCOS, p 9

³¹¹ Submission 218, Mental Health Co-ordinating Council, p 6

Under the current system NGOs and Area Health Services compete for the same funds, but it is often Area Health Services who decide or influence decisions about whether or not NGOs receive any new funding. This occurs because NGOs are requested to submit funding applications through the Area Health Service.³¹²

5.29 NCOSS referred to the Area Health Service Agreements, which NSW Health uses to direct and monitor the performance of AHS:

These agreements contain targets for service delivery and service development, and are negotiated at Area Health Service board level. Neither the performance agreements nor the reporting against them is publicly available. NCOSS is extremely concerned about the secrecy attached to this important data on Area Health Service resources and activities.³¹³

5.30 The Committee is concerned that resource allocation appears to be a contest between 'hospital' and 'community', or between a relatively well-resourced area and another.

5.31 The Committee considers that AHS should not determine the allocation of funding for NGOs who coordinate programs across the State. Differentiation should be made between the interests of these large statewide NGOs and locally oriented and determined service delivery organisations. Statewide NGOs are currently restricted in implementing comprehensive statewide programs, as they must apply separately to each relevant Area Health Service. Similarly, locally oriented NGOs are forced to compete for funding with organisations which are far better prepared and experienced in seeking funding, though not necessarily more proficient at providing the required service in a specific area. The Committee calls on NSW Health to re-evaluate the funding determination for NGO programs and that funding allocation for statewide NGOs be allocated to and determined by the Centre for Mental Health.

Recommendation 24

That the Centre for Mental Health consider and determine the funding allocation for statewide programs run by non-government organisations.

³¹² Submission 218, Mental Health Co-ordinating Council, p 7

³¹³ Submission 192, NCOSS, p 8

Transparency

- 5.32** To determine whether mental health funding allocation is efficient, and that matching expenditure achieves desired outcomes, AHS need to adopt transparent reporting mechanisms. Public accountability can only be achieved through transparency.

Expenditure reporting

- 5.33** NCOSS, among its roles, has historically acted as a review body for government social issues policies and funding programs. NCOSS expressed concern that mental health funding lacked transparency:

To date there is little budget transparency and public accountability, and consumers and community organisations have little confidence in what financial information is available. This includes the funding of mental health services, particularly within the Area Health Services.

...Information on resource allocation and expenditure is available in NSW Budget papers, the NSW Health Annual Report and Area Health Service Annual Reports, however this information is of little use in determining actual expenditure on particular services on types of service, such as mental health services in the community.³¹⁴

- 5.34** NCOSS indicated that determining how, where and why funding is allocated by AHS is problematic:

It is an indictment on the lack of transparency in health funding in NSW that more information is available about spending on mental health services in NSW from reports under the National Mental Health Strategy than through the state's own public budgeting and reporting mechanisms.³¹⁵

- 5.35** NCOSS has consistently called for greater transparency of health service budget priorities, and in particular, “the publication of disaggregated data of actual expenditure according to service type”.³¹⁶

- 5.36** The Director of the Centre for Mental Health, Prof Beverley Raphael, asserted that the Centre for Mental Health requests “quite specific reporting on what has been spent and what it has been spent on”,³¹⁷ and that:

there are now active reporting frameworks to address what is done in the use of the funding for the services...That has been one of the complexities, because, as you would be well aware, the area health services act as autonomous bodies under the Health Services Act of 1997 and it is their job to deliver services. It is the

³¹⁴ Submission 192, NCOSS, p 8

³¹⁵ *ibid*

³¹⁶ *ibid*

³¹⁷ B Raphael, Evidence, 12 August 2002, p 6

central agency's job to influence that delivery of services as much as possible, and we work in close liaison with the area health services to try to facilitate and improve that.³¹⁸

- 5.37** Prof Raphael acknowledged, however, that she was not happy with the accuracy of the information often received from the AHS.³¹⁹ The Australian Salaried Medical Officers Federation (ASMOF) cited consensus among psychiatrists that 'quarantining' of mental health budgets is completely ineffective, but stated that:

the budget process is so opaque that there are some Area Directors of Mental Health who are not told what their budgets are.³²⁰

Use of mental health service funding for other purposes

- 5.38** Concerns raised in various submissions and by witnesses suggest that in some instances there is an incubation period for quarantined mental health funding between its dispatch to an AHS or hospital and its receipt.³²¹ In regard to a question from the Committee regarding the claimed use of 25% of the quarantined mental health budget for administrative and overhead purposes by AHS, Prof Raphael responded:

Budgets have an overhead proportion. We monitor that. We have had difficulties in the past, which we have now taken to get a much better handle in areas in the current planning being asked to identify exactly what the components of overheads will be. While that has been a problem that has been of concern to us, we have been attempting to actively pin down and get a consistent figure for the overhead budget.³²²

- 5.39** Later, Prof Raphael agreed that the figure could be more than 25% in some areas, and agreed with the general call for greater transparency:

What I would like to see is a clear delineation of the overheads and cost structures. Then we can all work together with transparency about what the elements are with respect to the budget and what is a proper charge against mental health.³²³

- 5.40** Prof Raphael indicated that the Centre for Mental Health was meeting with each AHS Chief Executive Officer to review their budget and to have any discrepancies explained and felt that information was "improving progressively".³²⁴ According to Prof Raphael, the critical issue is the need to develop a uniform process for the overhead component of the mental health budget:

³¹⁸ B Raphael, Evidence, 12 August 2002, p 3

³¹⁹ *ibid*

³²⁰ Submission 91, Australian Salaried Medical Officers Federation, Attachment A

³²¹ Submission 192, NCOSS, p 9

³²² B Raphael, Evidence, 12 August 2002, p 5

³²³ *ibid*

³²⁴ *ibid*

I would support a concept of the Area Directors having senior and direct reporting to the CEO so that governance can be stronger at an Area Health Service level.³²⁵

- 5.41** In June 2001, Mr Ken Barker, General Manager, Financial Commercial Services, NSW Health, highlighted to another Legislative Council Committee, the potential vulnerability of mental health funding, though commented that NSW Health was developing a process to monitor program movements and allocations within AHS. Mr Barker added that:

The monitoring arrangement will allow us to understand better what Areas are doing so that if they are moving money from one program to another there is a sound reason to it and it is not for something that you might say is not 100 per cent correct...³²⁶

- 5.42** The evidence provided by witnesses, including Prof Raphael, indicates that NSW Health is yet to implement an effective monitoring system to enhance transparency and allow greater public assessment of outcomes and efficiency. In response to a question from the Committee requesting whether this expenditure could be made public so people could determine the amount of money being spent, Prof Raphael stated:

I see no reason why it would not be possible...I understand that. I have had those concerns myself and have been trying to pursue them.³²⁷

- 5.43** The Committee questioned Dr William Barclay, Psychiatrist, whether he felt there is a need for transparency and greater accountability in the allocation of funding by AHS. Dr Barclay responded that:

A constant problem has been to do just that, be able to identify the budget and identify where all the money has gone. The short answer is yes.³²⁸

- 5.44** While recommending robust reporting processes, the Committee remains concerned over reports that a number of AHS have diverted funds intended for mental health to other activities.³²⁹ The Committee is informed that it is not uncommon for figures to be 'adjusted' to meet Departmental requirements.³³⁰ The number of reports of such incidents to the Committee, including confidential submissions, raises some serious questions over the publicly reported funding of mental health services.

³²⁵ *ibid*

³²⁶ Mr Ken Barker, General Manager, Financial Commercial Services, Evidence, GPSC2 hearing, 3 June 2001, p 7

³²⁷ B Raphael, Evidence, 12 August 2002, p 7

³²⁸ Dr William Barclay, Psychiatrist, Evidence, 30 May 2002, p 8

³²⁹ Submission 192, NCOSS, p 9

³³⁰ *ibid*

External auditing

- 5.45** To encourage transparency and achieve public accountability, a number of submissions advocated the need for appropriate external auditing processes to monitor expenditure.
- 5.46** The ASMOF advised the Committee that in June 2000 it had recommended solutions to the Minister for Health to address problems regarding the breach of quarantined mental health funding:
- the amounts provided to each area health service for Mental Health services must be published and the expenditure of those funds needs to be externally audited.³³¹
- 5.47** The NSW Nurses' Association argued that:
- Funding issues in mental health services are of paramount importance and auditing systems must be introduced immediately into all AHS. The Government has a commitment to guarantee a true quarantining of mental health funding with total transparency and accountability.³³²
- 5.48** Similarly, NCOSS called for the adoption of a statewide audit of mental health funding:
- to determine the current allocation of funds, and the distribution of mental health resources between acute and community care. NCOSS also urges that this auditing process be undertaken on a regular basis to ensure ongoing, accurate reporting from Area Health Services.³³³
- 5.49** The Committee supports these recommendations and agrees that a statewide performance audit would reveal the current funding environment. The Committee further considers that, following a statewide performance audit, NSW Health should establish a regular auditing plan, which includes both the current financial audits and also physical audits of hospitals and other service providers.

Key Performance Indicators

- 5.50** In health related health service areas other than mental health, such as Emergency Departments in public hospitals, Key Performance Indicators (KPIs) are assigned and monitored as part of NSW Health service agreements. In February 1999, NSW Health issued *A Framework for Managing the Quality of Health Services in New South Wales* (Quality Framework), which was designed to be an overarching policy for managing quality of health care in NSW. The Quality Framework outlined the need for indicators of health care quality.³³⁴

³³¹ Submission 91, Australian Salaried Medical Officers Federation, Attachment A

³³² Submission 212, NSW Nurses' Association, p 15

³³³ Submission 192, NCOSS, p 10

³³⁴ NSW Legislative Council, General Purpose Standing Committee No.2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, p 27

- 5.51** NSW Health advised that 27 Mental Health Quality Indicators, reflecting aspects of the quality of mental health service provision at a local level, would be collected for all mental health services in NSW. The indicators would be reported on a monthly, quarterly or annual basis from July 2002 to monitor a range of procedures including “the management of sentinel events, discharge planning and consumer/carer participation.”³³⁵
- 5.52** The Committee commends the introduction of mental health quality indicators. Specific KPIs must, however, be assigned to core mental health service evaluation components within public hospitals. The evaluation of performance improvement through a series of key indicators must feature in performance agreements at all levels of the health service, including funding allocation.
- 5.53** Under the Quality Framework, the implementation of an appropriate committee structure was an essential component of managing and monitoring quality of care delivered by AHS. A similar committee within each Area, such as a Mental Health Quality Care Committee, reporting to the AHS Board and the Centre for Mental Health, should be established to provide a means by which the quality of clinical and secondary care to consumers within the Area can be defined, measured, monitored, reported and improved. The primary activities of the Mental Health Quality Care Committee would be to collect, collate and analyse Area broad KPI data and report to the Area Board, and to the Centre for Mental Health.
- 5.54** The Committee is mindful that the assignment of KPIs alone, monitored by a Mental Health Quality Care Committee, cannot prevent ‘gaming’ where an organisation’s internal structures are designed specifically to meet a pre-determined outcome.³³⁶ The Committee is however confident that NSW Health and the Audit Office of NSW are aware of such practices and would closely monitor them.³³⁷

Recommendation 25

That the Minister for Health immediately initiate and support a formal process where Area Health Service mental health directors report directly to the Chief Executive Officer of the relevant Area Health Service for the purposes of monitoring program movements and allocations.

Recommendation 26

That each Area Health Service publish in its annual report, detailed and transparent information regarding mental health funding allocations and direct mental health expenditure.

³³⁵ Submission 267, NSW Health, p E 2

³³⁶ Audit Office of NSW, NSW Legislative Council, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, p 32

³³⁷ NSW Legislative Council, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, pp 32-33

Recommendation 27

That the Minister for Health work with the Auditor-General to develop and initiate the following audit programs:

- a performance audit of mental health budget allocation and expenditure from July 2003 to 30 June 2004 in NSW, and that the performance audit report be tabled in Parliament
 - an audit plan designed for the annual audit of Area Health Services and service providers (hospitals and affiliated health organisations), that includes disclosure of mental health funding allocation and expenditure. Expenditure of mental health funding on non-mental health programs should be reported.
 - an on-going audit program to include both the current financial audit, as well as a physical audit of hospitals and other mental health service providers, to ensure that staffing, infrastructure and auxiliary budget costs are directly hypothecated.
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Recommendation 28

That NSW Health develop and implement a set of Key Performance Indicators for inpatient mental health services in public hospitals, and that these Key Performance Indicators be linked to service performance agreements and funding allocation. The performance against these Key Performance Indicators should be reported in each Area Health Service annual report.

Recommendation 29

That the Minister for Health establish a Mental Health Quality Care Committee within each Area Health Service. The functions of the Mental Health Quality Care Committee should include:

- reporting to the Area Health Service Board and the Centre for Mental Health
 - developing a means by which the quality of clinical and secondary care to consumers within the Area can be defined, measured, monitored, reported and improved and
 - collecting, collating and analysing Area Key Performance Indicator data and reporting findings to the Area Board and the Centre for Mental Health.
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Conclusion

- 5.55** The Committee has determined that for mental health funding and services to be effective, they must be transparent. The Committee is not particularly critical of NSW Health mental health policy and has made no comment on clinical practices. The basis of the Select Committee's Terms of Reference was the provision of mental health services. Unfortunately, the policy initiatives developed by NSW Health and, in particular, the Centre for Mental Health, are not being adequately implemented. Revolutionary reforms are required to improve how mental health services are delivered, accessed and maintained. These reforms must be given priority status by the NSW Government. Cultural and community acceptance of poor access to and delivery of mental health services must not be allowed to develop.
- 5.56** The gaps between policy and implementation must not be permitted to continue, let alone widen. Bi-partisan commitment to change is required. The Committee is highly conscious of a statement by the NSW Nurses' Association regarding outcomes of previous inquiries:
- We find it curious the number of reviews, reports and recommendations that have been undertaken in mental health over the past twenty years and still very little has changed.³³⁸
- 5.57** The Committee noted previously that the deficiencies in mental health services reported over 150 years ago are similar to those that currently exist. Resolving these deficiencies cannot be achieved immediately but a resolve is required to commit to a managed and sustainable reform process. The Committee acknowledges that NSW Health and the Premier's administration must be presented sufficient time to ensure that change does occur. As reform cannot be further delayed, the Committee has recommended an Office of Mental Health be established within the NSW Premier's Department to support NSW Health and catalyse reform.

³³⁸ Submission 212, NSW Nurses' Association, p 2

Chapter 6 Privacy, confidentiality and information

The moment Reno cancelled his authority for me as his Nominee meant that he had no-one that cared about him or had access to any information to help him. Had I known who his psychiatrist was and had I been able to get information, in order that there was a support team in place, maybe Reno would still be here.³³⁹
[Mr Robert Wirth]

In evidence presented to the Committee, carers, families and advocates for people with serious mental illnesses raised questions about whether or not upholding a person's right to privacy was always compatible with delivering appropriate care. Privacy and confidentiality laws shape the delivery of mental health services in NSW, from individual primary care through to statewide data collection. This chapter considers the legal and practical dimensions of mental health information exchange in NSW, and presents the different viewpoints of stakeholders in privacy and mental health information.

Confidentiality and consent

6.1 The right of people with a mental illness to privacy and confidentiality was acknowledged throughout the inquiry. The anguish families and carers experience due to mental health information disclosure restrictions, however, was encapsulated in many personal accounts related to the Committee by witnesses and in submissions. The Hon Frank Walker QC, President of the Schizophrenia Fellowship NSW described his own experience as follows:

If you are a parent you may have a different view, and I was twice. I found myself totally frustrated and very angry about the total lack of information. I never managed to get any explanation out of a psychiatrist ever about the nature of the disease. I had to find out for myself. I had to educate myself. I got no support at all at any stage over a long period of time, and nor did my family. Of course the families are often in just as much crisis. It is a very terrible thing, this schizophrenia disease. It has a massive impact upon family relationships and to be left in a vacuum is a very frightening thing for a family.

The disease, of course, presents with symptomatology that is delusional, often extremely delusional; these people live in an unreal world and you could get no information at the time when my son was in terrible delusions. He had five voices talking to him constantly year in, year out, and he had a total lack of sense of reality for large periods of time, but never once was I able to persuade a medical practitioner to assist me as to what the nature of the problem was or what should be done about it. Not only that, he was extremely paranoid and he feared any part of his medical record getting out because he knew that the CIA would get it and he knew that aliens with laser beams were likely to use that information to hurt him. Yet that was the excuse used to keep my family in the dark.³⁴⁰

³³⁹ Submission 303, Mr Robert Wirth, p 6

³⁴⁰ The Hon Frank Walker QC, President, Schizophrenia Fellowship NSW, Evidence, 8 August 2002, p 29

- 6.2** The mother of a man who had suffered schizophrenia for seven years described her own situation as follows:

As a carer I have felt in the ‘dark’. No-one sat down with me and explained the system, or how to get help and so on. When I visit my son in hospital no-one comes up to say how he is going, what the diagnosis is, what medication he has to have, when he is going home etc. I have had to be very ‘pushy’ and ‘demanding’ otherwise I would not have got any information. This all causes extra stress on the carer.³⁴¹

- 6.3** Another carer for a mentally ill relative commented at the Committee’s Public Forum on 7 August 2002:

We take on all the responsibilities of seeing them take medication, keep appointments, pay bills, but when we ring the doctors to see if they have arrived for an appointment we are so often told ‘I cannot tell you unless the patient gives his permission’. Our hands are tied in so many unnecessary ways.³⁴²

- 6.4** The laws and principles of confidentiality and privacy are complex. The following sections describe how they apply in NSW and the impact they have on mental health services and their clients, as well as on carers and families.

Confidentiality and privacy in mental health settings

- 6.5** The common law notion of patient-doctor ‘confidentiality’ outlines a clinician’s duty of confidence to his or her patient, and relies on the clinician’s ‘obligations of conscience’ on what information is disclosed, and how it is disclosed.³⁴³ An obligation of conscience may not only prevent the disclosure of information, but also the unauthorised use of that information. Confidentiality at common law does not mean that the patient-confider owns the information they disclose.³⁴⁴

- 6.6** Privacy NSW has described ‘privacy’ as meaning:

the right to be let alone, the right to personal space or autonomy, the right of people to exercise control over their personal information or the degree of interference with their personal life.³⁴⁵

- 6.7** Since 1988, a number of Commonwealth and NSW Acts have been enacted to protect the right to privacy of individuals. The *Commonwealth Privacy Act 1988*,³⁴⁶ the *NSW Privacy and Personal Information Protection Act 1998* (PPIP), and the recent *NSW Health Records and Information Privacy Act 2002* (HRIP), serve to protect individuals’ rights to privacy by defining the responsibilities of health service providers to their clients in dealing with

³⁴¹ Submission 177, Mrs Dorothy Ridley, p 2

³⁴² Mrs Jean Cooper, Speaker public forum, 7 August 2002

³⁴³ R Magnusson, *Data Linkage, Health Research and Privacy: Regulating Data Flows in Australia’s Health Care System*, Sydney Law Review, Vol 24, no 1, 2002, p 21

³⁴⁴ See *Breen v. Williams* (1996) 186 CLR 71 at 81.90. 128-29

³⁴⁵ Privacy NSW, *Submission to the ALRC/AHEC Issues Paper on Genetic Information and Privacy*, 2002, p 1

³⁴⁶ Amended by the *Privacy Amendment (Private Sector) Act 2000*

personal information. The *Commonwealth Privacy Act 1998* sets out ten National Privacy Principles (NPPs) that represent the minimum privacy standards for handling personal information. The HRIP has fifteen Health Privacy Principles (HPPs) which will be discussed later in this chapter.

- 6.8** The *National Standards for Mental Health Services* were first published in 1997. These standards are a ‘blueprint’ for services and quality improvement, and underpin National Mental Health Care Plans.³⁴⁷ National Standard Number 5 deals with privacy and confidentiality, where Mental Health Services must “ensure the privacy and confidentiality of consumers and carers”.³⁴⁸
- 6.9** In NSW, Section 289 of the *Mental Health Act 1990* prohibits disclosure of any information “obtained in connection with the administration or execution” of the Act or the regulations unless the person “about who the information was obtained” gives consent.

Consent and guardianship

- 6.10** Consent to any medical treatment must be obtained prior to the treatment commencing. If patients are to give consent to any medical treatment, they must be deemed capable of understanding the nature of the treatment or action proposed, possible outcomes and what will happen if they refuse to give consent.
- 6.11** Under the *Mental Health Act 1990*, and now the *Health Records and Information Privacy Act 2002*, a patient’s consent must also be sought to permit the disclosure of information about him or her to other parties. The HRIP allows for disclosure of information to an immediate family member of the individual for ‘compassionate reasons’ (see HPP 11 [g]). Where a person is incapable of giving consent, an ‘authorised representative’ may act on their behalf. Under Part 1, Clause 8 of the HRIP, the person may be:
- an attorney for the individual (under an enduring power of attorney)
 - a guardian within the meaning of the *Guardianship Act 1987* or a person responsible within the meaning of Part 5 of the Act
 - a person with parental responsibility if the person is a child
 - a person otherwise empowered under the law to act in the best interests of the individual.
- 6.12** The NSW *Guardianship Act 1987* permits decisions to be made for a person where they are incapable of giving consent and a Guardianship Order does not exist. Under Part 5 of the Act, a guardian, relative, friend, unpaid carer or other ‘person responsible’ may give consent where medical treatment is required. Currently, this provision for substitute decision-making in the *Guardianship Act* does not appear to be widely applied in the mental

³⁴⁷ Submission 226, Commonwealth Department of Health and Ageing, Attachment: *National Standards for Mental Health Services*, p i

³⁴⁸ Commonwealth of Australia, *National Standards for Mental Health Services* (1997), pp 7-12

health system. Mr Robert Ramjan, Executive Officer of the Schizophrenia Fellowship of NSW commented:

There is the legislation in the Guardianship Act that says there is a person responsible and that person responsible can be involved in medical decisions and medical information...You do not need a guardianship order if there is a person responsible who can make the consents and who can deal with the information... It just means the health authorities do not understand the concept of 'person responsible'. But the Act actually provides for a person responsible who can hear the information and make the decisions if the subject person is not competent to do it themselves.³⁴⁹

- 6.13** Mr Walker also commented that mental health care professionals appeared to be concerned they might offend under the *Mental Health Act 1990* if they sought decisions from a 'person responsible' even when a mentally ill person is clearly incapable and in need of treatment:

They will not tell you he is on the streets in King's Cross anyway, even though they know it. They will not tell you that... That is their duty under the Mental Health Act. That is the doctor's duty. District Court judges complain to me all the time that they make orders saying people are incompetent, they say they are a danger to themselves or are a danger to the general public; they then send them into the health system who will immediately discharge them into the community where they kill someone or they do some damage or they kill themselves. That is something that happens every day of the week. They are prepared to make that decision to overrule a judge's decision, a seriously taken judicial decision, they are prepared to do that, yet they are not prepared to say "This person is incompetent. He is delusional. He is suicidal. We are going to ring the parent and tell them that he is up the Cross trying to sell his body".³⁵⁰

- 6.14** The Office of the Public Guardian NSW commented in its submission that, even where formal Guardianship Orders exist, some mental health practitioners are nevertheless unaware of their obligations to obtain consent under Part 5 of the *Guardianship Act 1987*:

Often planning for a person is undertaken without the input of the person's appointed guardian. Consent to decisions made concerning discharge and follow up treatment may be required under the functions of the guardianship order. In some circumstances mental health professionals contact the guardian to 'inform' them of a decision rather than seek the consent of the legally appointed guardian. Greater discussion and inclusion of the guardian in the planning phase would avoid this.³⁵¹

- 6.15** This indicates that in some cases consent has not been properly obtained prior to decisions regarding treatment being taken. The Committee is concerned that this is contrary to both the *Guardianship Act 1987* and the *Mental Health Act 1990*.

- 6.16** The Committee acknowledges that in mental health settings, assessing a person's ability to make an informed decision can be difficult. Where an illness is episodic, obtaining and retaining consent can also be highly challenging. The family of a person who suffered

³⁴⁹ R Ramjan, Evidence, 8 August 2002, p 28-29

³⁵⁰ F Walker, Evidence, 8 August 2002, p 29

³⁵¹ Submission 255, Office of the Public Guardian NSW, pp 6-7

frequent and lengthy episodes of psychosis suggested a system of ‘secondary guardianship’ for those suffering episodic illnesses. The model was envisaged as follows:

A secondary guardian [would be] chosen by the mentally ill/disordered person to represent their personal interests and to make relevant decisions on the behalf of that person while under a mental health schedule. Secondary Guardians can only be chosen by the mentally ill/disordered person when they are not under schedule, agreed to in a signed legal contract.³⁵²

- 6.17** This model is similar to the existing provision for Enduring Guardianship in the NSW *Guardianship Act 1987*. Enduring Guardianship enables a person to choose another person or persons to make personal or lifestyle decisions for them only if they become incapable of doing it themselves. The authority to override a mentally ill person’s objections to medical treatment cannot be given to the Enduring Guardian. Only the Guardianship Tribunal can do this.³⁵³
- 6.18** The Committee notes that decisions relating to the appointment of guardians (including enduring guardians) can now be reviewed by the Administrative Appeals Tribunal under the *Guardianship and Protected Estates Legislation Amendment Act 2002*. This legislation would further protect the rights of people with a mental illness wishing to appoint guardians as per the Committee’s recommendations.
- 6.19** The complexities of establishing competence during an episode of severe mental illness mean that Enduring Guardianship in its current form may not be suitable for the ‘secondary guardianship’ model proposed above. A specific adaptation of the Enduring Guardianship system is worthy of further consideration. Under such a model, people with episodic mental illnesses, while they are capable, could nominate people of their choice to be secondary guardians. When the person is scheduled or deemed incapable of making informed consent, the secondary guardianship order would commence. The order would cease to apply as soon as:
- pre-agreed recovery milestones are met or
 - the person is no longer under schedule or
 - the person is deemed capable of giving informed consent, either by their psychiatrist or the Guardianship Tribunal.
- 6.20** Such a system would need to contain safeguards and frequent dates for review. Nominated secondary guardians would need to demonstrate to the Guardianship Tribunal their understanding of and commitment to secondary guardianship, and the principles of protecting patients’ rights.
- 6.21** Given the Public Guardian’s evidence that medical officers currently do not routinely seek the permission of appointed guardians for consent to treatment, it would appear that substitute decision making in NSW needs to be better understood in the mental health system.

³⁵² Submission 223, Mr Patrick Connoley and Ms Elizabeth Brennan, p 13

³⁵³ Guardianship Tribunal of NSW, ‘Enduring Guardianship’ Factsheet, p 1

Recommendation 30

That the Minister for Health and the Attorney General review the *Guardianship Act 1987* with respect to people who suffer severe and/or episodic mental illnesses during which they are not capable of making informed consent. This review should include the possibility of enduring guardianship.

Recommendation 31

That the Centre for Mental Health and the Office of the Public Guardian work together to develop an information package for mental health professionals that:

- outlines their obligations as well as the rights of families and carers under relevant mental health, privacy and guardianship legislation, and
- clarifies the existing definitions of ‘consent’ and ‘substitute decision-making’ in mental health settings and communicate this clarification to mental health professionals.

Recommendation 32

That the Minister for Health prepare a proposal for consideration by the Minister for Education to ensure that students in undergraduate and postgraduate health programs receive training regarding:

- their obligations to seek information from and disclose information to consumers, families, guardians, carers and other service providers, and
- the rights of consumers, families and carers under the relevant mental health, privacy and guardianship legislation.

Families’ and carers’ rights

6.22 Although evidence from carers, families and rehabilitation services endorsed the right of mental health service users to confidentiality and privacy, where a serious mental illness was involved, many families, carers and NGOs expressed frustration with the inconsistent application of privacy and confidentiality principles.

6.23 The NSW Consumer Advisory Group (NSW CAG) identified the ‘underlying tension’ between consumer, carer and health care providers in regard to the use of information:

rights to information about admission, treatment, and discharge planning (including the location to which the consumer will be discharged, and the date, time etc of planned discharge) currently either do not exist for carers, or are granted informally by hospitals/agencies, at their discretion and without a formal legal basis, or are subject to the consent of the consumer. While it is the right of the consumer to deny consent (a right which may not always be in the best

interest of the consumer) nevertheless situations where consumer consent is not sought, or given and not acted upon, give rise to considerable distress and danger. A consistent approach across the state, with a firm legal basis, could address this.³⁵⁴

6.24 Carers NSW reported that information withheld by mental health service providers could hinder rehabilitation:

They do not discuss their relative's care with them, do not ask the carer's opinion and do not tell them about medication changes. This makes it extremely difficult for some carers to manage their caring responsibilities effectively. The carers often feel as though they learn by trial and error...A major complaint of carers is often that confidentiality requirements are used to exclude them...However as the major people responsible for their relatives when they are unable to care for themselves, carers need information – both for effective management and their own safety.³⁵⁵

6.25 The Parents and Carers Mental Health Group, North Casino, also suggested that excessive application of confidentiality principles impeded appropriate treatment:

It is our view that the Mental Health Act does not provide for adequate input by carers/relatives/significant others. It is realised that confidentiality is extremely important. However, each family involved with mental health services in this area, who are members of the Parents and Carers Group, has experienced frustrating and dangerous situations caring for their family, due to the restrictions placed on them by the problems associated with confidentiality and the refusal by many mental health staff to acknowledge the validity and indeed, the importance of input into that person's care, appropriate intervention and ongoing treatment plan.³⁵⁶

6.26 Ms Cathy Heyes emphasised the need to include families in assessment procedures:

Clinicians must avail themselves of all available sources of information if they are to do comprehensive information gathering. Thus the family needs to be involved in the suicide assessment procedure...Unfortunately my experiences show that family are not taken seriously or included in the assessment yet they know the person better than any psychiatrist can through a one hour interview.³⁵⁷

6.27 Submissions such as that from Ms Heyes emphasised that not only do carers require information from mental health services to provide ongoing care, but they also need the opportunity to provide information when acute care may be required. At present, carers do not appear to have opportunities to either provide input or receive basic medical advice regarding the person they care for. In the case of people suffering from episodic illnesses, carers and families expressed the view that their ability to detect 'warning signs' or rapid deterioration needed be taken into consideration by health professionals, if early intervention is to work. Carers NSW stated:

³⁵⁴ Submission 162, NSW Consumer Advisory Group, pp 30-31

³⁵⁵ Submission 196, Carers NSW, p 6

³⁵⁶ Submission 49, Parents and Carers Mental Health Group, North Casino, p 2

³⁵⁷ Submission 150, Ms Cathy Heyes, p 10

The mental health system would do well to listen to carers' knowledge of the person they support. This will minimise the chances of a person becoming less manageable because they have not been adequately assisted with either medication or support.³⁵⁸

- 6.28** This observation is consistent with the findings of the *International Mid-Term Review of the Second National Mental Health Plan for Australia*. Despite the desired outcome in the Strategy of "increased consumer and carer satisfaction with clinicians' response to early warning signs"³⁵⁹, the reviewers found:

It was commonly reported by consumers and carers that crisis services were not responsive to those who were beginning a period of relapse.³⁶⁰

- 6.29** The NSW CAG argued for the right of carers and advocates to provide relevant information to mental health professionals. The submission states:

While we note that the Mental Health Act precludes the giving of information to carers by mental health professionals without consumer consent, the Act does not preclude the right of carers to give information. The rationale for adding this right for carers and advocates flows from the Mental Health Statement of Rights and Responsibilities (Australian Health Ministers 1991, p 18, para 1-3). This states very clearly that carers/advocates have rights to initiate contact and give relevant information to service providers. This request should not contravene issues of confidentiality but is often denied carers on that ground.³⁶¹

- 6.30** Like carers and families, NGOs outlined that, as providers of services for people with a mental illness, they require information about clients in order to provide appropriate care. In its submission, UnitingCare reported:

UnitingCare services also have problems getting information from mental health services – information which would be important in identifying how the welfare service can assist the client. In one case, a woman who has psychotic episodes was referred to UnitingCare Burnside from the Department of Community Services. Burnside was concerned about being able to support the woman properly, but mental health services would give it no information about the woman's condition.³⁶²

- 6.31** UnitingCare's submission also made the point that "while the mental system is supposed to be multidisciplinary", the model is still "very medically based". UnitingCare staff felt that their insights went unheard by psychiatrists.³⁶³

³⁵⁸ Submission 196, Carers NSW, p 8

³⁵⁹ Australian Health Ministers, *Second National Mental Health Plan*, Mental Health Branch, Commonwealth Department of Health and Family Services, 1998, p 14

³⁶⁰ V Betts and G Thornicroft, *International Mid-Term Review of the Second National Mental Health Plan for Australia*, 2001, p 11

³⁶¹ Submission 162, NSW Consumer Advisory Group, p 31

³⁶² Submission 78, UnitingCare, p 29

³⁶³ Sr M Harris, Evidence, 23 May 2002, p 28

Limited disclosures of confidential information

6.32 The Hon Frank Walker QC and Mr Robert Ramjan from the Schizophrenia Fellowship suggested an information disclosure model to involve families and carers while still observing privacy and confidentiality principles. The model would provide for an ‘interim order’ for substitute decision-making. Mr Walker explained how an interim order would be administered:

You would think that it would be easy to get an interim order situation the same as you can get a warrant from a judge; if there were someone in the health care system you could contact and say: “I think we really ought to tell the parents in this case”, and you have an interim order. If the person wants to challenge it there is a judicial challenge to it later but at least at that time the parents are advised and may be able to save the life of their child.³⁶⁴

6.33 In July 2002, Victoria amended Section 120A of its *Mental Health Act 1986* to allow limited disclosure of confidential information about clients of mental health services, without the consent of the client. The following circumstances are exceptions to confidentiality requirements that will allow information to be disclosed:

- to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client and the person who is receiving the information will be involved in providing the care
- where it is required in connection with the further treatment of a client.³⁶⁵

6.34 Section 120A of the Victorian *Mental Health Act 1986* also allows disclosure:

- for management purposes (HPP 2.2 [f])
- to prevent risk to a person or the public (2.2 [h]), or
- when a person is missing or dead.³⁶⁶

6.35 In NSW, Health Privacy Principle 11 (g) of the *Health Records Information Privacy Act 2002* allows for disclosure of information without consent to immediate family members for ‘compassionate reasons’ when a person is incapable of giving consent. This is restricted on the basis:

the disclosure is not contrary to any wish expressed by the individual (and not withdrawn) of which the organisation was aware or could make itself aware by taking reasonable steps.

6.36 In view of the current inconsistent application of privacy and confidentiality principles in the NSW mental health system in relation to patients, guardians, families, carers, and other service providers, the provision for disclosure for ‘compassionate reasons’ is ambiguous

³⁶⁴ F Walker, Evidence, 8 August 2002, p 30

³⁶⁵ Department of Human Services, Victoria, *Confidentiality: Amendments to Section 120A of the Mental Health Act 1986*, p 1

³⁶⁶ *ibid*, p 2

and open to interpretation. Specifically, it does not provide for disclosure to assist in the ongoing treatment and care of the client, as in Section 120A of the Victorian *Mental Health Act 1986*.

Recommendation 33

That the Minister for Health seek to amend the NSW *Mental Health Act 1990* to allow limited disclosure of confidential information about clients of mental health services without the consent of the client. These exceptions to confidentiality would allow information to be disclosed in the following circumstances:

- to guardians, family and primary carers if the information is reasonably required for the ongoing care of a client and the person who is receiving the information will be involved in providing the care and
- where it is required in connection with the further treatment of a client.

Recommendation 34

That, prior to the operation of the *Health Records Information Privacy Act 2002* in 2003, NSW Health and the NSW Privacy Commission ensure that public and non-public health care service providers, be provided with adequate information and training about consent and substitute decision-making laws in NSW.

Recommendation 35

That the Minister for Health allocate funds for the training of public health employees on the requirements of the *Health Records Information Privacy Act 2002*.

Police access to information in crisis situations

- 6.37** NSW Health and the NSW Police Service are co-parties to a Memorandum of Understanding (MOU) for the management of situations involving persons who may have mental illness.³⁶⁷ Despite this agreement, both the Police Association of NSW and NSW Police submissions argued that police information requirements were not being satisfied.
- 6.38** NSW Police submission noted the importance of mental health workers attending crisis situations. This was seen as crucial not only for early intervention in the situation, but also because specialists could provide background information on the person that might be crucial in assessing the current situation and determining an appropriate response.³⁶⁸
- 6.39** NSW Police is concerned that: “Police access to crisis teams is not available on a 24 hour basis statewide” and that the 24-hour general advice line did not provide operational support in attending scenes.³⁶⁹ The NSW Police submission recommended that mental

³⁶⁷ For a detailed understanding of the Memorandum of Understanding, refer to Chapter 14 of this report.

³⁶⁸ Submission 286, NSW Police Service, p 8

³⁶⁹ *ibid*, p 7

health teams be adequately funded to provide an operational 24-hour crisis team response to police and the community in all areas of the state.³⁷⁰

- 6.40** The Police Association recommended that police be allowed to access information about individuals in crisis situations:

This could take the form of a national health database for identification purposes in relation to the storing and updating of an individual's name and medical history. Access by hospitals to this information would in turn enable police to be better informed and more aware of how to best approach and interact with these individuals when they come in contact with them.³⁷¹

- 6.41** Mr Ian Ball, President of the Police Association, told the Committee that he recognised such a register would involve “quite considerable legislative change”,³⁷² but that:

We are not asking that we know the ins and outs of their illness. What we are asking is just tell us that these people have some problems so our members can be a little aware.³⁷³

- 6.42** The Committee asked the NSW Privacy Commissioner, Mr Chris Puplick, about the implications of enabling police access to information stored on a national mental health database. Mr Puplick responded:

I do not object to people, whether it is the police or others, having access to information which is held by a department like the Health Department if it can be demonstrated that it is to the positive benefit of the individual about whom the information is being sought or if it is to prevent imminent threat to life or health, or danger or security of other persons, and provided—and I think this is the important thing—that there is a proper audit trail and a proper degree of accountability.³⁷⁴

- 6.43** Instead of allowing police greater access to confidential information, the Privacy Commissioner emphasised the importance of establishing universal precautions, meaning that police would act the same in all crisis situations whether or not they knew a mental health issue existed.³⁷⁵

- 6.44** The Privacy Commissioner also highlighted the need for police training, keeping them informed about mental health, and ensuring mental health professionals were available to officers to provide advice in crisis situations:

My difficulty with all of this is exactly the same as the arguments we get about knowing people's HIV status, that is, if I knew X I would have dealt with it differently. The question is: Why would you have dealt with it differently? I understand; I have a great deal of sympathy for the fact that we are constantly

³⁷⁰ Submission 286, NSW Police Service, p 25

³⁷¹ Submission 254, NSW Police Association, p 14

³⁷² I Ball, President, Police Association of NSW, Evidence, 14 June 2002, p 13

³⁷³ *ibid*, p 3

³⁷⁴ Mr Chris Puplick, NSW Privacy Commissioner, Evidence, 8 August 2002, pp 2-3

³⁷⁵ *ibid*

putting on the Police Service and on individual police officers a degree of responsibility and pressure for doing welfare work of one sort or another for which they are not being properly trained or adequately equipped. But that does not mean that in fact you should change the health system or the privacy issues, rather than address the question about recognising situations where it would be appropriate to seek advice from a mental health professional.³⁷⁶

6.45 The role of police in the mental health sector is examined in Chapter 14.

6.46 Prof Beverley Raphael, Director of the Centre for Mental Health, informed the Committee that under the revised MOU between NSW Police and NSW Health, clinicians would now be able to advise police on a strictly ‘need to know’ basis.³⁷⁷ NSW Health will need to ensure that procedures regarding disclosure of health information comply with HPP 10 (c) ‘Limits on use of health information’ of the *Health Records and Information Privacy Act 2002*. HPP 10 (c) states that an organisation that holds health information must not use the information for a purpose (a ‘secondary purpose’) other than that for which it was collected (the ‘primary purpose’), unless there is a “serious threat to health or welfare”. Such situations would be where:

the use of the information for the secondary purpose is reasonably believed by the organisation to be necessary to lessen or prevent:

- (i) a serious and imminent threat to the life, health or safety of the individual or another person, or
- (ii) a serious threat to public health or public safety.

Recommendation 36

That the Centre for Mental Health prepare guidelines on limited disclosures under the *Health Records and Information Privacy Act 2002* and ensure these guidelines are:

- incorporated into a privacy protocol within the Memorandum of Understanding between NSW Health and the NSW Police Service and
- communicated to all mental health workers and police across NSW.

Recommendation 37

That NSW Health ensure that the NSW Police Service has access to mental health services on a 24 hour basis for support and urgent advice.

³⁷⁶ C Puplick, Evidence, 8 August 2002, p 3

³⁷⁷ B Raphael, Evidence, 12 August 2002, p 29

Recommendation 38

That the Minister for Health seek a further amendment to the NSW *Mental Health Act 1990* to enable guardians, family and primary carers to obtain an interim court order for:

- the release of confidential information from a health care provider or
- an urgent assessment of an individual's mental health, where it can be established there is a reasonable belief that there is:
 - a serious and imminent threat to the life, health or safety of the individual or another person or
 - a serious threat to public health or public safety.

NSW data collection and compliance with health privacy principles

- 6.47** The Commonwealth *Privacy Act 1988*³⁷⁸ applies nationally to both Commonwealth public sector agencies and the private health care providers. The ten National Privacy Principles set out in the Act do not apply to de-identified or statistical data. The *Privacy Act 1988* does not bind State or Territory agencies or authorities, including the NSW State public sector.³⁷⁹
- 6.48** Until recently, all NSW public sector agencies were subject to the NSW *Privacy and Personal Information Protection Act 1998* (PPIP). The NSW *Health Records Information Privacy Act 2002* (HRIP), passed by NSW Parliament on 25 September 2002, introduces a comprehensive system for the regulation of privacy in health information in NSW, including both the private and public sectors. The PPIP will no longer apply to health information. According to Privacy NSW, the HRIP will require holders of health information to comply with 15 Health Privacy Principles (HPPs). These principles are consistent with the Commonwealth National Privacy Principles and establish obligations in relation to the collection, retention, storage, use and disclosure of health information.³⁸⁰
- 6.49** The Commonwealth *Privacy Act* allows for 'implied' consent for personal information to be used for other purposes, however, Health Privacy Principle 15 of the HRIP prevents the creation of linked electronic health records without the express consent of the individual to whom the information relates.³⁸¹
- 6.50** Section 3 of the Commonwealth *Privacy Act* states that the Act is not to affect the operation of a law of a State or Territory that makes provision with respect to the collection, holding, use, correction, disclosure or transfer of personal information. As a result, if a privacy

³⁷⁸ Amended by the *Privacy Amendment (Private Sector) Act 2000*.

³⁷⁹ A Flannigan, *Health Records and Information Privacy Bill (NSW) 2001 – Release of Exposure Draft*, Australian Health Law Bulletin, Vol 10, No 8, 2002, p 88

³⁸⁰ Submission 239, Privacy NSW, p 3

³⁸¹ *ibid*

standard is the same or higher than the Commonwealth Act, that standard can operate concurrently.³⁸²

- 6.51** By calling for express rather than implied consent, the HRIP has introduced a different standard to the Commonwealth *Privacy Act*. Recognising the difference in Commonwealth and State standards, Privacy NSW noted:

Federal government agencies and private sector agencies outside NSW that are not covered by similar state legislation will, however, be able to use the principle of 'implied consent' as defined in the Privacy Act 1988.³⁸³

Unique Patient Identifiers

- 6.52** As part of NSW Health's Mental Health Information Development Project, Unique Patient Identifiers (UPI) will be attached to records, with data available through area and state Health Information Exchanges³⁸⁴. Data will be stored at Area Health Information Exchanges but few individuals will have access to names and only when it is necessary to their work³⁸⁵. Data at state level will be de-identified, in accordance with privacy requirements. NSW Health advised the Committee that:

The only level at which names and complete clinical data are available at present is the local services level, usually the hospital or community clinic. The legally permissible level is, however, the Area Health Services, which can maintain a complete and identified record.³⁸⁶

- 6.53** NSW Health has liaised extensively with Privacy NSW to ensure privacy principles are upheld in the UPI System. During 2001-2002 the UPI technical support processes were tested, the strategy evaluated, and approved by Privacy NSW.³⁸⁷ In its submission, Privacy NSW explained the need for strict protocols to limit access to data:

A UPI raises privacy issues because it allows information to be linked, and potentially accessed by a range of third parties who have no right to that information. An administrative system relying on a UPI in the health field will need to limit the scope of its use, and have the backing of a strong legislative regime.³⁸⁸

- 6.54** The Committee asked the NSW Privacy Commissioner, Mr Chris Puplick, whether a patient could exclude information being recorded on the register and avoid the UPI system by presenting to services under different names. Mr Puplick stated:

³⁸² A Flannigan, *Health Records and Information Privacy Bill (NSW) 2001 – Release of Exposure Draft*, Australian Health Law Bulletin, Vol 10, No 8, 2002, p 92

³⁸³ Submission 239, Privacy NSW, p 4

³⁸⁴ Submission 267, NSW Health, H 2

³⁸⁵ Correspondence from NSW Health to Committee, 23 September 2002, p 2

³⁸⁶ *ibid*

³⁸⁷ *ibid*

³⁸⁸ Submission 239, Privacy NSW, p 3

people operate in this community, and in particular in the health system, under a variety of different names. In some areas—community health areas and sexual health areas—we have gone to great lengths to preserve the right of anonymity of accessing health services, and if we had not done that, the capacity to intervene in areas like community mental health, trauma services and sexual health services would have been grossly compromised.³⁸⁹

- 6.55** The Privacy Commissioner cited considerable evidence from HIV and Hepatitis C research indicating that, if practitioners cannot guarantee that data will be protected from unauthorised third-party access, clients will disclose less information about themselves, give false names or not access services at all:

It is a balance, not just of community good, but also a balance of education that we are prepared to put into persuading people that the safeguards in place are sufficient and that they ought not to be overly concerned about co-operating with the system and helping to make the system work. It is a trust question.³⁹⁰

- 6.56** Mr Doug Holmes, Executive Officer of the NSW Consumer Advisory Group (NSW CAG) referred positively to NSW CAG's recent involvement in the development of electronic health records for NSW:

We have had quite a lot of input into electronic health records and we believe that that will overcome some of the problems you are talking about, because in time as people start to trust the system and to realise that there are safeguards in there where they will not be abused, I think some of those things you are suggesting will be able to take place.³⁹¹

- 6.57** NSW Health has agreed with the Commonwealth to meet its data collection requirements from 2000-2001 with 'interim' systems that will then migrate to a new strategic system, which was released for field testing in August 2002 in the Hunter Area Health Service.

- 6.58** Under National Mental Health Reform and Incentive Funding, NSW received \$90 million to develop and deliver data sets between 1998 and 2003. NSW received an additional \$12.5 million under an Information Development Agreement with the Commonwealth to move forward with its information infrastructure.³⁹² It was the first state to sign such an agreement, and is ahead of other jurisdictions in training programs and development of infrastructure to support the introduction of routine outcome measures.³⁹³ This was confirmed by Prof Beverley Raphael when she appeared as a witness before the Committee on 12 August 2002.³⁹⁴

³⁸⁹ C Puplick Evidence, 8 August 2002, p 6

³⁹⁰ *ibid*; see also United States Surgeon General (1999), *Mental Health: A Report of the Surgeon General*, Chapter 7, Section 2

³⁹¹ Mr Doug Holmes, Executive Officer, NSW Consumer Advisory Group, Evidence, 23 May 2002, p 32

³⁹² Commonwealth of Australia, *National Mental Health Report* (2002), p 54

³⁹³ *ibid*

³⁹⁴ B Raphael, Evidence, 12 August 2002, pp 26-27, 28

- 6.59** All services in NSW are expected to be reporting outcomes data by June 2003.³⁹⁵ The Committee congratulates NSW Health on its success in implementing a set of large-scale, complex reforms that have the necessary privacy safeguards in place.

Mental Health Outcomes and Assessment Tools (MH-OAT)

- 6.60** Many submissions to the inquiry commented on the NSW Health Mental Health Outcomes and Assessment Tools initiative (MH-OAT), which commenced in July 2001.³⁹⁶ The initiative aims to standardise the way in which clinical mental health records are kept in all public health providers in NSW. In this regard it is a ‘clinical tool’ to enable better diagnosis and record keeping. MH-OAT also aims to collect outcome measures on mental health clients in public health services in NSW.³⁹⁷ MH-OAT is significant because it is the first system of its kind in NSW, and its development has meant that NSW is ahead of other jurisdictions in training and developing infrastructure to support the introduction of routine outcomes measures.³⁹⁸

- 6.61** NSW Health describes MH-OAT as “fundamentally an initiative to improve quality of assessment and build the evaluation of service effectiveness at the individual, service, and system level.”³⁹⁹ It aims to achieve this by:

- ensuring documentation is consistent with National Standards for Mental Health Services
- ensuring service units or area health services all use the same processes
- strengthening mental health assessment skills of workers
- ensuring reliability and validity of standard clinical ratings used as outcome and case mix measures.⁴⁰⁰

- 6.62** At the end of June 2002, 4,191 of a targeted 6,000 NSW public sector mental health staff had been trained in MH-OAT.⁴⁰¹ Currently, MH-OAT is designed for use in public health settings, with private and NGO service providers continuing to use their own existing systems.

³⁹⁵ Commonwealth of Australia, *National Mental Health Report* (2002), p 54

³⁹⁶ Submission 267, NSW Health, H.3

³⁹⁷ Correspondence from NSW Health to Committee, 23 September 2002, p 5

³⁹⁸ Commonwealth Department of Health and Ageing, *National Mental Health Report 2002*, p 54

³⁹⁹ Correspondence from NSW Health to Committee, 23 September 2002, p 4

⁴⁰⁰ *ibid*

⁴⁰¹ *ibid*, p 1

The impact of MH-OAT on service delivery

- 6.63** In evidence to the Committee, clinicians tended to support the principles and aims of MH-OAT but expressed frustration with the time-consuming nature of compiling MH-OAT records. Some submissions expressed doubts about MH-OAT's effectiveness as a clinical tool. The Australian Salaried Medical Officers' Federation (NSW) remarked in its submission that:

MH-OAT is widely considered a burden on clinical time and the data it produces cannot be relied on. Psychiatrists are happy to participate in practical quality assurance activities that do not place an unreasonable burden on clinical time.⁴⁰²

- 6.64** The NSW Nurses' Association was involved in the development of the MH-OAT and is supportive of the project. The submission, however, noted that MH-OAT is not without its problems:

In this climate of extreme nursing shortages our members are finding it exceedingly difficult to complete all the necessary data collection and information gathering associated with MH-OAT. The nurses feel that the time taken for data collection and entry is time away from providing direct services to the client/patient. The Centre for Mental Health estimates that the time taken to complete the paperwork is equivalent to the time taken to complete the interview. In actual fact it is taking up to three times as long to complete the paperwork as opposed to the interview.⁴⁰³

- 6.65** Mr John Lyons, a Clinical Nurse Consultant, and member of the NSW Nurses' Association, stated that filling out the standard MH-OAT assessment took up to 140 minutes to fill out 34 to 36 pages. This took up a substantial amount of time that he felt could be spent in clinical work instead:

There is no question about getting outcomes later. No-one is complaining about that. No-one is complaining about the fact that there is a formalised assessment tool across the State. What clinicians are complaining about is the amount of time it is taking, and in a rural area when you are spending 140 minutes filling out one assessment, you have to do either one of two things: reduce the number of clients you see or do the paperwork haphazardly.⁴⁰⁴

- 6.66** The Comprehensive Area Service Psychiatrists Special Interest Groups made a similar point about the reduction in face-to-face hours, and further argued that this 'devalued' clinical workers:

The focus on promotion and prevention has often been translated into funding for special projects or project officers rather than more clinical services. More worryingly, the demand for increasing data-collection has often translated into reports, guidelines, audits and assessment formats, making further demands on frontline staff providing them with less support for their clinical interventions.⁴⁰⁵

⁴⁰² Submission 91, Australian Salaried Medical Officers' Federation (NSW), p 2

⁴⁰³ Submission 212, NSW Nurses' Association, p 14

⁴⁰⁴ Mr John Lyons, Clinical Nurse Consultant, Evidence, 30 July 2002, pp 44-45

⁴⁰⁵ Submission 209, Comprehensive Area Service Psychiatrists Special Interest Groups, p 5

6.67 With the growing number of GPs involved in mental health service provision, Port Macquarie Division of General Practice noted that:

GPs will need to be made cognisant of the content of the MH-OAT in order for them to be able to understand the reports on their patients that will originate in the Mental Health Services.⁴⁰⁶

6.68 NGOs have not been involved in the MH-OAT initiative, a point made by a number of submissions to the inquiry.⁴⁰⁷ NSW Health has advised that a national project to develop a minimum data set for NGOs is underway, with Victoria acting as the lead agency. A report on the project is due by 30 June 2003.⁴⁰⁸

Recommendation 39

That the Minister for Health ensure, through a process of monitoring and review, that the Mental Health Outcomes Assessment Tools do not have an adverse impact on clinical service provision.

⁴⁰⁶ Submission 149, Port Macquarie Division of General Practice, p 6

⁴⁰⁷ Submission 78, UnitingCare NSW; Submission 162, NSW Consumer Advisory Group; Submission 218, Mental Health Co-ordinating Council, p 19

⁴⁰⁸ Correspondence from NSW Health to Committee, 23 September 2002, p 1

Chapter 7 Housing and homelessness

Housing alone is not enough. It must be appropriately supported housing.
[Mission Australia]⁴⁰⁹

Research and anecdotal evidence indicates a high correlation between homelessness and mental illness.⁴¹⁰ Deinstitutionalisation has been blamed for increasing numbers of homeless people with mental illness. Poverty, lack of family and social support, and a shortage of affordable housing are however, important factors contributing to the incidence of homelessness among people with a mental illness.

The role of housing in recovery

7.1 Stable, secure and safe housing is the most important component of rehabilitation and recovery for people with a mental illness. This is acknowledged in the NSW Government *Framework for Housing and Accommodation for People with Mental Health Problems and Disorders* (2002).⁴¹¹ The Northern Rivers Area Mental Health Council noted that:

on a scale of one (one being the most crucial) to ten, poverty and accommodation show up in Australian and American studies as the most important problems facing people with a chronic mental illness.⁴¹²

7.2 The Richmond Report proposed that most people with mental health problems and illnesses can be cared for in the community.⁴¹³ Submissions to the Committee endorsed the community care model while emphasising that people with chronic and episodic mental illnesses will require adequate support to live successfully in the community.⁴¹⁴ Depending on the client's needs, 'support' can range from 24-hour high-level supported accommodation to a visit from a mental health worker once a month.

7.3 Evidence to the Committee overwhelmingly stated that support services for people with a mental illness living in the community are underfunded and in critically short supply in NSW. The Council of Social Service of New South Wales (NCOSS) stated that there is still a "serious lack of commitment" to provide affordable, secure, and appropriate housing for people with a mental illness.⁴¹⁵ Submissions have argued that the agencies that fund and deliver housing to people with a mental illness, including the Commonwealth and State

⁴⁰⁹ Submission 188, Mission Australia, p 7

⁴¹⁰ Submission 245, Schizophrenia Fellowship of NSW, pp 5-6; Submission 85, Parramatta City Council, p 2; Society of St Vincent de Paul, *Down and Out in Sydney* (1998).

⁴¹¹ NSW Health, *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, NSW Government Action Plan for Health, August 2002, p 5

⁴¹² Submission 76, Northern Rivers Area Mental Health Council, p 1

⁴¹³ D. Richmond (1983), *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* ("The Richmond Report").

⁴¹⁴ Submission 255, Office of the Public Guardian NSW, p 3; Submission 218, Mental Health Co-ordinating Council, p 2; Submission 209, Comprehensive Area Service Psychiatrists, p 2; Submission 198, Shelter NSW, p 3; Submission 238, The Salvation Army, p 3; Submission 159, The Richmond Fellowship of NSW, p 1; Submission 78, UnitingCare, p iii; Submission 178, Society of St Vincent de Paul – Wollongong Diocesan Council, p 3

⁴¹⁵ Submission 192, NCOSS, p 17

governments, non-government and private sector, do not effectively work together to deliver a range of supported accommodation options.

Housing options in NSW

7.4 NSW Health outlined the following accommodation options for people with a mental illness:

- public housing – secure, long term and affordable rental housing assistance
- supported housing – NGOs and then allocated to clients in need of specialist services and
- boarding houses – generally operated by the private sector and licensed by the NSW Department of Ageing, Disability and Home Care (DADHC). The licence stipulates that a boarding house cannot have more than two people with high support needs unless there is 24-hour supervision.⁴¹⁶

7.5 Evidence presented to the Committee identified five additional tiers of housing options for people with a mental illness:

- crisis and short-term accommodation
- private rental market
- unlicensed lodging houses⁴¹⁷
- psychiatric facilities⁴¹⁸ and
- gaols.⁴¹⁹

7.6 In May 2000, the Centre for Mental Health completed a survey of housing and accommodation support services for people with mental health problems in NSW.⁴²⁰ Some key findings of the survey were:

- half of the properties were share accommodation with three or more residents, one third had two residents and the remainder were single residency properties
- two thirds of the programs were for people aged between 19 and 65, one fifth targeted 17 and 18 year olds, with the remainder catering for persons aged over 65 years

⁴¹⁶ Submission 267, NSW Health, G 24

⁴¹⁷ Ms Leonie Manns, Evidence, 23 May 2002, p 37

⁴¹⁸ Submission 255, The Office of the Public Guardian, p 4; M Giuffrida, Evidence, 8 August 2002, p 51

⁴¹⁹ Submission 162, NSW Consumer and Advisory Group, p 25

⁴²⁰ Submission 267, NSW Health, p G 24, citing Centre for Mental Health, *Housing and Accommodation Survey*, May 2000

- 87% of the programs had an identified entry and exit policy
- 80% provided a service based on the person's prior residency in the Area Health Service and in some cases specific sector catchment area and
- 92% of programs had exclusion criteria – history of violence, criminal record, comorbid mental illness and substance abuse.⁴²¹

Crisis and short-term accommodation

7.7 The Salvation Army provides crisis contact centres, crisis accommodation facilities, night shelters, women's refuges, community houses, youth refuges and targeted programs.⁴²² Its key concerns about people presenting at crisis facilities included:

- difficulty accessing acute adult inpatient mental health services via crisis assessment and treatment teams, particularly for people who are homeless or have a mental illness and a substance abuse disorder (MISA)
- inadequate discharge planning and lack of support immediately post-discharge from hospital and
- after-hours mental health crises for individuals are more likely when staff levels are lowest.⁴²³

7.8 The Salvation Army expressed concern that the ability of crisis centres and night shelters to meet the needs of people with mental illness is limited. Staff in these facilities are usually welfare officers and not trained to give care to mentally ill clients. Low staff to client ratios may at times require that a mentally ill person be turned away.⁴²⁴ People who are 'truly homeless' are not served well by crisis care because they require 'long term, high support and accommodation'. The Salvation Army described these people as:

- not suitable for crisis admission to hospital as their illness is chronic
- not sufficiently insightful to attend properly to their own needs
- at potential risk of exploitation, emotional and mental abuse from other people in the community and
- a potential risk to staff and other persons in homeless persons' facilities.⁴²⁵

7.9 Without long-term accommodation, the Salvation Army stated that these people are cycled between the police, the courts, mental health workers and hostel and refuge workers. The

⁴²¹ Submission 267, NSW Health, G 24

⁴²² Submission 238, The Salvation Army, Australia Eastern Territory, p 2

⁴²³ *ibid*, p 5

⁴²⁴ *ibid*, p 5

⁴²⁵ *ibid*, p 3

submission urged that this group in particular receive supportive and therapeutic hostel and group home accommodation, as was recommended in the Richmond Report.⁴²⁶

- 7.10** Ms Elsworthy noted her own experiences in the community sector following the release of the Richmond Report:

Before this job I worked as the Co-ordinator at Randwick Information and Community Centre for five years, which was the community centre for the lower end of the eastern suburbs... A number of people came to see me in my position there, people living on housing estates who were pulling their hair out because of disputes, complaints, threats and violence. It all happened post Richmond. It was all a consequence of the Richmond Report... I went there in the late 1980s and I was there for five years. It was all because people were being shunted out.⁴²⁷

- 7.11** B. Miles also highlighted the lack of crisis accommodation for people with mental health issues, including accommodation for consumers who do not manage their medication. The submission further commented:

Entering crisis accommodation does not ensure consumers will be able to move into stable housing. This results in many women moving from one crisis accommodation services to another, further draining resources and exacerbating the individual's mental health problems.⁴²⁸

- 7.12** The Coalition for Appropriate Supported Accommodation (CASA) indicated that people with coexisting mental illnesses and substance abuse disorders were particularly disadvantaged in crisis accommodation services:

The type and intensity of support that is required by this group is almost totally unavailable. Between 20% and 30% of those residing in the inner city crisis hostels for men have [MISA].⁴²⁹

The Supported Accommodation Assistance Program (SAAP)

- 7.13** The Supported Accommodation Assistance Program (SAAP) is a joint Commonwealth-State-Territory support program, coordinated by the NSW Department of Housing, which aims to provide secure accommodation and support for people who are homeless or at risk of homelessness.⁴³⁰ NSW Health describes the goals of SAAP as being to:

Resolve crisis, re-establish family links where appropriate, and re-establish the capacity of clients to live independently of SAAP.⁴³¹

⁴²⁶ ibid, p 3

⁴²⁷ L Elsworthy, Evidence, 29 May 2002, p 12

⁴²⁸ Submission 98, B. Miles Women's Housing Scheme, p 9

⁴²⁹ Submission 172, CASA, p 5

⁴³⁰ Submission 192, NCOSS, p 18

⁴³¹ NSW Health, *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, NSW Government Action Plan for Health, August 2002, p 7

- 7.14** SAAP services are delivered by non-government organisations across NSW. The main models in 2000-2001 were crisis and short term supported accommodation and medium to long-term supported accommodation.⁴³²
- 7.15** Submissions received by the Committee indicated that crisis services funded under SAAP are finding it difficult to meet the needs of clients with mental illnesses. CASA commented that:
- SAAP services are generally unable to offer the type of intensive support required by those with a mental illness. As a result some people become trapped in SAAP crisis accommodation meant only for short-term stays. Too often people are discharged from inpatient wards to the street or crisis homeless services.⁴³³
- 7.16** NCOSS was concerned that SAAP services in NSW have not received any growth funding for the past eight years. It was also concerned about:
- the high proportion of people with a mental illness who are clients of SAAP services...this is indicative of a breakdown of the system of support services for people with a mental illness.⁴³⁴
- 7.17** UnitingCare described the situation facing the Hope Hostel, a SAAP-funded generic facility for homeless men operated by Parramatta Mission:
- At any one time 20% of its 36 residents could have mental health issues. The hostel employs one worker on duty and worker on sleepover, each night. The Mission describes the situation as 'an occupational health and safety time bomb'. Generic homeless men's facilities are the wrong place for people with psychiatric disabilities who are chronically homeless and the Mission believes that there needs to be a number (say three) of special facilities with no more than six beds each for those people.⁴³⁵

Supported accommodation

- 7.18** NSW Health describes mental health rehabilitation services as consisting of a clinical rehabilitation component as well as an accommodation and disability support component. The latter interventions are aimed at the maintenance of role functioning, skills and independence.⁴³⁶
- 7.19** In NSW, clinical rehabilitation is the responsibility of the public mental health sector, with supported accommodation and rehabilitation services largely delivered by the NGO sector.⁴³⁷ NSW Health describes the purposes of accommodation support services as:

⁴³² Commonwealth of Australia (2002), *SAAP Annual National Performance Report 2000-2001*, p 7

⁴³³ Submission 172, CASA, p 5

⁴³⁴ Submission 192, NCOSS, p 18

⁴³⁵ Submission 78, UnitingCare, p 25

⁴³⁶ Submission 267, NSW Health, G 40

⁴³⁷ *ibid*; Submission 218, Mental Health Co-ordinating Council, p 16

maximising the independence of the consumers receiving services. Interventions based on individualised assessment may target activities of daily living including domestic chores such as shopping, cooking and cleaning; personal care tasks, such as showering and taking medication as prescribed; health care, including identification of general health and mental health treatment, and rehabilitation needs, and seeking assistance when required. Interventions may also focus on income support issues such as the identification of a source of income, maintenance of budget, and rent payment.⁴³⁸

7.20 More than half of disability support services are provided by NGOs (53%), followed by AHS (11%), volunteers (12%) and other organisations (18%).⁴³⁹

7.21 The Mental Health Co-ordinating Council (MHCC) commented that there are overlaps between the public mental health sector and the NGO mental health sector in the areas of supported residential and psychosocial rehabilitation programs.⁴⁴⁰ The submission notes:

Historically, most of the rehabilitation services and some of the supported residential programs were managed by public health services. In the past decade supported residential services have been established mainly by the non-government sector.⁴⁴¹

7.22 This observation by the MHCC is supported in evidence provided by the Commonwealth Department of Health and Ageing. Since 1993, under the National Mental Health Strategy, the Australian non-government sector has increased its overall share of mental health funding from 2% to 5%. This shift has been accompanied by a 65% national increase in the number of beds in 24-hour staffed community residential units, “designed to replace the former role of psychiatric institutions”.⁴⁴² This trend has not occurred in NSW. According to the *National Mental Health Report* 2002, the number of psychiatric beds in NSW declined from 2,652 in 1992-1993 to 2,032 in 1999-2000. The number of 24-hour staffed community beds declined slightly from 283 in 1992-1993 to 276 in 1999-2000.⁴⁴³

7.23 The MHCC outlined three main models of supported residential services in the mental health NGO Sector:

- Outreach or continuous ‘on site’ support in high, medium or low support houses. As residents’ support needs change they move to a house with a different level of support or to independent housing. The more disabled clients often become long-term residents of the service. In this situation, the NGO leases or owns the property but may contract the landlord responsibilities for the property to a Housing Association (a housing NGO).
- partnership between health, housing and NGO services houses are owned by the NSW Department of Housing, and the Area Health Service contracts out the

⁴³⁸ ibid, p G.40

⁴³⁹ ibid, p G 25

⁴⁴⁰ Submission 218, Mental Health Co-ordinating Council, p 15

⁴⁴¹ ibid, p 15

⁴⁴² Submission 226, Commonwealth Department of Health and Ageing, p 22

⁴⁴³ Commonwealth of Australia (2002), *National Mental Health Report*, p 50

support services to a local NGO. In some services the NGO also provides the landlord function and in others a Housing Association is the landlord. The housing, health and NGO services involved in the partnership are coordinated by a committee that meets regularly to accept and discharge clients to and from the service. Houses in this model are also categorised as high, medium or low support houses.

- clients may live in public housing, a rental property or a privately owned property and NGO staff provide outreach support to assist clients in maintaining their accommodation and successfully live in the community.⁴⁴⁴

7.24 NSW Health explained how accommodation support services and mental health services work together:

Strong links are developed locally between accommodation support services and mental health services. Accommodation service staff and mental health staff work collaboratively with each individual to plan care, rehabilitation and support and identify the role of the individual, the accommodation support staff and the mental health staff.⁴⁴⁵

7.25 NSW Health also stated that care coordinators are responsible for the coordination of clinical care, rehabilitation and disability support services for people in supported accommodation.⁴⁴⁶

7.26 In contrast to the coordinated care described by NSW Health, the MHCC commented:

the public mental health services, in theory, provide the residents with case management or clinical care services. In practice, however, mental health NGOs report that case managers or similar staff rarely see clients living in supported residential services and that NGO key workers provide the case management service.⁴⁴⁷

7.27 The MHCC's observations about the inadequacy of clinical care services were supported by comments in the B. Miles submission:

The support workers at B. Miles are often expected to carry out the duties of the case manager as [community health] do not have the time to do so...Bondi Junction Community Health psychiatrists only provide episodic case management and will refer clients to private psychiatrists. This is not always a viable solution as women who access have limited financial reserves and are always in receipt of some form of benefit.⁴⁴⁸

⁴⁴⁴ Submission 218, Mental Health Co-ordinating Council, pp 16-17

⁴⁴⁵ Submission 267, NSW Health, p G 40

⁴⁴⁶ *ibid*

⁴⁴⁷ Submission 218, Mental Health Co-ordinating Council, p 17

⁴⁴⁸ Submission 98, B. Miles Women's Housing Scheme, pp 7-8

7.28 NCOSS also commented in its submission:

NCOSS has received regular reports that supported accommodation providers are consistently unable to obtain necessary support services from mental health teams, including crisis response services, to assess and manage clients with mental disorders.⁴⁴⁹

7.29 Charmian Clift Cottages, which provides a residential program for women with mental illness and their dependent children, explained how it was responding to a lack of case management services:

Charmian Clift Cottages has established its own community integration worker, in an attempt to support families and ease their transition back into independent living on completion of the program. This was as a direct result of a reduction in case management support for families.⁴⁵⁰

7.30 The reduction in case management support has increased pressure on existing mental health teams. UnitingCare commented on the heavy workload facing community mental health teams:

Several staff who work as part of community teams commented to our chaplains that their workload for the supported accommodation teams is so heavy (100 to 150 clients) that they can do nothing more than attend to the medical and/or pharmaceutical aspects of mental health. The focus seems to be on quantity rather than quality. Staff are burning out and dissatisfied.⁴⁵¹

7.31 The Hornsby Ku-ring-gai Association Action for Mental Health and the Schizophrenia Fellowship collaborated to establish the Hornsby New Housing Group. This initiative has established a family-style, independent living housing model that is integrated with the community. It highlights the importance of local level partnerships and high quality care. As the Committee has noted repeatedly of such projects, it is an isolated example that needs to be replicated in communities across NSW.⁴⁵²**Waiting lists for supported accommodation****7.32** As well as limited case management support, the Committee was concerned that there is grossly insufficient accommodation to meet current needs. The B. Miles Housing Scheme provides secure, affordable medium term (up to 18 months) housing for women (without dependent children) who are affected by mental illness. It also runs an after care program once tenants have left the service. The organisation advised that the success of the program is demonstrated by the very low readmission rate to the B. Miles scheme, averaging about one client per year.⁴⁵³

⁴⁴⁹ Submission 192, NCOSS, p 19

⁴⁵⁰ Submission 30, Charmian Clift Cottages, p 2

⁴⁵¹ Submission 78, UnitingCare, p 16

⁴⁵² Correspondence from Jane Woodall, Joint Coordinator, Hornsby New Housing Group, p 1

⁴⁵³ L. Elsworthy, Evidence, 29 May 2002, p 3

- 7.33** B. Miles houses up to 26 women at one time.⁴⁵⁴ With 70 women currently on the waiting list, the submission described the situation as ‘untenable’ and attributed it to the growing numbers of people with mental health problems living on the streets, coupled with a lack of secure long term housing to which it can refer its clients.⁴⁵⁵ Ms Leanne Elsworthy, Coordinator of B. Miles, informed the Committee that those on the waiting list would be currently located in a range of settings:

Some [are] in refuges, some are literally homeless and floating out there, some [are] in boarding houses, and some are living with their family but in highly stressful situations with the family at breaking point. Some are living in domestic violence situations...[others]...go into departmental accommodation, but it is not working for them, because there is no support there.⁴⁵⁶

- 7.34** Ms Elsworthy explained that, as the waiting periods with the NSW Department of Housing have increased, the average time of stay at B. Miles has also increased from 18 months to two years.⁴⁵⁷ This is because they are reluctant to take the ‘retrograde step’ of placing tenants back on the homelessness circuit,⁴⁵⁸ or ‘dumping’ them into inappropriate services.⁴⁵⁹

- 7.35** The Richmond Fellowship provides supported accommodation to people with mental illness.⁴⁶⁰ It supports 181 residents in 68 properties across NSW, providing varying levels of support, from 24 hour to drop in support on a needs basis. It is funded by NSW Health and DADHC, but funding has not kept up with increases in running costs over the past ten years, meaning that it can only provide ‘decreasing hours of service to the same number of people’. The accompanying increased need for community based supported accommodation has led to a waiting list in the organisation’s Central Sydney area of over 40 people, with some on the waiting list for more than five years.⁴⁶¹ The Richmond Fellowship confirmed that waiting lists were a feature of supported accommodation services:

The situation is mirrored in all other supported accommodation services across the state, resulting in people remaining in hospital simply because there is nowhere else to go or living in unsuitable accommodation where the support needs are not met and rehospitalisation, incarceration or homelessness are the end results.⁴⁶²

- 7.36** The Guardianship Tribunal also noted in its submission:

There is a lack of adequate discharge planning for people leaving psychiatric facilities. This is compounded by the lack of suitable supported accommodation

⁴⁵⁴ Submission 98, B. Miles Women’s Housing Scheme, p 4

⁴⁵⁵ *ibid*, pp 5-6, 8

⁴⁵⁶ L. Elsworthy, Evidence, 29 May 2002, p 8

⁴⁵⁷ Submission 98, B. Miles Women’s Housing Scheme, p 6

⁴⁵⁸ L. Elsworthy, Evidence, 29 May 2002, p 2

⁴⁵⁹ Submission 98, B. Miles Women’s Housing Scheme, p 6

⁴⁶⁰ The Richmond Fellowship is not connected to the 1983 *Richmond Report*. It is part of an international organisation that began in the suburb of Richmond in the UK

⁴⁶¹ Submission 159, The Richmond Fellowship of NSW, pp 2-3

⁴⁶² *ibid*, p 2

options available in the community...Waiting lists are long and there is often insufficient funding to enable the necessary level of support to be provided. As a result, people with mental illness are often forced to live in inappropriate boarding house or rooming accommodation.⁴⁶³

7.37 The Richmond Fellowship stated that the greatest unmet need in accommodation for people with mental illness is in the following three areas:

- high support (12 to 24 hour a day support)
- short to medium term (2 to 12 months) and
- supported accommodation for people with mental illness and substance addiction.⁴⁶⁴

7.38 The Richmond Fellowship highlighted an imbalance of funding structures from different government departments in NSW. The Committee was concerned that service users with similar needs are funded very differently depending on the funding source. For example, the Richmond Fellowship is unable to provide 24 hour supported accommodation to anyone who has not been identified for a 24 hour funding package from DADHC.⁴⁶⁵ Mr Fred Kong, Chief Executive Officer of the Richmond Fellowship, further explained to the Committee:

Health funding up to 1998 was \$8,000 to \$10,000 average per bed. DADHC allocates an average of about \$50,000 per bed. There is a huge difference. Therefore the level of support is quite different.⁴⁶⁶

7.39 The Society of St Vincent de Paul (Wollongong Diocesan Council) urged for the creation of more supported accommodation places to meet growing demand:

Our contact with public and community housing organisations suggests to us that the problem is not necessarily a lack of suitable accommodation but a dire shortage of funding for support programs. In most situations, existing public and community housing can be adapted for supported accommodation programs but housing organisations cannot find partners with sufficient funding to meet even a small proportion of the need for support programs.⁴⁶⁷

7.40 NSW Health advised the Committee that there will be 1,635 supported accommodation beds for people with mental disorders across NSW by early 2003. Of these, 100 new places will provide high-level support. The beds will be provided by non-government organisations in partnership with AHS and housing providers.⁴⁶⁸ Although NSW Health has committed to increasing supported accommodation beds, it is apparent from even the small volume of evidence cited here that this is still insufficient to meet to current needs.

⁴⁶³ Submission 106, The Guardianship Tribunal of NSW, pp 3-4

⁴⁶⁴ Submission 159, The Richmond Fellowship of NSW, p 3

⁴⁶⁵ *ibid*, p 4

⁴⁶⁶ Mr Fred Kong, Chief Executive Officer, Richmond Fellowship, Evidence, 29 May 2002, p 30

⁴⁶⁷ Submission 178, Society of St Vincent de Paul (Wollongong Diocesan Council), p 5

⁴⁶⁸ Correspondence from NSW Health to Committee, 19 September 2002, p 1

Bed numbers must accordingly increase to not only satisfy present requirements but also to accommodate future demands.

Recommendation 40

That the Minister for Health increase the number of supported accommodation places for people with mental disorders in NSW from 1,635 to 2,635 over the next two years, and that an average of 12 adult beds per 100,000 are available for 24-hour per day high level supported residential services.

Recommendation 41

That NSW Health match the level of funding provided by the NSW Department of Ageing, Disability and Home Care for 24 hour supported accommodation packages for people with psychiatric disabilities.

Psychiatric facilities and nursing homes

- 7.41** The post-Richmond Report policy to deinstitutionalise long-term care arrangements has not resulted in closure of all psychiatric facilities. Submissions recognised that there are still people in NSW who are institutionalised in large psychiatric facilities. Dr Michael Giuffrida, Director of Forensic Psychiatry, Westmead-Cumberland Hospital, explained to the Committee that patients waiting for a rehabilitation bed can wait in acute units for months on end. Dr Giuffrida stated that an acute unit may have up to four or five such people.⁴⁶⁹
- 7.42** UnitingCare observed in its submission that the ‘least restrictive environment’ requirement of the *Mental Health Act 1990*⁴⁷⁰ has decreased the incidence of abuse and destructive custodial care. People considered however, ‘indigent, less articulate and marginalised’ have become residents in the old state psychiatric hospitals,⁴⁷¹ with some unable to be discharged because of a lack of supported facilities to which the hospital can discharge them. The Richmond Fellowship commented in its submission:

Unfortunately, people often remain in hospital unnecessarily due to the lack of appropriate accommodation options. This is despite the obvious advantages of discharging people from hospital when ready – from the perspective of both cost and the individual’s mental health... our own research (conducted in May 1998) shows that the cost of a hospital rehabilitation bed is approximately \$232.00 per person per day. The funding to the Richmond Fellowship from Central Sydney Area Health Services is \$22.00 per person per day, or less than one-tenth of the cost of a hospital bed. This is significant when a person no longer requires a hospital bed but remains there simply because there is no alternative.⁴⁷²

⁴⁶⁹ M Giuffrida, Evidence, 8 August 2002, p 51

⁴⁷⁰ Section 4 (2a) of the *Mental Health Act 1990* states that the Act is to be performed or exercised so that persons who are mentally ill or mentally disordered receive the ‘best possible care and treatment in the least restrictive environment’.

⁴⁷¹ Submission 78, UnitingCare, p 10

⁴⁷² Submission 159, The Richmond Fellowship of NSW, p 2

7.43 UnitingCare described stand-alone psychiatric hospitals as ‘relaxed environments’, although ‘depersonalising and restrictive’.⁴⁷³ The Public Guardian raised a number of concerns about large psychiatric hospitals:

- these institutions remain separate and largely isolated from the community
- there is limited transitional planning or funding for people who have resided in institutions over a number of years and who need to be able to return to the community
- a number of people with mental illness under the guardianship of the Public Guardian have stated that they feel significantly at risk when residing in these facilities and
- discharge planning is often inadequate with the person often moving to a poorly supported housing arrangement that in turn places the person at risk of readmission.⁴⁷⁴

7.44 The Schizophrenia Fellowship emphasised that while long stay beds may be necessary for those with acute and prolonged episodes:

the moot point is where that care should be provided and whether what is required is a hospital or community environment.⁴⁷⁵

Public Housing

7.45 For the 2000-2001 year, there were 96,075 households on the NSW Department of Housing waiting list.⁴⁷⁶ This may reflect the general lack of affordable housing in NSW. Mission Australia commented that the Sydney housing market is:

characterised by high rents, low vacancy rates and very high cost of home purchase. There is also an historical mismatch between housing supply and demand. The relatively high supply of 3-4 bedroom housing located in the outer suburb housing estates is not suitable for people with mental illness. Many of those placed on estates find themselves being ‘cycled’ back through short-term crisis housing and refuges because they are unable to cope without the appropriate support.⁴⁷⁷

7.46 Shelter NSW informed the Committee that the NSW Department of Housing did not have access to statistics about the number of its tenants who indicated they were receiving treatment for a mental illness.⁴⁷⁸ NCOSS expressed a similar view that:

⁴⁷³ Submission 78, UnitingCare, p 10

⁴⁷⁴ Submission 255, Office of the Public Guardian NSW, p 4

⁴⁷⁵ Submission 245, Schizophrenia Fellowship of NSW, p 4

⁴⁷⁶ Department of Housing, *Annual Report 2000-01*, p 15

⁴⁷⁷ Submission 188, Mission Australia, p 6

⁴⁷⁸ Submission 198, Shelter NSW, p 4

there is little information about the housing support needs of public housing tenants and how these needs are being met.⁴⁷⁹

- 7.47** The B. Miles submission highlighted the limitations of the NSW Department of Housing in providing accommodation for people with mental illness:

The Department of Housing is limited in the housing choices it can make available to tenants. Allocations are often made on the basis of what house is available rather than what house is needed. Inappropriate allocations cause neighbourhood disputes and can place consumers at risk. This situation is compounded by a lack of services to support behavioural issues as they arise.⁴⁸⁰

- 7.48** Shelter NSW elaborated on the problems in providing public housing support to people with complex needs:

The policy of tightly targeting public housing support to only the most needy has meant that additional strain has been placed on the housing estates due to disadvantaged people being concentrated in these estates without adequate support...Those living with mental illness may engage in anti-social behaviour or become forgetful from time to time and fall into rent arrears. Ideally, they should receive support during times of episodic illness or hospitalisation and assistance in meeting their obligations to the Department of Housing. But all too often these supports are not available or are dependent on the understanding of a particular client service officer or mental health professional.⁴⁸¹

- 7.49** NSW Health and the NSW Department of Housing signed a Joint Guarantee of Service for People with a Mental Illness (JGOS) in 1997.⁴⁸² The JGOS was developed in response to concerns about the lack of coordination between health and housing services. It defines the roles and responsibilities of both departments and outlines the processes and procedures for the departments to follow to enable them to work together cooperatively.⁴⁸³

- 7.50** Shelter NSW stated in its submission that the NSW Department of Housing was unable to provide statistics on the number of its clients covered by Joint Service Agreements.⁴⁸⁴ Shelter NSW also made the following remarks about JGOS:

These work well in some areas, depending on local circumstances, and often, the commitment or competency of key individuals. However, application of these policies is patchy across NSW. Shelter NSW's constituents who work in the field continually tell us that although policies exist on paper, the situation as it really is does not match up with the rhetoric of integrated support, because the level of support required is either not available in some areas, or in poor supply.⁴⁸⁵

⁴⁷⁹ Submission 192, NCOSS, p 17

⁴⁸⁰ Submission 98, B. Miles Women's Housing Scheme, p 12

⁴⁸¹ Submission 198, Shelter NSW, p 3

⁴⁸² Submission 267, NSW Health, p G.41 *Joint Guarantee of Service for People with a Mental Illness* available at: www.health.nsw.gov.au

⁴⁸³ Submission 267, NSW Health, G.41

⁴⁸⁴ *ibid*, p 4

⁴⁸⁵ Submission 198, Shelter NSW, p 4

7.51 NCOSS similarly noted in its submission:

NCOSS understands that some [Joint Service Agreements between the Department of Housing and other agencies] are working well, but they are highly variable in their use and effectiveness across the state. A major barrier to effective work across agencies is the shortage of support services.⁴⁸⁶

7.52 The Northern Rivers Area Mental Health Council noted the limited scope of the JGOS as:

only aimed at maintaining accommodation for those already in public accommodation. So instability of accommodation remains a major health and security risk for people living with a mental illness.⁴⁸⁷

7.53 To address the inconsistency in application of the JGOS, NCOSS suggested:

NSW Health and the Department of Housing should explore models for effective integration, including outreach services in public housing and housing support workers. This integration should also provide effective support to clients exiting SAAP services, given the increasing number of SAAP clients with high and complex needs.⁴⁸⁸

7.54 The St Agnes Support Service, Port Macquarie, which conducts a volunteer visiting service for people with mental illness, informed the Committee that some people with mental illness are placed in public housing despite an inability to cope without adequate support:

A great number of people with mental illness live in Department of Housing homes but they lack the ability to do this. They have problems organising their money, they go without healthy food, have problems looking after their medication, and some cases their personal hygiene and state of their homes leave much to be desired.⁴⁸⁹

7.55 This was graphically illustrated by Ms Joyce Said, Chair of the MHCC and Executive Director of AfterCare:

[The] person was living at Merrylands in a public housing place. When my staff went there at the behest of the Public Guardian they found all the doors boarded up. The man had got rid of all his furniture, and the refrigerator and electricity had been disconnected because he was afraid of the power coming into his place. He was living on the floor of the kitchen, with cockroaches everywhere. The whole place was absolutely filthy. This man had not received any meals and was half starving.

Our staff could not get entry. All they could do was talk to the person through the door. After a period of time they got an agreement to arrange for Meals on Wheels for this person. So that opened the door, and he started to eat. The mental health team had not been to see him. He had gone off the books of the mental health team. That person eventually was relinked to the mental health system and

⁴⁸⁶ Submission 192, NCOSS, pp 17-18

⁴⁸⁷ Submission 76, Northern Rivers Area Mental Health Council, p 1

⁴⁸⁸ Submission 192, NCOSS, p 18

⁴⁸⁹ Submission 71, St Agnes Support Service, p 1

started receiving assistance. But if another NGO or another type of organisation had maintained contact with that person, he would not have got into that state.⁴⁹⁰

- 7.56** Several submissions raised the problem of people with mental illness losing their NSW Department of Housing home while hospitalised for acute episodes. Illawarra Legal Centre Tenants' Service gave an example of this from their case files:

The tenant is a woman in her early thirties. She has lived in a two bedroom Department of Housing flat for three years. She is separated from her partner and has her children stay on weekends. She had a psychiatric episode that resulted in hospitalisation. The initial medical assessment suggested she could be in hospital for two to three months. The departmental workers wanted the woman to relinquish her government housing and be placed on a priority list for housing after being discharged. They would also provide bond and rent assistance so she could take up a private rental premises until priority housing was available.

The tenant's father unsuccessfully sought to act on his daughter's behalf and prevent her from giving up the flat. The tenant's father was hindered in his efforts by the Department of Housing, who believed they could act in the tenant's best interest. However, a hospital social worker facilitated the signing over to the flat to the Department believing it would be in the tenant's interest.⁴⁹¹

- 7.57** Unsupported accommodation in public housing impacts not only on the mental health of the tenant, but also affects other vulnerable tenants. Submissions from public housing tenants described the difficulties of living in close proximity to people with untreated or unstable mental health problems.

- 7.58** Mr David Jobling, a member of the Public Housing Customer Council, commented that the most common reported problem is that no support is provided to ensure tenants are 'okay'.⁴⁹² The submission described the consequences for all tenants in a housing estate when an individual experiences an acute episode without proper care and attention:

An individual with (say) bipolar disorder who is on a heavy amount of prescribed medication will fail to comply with his/her medication routine and start to behave in a disruptive or damaging way towards him/herself, property, other people. The most regular response will be that someone calls the police and the police delivers the individual to a mental health unit. After a stay in a mental health unit, the individual is released, or to put it plainly, deposited back on the estate.

The nuisance and annoyance they may have caused while on an 'off medication bender' impacts on the Department of Housing estate community and creates friction amongst many tenants.⁴⁹³

- 7.59** Another public housing tenant described the anxiety vulnerable older people experienced as a result of intimidation and harassment while living in close proximity to people with acute mental illnesses.⁴⁹⁴ The Committee was also advised that:

⁴⁹⁰ Ms Joyce Said, Chair, MHCC, Evidence, 28 May 2002, p 39

⁴⁹¹ Submission 175, Illawarra Legal Centre Tenants' Service, pp 3-4

⁴⁹² Submission 13, Mr David Jobling, p 2

⁴⁹³ *ibid*, p 2

⁴⁹⁴ Supplementary Submission 44, Mr James Qusted, p 1

Putting mentally ill people among aged pensioners is very unsettling for both...It is very hard for the mentally ill people when they are not getting the support they need.⁴⁹⁵

- 7.60** CASA similarly advocated for helping public housing tenants with mental illnesses ‘make their tenancy work’ through adequate support rather than evicting them:

People with a mental illness can experience episodes of psychotic behaviour if they do not receive the right treatment and ongoing support. This can make them difficult to live near, but CASA does not believe they should be evicted from public housing as a result. Far better to ensure adequate support is available to assist them in making their tenancy work than contributing to the growing number of homeless.⁴⁹⁶

- 7.61** CASA, together with several other submissions, emphasised the importance of support services in helping people maintain tenancies and integrate more into their local community.⁴⁹⁷ UnitingCare also commented:

UnitingCare supports the public policy objective of supporting people with mental health issues, including those with psychotic illnesses, to live in a ‘normal community environment’. We note that for people without psychotic illnesses, living in the community is not just about a house of their own (a building) – it is about relationships with other people: at work, at leisure, etc...Integration of people with psychotic illnesses in the ‘community’ involves a careful consideration of appropriate housing situation (for example, cluster housing rather than isolated, individual units) and broader social supports that counter stigmatisation and the reinforcement of inferiority.⁴⁹⁸

- 7.62** NCOSS raised concerns that the recently announced social housing package for public housing tenants, which includes rental bonds and renewable tenancies may have a disproportionate and unfair impact on people with mental illness and mental disorders. Without adequate support services for these tenants, NCOSS is concerned that:

people with mental illness and other highly marginalised communities are more likely to face homelessness as a result of this policy change.⁴⁹⁹

Recommendation 42

That NSW Health inquire into and report publicly on the shortfall in support and case management services for people with a mental illness who are accommodated in public housing, and allocate adequate resources to meet the identified shortfalls.

⁴⁹⁵ Submission 39, Mrs Edna Crossingham, pp 1-2

⁴⁹⁶ Submission 172, CASA, p 8

⁴⁹⁷ *ibid*, p 5

⁴⁹⁸ Submission 78, UnitingCare, pp 14-15

⁴⁹⁹ Submission 192, NCOSS, p 18

Recommendation 43

That the proposed Office of Mental Health oversee the implementation of effective, coordinated support services for people with a mental illness living in public housing. This will require monitoring service agreements at state and local level between the NSW Departments of Housing, Health, Community Services and Ageing, Disability and Home Care.

Recommendation 44

That NSW Health and the NSW Department of Housing establish a clustered housing (intensive, managed) project for people with a mental illness who have had difficulty maintaining public housing tenancies.

Boarding houses

- 7.63** It is estimated that over 40% of people in licensed boarding houses have a mental illness.⁵⁰⁰ From submissions received by the Committee, it appears that boarding houses are considered an undesirable accommodation option, but at times are the only facilities available for people with complex needs. The Public Guardian stated:

There is limited ability of appropriate and safe community based accommodation to meet an individual's immediate and long-term needs. Referral to boarding house accommodation for people with mental illness is often the only option.⁵⁰¹

- 7.64** UnitingCare commented on the quality of life of those living in boarding houses:

While the residents of [government-licensed] boarding houses are not living in mental hospitals, they still largely have an institutionalised life. They lack privacy, because they might share rooms with from 1 to 6 people. They might have to move rooms when/if a reshuffle occurs after any resident changes, either through exit or intake of new residents.⁵⁰²

- 7.65** A number of submissions stated that people living in boarding houses or other group arrangements did not receive adequate treatment and follow-up from community mental health teams. CASA argued in its submission that this was because community mental health teams are understaffed and under-resourced and can only attend the 'direst' emergencies.⁵⁰³

- 7.66** Several submissions highlighted the problems that emerge when the homeless and people in single-room accommodation "experience day to day lives which are bereft of meaningful activity".⁵⁰⁴ Without employment and training opportunities, and limited recreational

⁵⁰⁰ Submission 172, Coalition for Appropriate Supported Accommodation (CASA), p 7

⁵⁰¹ Submission 255, Office of the Public Guardian NSW, p 3

⁵⁰² Submission 78, UnitingCare, p 26

⁵⁰³ Submission 172, CASA, p 6

⁵⁰⁴ Submission 238, The Salvation Army Australia Eastern Territory, p 4

activities, people in boarding house style accommodation frequently have limited scope for recovery and rehabilitation. The Salvation Army commented that these people are, as a result, unable to contribute to the community, and more likely to be caught up in antisocial and illegal activities.⁵⁰⁵ CASA commented that existing rehabilitation programs tend to be 'treatment focussed within the medical model', when studies have shown that social activities are of significant benefit to people with a mental illness. It cited the Mary MacKillop Outreach Program in Lewisham, Sydney, as a successful program run on limited resources.⁵⁰⁶

7.67 Shelter NSW, CASA and NSW CAG also pointed to the lack of legislative protection for tenants of boarding houses. Boarding houses are not covered by the *NSW Residential Tenancies Act 1986*. As a result boarders and lodgers are not classified as 'tenants' and regardless of whether or not boarding houses are licensed, tenants have no access to the rights afforded to ordinary tenants.⁵⁰⁷ CASA stated that Victoria, South Australia and Queensland resolved this problem when they introduced boarders and rooming house legislation.⁵⁰⁸

7.68 Shelter NSW commented that boarding houses could provide sustainable accommodation if adequate support is provided:

For some people group homes or boarding house style accommodation, combined with support services, can result in sustainable tenancies. However, this should be a genuine choice people make freely make rather than a cheap 'solution' which fits all circumstances and creates 'ghettos'.⁵⁰⁹

7.69 Ms Leanne Elsworthy, Coordinator, B. Miles Women's Housing Scheme, described to the Committee the concept of 'clustered housing', in which people with a mental illness could live in supported arrangements but in their own apartment and with separate staff facilities. Such arrangements, though costly, would avoid the 'institutional feeling' of boarding houses and enable individuals to become as independent as possible.⁵¹⁰

7.70 The Salvation Army advised that there was a closure of unlicensed boarding houses and other group homes due partly to the lack of community mental health support. The submission argues that these closures have increased the likelihood of mentally ill people needing to seek accommodation in crisis centres.⁵¹¹ The submission further argued that:

sufficient funding should be allocated for the provision of adequate services to tenants and landlords so that those people whose mental illness does not require high levels of care, can be sustained in low cost accommodation options. We understand that the lack of adequately trained staff in these services can be

⁵⁰⁵ Submission 238, The Salvation Army Australia Eastern Territory, p 4

⁵⁰⁶ Submission 172, CASA, p 7

⁵⁰⁷ Submission 198, Shelter NSW, p 6; Submission 172, CASA, p 7; Submission 162, NSW Consumer Advisory Group, p 26

⁵⁰⁸ Submission 172, CASA, p 7

⁵⁰⁹ Submission 198, Shelter NSW, pp 4-5

⁵¹⁰ L. Elsworthy, Evidence, 29 May 2002, p 13

⁵¹¹ Submission 238, The Salvation Army Australia Eastern Territory, p 3

addressed by the allocation of sufficient funding. This should include adequate provision and training of staff.⁵¹²

- 7.71** The NSW Government has sought to improve the quality of boarding houses in NSW through its \$66 million Boarding House Reform Strategy.⁵¹³ The Public Guardian commented favourably regarding its effect on services to boarding houses:

The Government's Boarding House Reform Strategy has significantly opened the boarding house sector to mental health and other services. NSW Health and the NSW Department of Ageing, Disability and Home Care (DADHC) have worked in close partnership to increase the access that people in boarding houses have to appropriate mental health and other services. It will be important that this continues.⁵¹⁴

- 7.72** The Coalition for Appropriate Supported Accommodation for People with Disabilities (CASA) argued in its submission that there was still much to be done for those with mental illness residing in low cost, congregate living arrangements and other 'marginal housing'.⁵¹⁵

Recommendation 45

That NSW Health, the NSW Department of Community Services, the NSW Department of Ageing, Disability and Home Care and the NSW Department of Housing, cooperate to conduct an assertive outreach campaign that includes raising the awareness of boarding house residents and landlords about residents' rights to health care, mental health care, legal services and other services relevant to their needs.

Recommendation 46

That the NSW Government fund the continuation and expansion of the Boarding House Reform Strategy.

The private rental market

- 7.73** The private rental market includes conventional housing as well as bedsits, hotels and caravans. People with a mental illness can experience difficulties in the private rental market. They can be vulnerable to exploitation by landlords, and unaware of their rights under the *Residential Tenancies Act 1986*.
- 7.74** The Illawarra Legal Centre 'Tenants' Service described two situations in which people with a mental illness had difficulties with private rentals. In one situation, a private landlord repeatedly visited the property of a man with a mental illness. The man decided to move, but relinquished his bond rather than taking formal action against the landlord, because he

⁵¹² Submission 238, The Salvation Army Australia Eastern Territory, p 4

⁵¹³ Submission 172, Coalition for Appropriate Supported Accommodation (CASA), p 5

⁵¹⁴ Submission 255, The Office of the Public Guardian, p 5

⁵¹⁵ Submission 172, Coalition for Appropriate Supported Accommodation (CASA), p 5

wished to avoid psychological distress. In another situation, a family of five could not find premises to rent because the father was listed on a private industry database of 'unsuitable' tenants. The father had experienced bouts of depression and had been late in paying rent at times, leading to a poor relationship with a real estate agent.⁵¹⁶

7.75 The Illawarra Legal Centre 'Tenants' Service commented that people 'blacklisted' in this fashion are often forced to live in caravan and residential parks, boarding houses, hostels and cramped arrangements with families and friends, because they cannot secure rental housing.⁵¹⁷

7.76 The Society of St Vincent de Paul (Wollongong Diocesan Council) commented:

It is common experience for our members to find people with mental illness living in caravans, sub-standard rooms in hotels or boarding houses or living alone in bedsits without apparent support.⁵¹⁸

7.77 The Tweed River Valley Fellowship found during its local consultations that due to a lack of supported accommodation facilities, brokerage funds are used to house people in caravan parks and motels:

This is proving to be problematic for consumers and the community, it is difficult for follow-up by acute care teams and often people are need of intensive supported accommodation...It is extremely difficult to convince caravan park [or] motel owners to tenant a person directly after discharge from inpatient stays nor is it appropriate for consumers with high disability support needs.⁵¹⁹

Coordination of housing service provision

The present situation

7.78 The analysis of accommodation options for people with a mental illness revealed a system that is under resourced and understaffed. In the view of Mission Australia:

The current environment of service provision is considered to be uncoordinated, fragmented and confusing for both those it is intended to help and those providing support services.⁵²⁰

7.79 Ms Joyce Said, Chair of the MHCC, told the Committee in May 2002 that NGOs were still an 'afterthought' in the area level planning and delivery of mental health services:

There is no direction from the Centre of Mental Health to the [Area Health Services] telling them how to fit the NGO sector, in a partnership way, into the services that are being provided. It would have been useful...to see the NGOs as

⁵¹⁶ Submission 175, Illawarra Legal Centre Tenants' Service, pp 4-6

⁵¹⁷ *ibid*, p 6

⁵¹⁸ Submission 178, Society of St Vincent de Paul (Wollongong Diocesan Council), p 5

⁵¹⁹ Submission 100, Tweed River Valley Fellowship, Appendix p 2

⁵²⁰ Submission 188, Mission Australia, p 5

true partners in the service provision and have us made part of a system of management for the people so that there is a seamless system for them to use...I think the lack of NGO inclusion in the planning is the same across the state. It is starting to happen in a small way in some of the metropolitan areas. There is a little bit of it happening but in the main there are insufficient numbers of NGOs. Northern NSW is quite good at working with NGOs but it is very patchy.⁵²¹

7.80 Ms Leanne Elsworthy from B. Miles stated to the Committee:

There needs to be someone keeping track of people, an organisation that is keeping an eye on how somebody is going, not tied up to case managers. Ideally case managers should be doing that but they cannot because their workloads are too high. Ideally there needs to be agencies responsible for overseeing how the person is going and someone to bring in the services as they are needed. People are episodic and unpredictable.⁵²²

7.81 UnitingCare observed in its submission:

It is clear that many of the most effective interventions follow from a collaborative approach in which non-profit organisations not deemed by the Department of Health to be psychiatric disability support services, or funded by that Department, play a key role.⁵²³

7.82 UnitingCare proposed that there be a greater focus on post-acute care:

We would like to see the mental health system in New South Wales recognised as a 'system', in which the Department of Health has a *lead agency* role. That system has three legs:

- promotion, prevention and early intervention
- acute care of people with mental disorders and
- post-acute care of people with chronic disabilities in community residential settings.

The government's focus has been on acute care. Greater attention is now being given to promotion, prevention and early intervention. Post-acute care of people with chronic disabilities in community residential settings is a public policy vacuum.⁵²⁴

7.83 NSW Health has acknowledged its responsibility to ensure access to appropriate accommodation:

The fundamental need for people to be housed to maintain health highlights the responsibility for NSW Health to work in close partnership with public, non-

⁵²¹ J Said, Evidence, 28 May 2002, p 30

⁵²² L Elsworthy, Evidence, 29 May 2002, p 23

⁵²³ Submission 78, UnitingCare, p iv

⁵²⁴ *ibid*, p iii

government and private housing providers to ensure access to safe, secure and affordable housing for people with mental health problems and disorders.⁵²⁵

- 7.84** During the inquiry, the Committee was informed about several good practice examples for housing people with a mental illness in Australia. These included the South Australian Special Needs Housing Unit and the Victorian Rooming House Program.⁵²⁶ In each initiative, there was an emphasis on encouraging innovation at local area level in order to best meet the needs of client groups. Mission Australia stated in its submission:

striking the correct balance between the provision of health service support and other forms of social support, through innovative models of service delivery, remains the critical question for integration of people with a mental illness into the community.⁵²⁷

NSW Health – Government Action Plan

- 7.85** In recognising the need to address the shortcomings of accommodation and support, NSW Health published the *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report* (Framework) in August 2002, as part of the NSW Government Action Plan for Health Framework.⁵²⁸ The Director General of NSW Health stated the Framework:

provides a template to assist NSW Mental Health Services, social housing providers, mental health NGOs and the mainstream NGO sector with service planning, development and evaluation.⁵²⁹

- 7.86** In the Framework document, NSW Health advises that it has developed new strategies that are related to the accommodation, support and wellbeing of people with a mental illness. These include increased funding, a comprehensive plan to address issues in boarding houses, an interdepartmental committee on challenging behaviours, interdepartmental Partnership against Homelessness and an interdepartmental agreement between NSW Health and the NSW Department of Housing to address the public housing needs of people with mental illness.⁵³⁰

- 7.87** The Framework specifies that each AHS will develop a Housing and Accommodation support plan that:

identifies key partners, resources and strategies for the development of housing and accommodation support options for people with mental health problems and disorders. They key partners will be the Department of Housing, the Office of Community Housing, community housing associations, non-government

⁵²⁵ NSW Health (2002), *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, p 3

⁵²⁶ Submission 78, UnitingCare, p 26

⁵²⁷ Submission 188, Mission Australia, p 6

⁵²⁸ NSW Health (2002), *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, p 2

⁵²⁹ *ibid*

⁵³⁰ *ibid*, p 8

providers of both disability services and services for homeless people, the Department of Ageing, Disability and Homecare and other community organisations. Area Health Services will identify their role as the providers of clinical support.⁵³¹

- 7.88** The Framework also indicates that the JGOS will be developed further at local levels, incorporating other ‘key partners’, designed to facilitate the availability of a range of housing and accommodation support options to meet local population needs.⁵³² The Centre for Mental Health has engaged in consultation with a range of other government departments including the NSW Department of Housing, the Office of Community Housing and the Commonwealth Department of Family and Community Services. This is to promote the development of strategies to evaluate innovative housing and accommodation support models for service delivery.⁵³³
- 7.89** Under the Framework, NGOs will participate at “systems, service provision and individual levels,”⁵³⁴ but their role at the strategic planning and policy level is left unstated.
- 7.90** It is important that the *Framework for Housing Accommodation Support for People with Mental Health Problems and Disorders* is seen to deliver against its objectives. One way of achieving this is to ensure that NSW Health publicly reports on the outcomes and achievements of the Framework.

Recommendation 47

That NSW Health publish a report on the outcomes of the *Framework for Housing Accommodation Support for People with Mental Health Problems and Disorders* within 6 months and then annually. The reports should include information from Area Health Services on:

- consumer satisfaction indicators
 - waiting list numbers for supported accommodation places and public housing and
 - indicators of unmet need at all local area levels.
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⁵³¹ NSW Health (2002), *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, p 3

⁵³² *ibid*, p 20

⁵³³ *ibid*, p 8

⁵³⁴ *ibid*, p 20

Homelessness

- 7.91** In Australia, homelessness is growing and its causes are increasingly complex.⁵³⁵ Homelessness of people with a mental illness is a serious problem for most Western industrialised countries.⁵³⁶ Under the *Supported Accommodation Assistance Program Act 1994*, a person is defined as homeless “if he or she has inadequate access to safe and secure housing”.⁵³⁷ The 1996 census found that 29,608 people in NSW were homeless under this definition,⁵³⁸ and that number is anticipated to rise when the corresponding 2001 census data is available.
- 7.92** A number of studies have estimated the number of homeless people that also have a mental illness ranges between 10% and 50%.⁵³⁹ In the 1996 census, this meant that between 2,960 and 14,804 people in NSW who were homeless on census night had a mental illness. A much-cited study from 1998, *Down and Out in Sydney*, estimated that 75% of homeless people in inner Sydney had at least one mental disorder.⁵⁴⁰
- 7.93** Of some concern to the Committee is a report from Parramatta City Council that, in its area, the number of homeless people with mental illness is rising rapidly:
- the number of people with mental illness admitted to Cumberland Hospital with no fixed abode has doubled since 1995.⁵⁴¹
- 7.94** NSW Health noted that the homeless population now includes a significantly high proportion of young people with a range of complex problems, including mental illness.⁵⁴² The Society of St Vincent de Paul (Wollongong Diocesan Council) commented:
- People with dual diagnosis [MISA] who are homeless are triply disadvantaged, as many homeless persons services do not have the capacity to assist people with mental illness or people who have a current substance abuse problem. The neat division of services into mental health, drug and alcohol or homeless persons services fails to take into account that many of the most vulnerable people in our state are people who are homeless and suffering mental illness and substance abuse problems.⁵⁴³

⁵³⁵ Commonwealth Department of Family and Community Services (2000), *National Homelessness Strategy: A Discussion Paper*, p 4

⁵³⁶ L. Craze, Discussion Paper, ‘SAAP Linkages with Mental Health: Improving Outcomes for Homeless People with a Mental Illness’, 2000, p 3

⁵³⁷ Commonwealth of Australia, *Supported Accommodation Assistance Program Act 1994*, Section 4. (1)

⁵³⁸ C Chamberlain, *Counting the Homeless: Implications for Policy Development 1996*, 1999, p 44

⁵³⁹ Submission 245, Schizophrenia Fellowship of NSW, pp 5-6; Submission 85, Parramatta City Council, p 2

⁵⁴⁰ St Vincent de Paul Society, Sydney City Mission, the Salvation Army, Wesley Mission and the Haymarket Foundation (1998), *Down and Out in Sydney*.

⁵⁴¹ Submission 85, Parramatta City Council, p 2

⁵⁴² NSW Health, *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, NSW Government Action Plan for Health, August 2002, p 4

⁵⁴³ Submission 178, Society of St Vincent de Paul (Wollongong Diocesan Council), pp 5-6

- 7.95** People who are discharged from psychiatric institutions do not necessarily become homeless.⁵⁴⁴ A range of factors, including available support networks upon discharge, determine whether someone becomes homeless.⁵⁴⁵ The Mental Health Co-ordinating Council (MHCC) noted that in the case of the Richmond Report, many people had erroneously associated the Report with deinstitutionalisation and increasing levels of homelessness among people with mental illness.⁵⁴⁶ The submission stated that:

Only relatively few patients were discharged from long stay wards to the community following the Richmond Report. The number of people residing in psychiatric hospitals in NSW in 1985 was 55 per 100,000 population and the total population was 5.6 million. Between October 1984 and October 1987, 208 long-term patients were discharged from hospitals and placed in supported group homes. As a follow up review, Andrews et al (1990) found that the majority was successfully living in the community, while 22 patients had been rehospitalised. At the time of the study, the residents had been living in the community for varying lengths of time, ranging from three to 40 months post discharge.⁵⁴⁷

- 7.96** Prof Ian Webster also addressed the misconception about the correlation of homelessness with the Richmond Report:

It is wrong to suggest that the increasing number of homeless people who are mentally ill is because of the closure of beds in psychiatric hospitals. It is especially wrong to ascribe the current situation to the Richmond Report. The situation is due to a 'pincer movement' in which the most vulnerable are squeezed out of secure housing. These pressures come from income disparities, lack of affordable housing, lack of opportunities for gainful employment or activities, problems with income support, difficulties in accessing health services and other support.

This is not because previously institutionalised patients are being discharged to the community, but due to a range of factors operating across many western countries such as the UK, Australia and US. The homeless mentally ill are those who might have been admitted in the past to institutions but now have reduced access to a declining number of institutional beds.⁵⁴⁸

- 7.97** Mental illness itself may not be the direct cause of homelessness, with other factors related to the mental illness having a significant influence such as poverty⁵⁴⁹, and discrimination in housing and employment markets.⁵⁵⁰ Research shows that among people with mental illness, those most at risk of becoming homeless:

⁵⁴⁴ Submission 218, Mental Health Co-ordinating Council, p 3

⁵⁴⁵ L. Craze, Discussion Paper, 'SAAP Linkages with Mental Health: Improving Outcomes for Homeless People with a Mental Illness', 2000, p 4

⁵⁴⁶ Submission 218, Mental Health Co-ordinating Council, p 1

⁵⁴⁷ *ibid*, p 1

⁵⁴⁸ Submission 193, Prof Ian Webster, p 3

⁵⁴⁹ Sydney City Mission, Society of St Vincent de Paul, the Salvation Army, Wesley Mission, and the Haymarket Foundation (1997), *Shifting the Deckchairs: Homeless People and Mental Health Services in Inner City Sydney*.

⁵⁵⁰ L. Craze, Discussion Paper, 'SAAP Linkages with Mental Health: Improving Outcomes for Homeless People with a Mental Illness', 2000, p 4

have higher rates of hospitalisation and arrest, are more likely to abuse alcohol and drugs than other patients, have higher psychiatric symptom levels, and are less likely to comply with medication.⁵⁵¹

7.98 The MHCC also commented in its submission that people with mental illness can become homeless if suitable accommodation and support is not provided in the community.⁵⁵² A six-year study of clients following deinstitutionalisation submitted by the Comprehensive Area Service Psychiatrists indicated that adequate community resources and continuity of care provides individuals with much greater life satisfaction, community tenure, clinical stability and social integration.⁵⁵³

7.99 CASA reported that in some areas, community based mental health teams will not attend if a person is homeless. It cited cases of this occurring in Parramatta and the City of Sydney.⁵⁵⁴

7.100 Carers Lodge, a drop-in centre at Young, illustrated in its submission that some people with mental health problems only require minimal support in order to avoid homelessness. While NSW Health funds the lease on the building, the Carer's Lodge is staffed solely by volunteers, providing a free, accessible service for its clients:

In providing this service we assist the client in locating more permanent accommodation so that accommodation is no longer an issue. We also ensure that the client is receiving all social security benefits that they are entitled to receive...Where appropriate the client is also referred to other agencies... Furthermore, as some of the clients are homeless and may have previously been unable to pay their rent, we encourage them to have Centrelink deduct the rent from their pension and pay it directly to their landlord, this in turns assists in providing security of tenancy.⁵⁵⁵

7.101 Prof Ian Webster stated that despite the suffering homelessness caused, some people with mental illness who are homeless prefer to be on the streets than in a psychiatric institution:

I have asked many homeless men with mental illness where they would prefer to be: in a mental hospital, or say, at the Matthew Talbot Hostel in Wolloomooloo. Almost all without exception say they prefer not to be in a psychiatric hospital. They value their freedom. It is important to them...The people who are homeless and mentally ill value the medical clinic (at the Matthew Talbot Hostel) because general nurses and doctors who are not part of the mental health system work there.⁵⁵⁶

7.102 In his submission, Prof Webster referred to the 'three week rule' of homelessness, a term used in the United Kingdom. The 'three week rule' is the amount of time it takes for a newly homeless person to become acclimatised to life on the street, after which they

⁵⁵¹ ibid

⁵⁵² Submission 218, Mental Health Co-ordinating Council, p 3

⁵⁵³ Submission 209, Comprehensive Area Service Psychiatrists Special Interest Groups, Attachments I and II.

⁵⁵⁴ Submission 172, CASA, p 6

⁵⁵⁵ Submission 8, Carers Lodge (Young Community Caring Group), p 2

⁵⁵⁶ Submission 193, Prof Ian Webster, p 3

become entrenched and it becomes more difficult to move back into mainstream society.⁵⁵⁷ Prof Webster was concerned that:

The event of homelessness has a powerful downward effect on a person's ability of function normally. A person quickly adapts and accepts their circumstances. They soon give up and sink into a state of hopelessness and helplessness... This means that early intervention, especially those with mental disorders, is an area in which innovation is required.⁵⁵⁸

7.103 Early discharge from psychiatric care without housing support liaison can trigger an episode of homelessness. UnitingCare commented:

UnitingCare Burnside services have worked with people who have come out of the local psychiatric unit (such as Waratah House in the Macarthur region) to inappropriate housing or no housing at all.⁵⁵⁹

7.104 CASA gave a case study of one woman's path to homelessness, which highlighted the 'marginal' nature of boarding house accommodation:

[A] Boarder with a psychiatric disability lived in a boarding house for 1 year. Her illness was managed and she was working. She got involved in an altercation with another resident, as a result the caretaker summarily locked her out of the premises.

She sought emergency accommodation, but it was not appropriate and [she] was homeless. As a result of the homelessness she developed severe psychiatric symptoms and is currently in and out of a psychiatric hospital.⁵⁶⁰

7.105 In view of this evidence, the Committee supports the initiative in the 2002 NSW *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders* that calls for the development of:

discharge planning protocols [to] inform the transition from acute hospital settings to home, housing and accommodation support programs.⁵⁶¹

7.106 In February 2002, the NSW Department of Housing announced that the NSW government would be introducing a protocol for all government agencies that come into contact with homeless people.⁵⁶² NCOSS strongly supported the development of a homelessness protocol, similar to the one developed for the Sydney Olympic Games. NCOSS emphasised in its submission that such a protocol must address the particular needs of homeless people with mental illness.⁵⁶³

⁵⁵⁷ *ibid*, p 7

⁵⁵⁸ Submission 193, Prof Ian Webster, p 7

⁵⁵⁹ Submission 78, UnitingCare, p 25

⁵⁶⁰ Submission 172, CASA, p 7

⁵⁶¹ NSW Health, *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders Report*, NSW Government Action Plan for Health, August 2002, p 21

⁵⁶² Submission 192, NCOSS, p 20

⁵⁶³ *ibid*

Bail hostels

7.107 The NSW *Bail Act 1978* was recently amended through the *Bail Amendment (Repeat Offenders) Act 2002* to allow the courts to consider additional options in granting bail.⁵⁶⁴ Section 32 of the *Bail Act* now allows the courts to consider the interests of a person with a mental illness when considering a bail application. In considering conditions of bail, the courts may consider whether placement “in accommodation for persons on bail” is available and suitable for the accused person. During the second reading speech on the *Bail Amendment (Repeat Offenders) Bill*, the Attorney General noted:

Often the lack of employment or appropriate residence will be a debilitating factor in deciding whether to grant bail. The availability of supervised bail accommodation and the suitability of the accused person to be bailed to this type of accommodation allows the court to both strengthen existing requirements of bail and divert offenders who might otherwise be incarcerated. This is particularly important for vulnerable accused persons such as juveniles, intellectually or disabled persons, or persons of an Aboriginal or Torres Strait Islander background.⁵⁶⁵

7.108 During the Second Reading debate on the *Bail Amendment (Repeat Offenders) Bill* in the Legislative Council, the House was informed that there is no accommodation in NSW for adult offenders and only one bail hostel for juvenile offenders.⁵⁶⁶ In order for homeless people with mental illness to meet bail requirements there appears to be a strong need for supervised accommodation with mental health service support, so that homeless mentally ill people can obtain bail and meet bail conditions. The Government must be committed to funding sufficient services for the provision of bail hostels or alternative accommodation to incarceration. The Committee is concerned that unless this commitment is made, homeless people who are mentally ill will continue to be denied bail.

Recommendation 48

That the NSW Departments for Housing, Community Services, Health, Ageing Disability and Home Care and Attorney General, coordinate to immediately initiate a specialist supervised and supported accommodation or ‘bail hostel’ program across NSW, for homeless people with a mental illness who have been charged with an offence.

Recommendation 49

That the Attorney General propose amendments to the NSW *Bail Act 1978* to legislate for the provision of supervised and supported bail hostels for people with a mental illness.

⁵⁶⁴ NSW Legislative Assembly, *Hansard*, 20 March 2002, p 818

⁵⁶⁵ NSW Legislative Assembly, *Hansard*, 20 March 2002, p 818

⁵⁶⁶ For example, the Hon John Ryan MLC referring to a letter from the Law Society of NSW: NSW Legislative Council, *Hansard*, 9 May 2002, p 1888

Initiatives to prevent homelessness in NSW

- 7.109** The Crisis Accommodation Program (CAP) is a program under the Commonwealth State Housing Agreement administered by the Office of Community Housing (an agency of the NSW Department of Housing). CAP provides funds to community-based providers to acquire, lease, renovate, convert or build accommodation specifically for homeless people and those at risk of homelessness.⁵⁶⁷
- 7.110** In 1999, the NSW Government established the Partnership Against Homelessness to coordinate and improve a wide range of housing and support services for homeless people in NSW. The participating agencies are the NSW Department of Housing (lead agency), Aboriginal Housing Office, Department of Community Services, NSW Health, The Cabinet Office and the Departments of Ageing, Disability and Home Care, Fair Trading, Women, Corrective Services, and Juvenile Justice. The key aims of the partnership are to:
- help homeless people access services
 - coordinate support services
 - provide accommodation in a crisis
 - make the move to long term housing.⁵⁶⁸
- 7.111** Projects initiated under the Partnership Against Homelessness include:
- *Homeless Action Team in Sydney*, to help long-term residents of accommodation find more suitable housing
 - *Providing Extra Support*, in which the NSW Department of Community Services coordinates support services that homeless or recently housed people need
 - *Broadening the Range of Accommodation Models*, with the NSW Department of Housing trialling two different supported housing arrangements to provide alternative housing models for people disabilities and low to moderate support needs
 - *Meeting Indigenous Needs*, developing services that meet the needs of the indigenous community for more accessible crisis and transitional accommodation
 - *Making a Smooth Transition*, which provides additional transitional accommodation to free up crisis services and
 - *Working together in Inner Sydney*, to assist people sleeping in public places.⁵⁶⁹

⁵⁶⁷ NSW Department of Housing, *Crisis Accommodation Program Delivery Plan 2002-03*, 2002 p 1

⁵⁶⁸ NSW Department of Housing, Fact Sheet, 'Partnership Against Homelessness', 2002, p 1

⁵⁶⁹ *ibid*

7.112 The submission from NSW Health described the Inner Sydney project in more detail:

The Woolloomooloo Homeless Project, coordinated by the Department of Housing is a Partnership Against Homelessness Project. The Steering Committee has been developing and monitoring strategies to reduce the number of people rough sleeping in the Woolloomooloo area and related issues...

A Partnership Against Homeless Working Party is developing a Draft Action Plan for Inner City Homeless. The development of the Action Plan has been identified as a desirable outcome of the Woolloomooloo Homelessness Project Steering Committee.

...The Action Plan aims to improve the quality of services rough sleepers receive from agencies, while at the same time increase the options available to meet their individual needs. The Plan also aims to enhance collaboration in service delivery and service management to target hotspots of rough sleepers in the inner city and move people into permanent housing options with support as necessary. Discussions have been taking place with inner city mental health service providers to map out the strategies...⁵⁷⁰

7.113 While there are a significant number of projects to address homelessness in NSW, frustration was expressed by NGO service providers regarding their lack of inclusion in an overall state strategy and area planning to combat homelessness:

[There are a] high amount of referrals to the NGO sector from government agencies especially in regard to accommodation support. Consumers who have long term psychiatric disability and are not acknowledged as having long term support needs...are being discharged to homelessness, however there is no recognition from the Centre for Mental Health of the responsibility of NSW Health providing housing (refer to Government Action Plan documents), only clinical treatment.⁵⁷¹

7.114 There also appeared to be dissatisfaction with the high number of pilot and one-off projects, as evidenced in the following comment:

What we are getting now is a whole lot of pilot programs, one-offs, and it just feels like flicking coins into a fountain.⁵⁷²

⁵⁷⁰ Submission 267, NSW Health, G.42

⁵⁷¹ Submission 100, Tweed River Valley Fellowship, p 1

⁵⁷² L. Elsworthy, Evidence, 29 May 2002, p 25

Recommendation 50

That NSW Health evaluate the success of existing pilot programs for homeless people with a mental illness and:

- discontinue programs shown not to be effectively and efficiently achieving their planned outcomes
- expand funding to programs identified as effectively and efficiently achieving planned outcomes.

Victorian strategies to assist people with a mental illness who are homeless or at risk of homelessness

7.115 Since 1997, initiatives for people with mental illness in Victoria include:

- residential rehabilitation services for young people with mental illness
- mental health funding of outreach services for people in marginalised housing.⁵⁷³

7.116 The Victorian Housing Strategy has a 'Joined Up Initiatives' Program which works with government and non-government agencies. The 2002-2003 Plan is highly detailed and targets identified areas for property acquisition across the state, staffing and funding levels for each service, and support staff ratios. The Program is coordinated with the SAAP and a range of specialist support providers. The Transitional Housing Management Program (THM) is coordinated with SAAP and delivered through 19 THM agencies throughout the state. Properties, either owned or leased by the Director of Housing, are allocated to THM agencies.⁵⁷⁴

7.117 Major initiatives under the Victorian strategy include:

- *The THM/Mental Health Housing Pathways Initiative 1.* This initiative targets people identified by mental health or homelessness services who are living on the streets or in crisis accommodation. The project aims to provide pathways out of homelessness for people with a serious mental illness and complex needs through the provision of specialist support packages and allocation of Transitional Housing Management housing stock. Twelve support providers are located across Victoria for the project, and support is intensive at a 1:5 to 1:10 ratio. The Office of Housing has supplied 68 THM properties over two years, and the Mental Health Branch of Department of Human Services has funded approximately 112 support packages.
- *The THM/Mental Health Housing Pathways Initiative 2* expands on Initiative 1. The Office of Housing has supplied a further 50 THM properties to this initiative, and Mental Health has funded 10 additional Psychiatric Disability Support Services.

⁵⁷³ Correspondence from Department of Human Services Victoria to the Committee, 19 November 2002, p 1

⁵⁷⁴ Department of Human Services, Victoria, Victorian Homelessness Strategy: Joined Up Initiatives 2002-2003, p 3

- *The Victorian Homelessness Strategy/Mental Health Discharge Planning Initiative* is an 18-month pilot that aims to reduce the risk of homelessness for people with a mental illness when leaving hospital, by improving discharge and access to appropriate housing and support options. It is being undertaken in two metropolitan regions and one rural region. Six THM properties have been allocated to this initiative.⁵⁷⁵

7.118 Agencies in Victoria work closely to support these initiatives. Properties are provided through THM agencies under nomination rights, with housing stock matched in capacity to support at the program/planning level. Locally negotiated protocol agreements between the housing and support provider assist the linkages. The Department of Human Services Victoria noted:

A key element of these initiatives has been the capacity for the Office of Housing and the Mental Health Branch to work closely in developing and coordinating resources. Colocation in a single department has greatly facilitated this work.⁵⁷⁶

7.119 The Intensive Home Based Outreach Psychiatry Disability Support Program in Victoria aims to assist people with a mental illness, complex needs and who are homeless to stabilise accommodation and improve their health and wellbeing. Individual support works within a framework of psychosocial rehabilitation, with individual program plans reflecting the consumer's goals. A key feature of the program is that relies on assertive outreach rather than referrals from other agencies.⁵⁷⁷

Improving access and service coordination in NSW

7.120 As detailed by submissions from the NGO sector, NSW needs to work harder on a 'joined up' strategy to deal with people with a mental illness who are homeless and those in housing crisis. Of particular concern is the lack of strategies to prevent people with a mental illness becoming homeless in the first place. Evidence provided to the Committee has demonstrated that people with a mental illness become homeless because they:

- live in marginal housing situations such as boarding houses, where they have no support in maintaining their tenancies and no protection under residential law⁵⁷⁸
- are unable to maintain public housing tenancies because they have no support services⁵⁷⁹
- are unable to afford or maintain tenancies in the private rental market⁵⁸⁰ and

⁵⁷⁵ Correspondence from Department of Human Services Victoria to the Committee, 19 November 2002, p 1-2

⁵⁷⁶ Department of Human Services Victoria, Correspondence to the Committee, 19 November 2002, p 3

⁵⁷⁷ Mental Health Branch, Department of Human Services Victoria, *Mental Health Homelessness Program: Intensive Home Based Outreach Psychiatric Disability Support*. 2002

⁵⁷⁸ Submission 172, CASA, p 8

⁵⁷⁹ *ibid*; Submission 78, UnitingCare, p 15; Submission 71, St Agnes Support Service, p 1; Submission 98, B. Miles Housing Scheme, p 13; Submission 192, NCOSS, p 18

⁵⁸⁰ Submission 175, Illawarra Tenants' Legal Service, pp 4-6; Submission 178, Society of St Vincent de Paul (Wollongong Diocesan Council), p 5

- are discharged from hospital with nowhere to go.⁵⁸¹

7.121 Once people with a mental illness are homeless and seek crisis accommodation, they once more ‘fall through the net’ because crisis services such as SAAP are generic and not designed to meet the complex needs of clients with mental illness. It is important to recognise that the SAAP sector was never mandated nor resourced to provide support to homeless people with a mental illness.⁵⁸²

7.122 People with serious mental illnesses require a specialist set of services if they are to sustain secure accommodation. Rather than expanding SAAP itself, a specialised supported housing program to which intake-level clients of SAAP can be referred is required. This point was emphasised by Mission Australia. Mission Australia included the following comment by Ms Jennifer Westacott, former Deputy Director General of the NSW Department of Housing, in its submission:

It is important that we understand that housing is not in and of itself one thing that can change people’s lives. In our business it is always something else: housing and support, housing and health, housing and community facilities. Many tenancies often fail because we have not been able to get that support coordinated effectively. We are housing people with very complex support needs as well as their housing needs. The access points to housing and support services are often unclear and often uncoordinated. People will have to access their needs from a number of services and multiple points and that can be quite confusing for people.⁵⁸³

7.123 The *NSW Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders* proposes that:

clinical care, rehabilitation, accommodation support and other required services be delivered to people in their homes wherever they may be.⁵⁸⁴

7.124 The Committee recognises a critical flaw in this statement. Without clinical care, rehabilitation and accommodation support, people will not have homes that can be visited. Early intervention before homelessness occurs is critical if the *Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders* is to have an effect on the lives of people with mental illness.

Recommendation 51

That the Partnerships Against Homeless initiative be expanded to include key non-government agencies that deliver services to homeless people.

⁵⁸¹ Submission 78, UnitingCare, p 25; Submission 172, CASA, p 5

⁵⁸² L. Craze, Discussion Paper, ‘SAAP Linkages with Mental Health: Improving Outcomes for Homeless People with a Mental Illness’, 2000, p 6. See also Section Five of the *Supported Accommodation Assistance Program Act 1994*.

⁵⁸³ Submission 188, Mission Australia, p 7

⁵⁸⁴ NSW Health, *NSW Framework for Housing and Accommodation Support for People with Mental Health Problems and Disorders*, p 11

Recommendation 52

That the participating agencies in Partnerships Against Homelessness, in collaboration with Supported Accommodation Assistance Program services, establish coordinated referral systems between participating agencies.

Recommendation 53

That the participating agencies in Partnerships Against Homelessness, fund assertive outreach services among homeless people in areas where the incidence of homelessness is identified as particularly high.

Recommendation 54

That the NSW Department for Housing and NSW Health develop a simple Housing Risk Identification Tool, which can serve as a proactive measure for managing an individual's housing risks. This should be incorporated into an 'Early Intervention Manual for People with Mental Illnesses at Risk of Homelessness'.

Recommendation 55

That NSW Health and the NSW Department of Housing adopt a housing strategy for people with a mental illness similar to the 'Joined Up Initiatives' program in Victoria where:

- the NSW Department of Housing allocates suitable housing stock for mentally ill people with complex needs and
- NSW Health funds non-government organisations to manage residential rehabilitation programs using the allocated housing stock.

This strategy should be developed and implemented within 6 months and allocation of housing stock commenced within 12 months of the strategy implementation.

Chapter 8 Multicultural issues

The large and diverse multicultural population in NSW poses many challenges for the provision of health services. This challenge increases where cultural and language barriers coincide with mental illness. This chapter will highlight various issues facing people from culturally and linguistically diverse (CALD) backgrounds.

Context

- 8.1** Cultural practices, religious beliefs and the language of a person affected by mental illness greatly influence the level of access to mental health services and the benefits they may receive. People from CALD backgrounds are less likely to use mental health services and less likely to be admitted voluntarily to inpatient hospital services. They are however, more likely to seek assistance from bilingual general practitioners (GPs) and may rely heavily on family members and other traditional methods for support and healing.⁵⁸⁵
- 8.2** The percentage of the NSW population born overseas rose from 27.2% in 1996 to 30.1% in 2001. The total proportion of the 2001 population who spoke a language other than English at home was 25%, compared with 21.8% in 1996.⁵⁸⁶

Recent policy initiatives

- 8.3** In 1998, NSW Health released *Caring for Mental Health in a Multicultural Society – A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds in NSW*. The strategy aims to improve the access to and effectiveness of the mental health system in meeting the needs of people from CALD backgrounds. Some of the goals outlined in the strategy aim to:
- provide information on mental health services in a manner sensitive to cultural values, practices and language
 - facilitate better coordination between mental health services and multicultural services to improve access and care
 - enhance and support the role of GPs and primary mental health carers to increase effectiveness of health care and
 - enhance the skills and capacity of mental health professionals to provide appropriate assessments, diagnosis and treatment.⁵⁸⁷

⁵⁸⁵ NSW Health, *Caring for Mental Health in a Multicultural Society – A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds in NSW*, 1998, p 1

⁵⁸⁶ NSW Health, *Report of the NSW Chief Officer*, 2002 p 99-100

⁵⁸⁷ NSW Health, *Caring for Mental Health in a Multicultural Society – A Strategy for the Mental Health Care of People from Culturally and Linguistically Diverse Backgrounds in NSW*, 1998 p 1

Factors influencing access to mental health services

8.4 The Transcultural Mental Health Centre (TMHC) has worked in partnership since 1993 with mental health services, consumers, carers and the community to improve the mental health of people from non-English speaking backgrounds in NSW.⁵⁸⁸ In its submission to the inquiry, the TMHC described the number of complex factors that influence or inhibit access to mental health services by people of CALD backgrounds.⁵⁸⁹ The *Caring for Mental Health in a Multicultural Society* policy strategy outlined the following factors as reasons for developing the strategy:

- People from particular cultural backgrounds utilise mental health services less frequently than the general community. When they access mental health services it is most often at a later stage in their illness and they are often hospitalised as involuntary patients
- Many people from culturally diverse backgrounds are unfamiliar with the mental health system and do not sufficiently understand the role of mental health services. Combined with different cultural concepts of mental health as well as English language difficulties, their access to appropriate diagnostic and treatment services may become limited
- Many mental health service professionals do not have culturally specific knowledge and the skills to identify psychiatric symptoms accurately in people from particular cultural backgrounds
- Some ethnic communities prefer to use traditional networks of support such as family members and traditional healers
- Bilingual and bicultural staff employed in mental health services are underutilised by mental health services
- People from particular cultural and linguistic backgrounds are overrepresented among the forensic patient population
- Some ethnic communities experience high levels of stigma and shame associated with mental illness.⁵⁹⁰

8.5 Ms Diana Qian, Acting Deputy Chairperson, Disability Council of NSW, explained to the Committee that the problem of stigma associated with mental illness and intellectual disability was still prevalent in some CALD communities:

Some ethnic communities have a very negative view about people with disabilities. People with disabilities and, in particular, people with mental illness, are regarded as bringing shame on a family. Of all the disabilities, mental illness is seen as a huge embarrassment to the family. So a lot of those people would have been hidden away, although they would have been well cared for by their families.⁵⁹¹

⁵⁸⁸ Submission 228, Transcultural Mental Health Centre, p 2

⁵⁸⁹ *ibid*, pp 7, 9

⁵⁹⁰ NSW Health, *Caring for Mental Health in a Multicultural Society – A Strategy for the Mental Health care of People from Culturally and Linguistically Diverse Backgrounds in NSW*, 1998, p 2

⁵⁹¹ Ms Diana Qian, Acting Deputy Chairperson, Disability Council of NSW, Evidence, 28 May 2002, p 11

- 8.6 Ms Qian and other members of the Disability Council of NSW supported the work of the TMHC but agreed there was still more to be done to raise awareness of available services for CALD communities:

About 15 or 16 per cent of the disability population are people from a non-English speaking background and the services access rate is about 3 per cent. So it is only a very few of them who actually access the services. The majority of them are hidden in the community not knowing that they have a right to access services and not fully aware of what is happening to them because there is a huge gap in terms of promoting community awareness about mental health issues in different communities. Usually you will have information in English about educational and mental health issues but they are not available, they are not penetrating the ethnic communities.⁵⁹²

- 8.7 Ms Leonie Manns, former Chairperson of the Disability Council NSW, commented that some community mental health teams seemed unaware of the existence of the TMHC.⁵⁹³

Access to mental health services

- 8.8 To inform this Committee on the effectiveness of access to mental health services by people of CALD backgrounds, the TMHC conducted a consultation with consumers and carers. Various major concerns emerged from the consultation:

- lack of consumer information about the mix of available mental health services such as multidisciplinary care, case management, community support and rehabilitation services
- need for mental health services to be more consumer responsive – professional staff are often rigid and clinically focused rather than focused on consumer needs⁵⁹⁴
- gaps in access to crisis services – 24 hour crisis services to people from CALD backgrounds are perceived as available only in certain areas of NSW and not operating on a 24 hour basis due to lack of resources
- gaps in inpatient services – focus on containment and not on discharge planning involving family and friends
- need to improve service linkages between GPs, the private sector and the public mental health system
- need to enhance the cultural and linguistic appropriateness of services.⁵⁹⁵

⁵⁹² D Qian, Evidence, 28 May 2002, p 10

⁵⁹³ L Manns, Evidence, 28 May 2002, p 10

⁵⁹⁴ Submission 228, Transcultural Mental Health Centre, p 15

⁵⁹⁵ *ibid*, p 14

8.9 With regard to consumer and carer information about services, there was a feeling that information was not easy to obtain and had to be directly requested from mental health professionals. The TMHC advocated that more information about different models of care needed to be made available, such as the ‘case management model’ and the ‘multidisciplinary team’ approach. It was recommended that ‘care kits’ be developed for consumers, which would outline information on mental health problems and services and rehabilitation options available, in addition to existing pamphlets and booklets.⁵⁹⁶ The Committee suggests that existing information for CALD consumers be reviewed and new packages be developed that are suitable for facilitating self-care.

8.10 The TMHC also reported a general perception that there were not enough bilingual mental health professionals available to meet the need. The TMHC submission highlighted research findings indicating that interpreters were generally underutilised and that there was a lack of compliance with NSW Health guidelines regarding interpreter use.⁵⁹⁷ A submission provided to the TMHC from a carer expressed concern that there is a general lack of knowledge about the availability of the Health Care Interpreter Service (HCIS) and the Telephone Interpreter Service by both consumers and mental health professionals. The submission stated that there was a:

- lack of training for health staff about the effective use of interpreters in clinical settings (even though all HCIS offer comprehensive training for health staff)
- lack of skills in identifying whether a consumer or carer needs an interpreter.⁵⁹⁸

8.11 The TMHC informed the Committee that one of the dominant strategies under the *Caring for Mental Health in a Multicultural Society* policy, has been an attempt to increase the availability of bicultural/bilingual mental health professionals. Initiatives include the Bilingual Counsellor Program, which employs approximately 28 bilingual mental health professionals and the TMHC’s Brokerage Program, which employs approximately 97 bilingual sessional workers. These workers speak about 45 languages to assist mainstream mental health workers to clarify diagnostic issues and to provide short-term specific intervention as required.⁵⁹⁹

8.12 A submission to the TMHC expressed concern that there are still insufficient bilingual mental health positions created under the Bilingual Counsellor Program. It argued that:

much of the work related to access has been left to generalist multicultural health workers...who do not have the skills to effectively promote access to mental health services.⁶⁰⁰

8.13 Similarly, the Multicultural Disability Advocacy Association of NSW (MDAA) submitted that there was an overall low level of cultural competencies among mental health professionals and that “a significant shift towards understanding of cultural diversity needs

⁵⁹⁶ Submission 228, Transcultural Mental Health Centre, p 15

⁵⁹⁷ *ibid*, p 11

⁵⁹⁸ *ibid*, p 20

⁵⁹⁹ *ibid*, p 12

⁶⁰⁰ *ibid*, p 20

to occur”.⁶⁰¹ All mental health professionals should be required to undertake cross-cultural training to increase sensitivity and awareness during service delivery.

- 8.14** The shortage of dedicated transcultural mental health service workers was particularly evident for rural and regional areas as outlined by Mr Jem Masters, President of the NSW branch of the Australian-New Zealand College of Mental Health Nurses. Mr Masters highlighted problems in obtaining transcultural mental health services outside Sydney:

I know the multicultural mental health service, [but] it is really hard to get resources to access different area health services other than in western Sydney, where they are based, and it could take two or three weeks to get a person from the multicultural centre to come out to a regional area. Even if it is crossing from western Sydney to south-western Sydney it is a problem. I think that is not just within mental health but across the board.⁶⁰²

- 8.15** The TMHC and MDAA submissions outlined the findings of various studies which highlighted that consultation with GPs tended to be the first point of contact for people of various CALD backgrounds seeking help. GPs consequently have a powerful role in mediating contact with mental health services within various cultural groups. Despite this, overall it appears that few GPs use interpreters or have established links with mental health professionals.⁶⁰³

- 8.16** The TMHC emphasised that the bulk of support for mental health consumers from CALD backgrounds tends to be provided by family and a significant portion of community care is provided by carers. This support often incurs a high personal cost.⁶⁰⁴ Carers NSW advised the Committee that coordinators of support groups for carers from non-English speaking backgrounds have reported that carers have difficulty accessing counselling provided by bilingual workers and that mainstream services do not use interpreters. NSW Carers stated that, consequently:

carers do not receive any support from the mental health service in coping with their caring situation.⁶⁰⁵

- 8.17** The Committee considers that due to the vital importance of the role of carers, appropriate carer support initiatives should be provided.

⁶⁰¹ Submission 265, Multicultural Disability Advocacy Association of NSW, p 9

⁶⁰² Mr Jem Masters, President, NSW branch of the Australian-New Zealand College of Mental Health Nurses, Evidence, 30 July 2002, p 63

⁶⁰³ Submission 265, Multicultural Disability Advocacy Association of NSW, p11; Submission 228, Transcultural Mental Health Centre, p 10

⁶⁰⁴ Submission 228, Transcultural Mental Health Centre, p 19

⁶⁰⁵ Submission 196, Carers NSW, p 13

Conclusion

- 8.18** NSW Health advised the Committee that *Caring for Mental Health in a Multicultural Society* will be reviewed through 2002-2003 and that further policy development processes will be set in place.⁶⁰⁶ The TMHC reported that in terms of the changes that have taken place since the Richmond Report:

all the consumer representatives felt that while there has been some fulfilment of the recommendations of the Report...opportunities for improvement still remained.⁶⁰⁷

- 8.19** It is apparent that more initiatives and enhanced funding are required to improve access to appropriate mental health care by people from CALD backgrounds, and to ensure equity in service provision. Accordingly, the Committee advocates a series of initiatives to be considered and implemented by NSW Health.

Recommendation 56

That NSW Health and the Centre for Mental Health develop information packages or 'care kits' for consumers that will enhance access to information facilitating self-care. Kits should contain information such as:

- contact details from the Health Care Interpreter Service and the Telephone Interpreter Service
- contact details and locations of 24 hour crisis services and
- rehabilitation options available, such as case management and multidisciplinary care as well as contact details for access to such services.

Recommendation 57

That NSW Health develop and conduct a consumer and carer perception survey for people from culturally and linguistically diverse backgrounds to:

- identify satisfaction with the manner and attitudes of mental health professionals in delivering services, and
 - assist in development of staff training programs designed to improve focus on individual care and flexibility in providing treatment suitable to the patient's needs.
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⁶⁰⁶ Submission 167, NSW Health, p G 23

⁶⁰⁷ Submission 228, Transcultural Mental Health Centre, p 14

Recommendation 58

That NSW Health provide, in accordance with its *Caring for Mental Health in a Multicultural Society* policy, a strategy to improve access to appropriately trained health care interpreters and services for people from culturally and linguistically diverse backgrounds, including:

- adequate funding so that bilingual crisis services are provided 24 hours per day
- recruitment of more interpreters and bilingual mental health workers in a broad range of language groups and
- education for mental health professionals about effective use of interpreters in clinical settings and referral of consumers and carers to the Health Care Interpreter Service and the Telephone Interpreter Service.

Recommendation 59

That NSW Health work with the Transcultural Mental Health Centre to develop and implement a cultural training program that requires:

- the participation of all mental health professionals and staff and
- ongoing cultural sensitivity training relative to the client group they support.

Recommendation 60

That NSW Health develop and initiate a program tailored for General Practitioners to inform them of the full range of public mental health service options available to people from culturally and linguistically diverse backgrounds.

Recommendation 61

That NSW Health investigate and implement support initiatives for carers of mental health consumers from culturally and linguistically diverse backgrounds, including counselling services with bilingual interpreters.

Chapter 9 Indigenous issues

Aboriginal Mental Health Services are at a disadvantage relative to the mainstream mental health system. It is of concern that there is still little coordination of mental health services for Aboriginal people and consequently there is a great deal of variability in the performance of different Area Health Services.⁶⁰⁸

[Council of Social Service of NSW]

Context

9.1 Aboriginal and Torres Strait Islander (ATSI) people have a holistic view of health. The National Aboriginal Health Strategy Working Party (1989) defines health as:

not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.⁶⁰⁹

9.2 The NSW Health *Aboriginal Mental Health Policy*, stated that Aboriginal people have adopted a holistic view of mental health which means that mental health is part of full health as defined above in the Aboriginal definition of health.⁶¹⁰ A major concern raised by groups representing Aboriginal and Torres Strait Islander (ATSI) people is the lack of cultural sensitivity in mainstream mental health services.

9.3 At the 2001 Census, 119,895 people living in NSW, or 1.9% of the population, identified as Aboriginal or Torres Strait Islander.⁶¹¹

Recent policy initiatives

9.4 The 1997 *NSW Aboriginal Mental Health Policy* was released after extensive consultation and development. Its strategic directions were:

- respect for the Aboriginal person as an individual, within a family, community, nation and society
- consultation with Aboriginal people, communities and community controlled organisations in all aspects of health programs and services
- recruitment of Aboriginal people into the public health system to be conducted in partnership with Aboriginal community controlled organisations and

⁶⁰⁸ Submission 192, Council of Social Services NSW, p 16

⁶⁰⁹ National Aboriginal Health Strategy Working Party (1989) cited in NSW Health, *NSW Aboriginal Mental Health Policy – A Strategy for the Delivery of Mental Health Services for Aboriginal People in New South Wales*, 1997, p 8

⁶¹⁰ NSW Health, *NSW Aboriginal Mental Health Policy – A Strategy for the Delivery of Mental Health Services for Aboriginal People in New South Wales*, 1997, p 8

⁶¹¹ Australian Bureau of Statistics (2001), *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*. Catalogue no 4704.0.

- education in the workplace for Aboriginal and non-Aboriginal people.⁶¹²

9.5 NSW Health stated in its submission that the major components of the policy are in place. A review process is underway and will produce the basis for the new Aboriginal Mental Health Policy for NSW.⁶¹³

Factors influencing access to mental health services

9.6 The *NSW Aboriginal Mental Health Policy* advised that there are a range of barriers unique to ATSI people accessing mental health services, including:

- inadequate assessment of Aboriginal persons presenting to accident and emergency departments of hospitals and in some instances to departments of surgery and medicine
- culturally inappropriate services or an absence of services that address the issues that are important to Aboriginal people
- lack of understanding of Aboriginal issues amongst mental health staff and lack of staff with training in mental health in Aboriginal Medical Services
- fragmentation of service delivery
- difficulties in accessing transport to mental health services
- lack of Aboriginal staff in mental health services and lack of training for Aboriginal people in mental health
- fear of mental health services and staff attitudes and behaviours and
- the role and functioning of police in relation to mental health services.⁶¹⁴

9.7 A submission from the Mid-North Coast Area Action Group for Addressing Mental Health Issues in the Justice System (a group of carers, supporters and mental health staff) indicated additional indigenous health issues that faced the Port Macquarie and Kempsey areas:

- pure psychiatric models disregard social and emotional wellbeing
- focus on centre based services rather than community delivered services
- lack of resources to provide community education relating to mental health in Aboriginal communities

⁶¹² NSW Health, *NSW Aboriginal Mental Health Policy – A Strategy for the Delivery of Mental Health Services for Aboriginal People in New South Wales*, 1997, p 13

⁶¹³ Submission 267, NSW Health, p G 22

⁶¹⁴ NSW Health, *NSW Aboriginal Mental Health Policy – A Strategy for the Delivery of Mental Health Services for Aboriginal People in New South Wales*, 1997, p12

- large burnout rates for Aboriginal mental health staff
- cultural awareness training for non-Aboriginal staff no longer conducted and
- families not involved in the assessment process.⁶¹⁵

9.8 The Health Care Complaints Commission drew attention to a number of serious concerns about mental health services for rural and remote Aboriginal communities. These concerns included:

- feelings of isolation and alienation when admitted to public psychiatric facilities
- numbers of suicides and unauthorised departures from care and
- variable levels of discharge planning and follow-up services.⁶¹⁶

9.9 The Commission's submission included the following comments from Aboriginal community members:

One community member advised that, when she rang the community mental health team for assistance, she was told, 'We can only do something if you are going to kill yourself'. Another community member was told, 'We can't do anything – call the police'. Some people were advised to consult their general medical practitioner despite their need for mental health services. In summary, most community members agreed with the statement that "Community mental health services only help you if you hit rock bottom".⁶¹⁷

Delivery of mental health services

9.10 On the issue of access to mental health services by ATSI people, the Council of Social Service of NSW (NCOSS) noted:

In certain areas Aboriginal mental health workers are placed in mainstream health services (or an Aboriginal staff member is designated that role), giving rise to problems of access and appropriateness when Aboriginal people won't utilise services for cultural and historical reasons.⁶¹⁸

9.11 NCOSS further commented in its submission that there had been progress in the treatment of the mental health of Aboriginal people with the development of the *Aboriginal Mental Health Strategy* and Aboriginal Mental Health Services. Despite this, however:

Aboriginal Mental Health Services are at a disadvantage relative to the mainstream mental health system. It is of concern that there is still little coordination of

⁶¹⁵ Submission 67, Mid-North Coast Area Action Group for Addressing Mental Health Issues in the Justice System, pp 7-8

⁶¹⁶ Submission 120, Health Care Complaints Commission, p 4

⁶¹⁷ *ibid*, p 4

⁶¹⁸ Submission 192, Council of Social Services NSW, p 16

mental health services for Aboriginal people and consequently there is a great deal of variability in the performance of different Area Health Services.⁶¹⁹

- 9.12** Mr Michael Roberts, Chief Executive Officer, Dharah Gibinj, Aboriginal Medical Service Aboriginal Corporation (Casino), explained to the Committee that Aboriginal people prefer to care for the sick, even the very frail and elderly, in the home.⁶²⁰ Where there is violence or acute mental illness however, both Mr Roberts and Ms Lexie Lord, Vice-President of the Parents and Carers' Mental Health Group, North Casino, told the Committee that the burden of full-time care could be overwhelming.⁶²¹ Carers NSW stated in its submission:

In certain Aboriginal communities, the prevalence of mental disorders is now starting to exceed illnesses such as diabetes. The needs of carers in these communities are even less likely to be met, as mainstream services often do not understand the cultural needs of Aborigines and therefore do not deliver services appropriately.⁶²²

- 9.13** Mr Roberts, Ms Lord and Carers NSW all believed that the burden on carers in Aboriginal communities could be alleviated by the introduction of greater numbers of Aboriginal mental health workers to look not only after the needs of the client, but the carer as well.⁶²³

- 9.14** NCOSS strongly supported the placement of Aboriginal mental health workers in Aboriginal community-controlled organisations. From there, they would work in conjunction with mainstream services to provide mental health services to the Aboriginal community.⁶²⁴

- 9.15** Dharah Gibinj expressed the need for Aboriginal health workers to be appointed to mainstream services and decision-making process committees as well as Aboriginal community controlled health services. While mainstream mental health services have received training in the holistic view of Aboriginal health, Dharah Gibinj's submission suggested that in reality, little attention was paid to the holistic model:

Aboriginal people usually hold strong cultural/spiritual belief systems that are not adequately dealt with in mainstream services. This is a compelling reason to employ ATSI people at every level of planning, implementing and evaluating mental health programs. It is imperative that ATSI people keep in touch with the land, their kin and their spiritual and cultural beliefs.⁶²⁵

- 9.16** Dharah Gibinj called in its submission for cultural awareness training for all health professionals, not just mental health workers.⁶²⁶

⁶¹⁹ Submission 192, Council of Social Services NSW, p 16

⁶²⁰ Mr Michael Roberts, Chief Executive Officer, Dharah Gibinj, Aboriginal Medical Service, Aboriginal Corporation (Casino), Evidence, 31 July 2002, p 5

⁶²¹ Ms Lexie Lord, Vice-President, Parents and Carers' Mental Health Group, North Casino, Evidence, 31 July 2002, p 15

⁶²² Submission 196, Carers NSW, p 13

⁶²³ M Roberts, Evidence, 31 July 2002, p 3; Lord Evidence, 31 July 2002, p 14; Submission 196, Carers NSW, p 13

⁶²⁴ Submission 192, Council of Social Services NSW, p 17

⁶²⁵ Submission 119, Dharah Gibinj Aboriginal Medical Service, p 2

⁶²⁶ *ibid*

9.17 A number of submissions focused in particular on mental health problems faced by ATSI males. The Men's Health Information and Resource Centre (MHIRC) raised concerns about the impact on communities of mental health problems in ATSI men.⁶²⁷ In 2001, the *NSW Public Health Bulletin* noted that many of the mental health problems identified in Aboriginal males are linked to historical factors such as disruption at colonisation, institutionalisation and separation from natural family. Mental health problems of Aboriginal men include alcohol abuse, violence, destructive behaviours, and the loss of a sense of personal worth. Indigenous people also have higher levels of psychosocial distress compared with non-indigenous people.⁶²⁸ Mental health problems among Aboriginal males may be related to other factors such as:

- an historical fear of hospitals
- 'lack of closure' and unresolved conflict due to past government policy and practice and the past separation of mothers and children
- the reduction of authority and status within families and sociological changes to the male role model in society and
- the intervention of family courts and government departments.⁶²⁹

9.18 NSW Health has initiated an *Aboriginal Men's Health Implementation Plan*, which includes mental health issues as a focus area.⁶³⁰ Mr Phillip Scott, Court Liaison Clinician for the Mid North Coast Area Health Service, cited the importance of establishing coordinated local area support for Aboriginal men, particularly in view of the high number of Aboriginal men who come into contact with the criminal justice system:

I have been concerned over the last 12 months also about the actual effect of Aboriginal males coming into contact with the courts. They are coming into contact with the court on charges such as domestic violence orientated types of crimes associated with alcohol and with low self-esteem and a very poor opinion of themselves. As a result of that the community is setting up a men's group to look at these types of issues within the Kempsey area. It is utilising the existing resources within that area to start to mobilise those types of areas to work for the best outcome.⁶³¹

9.19 The general shortage of mental health professionals, particularly in rural and regional areas, is magnified in the corresponding shortage in Aboriginal mental health workers. In its submission, Dharah Gibinj Aboriginal Medical Service cited a "dearth of psychiatrists" in the Northern Rivers Area Health Service. Considering the large ATSI population in the area, Dharah Gibinj stated that ways of obtaining the services of, and keeping, suitable staff needed to be examined.⁶³²

⁶²⁷ Submission 251, Mens' Health Information and Resource Centre, p 7

⁶²⁸ B Nielsen, E Katrakakis and B Raphael, *Males and Mental Health: A Public Health Approach*, NSW Public Health Bulletin, vol 12 no 12, 2001, p 330. Also noted in Submission 267, NSW Health, p G 21

⁶²⁹ *ibid*, p 330

⁶³⁰ *ibid*, p 331

⁶³¹ P Scott, Evidence, 1 August 2002, p 11

⁶³² Submission 119, Dharah Gibinj Aboriginal Medical Service, p 3

9.20 Dharah Gibinj made the following suggestions to attract more psychiatric staff and Aboriginal health workers:

- offer attractive packages to attract and retain the right workers
- explore partnerships with local general practitioners and
- provide more training and professional development opportunities for Aboriginal health workers, including scholarships, tutoring, and paid study leave.⁶³³

9.21 Mr Phillip Scott explained to the Committee the importance of having Aboriginal mental health workers, particularly in his court liaison work. He related his own experience in court liaison in Northern NSW:

In communication with that group professionally I need to recognise that possibly coming from a white background is not the most therapeutic in getting people talking on a truthful level. As a result of that, the use of Aboriginal liaison people or consumers has been utilised in a way to break that communication down, especially when we are communicating with people who have committed a crime...when they are in the cells they sometimes do not want to talk to me, but if I get a fellow like an Aboriginal mental health worker to come with me, he or she is able to communicate much better.⁶³⁴

9.22 Mr Michael Roberts suggested a diploma in Aboriginal mental health should be available to indigenous people living in NSW. Currently, only general Aboriginal health diplomas are available through TAFE NSW. Mr Roberts envisaged the diploma as not only providing clinical understanding of mental illness, but also skills in assessment, administration of medication and referral if required.⁶³⁵

Recommendation 62

That as part of its review of any Aboriginal Mental Health Policy, NSW Health should:

- review Aboriginal Mental Health Worker numbers and their distribution in NSW
 - assess obstacles and incentives to recruit and retain Aboriginal Mental Health Workers in NSW and
 - integrate review findings into the new Aboriginal Mental Health Policy.
-

⁶³³ Submission 119, Dharah Gibinj Aboriginal Medical Service, p 3

⁶³⁴ P Scott, Evidence, 1 August 2002, pp 10-11

⁶³⁵ M Roberts, Evidence, 31 July 2002, p 2 and p 6

Recommendation 63

That NSW Health, as part of any new Aboriginal Mental Health Policy, develop a strategy for recruiting and adequately resourcing Aboriginal Mental Health Workers throughout NSW.

Recommendation 64

That NSW Health continue to work towards partnerships between mainstream mental health services and Aboriginal community-based mental health services, including trial partnerships between local general practitioners and Aboriginal Mental Health Teams.

Recommendation 65

That the Minister for Health develop a proposal to the Commonwealth Ministers for Health and Education to initiate a post-graduate module in Aboriginal Mental Health for nursing and health related courses.

Recommendation 66

That the Minister for Health provide at least three fully funded scholarships for psychiatric nurses undertaking the proposed post-graduate module in Aboriginal Mental Health on an annual basis.

Treatment and care of Aboriginal patients who are acutely unwell

- 9.23** The Legal Aid Commission reported in its submission that some Aboriginal patients were receiving poor quality service, or no services, while acutely unwell:

The Commission's solicitors have observed that, for a variety of reasons, some Aboriginal clients act out more aggressively when unwell. Because of this, some hospitals are reluctant to hold them for longer than a few weeks. As a result, Aboriginal clients are routinely released before they are well, and are often released without a Community Treatment Order because they are considered to be too difficult to manage. This results in a high number of Aboriginal patients re-offending because of lack of inpatient and community based services. When the person comes back into custody the hospital will often refuse to accept them because they are too aggressive.⁶³⁶

- 9.24** The Commission provided a case study in which a hospital failed to provide duty of care to an Aboriginal client who was very unwell:

KL, a young Aboriginal man, was held in hospital under section 33 of the *Mental Health (Criminal Procedure) Act 1990*. An Aboriginal legal service dealt with his matters and he was referred to the hospital for further treatment. The hospital contacted the police alleging that KL had become aggressive. The police took him into custody. No charges were laid. The hospital was aware that there were no

⁶³⁶ Submission 216, Legal Aid Commission, p 6

charges current. It appears that the hospital discharged KL into police custody because they were afraid to discharge him into the community when he was still very unwell. Police contacted the Legal Aid Commission after KL had been held in police custody for 24 hours without charge. A Commission solicitor advised the police to release him. KL was released into the community with no medication. The medication he was on was a type which should not be discontinued suddenly, as this carries an increased risk of psychosis. There is a possibility that this young man will re-offend as he is currently receiving no treatment.⁶³⁷

- 9.25** In another case given by the Legal Aid Commission, a young Aboriginal woman with a chronic mental illness received no ongoing care and eventually committed a serious offence:

MN...becomes aggressive and highly distressed, making allegations of sexual assault against her father. Despite being extremely unwell she was consistently released under a Community Treatment Order after about one week without proper follow up. She would then assault her father with whom she was placed, and be returned to the hospital, where she was represented by a Legal Aid Commission solicitor. She eventually committed a serious offence while unwell and was placed in custody. ⁶³⁸

Recommendation 67

That NSW Health implement a policy that requires the Aboriginal and Torres Strait Islander Medical Service be involved, with the consent of the patient, once an Aboriginal and Torres Strait Islander person is admitted to hospital for psychiatric care and later when discharged.

- 9.26** While the Committee did not receive specific evidence regarding the mental health of ATSI people in prison, the Committee notes with concern recent Australian Bureau of Statistics figures indicating an 8% increase in the number of indigenous prisoners in the total prison population in NSW. ⁶³⁹ The Committee is well aware that the issue of suicide in custody was comprehensively covered in the Royal Commission on Aboriginal Deaths in Custody.⁶⁴⁰ Preventing ATSI people with mental health problems coming into contact with the criminal justice system is vital. Court diversionary programs for people with a mental illness are considered in Chapter 14.

⁶³⁷ Submission 216, Legal Aid Commission, p 6

⁶³⁸ *ibid*, p 6

⁶³⁹ Australia Bureau of Statistics (2002), Cat 4512.0, 'Corrective Services, Australia'.

⁶⁴⁰ Royal Commission on Aboriginal Deaths in Custody, 1991, National Report, Vol. 3

Chapter 10 Mental illness and substance abuse

One of the dilemmas being faced in hospitals and environments where people present with acute illness is how to manage the acutely disturbed person, the person who is psychotic, and there has in the past been the tendency to say, well, I am not prepared to look after that person unless you fix up their mental problem first or, if they have entered the drug and alcohol system, I am not prepared to look after that person unless their psychosis is managed. Clearly those things have to be better managed together. Hospital systems have to be better organised so that it happens.⁶⁴¹

[Prof Ian Webster, Emeritus Professor]

Throughout the course of the Committee's inquiry, the comorbidity of mental illness and drug and alcohol abuse was a recurring issue. The Committee notes the term 'dual diagnosis' is often used to describe this comorbidity, but that this term is also used interchangeably to describe intellectual disability and mental illness. To avoid confusion the Committee has adopted the term 'mental illness and substance abuse' (MISA), as referred to in the Burdekin Report.⁶⁴²

While the term 'abuse' may be considered politically incorrect in current health terminology, the term accurately conveys its historical meaning. Dr Richard Matthews, Chief Executive Officer, Corrections Health Service, succinctly distinguished between 'use' and 'abuse':

Alcohol is probably a good way of helping people to understand. If we all have a glass or two of wine with the evening meal, that is use. If we have more than the standard four drinks a day or we go to the pub on Friday night and have 12 schooners, that is abuse. In terms of opioids, it is a little bit more difficult to define, but the tool has a way of doing it. If I have been to a party once or twice in the past year and have snorted some cocaine, that would be use, and not abuse. If, on the other hand, I was doing that every day and missing time from work and my social functioning was disintegrating, that would be abuse or dependence.⁶⁴³

Incidence of comorbidity – mental illness and substance abuse

- 10.1** The 1997 *National Survey of Mental Health and Wellbeing* identified a considerable degree of coincidence of mental health disorders with substance use problems (comorbidity). The survey found that among men with a current anxiety disorder, 31% also had a current substance use disorder, while the rate of substance abuse and comorbidity with affective disorders, such as depression, was 34%.⁶⁴⁴

⁶⁴¹ I Webster, Evidence, 31 May 2002, p 4

⁶⁴² Human Rights and Equal Opportunity Commission, *Report of the National Inquiry into Human Rights of People with a Mental Illness*, 1993 [Burdekin Report] p 664

⁶⁴³ R Matthews, Chief Executive Officer, Corrections Health Service Evidence, 30 May 2002, p 25. Due to the variety of expressions for MISA in quoted material, the phrase 'use disorder' is used interchangeably with abuse for the purposes of this report.

⁶⁴⁴ G Andrews, W Hall, M Teeson, & S Henderson, *National Survey of Mental Health and Wellbeing, Report 2 – The mental health of Australians*, (Canberra, Commonwealth Department of Health and Aged Care), 1999, p 34

- 10.2** NSW Health stated that, depending on the population sample, 30% to 80% of people with a mental illness have a co-existing substance use disorder.⁶⁴⁵ A recent study of inpatients with an early episode of psychosis conducted in Queensland suggests that the incidence is probably more towards the higher end of the percentage range. The study found that 70% of young people admitted also had a current substance use disorder.⁶⁴⁶
- 10.3** In a submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into substance abuse in Australian communities, the Australian National Council on Drugs (ANCD) further confirmed the high percentage of comorbidity:
- Although it is difficult to accurately measure the prevalence of this problem, recent figures have suggested that as many as three quarters of all clients with drug and alcohol problems have a dual diagnosis. Similarly it is asserted that there is an equally high percentage of people with mental illness misuse who misuse alcohol and other drugs.⁶⁴⁷
- 10.4** The Committee notes that in 1993 the Burdekin Report determined that the prevalence of MISA in Australia would be comparable to that found in the United States of America.⁶⁴⁸ The National Co-morbidity Survey undertaken in the United States between 1990-1992.⁶⁴⁹ The study found that rates of such dual disorders were particularly high among those with alcohol dependence, with 78% of men and 86% of women having alcohol dependence and a co-existing mental disorder.⁶⁵⁰
- 10.5** More recently, the Hunter Health Service investigated the prevalence of substance abuse in a community outpatient clinic for people with schizophrenia. Of the 194 outpatients assessed the study found lifetime prevalence rates for schizophrenia and substance abuse to be 59.8% and six-month prevalence was 26.8%.⁶⁵¹
- 10.6** The Victorian Institute of Forensic Mental Health highlighted the correlation of MISA with violent offences. The Institute stated that for people with schizophrenia who did not have a problem with substance abuse, there was only a modest increase in committing a violent offence. The level of violent offences increases significantly with substance abuse:

⁶⁴⁵ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines* 2000, p 2

⁶⁴⁶ D J Kavanagh, *Social and Economic Costs of Comorbid Substance Abuse and Mental Disorder*, p 4 - submission to the House of Representatives Standing Committee on Family and Community Affairs, Inquiry into substance abuse in Australian communities, 2002

⁶⁴⁷ Australian National Council on Drugs, submission to the House of Representatives Standing Committee on Family and Community Affairs, Inquiry into substance abuse in Australian communities, 2002 cited at www.ancd.org.au/publications/parlinquiry.htm (accessed 11/11/02)

⁶⁴⁸ Burdekin Report, p 664

⁶⁴⁹ R C Kessler, et al, Lifetime and 12 month prevalence of DSM-11-R psychiatric disorders in the United States. Archives of General Psychiatry, 51, p 8-9 cited in NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper* (2000), p 4

⁶⁵⁰ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper*, 2000, p 4

⁶⁵¹ I L Fowler, et al (1998), Patterns of current and lifetime substance use in schizophrenia, Schizophrenia Bulletin, cited in NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper* 2000, p 4

People with schizophrenia however, who also had problems with substance abuse, were over 18 times more likely to have received a conviction for violent offending, and over 28 times more likely to be convicted of homicide. People with severe depression or bipolar illness showed a similar pattern with the risk of offending as that of the general population. Violent offending though skyrocketed when there was co-existing substance abuse. Among people with an affective disorder without substance abuse, violent offences were 2.9 times higher, but the incidence of violent offending was 19 times higher in those with substance abuse.⁶⁵²

- 10.7** The Institute also reported on general offences committed by those with schizophrenia and substance abuse problems:

There was a dramatic increase in offending if the patients also abused alcohol or drugs. In those with schizophrenia who did not abuse substances, their rates of offending were less than half of those who did abuse alcohol or drugs. In those with substance abuse and schizophrenia, their rates of violent offending were nearly 10 times higher than the general population.⁶⁵³

- 10.8** The *National Survey of Mental Health and Wellbeing* outlined the importance of examining MISA in this report:

The high rates of comorbidity have a number of implications for treatment and management. Mental disorders complicated by alcohol and other drug use disorders, and vice versa, have been recognised as having a poorer diagnosis than those without such comorbid disorders.⁶⁵⁴

The impact of the Richmond Report on drug and alcohol services

- 10.9** At the time of the Richmond Report, a number of drug and alcohol services, including detoxification programs, were provided within 5th Schedule⁶⁵⁵ psychiatric hospitals in NSW. The Richmond Report noted that a ‘significant proportion’ of psychiatric admissions to these hospitals had a drug or alcohol related association with the mental illness.⁶⁵⁶ The Report stated, however, that there is an:

important distinction between the actual taking of drugs, including alcohol, and the physiological, biochemical or psychological effects of drug taking. A person who takes drugs is not necessarily mentally ill and requires different assistance to one who is affected by drugs in a manner which manifests itself as mental illness.⁶⁵⁷

⁶⁵² Submission 302, Victorian Institute of Forensic Mental Health, p 4

⁶⁵³ *ibid*, p 4

⁶⁵⁴ G Andrews, W Hall, M Teeson, & S Henderson, *National Survey of Mental Health and Wellbeing, Report 2 – The mental health of Australians*, (Canberra, Commonwealth Department of Health and Aged Care), 1999, p 9

⁶⁵⁵ ‘5th Schedule hospitals’ were created under schedule 5 of the *Public Hospitals Act 1929*, repealed by the *Health Service Act 1997*

⁶⁵⁶ Richmond Report, Part 5, 7.2 (a) p 72

⁶⁵⁷ *ibid*

10.10 The Richmond inquiry heard evidence, based on this distinction, which argued that drug and alcohol services should not be provided within specialised psychiatric hospital services. It was decided that such hospitals should concentrate on providing services for “the longer term effects of drug and alcohol intake such as the management and rehabilitation of brain damaged persons”.⁶⁵⁸

10.11 The Richmond Report admitted that this area had not been investigated extensively; and this is reflected through the four paragraphs dedicated to drug and alcohol services.⁶⁵⁹ The report nevertheless supported the proposal to remove substance abuse treatment and care from psychiatric hospitals:

drug detoxification programmes including those for acute alcoholic states should be phased out of specialised psychiatric hospital services and provided for in general hospital and in appropriate community based services.⁶⁶⁰

10.12 The Report also stated:

Within health services it is considered that drug abuse programmes should be integrated with other health care activities within hospitals and community health programmes. These in turn should be linked at local level with a network of services involving other service providers outside the health system.⁶⁶¹

Illicit drugs, post-Richmond

10.13 The Richmond Report was compiled prior to the increasing potency of illicit drugs, and more significantly the heroin drought of the 1990s. Subsequently, that inquiry could not have foreseen the impact that amphetamines and similar drugs would have on people with MISA. Dr Richard Matthews, Chief Executive Officer, Corrections Health Service, outlined this issue:

Some evidence has been presented by Don Weatherburn that during the so-called heroin drought, those who were heavy injectors of heroin tended to switch to injecting amphetamines and cocaine. Those who were lighter users of heroin tended to switch to much heavier marijuana consumption. In some senses, a heroin drought is bad news.⁶⁶²

10.14 Dr Jennifer Gray, Director, NSW Health Drugs Program Bureau, informed the Committee of the difficulties the increase in amphetamine use has caused the health system:

The whole issue of amphetamines and amphetamine-related psychosis, as opposed to a person having a pre-existing psychosis...is new, it has occurred within the past few years. There were pockets of it but it is something that the system as a whole has to learn to respond to very quickly. For the very skilled and able staff and medical practitioners with years of experience, it is not such a tall

⁶⁵⁸ Richmond Report, Part 5, 7.2 (a) p 72

⁶⁵⁹ *ibid*

⁶⁶⁰ *ibid*

⁶⁶¹ *ibid*

⁶⁶² R Matthews, Evidence, 30 May 2002, p 27

order. For an NGO worker who is there because they themselves used to be substance dependent, learning new skills for how to manage more complex issues is quite problematic and complex so we need to spend a lot of time in assisting them to get to there.⁶⁶³

- 10.15** Given the increasing prevalence and complexity of MISA, there are clear implications for the provision of mental health and drug and alcohol services. The NSW Health document, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper*, has acknowledged the pressure MISA imposes on mainstream health services:

access to drug and alcohol services is limited on weekends and outside regular working hours, consequently the care and treatment of people with comorbid disorders is largely provided by mental health and mainstream health services. This clearly indicates the need for mainstream health staff to have up to date skills on the assessment and management of substance use disorders. Furthermore, attempts to develop collaborative partnerships with drug and alcohol professionals, in government and non-government sectors, are required for people with disorders which are complicated by substance use.⁶⁶⁴

MISA - NSW Government response

- 10.16** In 1993, the Burdekin Report found that the ability of the system to identify and manage people with MISA was diminished by the lack of an inclusive model of care. The Report identified that these people were often referred to one service or another, or had no access to services at all.⁶⁶⁵

- 10.17** In 1998 NSW Health published *Caring for Mental Health – A Framework for Mental Health Care in NSW*, which aimed ‘to improve coordination of mental health and drug and alcohol services’.⁶⁶⁶ A joint initiative between the Centre for Mental Health and the Drug Programs Bureau of NSW Health was subsequently developed to identify and address the gaps in service delivery, and:

to promote a model of collaborative partnerships and specifically, to develop service delivery guidelines to improve the health care and health outcomes for people affected by dual disorders.⁶⁶⁷

- 10.18** In 2000, the joint initiative produced two documents:

- *The Management of People with a co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines* and
- *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper*.

⁶⁶³ Dr J Gray, Director, Drug Programs Bureau NSW Health, Evidence, 8 October 2002, p 25

⁶⁶⁴ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper* 2000, p 8

⁶⁶⁵ Burdekin Report, pp 665-667

⁶⁶⁶ NSW Health, *Caring for Mental Health – A Framework for Mental Health Care in NSW* (1998), p 36

⁶⁶⁷ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper*, NSW Health 2000, p 8

- 10.19** The *Discussion Paper* acknowledged that there remain barriers to service provision in NSW and that the system of care lacked the necessary philosophy of inclusive and comprehensive health care.⁶⁶⁸ The *Discussion Paper* found that service provision relied more on the interest and expertise of individual clinicians than on a consistent, inclusive or comprehensive system of care. The review concluded, ‘a cultural shift in attitudes, from exclusion to one of holistic care is required’.⁶⁶⁹

NSW Health MISA Service Delivery Guidelines – general principles and models

- 10.20** The *Service Delivery Guidelines* placed responsibility for service provision with the AHS, primarily the Chief Executive Officers and service directors.⁶⁷⁰ The *Service Delivery Guidelines* also outlined NSW Health’s general principles for the management of people with MISA:

- harm minimisation
- health promotion, prevention and early intervention
- comprehensive and inclusive health care
- interagency links and partnerships
- evidence based good practise
- health outcomes and
- building self-efficacy.⁶⁷¹

- 10.21** The *Service Delivery Guidelines* included general service delivery models designed to fit within the primary role and functions of separate services. The models outline how services can meet the needs of people by identifying the severity and treatment needs of the individual.⁶⁷² MISA presentations, according to the model, should be handled individually or by a combination of mental health services, drug and alcohol services and general practitioners, as depicted in the following table:

⁶⁶⁸ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder –Discussion Paper*, NSW Health, 2000, pp 9-10

⁶⁶⁹ *ibid*, p 9

⁶⁷⁰ *ibid*, p 21

⁶⁷¹ *ibid*, p 4

⁶⁷² *ibid*, pp 5-6

Table 10.1 MISA Presentations (Service Delivery Guidelines)

Mental Health Services Primarily responsible for people severely disabled by current mental health problems and disorders and adversely affected by substance use disorders.	Drug and Alcohol Services Primarily responsible for people severely disabled by current substance use disorders and adversely affected by mental health problems and disorders.
Mental Health and Drug and Alcohol Services Shared responsibility for people severely disabled by comorbid disorders where both disorders are treated concurrently in the service best placed to meet the client needs.	General Practitioner Primarily responsible for people with mild to moderate comorbid disorders but with access to expertise from specialist mental health and drug and alcohol services as required.

Source: NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Service Delivery Guidelines*, NSW Health (2000), p 6

- 10.22** NSW Health acknowledges that the model outlined in the table must be supported by “flexibility and collaboration between service providers”⁶⁷³ to ensure services are accessible.

Screening and Assessment

- 10.23** The *Service Delivery Guidelines* advocated that engagement is the first step in developing a trusting alliance between client and service provider:

Successful engagement is critical to effective intervention or treatment and is dependent on a number of factors including a clear delineation of the interventions that can be offered and their potential value.⁶⁷⁴

- 10.24** Assessment tools are recommended by NSW Health to improve the ability of clinicians to detect comorbid conditions and assist the assessment process. For mental health clinicians, tools such as the Alcohol Use Disorders Identification Test (AUDIT) would provide the framework for taking a drug and alcohol history. For drug and alcohol staff, the incorporation of a mental state exam and psychological screening instruments with their regular assessments would increase the identification of a range of mental health problems.⁶⁷⁵

Integrated care

- 10.25** The *Service Delivery Guidelines* noted the importance of links between specialist and mainstream services and formal and informal collaborative partnerships across health and related care systems:

These may involve links between specialist services such as mental health and drug and alcohol with a Memoranda of Understanding or service agreement. They may also involve shared-care arrangements – for instance between these specialist

⁶⁷³ ibid, p 6

⁶⁷⁴ ibid, p 8

⁶⁷⁵ ibid, pp 8-9

services and general practitioners or between health services and non-government organisations and so forth. Understanding how and who to contact in other health and related organisations should be established as core, every day business.⁶⁷⁶

- 10.26** It was suggested that AHS should ensure that better identification, treatment and care coordination is achieved through sharing of expertise, such as joint assessment and co-management:

Collaborating in joint approaches should be two-way, mutually beneficial and focused on delivering comprehensive health care.⁶⁷⁷

- 10.27** AHS, according to the *Service Delivery Guidelines*, should facilitate the establishment of formal networks and regular liaison between primary care providers across service sectors, in order to better integrate the delivery of services and reduce the incidence of people falling through the gaps.⁶⁷⁸

- 10.28** In its submission to the Committee, NSW Health stated that the *Service Delivery Guidelines*, aimed at addressing issues in the *Discussion Paper*, have been implemented and that all AHS “should provide integrated services or collaborate as clinically appropriate”.⁶⁷⁹ According to Dr Jennifer Gray, Director of the Drug Programs Bureau within NSW Health, an integrated service system currently exists in NSW, and furthermore, that it is growing rapidly and positively.⁶⁸⁰

- 10.29** Dr Gray informed the Committee that it is necessary for drug and alcohol services to differentiate where, and which clients to treat:

In drug and alcohol very careful determinations and decisions are made about what the status of the person is. We must be careful about putting people into particular services where it is not good for them or for the other clients. Therefore, we find other ways of managing that person...It is not appropriate to have a severely mentally ill person in a regular detoxification unit because those units are not set up in terms of security or staffing to manage people with extreme mental health problems. The far better option is for that person to receive drug and alcohol treatment in the setting to which they are most suited. It is what I mean by ambulatory: We bring those services to those people at that particular point in time.⁶⁸¹

- 10.30** Evidence presented to the Committee suggests that a situation continues to exist where neither mental health services nor drug and alcohol services will accept responsibility for MISA patients. Consequently, the best-designed health care models remain inaccessible to a person with a mental illness and substance use disorder.

⁶⁷⁶ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder – Discussion Paper*, 2000, p 15

⁶⁷⁷ *ibid*

⁶⁷⁸ *ibid*

⁶⁷⁹ Submission 267, NSW Health, p G.30

⁶⁸⁰ J Gray, Evidence, 8 October 2002, p 29

⁶⁸¹ *ibid*, pp 43-44

Access to mental health and drug and alcohol services

- 10.31** The primary difficulty people with a MISA problem have accessing health services was identified in the Burdekin Report:

If someone with a psychiatric disability has a drug problem and is on medication, to try and get them into a detoxification centre is impossible because detox centres will not take anyone on medication...[and] try to get anyone with a drug problem into an accommodation service designed for psychiatrically disabled people, is almost impossible.⁶⁸²

- 10.32** The *Discussion Paper* published in 2000 by the Centre for Mental Health and the Drug Programs Bureau acknowledged comments in the Burdekin Report which indicated that, despite the high prevalence of MISA:

a severe lack of communication existed between mental health and drug and alcohol services. A result of this, the Inquiry was told that people with a dual diagnosis tend to “fall through” the gaps in the health care system.⁶⁸³

- 10.33** Evidence presented to the Committee indicates that the gaps continue to exist. In February 2000, the Australian National Council on Drugs (ANCD) conducted a NSW Local Agency Consultation Forum for over 100 people from the NSW drug and alcohol field. A major theme raised during the forum was MISA, including:

- the continuity of care between treatment for alcohol and other drug problems and treatment for mental illness
- funding for mental health services and the difficulty in attracting and retaining skilled professionals and
- problems placing people who are psychiatrically affected in detoxification or treatment services.⁶⁸⁴

- 10.34** Two years later in March 2002, ANCD conducted a similar forum on mental health and drug and alcohol services, which concluded:

The gap between mental health services and drug and alcohol services has existed for many years, and is not getting better. Integrated program delivery was seen as the most obvious way to improve the situation.⁶⁸⁵

- 10.35** The Mental Health Review Tribunal also informed the Committee that the lack of a coordinated approach to service delivery still exists:

[Issues] reported and discussed by tribunal members around Australia relate to the lack of expertise in treating and working with people with dual or multiple

⁶⁸² Burdekin Report, 1993, p 665

⁶⁸³ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder –Discussion Paper*, NSW Health (2000), p 10

⁶⁸⁴ Australian National Council on Drugs, NSW Local Agencies Consultation Forum Report, February 2000

⁶⁸⁵ Australian National Council on Drugs, Sydney Local Agencies Consultation Forum Report, February 2002

diagnosis (including drug and alcohol). In the absence of clear service pathways and "buy-in" by clinical services, people with dual diagnosis are frequently passed from one department to another.⁶⁸⁶

- 10.36** UnitingCare stated that people with a mental illness and co-existing substance use problem are victims of 'buck-passing' between health services:

For example, Burnside youth services in the Macarthur region report that if a young person has a dual diagnosis, for example alcohol or other drug abuse and a mental health issue, the mental health services say that it is a matter for alcohol and other drug services, while alcohol and other drug services say it is a mental health service problem. Alcohol and other drug usage (particularly prolonged usage) can be the catalyst for serious psychosis and suicide ideation, even with marihuana smoking. It is ludicrous that there is a difficulty in gaining access to services. This is an ongoing concern for all services in Macarthur, which, given the region has no after-hours mental health crisis team, is exacerbated considerably.⁶⁸⁷

- 10.37** Ms Patricia Zabaks made a submission to the Committee and spoke at the Committee's public forum. Ms Zabaks' daughter was diagnosed with schizoaffective disorder and has a co-existing drug problem. Ms Zabaks highlighted that mental health services would not recognise their duty of care, citing her daughter's substance abuse as the rationale for not treating her mental illness:

opinions from numerous psychiatrists, counsellors and the local mental health team were sought. Because of co-morbidity with drug use her father, my daughter and myself were frequently sent away to deal with the drug problem first. No advice or referral to an appropriate professional was ever given. Our observation that the mental illness persisted in the absence of illicit drug taking was ignored.⁶⁸⁸

- 10.38** Ms Colleen Deane also made a submission to the Committee and spoke at the public forum. Ms Deane's son Joseph had a mental illness and a co-existing drug and alcohol problem. Joseph committed suicide after absconding from the psychiatric unit of a general hospital. Ms Deane expressed her frustration at the barriers to treatment and care for her son:

The hospital did not want Joseph – he was a difficult patient with his drug and alcohol addictions and his violent psychotic episodes – so I was left to deal with Joseph.

...I called the crisis team so many times, only to be told it was a drug and alcohol problem, police problem or I was too emotional. I pleaded with them to help – but to no avail.⁶⁸⁹

- 10.39** Ms Diane Oakes's son suicided while in the psychiatric wing of a public hospital, after a history of drug induced psychosis and depression.⁶⁹⁰ Ms Oakes was critical of the diagnosis

⁶⁸⁶ Submission 266, Mental Health Review Tribunal, p 11

⁶⁸⁷ Submission 78, UnitingCare, p 24

⁶⁸⁸ Submission 205, Ms Patricia Zabaks, p 1

⁶⁸⁹ Submission 17, Ms Colleen Deane, p 1

⁶⁹⁰ NSW Police Service, Crime Agencies, Coroners Support Section, Investigation Report, p 2 cited in Submission 220, Ms Diane Oakes

and assessment of her son by health services, and stressed that health services must recognise their duty of care. In relation to mental health and drug and alcohol services, Ms Oakes expressed anger over the division of responsibility:

Mental Health and Drug and Alcohol Services must be seen as part of the same Service. Too many people with both mental health problems and drug and alcohol induced mental health are being shunted backwards and forwards between these two services with neither being willing or able to take responsibility for the complete and complex care required by these patients. This shirking of responsibility for the care of these patients in crisis must STOP.⁶⁹¹

- 10.40** Nine years after publication of the Burdekin Report, Sister Myree Harris RSJ and Mr Colin Robinson, Society of St Vincent de Paul, informed that Committee that:

People who are doubly disabled this way, are poorly served and tend to “fall through the cracks” of our mental health and drug and alcohol services. They are often shuffled back and forth between services which take responsibility for treatment of only half the condition.

Drug and alcohol services often refuse to treat people who have been prescribed psychotropic medication. Mental health services address only the mental illness component of the condition.⁶⁹²

- 10.41** Prof Ian Webster, Emeritus Professor, commented that the specialisation of services may actually hinder access to treatment and care:

Possessing dual diagnosis is not a problem of the affected person as such but a problem created by the specialisation of services. Specialisation arises for two main reasons. One is to deal with an area of need and the other is to cope with evolving new technologies.

...In mental health and drug and alcohol some of the specialised responses have developed around institutions and facilities...This has led to exclusiveness, as the facilities are designed around a culture for one problem exclusively so that other problems are unwelcome.⁶⁹³

- 10.42** The Legal Aid Commission referred to "tragic results" when the seriousness of MISA is not recognised:

The tendency to refuse service to people with dual problems of mental illness and drug usage has, in our view, been the cause of some tragic incidents.⁶⁹⁴

- 10.43** The Commission concluded:

For patients with a dual diagnosis of drug addiction and mental illness, there appears to be little assistance for the drug addiction while the patient is in hospital,

⁶⁹¹ Submission 220, Ms Diane Oakes, p 6

⁶⁹² Sr M Harris, Evidence, 23 May 2002, Tabled document no.7, p 2

⁶⁹³ Submission 193, Prof Ian Webster, p11

⁶⁹⁴ Submission 216, Legal Aid Commission, p 4

and when patients are discharged from hospital it is into hit and miss arrangements with drug rehabilitation services.⁶⁹⁵

10.44 An example of such tragic results was illustrated in the Society of St Vincent de Paul publication *A Long Road to Recovery*:

Annette suffers from anorexia as well as severe anxiety and depression, which have led her to become entrenched in chronically compulsive patterns of thought and behaviour. Her thoughts prevent her from standing still, literally, or caring for her physical well being and have led in the last four years to drug abuse as her latest way to escape her condition.

She is now a heroin addict and is homeless. Her body weight regularly plummets. Periodically, she is taken to the emergency room of a hospital where she is promptly discharged, if admitted at all, on the grounds that hers is a drug problem and that she needs to address that before hospitals will address her psychiatric condition.

However, even the most sophisticated and long-term drug rehabilitation programs admit that she needs help with her mental health at the same time as her drug rehabilitation. And so it is back to the public health system for more 'rejection therapy'.

With severely disordered thought patterns, life-threatening body weight, and a manifest inability to make basic choices to keep herself alive, the main public hospitals in inner-city Sydney have nonetheless discharged or not admitted her on several occasions over the last three years.

Recently her weight plummeted to 29 kilograms. Unable to stand, Annette was taken to St Vincent's public hospitals, Darlinghurst, and was discharged the same day. A lack of beds and the protection of Annette's freedom are two of the most frequently given reasons by the hospitals for their decision to discontinue her care. On one occasion, the phrase used by a young psychiatrist was 'we must not be paternalistic'. Sadly however, when a person is dying, what good is this to them?...The dual nature of Annette's problem effectively means she is in 'no-man's land'.⁶⁹⁶

10.45 Despite best practice models and the *Service Delivery Guidelines* developed by NSW Health, people with MISA are not necessarily receiving adequate treatment and care.

⁶⁹⁵ Submission 216, Legal Aid Commission, p 13

⁶⁹⁶ Submission 143, Society of St Vincent de Paul, *A Long Road to Recovery: a social justice statement on mental health*, July 2001 p 14

NSW Health - drug and alcohol responsibilities and funding

Table 10.2 Total drug and alcohol funding by year from State and Commonwealth

	1998-1999		1999-2000		2000-2001	
	\$	%	\$	%	\$	%
Commonwealth	13,100,000	17%	15,400,000	18%	21,400,000	20%
State	64,700,000	83%	72,000,000	82%	85,700,000	80%
Total	77,800,000	100%	87,400,000	100%	107,100,000	100%

Source: NSW Health, 14 November 2002

10.46 Considering the high prevalence of substance abuse by people with MISA, the Committee was interested in the allocation of funding and responsibility for drug and alcohol services in NSW. The Director of the Drug Programs Bureau, Dr Jennifer Gray and the Chief Health Officer of NSW, Dr Greg Stewart, informed the Committee of the complex system of drug and alcohol services funded and provided by the Commonwealth, NSW Health, and the Office of Drug Policy in the Cabinet Office.

10.47 Dr Stewart highlighted the division of responsibility between these agencies. In response to a question from the Committee regarding whether or not NSW Health is the principal agency in relation to drug and alcohol, Dr Stewart stated that:

In relation to drug treatment, yes. In relation to a broad range of services about drug and alcohol—drink-driving, for example—the answer is no.⁶⁹⁷

10.48 Dr Stewart later explained that NSW Health has a clear role in terms of services provided for drug and alcohol, though added:

I think it is important, though, to talk about how the Government has responded to drug and alcohol in general, not just the Drug Summit because the Health Department is not the leading agency.

...The lead Minister is the Special Minister of State. The lead agency—and they remind us of this from time to time—is the Cabinet Office.⁶⁹⁸

10.49 The complicated allocation of responsibility within drug and alcohol services in NSW was further highlighted by the Director of the Drug Programs Bureau, NSW Health:

We are no longer the lead agency. We were, prior to the repeal of the Drug Offensive, but that was stripped away from us. As a post-Drug Summit process the Office of Drug Policy was established in the Cabinet Office. They have the coordinating role of policy of all types across government to do with drug and alcohol.⁶⁹⁹

⁶⁹⁷ Dr G Stewart, Chief Health Officer, NSW Health, Evidence, 8 October 2002, p 40

⁶⁹⁸ *ibid*, p 41

⁶⁹⁹ J Gray, Evidence, 8 October 2002, p 41

- 10.50** As the Committee attempted to ascertain the roles and responsibilities within drug and alcohol services with respect to coordination with mental health services, Dr Stewart stated that the Committee was confusing drug and alcohol services and drug and alcohol treatment services. Dr Stewart explained:

Of course the Health Department is the lead agency in relation to drug and alcohol treatment services. We provide those services. It is our responsibility to provide them. After the Drug Summit, reconsideration was given to which government department will be the lead agency in relation to drug and alcohol services because they involve things that are much greater than just treatment services. They involve a whole lot of things that I have just talked about, such as training, police response, the response in youth, DOCS, so on and so forth.⁷⁰⁰

- 10.51** The Committee was interested to understand the allocation and accountability for drug and alcohol funding in NSW, particularly that which would be utilised by a significant percentage of people with a co-existing mental illness. Under the Commonwealth National Drug Strategy, the funding allocated to NSW stipulates that 10% must be expended on 'law enforcement' programs. NSW Health has historically directed this money to the NSW Department of Corrective Services. In response to a question from the Committee regarding the accountability of Corrective Services for this funding, Dr Stewart stated:

The important point here is that we are required to provide, out of this component of Commonwealth funds, 10 per cent for law enforcement. We provide it to Corrections, and they tell us they spend the \$1.3 million on counsellors.

...we are just a post box for that. You will have to ask Corrections how they spend the money.⁷⁰¹

- 10.52** The Committee then asked Dr Stewart how NSW Health evaluated that utilisation of funding to the NSW Department of Corrective Services. Dr Stewart responded:

surely, it is a matter for the Commonwealth what reporting it requires from an agency that is not NSW Health. I am quite happy to answer questions on what NSW Health reports. But I cannot possibly answer on how Corrective Services responds.

...It is the Commonwealth that provides the funds. It is the Commonwealth that should ask the additional questions.⁷⁰²

- 10.53** Dr Stewart was later asked whether or not he thought the \$1.3 million is "well spent on drug and alcohol issues by Corrections, in cooperation with Corrections Health". Dr Stewart responded:

in the end, surely it is the Commonwealth's responsibility, since it is the body to whom we report, to ask those kinds of questions. It is Commonwealth money.

⁷⁰⁰ G Stewart, Evidence, 8 October 2002, p 41

⁷⁰¹ *ibid*, p 34

⁷⁰² *ibid*, p 35

The Commonwealth has been satisfied for 10 years. It apparently has asked us no more questions.⁷⁰³

...I am not unconcerned but it is difficult for me as the Chief Health Officer or anyone within NSW Health when there is a mandate of 10 per cent to go to [Corrective Services] to have any powerful levers in relation to our money.⁷⁰⁴

10.54 As noted, the 10% component of the Commonwealth's funding for drug and alcohol services is allocated for 'law enforcement'. The distribution of this funding to the NSW Department of Corrective Services is at the discretion of NSW Health. The Committee expressed concern over the allocation of this funding to Corrective Services, and it is concerned by the Chief Health Officer's confusing response regarding allocation and accountability, in terms of coordinated service delivery.

10.55 Early in 1997-1998 the Centre for Mental Health was transferred from the Public Health division of NSW Health to the Policy division to integrate the various health policy components within the Department. As stated earlier, *The Management of People with a co-existing Mental Health and Substance Use Disorder - Service Delivery Guidelines* and the *The Management of People with a co-existing Mental Health and Substance Use Disorder - Discussion Paper* were a joint initiative between the Centre for Mental Health and the Drug Programs Bureau of NSW Health. Consequently, the Committee was concerned that Dr Stewart was unable to comment on mental health and substance abuse:

We cannot comment on what happens to a patient with predominantly a mental health problem, because we came along to talk about drug and alcohol. It does not fall within the public health division. But we can talk about drug and alcohol services.⁷⁰⁵

10.56 Prof Webster expressed concern over the perceived division of responsibility in health care between mental health and substance abuse:

Everyone working in primary health care needs upskilling in mental health and addiction. The illusion that these are rare problems and not the business of primary health care, must be set aside. Mental health and drug and alcohol problems are principal areas of focus for all human services but especially primary health care.⁷⁰⁶

10.57 The Committee considers that the division of responsibility within drug and alcohol services may be a barrier to the continuity of care for people with MISA. The Committee is concerned that a mental health service provider, especially an NGO, would have great difficulty in evaluating funding streams for MISA patients in order to determine the equity and accessibility of available programs.

⁷⁰³ ibid, p 37

⁷⁰⁴ ibid, p 38

⁷⁰⁵ ibid, p 47

⁷⁰⁶ Submission 193, Prof Ian Webster, p 15

- 10.58** Considering the evidence presented to the Committee, including that by the Legal Aid Commission, Mental Health Tribunal, the Society of St Vincent de Paul, and the Chief Health Officer, the Committee considers that effective integration of mental health and drug and alcohol services is required in NSW as a matter of urgency.

MISA – the need for service integration

There needs to be more communication between drug and alcohol services and mental health teams...In the case of dual diagnosis – they don't need to be further fragmented by being pushed between the services – they need to be treated holistically.⁷⁰⁷

[Ms Colleen Deane]

- 10.59** A 1999 study suggested that treatment for both drug problems and mental health disorders improves prognosis, whereas continued illicit drug use intensifies mental health problems.⁷⁰⁸ The *International Mid-Term Review of the Second National Mental Health Plan for Australia, November 2001*, stated however, that providing adequate services for people with mental health and substance use problems was consistently raised as “one of the greatest services limitations throughout Australia”.⁷⁰⁹
- 10.60** Dr David Kavanagh, Department of Psychiatry, University of Queensland, referred to a recent survey of professional staff across Queensland which found that:
- the separation of services produced a range of problems in co-ordination of treatment, information exchange and access to specialist services for people with comorbidity...We know from outcome trials that integrated treatment for comorbid disorders is more effective than parallel or sequential treatment (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998), so these service delivery problems are of significant importance in terms of maximising effectiveness and minimizing delivery costs.⁷¹⁰
- 10.61** The Australian National Council on Drugs submission to the Commonwealth House of Representative *Inquiry into substance abuse in Australian communities*, also highlighted the need for effective integrated service provision:

The Council is concerned about the lack of integration between mental health and alcohol and other drug services. Putting it very simply, clients with a dual diagnosis of a mental disorder and substance use, usually have to access different treatment services for their substance use and mental illness. Some have reported being referred to one service to treat one disorder/disease before being accepted for treatment at another.

⁷⁰⁷ Submission 17, Ms Colleen Deane, p 2

⁷⁰⁸ I B Crome, Substance misuse and psychiatric comorbidity: towards improved service provision. *Drugs: Education, Prevention and Policy*, 6 (2), 1999, p 149 – 174

⁷⁰⁹ Prof V T Betts, Prof G Thornicroft, *International Mid-Term Review of the Second national Mental Health Plan for Australia*, November 2001, Commonwealth Department of Health and Ageing, 2002 Canberra, p 16

⁷¹⁰ Dr D Kavanagh, Department of Psychiatry, University of Queensland, submission to the House of Representatives Standing Committee on Family and Community Affairs, *Inquiry into substance abuse in Australian communities*, 2002

Other problems include the difficulty in accurate diagnosis, comparative lack of skilled professionals in dealing with dual diagnosis patients and the statistical suggestion that people with dual diagnosis are more likely to experience negative outcomes (eg: increased levels of medication, suicidal behaviour, higher family burden, etc) and generally respond less-well to treatment than those with mental disorders alone.⁷¹¹

10.62 The need to treat and care for both substance abuse and mental illness problems concurrently is recognised by the Triple Care Farm (TCF). This is a youth project operated by Mission Australia, targeting young people with complex histories including substance abuse and mental illness issues.⁷¹² TCF receives only 9% of its funding base from government departments, and is supported primarily by the private sector. TCF made a submission to the inquiry to highlight “the growing number of young people with dual disorders, and specifically mental health and substance use”.⁷¹³

10.63 Mr Warren Holt, Manager of TCF, expressed that while the program was established to accept young people with a mental illness who were stabilised and had been through a detoxification program, in practice:

Often Triple Care Farm has been the first program to recognise the young person’s mental health problem, which had previously been seen as purely a drug problem by other services.

...On occasion, young people are withdrawing when they first come to the farm...Triple Care Farm ensures that the underlying factors contributing to the young person’s substance use problem are also addressed.⁷¹⁴

10.64 The *Service Delivery Guidelines* published by NSW Health acknowledged the need for service integration in NSW. The Guidelines advocate how suitable service delivery that meets the specific needs of various services and geographical areas across NSW could be developed by implementing a number of options, including:

- integrated service provision under one umbrella organisation
- establishing links between identified key staff in local services
- initiating a formal process of collaboration and networks in joint meetings, journal clubs and case reviews by service providers in mental health, drug and alcohol, general practice and non-government organisations
- employment of staff with drug and alcohol expertise in mental health services
- employment of staff with mental health expertise in drug and alcohol services.⁷¹⁵

⁷¹¹ Australian National Council on Drugs, submission to the House of Representatives Standing Committee on Family and Community Affairs, *Inquiry into substance abuse in Australian communities*, 2002

⁷¹² Submission 302, Triple Care Farm, p 1

⁷¹³ *ibid*, p 1

⁷¹⁴ *ibid*, p 2

⁷¹⁵ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder –Service Delivery Guidelines*, NSW Health, 2000, p 20

- 10.65** The Committee is concerned however, that the mental health policy and service review arm of NSW Health has little control over the implementation and monitoring of policy programs for mental health and drug and alcohol services. Implementation of service delivery guidelines is reliant upon the AHS. The Office of the Protective Commissioner highlighted this absence of control in its submission to the Committee:

Whilst the Centre for Mental Health offers some opportunity for state-wide overview of the strategic issues pertaining to mental health services, the provision and management of services through Area Health Services can sometimes be experienced as disjointed, if not inconsistent or absent.⁷¹⁶

- 10.66** Prof Raphael confirmed this observation when she informed the Committee that the Centre for Mental Health, the NSW Government's primary mental health policy and service development agency, has no control over the delivery of mental health services in NSW by AHS.⁷¹⁷

- 10.67** The division of responsibility exists despite the concerted efforts of NSW Health in developing interagency policies and protocols to provide continuity of care. The Office of the Protective Commissioner informed the Committee that:

While policies and protocols are in place an operational evaluation is required at the practice level of the NSW Health [system]...

While some interagency protocols have existed in the past it has been the experience of the OPC that its frontline staff are unaware of the existence of these protocols.⁷¹⁸

- 10.68** Based on the evidence received by the Committee, the health care system for people with MISA lacks integration. Clearly, there are gaps between policy development and implementation. The initiatives outlined in the *Service Delivery Guidelines* provided a foundation for bridging gaps in the delivery of mental health and drug and alcohol services. Nine years after the Burdekin Report highlighted the gaps in service provision for people with MISA, the 'links', 'collaborations' and skill sharing required to address this issue are still largely absent.

- 10.69** The Gethsemane Community reinforced this view:

The Mental Health system and the Drug and Alcohol system often work against each other. There is a desperate need for a combined approach to the treatment of people with both conditions⁷¹⁹.

- 10.70** Prof Webster succinctly outlined the fundamental change required in delivery of services to people with MISA:

The old idea of sequential treatment – get them off the drugs first, or treat their madness before we start rehabilitation – should go out the window.⁷²⁰

⁷¹⁶ Submission 219, The Office of the Protective Commissioner, p 9

⁷¹⁷ B Raphael, Evidence, 12 August 2002, p 18

⁷¹⁸ Submission 219, The Office of the Protective Commissioner, p 9

⁷¹⁹ Submission 75, Gethsemane Community, p 1

Re-integrating mental health and drug and alcohol services

- 10.71** The *International Mid-Term Review of the Second National Mental Health Plan for Australia* reported that the ‘way forward’ for MISA was to eliminate the barriers between mental health and substance use agencies, leading towards full integration of these two health services.⁷²¹ This approach was supported by Prof Webster:

Mental health promotion and prevention must be linked with a comprehensive approach to prevention that will deal with underlying causes and by virtue of this approach deal concurrently with risks for substance use disorders...⁷²²

- 10.72** The Western Australian Health Department recognised the lack of continuity of care between mental health and drug and alcohol services, and subsequently established the Joint Services Development Unit (JSDU). The JSDU was an initiative of the mental health division that aimed to combine the delivery of mental health and drug and alcohol services. Staffed by workers experienced in both mental health and drug and alcohol, the JSDU offers its services to both mental health and drug and alcohol services, including the provision of treatment, education and training services. In relation to this initiative the *International Mid-Term Review of the Second National Mental Health Plan for Australia* stated that:

WA considers that this is a necessary step to offer better integrated services for the dually diagnosed at the operational level, since they estimate that about 70% of specialist mental health service consumers also have substance use problems.⁷²³

- 10.73** The Committee acknowledges the achievements of the Drug Summit in NSW, and the subsequent establishment of the Office of Drug Policy within the Cabinet Office. While not recommending a change in this policy initiative, the Committee considers that an adequate component of the NSW drug and alcohol budget should be allocated to the Centre for Mental Health in order to reintroduce an integrated service program for people with a mental illness and a substance use disorder.
- 10.74** The process in NSW would be one of reintegration. As the NSW Health *Discussion Paper* noted, mental health and drug and alcohol services were not always segregated in NSW:

It should be noted however that these services were once part of an integrated service framework dealing with both types of disorders in one organisational system.⁷²⁴

⁷²⁰ Submission 193, Prof Webster, p11

⁷²¹ Prof V T Betts, Prof G Thornicroft, *International Mid-Term Review of the Second National Mental Health Plan for Australia*, November 2001, Commonwealth Department of Health and Ageing, 2002, p 7

⁷²² Submission 193, Prof Ian Webster, p14

⁷²³ Prof V T Betts, Prof G Thornicroft, *International Mid-Term Review of the Second national Mental Health Plan for Australia*, November 2001, Commonwealth Department of Health and Ageing, 2002, p 18

⁷²⁴ NSW Health, *The Management of People with a co-existing Mental Health and Substance Use Disorder –Discussion Paper*, NSW Health, 2000, p 10

- 10.75** The Committee supports the integration of service provision under the one organisation.⁷²⁵ This proposal is supported in-principle by a number of submissions to the Committee, including the Mental Health Association,⁷²⁶ the Gethsemane Community,⁷²⁷ the Office of the Protective Commissioner,⁷²⁸ and Prof Ian Webster,⁷²⁹ to name but a few.

Recommendation 68

That the Minister for Health provide additional funding to the Centre for Mental Health for the purposes of reintroducing an integrated service program for people with a mental illness and substance use disorder.

Recommendation 69

That the Centre for Mental Health develop and conduct a training program for drug and alcohol workers designed to increase the awareness and knowledge of mental illnesses and mental health practices.

⁷²⁵ *ibid*, p 20

⁷²⁶ Submission 171, Mental Health Association NSW, p 19

⁷²⁷ Submission 75, Gethsemane Community, p 1

⁷²⁸ Submission 219, The Office of the Protective Commissioner, p 1011

⁷²⁹ Submission 193, Prof Ian Webster, p 11

Chapter 11 Mental illness and intellectual disability (dual diagnosis)

There appears to be no single point of entry for a person to services provided by NSW Health should that person have complex needs. The person may be required to apply to a number of different health services as the one time if they have complex needs and is usually required to meet the different entry criteria to obtain a service. This often results in the person not receiving the necessary and timely treatment they require.⁷³⁰

[The Office of the Public Guardian]

People with a mental illness and an intellectual disability or acquired brain injury are often referred to as having a 'dual diagnosis'. Approximately 36% of Australian adults with intellectual disabilities can be expected to have major mental health problems, which translates to approximately 0.6% of the Australian population.⁷³¹ There are estimated to be 180,000 people in NSW with an intellectual disability.⁷³² This means that approximately 64,800 people in NSW with intellectual disabilities also have mental health problems.

The Committee acknowledges that people with a mental illness experience higher rates of physical and intellectual disability than the general population.⁷³³ The evidence before the Committee regarding disability and mental health focused almost exclusively on intellectual disability.

Access to services

Barriers faced by people with a dual diagnosis

- 11.1** One of the major recommendations of the Richmond Report was to move the 'developmentally disabled' out of mental health services.⁷³⁴ The NSW Government adopted this recommendation soon after the report was published.⁷³⁵ While it is clear that mainstream psychiatric models of intervention are unsuitable for people with intellectual disabilities, the strict division of mental health and disability services is not providing people with dual diagnosis with adequate care.
- 11.2** The NSW Council for Intellectual Disability (NSW CID) provided an overview of the major problems faced by people with a dual diagnosis in accessing services:

A person with an intellectual disability cannot get their mental health needs addressed adequately from the Mental Health sector as they do not have the

⁷³⁰ Submission 255, The Office of the Public Guardian, pp 5-6

⁷³¹ Submission 102, Special Interest Group in Intellectual Disability of the RANZCP, p 2

⁷³² H O'Connell, Executive Officer, NSW Council for Intellectual Disability, Evidence, 28 May 2002, p 16

⁷³³ R Coghlan, D Lawrence, C Holman, A Jablensky (2001), *Duty to Care: Physical Illness in People with Mental Illness*, The University of Western Australia, Perth

⁷³⁴ D. T. Richmond (1983), *Inquiry Into Health Services for the Psychiatrically Ill and Developmentally Disabled*, Part I, p 5

⁷³⁵ Submission 78, UnitingCare NSW, p 8

resources, understanding or expertise to accommodate for the 'intellectual disability'. Similarly the disability sector does not have the resources, understanding and expertise to address their mental health needs. The person therefore experiences falling through a very large 'gap'.⁷³⁶

11.3 Various submissions received by the Committee, including from the Disability Council of NSW⁷³⁷ and UnitingCare,⁷³⁸ identify specific problems with access to services by people with a dual diagnosis. These difficulties are also illustrated in the submission from a group of representatives of government and non-government service providers in the Maitland and Lower Hunter areas, in conjunction with Maitland City Council. Although the submission identified a number of difficulties experienced in the Maitland Local Government Area,⁷³⁹ most of these issues are general concerns that apply to other health service areas:

- waiting times for government services – insufficient staff at the Maitland Hospital Mental Health Unit
- cost of private providers is usually prohibitive
- bulk billing by a psychiatrist (if available) is rare and early intervention is typically on a fee for service basis⁷⁴⁰
- insufficient community residential units available
- limited non-government services and considerable reliance on community organisations to provide support with insufficient resources
- no crisis unit operating in the Maitland Local Government Area
- the mental health unit at Maitland Hospital is not a 24 hour service⁷⁴¹ and
- limited access to mental health services for people with physical disabilities or mobility problems as many mental health services are not physically accessible.⁷⁴²

11.4 The Public Guardian, the legal substitute decision-maker for approximately 1,680 people with disabilities (including intellectual disabilities) in NSW, commented:

There appears to be no single point of entry for a person to services provided by NSW Health should that person have complex needs. The person may be required to apply to a number of different health services at the one time if they have complex needs and is usually required to meet the different entry criteria to obtain

⁷³⁶ Submission 227, Disability Council of NSW, p 4

⁷³⁷ Submission 277, People with Disabilities (NSW)

⁷³⁸ Submission 78, UnitingCare, p 8

⁷³⁹ Submission 93, The MaiWel Group, pp 5-6

⁷⁴⁰ see also Submission 179, Disability Council of NSW, p 3

⁷⁴¹ Submission 93, Maitland City Council; submission 179, MaiWel Group, pp 5-6

⁷⁴² see also Submission 179, Disability Council of NSW, p 4

a service. This often results in the person not receiving the necessary and timely treatment they require.⁷⁴³

- 11.5** UnitingCare's submission highlighted the problems in gaining services for its clients with intellectual disability and psychiatric disability within its Supported Living service:

Despite the existence of a specific diagnosis (usually schizophrenia, in the case of Supported Living service users), there is frequently no success in calling on community-based mental health services, such as Crisis Teams, if there is some fear that the service user is experiencing mental health problems. At this point of contact, workers at Supported Living are informed that the person has a 'primary intellectual disability' (implying a 'secondary mental illness') and that they, as a disability service, are the most appropriate agency to deal with the problem. The response is more about funding and resources than it is about the best mode of support for the individual.⁷⁴⁴

- 11.6** UnitingCare's account of the lack of cooperation and coordination between mental health and disability services at the local level is a reflection of a lack of overarching interagency guidelines and policy.

Shortages of skilled mental health professionals

- 11.7** A number of submissions to the Committee have expressed a concern that psychiatric disorders can go undiagnosed in intellectually disabled people.⁷⁴⁵ Reasons cited for the failure to accurately assess a dual diagnosis include:

- people with an intellectual disability may not be able to articulate their feelings or symptoms⁷⁴⁶
- caregivers may not recognise a problem where emotional or behavioural changes may be attributed to the intellectual disability rather than a psychiatric disturbance
- a lack of accepted diagnostic criteria for assessing people with intellectual disabilities and psychiatric illnesses
- signs and symptoms of psychiatric illness may present as a mix of new behaviours and an increase in severity of pre-existing challenging behaviours⁷⁴⁷
- incorrect diagnoses are made due to a lack of training and
- a shortage of specialist staff.

⁷⁴³ Submission 255, The Office of the Public Guardian, pp 5-6

⁷⁴⁴ Submission 78, UnitingCare NSW, pp 20-21

⁷⁴⁵ For example, Submission 97, Life Activities, p 2

⁷⁴⁶ H O'Connell, Evidence, 28 May 2002, p 14

⁷⁴⁷ Submission 97, Life Activities, pp 2-5

11.8 The NSW CID and People with Disability NSW (PWD NSW) stated that there is an insufficient number of mental health practitioners with specialist skills or accreditation for treating intellectually disabled people. Those with complex circumstances such as epilepsy or acquired brain injury may take several hours to assess, yet due to demand, intense time restrictions are placed on professionals.⁷⁴⁸ It was argued that because of an insufficient emphasis in tertiary education concerning intellectual disability and mental illness, there is a general lack of awareness among health professionals that a person may have a dual diagnosis.⁷⁴⁹

11.9 Ms Helena O'Connell, Executive Officer of NSW CID explained that the area of dual diagnosis has only recently been recognised, and that it needed a 'lot more research':

In the past, there was an assumption that a person was acting out, or had what was called a challenging behaviour. This was often considered to be part of their intellectual disability. But more recently there is an understanding about the extremes of challenging behaviour or extreme difficulties in challenging behaviour. This is now described as a psychiatric disability or mental illness. Because of that, there is quite a clear lack of expertise in both fields, across disability and the health field.⁷⁵⁰

11.10 Where an intellectually disabled person encounters the mental health system, health professionals need to possess greater understanding of dual diagnosis to appropriately diagnose, treat and support the condition and needs of people with dual diagnosis.⁷⁵¹ Associate Professor Stewart Einfeld, School of Psychiatry, University of NSW, estimated the number of psychiatrists required to provide an appropriate level for service of people with a dual diagnosis:

The number of persons in Australia with intellectual disability is estimated as 1.5% of 18 million = 270,000, and 36% have a psychiatric disorder, then the number of persons with both intellectual disability and psychiatric disorder is 36% of 270,000 = 97,200. If one psychiatrist is required to serve 1,800 patients, then the number of psychiatrists required is 97,000 divided by 1,800 = 54.

This estimate rests on a number of assumptions, namely: a conservative estimate of the prevalence of intellectual disability; a conservative estimate of the proportion of this group with severe mental disorder; an assumption that the required amount of input from psychiatrists is equivalent to that for the community of psychiatric patients as a whole. The complexities of presentations might suggest a greater requirement for psychiatrists' time.

These individuals and families not only need more psychiatric care but also more assistance from psychologists, nurses and other therapists.⁷⁵²

11.11 The attitudes of service providers remain shaped by a medical model of care and a lack of knowledge of mental illness and psychiatric disability.⁷⁵³ The Mental Health Association

⁷⁴⁸ Submission 227, People with Disabilities (NSW), p 7, Submission 62, NSW Council for Intellectual Disability, pp 2, 3

⁷⁴⁹ Submission 62, NSW Council for Intellectual Disability, p 3

⁷⁵⁰ H O'Connell, Evidence, 28 May 2002, p 14

⁷⁵¹ Submission 227, People with Disabilities (NSW), p 7

⁷⁵² Submission 102, Special Interest Group in Intellectual Disability of the RANZCP, p 3

NSW (MHA) expressed concern that the “artificial separation of physiological and psychological illness leads to poor services”. The MHA suggested that when a person is admitted to a public hospital, they should be assessed on both levels. Consequently, nursing staff, especially triaging and medical officers would need appropriate training.⁷⁵⁴

- 11.12** Failure to accurately diagnose people with a dual diagnosis, as a result of insufficient training or availability of health professionals, presents a serious gap that must be resolved.

Division of mental health and disability service responsibilities

- 11.13** Ms Helena O’Connell, informed the Committee that health or disability services assessing a person with a dual diagnosis attempt to establish a ‘primary diagnosis’. This primary diagnosis categorises a person to determine who the service provider will be. If the primary diagnosis is of intellectual disability, then the person is deemed the responsibility of the disability sector, but if the primary diagnosis is of a mental health problem, the referral will be to mental health services. Ms O’Connell commented that this kind of “siloing of disability or diagnosis is not helpful to the person”.⁷⁵⁵ People with a dual diagnosis may require concurrent services if they are to receive effective treatment and support. This is difficult to coordinate under present service delivery guidelines. The NSW Public Guardian commented:

Strict service eligibility criteria often mean a person with ambiguous, unclear or disputed diagnosis does not receive the intervention and support they require.⁷⁵⁶

- 11.14** The Guardianship Tribunal, Disability Council of NSW and PWD NSW highlighted the problems that arise from the lack of linkages between government disability services and mental health services.⁷⁵⁷ The submission from PWD NSW stated:

Demarcation between government agencies such as the Department of Ageing, Disability and Home Care (DADHC) and NSW Health, and eligibility criteria for client intake means that people with dual diagnosis are constantly referred on to another agency, often not finding anyone to assume responsibility.⁷⁵⁸

- 11.15** The Office of the Protective Commissioner stated that service providers appear to devote time to debating primary diagnoses in an attempt to refer the person to another service provider.⁷⁵⁹ Further, it was stated that:

Rather than being provided with a service which meets their individual needs these people often end up receiving no service whatsoever as the presentation of

⁷⁵³ Submission 179, Disability Council of NSW, p 3

⁷⁵⁴ Submission 171, Mental Health Association NSW, p13

⁷⁵⁵ H O’Connell, Evidence, 28 May 2002, p 22

⁷⁵⁶ Submission 255, The Office of the Public Guardian NSW, p 3

⁷⁵⁷ Submission 106, The Guardianship Tribunal NSW, p 2; Submission 179, Disability Council of NSW, p 4; Submission 227, People with Disabilities (NSW), p 7

⁷⁵⁸ Submission 227, People with Disabilities (NSW), p 7

⁷⁵⁹ Submission 219, Office of the Protective Commissioner, p 5

their disabilities is such that no service provider on their own feels resourced to support them appropriately, or the service defines them out of service eligibility.⁷⁶⁰

- 11.16** The Committee was particularly concerned about the suggestion that some services would refuse to accept a person due to a division of responsibility. The Macarthur Disability Network reported:

All too often members of Macarthur Disability Network have observed that mental health services and the Department of Community Services squabble over whose responsibility it is to provide a service to these individuals and their families.

Also disability services who suspect that a service user has a mental illness have not had referrals accepted by the mental health service. The reason given is that the intellectual disability is the dominant disability so therefore not within the mental health service target group.⁷⁶¹

- 11.17** NSW Police stated that police frequently seek to admit people with complex needs for assessment in mental health facilities, but:

Quite often, hospitals will advise that the mental illness is not the primary disability and it is not their responsibility.⁷⁶²

- 11.18** UnitingCare commented that it was only when its clients required hospitalisation “that mental health services are forced to become involved”. The submission commented on this practice:

Members of the community who experience mental illness for the first time, or at infrequent times, do not and should not expect to be hospitalised before their condition is taken seriously. The range of clinical supports available in the community is designed to intervene before admission to hospital is necessary, and to prevent admission wherever possible.

...To deny this sort of support to people with intellectual disability, because of their disability, is unacceptable discrimination.⁷⁶³

- 11.19** The NSW Nurses’ Association commented on the invisibility of people with dual diagnosis living in the community generally:

People with dual diagnosis or multiple and chronic disabilities...are disadvantaged and not receiving adequate service in the community. People in boarding houses, homeless people, people with mental illness and/or an intellectual disability are often left without any intervention at all from health professionals.⁷⁶⁴

⁷⁶⁰ Submission 219, Office of the Protective Commissioner, p 11

⁷⁶¹ Submission 99, Macarthur Disability Network, p 5

⁷⁶² Submission 286, NSW Police Service, p 17

⁷⁶³ Submission 78, UnitingCare NSW.ACT, p 21

⁷⁶⁴ Submission 212, NSW Nurses’ Association, p 5

- 11.20** Debate about the hierarchy of diagnoses and the consequent demarcation of care services obviously does not benefit consumers or carers. Clearly, a shared responsibility for treatment and care is required to overcome the barriers to services currently encountered by people with a dual diagnosis.

Coordination of services

- 11.21** During the inquiry, various models were proposed for acute care and ongoing management for people with a dual diagnosis. These included “crisis response teams” through to “respite assessment facilities”⁷⁶⁵ and case management. Case management was addressed in Chapter 4 of this report and an assertive approach is proposed to minimise the requirement for crisis management.
- 11.22** Case managers in the NSW Department of Ageing, Disability and Home Care (DADHC) may not identify important issues regarding a person’s wellbeing due to inexperience and lack of training in mental health. The NSW CID suggested that case managers from the mental health sector may resolve part of this problem by taking on some of the caseload of people with intellectual disability.⁷⁶⁶
- 11.23** The NSW CID recommended that Service Agreements like that between the Bankstown office of DADHC and the Bankstown Mental Health Service (South Western Sydney Area Health Service), be expanded throughout NSW. This Agreement requires bi-monthly meetings of interdisciplinary staff members to discuss individual problems or concerns and potential ways to address these issues. The NSW CID stated:
- The ‘system’ has proved to be a positive way of achieving best service practice to enhance the quality of life for the client with a dual diagnosis and both mental health and disability teams have indicated that this works for them. By having this formal means of exchanging information and recommendations, there is a more effective way of documenting the needs of each individual and to monitor progress and outcomes. It is also a preventative measure to minimise the need for ‘crisis care’ in the future.⁷⁶⁷
- 11.24** PWD NSW welcomed the initiatives taken by these agencies to integrate their services, but was concerned that these initiatives are often ad hoc and “not driven by a coordinated whole of government agreement and strategic direction”.⁷⁶⁸ Ms Helena O’Connell emphasised that protocols for cooperation between departments “need to start from the top”.⁷⁶⁹
- 11.25** The NSW CID expressed concern that people with intellectual disabilities only encounter the mental health sector in times of crisis and that there are limited resources dedicated to mental health management. To address the issue, the NSW CID suggested that, where intellectually disabled people move from residence in institutions to the community, the

⁷⁶⁵ Submission 97 (Supplementary), Life Activities

⁷⁶⁶ Submission 62, NSW Council for Intellectual Disability, p 4

⁷⁶⁷ *ibid*

⁷⁶⁸ Submission 227, People with Disabilities (NSW), p 10

⁷⁶⁹ H O’Connell, Evidence, 28 May 2002, p 22

disability sector should establish a support, liaison and monitoring system to ensure individuals are:

provided with information and direction on how to best utilise the mental health facilities in their new area. They should be supported to make and keep these community connections. It should be the responsibility of the mental health sector to provide external support if the person needs them.⁷⁷⁰

- 11.26** The Public Guardian emphasised that while interdepartmental protocols can be an effective way of facilitating coordinated service responses to people with a range of needs, these protocols need to be communicated to all staff:

the Public Guardian's experience is that some staff of the respective agencies may lack an awareness of the existence of a protocol and hence not be aware of the service obligations identified in the protocol. This has particularly been the case with the protocol relating to service needs of people with a dual diagnosis of developmental disability and mental illness.⁷⁷¹

- 11.27** The Centre for Health Service Development suggested further discussions between the Commonwealth and NSW Governments regarding sustainable models of care for people with disabilities:

People with intellectual disabilities are still in psychiatric hospitals like Bloomfield at Orange, or in boarding houses and in residential aged care. This is a reflection of the failure of the Commonwealth State Disability Agreement [CSDA] to deliver a sustainable model of care for people with disabilities. While there has been some reform of disability administration, and some progress at the hard end in boarding houses, there are still unresolved issues around need that should be tied into the CSDA negotiations.⁷⁷²

Family and carer issues

- 11.28** The NSW CID submission stated that often there is no monitoring regime for prescribed medication such as anti-psychotic or anti-convulsive drugs. Families and carers are expected to administer the drugs without a proper understanding of potential short-term side effects (such as challenging behaviours) or long-term side effects (such as physical reactions).⁷⁷³ PWD NSW indicated that it was aware of situations where people with a dual diagnosis were:

inappropriately medicated because it was assumed that their 'challenging behaviour' was part of their mental illness.⁷⁷⁴

⁷⁷⁰ Submission 62, NSW Council for Intellectual Disability, p 5

⁷⁷¹ Submission 255, The Office of the Public Guardian NSW, p 5

⁷⁷² Submission 268, Centre for Health Service Development, p 8

⁷⁷³ Submission 62, NSW Council for Intellectual Disability, p 3

⁷⁷⁴ Submission 227, People with Disabilities (NSW), p 7

- 11.29** The Macarthur Disability Network raised concerns that health workers see families and individuals moving into crisis through lack of support and, in some cases, family members develop mental problems through attempting to manage the burden of caring for a person with a dual diagnosis.⁷⁷⁵ The phenomenon of carer burnout when a family member has complex disabilities is well documented in the report of the NSW Legislative Council, Standing Committee on Social Issues, *A Matter of Priority: Report on Disability Services - Second Report*. As Chapter 3 of that report recommends, carers need more information to assist them in caring duties. They also need to be able to alert services to ‘warning signs’ of crises in the people for whom they care.⁷⁷⁶
- 11.30** It is suggested that community participation initiatives that include consumers, families and carers would help to empower carers and consumers to have a better say in the services they use or encounter, and develop confidence in those services.

Criminal justice

- 11.31** A number of submissions raised concerns regarding the number of people with a dual diagnosis that encounter the criminal justice system.⁷⁷⁷ As Chapter 14 considers mental illness, prisons and police, this section will briefly deal with specific dual diagnosis issues.
- 11.32** PWD NSW expressed concern that:
- Without adequate housing and supported accommodation options, community care, legal protection and advocacy and coordinated diversionary programs, people with a mental illness are more likely to re-offend or to some degree remain in contact with the criminal justice system.⁷⁷⁸
- 11.33** NSW Police stated that on many occasions when police take people to mental health facilities for assessment, they are diagnosed as not having a mental illness and are released, only for the police to be called again:
- Generally, such people either have a dual diagnosis (eg mental illness and intellectual disability), intellectual disability or a behavioural disorder and links are not made to other appropriate services for assessment of the condition and case management, eg disability services or drug and alcohol services... This results in police resources continually being called to incidents involving the same person. Many of these incidents involve behaviours that present significant risks to the person and the community but police have little recourse to take action.⁷⁷⁹
- 11.34** NSW Police commented that while progress had been made with interagency partnerships at the local level, there are still issues to be resolved at corporate level, including:

⁷⁷⁵ Submission 99, Macarthur Disability Network, p 5

⁷⁷⁶ NSW Legislative Council, Standing Committee on Social Issues, *A Matter of Priority: Report on Disability Services - Second Report*, December 2000, pp 55-57

⁷⁷⁷ Submission 227, People with Disabilities (NSW), p 8; Submission 62, NSW Council for Intellectual Disability, p 6

⁷⁷⁸ Submission 227, People with Disabilities (NSW), p 8

⁷⁷⁹ Submission 286, NSW Police Service, p 4

exchange of information from disability and health services to police, containment of persons who are at risk to the community or themselves and/or at risk of continually committing offences.⁷⁸⁰

11.35 The Committee notes that the Intellectual Disability Rights Service and NSW CID have produced a *Framework Report*, which addresses the overrepresentation of those with an intellectual disability in the criminal justice system. The report makes 117 recommendations focusing on the development of a framework for provision of appropriate community services for people with intellectual disabilities who are in contact or at risk of contact with the criminal or juvenile justice system. The project behind the report focused on accommodation, case management, behaviour intervention and related services.⁷⁸¹

11.36 The recommendations in the *Framework Report* should be utilised to develop appropriate accommodation options, community care, legal protection and effective diversionary programs. As stated by the NSW CID:

By providing intervention and ongoing support as a preventative measure, there may be a reduced rate of contact between people with dual diagnosis and the criminal justice system.⁷⁸²

11.37 Further discussion of people with dual diagnosis in the NSW prison system can be found in Chapter 14 of this report.

Conclusion

11.38 The Disability Council of NSW indicated that mental health services have improved since the implementation of the Richmond Report, but there are significant improvements still required, particularly with respect to consumer capacity to influence the type of services received.⁷⁸³

11.39 It is anticipated that future trends such as continuing deinstitutionalisation and increasing age expectancy will create a greater demand for mental health services for people with a dual diagnosis.⁷⁸⁴ In its submission to the Committee, PWD NSW made the following comment with respect to the levels and methods of funding for mental health services:

It is clear that the level of funding in NSW is seriously inadequate and does not reflect the diversity of needs or situations of people with a mental illness or psychiatric disability.⁷⁸⁵

⁷⁸⁰ *ibid*, p 18

⁷⁸¹ Intellectual Disability Rights Service, *The Framework Report - Appropriate community services in NSW for offenders with intellectual disabilities and those at risk of offending*, July 2001. www.idrs.org.au/idrs/resources/resources.htm (accessed 16 October 2002)

⁷⁸² Submission 62, NSW Council for Intellectual Disability, p 6

⁷⁸³ Submission 179, Disability Council of NSW, p 2

⁷⁸⁴ Submission 102, Special Interest Group in Intellectual Disability of the RANZCP, p 3

⁷⁸⁵ Submission 227, People with Disabilities (NSW), p 9

Recommendation 70

That NSW Health and the NSW Department of Ageing, Disability and Home Care collaborate to develop policies and structures to enable intellectually and physically disabled people with mental health needs, to access appropriate mental health services, particularly where residents in institutions move into the community. This would include:

- inter-departmental 'Service Agreements' across NSW that require regular meetings between area mental health and disability teams to facilitate a collaborative approach to exchange of information and recommendations
- initiating a professional development program for disability and mental health sector professionals to better understand dual diagnosis and protocols and procedures necessary to provide appropriate services to people with dual diagnosis.

Recommendation 71

That the Minister for Health include a module on intellectual disability, for inclusion in the proposal suggested at Recommendation 17, regarding national undergraduate nursing courses.

Recommendation 72

That NSW Health liaise with general practitioner and specialist representatives to develop and implement a continuing medical education program designed to improve the knowledge and understanding of intellectual disability and dual diagnosis.

Recommendation 73

That the Centre for Mental Health support and promote further research into the identification and diagnosis of intellectually disabled people with mental health needs, with a view to:

- reviewing current intake and support protocols for mental health services
 - to promote interagency cooperation, including non-government service providers
 - providing consistent quantitative and qualitative information which can be used to develop more effective service provision and evaluate treatment outcomes.
-

Recommendation 74

That NSW Health and the NSW Police Service revise section 11.5 of the *Memorandum of Understanding between NSW Police and NSW Health* to:

- recognise dual diagnosis (mental illness/intellectual disability) as separate but frequently overlapping special needs groups
- require that local dual diagnosis protocols between police, mental health services, drug and alcohol services, and ageing and disability services include quarterly review meetings between local service partners.

Recommendation 75

That NSW Health, in consultation with mental health services, the NSW Police Service, and other stakeholders, develop a service protocol for people with an intellectual disability and behavioural disorder who are frequently presented to mental health facilities for assessment but not admitted.

Recommendation 76

That NSW Health consider intellectual disability within the court liaison program for people with suspected or confirmed intellectual disability and mental illness.

Chapter 12 Older people

Mental health is largely a State issue but if you have dementia and mental health problems, it can be no-one's issue, and that is one of the difficulties.⁷⁸⁶

[Professor Henry Brodaty, Psychiatrist]

The population and proportion of older people (over 65) is growing rapidly in NSW.⁷⁸⁷ Longer lifespan is accompanied by increased levels of disability and chronic illness, and higher demands on specialised mental health services for older people.⁷⁸⁸ The main mental health problems for older people identified in submissions were depression and dementia, although the high rate of suicide among older men was of particular concern. Three main issues concerning ageing and mental health featured in evidence presented to the inquiry:

- the effectiveness of general practitioners in detecting and treating of depression and dementia in older people
- access to Commonwealth and State funded services and
- lack of support and accommodation options for the confused and disturbed elderly

Mental health issues facing the aged

Anxiety and depression

12.1 In 1999, NSW Health conducted a survey of older people's health in NSW. Of the 9,418 older people questioned, around 75% reported feeling happy 'most of the time' in the past four weeks.⁷⁸⁹ Overall, 3% of older people stated that they felt depressed most of the time in the previous four weeks, while nearly 30% reported feeling depressed some or most of the time.⁷⁹⁰ Depression in older people has the same signs and symptoms as younger people, however in the elderly, these symptoms can be confused with the effects of other illnesses and the medicines used to treat them.⁷⁹¹

12.2 The 1997 *Survey of Mental Health and Wellbeing* in Australia showed that 4.5% of people aged 65 years or over had anxiety disorders, compared to 19.7% for the whole adult sample.⁷⁹² The NSW Aged Care Alliance Working Party (an NCOSS initiative) submitted that the survey underestimated levels of mental health problems in older people because it excluded those living in nursing homes, hostels, hotels, boarding houses and special accommodation

⁷⁸⁶ Prof H Brodaty, Psychiatrist, Evidence, 28 May 2002, p 42

⁷⁸⁷ Submission 267, NSW Health, p G 31; H Brodaty, Evidence, 28 May 2002, p 49

⁷⁸⁸ Submission 267, NSW Health, p G.31. The submission notes that the proportion of the population aged 65 and over is expected to increase from 12% in 1999 to between 24 and 27% in 2051. The proportion aged 85 and over is expected to almost quadruple from 1.3% in 1999 to around 5% in 2051.

⁷⁸⁹ NSW Health Department, *New South Wales Older People's Health Survey 1999*, (2000), p 34

⁷⁹⁰ *ibid*

⁷⁹¹ NSW Health, *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* (2001), pp 2-3

⁷⁹² Submission 160, NSW Aged Care Alliance Working Party, 'Surveys of Mental Health and Wellbeing: Critical Comments', p 3

houses, and those in hospital at the time. It is suggested that at least 40,000 elderly Australians at any one time (that is, 2% of the elderly) are in institutions and have major depression.⁷⁹³

- 12.3** The NSW Aged Care Alliance indicated that social isolation was a major precipitating factor in depression and suicide in older men:

A relatively new group called Older Men New Ideas [OMNI] is a group for older men coming together to work on strategies to assist and advance issues of older men. I had the privilege to attend their first or second conference, at which the suicide rate was being discussed in some detail, largely by older men. It was the social isolation that was seen to be amongst that group of 80 or 90 older men who were saying that was the issue that was most likely contributing....they were saying that social isolation was the issue that they thought most contributed to ill health and suicide in older men.⁷⁹⁴

- 12.4** The Alliance noted that older people tend to under-report depressive symptoms.⁷⁹⁵ Prof Henry Brodaty, Academic Department of Old Age Psychiatry, Prince of Wales Hospital, informed the Committee that, compared to younger people, depression in older people was frequently not detected.⁷⁹⁶

- 12.5** Prof Brodaty cited a 2001 study reporting that, according to Medicare data, older people are less likely to receive consultations by private psychiatrists in office practice:

compared to adults of younger ages, those aged 65 or more received one third to one quarter the number of office consultations. Even when older people do attend, their consultations are briefer. This under representation of the elderly cannot be accounted for by a lower rate of psychiatric illness. It appears to represent a discrimination against the aged either in their psychiatric illnesses being less detected, their being referred less frequently, or psychiatrists not choosing to see them as often.⁷⁹⁷

- 12.6** The Committee was advised that suicide among older men is particularly high.⁷⁹⁸ Suicide figures released by the Australian Bureau of Statistics in 1999 indicated the rate of suicide for men over 70 years was 31% higher than in 1998 (28.8 versus 22.0 per 100,000). The highest male suicide rate was in late old age (over 85 years) at 39.1 suicides per 100,000 people⁷⁹⁹. A recent article by Prof John Snowdon noted that most elderly people who committed suicide had seen their doctor only days or weeks before their death.⁸⁰⁰

⁷⁹³ Submission 160, NSW Aged Care Alliance Working Party, 'Surveys of Mental Health and Wellbeing: Critical Comments', p 4

⁷⁹⁴ C Regan, Evidence, 28 May 2002, p 57

⁷⁹⁵ Submission 160, NSW Aged Care Alliance Working Party, 'Surveys of Mental Health and Wellbeing: Critical Comments', p 4

⁷⁹⁶ H Brodaty, Evidence, 28 May 2002, p 42

⁷⁹⁷ Submission 48, Prof Henry Brodaty, p 1

⁷⁹⁸ Submission 251, Men's Health Information and Resource Centre, p 5

⁷⁹⁹ Submission 192, Council of Social Service NSW, p 16

⁸⁰⁰ J Snowdon (2001), 'Suicide in Old Age', www.ausienet.com/suiprev/occpapers (Accessed 25/11/02)

Dementia and mental illness

12.7 Dementia is a chronic or progressive syndrome in which there is disturbance of memory, thinking orientation, comprehension and other higher brain functions, which predominantly affects people over 65 years. It is caused by degenerative diseases of the brain, not mental illness, and is commonly accompanied by deterioration in emotional control, social behaviour and motivation.⁸⁰¹ Dementia is not addressed in the NSW *Mental Health Act 1990*, although NSW Health will admit persons with dementia to psychiatric beds where the main reason for referral is a mental health problem.⁸⁰²

12.8 Around 1% of 65 year olds show evidence of cognitive impairment associated with dementia, rising to 25% in people aged 85 years. The most common form of dementia is Alzheimer's disease, followed by vascular dementia and mixed dementia (a combination of the first two types).⁸⁰³ In some people, dementia may be complicated with a mental illness such as depression. NCOSS reported that:

Over 90% of people with dementia will at some stage experience mental health complications such as anxiety, depression, or episodes of psychosis.⁸⁰⁴

12.9 The Alzheimer's Association cited growing evidence that certain types of depression are linked to the onset of dementia. For this reason:

If there is not good access to diagnosis and treatment of depression in older people, many early dementias go undiagnosed. In the case of early Alzheimer's disease, treatment delayed is treatment denied.⁸⁰⁵

The role of General Practitioners in service delivery

12.10 As outlined in Chapter 3 of this report, GPs are usually the first health service encountered by people with a mental illness. Prof Brodaty however, cautioned against over-reliance on GPs in the detection and treatment of depression in older people:

general practitioners have been shown to be moderately good, at best, at detecting depression in older people and suicide risk.⁸⁰⁶

12.11 The NSW Aged Care Alliance also commented:

GPs have a very important role here but they often only treat the older person for the presenting symptoms rather than identifying and addressing any underlying mental health issues. [The Aged Care Alliance Working Party] acknowledged, however, that some GPs were providing more counselling services.⁸⁰⁷

⁸⁰¹ World Health Organisation, International Classification of Diseases 10, *Clinical Descriptions and Diagnostic Guidelines*, 1992

⁸⁰² Correspondence from NSW Health to the Committee, 4 October 2002, p 2

⁸⁰³ Department of Human Services, Victoria, *Dementia – Care and Support in Victoria 2000 and Beyond*, 2000, p 1

⁸⁰⁴ Submission 192, Council of Social Service NSW, p 15; also Submission 48, Prof Henry Brodaty, p 1

⁸⁰⁵ Submission 80, Alzheimer's Association of NSW, p 2

⁸⁰⁶ H Brodaty, Evidence, 28 May 2002, p 42

⁸⁰⁷ Submission 160, NSW Aged Care Alliance, p 3

- 12.12** A 2001 NSW Health publication, *Consensus Guidelines for the Assessment and Management of Depression in the Elderly*, provides guidance to GPs in the detection of depression in older people. The publication outlines both pharmacological and non-pharmacological treatment strategies for older people.⁸⁰⁸
- 12.13** Dr Jeffrey Rowland, President of the Australian Society for Geriatric Medicine, emphasised the need to better train GPs for screening of dementia and depression:

We...need to improve screening at the general practitioner level for cognitive deficits, for dementia and for depression so that we catch the things earlier and do not wait until it becomes a problem where presentation occurs at the time of carer stress and burden. At that point if you wait until the time when the carers are about to fall apart it is very hard to support them through it to the point where they can continue to care. The idea is that if you can catch the illness at an earlier stage and provide education and carer support where the illness is at its earlier points then you can deal with it in a much better fashion and keep people at home functioning better for longer periods of time, rather than getting to the point where people require sedation or a nursing home, which is not what we want.⁸⁰⁹

- 12.14** Dr Rowland emphasised that geriatricians, “general physicians who specialise in the care of the elderly”⁸¹⁰, served a vital function, but their role in relation to psychiatrists of old age was unclear because of the terms of the *Mental Health Act 1990*:

De facto, geriatricians have taken up a lot of dementia and delirium because psycho-geriatric services have been not as diffuse as they might be and also because, as far as I am aware, the last Mental Health Act excluded dementia as being part of mental health. This made it difficult for psychiatrists to get into the area of dementia, although there are clearly a whole group of psychiatrists who call themselves psycho-geriatricians or psychiatrists of old age who deal in this area. They find it very difficult to get funding and so on because of problems with the Mental Health Act. There is not just a problem with dementia and delirium, there are also the problems of what do you do with someone who has schizophrenia and who is now 66, or someone who has schizophrenia and who now develops dementia on top of that. Who deals with this problem? There is this constant shifting and movement to try to work out the boundaries, and this is always a problem.⁸¹¹

- 12.15** Prof Beverly Raphael, Director, Centre for Mental Health, disputed that dementia was excluded from the *Mental Health Act 1990*:

We have established a planning group for older people’s mental health and currently we are looking at a particular concern and at the broader planning group set up under the GAP initiative. The matters of concern centre around disturbed behaviour by people with dementia and the perception of the exclusion of dementia from the Mental Health Act, although that is actually not the case.⁸¹²

⁸⁰⁸ NSW Health, *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* (2001)

⁸⁰⁹ J Rowland, Evidence, 28 May 2002, p 56

⁸¹⁰ *ibid*, p 53

⁸¹¹ *ibid*, pp 53-54

⁸¹² B Raphael, Evidence, 12 August 2002, p 12

- 12.16** Early detection of depression and dementia in older people is vital to effective treatment and care. In view of the NSW Aged Care Alliance's concern that underlying mental health issues are often not addressed in GP settings, it would be helpful if the current *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* suggested diversionary or recreational activities for older people reporting symptoms of depression. Currently, to encourage social activities, the guidelines only encourage more regular visits by relatives and friends.⁸¹³

Recommendation 77

That the *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* be revised to include guidelines recommending a range of social and diversionary activities to assist with the treatment of symptoms of depression.

Recommendation 78

That NSW Health develop and implement strategies for improving referral rates of older people to psychiatrists, and that referral rates be monitored to identify whether or not more older people are referred as a result of the *Consensus Guidelines for the Assessment and Management of Depression in the Elderly*.

Access to services - State versus Commonwealth responsibilities

- 12.17** Management of health and ageing issues in NSW relies on intergovernmental cooperation with the Commonwealth. The Richmond Report commented that financial and organisational arrangement for the provision of services for care of the aged "is one of the most complex areas of all inter-government relations".⁸¹⁴ It would appear from submissions to the inquiry that this still remains the case.⁸¹⁵ Like people with intellectual disabilities and mental illness, and people with MISA and mental illness, older people with dementia and mental illness are falling between gaps in services.

- 12.18** The NCOSS submission to the Committee commented on the current system:

People experiencing the mental health consequences of dementia can fall between aged care services (largely funded by the Commonwealth government) and mental health services (funded by the NSW government). NCOSS believes that mental health services in NSW should be funded to treat the mental health consequences of dementia.⁸¹⁶

⁸¹³ NSW Health, *Consensus Guidelines for the Assessment and Management of Depression in the Elderly* (2001), p 3

⁸¹⁴ Richmond Report, Part Four, p 22

⁸¹⁵ For example, Submission 48, Prof Henry Brodaty, p 1; Submission 160, NSW Aged Care Alliance, p 2; Submission 192, Council of Social Service NSW, p 16; Submission 230, The Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age (NSW Branch), p 10

⁸¹⁶ Submission 192, Council of Social Service NSW, pp 15-16

12.19 Currently, community care of aged people in NSW is covered by the Home and Community Care (HACC) Program. This is a joint Commonwealth and State initiative that aims to support older people, younger people with disabilities, and their carers, in their homes and communities to prevent inappropriate or premature admission to long term residential care.⁸¹⁷ 60% of funding for HACC comes from the Commonwealth and 40% from the State government, for an agreed range of services.⁸¹⁸

12.20 The HACC Program covers persons with dementia and people with functional disabilities including those with mental health difficulties. People primarily with mental health problems, treatment, case management and specialist services come under state jurisdiction.⁸¹⁹

12.21 A number of submissions received by the Committee described problems caused by the division of responsibilities and funding between Commonwealth and State. In his submission, Prof Brodaty described how people in private homes and in nursing homes received different levels of care:

Dementia is complicated by behavioural and psychiatric symptoms in over 90% of cases during the course of the disease. The majority of cases are not severe and can be handled by carers, either in the family home or in a nursing home. However a significant minority are not able to be managed resulting in distress for the people with dementia, their families, other residents (if in a residential care facility) and staff. Dementia is by and large a Commonwealth issue – residential care Medicare-subsidised medical consultations; while Government mental health services are funded by the State.

People who have dementia complicated by mental health problems somehow fall between the two schools.⁸²⁰

12.22 Prof Brodaty emphasised the difficulties people suffering dementia as well as mental health problems had in accessing services:

In particular older people in nursing homes are disenfranchised. In many regions an older person with a psychiatric problem living in a private home, will be seen by community services while her counterpart living in a residential care facility will not. Yet there is ample data, including results from our own survey from a one in two sample of nursing homes in the Eastern Suburbs of Sydney, that rates of depression, psychosis and behavioural disturbances such as aggression, are very high.⁸²¹

12.23 The NSW Aged Care Alliance stated in their submission:

⁸¹⁷ Commonwealth Department of Health and Aged Care, 'The Home and Community Care (HACC) Program'. www.health.gov.au/acc/hacc/abthacc.htm

⁸¹⁸ Carers NSW (2002), 'Home and Community Care Program', Factsheet

⁸¹⁹ Commonwealth Department of Health and Aged Care, 'Aged Care Assessment Program – Operational Guidelines'. www.health.gov.au/publicat/opguides/acapog6.htm

⁸²⁰ Submission 48, Prof Henry Brodaty, p 1

⁸²¹ *ibid*

people with dementia must be able to access mental health services with appropriate resources and funding levels. Further, the relationship between residential and community aged care services must be fully clarified.⁸²²

- 12.24** The Royal College of Australian and New Zealand Psychiatrists pointed out that this lack of clarity of responsibility for dementia and related conditions was exacerbated by uneven resourcing of local areas:

The issue of the correct domain – Mental Health or Aged Care – for the management of dementia and related conditions depends on local services and expertise. However, the population model provided in the NSW Health Department's Mental Health and Clinical Care and Prevention Model does not recognise the level of involvement of Mental Health in Dementia management, either in acute care or community programmes.⁸²³

- 12.25** The Committee notes that the same issue of nursing home residents not receiving the same level of clinical attention as community members with mental health problems was raised in a previous parliamentary inquiry.⁸²⁴

Recommendation 79

That NSW Health develop systems to ensure access for older people in residential facilities to Aged Care Mental Health Teams.

Service coverage in NSW

- 12.26** The Faculty of the Psychiatry of Old Age (NSW Branch), Royal Australian and New Zealand College of Psychiatrists, advocated the need for more specialist mental health service teams for older people:

There is a need for every catchment area to have either a separate Mental Health Service for Older People (MHSOP) or a team which is dedicated to the mental health of older people within the Adult Mental Health Services. One of the key findings of [*The Review of Mental Health Service for People in NSW*] was that there were many areas of NSW that did not have services or teams dedicated to the elderly.

⁸²⁵

- 12.27** The College further argued that each MHSOP should include a multidisciplinary team comprising at least a psychogeriatrician, nursing staff, psychologist, social worker and occupational therapist.⁸²⁶

⁸²² Submission 160, NSW Aged Care Alliance, p 2

⁸²³ Submission 230, The Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age (NSW Branch), p 10

⁸²⁴ Legislative Council, Standing Committee on Social Issues, *Inquiry into Aged Care and Nursing Homes in New South Wales*, 1997

⁸²⁵ Submission 230, The Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age (NSW Branch), p 3

⁸²⁶ *ibid*

- 12.28** It also pointed to “substantial deficiencies in resources to be made up for older people’s mental health,”⁸²⁷ particularly in rural areas. Dr Jeffrey Rowland commented to the inquiry that “a lot of times we find it difficult to get the mental health teams involved if the person is over 65”.⁸²⁸

The NSW Health response

- 12.29** NSW Health noted in its submission that “there are a number of specialist mental health services for older people in some areas”, but did not state whether these services would extend to cover all areas.⁸²⁹ The submission also referred to the 1998 NSW Health document *Caring for Older People’s Mental Health: A Strategy for the Delivery of Mental Health Care for Older People in New South Wales*, which contains five key strategies:

- partnerships (such as with GPs and Aged Care Services)
- better mental health care (eg depression screening)
- promotion, prevention and early intervention (eg suicide prevention)
- specific groups of older people (eg culturally and linguistically diverse people)
- quality and effectiveness (eg outcome measurement, MH-OAT).⁸³⁰

- 12.30** By the end of 2002, *Caring for Older People’s Mental Health* will be four years old. In view of NSW Health’s acknowledgement of the increasing pressure on the health and aged care system and changes in the population profile of the aged,⁸³¹ it would appear that a new, comprehensive mental health care strategy for the aged is required from 2003 to 2008. NCOSS suggested NSW Health develop a comprehensive plan to meet the mental health needs of older people. The plan should address the level of need and the relationships between mental health services and aged care services.⁸³²

- 12.31** NSW Health advised the Committee that it is reviewing *Caring for Older People’s Mental Health* with a focus on two key outcomes:

- The forging of a collaborative approach in the planning of older people’s mental health care in the context of the Mental Health-Clinical Care and Prevention Model (MHCCP)
- Developing a planning and service delivery framework for older people with a mental illness.⁸³³

⁸²⁷ *ibid*, p 4

⁸²⁸ J Rowland, Evidence, 28 May 2002, p 54

⁸²⁹ Submission 267, NSW Health, G.32

⁸³⁰ Prof Beverley Raphael, Presentation to Members of the Select Committee on Mental Health Services, 7 March 2002, p 18

⁸³¹ Correspondence from NSW Health to Committee, 4 October 2002, p 2

⁸³² Submission 192, Council of Social Services NSW, p 16

⁸³³ Correspondence from NSW Health to Committee, 4 October 2002, pp 3-4

- 12.32** NSW Health has stated that a draft service plan is scheduled for consultation in late 2002, and that “it will form the basis of a new state policy for future strategic directions”.⁸³⁴ NSW Health also advised the Committee that it is working with the Commonwealth and DADHC to provide better care options at the service interface of mental health, aged care and disability.⁸³⁵
- 12.33** The Committee notes that a significant increase in the population aged over 65 will occur from 2012.⁸³⁶ The corresponding rise in the numbers of aged people with dementia and mental health problems requires that services be planned and funded to meet this demand.

Recommendation 80

That NSW Health ensure that its new mental health care strategy for the aged and accompanying service plan for the aged in NSW includes:

- consultations with stakeholders, funders and providers
 - defined roles and responsibilities for stakeholders, funders and providers in implementing and delivering the plan
 - regional population projections as part of service planning and infrastructure provision
 - clarification of intergovernmental responsibilities for dementia and co-existing mental health problems
 - clarification of the role of community health teams and services in relation to private or non-government organisations residential settings and
 - timelines for achievements with annual reporting requirements.
-

Care of the confused and disturbed elderly

The introduction of CADE units

- 12.34** Following the publication of the Richmond Report in 1983, the Minister for Health announced that 27 CADE (Confused and Disturbed Elderly) units would be constructed in hospitals in NSW.⁸³⁷ This was to ensure that confused and elderly people would not be placed in psychiatric hospitals. Instead, they would receive specialised treatment in general hospitals before being appropriately placed in care. This was consistent with the Richmond Report’s emphasis on ‘mainstreaming’ aged mental health services.

⁸³⁴ Correspondence from NSW Health to Committee, 4 October 2002, p 4

⁸³⁵ *ibid*, p 2

⁸³⁶ Australian Bureau of Statistics, Catalogue 3222.0, *Population Projections*, (2000), p 2

⁸³⁷ Submission 273, Prof John Snowdon, p 3

- 12.35** Nine CADE units were built in NSW hospitals before, according to the Australian Salaried Medical Officers' Federation, the "experiment was terminated midway".⁸³⁸ The nine units remain in operation and provide access to 144 state-owned beds.⁸³⁹
- 12.36** Submissions to the Committee indicated a division of opinion over the role and operations of CADE units, which are often referred to as 'psychogeriatric units'.⁸⁴⁰

Effectiveness of CADE units

- 12.37** The Committee heard various criticisms about the present operation of CADE units including that they do not appear to be part of a continuum of care, or have a clearly understood role. Prof John Snowdon remarked in his submission:

In my opinion the idea was right but the way they have been used has been wasteful of resources. For a start, I believe that 16-bed units are expensive, and that wings of 10 residents (making up 20-bed or 30-bed facilities) would have been more appropriate. But the other major problem seems to have been that the CADE units were not linked in with old age psychiatry services. People (eg those from Kenmore who went to the Queanbeyan Unit) settled well, but then stayed on, many being physically well and living many years. Some administrators believe that residential facilities should be 'homes for life'. Unfortunately, such policies mean that beds in CADE units rarely become available for use by people who would benefit from the excellent care and attitudes that are evident in these facilities.⁸⁴¹

- 12.38** Prof Brodaty discussed the need for neuro-behavioural units for the aged. He pointed out that, although CADE units were established for short to medium-term high level care, they have 'silted up':

The people who were transferred there are still there. As I understood it there were two aims. One was to close down some of the psychogeriatric wards in the large psychiatric hospitals and to facilitate the closure of those hospitals. Then as those people moved on they would become units for behaviourally disturbed people with dementia and they would stay there for a maximum of six or 12 months before they moved on into mainstream facilities. People with schizophrenia or alcohol-related brain damage are fairly stable. They have not deteriorated and they stay there for long periods of time. So they are not being moved on.⁸⁴²

- 12.39** Prof Brodaty further explained that coordinated care of people with dementia and behavioural problems could produce excellent results:

When we talk about CADE units, or special care units, it does not really recognise the organic or the physiological basis to these problems. People with these

⁸³⁸ Submission 91, Australian Salaried Medical Officers' Federation, p 4

⁸³⁹ Correspondence from NSW Health to Committee, 4 October 2002, p 3

⁸⁴⁰ Submission Alzheimer's Association; Submission 273, Prof John Snowdon; Submission 160, NSW Aged Care Alliance

⁸⁴¹ Submission 273, Prof John Snowdon, p 3

⁸⁴² H Brodaty, Evidence, 28 May 2002, p 46

behaviours can be dealt with in a better way with good behavioural management techniques, psychologists organising programs, better use of medication and a better environment. We have certainly had people who were aggressive, hitting out and dangerous. If we move them to an environment where they have room to move, where their privacy is not being impinged upon and where there are people of a similar gender and age, their behaviour settles down remarkably.⁸⁴³

- 12.40** The submission from UnitingCare gave an example of the difficulties in arranging for an aggressive person with dementia to receive a place in a psychogeriatric unit:

In one of our aged care residential facilities in Western Sydney, nursing home staff have been trying to move a resident out of the facility for 18 months without success. The resident is aggressive and has assaulted staff and trials of various antidepressants, sedatives and anticonvulsants have not been successful in controlling her behaviour. It was not until March 2002, that a specialist geriatrician documented his clinical opinion that the resident was in need of a placement permanently in a psychogeriatric unit. This opinion has assisted the facility to arrange a transfer, but it is still waiting for a vacancy. During its attempts to deal with this resident the facility found the Area Health Service less than fully cooperative.⁸⁴⁴

- 12.41** A number of submissions highlighted that nursing homes were reluctant to take on people with dementia and behavioural problems such as aggression. The NSW Aged Care Alliance stated:

While most people in CADE units do have dementia, all of them by definition are suffering from chronic psychosis or from challenging dementia-related behaviours. Many nursing homes will not admit residents of this type.⁸⁴⁵

- 12.42** The NSW Aged Care Alliance also commented:

The Select Committee is advised that many nursing homes do not accept older people with challenging behaviours and that there are often no other appropriate avenues [from CADE units] for support.⁸⁴⁶

- 12.43** NSW Health acknowledged that highly aggressive behaviour by older people has been “one of the most problematic areas” to manage for mental health and aged care services.⁸⁴⁷

- 12.44** In *Caring for Older People’s Mental Health: A Strategy for the Delivery of Mental Health Care for Older People in New South Wales* (1999), NSW Health stated that ‘special care suites’ would provide additional support to the management of older people with dementia and behavioural problems.⁸⁴⁸ NSW Health advised the Committee that it is conducting a full review of the directions and options for services for older people with mental health care

⁸⁴³ H Brodaty, Evidence, 28 May 2002, p 46

⁸⁴⁴ Submission 78, UnitingCare NSW.ACT, p 25

⁸⁴⁵ Submission 80, Alzheimer’s Association of NSW, p 3

⁸⁴⁶ Submission 160, NSW Aged Care Alliance, p 2

⁸⁴⁷ Submission 267, NSW Health, p G 33

⁸⁴⁸ NSW Health, *Caring For Older People’s Mental Health: A Strategy for the Delivery of Mental Health Services in New South Wales*, (1999), p 18

needs. As part of the review, several initiatives have been funded to examine models of care. 'Special care suites' is one of these initiatives.⁸⁴⁹ Consequently, NSW Health has not yet sufficiently addressed the need for adequate facilities for older people with dementia and behavioural or mental health problems such as aggression.

Concern over closure of CADE units

12.45 A number of submissions raised concerns that CADE units may be closed down by NSW Health. In its submission, the NSW Aged Care Alliance stated:

The Working Party found that the CADE Units were especially successful. There were particular concerns about the NSW Health proposal to close the Units despite their identified success and growing demand.⁸⁵⁰

12.46 Ms Marika Kontellis, from the Disability Council of NSW, commented:

There was some talk about de-funding [CADE] units. The Alzheimer's Association, in particular, had a loud voice and said that those units, which are legitimate, provide a very good service. If we take them away we will have nothing left. One of the messages is that we clearly have a mix of needs in our community; therefore, we need a mix of services. The CADE unit model is a good, valid model for people who are appropriately assessed as requiring that short-term support before they enter another level of care. Usually, that may be either stabilising their dementia or the mental health issue that is associated with ageing and supporting the carer to support them when they go back home or, more likely, they move into an aged care facility.⁸⁵¹

12.47 Fears over the closure of CADE units appear to stem from the lack of certainty about whether NSW Health will provide replacement psychogeriatric facilities for people needing high level care, or instead rely on the community to look after deinstitutionalised patients. The Alzheimer's Association stated:

Should the department's view prevail, that all CADE Unit residents be transferred to mainstream nursing homes 'with additional community-based psychogeriatric support', we may well expect a similar outcome to that following the Richmond Report's recommendations regarding the closure of Schedule 5 hospitals – a major lack of commitment and funding for the special needs of a small proportion of the dementia population who are not able to be cared for appropriately in mainstream nursing homes.⁸⁵²

12.48 NSW Health advised the Committee that it released a discussion paper in 2001 containing proposals for improving the interface between the aged and acute care sectors in NSW.⁸⁵³ One of the proposals was to care for older people with dementia who may have previously

⁸⁴⁹ Correspondence from NSW Health to the Committee, 4 October 2002, p 3

⁸⁵⁰ Submission 160, NSW Aged Care Alliance, p 2

⁸⁵¹ M Kontellis, Disability Council of NSW, Evidence, 28 May 2002, p 12

⁸⁵² Submission 80, Alzheimer's Association, pp 2-3

⁸⁵³ Correspondence from NSW Health to Committee, 4 October 2002, p 4

been accommodated in CADE units within Commonwealth funded aged care homes. Under this arrangement:

NSW Health and the Commonwealth could then develop a comprehensive dementia specific support system for older people with dementia in aged care.⁸⁵⁴

A three-tiered model of psychogeriatric care: Victoria

12.49 Mental health services for the aged in Victoria exist in three distinct levels that work as a 'continuum of care' throughout Victoria's regions:

- Aged Persons Mental Health Teams
- acute inpatient services and
- psychogeriatric nursing homes.

12.50 Aged Persons Mental Health Teams provide community-based assessment, treatment, rehabilitation and case management for older people. This prevents unnecessary hospitalisation and minimises the length of stay in acute inpatient facilities. The second tier, acute inpatient services, provides:

Short term inpatient management during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in a community-based setting. These services are located with other aged care facilities and/or general hospitals.⁸⁵⁵

12.51 The third tier in the Victorian system is psychogeriatric nursing homes for clients who cannot be managed in the general aged care system. They are described as:

Nursing homes in the community which specialise in caring for elderly persons with a mental illness. These psychogeriatric nursing homes are light, airy and purpose-built. Residents generally have their own room with their own bathroom. These psychogeriatric nursing homes are designed to have a familiar, homelike atmosphere, and residents can participate in cooking and other supervised activities.⁸⁵⁶

12.52 The description of psychogeriatric nursing homes in Victoria reflects strongly the principles endorsed by the Richmond Report in the provision of residential care for the confused and disturbed elderly. These included:

- A warm, stable, supportive domestic type of environment in which the dementing old person can feel at home and take part in stimulating activities. Any necessary restrictions of wandering should be as unobtrusive as possible.

⁸⁵⁴ Correspondence from NSW Health to Committee,, 4 October 2002, p 4

⁸⁵⁵ Department of Human Services, Mental Health Branch, *New Directions for Victoria's Mental Health Services: The Next Five Years*, (2002), p 47

⁸⁵⁶ Department of Human Services Victoria, Mental Health Branch, 'Aged Care Services', (2002), www.health.vic.gov.au/mentalhealth/services/aged

- Residents should be encouraged to keep old photographs or treasured possessions in their rooms.
- The environment should be kept simple and stable so that residents can become familiar with it.
- Confused and disturbed elderly people respond fairly appropriately to social interactions.⁸⁵⁷

12.53 The Royal Australian and New Zealand College of Psychiatrists suggested that NSW follow Victoria's lead in accommodating the disturbed and confused elderly:

A small population of elderly exhibit such confusion and behaviour disturbance that they cannot be adequately and safely assessed in their usual accommodation, conventional nursing homes or conventional hospital wards be they in general psychiatry or geriatric medicine or general medical departments. Richmond recognised this need. The situation remains that there is a need for appropriate purpose-built environments, within the structure of general hospitals, for managing this challenging group properly. There is also a need for the development of medium-stay environments within the nursing home system, to allow for the ongoing management of this group since the challenging behaviours are not always settled quickly. These are sometimes referred to as 'psychogeriatric nursing homes', providing an environment and expertise quite separate from the CADE Unit model, and for which some appropriate working examples are located in Victoria.⁸⁵⁸

12.54 Prof Brodaty also suggested an aged mental health care model similar to that in Victoria:

For each area of, say, 25,000 older people, there must be a psychogeriatric team which would look after people in the community, visit people in residential care, run outpatients and look after a number of beds for in-patients. That number of beds has variously been defined as five or probably 10 beds for 25,000 people. So there is a psychogeriatric team, there is an in-patient unit and there would need to be some neurobehavioural beds, CADE-unit type beds, psychogeriatric nursing home-type beds, or whatever. For about 50,000 people, there would need to be about 12 beds.⁸⁵⁹

⁸⁵⁷ Richmond Report, Part Four, p 19

⁸⁵⁸ Submission 230, The Royal Australian and New Zealand College of Psychiatrists, Faculty of Psychiatry of Old Age (NSW Branch), pp 11-12

⁸⁵⁹ H Brodaty, Evidence, 28 May 2002, p 47

Recommendation 81

That the Minister for Health collaborate with the non-government and private sectors to establish and fund the following facilities across metropolitan and regional NSW:

- purpose built high quality psychogeriatric nursing homes and
- purpose built acute care psychogeriatric units in hospitals.

The Minister for Health should seek Commonwealth funding assistance for this purpose, although establishment of facilities should not be contingent on Commonwealth funds.

Recommendation 82

That NSW Health should, when a sufficient number of psychogeriatric nursing homes and acute care psychogeriatric units are operational:

- develop individual service plans for existing Confused and Disturbed Elderly (CADE) unit residents guaranteeing ongoing treatment and accommodation
- transfer all CADE unit residents to high quality psychogeriatric facilities and then
- close or redevelop the nine CADE units currently operating in NSW.

Ageing carers of people with a mental illness

12.55 Older people face mental illnesses not only as they relate to their own state of mental health, but also as primary carers for spouses or children with mental illnesses. The Committee intends that this group of people receive appropriate recognition and care.

12.56 The NSW *Older People's Health Survey 1999* found that almost one in ten older people had primary responsibility as carer for someone who had a long-term illness, disability, or other problem. The person cared for was most commonly the spouse (73.4%), followed by a son or daughter (7.8%). The reason for care was physical illness or disability in 85.5% of cases and memory problem or intellectual disability (including dementia/Alzheimer's disease) in 19.4% of cases.⁸⁶⁰

12.57 At the Committee's public forum on 7 August 2002, Ms Janet du Buisson Perrine, representing the South West Carers' Network, highlighted the plight of older carers:

Our older carers fear for their future of their loved one when they will no longer be able to provide care and a growing number of our carers are worn out with their responsibilities.⁸⁶¹

⁸⁶⁰ NSW Health Department, *New South Wales Older People's Health Survey 1999*, (2000), p 22

⁸⁶¹ Tabled Document no 48, Janette Du Buisson Perrine, South Western Sydney Carers' Network, p 3

- 12.58** One submission from an older carer of a son with acquired brain damage and schizophrenia stated:

I show so much love and care to my son but this has a profound impact on my quality of life...There is no supported accommodation for people who are in my son's position...I have failed to obtain hostel accommodation from the aged and disabled unit...My son is aged 44 years and I am aged 70 (a widower) and like many such carers I am concerned that, as I grow old, I will not be able to care for him. What happens when I am no longer alive?⁸⁶²

- 12.59** The Society of St Vincent de Paul (Wollongong Diocesan Council) stated in its submission:

In our part of NSW, there are some quite positive examples of supported accommodation programs but all such services have no hope of meeting the demand... Many ageing parents are left as the primary or sole carers of older children with mental illness and are deeply fearful of what will happen to their children when they as parents are too frail or no longer around to act as carers.⁸⁶³

- 12.60** Mr Ted Campbell, Director of Mental Health Services at Port Macquarie Base Hospital, provided the following insights about ageing carers in his area, particularly their own needs for respite, and fears for the people they will leave behind when they die:

We do not have respite care for the carers. I have just asked my staff to give me the figures on this: currently I am aware of a number of people who have chronic and severe mental illness who are being looked after by their parents and in those cases both parents are well into their eighties. The chances are that in four or five years these young patients will be on their own, but they cannot survive. The only option that we have for them is to somehow send them to Sydney, but if we do that your own figures suggest they are going to finish up in the doss houses anyway because they do not have the coping skills to be able to manage independently.⁸⁶⁴

- 12.61** The Committee considers that ageing carers should not have to suffer anxiety relating to the welfare of their dependents.

Recommendation 83

That NSW Health conduct an awareness program for mental health professionals to:

- assess the level of care required for a person with a mental illness in conjunction with the age and physical condition of the carer
 - where necessary, refer the carer to information about alternative care and guardianship arrangements and
 - seek respite care services for people with a mental illness and their elderly carers.
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⁸⁶² Submission 146, Mr John McMahon, p 1

⁸⁶³ Submission 178, Society of St Vincent de Paul (Wollongong Diocesan Council), p 5

⁸⁶⁴ T Campbell, Director Mental Health, Port Macquarie Base Hospital, Evidence, 1 August 2002, pp 31-32

Chapter 13 Young people

My son...was diagnosed with bipolar manic depression at 23 years of age...In my experience the system has failed to provide my son with effective support and rehabilitation over the past ten years. The net effect of the past ten years of my son's life has progressively reduced it to ruins, mentally, physically and financially...He has been cast out into the community on repetitive occasions amidst his treatment, long before any effective treatment had actually taken place.⁸⁶⁵ [Ms Patricia Bayley]

Many submissions received by the Committee acknowledged the importance of protective, preventative and early intervention strategies in mental health services for people under 25 years of age. Evidence provided to the Committee suggests that the other end of the intervention spectrum – rehabilitation – has not received enough attention in NSW. A growing demand for more acute treatment services for younger people in NSW also became apparent during the inquiry.

Occurrence of mental illness in younger people

- 13.1 The child and adolescent component of the 2000 *National Survey of Mental Health in Australia* established that 14% of children and young people have mental health problems, compared to 18% of adults. This is consistent with findings in other countries.⁸⁶⁶
- 13.2 NSW Health provided projections that, in the next 10 years, the rate of all mental health disorders for 0-17 year olds will rise to 15.4%, that is, up to 236,000 young people in NSW.⁸⁶⁷ NSW Health advises that disorders are “coming on more severely and at a younger age.”⁸⁶⁸
- 13.3 The 1997 *Australian National Survey of Mental Health and Wellbeing* (NSMHW) survey found that 27% of young people aged 18-24 years had mental disorders in the twelve months prior to being surveyed. This was the highest prevalence of any age group in the survey. In the 12 months before being surveyed, 11% of young people in the NSMHW aged 18-24 years had anxiety disorders, 7% had affective disorders and 16% had substance use disorders. Only one in fifty with mental health problems had consulted specialist mental health services.⁸⁶⁹
- 13.4 In the discussion paper *Promoting the Mental Health and Wellbeing of Children and Young People*, Prof Beverley Raphael described the adolescent years as characterised by “significant biological, psychological and social change and maturation both in the individual young

⁸⁶⁵ Submission 79, Ms Patricia Bayley, p 1

⁸⁶⁶ B Raphael, *Promoting the Mental Health and Wellbeing of Children and Young People*, Discussion Paper, Commonwealth of Australia, 2000, p 8; Submission 92, NSW Faculty of Child and Adolescent Psychiatry, p 1

⁸⁶⁷ Submission 267, NSW Health, p G.8

⁸⁶⁸ *ibid*

⁸⁶⁹ NSW Health, *Getting in Early: A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW*, p 7

person and their environment.”⁸⁷⁰ For a minority of young people, it is a time of the onset of mental health problems and mental illnesses.

- 13.5** In the mid to adolescent years, depression and anxiety approach adult levels, especially in girls. Eating disorders also emerge in this time, with delinquent and conduct disorders being more established and difficult to treat or prevent.⁸⁷¹ 25% of those with manic depressive illness and bipolar disorder present before the age of 20.⁸⁷² Young people from culturally and linguistically diverse backgrounds may find themselves under the psychological pressure of being ‘caught between two worlds’, as described by Mr Abd Malak, Director of the NSW Transcultural Mental Health Centre:

Kids from different cultures sometimes live in two different worlds: one in the morning at school and one at home...in the Westmead hospital anorexia clinic 80% of the 12 beds are for people from two language groups, Arabic and Chinese, from one locality, Auburn. That is part of people’s stress. You have a very strict family but there is a different way to deal with them.⁸⁷³

- 13.6** Evidence indicates that early intervention with first onset psychosis can reduce the severity and frequency of recurrent episodes.⁸⁷⁴ The connection between psychosis in young people and the use of drugs including marijuana, hallucinogenics, stimulants and opiates was widely discussed in submissions and hearings (addressed below).
- 13.7** Prof Kenneth Nunn, Area Director, Mental Health, The Children’s Hospital at Westmead, emphasised to the Committee that the early treatment of emotional and behavioural problems in young people could still have a major impact in reducing rates of crime and mental disorders in adult life.⁸⁷⁵

Mental health services for young people

- 13.8** The *Mid-Term Review of the Second National Mental Health Plan* in 2001 identified “a lack of child and adolescent and aged mental health services in Australia as a key matter for attention”.⁸⁷⁶ The Review stated:

The numbers of qualified providers for children and youth services for the continuum of services needed from health to serious disorders is well below population needs.⁸⁷⁷

- 13.9** NSW Health has committed through policies and programs to improve services for young people, particularly in prevention programs and early intervention.⁸⁷⁸ Early intervention

⁸⁷⁰ B Raphael (2000), *Promoting the Mental Health and Wellbeing of Children and Young People*, p 22

⁸⁷¹ B Raphael, *Promoting the Mental Health and Wellbeing of Children and Young People*, 2000, p 23

⁸⁷² K Nunn, Area Director, Mental Health, The Children’s Hospital at Westmead, Evidence, 30 July 2002, p 35

⁸⁷³ A Malak, Director, Transcultural Mental Health Centre, Evidence, 31 July 2002, p 69

⁸⁷⁴ NSW Health, *Getting in Early: A framework for early intervention and prevention in mental health for young people in NSW*, 2001, p 5

⁸⁷⁵ K Nunn, Evidence, 30 July 2002, p 33

⁸⁷⁶ Submission 226, Commonwealth Department of Health and Ageing, p 7

⁸⁷⁷ V Betts and G Thornicroft, *International Mid-Term Review of the Second National Mental Health Plan For Australia*, 2001, p 7

refers to intervening at the earliest possible phase of an illness. It is recommended when there is evidence to show that the illness can be accurately diagnosed, when there is effective treatment for the illness available, and where intervening early will have a positive impact on health outcomes.⁸⁷⁹

- 13.10** NSW Health advised the Committee that it is implementing strategies to strengthen child and adolescent service networks, conducting mental health promotion and prevention programs.⁸⁸⁰ Establishing the right ‘spectrum’ of services for children and adolescents is a challenge, as the Centre for Health Service Development acknowledged in its submission:

The full spectrum of mental health interventions includes prevention, treatment and rehabilitation activities, many if not most of which are done outside the mental health system. The role of specialist mental health care is limited to what might be called the ‘pointy’ end. This part of the spectrum is made up of the treatment domain – case identification, treatments that work for known disorders, relapse prevention and support services aimed at encouraging the maintenance of change.⁸⁸¹

- 13.11** Submissions indicated however, that NSW Health initiatives in child and adolescent mental health services are just a fraction of what is required. The NSW Faculty of Child and Adolescent Psychiatry stated in its submission:

Child psychiatry services in New South Wales are currently provided by a combination of different services, including Child and Family Health Centres, specialised Child or Adolescent Mental Health Workers, and a handful of tertiary services. These services do not cover the range that is needed.⁸⁸²

- 13.12** The submission further stated:

NSW spends roughly as much as other states in adult mental health [\$95 per adult annually], but dedicates much less to the young, \$17 per child per year – a ticket to the movies and hamburger. This is half as much the amount spent by South Australia (\$31) and Victoria (\$29). Clearly, the public sector is not meeting the need, particularly in NSW. It is not surprising that half of the parents whose children have mental health problems said in the National Survey that it is too expensive to get help.⁸⁸³

- 13.13** The NSW Association of Adolescent Health submission argued that while there is a need for more ‘dedicated psychiatric beds for young people’, community support had a vital role for those with non-acute mental illness:

⁸⁷⁸ See NSW Health, *NSW Strategy: Making Mental Health Better for Children and Adolescents* (1999); NSW Health, *SchoolLink: Helping Adolescents with Depression and Related Disorders*; NSW Health, *Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales*, 2001.

⁸⁷⁹ NSW Health, *Getting in Early: A framework for the early intervention and prevention in mental health for young people in NSW*, pp 16-19

⁸⁸⁰ Submission 267, NSW Health, pp G.10–G.15

⁸⁸¹ Submission 268, Centre for Health Service Development, p 12

⁸⁸² Submission 92, NSW Faculty of Child and Adolescent Psychiatry, p 2

⁸⁸³ *ibid*

Community support services with a holistic approach to working with their client group are particularly successful with young people, who do not want to be stigmatised or categorised by their illness.⁸⁸⁴

- 13.14** The Association however, raised concerns about the way mental health services dealt with young people with non-acute illnesses:

people who do not have a 'serious mental illness', for example, young people with PTSD, severe anxiety disorders and personality disorders (that can result in suicide or severe self-harming behaviours) are often marginalised and trivialised by mental health services.⁸⁸⁵

- 13.15** The Shopfront Youth Legal Centre made a similar observation:

The New South Wales mental health system seems to be geared towards people with recognised psychotic illnesses which respond to medication. We do not suggest it is inappropriate that these people be given high priority, but we suggest that there are other people with non-psychotic illnesses who also need help.

For people...who are depressed, suicidal and in need of long-term psychotherapy, it seems that the mental health system has little to offer apart from 'band aid' measures such as a dose of medication.⁸⁸⁶

- 13.16** The Shopfront Youth Legal Centre flagged concerns that some practitioners are reluctant to 'label' young people with a certain mental health problem:

During adolescence, it can be difficult to separate mental health problems from normal behavioural changes or substance abuse. There is also reluctance by some professionals to 'label' a person at a young age. This diagnostic difficulty or reluctance is recognised by some adolescent mental health programmes, which are able to work with young people despite a lack of a clear diagnosis. However, we suggest that there is room for improvement in this area.⁸⁸⁷

- 13.17** While there is no doubt that young people require access to a full range of mental health interventions including prevention and education, submissions to the Committee emphasised that there remains a critical need for acute facilities as well as medium to long-term treatment and rehabilitation services for young people.

Access to acute services

- 13.18** Admission to hospital is reported to be the 'last resort' in the range of mental health care options for children and adolescents.⁸⁸⁸ Inpatient care is needed where young people are severely or acutely ill.⁸⁸⁹ Currently, 800 young people in NSW experience a first episode of

⁸⁸⁴ Submission 214, NSW Association for Adolescent Health, p 3

⁸⁸⁵ Submission 214, NSW Association for Adolescent Health, p 3

⁸⁸⁶ Submission 243, The Shopfront Youth Legal Centre, p 6

⁸⁸⁷ *ibid*, p 8

⁸⁸⁸ Dr J Starling, Evidence, 30 July 2002, p 7

⁸⁸⁹ Submission 267, NSW Health, p G.8

psychosis each year.⁸⁹⁰ The number of suicide attempts for young people remains high, with 1996-1997 figures for NSW showing 1,959 episodes of inpatient care for 15 to 24 year olds following suicide attempts.⁸⁹¹

Availability of beds

13.19 NSW Health informed the Committee that the following beds for children and young people will be operational in 2002-2003:

- Hunter (acute): 12 beds from existing funds
- Sydney Children's hospital (acute): 8 from new funds
- New Children's hospital (acute): 8 from new funds.⁸⁹²

13.20 Prof Beverley Raphael informed the Committee on 12 August 2002, that the beds at the Sydney Children's Hospital and the New Children's Hospital would be open by March 2003.⁸⁹³

13.21 The NSW Faculty of Child and Adolescent Psychiatry welcomed these additional beds, but stated that the required levels were still greater than the number supplied and that full staffing levels had not yet been achieved for the beds already established:

At the point of writing, to the best of our knowledge, there are two inpatient units in NSW designated for the admission of adolescents under the Mental Health Act, with eight and ten beds respectively, though six are closed because of staff shortages. There are also three services that provide beds for less acute conditions. There are no acute beds for children. All services have waiting lists.⁸⁹⁴

13.22 This lack of beds has led to the unsatisfactory situation of some children and young people with acute illness being admitted to adult units, or general wards of children's hospitals. The Faculty of Child and Adolescent Psychiatry observed:

young people with acute psychiatric conditions are often admitted to Adult Units, where their development needs are not met, and where they may be exposed to very disturbed adults, or to Paediatric Hospitals, where large amounts of sedation may be needed to keep them and other children safe. Even after they have been admitted, they may be kept in hospital longer than necessary because there are no backup services such as Crisis Teams that can provide intensive support in their own homes.⁸⁹⁵

⁸⁹⁰ ibid, p G.14

⁸⁹¹ NSW Health, *Suicide in NSW – We need to know more*, 2000, p 44

⁸⁹² Tabled document no 40, Prof Beverley Raphael, p 1

⁸⁹³ B Raphael, Evidence, 12 August 2002, p 14

⁸⁹⁴ Submission 92, NSW Faculty of Child and Adolescent Psychiatry, p 2

⁸⁹⁵ ibid

- 13.23** The Hornsby Ku-ring-gai Association, Action for Mental Health, described the following situation in their submission:

In Hornsby Ku-ring-gai we have one acute hospital service containing 25 beds. This serves for all age groups. Newly admitted younger people are co-mingled with older individuals who have been in hospital on several occasions, as well as the frail aged. For both the young people and their families this image of the potential future is disturbing and may exacerbate the psychotic episode.⁸⁹⁶

- 13.24** Prof Kenneth Nunn described the pressure on units to cope with the spiralling number of young people with drug induced psychosis:

we acknowledge that there are some—particularly older teenagers—with drug-induced psychosis who may end up being able to be managed only in existing adult facilities. Last year there were more than 300 of those. That is not good enough and, bit by bit, that number must drop.⁸⁹⁷

- 13.25** The Police Association of NSW highlighted the difficulties its members were having in scheduling young people to acute facilities in rural and regional areas:

Our members have...noticed that juvenile mental health is becoming a big problem and is in need of major attention, particularly in country areas. In many cases, juveniles whom police have attempted to schedule have been flat out refused on the basis that no accommodation was available for the person, which in turn places strain on the families.⁸⁹⁸

Continuity of care and early discharge

- 13.26** Overall, submissions to the inquiry indicated that mental health services for young people were unevenly distributed, poorly coordinated and funded and appear to be geared to deal only with situations that had reached 'crisis point'.⁸⁹⁹ Service coordination is a particular challenge. Mental Health Reconnect, a federally funded, interagency service, stated in its submission:

Other states have CAMHS, that is, Child and Adolescent Mental Health Services. However, NSW has a variety of services with a variety of names and it is therefore *extremely* difficult to find the appropriate services for one's needs.

Services are unable to respond to young people in high need quickly, [who] may have to wait six weeks, which is unacceptable when a young person's mental health status is requiring immediate intervention.⁹⁰⁰

⁸⁹⁶ Submission 108, Hornsby Ku-ring-gai Association, Action for Mental Health, p 7

⁸⁹⁷ K Nunn, Evidence, 30 July 2002, p 32. The practice of placing adolescents in adult wards was also noted by Submission 214, NSW Association for Adolescent Health, p 3; and Submission 243, The Shopfront Youth Legal Centre, p 8

⁸⁹⁸ Submission 254, Police Association of NSW, p 10

⁸⁹⁹ Submission 191, Central West Women's Health Centre, p 5

⁹⁰⁰ Submission 236, Mental Health Reconnect, p 1

13.27 Prof Nunn commented to the Committee:

I think all of us are deeply aware that the coverage is shallow, the collaboration between multiple agencies is inadequate and the fragmentation of all the different areas working towards the care of these young people needs to be bound together in a much more coherent, effective force that does not correspond with government portfolios.⁹⁰¹

13.28 Prof Nunn later acknowledged that even though paediatricians and child psychiatrists were working more closely together on complex cases, this was not common:

We have increasingly been bringing paediatricians in to work with us and we have been increasingly encouraging child psychiatrists to have medical interests and skills. We are working and co-locating everything within children's facilities and working together closely in medical teams, but that is the exception rather than the rule on a national level.⁹⁰²

13.29 Negative outcomes arising from lack of continuity in community mental health teams, the inability of hospitals to offer inpatient care when it is needed most, as well as early discharge (sometimes within 24 hours), were all highlighted in a number of submissions from families and health care professionals. In several instances the failure to obtain appropriate care was followed by drastic deterioration in health, contact with the criminal justice system, or death by suicide of the young person affected.⁹⁰³**13.30** Based on its own investigations, the Health Care Complaints Commission provided examples of young people committing suicide following early discharge from hospital, including the following:

V, an adolescent girl, had been experiencing emotional difficulties over several months. When V became suicidal, her mother sought assistance from the local hospital. She was informed that there would be appropriate assistance available to her on presentation at the Accident and Emergency Department, however, when they arrived, they had to wait many hours before being seen. After V was examined at the A and E Department, the hospital advised that it did not have a bed available for her. Despite V's mother's initial request that she be admitted, she was discharged. The mother was told that a Crisis Team would contact her at home to provide support, and to watch V 24 hours a day. The Crisis Team did not visit, and the family maintained contact with private therapists. Following her discharge from the hospital, the mother left V unsupervised for a short period. She returned to find V had killed herself.⁹⁰⁴

13.31 In other situations, early discharge has resulted in the condition worsening, leading to enormous distress for the young person's family, and repeated attempts to readmit the patient. The mother of a 24-year-old man first diagnosed with schizophrenia at the age of 17, explained that only contact with the police had resulted in her son gaining admission to

⁹⁰¹ K Nunn, Evidence, 30 July 2002, p 30

⁹⁰² K Nunn, Evidence, 30 July 2002, p 36

⁹⁰³ Submission 120, Health Care Complaints Commission; Submission 243, The Shopfront Youth Legal Centre; Submission 101, Mrs Margaret Oliver, Submission 120, Mrs Dorothy Ridley; Submission 220, Ms Diane Oakes

⁹⁰⁴ Submission 120, Health Care Complaints Commission, p 3

hospital. He was discharged after four days. Following discharge his condition deteriorated further, causing considerable anguish to the family before eventual re-admission:

I tried over and over again to get him into hospital, but did not succeed. My recollection is that the health workers kept trying to get him up to the community centre, or that the crisis team would come and then leave, or that the psychiatrist would tell him he was close to being scheduled, but did not schedule him etc etc...Finally he was causing a disturbance in a shopping centre and got arrested by Police who realised instantly (thank goodness they did) that he needed to go to hospital. He was scheduled but then discharged after four days. Within a few days he was unwell again and even worse.⁹⁰⁵

- 13.32** A submission from Mrs Margaret Oliver highlighted her family's difficulties in getting adequate inpatient or community care for their son, who suffered depression from age 15 years to his suicide at 20 years of age. He was hospitalised for six days for suicidal behaviour at 18 years of age, prescribed medication, and discharged with limited ongoing community support. In the final three weeks of his life, the local mental health service told the parents 'not to leave him alone'.⁹⁰⁶ On the day of his suicide, the young man was told he would have to wait a week to see his case manager. Mrs Oliver commented:

Our youth, or anyone who suffers mental illness, need more time in hospital and more time for therapy, not just a few visits, not just six days and a few tablets. Any medication prescribed needs to be monitored regularly, not just dispensed with a pat on the head and then the patient sent off.⁹⁰⁷

- 13.33** The mother of a young man described in her submission how he was unable to access adequate community care, deteriorated, and eventually suicided after being admitted to hospital. Ms Diane Oakes questioned the concept of 'support in the community' and highlighted the inadequacy of telephone follow-up by community health teams in the critical period following discharge.

The thought that these patients [at serious risk of death by suicide] can be successfully cared for and managed through their crisis by placing them in the community is ridiculous...Medical patients with life threatening illnesses, such as a heart attack, are not told to go home and we will ring you from time to time to check on how you are going and just hope you survive.⁹⁰⁸

- 13.34** The Shopfront Youth Legal Centre commented on the *Mental Health Act 1990* provision for 'mentally disordered persons' who, under the Act, cannot be detained in hospital for a continuous period of more than 3 days (not including weekends and public holidays):

Although people are frequently involuntary admitted to hospital after suicide attempts, there are generally admitted as 'mentally disordered' patients and are discharged after a day or two, often onto the street.

⁹⁰⁵ Submission 177, Mrs Dorothy Ridley, p 1

⁹⁰⁶ Submission 101, Mrs Margaret Oliver, p 2

⁹⁰⁷ *ibid*, p 4

⁹⁰⁸ Submission 220, Ms Diane Oakes, p 4

...We do not necessarily support an extension of the time for which a 'mentally disordered' person can be detained under the *Mental Health Act*. However, we believe there is a need for more follow-up and support in the community (after discharge from hospital or, better still, before a hospital admission becomes necessary).⁹⁰⁹

- 13.35** The practice of early discharge into the community for young people (and adults) who have just attempted suicide requires fundamental review, since the most difficult period for mental health clients is often just after their discharge from hospital. At this time the risk of suicide is up to 200 times greater than that of the general population.⁹¹⁰ To prevent suicide in this group, the 1999 NSW Suicide Prevention Strategy, *Suicide: We can all make a difference* states:

Discharge planning, community mental health interventions and improved links between hospital and community services are critical.⁹¹¹

- 13.36** In view of the higher risk of suicidal behaviour in young people, one of the resulting aims of the Strategy is:

To strengthen prevention, early intervention and management of those at high risk of suicide by child and adolescent mental health services.⁹¹²

- 13.37** Evidence received by the Committee strongly indicates that discharge planning, and liaison between community mental health teams and hospitals for young people who have attempted suicide is, at best, fragmented in NSW. This is because many area health services do not have specialised child and adolescent mental health teams, there are limitations on the extent to which community services can take on the responsibility of follow up care and hospitals do not have named responsibilities for follow-up care under the *Mental Health Act 1990*. Instructing parents to 'watch' their children 24 hours a day, as cited in the submissions above, is a clearly inadequate response to supervision for young people deemed at high risk of suicide.

Recommendation 84

That NSW Health urgently establish and recruit staff for child and adolescent acute units in each major region of NSW, with bed numbers based on a population distribution formula.

Recommendation 85

That the Minister for Health immediately implement procedures to eliminate or minimise the incidence of adolescents being placed in adult psychiatric wards.

⁹⁰⁹ Submission 243, The Shopfront Youth Legal Centre, pp 6-7

⁹¹⁰ NSW Health, *Suicide: We can all make a difference*, p 26

⁹¹¹ NSW Health, *Suicide: We can all make a difference*, p 26

⁹¹² *ibid*

Recommendation 86

That the Minister for Health direct that, where no psychiatric facilities are available for young people in a hospital, specialist staff should be assigned to adolescent beds in paediatric wards for the duration of all adolescent admissions.

Recommendation 87

That the Minister for Health, in relation to people who have attempted suicide and been admitted to hospital as mentally disordered:

- propose the *Mental Health Act 1990* be amended to require a post-discharge assessment appointment
- the appointment be allocated and the patient informed of the appointment and
- the assessment be conducted within 5 days of discharge.

Recommendation 88

That NSW Health ensure that discharge plans are created for all young people admitted to an acute care facility to ensure continuous post-discharge care. The discharge plan must include an appointed case manager.

What happens after early intervention?

13.38 In 2001, NSW Health produced *Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales*. The document promotes collaboration between mental health services and schools, general practice and youth, community health and juvenile justice services 'to ensure that mental health problems in young people are prevented, identified early and that appropriate mental health care is provided'.⁹¹³ In order to do this, Area Mental Health Services are required to 'prepare Area or sector plans to progress initiatives for first onset psychosis and depression and related disorders'.⁹¹⁴

13.39 NSW Health has established a number of early intervention programs with first onset psychosis for young people such as the YPPI (Young People and Early Psychosis Intervention) Project on the Central Coast. Coverage across the State for young people with first onset psychosis is however, far from complete. The NSW Association for Adolescent Health commented in its submission:

The Association has concerns about the variability in the provision of early intervention services to young people from one Area Health Service to the next - different service models exist and there is a lack of clarity around what might be models of best practice.⁹¹⁵

⁹¹³ NSW Health, *Getting in Early: A framework for the early intervention and prevention in mental health for young people in NSW*, p 1

⁹¹⁴ *ibid*, p 22

⁹¹⁵ Submission 214, NSW Association for Adolescent Health, p 3

- 13.40** Dr Barclay also referred to the existence of different and unevenly distributed service models, as well as the uncertainties of funding for early intervention programs:

There was an excellent program on the Central Coast, the YPPI program. It was first class... Does it get axed, I do not know. It is an excellent program... There are some early psychosis intervention programs. I know the one at Hornsby is excellent and it sees mostly young adults. The Illawarra early psychosis program takes adolescents and young adults. It is a very good program but it is very patchy.⁹¹⁶

- 13.41** Ms Leanne Elsworthy, Coordinator of B. Miles Women's Housing Scheme, emphasised to the Committee that effective early intervention relies on interservice cooperation and clarity of responsibilities:

We had a young person through the early intervention team who was placed in our scheme. Her clinical support was someone from the early intervention team. This young woman stopped paying her rent. So I met with her. It became evident that she was not paying her rent because she was losing her organisational skills. She was wanting to pay the rent but she simply could not organise herself to be able to do it. So we alerted the case worker from the early intervention team. That person told us it was our job, which is completely untrue. It is not our job. And she did nothing. I was there. That woman deteriorated. We were trying to get intervention early to stop this woman from getting too unwell. I had to let the police in. She was handcuffed eventually and dragged screaming by police to Prince of Wales Hospital and ended up having shock treatment. I believe that may have been avoided had the people from the early intervention team listened to us.⁹¹⁷

Rehabilitation⁹¹⁸

- 13.42** Prevention and early intervention are crucial to working with young people at risk of, or in the first stages of, developing a mental illness. Rehabilitation however, appears to be the forgotten element of the mental health intervention 'spectrum', replaced instead by the principles of 'long term treatment', 'relapse prevention' and 'long-term care'.⁹¹⁹ Mr Phil Nadin, Deputy Chair of the Mental Health Co-ordinating Council, remarked that rehabilitation is now often referred to as 'clinical maintenance', a term that does not include the range of services such as supported accommodation, living skills centres, home care and vocational training needed for successful rehabilitation.⁹²⁰
- 13.43** Based on evidence received by the Committee, many young people and families would like to see a rehabilitation model rather than an ongoing treatment or relapse prevention model.⁹²¹ The following submission highlighted the reasons why:

⁹¹⁶ W Barclay, Evidence, 30 May 2002, p 12

⁹¹⁷ L Elsworthy, Co-ordinator, B.Miles Women's Housing Scheme, Evidence, 29 May 2002, pp 5-6

⁹¹⁸ See Chapter Four of this report for further information on rehabilitation.

⁹¹⁹ See NSW Health (1999), *Young People's Health: Our Future*, and B Raphael, *Getting in Early: A framework for early intervention in mental health for young people in NSW*, 2000, p 17

⁹²⁰ P Nadin, Psychiatric Rehabilitation Association, Evidence, 28 May 2002, p 31

⁹²¹ Submission 79, Ms Patricia Bayley, p 1; Veratau Evidence, 30 July 2002; Submission 220, Ms Diane Oakes

My son...was diagnosed with bipolar manic depression at 23 years of age...In my experience the system has failed to provide my son with effective support and rehabilitation over the past ten years. The net effect of the past ten years of my son's life has progressively reduced it to ruins, mentally, physically and financially...He has been cast out into the community on repetitive occasions amidst his treatment, long before any effective treatment had actually taken place.⁹²²

- 13.44** Mr Fred Kong, Chief Executive of the Richmond Fellowship, described to the Committee a Richmond Fellowship step-down program for young people following their first psychotic episode. The program could extend up to 18 months, if the young person required it:

In the young people's program we normally state that they stay with us no longer than 12 months but we do extend it if the need arises.⁹²³

- 13.45** Ms Georgie Ferrari, Executive Officer of the NSW Association for Adolescent Health, was concerned that the Richmond Fellowship program was extremely limited in numbers and geographic coverage:

The Richmond Fellowship at Emu Plains has an adolescent unit that...has different stages of supported accommodation. It has other units or houses across the State for adults, but there is no consistency with that. So if you do not live in Emu Plains you cannot get into that adolescent unit. It is like a patchwork of services and providers.⁹²⁴

- 13.46** Dr Rachel Falk, a psychiatrist, agreed that while new medications are more sophisticated and can be used successfully to help manage serious mental illnesses, a proportion of people still require intensive support and rehabilitation following their first psychotic episode:

the story [is] that, if patients are given time to reintegrate with support and care, some of them never break down again. The old statistics are that one-third of patients who suffered a psychotic breakdown never get ill again. I do not think we would say that these days. That is what happens when care is provided.⁹²⁵

Accommodation

- 13.47** Although Chapter 7 of this report examines homelessness and housing issues in detail, the following highlights the difficulties young people with mental illness face in securing housing or supported accommodation. Youth refuges can be reluctant to take on young people with mental illness.⁹²⁶ The Shopfront Youth Legal Centre stated in its submission:

⁹²² Submission 79, Ms Patricia Bayley, p 1

⁹²³ Mr F Kong, Richmond Fellowship, Evidence, 29 May 2002 p 44

⁹²⁴ Ms Georgie Ferrari, Executive Officer, NSW Association for Adolescent Health, Evidence, 30 July 2002, p 22

⁹²⁵ Dr Rachel Falk, NSW Representative, National Association of Practising Psychiatrists, Evidence, 29 May 2002, p 55

⁹²⁶ Submission 192, Council of Social Service NSW, p 19; L Manns, Evidence, 28 May 2002, p 54

There are some very good youth refuges and supported accommodation programs for young people. Many of these services do their best to accommodate young people with mental health problems. However, their funding does not permit them to provide the high level of supervision and support that is often required, nor does it enable them to employ highly qualified specialist staff.

We know of at least one youth service that can find no appropriate accommodation for young people with a mental illness. Its only option is to refer them to a service that houses them together with people in their 40s.⁹²⁷

- 13.48** One witness, whose son (diagnosed with mental health and substance use problems) was currently residing in a backpacker's hostel, expressed serious concerns to the Committee:

The second time my son was admitted to Prince of Wales I was told, 'Your son has to leave now, we cannot afford to keep him here anymore. He is still clearly not well and we cannot find any accommodation. You had better find some somewhere. Can you get somewhere for him?' We were desperate and we felt as a family we just could not have him at home, he was still too volatile.... Where do I go? That is my situation even now. Generally, I have no safe place to put my son.⁹²⁸

- 13.49** Mr Phillip French, Chair of Shelter NSW, stated that there are models that can work for young people with high needs:

There are a couple of examples of social housing providers, community housing providers or refuges and so forth providing boarding-style accommodation that has worked very effectively for some groups of people. A particular model called the Foyer model has worked well for high-need young people and it is being discussed with the Department of Housing at the moment.⁹²⁹

- 13.50** At the public forum on 7 August 2002, parents of young people with a mental illness reiterated the same message: that early intervention, while crucial, is often only the beginning of a difficult journey for both young people and their families. There remains an outstanding need for programs to rehabilitate and support young people with serious mental illnesses so that they stand the best chance of living rewarding and stable lives.

Recommendation 89

That NSW Health ensure that when young people in early psychosis programs are discharged, where required, individual service plans should include medium to long-term rehabilitation and supported accommodation.

Recommendation 90

That NSW Health fund and provide support for adequate places in medium to long-term rehabilitation and supported accommodation for young people requiring such support following their first episode of psychosis.

⁹²⁷ Submission 243, The Shopfront Youth Legal Centre, p 5

⁹²⁸ M Veratau, NSW Association for Adolescent Health, Evidence, 30 July 2002, p 28

⁹²⁹ P French, Chair, Shelter NSW, Evidence, 29 May 2002, p 47

Recommendation 91

That NSW Health publish a progress report on the implementation of *Getting in Early: A framework for early intervention and prevention in mental health for young people in New South Wales* within six months.

Recommendation 92

That NSW Health cooperate with other mental health service providers in NSW, to produce a service framework for accommodation and rehabilitation for young people following acute episodes of mental illness.

Recommendation 93

That the NSW Department of Education and Training, in consultation with NSW Health and non-government service providers, develop and provide specialist, supported and task-focused vocational and employment training programs for young people with a mental illness. The programs should focus on young people with varying degrees of cognitive, social or communication difficulties secondary to mental illness who may not succeed in mainstream training programs or paid employment.

Young people with substance abuse and mental health problems

13.51 Chapter 10 of this report discusses mental health and substance abuse disorders (MISA) in detail, and the difficulties people with these disorders have in accessing services. MISA has a high prevalence among young people and presents particular challenges in service provision. Over 50% of the young people in the *National Study of Mental Health and Wellbeing* who had substance use disorders in the 12 months prior to being surveyed, also had other mental health or physical problems.⁹³⁰ Submissions to the Committee indicated that the number of young people presenting to acute services with coexisting substance abuse and mental health problems is increasing.

13.52 Sister Myree Harris, President of the State Advisory Committee for the Care of People with Mental Illness, Society of St Vincent de Paul, explained to the Committee the changes St Vincent de Paul had observed:

Taking, say, Matthew Talbot, the big homeless refuges particularly and Vincentian Village, drop-in centres and things, the great change is in the age of the clients coming in. They are much younger, so we are getting younger people, particularly men, who often have very heavy drug use and have mental illness, so that is the greatest change. They are young, energetic, often aggressive, volatile and on a cocktail of drugs, and that makes it very difficult.⁹³¹

13.53 This development is placing enormous pressure on acute beds and services, as described by Dr William Barclay, an experienced psychiatrist:

⁹³⁰ NSW Health, *Getting in Early: A framework for early intervention and prevention in mental health for young people in NSW*, p 7

⁹³¹ M Harris, President, State Advisory Committee for the Care of People with Mental Illness, Society of St Vincent de Paul, Evidence, 23 May 2002, p 14

the mental health service faces a shortage of acute beds and that has been developing over many years. Part of the acute situation that exists in virtually all of the admission centres is now due to the very substantial increase in the number of people, particularly young people, using and abusing mind-altering drugs. This has resulted in a very big increase in admissions to acute psychiatric units of persons with what is called drug-induced psychosis.⁹³²

13.54 Prof Kenneth Nunn described the same phenomenon to the Committee:

In child and adolescent psychiatry, the age at which we have been identifying and seeing kids with major alcohol and drug abuse problems has dropped and the rate of psychosis has increased...The distinction between psychosis induced by illicit substances and psychosis that arises so-called *de novo* is artificial because in young people the tendency to use illicit substances as a form of self-medication is very strong, and vice versa.⁹³³

13.55 Ms Amanda Hale, a community welfare worker at Nimbin Neighbourhood Information Centre indicated how amphetamine abuse in particular was contributing to rising levels of psychosis in the Nimbin area:

In the Nimbin community mental health problems are exacerbated by drug use. We are seeing an explosion of amphetamine use, particularly among the young, and to a lesser extent among the injecting drug using community when the heroin supply dried up recently. This has caused a significant rise in violent and anti-social behaviour and psychosis. We are also seeing mental health problems that appear to be linked to high or long-term cannabis use. Many clients... have both a mental health and a drug problem. It is these clients who are most at risk and who experience the most barriers to accessing services.⁹³⁴

13.56 Prof Kenneth Nunn told the Committee that services have difficulty coping with treating young people presenting with co-existing substance abuse problems and mental illnesses. The practice of insisting that the substance abuse problem be resolved before psychosis treatment began served little purpose, as Prof Nunn pointed out:

The issue...of withholding treatment of psychosis, if it is in young people, is not only unwise; it amounts to neglecting our duty because you exclude, effectively, 90% of the young psychotic population. Many of them will need to be treated for some time before they relinquish their use of illicit substances. They will need a period of time when they are treated with antipsychotic medication or antidepressant medication, depending on their dominant picture.⁹³⁵

13.57 The NSW Association for Adolescent Health suggested a program targeted for young people, similar to that in Victoria:

A pilot project in Victoria that placed mental health workers in drug and alcohol services to work specifically with [MISA] clients made significant progress with

⁹³² W Barclay, Evidence, 30 May 2002, p 1

⁹³³ K Nunn, Evidence, 30 July 2002, p 30

⁹³⁴ Submission 26, Nimbin Neighbourhood and Information Centre, p 1

⁹³⁵ K Nunn, Evidence, 30 July 2002, p 30

clients, on both presenting health problems. The Association would very much like to see a similar project funded in NSW.⁹³⁶

- 13.58** Mr Fred Kong described to the Committee a project the Richmond Fellowship was running for young people with mental illness and cannabis problems. Called Quit Cannabis, the project provides a range of support, information and education services to young people. Mr Kong commented on Quit Cannabis:

It was funded for four years. It will probably expire in 12 months' time. The future of the program is uncertain, although I got the impression that it is a very well regarded program. The program addresses...the diagnosis of mental illness and substance use—which is a topical subject.⁹³⁷

- 13.59** The Committee considers that NSW Health should closely examine these initiatives with a view to continued and expanding pilot programs.
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Recommendation 94

That NSW Health investigate and evaluate pilot programs to manage young people with a mental illness and substance abuse problem while addressing the following objectives:

- expansion of such programs across metropolitan, rural and regional NSW
 - to inform further local area mental health planning.
-

Rural and regional issues

- 13.60** Rural and regional issues featured strongly in several submissions to the Committee about young people's mental health needs. In particular, they highlighted lack of access to specialist child and adolescent psychiatrists and limited acute care facilities. The NSW Faculty of Child and Adolescent Psychiatry stated in its submission:

Most child and adolescent psychiatrists in NSW are in Sydney, with few public or private practitioners beyond Western Sydney. Further, these practitioners are unable to meet the demand, so that general practitioners, paediatricians and families complain that it is excessively difficult to arrange consultation with a child psychiatrist. Private psychologist services are not covered by Medicare. These problems in accessing services are even more acute in rural areas and for some subgroups of young people.⁹³⁸

- 13.61** The NSW Association for Adolescent Health had concerns about accessibility to mental health services for rural and regional and Aboriginal young people.⁹³⁹ The Central West

⁹³⁶ Submission 214, NSW Association for Adolescent Health, p 2

⁹³⁷ F Kong, Evidence, 29 May 2002, p 41

⁹³⁸ Submission 92, NSW Faculty of Child and Adolescent Psychiatry, p 2

⁹³⁹ Submission 214, NSW Association for Adolescent Health, p 4

Women's Health Centre stated that in its area, a child and adolescent psychiatrist visited Bathurst one day a month, creating 'substantial waiting times for service'.⁹⁴⁰

13.62 The submission stated that while there were more adolescent beds at Bloomfield Hospital in Orange, "access is limited because of staffing", and people with anorexia nervosa sometimes had to wait up to 2 to 3 months for referral, with the only treatment beds in Sydney.⁹⁴¹

13.63 Dr Jean Starling described the distribution of child psychiatrists in NSW:

If we start going outside the Sydney, Wollongong, Newcastle axis, there is a child psychiatrist in Orange who covers most of the Central West, and a child psychiatrist at Albury, both of whom are part-time private and who do a little bit of public work. Apart from that it is the tele-psychiatry service that is run through our hospitals with the Health Department funds.⁹⁴²

13.64 Dr Starling highlighted that the close-knit nature of rural communities could have positive benefits for young people in preventing and treating mental health problems:

My last trip to the country was Tamworth one month ago and Inverell two months ago. The schools are very good, as they are generally throughout NSW, and they have superb links to local communities. We gave a talk in Inverell and 65 professionals working with children attended. Inverell has a population of about 5,000. There were community service people, teachers and school counsellors. What they make up for in the disadvantage of having fewer professionals is that the community networks are stunning.⁹⁴³

13.65 Dr Starling was also positive about the NSW Health Telepsychiatry initiative in rural areas:

I do telepsychiatry consultations over the television screen. Last week I saw a boy from Moree. He is from a school whose counsellor is an acting school counsellor. The counsellor is trained, but she is in her intern year. The school had seven principals in the past six years. In the particularly socially disadvantaged areas there are quite significant problems with staffing... The child's parents, the child, a local community psychologist, who is very good, and a school counsellor was at the conference. We discussed some more evaluation of him. The school counsellor and the psychologist from the community health centre will start a management program with him and his family.⁹⁴⁴

13.66 In light of the increased responsibilities rural GPs now have for mental health, evidence before the Committee indicates that access to specialist advisory services is a growing necessity for good clinical care.

⁹⁴⁰ Submission 191, Central West Women's Health Centre, p 2

⁹⁴¹ *ibid*, p 3

⁹⁴² J Starling, Chair, NSW Faculty of Child and Adolescent Psychiatry, Evidence, 30 July 2002, p 8

⁹⁴³ *ibid*, p 3

⁹⁴⁴ *ibid*, p 5

Recommendation 95

That NSW Health initiate a program to encourage general practitioners to utilise Telepsychiatry services in child and adolescent mental health, to improve the availability of specialist psychiatric services.

Children of parents with a mental illness

- 13.67** Children of parents with psychiatric illness carry a significant emotional burden and are at increased risk of developing problems themselves.⁹⁴⁵ St John of God Health Services commented in its submission:

This is a largely ignored, very invisible and poorly understood population. The size of this population is not known. It is known that they may suffer long-term effects, they often live in single parent families, they suffer the stigma associated with mental illness, and they are often isolated from other supports, as are carers in general.⁹⁴⁶

- 13.68** The NSW Consumer Advisory Group commented in its submission on the difficulties in keeping families together where a parent suffers a mental illness:

Parents with a mental illness who do not have a supported extended family find that they are often in danger of losing their children to state care. With ongoing support these parents are in a better position to maintain their family unit. By providing such support, pressure on state services will be eased in the medium and longer term.⁹⁴⁷

- 13.69** NSW Health stated that 29% to 35% of female clients of mental health services have children aged under 18 years. Recognising that these children are at increased risk of developing problems as a result of 'parenting problems, family disruption during hospitalisation, and associated genetic factors', NSW Health has been developing programs for children and young people in this situation.⁹⁴⁸ For further information on this issue, see the Legislative Council, Standing Committee on Social Issues, *Care and Protection - Inquiry into Child Protection Services, Final Report*, December 2002.⁹⁴⁹

Recommendation 96

That NSW Health fund support services on a statewide basis to children and young people with parents with a mental illness.

⁹⁴⁵ Submission 182, St John of God Health Services, p 28; Submission 267, NSW Health, p G.11

⁹⁴⁶ Submission 182, St John of God Health Services, p 28

⁹⁴⁷ Submission 162, NSW Consumer Advisory Group, p 32

⁹⁴⁸ Submission 267, NSW Health, p G.11

⁹⁴⁹ Source: www.parliament.nsw.gov.au (Legislative Council Standing Committee on Social Issues)

Chapter 14 Police, forensic patients and prisons

The harsh truth in NSW in the year 2002 is that the large mental institutions of the pre 1980s have been replaced with gaols.⁹⁵⁰

[The Hon Frank Walker QC, President, Schizophrenia Fellowship NSW]

This chapter focuses on the role of police in mental health service delivery and people with a mental illness who encounter the criminal justice system. While at first glance it would appear this chapter is about law enforcement, it actually examines and questions how appropriate it is for people with a mental illness to encounter aspects of the criminal justice system.

NSW Police Service

- 14.1** Evidence from many individuals and organisations expressed a high regard for police in their conduct when dealing with people with a mental illness. There are many instances where police involvement is necessary and as a result police will continue to have a significant role in dealing with people with a mental illness. The President of the Police Association of NSW, Mr Ian Ball, expressed the members' acceptance of this role:

Police officers do not have a difficulty with being first point of contact. That is quite natural. It is obvious we would be the most appropriate people to be the first point of contact...⁹⁵¹

- 14.2** The NSW Police Service acknowledged that there would always be a clear role for law enforcement officers in emergency and public settings where people with a mental illness are posing a risk to themselves or to other individuals.⁹⁵²

Memorandum of Understanding between NSW Police and NSW Health

- 14.3** In August 1998, a Memorandum of Understanding (MOU) between the NSW Police Service and NSW Health was initiated to provide a framework for an inter-agency response to situations involving mentally ill persons when the services of both agencies are required.⁹⁵³
- 14.4** As essentially autonomous administrations, the Area Health Services (AHS) allocate resources and funding for services, including the development of local protocols based on the MOU framework. The NSW Police submission indicated difficulties with aspects of the MOU:

⁹⁵⁰ The Hon Frank Walker, *The Quest for Justice with Dignity 2*, tabled document, 8 August 2002, p 2; The Hon Frank Walker QC, career includes: MHR (ALP) Robertson NSW - 1990-96 Fed Minr Admin Services 1994-96, Special Minr State, V-Pres Exec Council 1993-94; NSW MLA (ALP) Georges River - Minr Arts 1986-88, Housing 1983-88, Youth and Community Services 1983-88, Aboriginal Affairs 1981-84, Attorney-General 1976-83

⁹⁵¹ Mr Ian Ball, President, Police Association of NSW, Evidence, 14 June 2002, p 2

⁹⁵² Submission 286, NSW Police Service, p 3

⁹⁵³ *ibid*, p 5

The negotiation of these protocols at the local level has been challenging exercise in many areas largely due to lack of available resources and services, distances involved for travel or contention over roles and responsibilities. At present, there are 51 local protocols and 35 in various stages of development.⁹⁵⁴

- 14.5** The Police Association was highly critical of some medical practitioners who make inappropriate use of the MOU:

Our members have described clear breaches of the MOU. A common complaint is that doctors seem to regularly and somewhat routinely sign the schedule that police are required as escorts in situations where they are definitely not required, for example, where the patient is drugged up and sleeping. This is merely a waste of police time and resources.⁹⁵⁵

- 14.6** Mr Ball argued that, unless any heads of agreement or MOU can translate at a local level to the officer and health worker on duty, the agreements will continue to fail:

Government heads can sit together and say: Yes, we agree to this, this and this, but the fact is that if this is not happening, for whatever reason, at the local level then it cannot work.⁹⁵⁶

- 14.7** The MOU Revision 2002 recently superseded the MOU. The revised MOU includes more developed flowcharts to allow improved local protocols to address the concerns expressed by the police. In its submission to the inquiry, NSW Police indicated that a more detailed explanation of the partnership approach supports the flowcharts in the revised MOU. The NSW Police concluded that:

Notwithstanding this, the Police Service believes that legislation and present government policy should be reviewed to limit the extent to which police are involved in some aspects of situations involving mentally ill persons.⁹⁵⁷

- 14.8** The Committee supports the evidence presented by NSW Police and the Police Association, which highlights that health authorities and administrators must adhere more thoroughly to the MOU. The operational success of any procedural agreement, particularly between different agencies, requires the observance of protocols by every level of authority within its purview.

Police intervention

- 14.9** Section 24 of the *Mental Health Act 1990* allows police to take a person suspected of being mentally ill or mentally disordered to a mental health facility for assessment where:

- the person is committing or has committed an offence, or
- the person has recently attempted or is likely to attempt to kill himself or herself.

⁹⁵⁴ Submission 286, NSW Police Service, p 5

⁹⁵⁵ Submission 254, Police Association of NSW, p 21

⁹⁵⁶ I Ball, Evidence, 14 June 2002, p 3

⁹⁵⁷ Submission 286, NSW Police Service, p 5

14.10 The NSW Police submission outlined numerous changes that have increased the demand on police resources since the Richmond Report:

- the use of police to transport or escort mentally ill patients
- the use of police to supervise persons at hospitals (Mental Health facilities and Emergency Departments) whilst waiting for medical and psychiatric assessment to be conducted
- the lack of security in mental health facilities resulting in the use of police to search for and retrieve missing patients and
- police assuming responsibility for persons who are not admitted into a facility because their condition is defined as not being a mental illness but some other disorder, eg., behavioural disorder, personality disorder, intellectual disability, MISA, etc.⁹⁵⁸

14.11 NSW Police expressed concern that some mental health workers view the police as de-facto mental health workers.⁹⁵⁹ As well as the drain on police resources, the Police Association noted the stigma that may be associated with police attending a disturbance, citing the potential for incidents to escalate, as people with a mental illness may become fearful of the police uniform.⁹⁶⁰ NSW Police contend that much of the stress arises due to the unnecessary intervention demanded of police.

14.12 This concern was also reflected in the submission from NSW Carers, which stated that the involvement of police in the management of people with a mental illness is distressing for the individual concerned and that police intervention within mental health services should be limited:

Although some carers have mentioned to us how helpful the police have been, it is both distressing and stigmatising for families to have to involve the police.⁹⁶¹

14.13 Both NSW Police and the Police Association highlighted what they determined are unjustified and unrestrained use of police resources and time. NSW Police contend that their resources are being used in a manner which is not consistent with the intended implementation and integration of services within the community, for example:

using police to ensure occupational, health and safety requirements for hospital staff, ambulance officers and mental health workers or to reduce costs that might otherwise be incurred by Area Health Services are both inconsistent with the government's philosophy of putting police back on the street.⁹⁶²

⁹⁵⁸ Submission 286, NSW Police Service, p 4

⁹⁵⁹ *ibid*, p 7

⁹⁶⁰ Submission 254, Police Association of NSW, p 25

⁹⁶¹ Submission 196, Carers NSW, p 8

⁹⁶² Submission 286, NSW Police Service, p 3

14.14 NSW Police stated that the community expect a visible police presence, however:

our capacity to put more officers on the front-line and respond appropriately is hampered by the use of police in other settings that we consider would be more appropriately be handled by NSW Health.⁹⁶³

Transport**14.15** Due to the demand for acute psychiatric beds, the Committee heard that patients are often transported long distances to find an available bed. The transporting of psychiatric patients is often delegated to police.**14.16** NSW Police argued that police resources are consistently being strained because of inadequate health resources. A common problem cited by police is the “shopping around”⁹⁶⁴ they are required to undertake to locate an available bed or hospital to accommodate a person under section 24 of the *Mental Health Act 1990*:

Some hospitals will refuse to assess and often refuse to admit where a person resides outside of their geographic boundary regardless of where the person came under police notice.

...Hospitals direct police to take the person elsewhere and, in many cases, transport them in a caged truck over significant distances...Gosford police advised that on one occasion they were advised that the only available bed in the State was at Orange.⁹⁶⁵

14.17 NSW Police expressed disquiet over the improper use of section 22 of the *Mental Health Act* by many medical practitioners. Section 22 allows a medical practitioner, who has endorsed an involuntary admission, to determine that the condition of the person requires a member of the NSW Police Service to transport that person to hospital, provided that no other means are reasonably available.⁹⁶⁶**14.18** The Act does not allow for police discretion to determine whether or not the endorsement was made in accordance with the Act. While acknowledging that medical practitioners are in the best position to determine a person’s condition, police are concerned that they are at times considered surrogate carers within the health system:

Police believe that many general practitioners are routinely directing police assistance in the transport of mentally ill persons or in some cases have been pressured by mental health workers or ambulance officers to do so. There appears to be perception by some workers that once doctors endorse a schedule for police to transport or assist in transport, they play no further role in the matter.⁹⁶⁷

⁹⁶³ Submission 286, NSW Police Service, p 3

⁹⁶⁴ I Ball, Evidence, 14 June 2002, p 6

⁹⁶⁵ Submission 286, NSW Police Service, pp 9-10

⁹⁶⁶ *Mental Health Act 1990*, Part 2, s.21 and s.22

⁹⁶⁷ Submission 286, NSW Police Service, p 13

14.19 NSW Police recognise that police powers are needed in some situations involving mentally ill persons, but argue that there are many situations where NSW Health resources, not police, should be called upon. NSW Police consider that the lack of accountability required from medical practitioners when using s.21 and s.22 of the *Mental Health Act* may have the effect of:

- criminalizing mental illness as opposed to treating it as a health issue
- reducing the police and vehicle resources available in local areas and
- imposing a financial burden on the budgets of Local Area Commands.⁹⁶⁸

14.20 The Police Association provided a number of case studies highlighting the dismissive nature with which health authorities often accord legislation and police duties, for example:

On 3/8/01 a doctor from Medical Centre contacted local police within the northern coastal town in relation to a schedule II patient. The doctor had completed the schedule and the section requiring police assistance to convey the patient (a 72 year old female suffering from dementia and unable to look after herself) to a mental health facility, which is part of a certain hospital. Police explained to the doctor that they should only be used as a last resort and only if the patient has or could have violent tendencies. The doctor stated that on his last visit, the patient had waved her walking stick at him and ordered him off her property hence according to the doctor, this was confirmation of her apparent violent tendencies.

The police became concerned that it was not appropriate for them to drag a 72 year old lady off her property and hence contacted the local mental health team seeking their assistance. After being given numerous excuses by them, and with the relatives of the patient also offering no assistance, the doctor was again contacted by police. When they suggested that an ambulance be used, the doctor again raised the issue of the patient's apparent violent tendencies. With no other alternative open to them, the police went to the patient's premise, discovering a frail 72 year old woman who offered no resistance after they explained the reasons for their attendance. The whole episode occupied the only two police officers working in the area from 10am-12pm upon their return from the hospital. Police were in this instance unnecessarily tied up as a result of this incident which could have easily been handled by the mental health team in conjunction or assistance by the doctor.⁹⁶⁹

14.21 The unnecessary use of police resources requires a new approach by NSW Health to address this issue. In response to a question by the Committee regarding the possible introduction of 'mental health ambulances', Mr Ball stated that the Police Association would support a move in that direction, highlighting the unfortunate circumstances with which many patients are currently transported:

Let us be clear about what it means for a sick person to be in the back of a police truck and driven around this city in the middle of winter: They are prisoners. I do

⁹⁶⁸ Submission 286, NSW Police Service, p 14

⁹⁶⁹ Submission 254, Police Association of NSW, pp 39-40; Mr Ian Ball, President, Police Association of NSW, Evidence, 14 June 2002, p 17

not apologise for the police not putting them in front because there is far too much gear in the cabin that could present a problem. The problem is that, once people are in the back of the truck being transported around the city, the next time the police have something to deal with, what is in their head is: I end up in the back of the police truck being driven all over the countryside; so the next time they come in contact with a police officer we have a problem.⁹⁷⁰

14.22 NSW Police reinforced the need for specialised patient transfer services for people with a mental illness:

Police believe that the transport or retrieval of persons in all settings should be conducted by a specific NSW Health patient transfer service comprising persons trained in the management of mentally disordered persons and with limited powers to restrain such persons.⁹⁷¹

14.23 The Committee concludes that NSW Health should assume the responsibility for the transport and escort of persons who have a mental illness. The introduction of a mental health ambulance service for the purpose of transporting mental health patients to and from hospitals in addition to other health and community facilities would be a positive step to improving mental health services in NSW.

Recommendation 97

That the Minister for Health seek to amend section 22 of the *Mental Health Act 1990*, to incorporate criteria with which medical practitioners must comply before they can request police escort of mental health patients under Section 22 (1) (a).

Recommendation 98

That NSW Health initiate and maintain a mental health patient transfer service for the transport of people with a mental illness that includes:

- vehicles staffed by appropriately trained mental health professionals
- all inter-hospital transfers including, from emergency departments to mental health facilities
- return of missing patients (non-violent) and
- breaches of community treatment and community counselling orders.

⁹⁷⁰ I Ball, Evidence, 14 June 2002, p 7

⁹⁷¹ Submission 286, NSW Police Service, p 4

Access to mental health services

- 14.24** A central theme throughout the inquiry was the inability to access mental health services either through a lack of services or barriers to access. The lack of adequate access, according to NSW Police, is a major issue in the performance of their duty.⁹⁷²
- 14.25** According to NSW Police, the partnership with NSW Health has not functioned adequately for police due to difficulties to accessing mental health workers. NSW Police complained that some mental health workers:
- will not work outside of business hours
 - will not attend if the person's behaviour is violent
 - are unable to attend because of other commitments
 - will not be called out on overtime
 - will not attend if it is suspected that the person has some other condition, eg., personality disorder, drug induced psychosis, etc, and
 - may not replace members when they go on leave due to financial restrictions. This could mean that there is only one person who constitutes the mental health team and workers will not attend call outs on their own.⁹⁷³
- 14.26** Mr Ball was concerned that, although 24-hour mental health teams are technically 'available', more and better resourced teams are required to ease the burden on police:
- We are just asking for more - and we are not asking for more police, we are asking for the capability of sufficient mental health crisis teams to respond and to get out and do those jobs rather than be in a position where the cops have to do it as their de facto team.⁹⁷⁴
- 14.27** NSW Police provided the Committee with a list of mental health crisis teams by local area command and their hours of operation.⁹⁷⁵ The great majority do not operate after 9:00pm Monday – Friday, and do not operate at all on weekends. In some rural areas police are referred to a 24-hour telephone advice line, however, it does not provide operational support in attending scenes.⁹⁷⁶
- 14.28** NSW Police supported assertions by family and carers that hospitals will often advise that the mental illness is not the primary disability and it is therefore not their responsibility. For example, there are occasions where doctors will not conduct an assessment because:

⁹⁷² ibid, p 16

⁹⁷³ Submission 286, NSW Police Service, p 7

⁹⁷⁴ I Ball, Evidence, 14 June 2002, p 13

⁹⁷⁵ Submission 286, NSW Police Service, pp 7-8

⁹⁷⁶ ibid, p 7

- the person has been sedated
- it is suspected the person is drug or alcohol affected
- the person is violent
- the person would not benefit from treatment.⁹⁷⁷

14.29 As a result, police are repeatedly called to incidents involving the same person.⁹⁷⁸ In relation to disabilities that complicate mental illnesses, Dr Michael Giuffrida, Director of Forensic Psychiatry, Westmead-Cumberland Hospital, expressed the need for doctors to sufficiently assess all people that are presented to them:

The real issue, if they are mentally disordered within the meaning of the Mental Health Act—and that does not necessarily exclude drug and alcohol intoxication and the behavioural effects of that—is that everybody should be assessed on the basis of their mental disorder regardless of the aetiology of it.⁹⁷⁹

14.30 Dr Giuffrida however, noted the resource related pressures on doctors in such situations:

I think it is quite complex. It is also a question of the reality of the system. You only have so many resources available to you. If you are an admitting doctor in an admission centre and you have only two or three beds available over the weekend, you are going to narrow down or give priority to those people who are unequivocally mentally ill within the meaning of the Mental Health Act and for whom you can provide effective and rapid treatment.

...You do not admit everyone. It is not appropriate to admit every person who is brought into a hospital by the police on a section 24 Certificate. Some people are brought into hospital who are just behaviourally disturbed as a function of their intoxication from alcohol and who may well settle down over the next few hours. If the police think that person has some associated medical condition, they can take them to the casualty department of the hospital, but I do not think it is appropriate that we try and admit everyone who develops some sort of behavioural disturbance in the community.⁹⁸⁰

14.31 Incidents involving people with personality or behavioural disorders present a difficult challenge to police, as medical practitioners will not admit them if they are not suffering from a mental illness. As these people often present significant risk to themselves and the community if they are not admitted to hospital, police have little option other than to let them go or charge them if some form of offence has been committed.⁹⁸¹ Dr Meg Smith, President of the Mental Health Association and the Depression and Mood Disorder Association stated that:

⁹⁷⁷ Submission 286, NSW Police Service, p 17

⁹⁷⁸ *ibid*

⁹⁷⁹ Dr Michael Giuffrida, Forensic Psychiatrist, Evidence, 8 August 2002, p 48

⁹⁸⁰ M Giuffrida Evidence, 8 August 2002, p 48

⁹⁸¹ Submission 286, NSW Police Service, p 17; I Ball, Evidence, 14 June 2002, p 5

Mental health services in many areas do not see people with personality disorders since their service is confined to people with biochemical disorders such as schizophrenia, bipolar disorder and depression...Unfortunately, people with personality disorders who do not receive treatment have a higher risk of coming into contact with the criminal justice system and have poorer social and employment networks.⁹⁸²

- 14.32** A number of submissions argued that government agencies have also failed to take responsibility for those in the community who present with very challenging behaviour. Prof Kenneth Nunn, Area Director of Mental Health, Children's Hospital, Westmead argued that there are a number of reasons for this, including how a personality disorder is defined:

The first is that we psychiatrists as a group have become very good at defining what we are not going to do...We use the term "personality disorder" and as the late David Maddison said, "Who, with any brain disorder you like, has not got a personality disorder?" The word "personality disorder" is just the least helpful term in psychiatric treatment and "conduct disorder" is shortly after it. I think that is the first point. That may be because the boundaries of the wider psychiatry have been drawn, the fear was that you would just get overwhelmed, and I understand that fear. But I think it is better for us to say, "Look, there are all those issues out there. We might not be able to deal with them all", but what we normally do is we build up explanations post hoc for why we are not doing that, such as "They do not respond".⁹⁸³

- 14.33** Prof Nunn confirmed the confusion and frustration expressed by police where a person is presented to a hospital under a Section 24 certificate, only to have them rejected on the basis of behavioural problems:

I have been studying in the field for years and years and I do not understand that distinction. Emotion and behaviour are the thing that psychiatrists deal with all the time. I think the other problem is that the drug research literature is dominated by social explanations. Those social explanations very rapidly move into the nature of everything. People believe that when you try to address the problems, you have to try to address the nature of everything. As enlightened as it might be for us to see the connectedness of everything with everything else, it is not actually very helpful if you have to get up in the morning and do something about it.⁹⁸⁴

- 14.34** NSW Police recognised the establishment and efforts of a government taskforce on persons with challenging behaviour. While acknowledging some progress had been made, NSW Police argued that issues still need to be addressed at the corporate level. These include information exchange between disability, health and police services, and management of persons who are at risk to the community or themselves, especially those at risk of continually committing offences.⁹⁸⁵ NSW Police stated:

⁹⁸² Submission 171, Dr Meg Smith, Mental Health Association NSW, appendix III, p 26

⁹⁸³ K Nunn Evidence, 20 July 2002, p 34

⁹⁸⁴ *ibid*

⁹⁸⁵ Submission 286, NSW Police Service, p 18

It would be beneficial if a framework for inter-agency partnerships be addressed at a corporate level, as a matter of urgency.⁹⁸⁶

- 14.35** The evidence of Dr Giuffrida and Prof Nunn was representative of a number of submissions that highlighted the difficult nature of personality or behavioural disorders for health authorities. While mental disorders are currently not determined to be a mental health responsibility, the Committee is concerned that NSW Police and NSW Health resources are being negatively affected due to the lack of accepted responsibility by government, community and disability services. The Committee considers that, in accordance with Recommendation 1, the Office of Mental Health under the Premier's administration assist in the delivery of an inter-agency partnership for the case management of persons diagnosed as having a mental disorder rather than a mental illness.

Emergency Departments and hospital security

- 14.36** Under the *Mental Health Act 1990*, police are required to take a mentally ill person to the nearest gazetted hospital. The mainstreaming of health services essentially requires police to deliver patients to an Emergency Department (ED) at a NSW hospital. NSW Health cited four main issues relating to Emergency Departments and mental illness presentations:

- EDs are the entry point for acutely disturbed patients
- EDs have a highly charged atmosphere
- 2-4% of ED presentations are recognised acute mental health problems and
- acute mental illnesses are difficult to manage in ED, although there is a need for thorough physical and psychiatric assessment.⁹⁸⁷

- 14.37** NSW Health outlined that the Emergency Department mental health response includes:

- Liaison and consultation, between mental health staff and other hospital personnel
- a mental health manual
- MOU with ED and
- an MOU with police.⁹⁸⁸

- 14.38** NSW Police assert that hospital personnel are often not staffed sufficiently to assume responsibility for the person, until both a physical and psychological assessment has been conducted. As the mental health personnel are generally not located within the Emergency Department and only work 'office hours'⁹⁸⁹, it was the experience of the NSW Police that the process consumes a significant amount of time:

⁹⁸⁶ ibid

⁹⁸⁷ Submission 267, NSW Health, p G 18

⁹⁸⁸ ibid

⁹⁸⁹ Correspondence from NSW Health to Committee, 15 November 2002, p 3

As hospitals will not supervise persons, this results in police being required to wait with and supervise persons until such time as a medical practitioner can attend and make an assessment. It is not uncommon for police to be waiting for several hours which means that 2 police officers are diverted from other core duties.⁹⁹⁰

14.39 A major drain on police resources is the frequent lack of adequate hospital security. The NSW Police informed the Committee that where security is present, their numbers are often either insufficient or inexperienced to assume supervision and management of the patient upon police arrival.⁹⁹¹

14.40 Insufficient hospital security was consistently raised by submissions in regard to the high incidence of patients absconding from hospital care. As discussed in chapter 4, the lack of nurses on duty and the increasing intensity of the care required have resulted in frequent absconding by voluntary and involuntary mental health patients. A lack of resources has impacted on the ability of hospitals to conduct a search or liaise with community mental health teams, despite legislation providing hospitals that authority.⁹⁹² As a result, according to NSW Police:

Matters are routinely reported to police with perhaps a view by some health practitioners that they have discharged their duty of care and all missing patients become a police matter.

...Aside from often being an unnecessary use of police resources, it also contributes to a feeling of fear and hatred by mentally ill persons against police.⁹⁹³

14.41 The Committee heard numerous cases where scheduled patients had absconded from the care of a mental health facility, were later located by police and returned to the facility, only to have them reported missing again, sometimes within hours.⁹⁹⁴ The Police Association of NSW provided case examples highlighting common problems that police face:

For example, the only mental health holding facility in one area is a clinic situated in a northern regional centre. Police officers there are complaining that almost on a daily basis, both voluntary and involuntary patients are managing to leave the facility without the permission of staff. Little effort appears to be made by the staff there to return the patient other than on some occasions making a telephone call to the local police station advising them of the missing patient's name and description. This information is then circulated via memo for the information of police patrolling vehicles. Police in a northern coastal town are dealing with mentally ill persons a number of times each shift, with little information given about these individuals. When police inquire at a local clinic to see if staff know the person, it is often revealed that the person is a missing patient who has not been formally reported to police as a missing or escaped patient.⁹⁹⁵

⁹⁹⁰ Submission 286, NSW Police Service, p 15

⁹⁹¹ Submission 286, NSW Police Service, p 15

⁹⁹² *Mental Health Act 1990*, Section 76 (a), Section 111. (1) (a)

⁹⁹³ Submission 286, NSW Police Service, p 19

⁹⁹⁴ Submission 286, NSW Police Service, p 20; Submission 254, Police Association of NSW, p 12

⁹⁹⁵ Submission 254, Police Association of NSW, p 13

- 14.42** The lack of adequate security can have devastating consequences. Ms Colleen Deane made a submission to the inquiry that detailed the unfortunate death of her son Joseph. Ms Deane stated that on Sunday 1 July 2001, Joseph absconded from the acute care ward of Royal Prince Alfred Hospital (RPAH), even though he had been classified as extreme high risk. Police had taken him there after he was rescued from rail tracks five days earlier. The night Joseph absconded, he threw himself under a train at another railway station. RPAH had not reported him missing and it was only through the efforts of his mother, who reported him missing to her local police station, that his body was eventually identified.⁹⁹⁶
- 14.43** The Police Association offered possible solutions to this problem, including secure wards or the employment of more security officers to ensure involuntary patients remain on premises:
- The security officers would have their special constable status returned (if it has been removed) and police would only be used in instances that involve either a breach of the peace, or an extremely violent patient. Once a patient absconds from a hospital, the local mental health crisis team should be notified and be sent to follow and apprehend the individual by following a set process, including firstly contacting the individual's next of kin etc. Mental health units should be making all reasonable attempts to locate the absconder (which they may maintain they already do, but which unfortunately according to our members, it is not often the case)...⁹⁹⁷
- 14.44** The Committee considers that there is a role for police in the restraint, delivery and location of mental health patients, particularly those that are violent. This role should not, however, replace the duty of care of health care facilities and personnel.
- 14.45** The MOU Revision 2002 may address many of the issues expressed to the Committee. The reported breakdown in the original MOU highlights, however, that it is incumbent on health and police personnel at local command level to ensure its operational success. The Committee is concerned that assessment and determination of patients may remain under pressure where health administrators attempt to operate within resource and financial restrictions.

Training

- 14.46** The accounts of witnesses before the Committee have demonstrated that the police do a commendable job when encountering and assisting people with a mental illness. Police are not, however, trained to undertake the level of service they currently perform. The Police Association indicated that training has improved, but that it does not go far enough.⁹⁹⁸ The Police Association supported a report by the NSW State Coroner, John Abernethy, who recommended police be given better training:

That the NSW Police Service urgently provides comprehensive training to all NSW Police Academy students and operational police officers in the appropriate dealing with the mentally ill. Such issues should include issues such as the

⁹⁹⁶ Submission 17, Ms Colleen Deane, p 1-5

⁹⁹⁷ Submission 254, Police Association of NSW, pp 12-13

⁹⁹⁸ *ibid*, p 26

recognition of common and significant psychiatric problems, techniques for dealing with mentally ill persons and legal issues associated therewith.⁹⁹⁹

- 14.47** The Ministry for Police informed the Committee that there is no specific mandatory training for police in dealing with people with a mental illness.¹⁰⁰⁰ The Police Association stated that the general police training course:

focuses on a range of areas including police recruitment training and training of detectives, custody managers and 000 operators, only **components** of which relate to mental health.¹⁰⁰¹

- 14.48** Mr Ian Ball, President of the Police Association, summed up the situation confronting police, health authorities and the criminal justice system:

We have so limited a resource available to us but we have to do something with these people. We have a duty of care to people. We get litigated against every day on duty of care. Here we sit. We have a problem: Where do we take people? Where do we put people? How do we care for them in some real way so that they are not out in the streets? The reality is that people are getting charged with criminal offences where really we should be applying another section to take the opportunity to deal with psychiatric illness. We cannot do that.¹⁰⁰²

- 14.49** The Committee agrees with both the Police Association of NSW and the NSW Police that it is detrimental to mentally ill persons and to the community for mental health services to rely so heavily on the use of police resources.¹⁰⁰³

Recommendation 99

That the Minister for Health and the Minister for Police initiate a mandatory comprehensive training program to provide all police officers with training to better respond to mental health problems in the community. The training program should be funded by NSW Health and include training in:

- recognition of common and significant psychiatric problems
- techniques to deal with people with a mental illness and
- understanding of the relevant legislation and associated legal issues.

Recommendation 100

That the most recent Memorandum of Understanding between NSW Health and NSW Police include as signatories, nursing, general practice and medical specialist area representative groups.

⁹⁹⁹ ibid, citing NSW State Coroner Mr John Abernethy, inquest into the shooting death of Ali Hamie, 1 February 2002

¹⁰⁰⁰ Correspondence from Ministry for Police to Committee, 13 November 2002

¹⁰⁰¹ Correspondence from Police Association of NSW to Committee, 18 November 2002

¹⁰⁰² I Ball, Evidence, 14 June 2002, p 2

¹⁰⁰³ Submission 286, NSW Police Service, p 4, I Ball, Evidence, 14 June 2002, p 2

Recommendation 101

That the proposed Office of Mental Health within the NSW Premier's Department should, after 12 months operation of the Memorandum of Understanding Revision 2002:

- conduct a review of the instrument's operation
- amend the instrument as required and
- seek to amend the *Mental Health Act 1990* to incorporate key components of the Memorandum of Understanding.

Recommendation 102

That NSW Health require all Area Health Services to introduce or improve security arrangements at public hospitals and mental health units in NSW for the purposes of monitoring and managing mental health patients.

Recommendation 103

That NSW Health require all Area Health Services to monitor and report publicly on the incidence of the 'absence without leave' (AWOL) of mental health patients from public hospitals and mental health units. These reports should include:

- the incidence of AWOL from the hospital or unit
- a record of all reasonable attempts made to locate the missing patient and
- the incidence of requests by hospitals for police assistance in locating and returning of missing mental health patients.

Recommendation 104

That the Minister for Health provide funding to NSW Health to increase specialist mental health staff so that hospitals can manage the detention and care of a person presented by police under sections 21, 22 and 24 of the *Mental Health Act 1990*.

Recommendation 105

That the proposed Office of Mental Health (see Recommendation 1), when established, should initiate and oversee the coordination of an inter-agency specialised program for the care of persons with a mental disorder not currently recognised under the *Mental Health Act 1990*.

Forensic mental health services

- 14.50** Forensic mental health services are specialised services focusing primarily on assessment, treatment and rehabilitation of people suffering from a mental illness who become involved in the criminal justice system. Forensic mental health services provide specialist

services in a number of areas within the criminal justice system, including the courts, prisons, the community and secure inpatient units.

- 14.51** Forensic patients, in terms of the *Mental Health Act 1990*, are those found not guilty by reason of mental illness, those found unfit to plead and those imprisoned who are later found to be mentally ill and are transferred to hospital for treatment. Forensic patients are currently located within hospitals in the community, minimum-medium secure units and correctional centres. The two main forensic mental health services are the Corrections Health Service and the Mental Health Review Tribunal.

Corrections Health Service (NSW Health)

- 14.52** The Corrections Health Service (CHS) is a statutory health corporation created under the *NSW Health Services Act 1997*, to care for a health community that is unique to NSW – almost 7,800 inmates in 25 correctional centres, ten periodic detention centres and six police and court cell complexes.¹⁰⁰⁴

- 14.53** CHS informed the Committee that the key issues for the service include:

- a high incidence of mental illness
- many drug and alcohol dependent patients who require management of detoxification
- a high prevalence of hepatitis C
- prevention of self harm and suicide and effective management of incidents and attempts
- meeting the health needs of female inmates, whose numbers have increased by 45% since 1998 and
- provision of care for an increasing number of inmates over 45 years.¹⁰⁰⁵

- 14.54** The Royal Australian and New Zealand College of Psychiatrists informed the Committee that mental health and psychiatric services within correctional centres are characterised by a fragmented approach to the planning and delivery of services.¹⁰⁰⁶ The CHS contracts consultant psychiatrists at Visiting Medical Officer (VMO) rates in lieu of staff specialists. VMOs are employed on an hourly rate, currently \$152.95 an hour, whereas Staff Specialists receive from \$62.06 to \$83.85 per hour.¹⁰⁰⁷ The differential is justified on the basis that staff specialists' award rates include entitlements to leave and other on-costs.¹⁰⁰⁸

¹⁰⁰⁴ Correspondence from NSW Health to Committee, 10 September 2002

¹⁰⁰⁵ *ibid*

¹⁰⁰⁶ Submission 22, Royal Australian and New Zealand College of Psychiatrists, pp 2-3

¹⁰⁰⁷ Submission 267, NSW Health, p F 5

¹⁰⁰⁸ *ibid*, p F 5

- 14.55** Considering the demand on clinical psychiatrists, the Committee is concerned that a significant number of consultant psychiatrist's hours per week are utilised for the preparation of psychiatric reports for the courts, Legal Aid and the Offenders Review Board, which considers applications for parole. While these reports are clearly required, the Committee considers that CHS should not be meeting the costs for VMOs compiling such reports, which is reducing face-to-face clinical treatment hours. The body responsible for the report (Legal Aid and Offenders Review Board for example) should be meeting these VMO costs. For court reporting duties see paragraph 14.149–14.156 and Recommendation 119.

Recommendation 106

That the Minister for Health ensure that the contracts for employment of consultant psychiatrists with Corrections Health Service require them to only address patient treatment related needs.

Recommendation 107

That the Minister for Health increase funding to employ additional psychiatrists to meet the increased forensic mental health assessment, consultation and treatment needs.

Mental Health Review Tribunal

- 14.56** Established under the NSW *Mental Health Act 1990*, the Mental Health Review Tribunal (MHRT) is a quasi-judicial body with powers to review decisions, make orders and hear appeals about the treatment and care of people with a mental illness. The MHRT operates in both civil and forensic jurisdictions.¹⁰⁰⁹ In the forensic jurisdiction, the MHRT has a number of responsibilities under the *Mental Health Act 1990* and the *Mental Health (Criminal Procedure) Act 1990*.
- 14.57** Where a person is found to be 'unfit to be tried' for an offence, the MHRT must review the case and determine whether the person is likely to become fit for trial within the next twelve months. The MHRT may also need to consider whether the person is suffering from a mental illness, or from a mental condition for which treatment is available in a hospital.¹⁰¹⁰
- 14.58** For those found 'not guilty by reason of mental illness', the MHRT must review the case and make recommendations to the Minister for Health concerning the person's detention, care and treatment, and whether it is appropriate to release the person either conditionally or unconditionally.¹⁰¹¹

¹⁰⁰⁹ Submission 266, Mental Health Review Tribunal, p 2

¹⁰¹⁰ *ibid*, p 3

¹⁰¹¹ *ibid*

14.59 The MHRT is required to review the case of each forensic patient every six months and make a recommendation to the Minister concerning the person's continued detention, care and treatment, or the appropriateness for release. That recommendation may stipulate:

where the patient is to be held, under what kind of security, the range and kind of leave privileges (if any) which can be enjoyed, and, if the patient is on conditional release, the range and kinds of conditions which apply in order to allow the patient's continuing presence in the community.¹⁰¹²

14.60 The number of hearings conducted by the MHRT concerning forensic patients has increased in the last decade, from 185 forensic patient case reviews in 1991 to 481 in 2001.¹⁰¹³ The total number of hearings conducted by the MHRT has tripled since 1991 with a total of 6,931 hearings in 2001. The number of forensic patients within the correctional system increased from 52 in 1991 to 259 in 2001.¹⁰¹⁴ CHS informed the Committee that forensic patient numbers are projected to increase to about 400 by 2006.¹⁰¹⁵

14.61 An increase in forensic patient numbers would necessitate increased legal representation. In its submission to the inquiry, the MHRT expressed concern, also expressed by consumer organisations, that there was a shortage of legal representation available from the Legal Aid Commission's, NSW Mental Health Advocacy Service (MHAS):

Legal representation for involuntary detained and treated people is a right provided for by the Mental Health Act but is a right that currently cannot be effectively ensured. Not only is the MHAS stretched beyond all limits but it has also had to use 'agents' whose knowledge of mental health issues and legislation can be lacking.¹⁰¹⁶

14.62 The MHRT asserted that responsibility for community supervision of forensic patients released into the community was not clear:

Currently, the Tribunal not only undertakes required statutory reviews of forensic patients...but also provides what amounts to unofficial supervision of these patients...once they are conditionally released into the community. This 'supervision' is undertaken on what is largely an ad-hoc and informal basis.¹⁰¹⁷

14.63 The MHRT also informed the Committee that there is no formal agreement between the MHRT and the various groups of people involved in the supervision of released patients. There is no formal understanding regarding what is expected of supervisors or the line of responsibility that should be followed when things do not go according to plan.¹⁰¹⁸

¹⁰¹² *ibid*, p 3

¹⁰¹³ Submission 266, Mental Health Review Tribunal, p 4 and slide presentation, 14 June 2002

¹⁰¹⁴ *ibid*, p 6

¹⁰¹⁵ Correspondence from Corrections Health Service to Committee, 19 August 2002

¹⁰¹⁶ Submission 266, Mental Health Review Tribunal, p 10

¹⁰¹⁷ *ibid*, p 12

¹⁰¹⁸ *ibid*

- 14.64** When a forensic patient breaches their release conditions it is usual for the patient to be sent to a secure setting such as Long Bay Prison Hospital. This is a process and response described as “draconian” by the MHRT.¹⁰¹⁹ The MHRT concludes that it should not continue to perform the supervision function unless it is accorded formal legal recognition and allocation of adequate resources.¹⁰²⁰ The Committee supports extending the MHRT’s purview to alleviate the fragmented approach to the management of released forensic patients.

Recommendation 108

That the Minister for Health implement a formal agreement with the Mental Health Review Tribunal for the supervision and management of released forensic patients, including:

- clarification of the responsibility of clinical services in the monitoring and reporting of clinical supervision, including the role of the Mental Health Review Tribunal in monitoring progress and
 - clarification of formal procedures for managing breaches of release conditions.
-

Forensic patients

- 14.65** The CHS has 60 forensic psychiatric beds located at the Long Bay Hospital that are gazetted as a hospital within the meaning of the *Mental Health Act 1990*. These beds are simultaneously gazetted as part of the State’s maximum-security prison facility. There are currently 83 patients under forensic orders in the Long Bay Hospital. These patients are accommodated within in a maximum-security prison, are subject to the provisions of the *Crimes (Administration of Sentences) Act 1999* and consequently, under the authority of correctional staff. Under these conditions, forensic patients are locked in their cell for approximately 11 hours each day at Long Bay, and for 16 hours each day at the Metropolitan Remand and Reception Centre, Silverwater Complex.¹⁰²¹

Not guilty, proceed to gaol

- 14.66** NSW is the only State in Australia and one of only a few in the Western World that hospitalises forensic patients within the precincts of a correctional facility and under the authority of Corrective Services staff. Dr Stephen Allnutt, Clinical Director Forensic Psychiatry, was critical of the establishment of forensic mental health services within correctional facilities and indicated that this was contrary to national and international trends:

¹⁰¹⁹ Submission 266, Mental Health Review Tribunal, p 12

¹⁰²⁰ *ibid*

¹⁰²¹ Correspondence from Corrections Health Service to Committee, 19 November 2002

In the late 80s and early 90s, other jurisdictions both national and international built and developed Forensic Mental Health Services in the community with facilities administered and staffed by health professionals, separate from the Criminal Justice system. At the same time, New South Wales determined that a better option at that time would be to share the care of offenders with mental illness with the Department of Corrective Services. NSW therefore based Forensic Mental Health Services within the prison environment and as a consequence, Long Bay Hospital was built. This single decision, in my view, has made a significant contribution to the ongoing inadequate state of forensic mental health services in New South Wales.¹⁰²²

- 14.67** Many forensic patients have committed violent crimes and there are clearly concerns regarding their secure detainment. The Hon Frank Walker QC, President of the Schizophrenia Fellowship, accepted that forensic patients must be detained in secure facilities, though expressed that this should not be within a correctional facility:

We believe in secure facilities for people who have committed violent crimes. We believe in it because it is political reality. The public is simply not going to accept letting those sorts of people back out into the community on any short-term basis. We believe they ought to be there, and we also believe that the facilities ought to be small and decent places to live in, not your usual harsh prison environment. These are people with serious illnesses. We think they ought to be all over the State.¹⁰²³

- 14.68** Mr Robert Ramjan, Executive Director, Schizophrenia Fellowship related his own experience as a visitor to Long Bay Hospital:

I know my mental health suffered just being in the environment. I do not know how somebody who does not have a sentence but whose release is reliant on being mentally well again becomes mentally well in that environment. It is a frightening place to be.¹⁰²⁴

- 14.69** The NSW Consumer Advisory Group (NSW CAG) cited that the care of forensic patients in a correctional facility is governed by the NSW *Crimes (Administration of Sentences) Act 1999*, and is in contravention of the States own *Mental Health Act 1990* and the United Nations *Declaration of Human Rights 1948*.¹⁰²⁵

- 14.70** The Standard Minimum Rules for the Treatment of Prisoners, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955 referred to insane and mentally abnormal prisoners.¹⁰²⁶ Section 82 (1) of the United Nations Standard stated:

¹⁰²² Submission 281, Dr Stephen Allnutt, p 2

¹⁰²³ F Walker, Evidence, 8 August 2002, p 34

¹⁰²⁴ R Ramjan, Evidence, 8 August 2002, p 34

¹⁰²⁵ Submission 162, NSW Consumer Advisory Group, p 25

¹⁰²⁶ United Nations Congress on the Prevention of Crime and the Treatment of Offenders, *The Standard Minimum Rules for the Treatment of Prisoners*, Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.¹⁰²⁷

- 14.71** Dr Brian Boettcher, Forensic Psychiatrist, informed the Committee that under the Queensland mental health model, it is illegal to have a mentally ill person in a prison:

Even if they are sentenced, they have got to be removed and placed under a special order into usually the forensic hospital. If not, then the district secure unit, but usually the forensic hospital.

...if the forensic psychiatrist looking after them feel that they are now able to cope back in the prison then they go back.¹⁰²⁸

- 14.72** Dr Michael Giuffrida, Forensic Psychiatrist, outlined the difficulties in providing adequate psychiatric treatment within the prison system. He stated that if patients refuse medication, the only way to ensure that they receive appropriate medication is to obtain two Schedule 3 certificates. These certificates certify examination of a prisoner and that they are mentally ill or suffer a mental condition for which treatment is available in a hospital.¹⁰²⁹ Those certificates are then forwarded to the NSW Health Chief Health Officer, who signs the orders. The person then becomes a forensic patient and can be transferred to a mental facility.¹⁰³⁰

- 14.73** Dr Giuffrida stated, however, that more beds for males and females in freestanding forensic hospitals outside of prison facilities are required if adequate care is to be provided.¹⁰³¹ Adequate psychiatric treatment for prisoners remains difficult to administer. Based on the evidence presented before the Committee, the CHS receives insufficient funding and resources to ensure adequate care.

Why are forensic patients in correctional facilities?

- 14.74** Forensic patients are currently detained in correctional centres either by formal custodial admission or, at times, by non-custodial detention.

- 14.75** During the second reading debate on the *Mental Health Legislation Amendment Bill* of 16 April 1997 in the NSW Legislative Assembly, Mr Ian Glachan MP noted this latter problem:

In the Albury electorate a young man accused of committing murder was not able to go for trial because of his condition. He was held in custody for a long time, which caused great stress for everyone involved. Finally, he was released because it was felt that he could not be detained any longer. He had been kept for as long as he would have been gaoled had he been convicted of the crime. This caused enormous distress to the family of the victim of the crime and to the community.

¹⁰²⁷ United Nations Congress on the Prevention of Crime and the Treatment of Offenders, *The Standard Minimum Rules for the Treatment of Prisoners*, section 82 (1)

¹⁰²⁸ Dr Brian Boettcher, Forensic Psychiatrist, Evidence, 8 August 2002, p 42

¹⁰²⁹ M Giuffrida Evidence, 8 August 2002, pp 46-47

¹⁰³⁰ *ibid*

¹⁰³¹ *ibid*

People were concerned that someone like him would be wandering around in society without proper care and control.¹⁰³²

- 14.76** The Hon Frank Walker QC explained that many people with a mental illness become incarcerated because of misgivings the Judges and Magistrates have with the health system:

Judges and Magistrates working in the criminal law have the powers to divert such offenders back into the health system. They tell the Fellowship that they have become disillusioned because having made such an order they regularly find their decision rejected by the hospital who immediately releases the prisoner who the Court has determined is at risk to himself or the public back into the community.¹⁰³³

- 14.77** The Legal Aid Commission advised the Committee that, a Magistrate's discretion to either deal with a person within the legal system, or divert them to the mental health system, does not appear to be sufficiently understood or accepted by the hospitals:

Regularly persons who are clearly mentally ill persons are returned to court, either assessed as not being mentally ill or with a frank admission that the hospital does not have the security or the staff to provide service to the person, and recommending that they be referred to the Long Bay Prison Hospital.

This, in effect, means that the Prison Hospital is being incorporated into the civil mental health system.

...The Commission is of the view that it is quite unacceptable that a person who the magistrate has determined should be diverted from the legal system to hospital may nevertheless end up in the prison system.¹⁰³⁴

- 14.78** This occurrence, according to Mr Walker, has been accompanied by a shift in public and judicial attitudes, that formerly regarded a mental illness as a mitigating factor in sentencing, but now see it as a factor that should attract a longer than usual sentence.¹⁰³⁵

- 14.79** Waiting periods impede the transfer of forensic patients from high security institutions such as Long Bay Prison Hospital to medium security units. The Legal Aid Commission explained that there is a long waiting time for transfer out of the Long Bay Prison Hospital due to the delay in moving recovering patients from medium secure units to minimum security units, generally cottage type rehabilitation accommodation on hospital grounds. The Legal Aid Commission expressed that there is immense competition for this type of accommodation, and highlighted the difficulties in determining what is actually available:

Commission solicitors are invariably told that there is a chronic undersupply of cottage accommodation for civil detained patients as well as forensic patients. It has so far proved impossible to ascertain the number of cottage beds available for forensic patients at each hospital. All attempts to obtain this information have met with conflicting and inconsistent responses.

¹⁰³² Mr Glachan MP, Hansard, NSW Legislative Assembly, Second Reading Debate - Mental Health Legislation Amendment Bill, 16/04/1997

¹⁰³³ The Hon Frank Walker, *The Quest for Justice with Dignity* 2, tabled document, 8 August 2002, p 2

¹⁰³⁴ Submission 216, Legal Aid Commission, pp 10-11

¹⁰³⁵ The Hon Frank Walker, *The Quest for Justice with Dignity* 2, tabled document, 8 August 2002, p 3

It appears to be the policy of some of the Area Health Services to deny access to cottage accommodation to patients deemed to be out of area. In our view, given the itinerant lifestyle and long history of many forensic patients, it is arbitrary to classify them as belonging to any particular area.¹⁰³⁶

- 14.80** The Committee is concerned with the general lack of accommodation for forensic patients and prisoners after release into the community. NSW Health informed the Committee that 92% of hostels had exclusionary criteria that included a criminal record.¹⁰³⁷ The Legal Aid Commission noted that agencies such as the Richmond Fellowship, which could provide quality placements for forensic patients, have strict admission guidelines and limited capacity to accept the increasing number of forensic patients.¹⁰³⁸

Forensic patients in prison uniforms

- 14.81** During the Committee's site visit to Long Bay Prison Hospital, Members were shocked that forensic patients were dressed in prison uniform and were indistinguishable from prison inmates. While forensic patients must currently be located within correctional facilities, the Committee feels strongly that they should not also be subjected to the stigma of wearing the same attire as prison inmates, particularly those patients not under a custodial sentence.

- 14.82** The Committee raised this issue with the CHS, the Centre for Mental Health, and NSW Health. The Committee enquired whether CHS could address this issue immediately and exempt forensic patients from wearing prison attire. In response, NSW Health advised the Committee that:

The care and treatment of forensic patients will substantially improve when patients are relocated to the new hospital outside Long Bay Correctional Centre. In the meantime, any changes in conditions of patients in Corrective Services' custody will require negotiation with the Department of Corrective Services.¹⁰³⁹

- 14.83** The Committee understands that the new forensic hospital may be several years away from completion. No clear reason has been advanced to refuse forensic patients access to clothing distinct from prison inmates. Accordingly, the Committee calls on the Minister of Health and the Minister of Corrective Services to negotiate to resolve the situation as a matter of urgency.

The new forensic hospital

- 14.84** By treating forensic patients within the precincts of a correctional facility, NSW is currently the only State of Australia not complying with the *National Medical Health Forensic Policy*.¹⁰⁴⁰

¹⁰³⁶ Submission 216, Legal Aid Commission, p 3

¹⁰³⁷ Submission 267, NSW Health, p G 24

¹⁰³⁸ Submission 216, Legal Aid Commission, p 8

¹⁰³⁹ Correspondence from NSW Health to Committee, 20 September 2002

¹⁰⁴⁰ *The National Medical Health Forensic Policy*, cited in Legislative Council, Standing Committee on Social Issues, *Increase in Prisoner Population – Final Report*, 13 November 2001, p 92

The Committee was informed that CHS has been seeking the establishment of a 135-bed secure forensic psychiatric hospital outside the perimeter of a correctional facility, and that seed funding has been provided to develop a proposal for its construction.¹⁰⁴¹ NSW Health has indicated that a Procurement Feasibility Plan has been completed for a maximum secure forensic hospital to be built outside the Long Bay Correctional Complex. The plan was submitted to NSW Treasury for funding under NSW Health's 2002-2003 Asset Acquisition Program.¹⁰⁴² NSW Health explained that the facility was to conform with the *National Medical Health Forensic Policy*:

The planning precepts for the Procurement Feasibility Plan reflected the aims and philosophies of the National Medical Forensic Policy, in that the location of the new hospital is to be outside the correctional facility, with an emphasis upon the clinical aspects of this specialist service.¹⁰⁴³

- 14.85** At present funding of only \$150,000 has been approved in 2002-2003 for planning to proceed to the development of a Project Definition Plan.¹⁰⁴⁴
- 14.86** During the Committee's site visit to Victoria, it was informed that from seed funding to completion for a maximum security forensic hospital can take up to seven years. A forensic hospital for NSW is potentially several years from operation. To avoid the stigma of association with a prison, it would be more appropriate for a forensic hospital to be located away from a correctional facility. The Committee nevertheless concedes that the necessary community consultation period required to locate a hospital elsewhere would further delay the establishment of the facility. The Committee consequently supports the construction of the hospital at the proposed location, though urges the Government to consider the Thomas Embling Hospital built in Victoria as a model for the facility in NSW.
- 14.87** While the construction of a new hospital will take some years to complete, many issues can be addressed in the interim, including:
- continued development and enhancement of court diversion programs
 - transferring patients from medium secure units to the next stage of treatment, generally cottage-type rehabilitation accommodation on hospital grounds
 - exempting forensic patients from wearing prison uniform and
 - addressing the erroneous interpretation and understanding by hospital administrators of the legislation pertaining to mental health and forensic patients.
- 14.88** In addition to the proposed forensic psychiatric hospital outside the perimeter of Long Bay Correctional Complex, the Committee considers that the projected increase in forensic patients requires NSW Health to begin planning the development of more forensic

¹⁰⁴¹ Correspondence from NSW Health to Committee, 2 August and 19 September 2002

¹⁰⁴² *ibid*

¹⁰⁴³ *ibid*

¹⁰⁴⁴ *ibid*

hospitals in other areas of NSW. CHS estimates that there will be a need for 190 formal forensic patient beds in NSW by 2011.

Recommendation 109

That as a matter of urgency the Minister for Health finalise plans, allocate funding and provide all other support necessary to construct a secure forensic mental health unit outside the perimeter of Long Bay Correctional Complex and that the facility be staffed by health professionals and non-corrections personnel.

Recommendation 110

That the Minister for Health allocate funding for the development of plans to construct further maximum and medium security forensic mental health units in NSW, in order to meet the projected needs of the increasing population.

Recommendation 111

That the Minister for Health ensure that there is sufficient minimum security accommodation to avoid undue detention of patients in medium security units.

Recommendation 112

That the Minister for Health and the Minister for Corrective Services immediately act to exempt forensic patients from wearing prison attire.

Prison population

14.89 In November 2001, the final report of the Select Committee on the Increase In Prisoner Population (SCIPP) stated that the current capacity of the NSW prison system is 8,105.¹⁰⁴⁵ To address the increasing prison population, the NSW Government committed to increase capacity to almost 10,000 by the year 2005.¹⁰⁴⁶

14.90 The SCIPP found that inmates suffered disadvantage on a whole range of specific health problems associated with mental illness, drug abuse and general neglect of health.¹⁰⁴⁷

Inmates with a Mental Illness

14.91 The NSW Department of Corrective Services and the CHS informed the SCIPP that for male prisoners:

- 12% have been diagnosed with some form of psychiatric disorder, including depression, anxiety disorder, schizophrenia, or bipolar disorder

¹⁰⁴⁵ Legislative Council, Select Committee on The Increase in Prisoner Population, *Final Report*, November 2001, p xiv

¹⁰⁴⁶ *ibid*

¹⁰⁴⁷ *ibid*, p 19

- 2.6% have been diagnosed with schizophrenia
- 33% have undergone some form of treatment or assessment for emotional and psychological problems and
- 21% have attempted suicide.¹⁰⁴⁸

14.92 During the SCIPP inquiry, Dr Richard Matthews, Chief Executive Officer of CHS, advised the Committee that:

more worryingly, 30% of males and 50% of females had had contact with public mental health services in the 12 months prior to incarceration.¹⁰⁴⁹

14.93 While appearing before this Mental Health Committee, Dr Richard Matthews considered that CHS managed to identify major mental illnesses:

We believe that we are pretty good at picking up major mental illness. Most people are known to us. I think if we have a gap, it is probably more in the area of anxiety disorders, post-traumatic stress disorders and so on.¹⁰⁵⁰

14.94 By contrast, a paper by the Hon Frank Walker QC, President of the Schizophrenia Fellowship of NSW, *The Quest for Justice with Dignity 2*, referred to a 1997 Corrections Health survey which identified that of the 50% of women and 33% of men in NSW prisons needing treatment for a diagnosed mental illness, a proportion were not receiving it. In relation to the statistics the Mr Walker stated:

Sadly only 8 per cent of males (214) and 23 per cent of women (115) were on psychiatric medication. No one in the general prison population save the few lucky enough to get into forensic wards received appropriate medication for psychiatric conditions.

Although we have about 17,600 prisoners received into our gaols annually there are only 90 hospitals beds to treat psychiatric illnesses. About 11 per cent of male prisoners and 14 per cent of female are psychotic. That would suggest that about 1,000 psychotic prisoners are without appropriate medication and need to be isolated from other prisoners in a health setting rather than a prison cell.¹⁰⁵¹

14.95 The Committee asked Dr Richard Matthews whether or not everyone presenting at the Silverwater remand centre receives treatment when required. Dr Matthews responded that:

“Everybody” is a big call. Some people who come there are very quietly psychotic.¹⁰⁵²

¹⁰⁴⁸ Legislative Council, Select Committee on the Increase in Prisoner Population, *Final Report*, November 2001, p 25

¹⁰⁴⁹ *ibid*

¹⁰⁵⁰ R Matthews, Evidence, 30 May 2002, p 21

¹⁰⁵¹ The Hon Frank Walker, *The Quest for Justice with Dignity 2*, tabled document, 8 August 2002, p 1

¹⁰⁵² R Matthews, Evidence, 30 May 2002, p 21

- 14.96** Dr Boettcher, Forensic Psychiatrist, argued that many men and women remain dangerously psychotic and are not treated in prison:

I am perfectly sure that, should the public become aware of the situation, there would be an outcry as it goes against every instinct of humanity. The biggest outrage is that this has been allowed to continue for so long. In my view, the law should deal with the people responsible. Corrections Health is the most dysfunctional organisation I have ever seen. In relation to general psychiatry, the Committee has heard extensive evidence that there has been an acute beds shortage in NSW which has developed over some years. With the introduction of a parliamentary inquiry and the threat of industrial action by doctors at Cumberland Hospital and Penrith hospital, various promises have been made and a few beds have been opened up. However, it is a very dangerous situation and deaths have resulted.¹⁰⁵³

- 14.97** Dr Boettcher later argued:

It is a very hit and miss affair, whether or not somebody who is psychotic is picked up. Admittedly the psychologists are pretty good at picking up. The real problem occurs when somebody refuses medication and there is nothing you can do about it. You can go into any yard—I do not know if you saw them when you visited—and nearly always you can pick out psychotic patients who are not being treated. That is the real problem. What do you do with them then? When I used to see them I would make them forensic patients and put them on the waiting list for the forensic hospital at Long Bay, but often there would be 25 people on the waiting list and it may be weeks before they got over there.¹⁰⁵⁴

- 14.98** There is a critical need for the establishment of a far more effective and continuous receptions screening program. While the CHS asserts that it screens every new reception, it may be that screenings are constrained by time, and in some cases by staff expertise. The Committee considers that this is one area that CHS requires more resources from NSW Health.

Recommendation 113

That NSW Health allocate additional resources to the receptions screening program, including adequate funding and staffing to ensure that remand inmates with a mental health problem are identified.

Inmates with an intellectual disability and a mental illness (dual diagnosis)

- 14.99** Prisoners with psychiatric illnesses and intellectual disabilities are at a double disadvantage in prison. According to a recent report commissioned by the NSW Council for Intellectual Disability and People with Disabilities (NSW),¹⁰⁵⁵ the NSW Department of Corrective Services described the accurate identification of intellectual disability alone as ‘extremely

¹⁰⁵³ B Boettcher, Evidence, 8 August 2002, p 39

¹⁰⁵⁴ *ibid*, p 56

¹⁰⁵⁵ J Simpson, M Martin, and J Green (2001), *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disability and Those at Risk of Offending*, NSW Council for Intellectual Disability.

difficult'.¹⁰⁵⁶ As an indication of the prevalence of dual diagnosis in the prison population, a 1996 NSW Law Reform Commission Report found that of the people appearing at two rural courts, 36% had an intellectual disability and 40% indicated the need for further assessment, based on the Mini-Mental State Examination. 22% of the sample indicated serious mental state abnormalities.¹⁰⁵⁷

- 14.100** The NSW Law Reform Commission report also found that, even where people had been identified as having intellectual disabilities in court proceedings, this information was not always passed onto the next stage, for example, prison. The report commented that this transfer of information was particularly important where people with intellectual disability were Aboriginal or Torres Strait Islander, of non-English speaking background, or had a mental illness. These groups are more likely to be assaulted or abused in prison, and not receive specialist services.¹⁰⁵⁸ (see Chapter 10, Intellectual disability)

Prison mental health facilities – re-institutionalisation

- 14.101** The operation of correctional facilities as surrogate institutions for people with a mental illness was a major issue of concern during the inquiry. This section will focus predominately on the Mulawa Correctional Centre as an example of the issues arising in prisons.
- 14.102** According to the Hon Frank Walker QC, prisons in NSW stand as a contradiction to the government policy of deinstitutionalisation:

The harsh truth in NSW in the year 2002 is that the large mental institutions of the pre 1980s have been replaced with gaols. The difference is that there are more mentally ill folk in our gaols than ever were in the asylums and instead of being treated by health professionals with medication they are being treated by prison wardens in a punitive environment.¹⁰⁵⁹

- 14.103** Mr Walker stated that somebody with a 'cynical perspective' might assert that:

it is all about the bottom line of the budget and rationalist economics. The annual costs to keep a NSW prisoner is \$60,000 while the annual cost of a secured hospital bed is \$200,000. You won't find our Treasury bureaucrats campaigning to build more psychiatric hospitals instead of gaols.¹⁰⁶⁰

¹⁰⁵⁶ J Simpson, M Martin and J Green (2001), *The Framework Report: Appropriate Community Services in NSW for Offenders with Intellectual Disability and Those at Risk of Offending*, NSW Council for Intellectual Disability, p 9

¹⁰⁵⁷ NSW Law Reform Commission (1996), Report no 80, *People with an Intellectual Disability and the Criminal Justice System*, Summary, p 1

¹⁰⁵⁸ *ibid*, paragraph 10.5

¹⁰⁵⁹ The Hon Frank Walker, *The Quest for Justice with Dignity 2*, tabled document, 8 August 2002, p 2

¹⁰⁶⁰ *ibid*

- 14.104** Mrs Kay Valder, Official Visitor for the NSW Department of Corrective Services, described the current pressure on beds within the correctional system:

I am now at Mulawa, a maximum security prison for women where there are 30 women at any one time suffering from a chronic mental disorder and 144 currently suffering with some kind of mental disorder out of 250 inmates in total.

There is not enough suitable accommodation to house the chronically ill at Mulawa and it is exhausting staff trying to manage them.¹⁰⁶¹

- 14.105** The 1999 inmate health survey flagged the incidence of serious mental illness among inmates as a problem that would continue to escalate. Dr Giuffrida referred to a survey, which was commissioned by the CHS:

There were 132 female inmates at Mulawa. An alarming number of patients were shown to be seriously mentally ill: 50 per cent of the patients surveyed stated that they had received some form of treatment or undergone assessment for an emotional or mental health problem by a psychiatrist or a psychologist at some time in their life, and 36 per cent had previously been admitted to a psychiatric unit or psychiatric hospital. That is a very interesting figure.

A little more than a third of these women had actually been in a psychiatric hospital.¹⁰⁶²

- 14.106** Part of the increase in female prisoners with a mental illness may be attributed to the misconception that Mulawa Annexe contains full psychiatric facilities. Dr Giuffrida stated that:

It has been assumed that this unit has the facilities of a hospital. I think I need to point out that there is no hospital at Mulawa. Many magistrates believe mistakenly that there is a fully fledged psychiatric hospital at Mulawa to which they can safely remand mentally ill women knowing that they will get full and proper treatment. Nothing could be further from the truth. Neither is there a medical hospital there.¹⁰⁶³

- 14.107** Mrs Valder referred to the increasing trend of mentally ill persons presenting to prisons:

It is unfair to expect the Department of Corrective Services to be the carers, surely it is the responsibility of the Department of Health to provide adequate facilities and support which could help stem the flow of people committing crimes and going to prison.¹⁰⁶⁴

- 14.108** The Committee visited Mulawa Correctional Centre on 29 July 2002. Members were shocked and seriously concerned about the conditions that inmates and staff endure. Conditions were generally considered to be unacceptable, and that the ability to provide appropriate mental health services presents a major challenge.

¹⁰⁶¹ Supplementary Submission 271A, Mrs Kay Valder, p 1

¹⁰⁶² M Giuffrida, Evidence, 8 August 2002, p 51

¹⁰⁶³ *ibid*, p 52

¹⁰⁶⁴ Submission 271, Mrs Kay Valder, p 1

- 14.109** In response to a question from the Committee concerning the treatment and care of those at risk to themselves at Mulawa, Dr Giuffrida stated:

Women that are judged to be a risk to themselves are put in what are euphemistically called safe cells. I think the Committee has viewed some of these. They are the very last place on earth that I would place a woman who was severely depressed and who was having thoughts of suicide. This is isolation for a start. It is totally antitherapeutic.¹⁰⁶⁵

- 14.110** Ms Trish Butrej, Professional Officer (Occupational Health and Safety), appeared before the Committee as a representative of the NSW Nurses' Association. Ms Butrej provided the Committee with a copy of an Occupational Health and Safety (OHS) Inspection Report on Mulawa Correctional Centre Medical Clinic from February 2002.¹⁰⁶⁶ The inspection report made 31 findings, including that nurses were not provided with duress alarms and the mental health unit did not have duress alarms. The report made 28 recommendations to upgrade the facility to satisfy OHS standards, including removing items that could be used as weapons (microwave, fire extinguishers, glass mirrors), providing nurses with personal duress alarms and improving the ventilation in the mental health unit.¹⁰⁶⁷ In July 2002, during its visit, the Committee noted that many OHS issues were still evident at Mulawa.

- 14.111** The Mum Shirl Unit at Mulawa was opened in 1997 and accommodates inmates with identified mental health and behavioural issues. In July 2000, the Select Committee on the Increase in Prisoner Populations, *Interim Report: Issues Relating to Women*, recommended that the:

Minister for Health and the Minister for Corrective Services undertake a review of the conditions of the Mum Shirl Unit with a view of improving the quality of the conditions for women who are admitted there.¹⁰⁶⁸

- 14.112** The Ministers for Health and Corrective Services later agreed that a review should be undertaken within the next twelve months.¹⁰⁶⁹ The Minister for Health recently advised that the scheduled review is continuing:

The Mum Shirl Unit is run by the Department of Corrective Services. A Committee, chaired by Ms Lee Downes, Governor, Mulawa Correctional Centre, is undertaking a review of the conditions of the Unit. Corrections Health Service is represented on the Committee.¹⁰⁷⁰

- 14.113** Mrs Valder wrote that there was an urgent need for a hospital to house women with chronic mental disorders within the Mulawa grounds. The evidence of this is glaring when

¹⁰⁶⁵ M Giuffrida, Evidence, 8 August 2002, p 52

¹⁰⁶⁶ Ms Trish Butrej et al, Professional Officer (OHS), Mulawa Correctional Centre Medical Clinic OHS Inspection, 27 February 2002

¹⁰⁶⁷ *ibid*

¹⁰⁶⁸ The Select Committee on the Increase in Prisoner Populations, *Interim Report: Issues Relating to Women, July 2000*, Recommendation 5.127, p 138

¹⁰⁶⁹ NSW Legislative Council, Select Committee on the Increase in Prisoner Population – *Final Report*, November 2001, p 139

¹⁰⁷⁰ Correspondence from NSW Minister for Health to Committee, 19 September 2002

considering the following case outlined by Mrs Valder, which was verified by the Serious Offenders Review Council:¹⁰⁷¹

Recently, two of the most difficult to manage inmates have been moved to Parklea Prison, a male prison, as there was no women's prison with suitable secure accommodation. I am very concerned for the welfare of these women. Being sent to a male prison is no place for them but the Department of Corrective Services has no other choice as the Long Bay Hospital always appears to be short of beds.¹⁰⁷²

- 14.114** There can be no question that the incarceration of females in a male prison is inappropriate. The Committee is aware that at least one of the women is a forensic patient under the *Mental Health Act 1990*. Consequently she should not be in prison at all.
- 14.115** While the NSW Government is planning a new maximum-security forensic hospital alongside Long Bay Correctional Complex, the Committee considers that it should give equal consideration to the treatment and care of female forensic patients within a segregated unit of the proposed facility.
- 14.116** Facilities at Mulawa and, more specifically, the Mum Shirl Unit, need to be immediately and dramatically improved. The Select Committee on the Increase in Prisoner Populations recommended that a review of the Mum Shirl Unit be completed within twelve months. As it is now more than two years since the tabling of that report, the Committee considers sufficient time for completion of the review has elapsed. The Minister for Health and Minister for Corrective Services must expedite this review by providing adequate resources and facilitating through bureaucratic processes.

Recommendation 114

That the Minister for Health and Minister for Corrective Services ensure that, in relation to the current review of conditions of the Mum Shirl Unit, Mulawa Correctional Centre:

- the Chair of the review committee is provided with adequate funding and administrative resources to expedite the review and
- recommendations of the review committee be implemented without delay.

Recommendation 115

That the Minister for Health fund a secure forensic mental health facility for women.

¹⁰⁷¹ Submission 285, Serious Offenders Review Council

¹⁰⁷² Supplementary Submission 271A, Mrs Kay Valder, p 1

Recommendation 116

That NSW Health provide the Governor of Mulawa Correctional Centre with funding to improve the facilities for the treatment of women with a mental illness or disorder. The funding allocation should cover the following:

- comprehensive occupational health and safety review by an independent WorkCover accredited consultant and
- implementation of the occupational health and safety review recommendations.

Recommendation 117

That the Minister for Health and the Minister for Corrective Services ensure that any future maximum and medium security forensic hospital built in NSW should incorporate segregated accommodation suitable to male and female patients.

Court Liaison Clinician Service

14.117 In Newcastle in 1997, a pilot court diversion program for people with a mental illness was initiated to manage the high prevalence of mental illness amongst the prison population. After the success of the program, other court-based psychiatric services commenced at Central and Parramatta Courts in 1999 through funding by the CHS. The Mid North Coast Liaison Service established further services in Kempsey and Port Macquarie Local Courts.¹⁰⁷³ The services are administered by the Mid North Coast Area Health Service, and are funded by a Commonwealth Grant for three years ending June 2003.¹⁰⁷⁴

14.118 There is currently one Court Liaison Clinician per court and police cell complex in:¹⁰⁷⁵

- | | |
|-----------------------|--------------|
| • Central | • Penrith |
| • Liverpool/Fairfield | • Sutherland |
| • Burwood | • Parramatta |
| • Lismore | • Newcastle |
| • Port Macquarie | • Wollongong |

14.119 Mr Phillip Scott, Court Liaison Clinician at Port Macquarie, stated that the aim of the Court Liaison Clinician is to liaise, not treat people:

¹⁰⁷³ Submission 267, NSW Health, p A.26

¹⁰⁷⁴ Mid-North Coast Area Action Group, Submission 67, attachment: Mid-North Coast Mental Health Court Liaison Service, p 1

¹⁰⁷⁵ Correspondence from NSW Health to Committee, 15 November 2002, p 3

I possibly am able to assess a person, and how I assess a person is by utilising my expertise that I have learnt as a psychiatric nurse and as a general nurse over the last 30 years. The major assessments I do are, firstly, to look at the risk assessment with reference to suicidality; secondly, to make sure that they are not psychotic; and thirdly, to see that they are not suffering from a substance withdrawal syndrome...It is also primary to be able to identify to the court options available to the court other than imprisonment.¹⁰⁷⁶

14.120 Mr Scott indicated that over the two year period of this position, a total of 430 clients have been referred to the Mid North Coast service, and the role of the Court Liaison Clinician is reliant on the ability to obtain the client's personal permission to represent them from a mental health and health aspect. By obtaining the client's signature and consent to access medical records provides the Liaison Clinician with capacity to indicate to the Court the illness the client may be suffering.¹⁰⁷⁷

14.121 The Court Liaison service has been widely recognised as a successful initiative. As an indication, Mr Scott referred to outcomes for clients referred to the Court Liaison Service in Port Macquarie. For the first twelve months of the service, between June 2000 and June 2001, 19 (10%) clients received were dismissed or diverted from the court to mental health services under Section 32 of the *Mental Health (Criminal Procedure) Act 1990*.¹⁰⁷⁸

14.122 Considering the diversion rate of the Port Macquarie service, Mr Scott argues that the overcrowding and the increasing number of prisoners with mental health issues in the prison system could be reduced if the service was expanded. This could be achieved for the cost of the liaison service and community care within each court's jurisdiction:

It could be argued that if each court in NSW had access to a Court Liaison Service, the effect of 10 clients not being imprisoned for 1 year would multiply directly in proportion to the number of Courts. For example: For 20 Courts, the expected cost saving to the prison system would be 200 inmates per year.¹⁰⁷⁹

14.123 The Committee is mindful that the Select Committee on the Increase In Prisoner Population, *Final Report, November 2001* presented evidence indicating that the efforts of diversionary programs might be restricted by the lack of a community-based alternative:

Probation and Parole staff have made a number of submissions to the Committee regarding the difficulty of finding appropriate services for people with mental illness and intellectual disabilities within the community. They have also reported that finding appropriate activities which offenders with mental illness and intellectual disability can participate in, as part of a Community Service Order is also frequently very difficult. They have told the Committee that this sometime limits the capacity of a court to sentence offenders with mental illness or intellectual impairment into non-custodial options.¹⁰⁸⁰

¹⁰⁷⁶ P Scott, Evidence, 1 August 2002, p 5

¹⁰⁷⁷ *ibid*

¹⁰⁷⁸ *ibid*, p 6

¹⁰⁷⁹ *ibid*, p 7

¹⁰⁸⁰ Legislative Council, Select Committee On The Increase In Prisoner Population, *Final Report*, November 2001, p 100

- 14.124** The Committee commends the successful establishment of the Court Liaison Service and supports not only the continued funding and resources for existing services but also the extension of the service to other regions. A substantial increase in secondary mental health care facilities in the community is required to ensure that successful programs such as the Court Liaison Service remain effective.

Recommendation 118

That NSW Health continue to extend the Court Liaison Service to all regions, including enhanced funding and resources for existing services.

Coordination of forensic mental health services

- 14.125** Coordination of mental health services in the community was demonstrated in Chapter 4 to be complex and fragmented. Coordination of mental health services in a forensic or prison context also raised issues of concern.

- 14.126** A Forensic Psychiatrist working at Long Bay Hospital, Dr Stephen Allnutt, explained that coordination problems often arise with allied mental health services such as social workers and psychologists, who are provided by the NSW Department of Corrective Services:

This creates obvious difficulties when it comes to the sharing of mental health information between two different services, especially when dealing with individuals who are mentally incompetent to give informed consent for release of information.¹⁰⁸¹

- 14.127** Dr Allnutt argued that, in order for mental health services to function efficiently and adequately, service provision to all areas such as courts, prisons, and secure patients need to be:

integrated and administered centrally by a statewide forensic mental health directorship...The provision of psychiatric assessment and care to mentally ill patients in the criminal justice system requires knowledge and careful management of interplay between corrections, justice and health. Each professional paradigm approaches the individual with different agendas, responsibilities, accountabilities, ethical base and expected outcomes.¹⁰⁸²

- 14.128** Dr Olav Nielssen, Forensic Psychiatrist, concurred, calling for the establishment of an integrated Statewide Forensic Mental Health Service (SWFMHS):

The SWFMHS would coordinate the existing court liaison service, prison hospital and gaol clinics, the proposed secure hospital outside the gaol, existing medium and low security beds, a forensic liaison service to community health centres, an assessment and treatment service to Probation and Parole and an academic unit for teaching and research.¹⁰⁸³

¹⁰⁸¹ Submission 281, Dr Stephen Allnutt, pp 1-2

¹⁰⁸² *ibid*

¹⁰⁸³ Submission 22, Dr Olav Nielssen, pp 3-4

14.129 According to Dr Nielssen, the coordination of services would not only improve care for forensic patients but would actually lead to cost savings in some areas.¹⁰⁸⁴

14.130 Dr Allnutt contends that a lack of trained and experienced forensic mental health leadership exists in NSW, which he asserts is a consequence of the inadequate services and working conditions leading to the shortage of high quality forensic professionals within the system.¹⁰⁸⁵ While critical, Dr Allnutt praised the ‘courageous steps’ taken in the last three years by CHS and the NSW Department of Corrective Services to improve the manner in which services are provided. He further argued that NSW needs to place priority on the acceleration of an integrated forensic mental health service.¹⁰⁸⁶

14.131 The Mental Health Review Tribunal acknowledged the establishment by NSW Health of a State Forensic Mental Health Review Group, though it stated that the inadequate services and ‘bottle-neck’ conditions have not yet been addressed:

NSW currently lags behind other states in relation to forensic mental health services, inclusive clinical treatment, rehabilitation and support as well as non-clinical support.

...Community safety is not enhanced by the absence of the comprehensive and coordinated clinical treatment and support which are prerequisite to a forensic patient’s transitional and safe progression through phased levels of security, treatment, rehabilitation and supervision both in custody and during conditional release.¹⁰⁸⁷

14.132 The NSW Legal Aid Commission argues that the lack of integration between mental health services, the courts and the NSW Department of Corrective Services, has resulted in people being treated for a mental illness in prison, frequently released into the community on discharge without being integrated back into mental health services.¹⁰⁸⁸ Subsequently, they deteriorate without treatment and frequently resume the offending behaviour that led to their involvement with the criminal justice system.¹⁰⁸⁹

14.133 The Commission acknowledged the efforts by CHS to refer the person to a community mental health service, but stated that this is unsuccessful because of the unwillingness of those services to accept former prisoners.¹⁰⁹⁰ The Commission provided a number of case studies to highlight the lack of service integration, including that of ‘CD’:

CD appeared before Parramatta District Court on a robbery charge. He was represented by a Legal Aid Commission solicitor. He was found not fit to plead, and acquitted. After spending 18 months in Long Bay Prison Hospital, he was released with no referral for ongoing treatment, no money and nowhere to go. The Legal Aid Commission solicitor gave CD \$20 and organised a bed for him at

¹⁰⁸⁴ Submission 22, Dr Olav Nielssen, pp 3-4

¹⁰⁸⁵ Submission 281, Dr Stephen Allnutt, p 3

¹⁰⁸⁶ *ibid*, p 3-5

¹⁰⁸⁷ Submission 266, Mental Health Review Tribunal, p 13

¹⁰⁸⁸ Submission 216, Legal Aid Commission, p 1

¹⁰⁸⁹ *ibid*, p 2

¹⁰⁹⁰ *ibid*

the Matthew Talbot Hostel. Some time later he was arrested and charged with attempted murder. He was found unfit to be tried, and the matter was referred to the Mental Health Review Tribunal. CD is currently in gaol awaiting the determination of the Mental Health Review Tribunal.¹⁰⁹¹

- 14.134** According to the Commission, AHS staff are reluctant to provide care for forensic patients once they have left the care of CHS, and this is particularly the case if substance abuse issues are involved (see Chapter 10, MISA).¹⁰⁹²

State Forensic Mental Health Directorate

- 14.135** NSW Health has approved the establishment of a State Forensic Mental Health Directorate. The Directorate is to be responsible for matters such as court and community liaison, mental health services in correctional centres, the new forensic hospital and the development of a liaison service to assist area health services with the management of difficult and dangerous patients.¹⁰⁹³
- 14.136** The State Director of Forensic Mental Health Services will report to the Director of the Centre for Mental Health, in a professional context, but report to the CEO of CHS, from an operations context.¹⁰⁹⁴
- 14.137** The Committee applauds the planned establishment of the Directorate, since coordination of forensic mental health services is manifestly required. The Legal Aid Commission stated that the ad-hoc delivery of services and the difficulty in locating adequate accommodation for forensic patients is symptomatic of the lack of a coordinated statewide approach to forensic mental health services.¹⁰⁹⁵
- 14.138** An issue the Directorate must address is the erroneous interpretation and understanding by hospital administrators of the legislation pertaining to mental health. The Legal Aid Commission informed the Committee that a common comment from hospital staff is: "This is not a forensic unit".¹⁰⁹⁶ According to the Commission:
- There is obviously a feeling amongst some hospital staff that anyone who commits an offence should be processed through the legal system and not diverted. However, section 33 of the *Mental Health (Criminal Procedure) Act 1990* has been enacted in order to give to the Magistrate, not the hospital, the discretion to divert mentally ill persons out of the criminal justice system.¹⁰⁹⁷
- 14.139** NSW must improve mental health services for prisoners. The lack of access to services, the conditions of service and resources made available to health personnel working within the system is unacceptable.

¹⁰⁹¹ Submission 216, Legal Aid Commission, p 2

¹⁰⁹² *ibid*, pp 2-3

¹⁰⁹³ Correspondence from NSW Health to Committee, 20 September 2002

¹⁰⁹⁴ *ibid*

¹⁰⁹⁵ Submission 216, Legal Aid Commission, p 8

¹⁰⁹⁶ *ibid*, p 11

¹⁰⁹⁷ *ibid*

A new approach

14.140 During the inquiry the Committee repeatedly asked witnesses, including NSW Health representatives, why people that were found not guilty by reason of mental illness were being hospitalised within a correctional facility. There were two predominant answers:

- that Long Bay Prison Hospital was the only maximum security forensic hospital in NSW and
- there are insufficient forensic beds in the community.

14.141 The consequence of this is that people found not guilty by reason of mental illness or unfit to stand trial are treated as prison inmates. Dr Allnutt highlights that this runs contrary to the fundamental tenets of criminal responsibility and punishment.¹⁰⁹⁸ Currently in NSW, the court verdict for a diagnosed psychiatric patient may only influence the length of sentence, rather than the freedom versus punishment of innocence or guilt.

14.142 Clearly the provision of care and treatment for forensic patients at Long Bay Prison Hospital is outdated, inappropriate and dramatically under-funded. NSW Health must ensure that the development of the proposed new forensic facility is not only adequate for the present situation but also for the future.

The Victorian Model – Thomas Embling Hospital

14.143 On 9 October 2002, the Committee visited the Thomas Embling Hospital in Victoria. The hospital, completed in April 2000, is a maximum-security forensic hospital with a 100 bed capacity spanning acute care, women's care and continuing care.

14.144 The hospital is operated by Forensicare, the trading name for the Victorian Institute of Forensic Mental Health, which is a statutory body established by the Parliament of Victoria. Forensicare is mandated by the Victorian *Mental Health Act 1986*, the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* and other legislation, to provide inpatient and community services to mentally ill offenders in Victoria. Forensicare patients are referred through the courts, public mental health services, the police, the prison system and justice agencies. Under the *Mental Health Act*, Forensicare is also mandated to provide research, training and professional and community education.

14.145 The Chief Executive Officer, Mr Michael Burt and the Clinical Director of Forensicare, Prof Paul Mullen escorted the Committee on a tour of the hospital, which is set on 8.4 hectares of land. The landscape planning, building design and the fact that the patients were not in uniform impressed the Committee Members. The facilities were superior to those available in NSW and as far as the Committee could determine, NSW should adopt Thomas Embling Hospital as a model for its proposed forensic hospital. This facility has received international acclaim. Prof Sir David Goldberg, Emeritus Professor, Institute of Psychiatry, King's College, London made the following comments after visiting Thomas Embling Hospital:

¹⁰⁹⁸ Submission 281, Dr Stephen Allnutt, p 3

The forensic hospital was the best I have seen anywhere, and the relaxed atmosphere and close contact with the patients was made possible by splendid and innovative architecture.¹⁰⁹⁹

14.146 The Committee was surprised by the absence of Closed Circuit Television (CCTV) cameras, other than for perimeter security. By contrast, Long Bay Prison Hospital, Mulawa and MRRC correctional facilities have many CCTV cameras intended to closely monitor inmates. Prof Mullen informed the Committee that, rather than a reliance on cameras and monitors, physical clinical care, management and adequate staffing are critical in providing appropriate care. That there have not been any suicides or homicides within the hospital would support Prof Mullen's assertion.

14.147 The Thomas Embling Hospital experienced some initial problems, however the Committee understands that a good clinical and security relationship has been established following a security redevelopment. The Victorian experience should be viewed as an educational experience for NSW. Despite the international acclaim for the Thomas Embling Hospital, Prof Mullen recognised the importance of consolidating the achievements made in Victoria in the *Forensic Annual Report 2000/2002*:

The advances and accomplishments of the last year notwithstanding we still have a long way to go before our forensic mental health services is developed to its full potential. Mental health services in prisons require improvements in scope and organisation. Our specialist community forensic service, whilst excellent, requires expansion to more properly meet the needs of courts, corrections and our public mental health service colleagues. In short, a good year, but still a long way to travel.¹¹⁰⁰

14.148 The bipartisan commitment to the Thomas Embling Hospital shown by a number of different governments in Victoria, Labor and Liberal, ensured its construction and success. This bipartisan commitment is critical if reform of NSW forensic psychiatric services is to occur. The Committee considers that the NSW Parliament should accordingly adopt a bipartisan commitment to this process. Adequate care for the mentally ill, whether they are prisoners or forensic patients, must be distinguished from general law and order issues.

A coordinated approach - NSW State Institute of Forensic Science

14.149 The Committee acknowledges that in February 2001, the Standing Committee of Law and Justice noted in its *Review of the Crimes (Forensic Procedures) Act 2000*, that a State Institute of Forensic Science (SIFS) was proposed to oversee the organisation and management of forensic sciences and the use of technology in criminal investigations and prosecutions.¹¹⁰¹ The SIFS is a joint proposal of the NSW Police Service, the Attorney General's Department and NSW Health. The Law and Justice Committee recommended that its establishment be given priority attention.¹¹⁰²

¹⁰⁹⁹ Prof Sir David Goldberg, Professor Emeritus, *Australian Psychiatry*, Vol. 8, No. 4, December 2000

¹¹⁰⁰ Clinical Director's Report, Forensic, *Annual Report 2000/2001*, p 4

¹¹⁰¹ NSW Legislative Council, Standing Committee on Law and Justice, *Review of the Crimes (Forensic Procedures) Act 2000*, February 2001, p 32

¹¹⁰² *ibid*

- 14.150** While the recommendation for the SIFS by the Law and Justice Committee specifically concerned the most effective means of accurately presenting the significance of DNA profile matches, this Select Committee sees merit in the establishment of the SIFS in an expanded form, to include forensic mental health services. The relocation of the State Forensic Mental Health Directorate to the SIFS, with reporting duties to a SIFS Board of Management, is also desirable.
- 14.151** The prisoner population has increased from 3,000 in 1995-1996 to almost 8,000 in 2000-2001. The percentage of mental health expenditure of the total CHS expenditure has increased from 33.75% in 1995-1996 to only 34.29% in 2000-2001.¹¹⁰³ Supplementary funding to even maintain existing mental health services in correctional facilities in NSW is required. The Committee sees an expanded role and funding for the CHS in the treatment and care of prisoners with a mental illness.
- 14.152** The shortage of practising forensic psychiatrists is a major hindrance in the provision of adequate care. The Committee has heard that the conditions under which many forensic psychiatrists are required to work remain a deterrent to continued practice in the field.
- 14.153** Forensicare has, however, managed to reverse this trend. Psychiatrists with Forensicare are on staff, resulting in little or no requirement for VMOs. Staff psychiatrists are only allocated one day for private practice and research, as opposed to two days in NSW. Prof Mullen argues that it is the conditions and variety of workplace that Forensicare provide which are attractive to staff.
- 14.154** For all of the above reasons, the Committee advocates the establishment of the SIFS, incorporating the organisation and management of forensic sciences, including DNA profiling, the Department of Forensic Medicine, and forensic mental health services.
- 14.155** In order to attract forensic psychiatrists to work in the prison and forensic environment, the Committee considers that the funding of forensic psychiatrists within NSW should be allocated to the SIFS. The allocation of forensic psychiatric services would then be determined through a purchaser-provider model between CHS and the SIFS. Psychiatrists would consequently be employed by the SIFS, operating within its clinical guidelines, funding rationale and responsiveness.
- 14.156** This Committee understands that the Director of the Centre for Mental Health and the Chair of the Corrections Health Board are yet to visit Thomas Embling Hospital. A visit by these officers to examine the process by which Forensicare established the Thomas Embling Hospital would assist in the planning for the proposed unit in NSW.

¹¹⁰³ Correspondence from NSW Health to Committee, 20 September 2002, expenditure on the mental health program as a percentage of total area expenditure

Recommendation 119

That the Attorney General and the Minister for Health cooperate to expedite the establishment of a State Institute of Forensic Science, and include forensic mental health within its responsibilities. Features relating to forensic mental health to be incorporated within the State Institute of Forensic Science include:

- provision of forensic mental health services, including court liaison services and court reports
- responsibility as a provider for all forensic psychiatric services in NSW
- a Board of Management to oversee operations and
- a State Forensic Mental Health Service located within the State Institute of Forensic Science which reports through the State Institute of Forensic Science Board to the Director General of NSW Health.

Recommendation 120

That NSW Health evaluate the model and structure of mental health services provided by Forensicare at the Thomas Embling Hospital in Victoria with a view to implementing this model for any planned forensic hospital facility in NSW.

Appendix 1

Developments in mental health since
inquiry commencement

Developments in mental health since inquiry commencement

A number of significant developments have occurred in mental health since the Select Committee on Mental Health commenced the inquiry in January 2002. Many of these developments were incidentally or coincidentally, related to evidence presented to the Committee concerning deficiencies in policies and programs for those with mental illnesses.

NSW Health provided the following information which is reproduced in full, without comment.

NSW HEALTH – ACHIEVEMENTS AND INITIATIVES IN MENTAL HEALTH IN 2002

These achievements and initiatives are a snapshot of the quality clinical programs and other initiatives in mental health that have occurred this year. It is not intended to be an exhaustive list of projects but representative of the substantial activity that has occurred.

ONGOING

Beds

- 300 additional beds and places for supported accommodation released throughout 2002 and into early 2003
- Development of effective models of clinical care and service organisation within inpatient services, and a coordinated Bed Management Program

Quality Initiatives

- Section 237 reviews completed on all gazetted acute psychiatric inpatient units in NSW
- Monthly and quarterly reports provided by Areas on quality indicators

Workforce

- Mental health continues to be a priority area for the appointment of mental health nurse practitioners; masters of clinical practice programs are being aligned to offer the required training
- The Centre for Mental Health, in collaboration with the Office of the Chief Nursing Officer, allocated approximately \$5.35 million Commonwealth funds to implement a range of mental health nursing education strategies, to build and market career paths in mental health nursing, with nursing recruitment through this process
- The provision of training posts for general practitioners in rural psychiatry with a curriculum being developed by the Institute of Psychiatry and the RANZCP

Suicide Prevention

- Ongoing review and training for clinicians in 98/31 Policy Management Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities
- Australian data shows that the NSW suicide rate is at or below the Australian average. The Report of the Chief Health Officer 2002 shows that the NSW youth suicide rate in 1999 and 2000 was the lowest since the mid-1980's

Non-Government Organisations (NGOs)

- \$1 million has been allocated to NGOs and NGO & Area Mental Health consortiums to pilot 8 family and caring for carers mental health programs

- Carers NSW has commenced a project to provide support and training, counseling and emotional support and build responsiveness of services to the needs of families and carers in 3 pilot locations; 1 rural, 1 regional and 1 metropolitan
- The Mental Health Co-ordinating Council has been allocated \$1 million over two and half years to develop partnerships between NGOs and Area Mental Health Services. The positions will provide project support, assistance with training and quality improvements as well as with the evaluation of services and models of care.

JANUARY

Information management

- Delivery completed on time to the Commonwealth of required de-identified unit record data for the National Minimum Dataset Community Client Care. The first statewide ambulatory client data ever produced in NSW, including State level unique client identifiers in frameworks within the primary regulations and requirements

Promotion and Prevention

- Article was published in the Auseinet Newsletter about the consultation in NSW for the National Action Plan for Promotion, Prevention and Early Intervention in Mental Health; circulated to Area CEO's

NGOs

- Macquarie Area Mental Health Service contracted a local Non-Government Organisation to coordinate and assist this rural community to commence their own mental health advocacy groups

FEBRUARY

Quality Initiatives

- State-wide consultation between NSW Health, NSW Police and NSW Ambulance Service has commenced, extending the Memorandum of Understanding between these entities

Suicide

- Supporting Children After Suicide Booklet developed by South Western Sydney Area Health Service. The booklet was launched as a statewide resource on February 19, 2002 in Dubbo by the National Association for Loss and Grief

Comorbidity

- NSW Health coordinated a national meeting on acute patients with comorbidity of drug and alcohol problems to determine clinical and good practice domains and to contribute to improved patterns of care

Depression

- Premier announced the establishment of the Black Dog Institute, a research, treatment and training facility for depression, located on the campus of the Prince of Wales Hospital

MARCH

Quality Initiatives

- Draft quality portfolio developed by The Centre for Mental Health, comprising 15 components
- 237 Inspections commenced reviewing acute inpatient programs in all Area Health Services

Aboriginal Mental Health

- Development of the Care & Support Pack for Aboriginal health workers

Families and Parents

- The final draft of strategic framework for the project, NSW Parenting Partnerships: Framework for 2002-2004 distributed to NSW Health, other government Departments, non-government organisations and peak bodies representing agencies working with families

- The clinical access to parenting programs (capp) centre began pilots of these programs, to determine their efficacy for populations across NSW.
- The NSW Parenting Program for Mental Health met with the NSW Parenting Centre, DoCS regarding areas for collaboration and cooperation in providing parents with access to evidence based parenting information.

APRIL

Suicide Prevention

- StateRail: Suicide Prevention Collaboration meeting held, hosted by StateRail with staff from NSW Health attending. Meeting identified future joint suicide prevention strategies/projects to improve collaboration and share information and knowledge concerning suicide prevention initiatives.
- Hunter Institute of Mental Health Project commenced work with the Elderly Suicide Prevention Network to further develop and to disseminate the video resources relating to Depression and Suicide Prevention for Older Persons; and to support the implementation across NSW of the elderly suicide prevention 98/31 training programs

Beds and Housing

- The NSW Aboriginal Housing Office and the Aboriginal Health and Medical research Council are invited to join the Joint Guarantee of Service (JGOS) for people with mental health problems and disorders

Workforce Developments

- Consultation between General Practitioners and Mental Health staff in Tamworth and Armidale for Teams of 2 – Joint Learning Initiative

MAY

Aboriginal Mental Health

- The inaugural Aboriginal Mental Health Workers Forum was held in Sydney, for all Aboriginal Mental Health and Social and Emotional Well-being workers from throughout NSW

Young People

- Statewide Area School-Link Coordinators Forum was held with speakers invited to provide information to School-Link Coordinators
- The New England Area Health Service in partnership with the Lion's Club of Tamworth commenced a 6 month education/awareness project targeting depression in men. This is one of a series of projects addressing depression in the area

JUNE

Funding

- The Premier announced an increase of \$20 million recurrent for mental health in NSW to support an accelerated beds, supported accommodation and clinical programs to in addition to the current budget of \$107.5 million recurrent.

Quality Initiatives

- The Memorandum of Understanding between the NSW Police, Ambulance and Health ratified protocols and established a collaborative response to crisis or emergency situations involving persons suspected of having a mental disorder of illness, including specific flow charts

Suicide Prevention

- Suicide Prevention Conference The 9th Annual National Conference of Suicide Prevention held at Darling Harbour Convention Centre, Sydney on 21-23 June 2002
- Elderly Suicide Prevention Training Support Project being conducted by the Hunter Institute of Mental Health, in collaboration with the ESPN commences

Bereavement Support

- Review of bereavement support services undertaken by the Centre for Mental Health, focusing on the availability of bereavement support services across NSW, establishment of a database on provider qualifications and evidence based practice, and development of a CDROM training package

Children & Young People

- Two regional School-Link Conferences held; Western Sydney and Northern Sydney, covering a range of issues relating to children and adolescents' mental health.

JULY**Quality Initiatives**

- Memorandum of Understanding implementation schedule commenced

Information Management

- Approximately 80% of all mental health clinical staff trained in MH-OAT and over 50% of services had commenced outcomes collection data

Workforce

- Inaugural workshop for rural Psychiatry Trainees held in Sydney

AUGUST**Quality Initiatives**

- Inaugural meeting of the NSW Mental Health Sentinel Events Committee; a committee established by the Minister to monitor serious mental health incidents, including suicides and homicides

Children and Young People

- Network consultation commences for Child and Adolescent Mental Health Service Networks

Beds and Housing

- Beds network project commences with consultations and formulation of project

SEPTEMBER**Forensics**

- Administration of the Forensic Patient Victims Register transferred to NSW Health

Quality Initiatives

- Comprehensive risk assessment guidelines, discharge protocols, and access to means checklist for inpatient units developed by Northern Sydney Area Health Service in collaboration with NSW Health

Beds and Housing

- Mental Health Reconnect established to provide brokerage and outreach services to homeless youth and their families

Information Management

- Training package for Early Psychosis MH-OAT module commenced.

OCTOBER**Bali Response**

- Bali response; Mental Health Services provided a systematic support response for people affected, families and the community
- Helpline established to provide immediate information and referral to Area Mental Health Services to respond to people affected by the Bali disaster

Suicide Prevention

- Policy Circular 98/31– Suicide Prevention One-Day Forum held for Area health staff responsible for implementation of the policy guidelines.

- State Rail one-day forum organised by State Rail, NSW Department of Transport, Rail Infrastructure Corporation and the Centre for Mental Health, held to explore and discuss the issues of mutual concern to address suicide prevention
- Australian data shows that the NSW suicide rate is at or below the Australian average. The Report of the Chief Health Officer 2002 shows that the NSW youth suicide rate in 1999 and 2000 was the lowest since the mid-1980s.

Parenting and Young People

- Central Coast Area Health Service launched a resource and training kit to promote positive mental health in families

Information Management

- Release of SCI MHOAT system v1.05 including ability to extract MHOAT data for delivery to the Commonwealth by December 2002
- By the end of October 2002 NSW had 100% of staff trained and 89% of services collecting data. These figures are averages across Areas.

NOVEMBER

Rehabilitation

- Launch of the final document frameworks; Housing and Accommodation Support for People with Mental Health Problems and Disorders and Rehabilitation for Mental Health and CDROM aimed to assist clinicians and consumers in current best practice and evidence base for rehabilitation in mental health

Workforce

- Partnership to develop learning curriculum for rural general practitioners, between the Institute of Psychiatry, RANZCP and Rural General Practice Training Consortia commences

Families Consumers and Carers

- Macquarie Hospital expo for mental health consumers and service providers

Aboriginal mental Health

- Partnership between South East Sydney Area Mental Health Service and Redfern Aboriginal Medical Service, Women's Art Group present The Centre for Mental Health with the Artwork "Connections"

DECEMBER

Beds and Housing

- The new 16 bed non-acute unit at Bloomfield to open

EARLY 2003

Workforce

- Bed networks project due to formally commence
- Pilot of the first Teams of 2 module – Physical Health/Mental Health, February 200
- New England Area Health Service and the Barwon Division of General Practice will commence the pilot of it's telehealth initiative allowing GPs in Narrabri and Moree to case conference with a psychiatrist, February 2003
- Release of a book 'State of the Art', a compilation of practical examples of different approaches to local partnerships between mental health workers and general practitioners

Appendix 2

Submissions

Submissions¹¹⁰⁴

No	Author	Published by Committee
1	Private and confidential	No
2	PRATT Ms Anne	No
3	SHEEDY Mr Jim	No
4	WILLIAMSON Mr David	No
5	MYJAVEC Mr Paul	No
6	MCNAUGHT Mr Don	No
7	Private and confidential	No
8	SMITH Mr Eric (Carers Lodge, Young Community Caring Group)	Yes
9	Private and confidential	No
10	Private and confidential	No
11	Office Of The State Coroner	Yes
12	CASEY Ms Desley	No
13	JOBLING Mr David	No
14	PIERCE Ms Emma	No
15	SWAN Dr H P	Yes
16	GARDINER Ms Fenella	Yes
17	DEANE Ms Colleen	No
18	Private and confidential	No
19	Private and confidential	No
20	FORD Mr Roger	No
21	DIXON Ms Barbara	No
22	NIELSEN Dr Olav (Royal Aust & NZ College of Psychiatrists)	Yes
23	ALCOCK Mr Barry	Yes
24	FAIRFAX Miss Pia	No
25	JACKSON Ms Glenys	No
26	HALE Ms Amanda (Nimbin Neighbourhood & Information Centre)	Yes
27	JAMES Ms Sharon	No
28	LIEBMANN Mr John Justin	No
29	BRIGHT Mrs Rita	No
30	CRIPPS Ms Sue (Director Charmian Clift Cottages)	Yes
31	HODSON Mr Craig	No

¹¹⁰⁴ Supplementary submissions received are recorded within the original allocated submission number.

No	Author	Published by Committee
32	KINNINMENT Ms Pam	No
33	BULGIN Mr D A	No
34	STEWART Mr Tom	No
35	COOMBES Dr Bruce	Yes
36	BARRA Ms Louisa	No
37	GRAY Mr Peter	No
38	ANONYMOUS	No
39	CROSSINGHAM Ms Edna	No
40	BLEASDALE Ms Catherine	Yes
41	HUTTEN Mr Peter	No
42	Private and confidential	No
43	CHARLTON Ms Jean	Yes
44	QUESTED Mr James	No
45	ROGERS Ms Trish	No
46	HEAL Mr John	No
47	BLOOMFIELD Mr Greg	Yes
48	BRODATY Professor Henry	Yes
49	LORD Ms Lexie (Parents and Carers Mental Health Group)	No
50	COOPER Mrs Jean	No
51	ANONYMOUS	No
52	Australian Medical Association (NSW)	Yes
53	KILKEARY Mr Stephen	No
54	WOOLLEY Dr Judith	No
55	YATES Mr Pat	No
56	Private and confidential	No
57	BILLS Mr Bruce	No
58	Kempsey Mental Health Support Group	Yes
59	O'LEARY Mrs Carmel	No
60	Civil Chaplaincies Advisory Council	Yes
61	BEITL Ms Julia	No
62	NSW Council for Intellectual Disability	Yes
63	FLETT Ms Josie	No
64	Macksville Positive Living Skills Centre	Yes
65	Coffs Harbour Living Skills Centre	Yes
66	Private and confidential	No

No	Author	Published by Committee
67	SCOTT Mr Philip (Mid-North Coast Area Action Group)	Yes
68	BELL R.	No
69	ROWE Mr Graham	No
70	ROWE Ms Val	No
71	St Agnes Support Service	Yes
72	Private and confidential	No
73	Private and confidential	No
74	Private and confidential	No
75	Gethsemane Community	Yes
76	Northern Rivers Area Health Service	Yes
77	Mental Illness Education Australia (NSW)	Yes
78	UnitingCare	Yes
79	BAYLEY Ms Patricia	No
80	Alzheimer's Association NSW	Yes
81	BEVERLEY Ms Pamela	No
82	HAMILTONS Mr Thomass	No
83	Private and confidential	No
84	BARRA Ms Louisa	No
85	Parramatta Council	Yes
86	REGAN Ms Christine	No
87	FRANKLIN Ms Liz	No
88	Faculty Of Psychiatry Of Old Age (NSW)	Yes
89	Private and confidential	No
90	Illawarra A.R.A.F.M.I	Yes
91	Australian Salaried Medical Officers' Federation	Yes
92	STARLING Dr Jean (NSW faculty of Child & Adolescent Psychiatry)	Yes
93	The MaiWel Group	Yes
94	Private and confidential	No
95	PARSONS Mr Robert	No
96	Parramatta Mission	Yes
97	Life Activities	Yes
98	B. Miles Women's Housing Scheme	Yes
99	Macarthur Disability Network	Yes
100	Private and confidential	No

No	Author	Published by Committee
101	OLIVER Ms Margaret	No
102	Special Interest Group In Intellectual Disability of the RANZCP	Yes
103	Assoc of Relatives & Friends of the Mentally Ill (NSW)	Yes
104	Australia Consumers Association	Yes
105	The Compeer Program, St Vincent de Paul Society	Yes
106	Guardianship Tribunal	Yes
107	MARCHLEWSKI Mr Roman	Yes
108	Hornsby Ku-ring-gai Association Action for Mental Health	Yes
109	Partners of Veterans of Australia	Yes
110	Private and confidential	No
111	St George Community And Consumer Consultative Committee	Yes
112	Second Opinion Society Australia	Yes
113	Serenity NSW	Yes
114	Private and confidential	No
115	Private and confidential	No
116	Private and confidential	No
117	SIMPSON Ms Geraldine	No
118	REYNOLDS Mrs Leslee	No
119	Aboriginal Medical Service, Dharah Gibinj	Yes
120	Health Care Complaints Commission	Yes
121	Lake Macquarie Clubhouse	Yes
122	Mission Australia	Yes
123	JewishCare Family and Community Services	Yes
124	MONRO Mr James	No
125	Couselling And Retraining for Employment (CARE)	Yes
126	Northern Rivers Area Mental Health Council	Yes
127	Private and confidential	No
128	Northern Beaches Mental Health Support Group	Yes
129	WISEMAN Ms Dianne	No
130	Australian Association of Social Workers (NSW)	Yes
131	WALSH Ms Helen	No
132	SANE Australia	Yes
133	Anonymous	No
134	PICCOLI MP The Hon Adrian	Yes
135	MARSH Mr Chris	No

No	Author	Published by Committee
136	TWOHILL Ms Ros	No
137	OLIVER Ms Margaret	No
138	HINES Ms Christine	No
139	MARSH Ms Joy	No
140	Community Consultative Committee for Mental Health Services, Mid West Area, Bloomfield Hospital	Yes
141	Private and confidential	No
142	BOHM Ms Barbara	No
143	Society of St Vincent de Paul, State Council of NSW	Yes
144	BRERETON Mr Graham	No
145	BILLS Mr/Ms J	No
146	MCMAHON Mr John	No
147	THOMPSON Ms Helen	No
148	BAILEY Mr John	No
149	Port Macquarie Division of General Practice Ltd	Yes
150	HEYES Ms Cathy	No
151	Private and confidential	No
152	LORD Mrs Christine	No
153	NEWLING Mr William	No
154	WAGSTAFF Mrs Patricia	No
155	DOYLE Ms Maureen	No
156	MCDONALD Mr Ray	No
157	Private and confidential	No
158	Private and confidential	No
159	The Richmond Fellowship	Yes
160	NSW Aged Care Alliance Working Party (NCOSS)	Yes
161	REGAN Ms Christine (supplementary)	Yes
162	NSW Consumer Advisory Group	Yes
163	Northern beaches Consumer Network & Pioneer Clubhouse	Yes
164	Griffith Suicide Prevention & Support Group	Yes
165	BOHM Ms Barbara	No
166	Private and confidential	No
167	DAGGER Mrs Lyn	No
168	OLSEN Mr John	No
169	BROTHERTON Mrs Clare	No

No	Author	Published by Committee
170	MONRO Mr James	No
171	Mental Health Association NSW	Yes
172	Coalition for Appropriate Supported Accommodation (CASA)	Yes
173	Private and confidential	No
174	Whistleblowers Australia	Yes
175	Illawarra Legal Centre Tenant's Service	Yes
176	POWELL Ms Helen	No
177	RIDLEY Ms Dorothy	Yes
178	POWER Mr Paul	Yes
179	Disability Council of NSW	Yes
180	YOUNG Ms Lydia	No
181	LENNANE Dr Jean	Yes
182	St John of God Health Services	Yes
183	Uniting Care NSW.ACT	Yes
184	FOWLER Ms Gabriel	Yes
185	DEVESON Ms Anne	No
186	Association of Children's Welfare Agencies	Yes
187	South West Sydney Area Carer Network	Yes
188	Mission Australia NSW & ACT	Yes
189	National Association of Practising Psychiatrists	Yes
190	Illawarra Women's Health Service	Yes
191	Central West Women's Health Service	Yes
192	Council of Social Service of NSW (NCOSS)	Yes
193	WEBSTER AO Prof. Ian	Yes
194	Lifeline NSW	Yes
195	Private and confidential	No
196	Carers NSW	Yes
197	KORNER Dr Nils (ARAFMI NSW)	No
198	Shelter NSW	Yes
199	Private and confidential	No
200	KELLY Mr Warwick	No
201	CAMPBELL Mr Ted	Yes
202	GALVIN Ms Fran	Yes
203	BALDRY Dr Eileen	Yes
204	Country Women's Association of NSW	Yes

No	Author	Published by Committee
205	ZABAKS Ms Patricia	No
206	Salvation Army, Australian Eastern Territory	Yes
207	Medical Consumers Association	Yes
208	SEI Ms Christina	No
209	Comprehensive Area Service Psychiatrists (CASP)	Yes
210	BERRUTTI Ms Patricia	No
211	JACKSON Ms Leonie	No
212	New South Wales Nurses' Association	Yes
213	Private and confidential	No
214	NSW Association for Adolescent Health	Yes
215	Private and confidential	No
216	Mental Health Advocacy Service (Legal Aid)	Yes
217	Grafton ARAFMI	No
218	Mental Health Co-ordinating Council	Yes
219	Office of the Protective Commissioner	Yes
220	OAKES Ms Diane	No
221	Australian Mental health Suicide Consumer-Alliance (Club SPERANZA)	Yes
222	Private and confidential	No
223	CONNOLEY Mr Patrick & BRENNAN Ms Elizabeth	No
224	SCOTMAN Ms Gwen	No
225	CONNELLY Mr Julian	No
226	Commonwealth Department of Health and Ageing	Yes
227	People with Disabilities (NSW)	Yes
228	NSW Transcultural Mental Health Centre	Yes
229	Private and confidential	No
230	The Royal Australian & New Zealand College of Psychiatrists (NSW Branch)	Yes
231	ROWNEY Ms Veronica	No
232	CARNE Mr Jonathan	Yes
233	CAMPBELL Dr Andrew (CASP)	Yes
234	HUNTT Mr Denis	No
235	Private and confidential	No
236	Mental Health Reconnect	Yes
237	SULIMA Mr/Ms JM	Yes

No	Author	Published by Committee
238	MIDDLETON Major Lyn	Yes
239	PUPLICK Mr Chris	Yes
240	WADE Ms Margaret	No
241	Life Activities (Newcastle NSW)	Yes
242	The Mental Health Network, Fairfield Health Forum	Yes
243	Shopfront Youth Legal Centre	Yes
244	STEPHAN Ms Jill	No
245	Schizophrenia Fellowship of NSW	Yes
246	KIRKBY Ms Elisabeth	No
247	PATEMAN Mr & Mrs	Yes
248	VICKERY Mr Rick	Yes
249	The Women's Centre	Yes
250	OAKESHOTT MP Mr Robert	Yes
251	Men's Health Information and Resource Centre	Yes
252	STEEL Mr Grahame	Yes
253	CAMPBELL Mr Ted	Yes
254	Police Association of New South Wales	Yes
255	Office of the Public Guardian (NSW)	Yes
256	SMITH Mrs Patricia	No
257	TYACK Mrs Joy E	No
258	Australian & New Zealand College of Mental Health Nurses	Yes
259	Women and Mental Health	Yes
260	D'ARRIETTA Mrs Rosemrie	No
261	Lithgow Family and Community Mental Health Support Group	Yes
262	Waromi Carer's Support Group	No
263	BARCLAY AM Dr William	Yes
264	RICHARDS Mr Douglas	No
265	Multicultural Disability Advocacy Association of NSW	Yes
266	Mental Health Review Tribunal	Yes
267	MCGREGOR Mr Robert	Yes
268	Centre for Health Service Development	Yes
269	GADDIN Ms Dianne	No
270	YOUNG Ms Lydia	No
271	VALDER Ms Kay, Official Visitor, Mulawa Correctional Centre	Yes
272	Freedom Pastoral Care	Yes

No	Author	Published by Committee
273	SNOWDON Assoc Prof John	Yes
274	Waromi, Wentworth Area Relatives of the Mentally Ill	Yes
275	Australian Psychological Society Ltd	Yes
276	WEBSTER Mrs Patricia	No
277	ROSEN Dr Alan	Yes
278	WEBSTER Mr Allan	No
279	Alliance of NSW Divisions Ltd	Yes
280	BOETTCHER Dr Brian	Yes
281	ALLNUTT Dr Stephen	No
282	CLEMENTS Mrs Janet	No
283	CURBY Mrs J K	No
284	NUNN Prof Ken	No
285	Private & confidential	No
286	NSW Police Service	Yes
287	ALI Ms Pam	No
288	HARVEY Dr Peter	Yes
289	Citizens Commission on Human Rights (Church of Scientology)	Yes
290	Citizens Commission on Human Rights (Church of Scientology)	Yes
291	MADDEN Mr R & Mrs J	No
292	STRINGER Ms Sophie	No
293	ROSS Mrs Jillian	No
294	GOUCH Mr Alex	Yes
295	WALLEY Mrs Jenny	No
296	HATCH Mrs Tricia	No
297	McKesson Asia Pacific Pty Ltd	Yes
298	BLYDENSTEIN Mrs Kerrie P	No
299	ROCHE Mrs E	No
300	CARTER Mr John	No
301	Forensicare	Yes
302	Triple Care Farm	Yes
303	WIRTH Mr Robert	No

Appendix 3

Witnesses at hearings

Witnesses at Hearings

Date	Name	Representative organisation/capacity
23 May 2002	Sr Myree Harris	Society of St Vincent de Paul
	Ms Judith Ball	Society of St Vincent de Paul
	Mr Owen Rogers	Society of St Vincent de Paul
	Dr Robert Brooks	St John of God Hospital
	Dr Rupert Elliott	St John of God Hospital
	Dr Pieter Rossouw	St John of God Hospital
	Ms Michelle Thompson	St John of God Hospital
	Mr Peter Gates	Consumer Advisory Group, Mental Health
	Mr Douglas Holmes	Consumer Advisory Group, Mental Health
	Ms Gillian Church	Mental Health Association NSW
	Ms Leonie Manns	Mental Health Association NSW
	Dr Meg Smith OAM	Mental Health Association NSW
28 May 2002	Ms Diana Quian	Disability Council NSW
	Mr Donald Byrne	Disability Council NSW
	Ms Marika Kontellis	Disability Council NSW
	Ms Leonie Manns	Former Chair, Disability Council NSW
	Ms Helena O'Connell	New South Wales Council for Intellectual Disability
	Ms Jenna Bateman	Mental Health Co-ordinating Council
	Ms Joyce Said AM	Mental Health Co-ordinating Council
	Mr Phil Nadin	Mental Health Co-ordinating Council
	Prof Henry Brodaty	Academic Dept for Old Age Psychiatry, Prince of Wales Hospital
	Mr Anthony Brown	Men's Health Information Resource Centre
	Ms Christine Regan	NSW Aged Care Alliance (Council of Social Service of NSW)
	Dr Jeffery Rowland	Australian Society Geriatric Medicine (NSW Branch)
29 May 2002	Ms Leanne Elsworthy	B. Miles Women's Housing Scheme
	Ms Geral Wallwork	B. Miles Women's Housing Scheme
	Mr Fred Kong	Richmond Fellowship
	Mr Michael Sterry	Richmond Fellowship
	Mr Philip French	Shelter NSW
	Ms Hazel Blunden	Shelter NSW

Date	Name	Representative organisation/capacity
	Dr Jonathan Carne	Psychiatrist, National Association Practising Psychiatrists
	Dr Rachel Falk	Consultant Psychiatrist, National Association Practising Psychiatrists
	Mr Glen Ramos	National Association Practising Psychiatrists
	Sr Myree Harris	Coalition for Appropriately Supported Accommodation for People with Disabilities
30 May 2002	Dr William Barclay AM	Psychiatrist
	Dr Richard Matthews	NSW Corrections Health Service
	Dr Olav Nielssen	Forensic Psychiatrist (FRANZCP)
	Ms Nihal Danis	Mental Health Advocacy Service (Legal Aid)
	Mr Robert Wheeler	Mental Health Advocacy Service (Legal Aid)
	Dr Jonathan Carne	Forensic Psychiatrist
31 May 2002	Prof Ian Webster AO	Emeritus Professor, Medical Practitioner
	Dr Jean Lennane	Psychiatrist
14 June 2002	Mr Ian Ball	Police Association of NSW
	Ms Sandra Soldo	Police Association of NSW
	Mr Rodney Brabin	Mental Health Review Tribunal
	Mr Michael Sterry	Mental Health Review Tribunal
	Prof Duncan Chappell	Mental Health Review Tribunal
	Dr Allan Cala	Forensic Pathologist
	Dr Ella Sugo	Forensic Pathologist
30 July 2002	Dr Jean Starling	Chairperson, NSW Faculty of Child and Adolescent Psychiatry
	Ms Georgie Ferrari	NSW Association for Adolescent Health
	Ms Margaret Veratau	Private citizen (NSW Association for Adolescent Health)
	Prof Kenneth Nunn	Area Director – Mental Health, The Children's Hospital, Westmead
	Ms Kate Adams	Professional Officer, NSW Nurses' Association
	Ms Petrusia Butrej	Professional Officer (Occupational Health and Safety Coordinator), NSW Nurses' Association
	Ms Susan Karpik	Nurse Manager, member of NSW Nurses' Association
	Mr John Lyons	Clinical Nurse Consultant, member of NSW Nurses' Association
	Mr Jeremy Masters	Australian & New Zealand College Mental Health Nurses

Date	Name	Representative organisation/capacity
	Mr Ian Wilson	Australian & New Zealand College Mental Health Nurses
31 July 2002	Mr Michael Roberts	Aboriginal Medical Service Dharah Gibinj (Casino)
	Ms Lexie Lord	Aboriginal Medical Service Dharah Gibinj (Casino)
	Ms Judith Meppem	Chief Nursing Officer, NSW Health
	Ms Ros Bragg	Council of Social Service of NSW
	Mr Tim Goodwin	Council of Social Service of NSW
	Mr Abd Malak	NSW Transcultural Mental Health Centre
	Mr Ted Quan	NSW Transcultural Mental Health Centre
1 August 2002	Mr Philip Scott	Court Liaison Clinician, Mid North Coast Area Health Service
	Mr Ted Campbell	Director, Mental Health, Port Macquarie Base Hospital
8 August 2002	Mr Chris Puplick	Privacy Commissioner, Privacy NSW
	Mr Robert Ramjan	Schizophrenia Fellowship of NSW
	The Hon Frank Walker QC	Schizophrenia Fellowship of NSW
	Dr Brian Boettcher	Forensic Psychiatrist
	Dr Michael Giuffrida	Forensic Psychiatrist
12 August 2002	Prof Beverley Raphael	Director, Centre for Mental Health, NSW Health
	Dr Stephen Allnutt	Forensic Psychiatrist
8 October 2002	Dr Jennifer Gray	Director, Drug Programs Bureau, NSW Health
	Dr Peter Harvey	Private Citizen and Official Visitor, Health Department Mental Hospitals
	Dr David McGrath	Psychologist and Acting Clinical Director, Drug Programs Bureau, NSW Health
	Dr Gregory Stewart	Chief Health Officer and Deputy Director-General, NSW Health

Appendix 4

Public forum participants

Public forum speakers

Tony Humphrey	Sophie Jackson
Laurie Hallinan	Dorothy Ridley
Deborah Duthie	Jean Cooper
Rosemrie D'Arrietta	Fred Pateman
Patricia Zabaks	Robyn Leitch
Dianne Gaddin	John McLean
Patricia Webster	Stephen Kilkeary
John Liebmann	Julia Beitzl
Ray MacDonald	Pia Fairfax
Gillian Holt	Peter Hutten
Julian Connolly	Janette du Buisson Perrine
Eric Smith	Margaret Oliver
Patrick Connoley	Margaret Veratau
Elizabeth Brennan	

Appendix 5

Minutes of Proceedings

Minutes of Proceedings

Minutes No. 1a

Tuesday, 22 January 2002
at Parliament House, Sydney at 3.00 pm

1. MEMBERS PRESENT

Mr Breen
Dr Chesterfield-Evans
Ms Fazio

Mr Hatzistergos
Mr Moppett
Dr Pezzutti

2. ELECTION OF THE CHAIR

The Clerk declared the meeting open and called for nominations for the Chair.

Mr Moppett nominated the Hon Dr Brian Pezzutti.

There being no other nominations, the Clerk declared Dr Pezzutti elected as Chair.

Dr Pezzutti took the Chair.

3. ADOPTION OF PROCEDURAL MOTIONS

Dr Chesterfield-Evans moved:

1. That arrangements for the calling witnesses be left in the hands of the Chairman and the Clerk.
2. That media statements concerning the deliberations of the Committee be made only by the Chairman on behalf of the Committee.
3. That, unless otherwise ordered, parties appearing before the Committee will not be represented by members of the legal profession.
4. That, unless otherwise ordered, transcripts of evidence taken by the Committee be not made available to any person, body or organisation, provided that each witness will be given a proof copy of their evidence for correction and return to the Clerk.
5. That the Chairman and Clerk be empowered to request that funds be provided to meet expenses in connection with travel, accommodation, advertising and approved incidental expenses of the Committee, including additional staff.

Put and passed.

4. CALL FOR SUBMISSIONS

The Committee resolved:

- to call for submissions by 4 April 2002;
- to publish the advertisement as previously circulated in the Sydney Morning Herald, Daily Telegraph, The Land and major regional newspapers and to request the Chair to issue a press release noting the call for submissions.

5. INVITATIONS TO STAKEHOLDERS

The Committee agreed that the Chair shall invite to make a submission the stakeholders in the list distributed and Consumers' Health Forum, Illawarra Institute for Mental Health, Public Interest Advocacy Centre, Centre for Health Services Development, Consumer Consultative of all Area Health Services, Social Policy Research Centre, Compeer, Ambulance Service of NSW, AIDS Council of NSW, Hospital Emergency Departments, Area Health Service Alcohol and other Drug Services, Department of Community Services, Australian Medical Association, Institute of

Psychiatry, Youth Action Policy Association, Council for Intellectual Disability, Kempsey Shire Council, Coffs Harbour Shire Council, Anti-Discrimination Board, Hep C Council, Prison Officers Association, Police Association, Corrections Health Service, Beyond Blue, Challenge, friends of Stockton, friends of Bloomfield and community visitors.

6. GENERAL BUSINESS

The Committee agreed to seek a background briefing from the Department of Health.

Dr Pezzutti tabled the following papers:

- (a) Paper on Mandala Clinic Gosford
- (b) NAPP Briefing Paper – CBCM 4 December 2001-12-05, “The public mental health services in NSW – the clinicians’ perspective”
- (c) Mental Health Implementation Group *Mental Health Non-Acute Inpatient Services Plan: Draft Framework Version 2.31* dated June 2001
- (d) Beverly Raphael and Katrina Hasleton, “Mental Health reform in NSW and the NSW Government’s *Action Plan for Health*”, *HealthCover*, October-November 2001
- (e) correspondence from Patricia Bayley to Dr Pezzutti dated 5 November 2001
- (f) correspondence from the Schizophrenia Fellowship to Dr Pezzutti dated 14 November 2001.
- (g) correspondence from Ms Erika Inessa Tyconi
- (h) Mental Health Review Tribunal 2000 Annual Report

7. ADJOURNMENT

The Committee adjourned at 4:00 pm until Thursday 9 May 2002 at 1:30 pm

Russell Keith

Clerk to the Committee

Minutes No. 1b¹¹⁰⁵

Wednesday, 20 March 2002
at Parliament House, Sydney at 1.10 pm

1. MEMBERS PRESENT

Mr Breen
Dr Chesterfield-Evans
Ms Fazio

Mr Hatzistergos
Mr Moppett
Dr Pezzutti

2. ELECTION OF THE CHAIR

The Clerk declared the meeting open and called for nominations for the Chair.

Mr Moppett nominated the Hon Dr Brian Pezzutti.

There being no other nominations, the Clerk declared Dr Pezzutti elected as Chair.

Dr Pezzutti took the Chair.

3. ADOPTION OF PROCEDURAL MOTIONS

Mr Hatzistergos moved:

1. That arrangements for the calling witnesses be left in the hands of the Chairman and the Clerk.
2. That media statements concerning the deliberations of the Committee be made only by the Chairman on behalf of the Committee.
3. That, unless otherwise ordered, parties appearing before the Committee will not be represented by members of the legal profession.

¹¹⁰⁵ Minutes recommenced at No. 1 after prorogation of Parliament.

4. That, unless otherwise ordered, transcripts of evidence taken by the Committee be not made available to any person, body or organisation, provided that each witness will be given a proof copy of their evidence for correction and return to the Clerk.
5. That the Chairman and Clerk be empowered to request that funds be provided to meet expenses in connection with travel, accommodation, advertising and approved incidental expenses of the Committee, including additional staff.

Put and passed.

4. INQUIRY PLANNING

The Committee discussed the conduct of the inquiry.

The Committee agreed to set aside dates for meetings until August.

The Committee agreed it wished to visit the Long Bay mental health facility.

Russell Keith

Clerk to the Committee

Minutes No. 2

Thursday 9 May 2002
Room 1153, Parliament House at 1.30 pm

1. Members Present

Dr Pezzutti (in the Chair)	Ms Fazio
Mr Breen	Mr Hatzistergos
Dr Chesterfield-Evans	Mr Moppett

2. Confirmation Of Minutes

Resolved, on motion of Ms Fazio, that: the Minutes of meeting number 1 be confirmed.

3. Inquiry Into Mental Health Services In New South Wales

The Committee discussed various matters in relation to future direction of the inquiry.

Resolved, on motion of Mr Moppett, that: the Committee Secretariat, in consultation with the Chair, prepare a proposal for a future hearing schedule.

The Committee deliberated.

The Committee allocated the following dates for hearings: 23, 28, 29, 30 and 31 May 2002.

4. Adjournment

The meeting adjourned at 2.15 pm until 9.30am, Thursday 23 May 2002, Room 814/815

Rob Stefanic

Director

Minutes No 3

Thursday 23 May 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)	Ms Fazio
Mr Breen	Mr Moppett
Dr Chesterfield-Evans	

2. APOLOGIES

Mr Hatzistergos

3. CONFIRMATION OF MINUTES

Resolved, on motion of Mr Moppett, that: the Minutes of meeting number 2 be confirmed.

4. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Resolved, on motion of Dr Chesterfield-Evans: That in accordance with the Resolution of the Legislative Council of 11 October 1994 the Committee authorizes the sound broadcasting and television broadcasting of its public proceedings held today.

The public and media were admitted.

The Chair welcomed the gallery and reminded the media of their obligation under Standing Order 252 of the Legislative Council in relation to evidence given before, and documents presented to the Committee. The Chair also distributed copies of the guidelines governing broadcast of proceedings.

Mr Owen Rogers, Executive Officer, New South Wales State Council, Society of St Vincent de Paul, Sr Myree Harris, President, State Advisory Committee for the Care of People with Mental Illness, Society of St Vincent de Paul and Judith Ball, Co-ordinator of the Compeer Program, Society of St Vincent de Paul, were sworn and examined.

Sr Myree Harris tendered several documents supporting her evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents.

Evidence concluded and the witnesses withdrew.

Dr Rupert Elliott, Medical Practitioner, St John of God Hospital, Dr Pieter Rossouw, Program Consultant, Senior Clinical Psychologist, St John of God Hospital, Ms Michelle Thompson, Chief Executive Office, St John of God Health Services and Dr Robert Brooks, Research Psychologist, St John of God Health Services, were sworn and examined.

The media and public withdrew.

The Committee continued *in camera*.

The media and public were admitted.

Evidence concluded and the witnesses withdrew.

Mr Peter Gates, Business Consultant, NSW Consumer Advisory Group and Mr Douglas Holmes, Executive Officer, NSW Consumer Advisory Group, were sworn and examined.

Mr Holmes tendered several documents supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents.

Evidence concluded and the witnesses withdrew.

Dr Meg Smith, President, Mental Health Association NSW, Ms Gillian Church, Executive Director, Mental Health Association NSW and Ms Leonie Manns, Chairperson, Mental Health Association NSW, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Public hearing concluded, the media and public withdrew.

The Committee deliberated.

Resolved, on motion of Mr Chesterfield-Evans: That pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish submissions and corrected transcripts with the exception of documents or part documents identified as "confidential" or "not publicly available".

5. ADJOURNMENT

The meeting adjourned at 4.40 pm until 9.30am Tuesday 28 May 2002 in Room 814/815.

Rob Stefanic
Director

Minutes No 4

Tuesday 28 May 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Dr Chesterfield-Evans

Ms Fazio
Mr Hatzistergos

2. APOLOGIES

Mr Breen

Mr Moppett

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

The public and media were admitted.

Ms Diana Qian, Acting Deputy Chairperson, Disability Council of NSW, Mr Donald Byrne, Executive Officer, Disability Council of NSW, Ms Leonie Manns, Former Chairperson, Disability Council of New South Wales and Ms Marika Kontellis, Counsellor, Disability Council of New South Wales, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Ms Helena O'Connell, Executive Officer, New South Wales Council for Intellectual Disability, was sworn and examined.

Evidence concluded and the witness withdrew.

Ms Joyce Said, Executive Director, After Care, Chair, Mental Health Co-ordinating Council, Rozelle Hospital, Mr Phil Nadin, Deputy Chair, Mental Health Co-ordinating Council, Rozelle Hospital and Ms Jenna Bateman, Executive Officer, Mental Health Co-ordinating Council, Rozelle Hospital, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Prof Henry Brodaty, Professor of Psychogeriatrics, Academic Department for Old Age Psychiatry, Prince of Wales Hospital, Randwick, was sworn and examined.

Prof Brodaty tendered several documents supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents.

Evidence concluded and the witness withdrew.

Ms Christine Regan, Senior Policy Officer, New South Wales Aged Care Alliance, Dr Jeffrey Rowland, President, Australian Society for Geriatric Medicine, New South Wales Branch, and Mr Anthony Brown, Project Officer, Men's Health Information Resource Centre, University of Western Sydney, were sworn and examined.

Evidence concluded and the witnesses withdrew.

4. ADJOURNMENT

The meeting adjourned at 4.10 pm until 29 May 2002

Rob Stefanic
Director

Minutes No 5

Wednesday 29 May 2002
Jubilee Room, Parliament House at 10.00 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Ms Fazio
Mr Hatzistergos

2. APOLOGIES

Mr Moppett

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Ms Leanne Elsworthy, Co-ordinator, B. Miles Women's Housing Scheme, and Ms Geral Wallwork, Social Worker and Housing Support Worker, B. Miles Women's Housing Scheme, were sworn and examined.

Ms Elsworthy tabled a document supporting her evidence

Evidence concluded and the witnesses withdrew.

Mr Fred Kong, Chief Executive Officer, Richmond Fellowship of New South Wales and Michael Sterry, Counsellor and Board Member, Richmond Fellowship of New South Wales, were sworn and examined.

Mr Kong tabled documents supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents.

Evidence concluded and the witnesses withdrew.

Mr Phillip French, Chairperson, Shelter New South Wales and Ms Hazel Blunden, Policy Officer, Shelter New South Wales, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Dr Jonathan Carne, Psychiatrist, Mr Glen Ramos, Assistant National Co-ordinator, National Association of Practising Psychiatrists and Dr Rachel Falk, Consultant Psychiatrist, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Sr Myree Harris, Convener, Coalition for Appropriate Supported Accommodation for People with Disabilities in New South Wales, previously sworn and examined.

Evidence concluded and the witness withdrew.

Resolved, on motion of Ms Fazio: That uncorrected transcripts of evidence from hearings of this Committee, except *in camera* evidence, be made available to the public.

4. ADJOURNMENT

The meeting adjourned at 5.15 pm until 9.30am Thursday 30 May 2002.

Rob Stefanic
Director

Minutes No. 6

Thursday 30 May 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Ms Fazio
Mr Hatzistergos

2. APOLOGIES

Mr Moppett

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Dr William Barclay, Psychiatrist, Epping was sworn and examined

Evidence concluded and the witness withdrew.

Dr Richard Matthews, Medical Practitioner and Chief Executive Officer of Corrections Health Service was sworn and examined.

Dr Matthews tabled a document supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witness withdrew.

Dr Olav Nielssen, Psychiatrist, and Chairman, Forensic Section, New South Wales Branch, Royal Australian and New Zealand College of Psychiatrists, was sworn and examined.

Evidence concluded and the witness withdrew.

Mr Robert Wheeler, Solicitor, Mental Health Advocacy Service (Legal Aid) and Ms Nihal Danis, Solicitor, Mental Health Advocacy Service (Legal Aid), were sworn and examined.

Evidence concluded and the witnesses withdrew.

Dr Jonathan Carne, Psychiatrist, previously sworn and examined.

Dr Carne tabled a document supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

4. ADJOURNMENT

The meeting adjourned at 5.10 pm until 9.30 am Friday 31 May 2002.

Rob Stefanic
Director

Minutes No 7

Friday 31 May 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Dr Chesterfield-Evans

Mr Hatzistergos

2. APOLOGIES

Mr Breen
Ms Fazio

Mr Moppett

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Prof Ian Webster, Emeritus Professor, Medical Practitioner, was sworn and examined

Evidence concluded and the witness withdrew.

Dr Jean Lennane, Psychiatrist, was sworn and examined.

Dr Lennane tabled documents supporting her evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents.

Evidence concluded and the witness withdrew.

The Committee deliberated.

The Chair tabled the following documents:

NSW Government, *Caring for People with Mental Illness, Response to the Human Rights and Equal Opportunity Commission Report into the human rights of people with mental illness*, circa 1994

NSW Department of Health, Centre for Mental Health & NSW Police Service, *Memorandum of Understanding Between NSW Police and NSW Health*, June 1998

NSW Health Department, *Directory of Mental Health Services in NSW*, 1993

NSW Health Department, *Leading the Way – A Framework for NSW Mental Health Services 1991-2001*, 1993

The Chair proposed that the Committee conduct a further three hearings, a public forum, a site visit to Long Bay Correctional Complex and a study visit to a Victorian correctional facility.

4. ADJOURNMENT

The meeting adjourned at 1.30 pm until 10.00 am Friday 14 June 2002.

Rob Stefanic

Director

Minutes No 8

Friday 14 June 2002

Jubilee Room, Parliament House at 10.00 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)

Mr Breen

Dr Chesterfield-Evans

Ms Fazio

Mr Hatzistergos

Ms Burnswoods (participating)

Mr West (participating)

2. APOLOGIES

Mr Moppett

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Mr Ian Ball, President and Ms Sandra Soldo, Project Officer from Police Association NSW, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Prof Duncan Chappell, President, Mr Michael Sterry, Deputy President and Mr Rodney Brabin, Registrar from the Mental Health Review Tribunal, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Dr Allan Cala, Staff Forensic Pathologist and Dr Ella Sugo, Staff Forensic Pathologist from the Department of Forensic Medicine, Central Sydney Laboratory Service, were sworn and examined.

Evidence concluded and the witnesses withdrew.

4. **ADJOURNMENT**

The meeting adjourned at 2.45 pm.

Rob Stefanic
Director

Minutes No 9

Monday 29 July 2002
Long Bay Correctional Complex, Malabar NSW at 10.30 am

1. **MEMBERS PRESENT**

Dr Pezzutti (in the Chair)	Ms Fazio
Mr Breen	Mr Jobling
Dr Chesterfield-Evans	

2. **APOLOGIES**

Mr Hatzistergos

3. **SITE VISIT LONG BAY HOSPITAL, LONG BAY CORRECTIONAL COMPLEX**

Briefings were given and site visit conducted at the Long Bay Hospital, Long Bay Correctional Complex, Malabar by the following persons:

Dr Richard Matthews, Chief Executive Officer, Corrections Health Services
Ms Anne Doherty, Acting Director, Mental Health, Corrections Health Services
Mr Brian Kelly, Superintendent, Department of Corrective Services

Briefings were given and a site visit conducted at the Metropolitan Remand and Reception Centre and Mulawa Correctional Centre, Silverwater Complex by the following persons:

Dr Richard Matthews, Chief Executive Officer, Corrections Health Services
Mr Brian Kelly, Superintendent, Department of Corrective Services
Ms Lee Downes Governor, Mulawa Correctional Centre
Ms Maxine McCarthy, Nursing Unit Manager, Mulawa Clinic
Ms Sandra Kelly, Mental Health Nurse Mulawa
Mr Don Rogers, Commander remand facilities, Metropolitan Remand and Reception Centre
Mr Charles MacKay, Programs Manager, Metropolitan Remand and Reception Centre

4. **ADJOURNMENT**

The meeting adjourned at 5.30 pm until 9.30 am Tuesday 30 July 2002.

Rob Stefanic
Director

Minutes No 10

Tuesday 30 July 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)	Ms Fazio
Mr Breen	Mr Jobling
Dr Chesterfield-Evans	

2. APOLOGIES

Mr Hatzistergos

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Dr Jean Starling, Chair, NSW Faculty of Child & Adolescent Psychiatry was sworn and examined.

Evidence concluded and the witness withdrew.

Ms Georgie Ferrari, Executive Officer, NSW Association for Adolescent Health and Ms Margaret Veratau, private citizen were sworn and examined.

Evidence concluded and the witnesses withdrew.

Prof Ken Nunn, Area Director - Mental Health, Children's Hospital Westmead was sworn and examined.

Prof Nunn tabled a document supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witness withdrew.

Ms Kate Adams, Professional Officer, NSW Nurses' Association, Ms Trish Butrej, Professional Officer – OH&S, NSW Nurses' Association, Ms Sue Karpik, Nurse Manager Mental Health Illawarra Area Health Service, NSW Nurses' Association, Mr John Lyons, Clinical Nurse Consultant (Coonabarrabran), NSW Nurses' Association were sworn and examined.

Evidence concluded and the witnesses withdrew.

Mr Jem Masters, NSW Branch President, Australian & New Zealand College of Mental Health Nurses, Mr Ian Wilson, Practised Development Fellow, Professorial Mental Health Nursing Unit, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Resolved, on motion of Dr Chesterfield-Evans: That pursuant to the provisions of section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish documents tabled before the Committee during today's hearings.

4. ADJOURNMENT

The meeting adjourned at 4.00 pm until 10.00 am Wednesday 31 July 2002.

Rob Stefanic
Director

Minutes No 11

Wednesday 31 July 2002
Jubilee Room, Parliament House at 10.00 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)	Ms Fazio
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Mr Breen
Dr Chesterfield-Evans

Mr Jobling

2. APOLOGIES

Mr Hatzistergos

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Mr Michael Roberts, Chief Executive Officer, Dharah Gibinj - Aboriginal Medical Service, Aboriginal Corporation (Casino) and Ms Lexie Lord, Volunteer, Dharah Gibinj - Aboriginal Medical Service were sworn and examined.

Mr Roberts tabled a document supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Ms Lord tabled a document supporting her evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witnesses withdrew.

Ms Judith Meppem, Chief Nursing Officer, NSW Health

Ms Meppem tabled a document supporting her evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witness withdrew.

Ms Ros Bragg, Deputy Director, Policy and Mr Tim Goodwin, Senior Policy Adviser from the Council of Social Service of New South Wales, were sworn and examined.

Mr Abd Malak, Director, and Mr Ted Quan, Representative, from the New South Wales Transcultural Mental Health Centre, were sworn and examined.

Evidence concluded and the witnesses withdrew.

Resolved, on motion of Mr Jobling: That pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish documents tabled before the Committee during today's hearings.

4. ADJOURNMENT

The meeting adjourned at 4.00 pm until 10.00am Thursday 1 August 2002.

Rob Stefanic
Director

Minutes No 12

Thursday 1 August 2002
Jubilee Room, Parliament House at 10.00 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Ms Fazio
Mr Jobling

2. APOLOGIES

Mr Hatzistergos

3. INQUIRY INTO MENTAL HEALTH SERVICES IN NEW SOUTH WALES

Mr Phillip Scott, Court Liaison Clinician, Mid North Coast Area Action Group was sworn and examined.

Mr Scott tabled a document supporting his evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witness withdrew.

Mr Ted Campbell, Director, Mental Health, Port Macquarie Base Hospital was sworn and examined.

Evidence concluded and the witness withdrew.

The public and the media withdrew.

The Committee deliberated.

Resolved, on motion of Mr Jobling: That pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish documents tabled before the Committee during today's hearings.

Resolved, on motion of Mr Jobling: That the Chair write to the News Editor of the Daily Telegraph newspaper in relation to the news article by Anna Patty published on 1 August 2002 and stating that:

- the submission quoted from Dr Alan Cala has not been published by the Committee therefore unauthorised publication of the submission is a breach of parliamentary privilege
- the Daily Telegraph refrain from further references to Dr Cala's submission.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee undertake a site visit to Victoria for the purposes of examining Victoria's forensic and community services within the mental health system.

Resolved, on motion of Mr Jobling: That the Chair submit a research travel proposal to the President for consideration and approval.

4. ADJOURNMENT

The meeting adjourned at 2.30 pm until 9.30 am on Wednesday 7 August 2002.

Rob Stefanic

Director

Minutes No 13

Wednesday 7 August 2002
Jubilee Room, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Ms Fazio
Mr Hatzistergos

2. APOLOGIES

Mr Jobling

3. PUBLIC FORUM

The public and media were admitted.

The Chair made an opening statement outlining procedural guidelines for the public forum and invited the following members of the public to participate in the public forum.

Tony Humphrey
Laurie Hallinan
Deborah Duthie
Rosemrie D'Arrietta
Patricia Zabaks
Dianne Gaddin
Patricia Webster
John Liebmenn
Ray MacDonald
Gillian Holt
Julian Connolly
Eric Smith
Patrick Connoley
Elizabeth Brennan

Sophie Jackson
Dorothy Ridley
Jean Cooper
Fred Pateman
Robyn Leitch
John McLean
Stephen Kilkeary
Julia Beidl
Pia Fairfax
Peter Hutten
Janette du Buisson Perrine
Margaret Oliver
Margaret Veratau

Public forum concluded.

The public and the media withdrew.

The Committee deliberated.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the documents tabled by: Tony Humphrey, Laurie Hallinan, Diane Gaddin, Elizabeth Brennan, John McLean, Peter Hutten, Janette du Buisson Perrine and Margaret Oliver.

Resolved, on motion of Dr Chesterfield-Evans: That pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish submission numbers 177, 221 and 247.

The Committee noted that the author of "not publicly available" submission number 229 be now marked "confidential".

4. ADJOURNMENT

The meeting adjourned at 4.15 pm until 9.30 am on Thursday 8 August 2002.

Rob Stefanic
Director

Minutes No 14

Thursday 8 August 2002
Room 814/815, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Dr Chesterfield-Evans

Ms Fazio
Mr Jobling

2. APOLOGIES

Mr Breen

Mr Hatzistergos

3. PUBLIC HEARING

The public and media were admitted.

Mr Chris Puplick, Privacy Commissioner, Privacy NSW was sworn and examined

Evidence concluded and the witness withdrew.

Mr Robert Ramjan, Executive Director and the Hon Frank Walker QC, President, Schizophrenia Fellowship, were sworn and examined.

Mr Ramjan tabled documents supporting his evidence.

Resolved, on motion of Ms Fazio: That the Committee accept the documents.

Evidence concluded and the witnesses withdrew.

Dr Michael Giuffrida, Director, Forensic Psychiatry, Westmead/Cumberland Hospital

Dr Brian Boettcher, Senior Staff Forensic Psychiatrist, Forensic Psychiatry, Cumberland/Westmead Hospital.

4. ADJOURNMENT

The meeting adjourned at 4.00 pm until 10.00 am on Monday 12 August 2002.

Rob Stefanic

Director

Minutes No 15

Monday 12 August 2002

Waratah Room, Parliament House at 10.00 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)

Mr Breen

Dr Chesterfield-Evans

Ms Fazio

Mr Jobling

2. APOLOGIES

Mr Hatzistergos

3. PUBLIC HEARING

The public and media were admitted.

Prof Beverley Raphael, Director, Centre for Mental Health, NSW Health was sworn and examined.

Prof Raphael tabled documents supporting her evidence.

Resolved, on motion of Dr Chesterfield-Evans: That the Committee accept the document.

Evidence concluded and the witness withdrew.

Dr Stephen Allnutt, Clinical Director Forensic Psychiatry, Senior Forensic Psychiatrist, Department of Psychiatry University of NSW was sworn and examined.

Evidence concluded and the witnesses withdrew.

The Chair made a statement concerning the reports of two previous inquiries on mental health entitled, *Report from the Select Committee on the Lunatic Asylum, Tarban Creek*, dated 21 October 1846 and *Report from the Commissioners of Inquiry on the Lunatic Asylums of New South Wales*, dated 6 June 1855.

The public and media withdrew.

The Committee deliberated.

Resolved, on motion of Ms Fazio: That pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under authority of Standing Order 252, the Committee authorises the Clerk to the Committee to publish:

- documents tabled before the Committee during today's hearings
- the speech notes tabled by Mr Petter Hutten during the Public Forum on 8 August 2002.

4. ADJOURNMENT

The meeting adjourned at 4.00 pm.

Rob Stefanic

Director

Minutes No 16

Monday 28 August 2002
Room 1108, Parliament House at 1.00 pm

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Ms Fazio
Mr Hatzistergos
Mr Jobling

2. Mental Health Services in NSW

The Chair submitted his draft report entitled “Mental Health Services in NSW – Interim Report”, which, having been circulated to each Member of the Committee, was accepted as having been read.

The Committee proceeded to consider the draft report.

Chapter 1 read.

Ms Fazio moved that paragraph 1.3 be deleted.

Question put.

The Committee divided:

Ayes
Ms Fazio
Mr Hatzistergos

Nos
Dr Pezzutti
Dr Chesterfield-Evans
Mr Jobling
Mr Breen

Question resolved in the negative.

Chapter 1, as amended agreed to.

Chapter 2 read.

Resolved on the motion of Ms Fazio: That paragraph 2.7 be amended by deleting the word “concerns” and inserting the words “problems, which the Richmond Program encountered”.

Resolved on the motion of Mr Jobling that paragraph 2.9 be amended by deleting the words “Around the time of the election of the Greiner Government”.

Resolved on the motion of Dr Chesterfield-Evans that paragraph 2.18 be amended by deleting the words “An increase in specialised treatment, car and facilities for specific groups and disorders such as drug and alcohol, the aged, adolescents and disability accompanied the move to community care”, and instead inserting, “Affiliated to this trend has been the advent of specialised treatment facilities, specifically for drug and alcohol disorders, adolescents, aged care and the such like”.

Chapter 2, as amended agreed to.

Chapter 3 read.

Resolved on the motion of Mr Jobling: That paragraph 3.3 be deleted and re-inserted under table 3.1.

Chapter 3, as amended agreed to.

Chapter 4 read.

Resolved on the motion of Mr Hatzistergos: That second paragraph of introduction be amended by deleting the words “within the following subject areas”.

Resolved on the motion of Ms Fazio: That paragraph 4.4 be amended by inserting the words “inpatient and community based care” after the words “regional issues”.

Resolved on the motion of Mr Hatzistergos: That paragraph 4.12 be amended by inserting the words “for people with a mental illness” after the words “New South Wales”.

Resolved on the motion of Dr Chesterfield-Evans: That after paragraph 4.13, the following paragraph be inserted:

“Part three – Mental illness and substance abuse (MISA)”

The inquiry has heard evidence that suggests that mental health and substance abuse (MISA) disorders frequently co-exist and their prevalence may be increasing. This chapter will consider funding issues, the current problems experienced by those with MISA in accessing mental health services and the difficulties in delivering mental health services to those with MISA.”

Resolved on the motion of Dr Pezzutti: That the heading above paragraph 4.16 be amended by inserting the words “(dual diagnosis)” after the word “Disability”.

Resolved on the motion of Dr Chesterfield-Evans: That paragraph 4.20 be amended by deleting the words “The funding and provision of services for older people is split between the Commonwealth and the NSW Government”, and instead inserting the words “including the split between the Commonwealth and the NSW Government, and” after the words “allocation of funding”.

Chapter 4, as amended agreed to.

Resolved on the motion of Dr Chesterfield-Evans: That the draft report (as amended) be the Report of the Committee and that the Chairman, Director and Senior Project Officer be permitted to correct stylistic, typographical and grammatical errors.

Resolved on the motion of Dr Chesterfield-Evans: That the report, together with the transcripts of evidence, public submissions, documents and correspondence in relation to the inquiry, be tabled and made public.

4. ADJOURNMENT

The meeting adjourned at 2.20 pm, *sine die*.

Bayne McKissock
Senior Project Officer

Minutes No 17

Tuesday 8 October 2002
Jubilee Room, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Dr Chesterfield-Evans
Mr Jobling

2. APOLOGIES

Mr Breen
Ms Fazio
Mr Hatzistergos

3. PUBLIC HEARING

The public and media were admitted.

Dr Peter Harvey, retired medical practitioner, was sworn and examined

Evidence concluded and the witness withdrew.

Dr Greg Stewart, Chief Health Officer & Deputy Director, Dr Jennifer Gray, Director, Drug Programs Bureau, Dr David McGrath, Clinical Director, all from NSW Health, were sworn and examined.

Evidence concluded and the witnesses withdrew.

4. ADJOURNMENT

The meeting adjourned at 1.10 pm.

Rob Stefanic
Director

Minutes No 18

Tuesday 26 November 2002
Room 1136, Parliament House at 9.30 am

1. MEMBERS PRESENT

Dr Pezzutti (in the Chair)
Mr Breen
Dr Chesterfield-Evans

Mr Hatzistergos
Mr Jobling

2. APOLOGIES

Ms Fazio

3. CONFIRMATION OF MINUTES

Resolved, on motion of Mr Jobling, that: the Minutes of meeting numbers 16 and 17 be confirmed.

4. CONSIDERATION OF DRAFT FINAL REPORT

The Chair submitted his draft report entitled “Mental Health Services in NSW – Final Report”, which, having been circulated to each Member of the Committee, was accepted as having been read.

The Committee proceeded to consider the draft report.

Chapter 1 read.

Resolved on the motion of Mr Hatzistergos: that the Committee Secretariat be permitted to correct stylistic, typographical and grammatical errors.

Chapter 1, as amended, agreed to.

Chapter 2 read.

Resolved on the motion of Mr Hatzistergos: that after paragraph 2.19 insert the following paragraph:

The *Mental Health Act 1990* was the first Act in NSW to define mental illness in legislation. The basis of the definition was symptoms and signs, rather than a delineation between functional and organic disorders. The Act made significant steps forward from the *Mental Health Act 1958* (which had replaced the *Lunacy Act 1898*) through the following:

- alternatives to compulsory hospital treatment such as community counselling orders and community treatment orders
- a distinct preference for community care
- the principle of ‘least restrictive care’
- an extensive statement of the legal rights of people thought to be mentally ill or disordered.

The *Mental Health Act 1990* was reviewed in 1992 by the Mental Health Act Implementation Monitoring Committee, and found to be an effective, humane piece of legislation

Chapter 2, as amended, agreed to.

Chapter 3 read.

Resolved on the motion of Dr Chesterfield-Evans: that all words in the introduction to chapter 3 be deleted and instead insert:

The Committee received a significant number of comprehensive submissions from government and non-government mental health service providers, and family and carers in New South Wales. This chapter provides a snapshot of the mental health sector in NSW, as presented to the Committee.

Resolved on the motion of Mr Hatzistergos: that after paragraph 3.8 insert the following line:

Public sector mental health services are identified below, and discussed briefly. Detailed discussion on these providers will occur in the following chapters.

Resolved on the motion of Dr Chesterfield-Evans: that paragraph 3.19 be deleted and insert instead:

In *Crime Prevention through Social Support - Second Report* the Legislative Council Standing Committee on Law and Justice reported that forensic patients are often under the care of CHS by default. The report quoted that a local magistrate had:

sent people to jail because it was the only place they could receive proper treatment programs for the mental illness which was greatly contributing to their offending. At a conference, the same magistrate also spoke of having to wait 9 weeks for a psychiatric assessment, leading to defendants with a mental illness being held on remand because of lack of alternative facilities.

Resolved on the motion of Mr Jobling: that paragraph 3.25 and 3.26 be deleted and insert instead:

The NSW Government and the Commonwealth Government are both signatories to the Supported Accommodation Assistance Program (SAAP), which provides transitional, supported accommodation to people who are homeless or at risk of becoming homeless. The NSW Department of Housing has a Crisis Accommodation Program and is part of the interagency Partnerships Against Homelessness. The Office of Community Housing has established five mental health projects in partnership with various area mental health services providing 19 units of accommodation, 12 of which are in non-metropolitan or rural areas.

The funding for SAAP is allocated to more than 400 services provided by non-government organisations. SAAP services provide support such as outreach, advocacy and living skills development. They also link people to other services such as health and aged care. Agencies on the SAAP Committee include the Departments of Housing, NSW Health, Ageing and Disability, Fair Trading, Corrective Services, Women, Juvenile Justice, and Department of Community Services.

Resolved on the motion of Mr Jobling: that after paragraph 3.29 insert the following paragraph:

Submissions to the inquiry also described other housing options for people with a mental illness, including various supported accommodation models and boarding houses.

Resolved on the motion of Dr Chesterfield-Evans that: paragraph 3.50 be deleted.

Resolved on the motion of Mr Jobling: that the following paragraph be inserted after paragraph 3.57:

The Committee notes that decisions relating to the appointment of guardians (including enduring guardians) can now be reviewed by the Administrative Appeals Tribunal under *The Guardianship and Protected Estates Legislation Amendment Act 2002*. This legislation will further protect the rights of people with a mental illness wishing to appoint guardians.

Moved by Mr Hatzistergos: that paragraph 3.75 onwards be deleted and insert instead, the following paragraph and recommendations:

The Committee views the creation of the Office of Mental Health under the Premier's Department as adding another layer of complexity in governance issues. The main problems appear to be in delivery of clinical services. Accordingly, the following recommendations are made:

Recommendation #

That NSW Health be identified as the lead agency to provide advice and coordination of mental health services in NSW.

Recommendation #

That the Minister for Health ensure that greater resources, support and power be applied through NSW Health mental health services coordinated through the Centre for Mental Health.

Question put

The Committee divided:

Ayes

Mr Hatzistergos

Nos

Mr Breen

Dr Chesterfield-Evans

Mr Jobling

Dr Pezzutti

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that recommendation 1 be amended by deleting all words and inserting instead:

Recommendation#

That the Premier of New South Wales establishes an Office of Mental Health in the Premier's Department. The Office of Mental Health should provide integrated government advice and coordination of mental health services in NSW, to coordinate effectively the:

- Department of Housing
- Department of Ageing, Disability and Home Care
- NSW Health
- NSW Police
- Attorney General's Department
- non-government organisations and community service providers

Recommendation#

That the proposed Office of Mental Health be adequately funded and resourced for a period of 5 years. At the end of this period its functions, objectives and continuation should be reviewed.

Chapter 3, as amended, agreed to.

Chapter 4 read.

Resolved on the motion of Mr Hatzistergos: that the following line be inserted after paragraph 4.16:

The Committee notes that the Sentinel Review Committee, chaired by Prof Peter Baume, is reviewing this issue. The Minister for Health may satisfy Recommendation # by extending the Sentinel Review Committee's terms of reference.

Resolved on the motion of Mr Jobling: that recommendation 2 be amended by inserting after the last line, "This information should be made available publicly."

Resolved on the motion of Mr Jobling: that recommendation 3 be deleted.

Resolved on the motion of Mr Jobling: that the relevant sections of the *Health Services Act* in recommendation 4 be footnoted.

Moved by Mr Hatzistergos: that recommendation 5 be deleted and the following recommendations inserted instead:

Recommendation#

That the Minister for Health ensures additional resources are made available for appropriate and effective community mental health programs tailored to the needs of the individual.

Recommendation#

That the Minister for Health provide longterm recurrent funding to support a range of appropriate community based mental health programs including Assertive Community Treatment for those patients for whom it is appropriate.

Question put.

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that the heading before paragraph 4.85 be amended by deleting the words and inserting instead: "Rozelle Hospital – a place of asylum".

Resolved on the motion of Mr Jobling: that the heading before paragraph 4.86 be deleted.

Moved by Mr Hatzistergos: that recommendation 9 be deleted and the following recommendation inserted instead:

That NSW Health should increase and fund medium to long term rehabilitation services in appropriate facilities including community and hospital settings and involving the expertise of NGO agencies. Hospital facilities should be at Concord Hospital with carefully planned appropriate rehabilitation services.

Question put.

Question resolved in the negative.

Moved by Jobling: that recommendation 9 be amended by deleting the last sentence.

The Committee divided:

Ayes

Mr Hatzistergos

Mr Jobling

Nos

Mr Breen

Dr Chesterfield-Evans

Dr Pezzutti

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that the following recommendation be inserted after recommendation 9:

That NSW Health increase the number of long term rehabilitation facilities for people with a mental illness in appropriate settings

Moved by Mr Hatzistergos: that recommendations 11 and 12 be amended by deleting the words “Office of Mental Health” and inserting instead, “NSW Health”.

Question put.

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that paragraph 4.115 be amended by deleting the last sentence and inserting instead:

Any issues of privacy must be interpreted in a constructive manner so as to ensure the information needs of consumers, carers and families are met. (see Chapter 6)

Resolved on the motion of Dr Chesterfield-Evans that: the following recommendation be inserted after recommendation 13:

That carers be included in discussions for determining assertive care plans and Community Treatment Orders.

Resolved on the motion of Mr Jobling: that paragraphs 13.117 – 13.133 and Recommendation 20 be inserted at the end of Chapter 4.

Moved by Mr Hatzistergos: that point 1 in recommendation 20 after paragraph 13.133 be deleted

Question put.

Question resolved in the negative.

Chapter 4, as amended, agreed to.

Chapter 5 read.

Resolved on the motion of Dr Chesterfield-Evans that: the following note to Table 5.1 be inserted:

The Committee did not seek data earlier than 1992. The introduction of accrual accounting in all departments from 1990 to 1991 would make comparisons difficult with financial reports earlier than this period.

Resolved on the motion of Dr Chesterfield-Evans that: the following paragraph be inserted after paragraph 5.22:

In contrast, the National Mental Health Report 2002 noted that Victoria, which had the highest expenditure on NGOs:

continued as the leading State in the extent of structural reform, with resource distribution greater than all other jurisdictions combined. [There was a] 128% increase in expenditure on community based services since 1992-1993...[The] reduction in inpatient beds was more than offset by the development of alternative community based residential units.

Resolved on the motion of Mr Jobling: that recommendation 6 be amended by inserting at the end, “The performance against these Key Performance Indicators should be reported in each Area Health Service annual report.”

Chapter 5, as amended agreed to.

Chapter 6 read.

Resolved on the motion of Mr Jobling: that the following paragraph be inserted after paragraph 6.16:

The Committee notes that decisions relating to the appointment of guardians (including enduring guardians) can now be reviewed by the Administrative Appeals Tribunal under the Guardianship and Protected Estates Legislation Amendment Act 2002. This legislation would further protect the rights of people with a mental illness wishing to appoint guardians as per the Committee's recommendations.

Resolved on the motion of Mr Hatzistergos: that recommendation 1 be amended by deleting all words and inserting instead:

That the Minister for Health and the Attorney General review the Guardianship Act 1987 with respect to people who suffer severe and/or episodic mental illnesses during which they are not capable of making informed consent. This review should include the possibility of enduring guardianship.

Resolved on the motion of Mr Breen: that recommendation 7 be deleted.

Chapter 6, as amended, agreed to.

Chapter 7 read.

Resolved on the motion of Mr Breen that: the following paragraph be inserted after paragraph 7.9:

Ms Elsworthy noted her own experiences in the community sector following the release of the Richmond Report: Before this job I worked as the Co-ordinator at Randwick Information and Community Centre for five years, which was the community centre for the lower end of the eastern suburbs... A number of people came to see me in my position there, people living on housing estates who were pulling their hair out because of disputes, complaints, threats and violence. It all happened post Richmond. It was all a consequence of the Richmond Report... I went there in the late 1980s and I was there for five years. It was all because people were being shunted out

Resolved on the motion of Mr Breen that: recommendation 1 be amended by deleting all words and inserting instead:

That the Minister for Health increase the number of supported accommodation places for people with mental disorders in NSW from 1,635 to 2,635 over the next two years, and that an average of 12 adult beds per 100,000 are for 24-hour a day high level supported residential services.

Resolved on the motion of Mr Breen: that recommendation 2 be amended by deleting all words and inserting instead.

That NSW Health match the level of funding for 24 hour supported accommodation packages for people with psychiatric disabilities provided by the Department of Ageing, Disability and Home Care.

Moved by Mr Hatzistergos: that recommendation 4 be amended by deleting the words "Office of Mental Health" and inserting instead, "NSW Health".

Question put.

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that paragraphs 7.72 - 7.75 be inserted after paragraph 7.38 and that paragraph 7.76 be inserted after paragraph 7.29.

Moved by Mr Hatzistergos: that recommendation 15 be amended by deleting the words "Office of Mental Health" and inserting instead, "NSW Health".

Question put.

Question resolved in the negative.

Chapter 7, as amended, agreed to.

Chapter 8 read.

Resolved on the motion of Mr Hatzistergos: that Chapter 7, Cultural and indigenous issues, be divided into separate chapters for “Multicultural issues” and “Indigenous issues”.

Resolved on the motion of Dr Chesterfield-Evans that: recommendation 11 be amended by deleting all words and inserting instead:

That the Minister for Health provide at least three fully funded scholarships for psychiatric nurses undertaking the proposed post-graduate module in Aboriginal Mental Health on an annual basis.

Moved by Mr Hatzistergos: that recommendation 12 be amended by deleting all words after “services” and insert instead, “be involved, with the consent of the patient, once an ATSI person is admitted to hospital for psychiatric care and later when discharged”

The Committee divided:

Ayes

Mr Breen
Mr Hatzistergos
Mr Jobling
Dr Pezzutti

Nos

Dr Chesterfield-Evans

Question put and passed.

Resolved on the motion of Dr Chesterfield-Evans: that the following paragraph be inserted after recommendation 12:

While the Committee did not receive specific evidence regarding the mental health of ATSI people in prison, the Committee notes with concern recent Australian Bureau of Statistics figures indicating an 8% increase in the number of indigenous prisoners in the total prison population in NSW. The Committee is well aware that the issue of suicide in custody was comprehensively covered in the Royal Commission on Aboriginal Deaths in Custody. Preventing ATSI people with mental health problems coming into contact with the criminal justice system is vital. Court diversionary programs for people with a mental illness are considered in Chapter 14.

Chapter 8, as amended, agreed to.

Chapter 9 read.

Moved by Dr Chesterfield-Evans: that paragraph 9.54 be amended by deleting the words “has no issue” in the second sentence and inserting instead “expresses concern” and inserting at the end “in terms of coordinated service delivery”.

The Committee divided:

Ayes

Mr Breen
Dr Chesterfield-Evans
Mr Jobling
Dr Pezzutti

Nos

Mr Hatzistergos

Question put and passed.

Resolved on the motion of Mr Hatzistergos: that paragraph 9.75 be amended by deleting the first sentence and inserting instead “The Committee supports the integration of service provision under the one organisation”.

Resolved on the motion of Mr Jobling: that recommendation 1 be amended by deleting the words “transfer an adequate component of the NSW Health drug and alcohol budget” and inserting instead “provide additional funding”.

Chapter 9, as amended agreed to.

Chapter 10 read.

Resolved on the motion of Dr Chesterfield-Evans that: paragraph 10.10 be amended by deleting all words after the first sentence and inserting instead the following quote:

The number of persons in Australia with intellectual disability is estimated as 1.5% of 18 million = 270,000, and 36% have a psychiatric disorder, then the number of persons with both intellectual disability and psychiatric disorder is 36% of 270,000 = 97,200. If one psychiatrist is required to serve 1,800 patients, then the number of psychiatrists required is 97,000 divided by 1,800 = 54.

This estimate rests on a number of assumptions, namely: a conservative estimate of the prevalence of intellectual disability; a conservative estimate of the proportion of this group with severe mental disorder; an assumption that the required amount of input from psychiatrists is equivalent to that for the community of psychiatric patients as a whole. The complexities of presentations might suggest a greater requirement for psychiatrists' time.

Chapter 10, as amended, agreed to.

Chapter 11 read.

Resolved on the motion of Mr Jobling: that recommendation 4 be amended by deleting all words in the last point and inserting instead, "timelines for achievements with annual reporting requirements"

Chapter 11, as amended agreed to.

Chapter 12 read.

Resolved on the motion of Mr Jobling: that recommendation 4 be amended by deleting all words and inserting instead:

That the Minister for Health, in relation to people who have attempted suicide and been admitted to hospital as mentally disordered:

- propose the *Mental Health Act 1990* be amended to require a post-discharge assessment appointment
- the appointment be allocated and the patient informed of the appointment and
- the assessment be conducted within 5 days of discharge.

Resolved on the motion of Mr Hatzistergos: that recommendation 10 be amended by deleting all words and inserting instead:

That the NSW Department of Education and Training and non-government service providers develop and provide specialist, supported and task-focused vocational and employment training programs for young people with a mental illness in consultation with NSW Health. The programs should focus on young people with varying degrees of cognitive, social or communication difficulties secondary to mental illness who may not succeed in mainstream training programs or paid employment.

Resolved on the motion of Dr Chesterfield-Evans: that recommendation 12 be amended by inserting at the end, "to improve the availability of specialist psychiatric services".

Chapter 12, as amended, agreed to.

Chapter 13 read.

Moved by Mr Hatzistergos: that recommendation 2 be amended by deleting all words and inserting instead, the following:

That additional funding be provided to increase training for ambulance staff and NSW Police to manage people with mental health problems and that this be supported by the renewed Memorandum of Understanding.

Question put

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that recommendation 4 be amended by inserting the words "as signatories" after the word "include".

Moved by Jobling: that recommendation 5 be amended by inserting the words "proposed Office of Mental Health within the" after the word "the" where it first appears.

The Committee divided:

Ayes

Mr Breen
Dr Chesterfield-Evans
Mr Jobling
Dr Pezzutti

Nos

Mr Hatzistergos

Question put and passed.

Resolved on the motion of Mr Hatzistergos: that recommendation 8 be amended by deleting all words and inserting instead, the following words:

That the Minister provide funding to NSW Health to increase specialist mental health staff so that hospitals can manage the detention and care of a person presented by police under s 21, 22 and 24 of the *Mental Health Act 1990*. Staffing levels should reflect the intensity of care.

Resolved on the motion of Mr Hatzistergos: that recommendation 9 be amended by deleting the words “partnership for the case management” and inserting the words “specialised program for the care”.

Mr Hatzistergos made a statement noting his objection to the proposed Office of Mental Health in recommendation 9.

Resolved on the motion of Mr Jobling: that recommendation 10 be amended by deleting all words and inserting instead:

That the Minister for Health ensure that the contracts for employment of consultant psychiatrists with Corrections Health Service require them to only address patient treatment related needs.

Resolved on the motion of Mr Hatzistergos: that the following recommendation be inserted after recommendation 10:

That the Minister for Health increase funding to employ additional psychiatrists to meet the increased forensic mental health assessment, consultation and treatment needs.

Resolved on the motion of Mr Hatzistergos: that recommendation 11 be amended by deleting all words in bullet points and inserting instead:

- * clarification of the responsibility of clinical services in the monitoring and reporting of clinical supervision, including the role of the Mental Health Review Tribunal in monitoring progress and
- * clarification of formal procedures for managing breaches of release conditions

Resolved on the motion of Mr Hatzistergos: that recommendation 14 be amended by deleting all words and inserting instead:

That the Minister for Health ensure that there is sufficient minimum security accommodation to avoid undue detention of patients in medium security units.

Resolved on the motion of Mr Hatzistergos: that the following recommendation be inserted after recommendation 17:

That the Minister for Health fund a secure forensic mental health facility for women.

Resolved on the motion of Dr Chesterfield-Evans: that recommendation 19 be amended by inserting the words “and medium” after the word “maximum”.

Moved by Mr Hatzistergos: that all paragraphs after 13.165 be deleted and insert instead, the following recommendation:

That the Minister for Health should establish a State Director of Forensic Mental Health with Corrections Health with linkages to the Centre for Mental Health.

Question put.

Question resolved in the negative.

Resolved on the motion of Mr Jobling: that recommendation 22 be amended by inserting at the end of the first point, “including court liaison services and court reports”.

Chapter 13, as amended, agreed to.

Appendices read

Resolved on the motion of Mr Jobling: that Appendix 1 be amended by inserting the words “without comment” at the end of the second paragraph.

Appendices, as amended, agreed to.

Moved by of Dr Chesterfield-Evans: that the following recommendation be inserted as the first recommendation of the report:

There must be graded community support systems for people with mental health problems. This support system should be generic and across all aspects of life, with specialised expertise available if required.

This community support should be the norm and institutions only brought in to cover areas that community support cannot manage.

The Committee divided:

Ayes

Dr Chesterfield-Evans

Nos

Mr Breen

Mr Hatzistergos

Mr Jobling

Dr Pezzutti

Question resolved in the negative.

Mr Hatzistergos, by leave, made the following statement on behalf of the Government Members on the Committee:

The Government members support the current strategies of the NSW Government to provide a modern mental health system which prioritises direct services for patients. As a consequence, we believe that additional resources should target services rather than setting up additional bureaucracies. For this reason we do not support the establishment of an Office of Mental Health under the Premier's department. Any future additional resources should be prioritised to patient services in areas which have been historically under-resourced including Western Sydney, the Central Coast and the North Coast.

At the same time Government members oppose the establishment of Rozelle Hospital as "an asylum for the mentally ill". Putting mentally ill people in asylums is an outmoded practice which is not supported by the World Health Organisation. Our preferred approach is to increase long-term rehabilitation services in appropriate facilities, including community and hospital settings and involving the expertise of non-government agencies. Hospital facilities from Rozelle should be moved to an up to date facility at Concord Hospital. We note that this is the current approach of the Government with construction of a new mental health facility at Concord Hospital to commence shortly. The Government's plan also includes legislation which will preserve Callan Park as a public park.

Resolved, on the motion of Mr Jobling: that the final report of the Select Committee on Mental Health, as amended, be adopted.

Resolved, on the motion of Mr Jobling: that the final report be signed by the Chair and presented to the House in accordance with the provisions of the Resolution of the House.

Resolved, on motion of Dr Chesterfield-Evans: that pursuant to the provisions of section 4 of the *Parliamentary Papers (Supplementary Provisions) Act 1975* and under the authority of Standing Order 252, the Committee authorises the Clerk of the Committee to publish the report, submissions, corrected transcripts, and related documents and material with the exception of documents identified as "confidential" or "not publicly available".

4. ADJOURNMENT

The meeting adjourned at 5.00 pm.

Rob Stefanic

Director