

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 “siloeing 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.
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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.

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 hospital 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 *Forensicare 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, *Forensicare, 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.
