

Select Committee on Mental Health

Mental Health Services in New South Wales

Final Report

Ordered to be printed according to the Resolution of the
House

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Terms of Reference

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

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

Committee Membership



The Hon Dr Brian Pezzutti RFD MLC

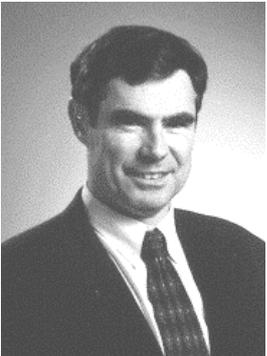
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Chair



The Hon Peter Breen MLC

Reform the Legal System



The Hon Dr Arthur Chesterfield-Evans MLC

Australian Democrats



The Hon Amanda Fazio MLC

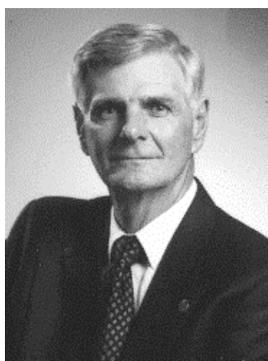
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Australian Labor Party



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(Appointed to Committee 20 June 2002)



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Chair's Foreword

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hon Dr Brian Pezzutti RFD MLC

Chair

Summary of Recommendations

Recommendation 1

Page 35

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

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

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

Recommendation 2

Page 35

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

Recommendation 3

Page 41

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

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

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

Recommendation 4

Page 46

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

Recommendation 5

Page 53

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

Recommendation 6

Page 55

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

Recommendation 7**Page 55**

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

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

Recommendation 8**Page 59**

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

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

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

Recommendation 9**Page 63**

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

Recommendation 10**Page 63**

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

Recommendation 11**Page 63**

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

Recommendation 12**Page 64**

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

Recommendation 13**Page 64**

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

Recommendation 14**Page 64**

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

Recommendation 15**Page 66**

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

Recommendation 16**Page 66**

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

Recommendation 17**Page 71**

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

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

Recommendation 18**Page 71**

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

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

Recommendation 19**Page 73**

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

Recommendation 20**Page 73**

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

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

Recommendation 21**Page 75**

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

Recommendation 22**Page 79**

That the position of the Principal Official Visitor:

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

Recommendation 23**Page 86**

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

Recommendation 24**Page 90**

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

Recommendation 25**Page 95**

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

Recommendation 26**Page 95**

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

Recommendation 27**Page 96**

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

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

Recommendation 28**Page 96**

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

Recommendation 29**Page 96**

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

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

Recommendation 30**Page 104**

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

Recommendation 31**Page 104**

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

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

Recommendation 32**Page 104**

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

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

Recommendation 33**Page 108**

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

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

Recommendation 34**Page 108**

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

Recommendation 35**Page 108**

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

Recommendation 36**Page 110**

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

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

Recommendation 37**Page 110**

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

Recommendation 38**Page 111**

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

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

Recommendation 39**Page 116**

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

Recommendation 40**Page 127**

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

Recommendation 41**Page 127**

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

Recommendation 42**Page 132**

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

Recommendation 43**Page 133**

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

Recommendation 44**Page 133**

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

Recommendation 45**Page 135**

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

Recommendation 46**Page 135**

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

Recommendation 47**Page 139**

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

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

Recommendation 48**Page 144**

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

Recommendation 49**Page 144**

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

Recommendation 50**Page 147**

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

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

Recommendation 51**Page 149**

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

Recommendation 52**Page 150**

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

Recommendation 53**Page 150**

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

Recommendation 54**Page 150**

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

Recommendation 55**Page 150**

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

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

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

Recommendation 56**Page 156**

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

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

Recommendation 57**Page 156**

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

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

Recommendation 58**Page 157**

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

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

Recommendation 59**Page 157**

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

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

Recommendation 60**Page 157**

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

Recommendation 61**Page 157**

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

Recommendation 62**Page 164**

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

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

Recommendation 63**Page 165**

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

Recommendation 64**Page 165**

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

Recommendation 65**Page 165**

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

Recommendation 66**Page 165**

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

Recommendation 67**Page 166**

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

Recommendation 68**Page 186**

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

Recommendation 69**Page 186**

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

Recommendation 70**Page 197**

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

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

Recommendation 71**Page 197**

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

Recommendation 72**Page 197**

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

Recommendation 73**Page 197**

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

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

Recommendation 74**Page 198**

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

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

Recommendation 75**Page 198**

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

Recommendation 76**Page 198**

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

Recommendation 77**Page 203**

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

Recommendation 78**Page 203**

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

Recommendation 79**Page 205**

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

Recommendation 80**Page 207**

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

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

Recommendation 81**Page 213**

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

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

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

Recommendation 82**Page 213**

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

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

Recommendation 83**Page 214**

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

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

Recommendation 84**Page 223**

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

Recommendation 85**Page 223**

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

Recommendation 86**Page 224**

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

Recommendation 87**Page 224**

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

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

Recommendation 88**Page 224**

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

Recommendation 89**Page 227**

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

Recommendation 90**Page 227**

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

Recommendation 91**Page 228**

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

Recommendation 92**Page 228**

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

Recommendation 93**Page 228**

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

Recommendation 94**Page 230**

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

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

Recommendation 95**Page 232**

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

Recommendation 96**Page 232**

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

Recommendation 97**Page 238**

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

Recommendation 98**Page 238**

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

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

Recommendation 99**Page 245**

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

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

Recommendation 100**Page 245**

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

Recommendation 101**Page 246**

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

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

Recommendation 102**Page 246**

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

Recommendation 103**Page 246**

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

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

Recommendation 104**Page 246**

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

Recommendation 105**Page 246**

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

Recommendation 106**Page 248**

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

Recommendation 107**Page 248**

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

Recommendation 108**Page 250**

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

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

Recommendation 109**Page 256**

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

Recommendation 110**Page 256**

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

Recommendation 111**Page 256**

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

Recommendation 112**Page 256**

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

Recommendation 113**Page 258**

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

Recommendation 114**Page 262**

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

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

Recommendation 115**Page 262**

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

Recommendation 116**Page 263**

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

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

Recommendation 117**Page 263**

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

Recommendation 118**Page 265**

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

Recommendation 119**Page 271**

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

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

Recommendation 120**Page 271**

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

Glossary

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

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

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

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

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

Abbreviations

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

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

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

Chapter 1 Background to the inquiry

Terms of reference

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

Conduct of this inquiry

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

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

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

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

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

- 1.6 The media release was circulated to all major newsprint and electronic media sources. Communication of these media releases to the public is dependent on media interest.
- 1.7 Secondly, the Committee advertised its terms of reference inviting public submissions in the major metropolitan and regional print media delivering to all areas of NSW. Advertisements were placed in the following newspapers during the period 2 February 2002 to 7 February 2002.

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

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

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

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

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

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

Table 1.2 Number and percentage of submissions by organisation type

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

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

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

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

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

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

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

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

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

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

Previous inquiries into mental health services

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

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

Scope and nature of this report

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

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

Issues not discussed

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

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

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

Chapter 2 Historical context

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

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

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

Richmond Report

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

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

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

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

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

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

¹⁰ Royal Commission on Lunacy Law and Administration, 1923

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

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

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

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

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

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

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

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

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

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

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

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

¹⁶ *ibid*, p 9

¹⁷ *ibid*, pp 9-10

Barclay Report

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

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

2.7 The Report concludes:

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

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

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

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

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

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

²⁰ *ibid*

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

²² NSW Parliamentary Library Briefing Paper, 1996, p 14

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

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

Burdekin Report

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

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

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

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

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

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

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

²⁵ Burdekin Report, p 298

²⁶ NSW Parliamentary Library Briefing Paper, 1996, p 6

²⁷ *ibid*

²⁸ *ibid*, p 7

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

- 2.14** The issue of forensic patients (those deemed to be not guilty, or unfit to stand trial by reason of mental illness) was not addressed in the recommendations of the Richmond Report, but was identified in the Burdekin Report:
- Mentally ill people detained by the criminal justice system are frequently denied the health care and human rights protection to which they are entitled.³⁰
- 2.15** The Burdekin Report stated that distinctions between mental illness and criminal behaviour need to be made and the protection of the rights of forensic patients guaranteed across all jurisdictions.³¹
- 2.16** While the Burdekin Report highlighted insufficient funding of community care and lack of trained staff to care for patients after discharge, of greater concern was the analysis of the government's implementation of mental health reform. The Burdekin Report identified not only inefficient planning and organisational arrangements to integrate services within hospitals, but also a lack of procedures to involve families in the community treatment process. It was considered that these issues had not been adequately addressed. Evidence received by this Select Committee indicates that in NSW these issues still require further attention.

Post-Barclay Report

- 2.17** In its submission to this Committee, NSW Health outlined policy developments since the Barclay Report:
- In 1992 all Australian Health Ministers adopted the National Mental Health Strategy, which provided, and continues to provide, a national framework for dealing with mental health issues. The Strategy now comprises the Mental Health Statement of Rights and Responsibilities (1991), the National Mental Health Policy (1992), the first National Mental Health Plan (1993-98), the Commonwealth/State healthcare agreements, and the Second National Mental Health Plan (1998-current).³²
- 2.18** Following the publication of the Burdekin Report in 1993, the NSW Health *Annual Report 1994-1995* identified that continued development of community based services and strengthening the role of the non-government sector in service provision, were priorities in the mental health area for NSW. The Annual Report identified that areas such as services for people of indigenous and non-English speaking backgrounds, people living in public housing and prisoners, were to be specifically targeted.³³

³⁰ Burdekin Report, p 940

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

³² Submission 267, NSW Health, p i

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

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

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

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

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

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

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

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

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

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

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

³⁵ Submission 267, NSW Health, p i

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

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

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

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

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

[NSW Consumer Advisory Group]

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

Background

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

Implications of the Richmond Report

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

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

³⁸ Submission 162, NSW Consumer Advisory Group, p 18

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

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

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

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

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

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

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

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

Government sector

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

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

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

⁴¹ Submission 78, UnitingCare, p 13

⁴² *ibid*, p ii

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

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

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

Centre for Mental Health

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

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

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

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

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

⁴⁶ *ibid*

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

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

Area Health Services

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

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

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

Corrections Health Service

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

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

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

⁴⁷ ibid

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

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

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

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

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

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

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

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

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

⁵¹ ibid

⁵² Submission 267, NSW Health, p A 21

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

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

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

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

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

Community care

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

Housing service sector

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

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

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

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

⁵⁵ Submission 267, NSW Health, p A 26

⁵⁶ *ibid*, p ii

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

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

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

⁵⁷ Submission 198, Shelter NSW, p 4

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

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

⁶⁰ *ibid*, p 2

⁶¹ Submission 267, NSW Health, p G 41

⁶² *ibid*

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

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

Commonwealth agencies

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

Non-government organisations

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

⁶³ Submission 198, NSW Shelter, p 40

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

⁶⁵ Submission 267, NSW Health, p i

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

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

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

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

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

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

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

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

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

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

⁶⁶ Submission 267, NSW Health, p G 28

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

⁶⁸ Submission 267, NSW Health, p G 28

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

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

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

Registered charities

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

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

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

General Practitioners

3.43 There are more than 7,000 General Practitioners (GPs) in NSW providing health assessments to 80% of the Australian community each year. GPs provide mental health interventions to 27% of people attending their practices.⁷³

3.44 The NSW Transcultural Mental Health Centre noted that the vast majority of those receiving care for mental disorders receive it from GPs. Consequently, consideration needs to be given to the provision of such care by GPs, mental health services, private psychiatrists and the linkages and service delivery partnerships between these service providers.⁷⁴

3.45 In its submission, the Alliance of NSW Divisions, a Commonwealth funded, State based organisation representing GPs, stated that:

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

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

⁷² Submission 267, NSW Health, p A 27

⁷³ *ibid*, p G 27

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

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

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

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

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

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

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

Carers and family

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

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

⁷⁶ *ibid*

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

⁷⁸ Public forum, NSW Parliament House, 7 August 2002

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

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

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

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

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

Office of the Protective Commissioner (NSW)

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

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

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

⁸⁰ Submission 162, NSW Consumer Advisory Group, p 28

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

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

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

⁸⁴ *ibid*, p 2

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

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

Office of the NSW Public Guardian

3.56 The NSW Public Guardian can be appointed by the Guardianship Tribunal to be the legal substitute decision maker for a person with a disability, which can include a person with a mental illness.⁸⁶

3.57 The Public Guardian is currently the guardian for approximately 1,680 people with disabilities who reside across NSW. Over the past two and a half years the number of people under guardianship with a primary diagnosis of mental illness has been approximately 12%. A significant number may also have both a mental illness and another disability, such as a developmental or intellectual disability.⁸⁷

3.58 The Office of the NSW Public Guardian detailed its role in representing a person under guardianship:

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

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

De facto mental health services – NSW Police

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

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

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

⁸⁷ *ibid*

⁸⁸ *ibid*

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

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

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

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

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

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

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

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

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

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

⁹⁰ Submission 254, Police Association of NSW, p 4

⁹¹ *ibid*, p 3

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

Coordination of mental health services

Centre for Mental Health perspective

- 3.67** NSW Health advised the Committee that the Centre for Mental Health coordinates the Mental Health Quality Portfolio (MHQP). The MHQP was intended to implement a “comprehensive quality strategy” developed in response to two NSW Health policy and planning documents, *Caring for Mental Health*, October 1998 and *A Framework for Managing the Quality of Health Services in New South Wales*, February 1999.⁹⁴ NSW Health explained that issues associated with the day-to-day delivery of mental health services in NSW have also been incorporated into the portfolio:
- The implementation of this quality agenda has involved, and will continue to involve, close cooperation between the Centre for Mental Health and area health services as well as partnerships between these bodies and a wide range of non-government organisations and other government agencies.⁹⁵
- 3.68** NSW Health also advises that “public sector mental health services are building upon emerging service networks” and referred to a statement in the World Health Organisation’s (WHO) *World Health Report 2001*:

WHO’s message is that every country, no matter what its resource constraints, can do something to improve the mental health of its people. What it requires is the courage and the commitment to take the necessary steps.⁹⁶

⁹² *ibid*, p 4

⁹³ Submission 254, Police Association of NSW, p 2

⁹⁴ Submission 267, NSW Health, p E 2

⁹⁵ *ibid*

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

Mental health service consumers' perspective

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

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

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

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

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

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

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

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

Conclusions

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

⁹⁷ Submission 162, NSW Consumer Advisory Group, p 18

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

⁹⁹ Submission 162, NSW Consumer Advisory Group, p 51

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

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

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

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

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

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

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

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

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

¹⁰⁰ Submission 192, NCOSS, p 12

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

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

¹⁰³ *ibid*

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

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

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

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

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

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

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

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

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

¹⁰⁵ *ibid*

Recommendation 1

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

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

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

Recommendation 2

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

Chapter 4 Service provision, treatment and care

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

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

Defining mental health services

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

Policy foundation – the Population Health Model

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

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

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

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

¹⁰⁸ Submission 267, NSW Health, p G 1

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

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

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

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

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

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

Policy - Mainstreaming

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

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

¹⁰⁹ Submission 267, NSW Health, p G 1

¹¹⁰ Submission 192, NCOSS, p 5

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

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

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

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

Acute care

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

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

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

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

¹¹² Submission 267, NSW Health, p D 3

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

¹¹⁴ Submission 267, NSW Health, p G 39

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

¹¹⁶ *ibid*

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

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

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

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

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

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

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

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

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

¹¹⁷ Submission, NSW Health, p A 13

¹¹⁸ Submission 120, Health Care Complaints Commission, p 2

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

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

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

4.16 The Committee acknowledges that sometimes anecdotes may represent isolated or atypical instances of a breakdown in the system, rather than representing any systemic problems. The number of similar incidents detailed to the Committee, however, raises real concerns about the provision of inpatient and community services in NSW. Based on the evidence received by the Committee, NSW Health needs to better coordinate policy development with service provision for both community and inpatient care.

4.17 The Committee notes that the Sentinel Review Committee, chaired by Prof Peter Baume, is reviewing this issue. The Minister for Health may satisfy Recommendation 3 by extending the Sentinel Review Committee's terms of reference.

Recommendation 3

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

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

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

Psychiatric beds

Availability

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

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

¹²¹ Submission 212, NSW Nurses' Association, p 6

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

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

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

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

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

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

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

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

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

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

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

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

¹²⁴ Submission 267, NSW Health, A.12

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

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

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

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

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

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

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

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

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

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

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

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

Management of beds

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

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

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

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

¹³³ *ibid*

¹³⁴ Submission 209, Comprehensive Area Service Psychiatrists, p 3

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

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

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

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

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

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

- 4.30** The NAPP also asserted that:

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

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

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

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

¹³⁷ *ibid*

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

¹³⁹ *ibid*, p 9

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

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

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

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

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

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

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

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

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

¹⁴¹ Submission 263, Dr William Barclay, p 3

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

¹⁴³ *ibid*

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

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

Conclusion

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

Recommendation 4

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

Acute care to secondary care – service linkages

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

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

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

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

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

¹⁴⁸ *ibid*, A.19

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

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

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

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

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

Intervention through community care/crisis teams

4.42 The Legal Aid Commission stated that it regularly sees a failure to recognise the seriousness of a situation and a lack of assertive intervention. According to the Commission, this failure highlights poor quality service at the critical early assessment phase, which can subsequently lead to quite dramatic outcomes.¹⁵³

4.43 Mr Fred Pateman's son had schizophrenia and was killed by a close friend also suffering chronic schizophrenia. Mr Pateman's submission to the Committee included a copy of a letter he sent to the Minister for Health, which stated:

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

¹⁴⁹ Submission 267, NSW Health, A.19

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

¹⁵¹ *ibid*

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

¹⁵³ Submission 216, Legal Aid Commission, p 4

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

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

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

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

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

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

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

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

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

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

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

¹⁵⁵ Submission 273, Prof John Snowdon, p 2

¹⁵⁶ Submission 75, Gethsemane Community, p 2

¹⁵⁷ *ibid*

¹⁵⁸ *ibid*, p 3

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

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

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

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

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

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

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

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

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

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

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

¹⁶¹ *ibid*, pp 5-6

¹⁶² *ibid*, p 5

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

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

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

General Practitioners

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

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

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

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

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

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

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

¹⁶⁴ Submission 286, NSW Police Service, p 7

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

¹⁶⁶ Submission 267, NSW Health, p G 26

¹⁶⁷ *ibid*

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

4.58 Dr Hoekstra expressed doubt that partnership programs would succeed:

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

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

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

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

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

Non-government sector

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

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

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

¹⁷⁰ Submission 75, Gethsemane Community, p 2

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

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

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

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

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

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

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

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

¹⁷³ Submission 276, NSW Health, p G.28

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

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

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

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

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

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

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

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

Recommendation 5

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

Assertive case management

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

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

¹⁷⁶ *ibid*

¹⁷⁷ *ibid*, p 3

¹⁷⁸ Submission 162, NSW Consumer Advisory Group, p 47

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

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

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

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

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

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

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

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

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

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

¹⁸² Submission 75, the Gethsemane Community, p 2

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

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

¹⁸⁵ *ibid*

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

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

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

Recommendation 6

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

Recommendation 7

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

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

Long-term care and rehabilitation

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

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

The debate on institutionalised care

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

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

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

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

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

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

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

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

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

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

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

¹⁸⁹ Submission 155, Ms Maureen Doyle, p 2

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

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

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

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

Shortage of long-term care

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

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

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

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

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

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

¹⁹³ *ibid*

¹⁹⁴ Submission 233, CASP, p 1

¹⁹⁵ M Giuffrida Evidence, 8 August 2002, p 51

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

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

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

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

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

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

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

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

¹⁹⁷ *ibid*, p 55

¹⁹⁸ Submission 75, Gethsemane Community, p 2

¹⁹⁹ *ibid*

Recommendation 8

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

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

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

Rozelle Hospital – a place of asylum

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

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

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

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

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

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

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

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

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

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

²⁰³ *ibid*

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

²⁰⁵ *ibid*, p 115

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

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

4.96 Ms Zelinka nevertheless noted that:

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

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

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

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

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

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

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

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

²⁰⁷ *ibid*

²⁰⁸ *ibid*, p 120

²⁰⁹ *ibid*

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

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

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

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

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

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

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

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

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

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

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

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

²¹² *ibid*

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

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

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

²¹⁶ *ibid*

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

Recommendation 9

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

Recommendation 10

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

Recommendation 11

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

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

Conclusion

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

Recommendation 12

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

Recommendation 13

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

Recommendation 14

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

Family and carers

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

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

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

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

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

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

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

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

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

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

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

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

²²⁰ Public forum, 7 August 2002, NSW Parliament House

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

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

²²³ *ibid*, p 1

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

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

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

Recommendation 15

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

Recommendation 16

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

Staffing

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

²²⁴ Submission 218, MHCC, p i

²²⁵ Submission 267, NSW Health, p F 1

²²⁶ *ibid*, p F 6

²²⁷ Submission 162, NSW Consumer Advisory Group, p 37

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

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

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

Nursing

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

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

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

²²⁸ Submission 212, NSW Nurses' Association, p 5

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

²³⁶ *ibid*, p 21

²³⁷ Submission 189, NAPP, p 13

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

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

²⁴⁰ Submission 267, NSW Health, p F 2

²⁴¹ *ibid*

²⁴² Submission 212, NSW Nurses’ Association, p 6

²⁴³ B Raphael Evidence, 12 August 2002, p 9

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

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

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

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

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

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

²⁴⁴ Submission 212, NSW Nurses' Association, p 6

²⁴⁵ Submission 267, NSW Health, p F 5

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

Recommendation 17

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

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

Recommendation 18

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

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

Nurse practitioners

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

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

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

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

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

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

²⁴⁹ *ibid*

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

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

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

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

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

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

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

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

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

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

²⁵² *ibid*

²⁵³ *ibid*

²⁵⁴ *ibid*

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

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

²⁵⁷ *ibid*, p 26

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

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

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

Recommendation 19

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

Recommendation 20

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

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

Caring for carers

- 4.146** The focus of the public mental health system on acute treatment services has shifted an increasing responsibility to the community sector. Adequate support services for family and carers have not accompanied this shift.
- 4.147** The public forum conducted by the Committee on 7 August 2002 for consumers, carers and families provided the Committee with a harrowing, but valuable account of the difficulties and anguish which carers and family often experience. The Committee heard how, despite their commitment, they often felt isolated from the mental health system and support services. Mr Fred Pateman summed up the feelings of many at the forum:

²⁵⁸ J Meppem, Evidence, 31 July 2002, p 30

I could talk about not enough money for mental illness, not enough beds in psychiatric hospitals, psychiatrists not wanting to go to country areas, the number of people who suffer mental illness in gaols...we've heard that all day today...police wanting to deal with criminals not illness, all the glossy books...and I hope this [inquiry] goes further than glossy books. I could talk and write about all the suggestions you have on your call for submissions...but you have more qualified people than me to do that.

I would like to talk about something lifetime experience has made me qualified to comment on; since the death of our son...I have been approached by many friends, carers and relations, all of whom have the same problems, the problems coming through today. When they call on the mental health system they are told nothing can be done until their sons and daughters have become a danger to themselves and others. It's about time the family and friends were taken notice of. They see the person with their mental illness most of the time doctors only see them occasionally.²⁵⁹

4.148 In *A Long Road to Recovery*, one young carer aged 12 said:

I've never been to a school camp. I used to lie and tell them that we didn't have enough money, but it was really because Mum was too sick. I just couldn't leave her. If I wasn't around, she would have nobody.²⁶⁰

4.149 The Centre for Mental Health stated it provides \$1 million each year to fund programs designed to support carers of people with a mental illness. The programs include a focus on providing personal and emotional support and training, targeting children of parents with a mental illness, support for self-help groups and information services.²⁶¹

4.150 The nature of the submissions from family and carers however, suggested that this funding was entirely inadequate and that access to such services is poor. Ms Lexie Lord, Parents and Carers Mental Health Group, Casino, expressed that:

Virtually we are a support group among ourselves because there is nothing much out there for carers. We save the Government a fortune but there is not the mental health staff to also take into consideration the parents who are particularly traumatised.²⁶²

4.151 The sentiments expressed by family and carers was supported by the NSW Nurses' Association, which stated that:

It is our contention that very little funding has been allocated in NSW for consumers and carer run programs or consumer support groups.²⁶³

²⁵⁹ Mr Fred Patemen, speaker, public forum, NSW Parliament House, 7 August 2002

²⁶⁰ Submission 143, Society of St Vincent de Paul, attachment, *A Long Road to Recovery – a social justice statement on mental health*, p 18

²⁶¹ Submission 267, NSW Health, p G 36-37

²⁶² Ms Lexie Lord, Parents and Carers Mental Health Group, Casino, Evidence 31 July 2002, pp 12-13

²⁶³ Submission 212, NSW Nurses' Association, p 7

- 4.152** According to the NSW Nurses' Association, the inability for carers to access support services could be attributed to the lack of Consumer Advisors, not yet employed by health services, despite recommendations and guidelines from the Centre for Mental Health. The Association summed up by stating: "consumer participation is tokenistic in far too many Area Health Services".²⁶⁴
- 4.153** A government program that provides respite care and other supports for those people looking after people with a mental illness is required. These support services would recognise the significant role of carers and family, which was previously the responsibility of the public system.

Recommendation 21

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

Official Visitors

- 4.154** The role of an Official Visitor is to inspect and report on the conditions of mental health care, treatment and control of patients. The role and requirements of Official Visitors, as legislated in the *Mental Health Act 1990*, are an important component of the Minister's management of public mental health facilities and services in NSW. The Principal Official Visitor is therefore in a significant position to independently advise the Minister on the running of NSW mental health facilities.
- 4.155** According to Chapter 8, Part 2 of the *Mental Health Act 1990*, the Principal Official Visitor oversees the Official Visitor program. Section 227 of the Act outlines the functions of the Principal Official Visitor:
- The Principal Official Visitor:
- (a) must assist in the exercise by Official Visitors of the functions conferred or imposed on them by or under this Act, and
 - (b) may, in relation to any hospital or health care agency, exercise any such function, and
 - (c) must, in accordance with such directions as are given by the Minister, report to the Minister as to the exercise of the functions of the Principal Official Visitor and of Official Visitors.
- 4.156** In relation to the inspection of hospitals, Section 230 of the Act requires that at least two Official Visitors, one being a medical practitioner, 'must visit':

²⁶⁴ Submission 212, NSW Nurses' Association, p 7

- (a) each hospital under their control of the area health service concerned, and each authorised hospital situated in the area of the area health service, at least once a month, and
- (b) each health care agency under the control of the area health service concerned, and each other health care agency situated in the area of the area health service, at least once every 6 months

with or without any previous notice, at such time of time of the day or night and for such length of time as they think fit.

4.157 The Act further states that the Official Visitor ‘must, so far as practical’, inspect every part of the hospital at least once each visit, inquire into the care, treatment and control of patients and informal patients and report to the Principal Official Visitor as soon as practical after each visit.²⁶⁵

4.158 NSW Health considers the role of the Principal Official Visitor (a part-time position) to undertake advocacy on behalf of consumers, act as a resource person to Official Visitors with respect to current issues and developments in the mental health field and to refer appropriately matters of significance.²⁶⁶ NSW Health outlined the activities involved and an estimate of the resources required in the role of the Principal Official Visitor:

- read all Official Visitors’ monthly reports with the assistance of the designated officer in the Centre for Mental Health and decide what matters should be further investigated. Follow up matters not satisfactorily resolved (6 hours/week)
- report on those matters (in anonymous format) referred to the Health Care Complaints Commission (varies, but average 2 hours/week)
- compile quarterly report to the Minister on the Official Visitor program (5 days per quarter)
- report immediately to the Minister on matters of grave concern (variable)
- be available for consultation by all Official Visitors (“on-call” for office hours)
- be responsible for conducting the Annual Official Visitor Conference and Training Program for newly appointed Official Visitors (10 days for each, spread over 2 months for each, with conference once per year, training twice every 3 years)
- chair the Official Visitor Advisory Committee and prepare/edit material as required (2 hours/week)
- prepare quarterly News Bulletin for distribution to all Official Visitors (2 hours/week)

²⁶⁵ *Mental Health Act 1990*, Part 2, section 230

²⁶⁶ Correspondence from NSW Health to Committee, 14 October 2002, p 1

- responsible for recruitment and assisting in development of Official Visitors (Varies, 8 days work twice every 2 years, may involve recruitment between terms upon retirement of an Official Visitor).²⁶⁷

4.159 In 1846, the Select Committee on the Lunatic Asylum, Tarban Creek, noted that reports by Official Visitors, commissioned to inspect and report on the conditions of mental health care, were not being accorded appropriate recognition. Mr Charles Cowper Esq, Committee Chairman, reported:

That the present mode of inspection is a comparative failure, the Council will have already seen is the opinion of the Committee; and the only plan which they feel safe in suggesting in lieu of the present is, that the English system be adhered to closely as possible.²⁶⁸

4.160 The problems encountered by Official Visitors in 1846 appear similar to those present now. Dr Peter Harvey, retired Cardiologist, now an Official Visitor of mental health facilities operated by NSW Health, raised serious questions over the true value of the Official Visitor program as it currently functions. Dr Harvey referred to the demand that is placed on the Official Visitor:

as I see it, a visit is a pretty arduous ordeal; you are there for about four hours... and in that...you are supposed to cover: from hospital services, from the amount of drugs used, from the way the records are written, talking to individual patients—and you can imagine how far you get talking to five very certifiable people and sorting out the truth from fantasy and hallucinations. We do all this, and a whole lot more.²⁶⁹

4.161 Dr Harvey stated that many Official Visitors are well established and have good working relationships with the hospital, but to come into the system currently is a daunting experience, citing the complex nature of the *Mental Health Act 1990* and the strenuous requirements.²⁷⁰

4.162 While Dr Harvey described the duties of the Official Visitor, he informed the Committee that he was not provided with training, nor was he invited to attend an induction program when he became an Official Visitor:

when I came into the system it was out of sync with the training program and I was given no training. I am a cardiologist.

Some months later after I repeatedly pointed this out I was given three weeks notice to say that a special training day had been arranged for me to go through all this material...[which Dr Harvey couldn't attend due to prior engagement]...They did not even consult me as to when to have it, so they cancelled it and I have never had any training. I have just sort of read the Act and tried to talk to the Principal Official Visitor.²⁷¹

²⁶⁷ Correspondence from NSW Health to Committee, 14 October 2002, pp 1-2

²⁶⁸ Legislative Council, *Report from the Select Committee on the Lunatic Asylum, Tarban Creek*, 21 October 1846, p 4

²⁶⁹ Dr Peter Harvey, Official Visitor, NSW Health, Evidence, 8 October 2002, p 2

²⁷⁰ *ibid*, p 5

²⁷¹ *ibid*, p 4

4.163 According to Dr Harvey, there are often not enough visitors available to visit the hospitals each month, as required under the Act. Dr Harvey informed the Committee that the lack of training and demands for Official Visitors, who more often than not are retired health workers, places undue pressure on them:

One of my complaints is that it is putting an awful lot on—I am a retired cardiologist and chest physician and one of my colleagues was a Deputy Vice-chancellor of the University of NSW, another was a nursing administrator, another was a social worker and we are asked to consider such things as, "Do you consider excessive amounts of medication are being prescribed?" You walk into a unit with 30 or 40 people, some of them talking to the walls, some of them prancing up and down shouting for the nurses and you are supposed to look at this.²⁷²

4.164 In addition to fulfilling these roles, Dr Harvey stated that the Official Visitor must complete a monthly report to the Principal Official Visitor, which involves filling in a quite extensive form. Dr Harvey expressed concern however, that once the report is filed, no feedback is relayed to the Official Visitor:

We get no feedback. Occasionally if you refer a matter to the Principal Official Visitor you will get a report back from one of her underlings—never from the organ grinder, always from an underling. Often, the issues that require following up are totally ignored. At least we are not informed of any action.²⁷³

4.165 As Official Visitors are meant to receive a feedback report every three months, Dr Harvey was concerned that the information, diligently gathered by Official Visitors, was not being fully utilised:

I have been attending for 20 months and I have not seen a report yet. Going back with my colleagues, the last one I can find was January 1998. There may have been others but there certainly have not been any since March 2001. So we collect all this information and it is valuable and it is hard to gather and we feed it into a system and we get no feedback. This is one of my complaints.²⁷⁴

4.166 In referring to the Annual Official Visitor Conference and Training Program, Dr Harvey was complementary of some of the addresses by psychiatrists and police. Dr Harvey was, however, critical of the lack of feedback on the action taken following Official Visitor reports:

The Principal Official Visitor was supposed to give us a report, the title of which was "What happens to your reports when we get them?" Her formula was to list all the reports, subdivide them, so many about "food", about "the toilets", about "not seeing enough of the patients", that "it was dirty". She just went through all the complaints. She did not ever tell us what she did with them or what happened to all this information that we feed in. So that is the official meeting, and then you might meet a couple of other people but there is really no question time. It is all didactic and instructive. There is not enough question time.²⁷⁵

²⁷² P Harvey, Evidence, 8 October 2002, p 3

²⁷³ *ibid*

²⁷⁴ *ibid*

²⁷⁵ *ibid*, p 4-5

- 4.167** In response to a question from the Committee regarding additional efforts he may have made to obtain feedback on issues, Dr Harvey stated that he had previously attempted to contact the Principal Official Visitor but person was never available on the telephone, never answered the paging system, and did not return his calls.²⁷⁶
- 4.168** The Committee expects that the majority of Official Visitors receive adequate training and that the Principal Official Visitor intends to function as effectively as possible. The Principal Official Visitor is responsible, however, for visiting 58 hospitals and 70 agencies and addressing every matter that is raised. The Committee cannot ignore the evidence presented by Dr Harvey, given the apparent frustration he has experienced:
- The system is not run efficiently. That is why I am here. I feel that I have done my best. I do not know how much longer I will have the energy to do this. I am thinking strongly of just giving it up but I thought I would like to see your Committee perhaps do something before I drop out of the system.²⁷⁷
- 4.169** Following Dr Harvey's appearance before the Committee, NSW Health advised that a selection of Official Visitors to rural areas for the next three-year term had been completed and that training for this group was planned for 2-3 December 2002.²⁷⁸ NSW Health indicated that Dr Harvey would be invited to attend this training.
- 4.170** Given the value of the Official Visitor program, the Committee considers that the program might be best served by locating the Principal Official Visitor within the proposed Office of Mental Health within the NSW Premier's Department. To improve accessibility of Official Visitors to the Principal Official Visitor, the Committee considers that the position of the Principal Official Visitor must either be designated as a full-time position, or that the Principal Official Visitor establish allocated and adequate consultation periods during office hours for Official Visitors.

Recommendation 22

That the position of the Principal Official Visitor:

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

²⁷⁶ P Harvey, Evidence, 8 October 2002, p 7

²⁷⁷ *ibid*, p 17

²⁷⁸ Correspondence from NSW Health to Committee, 10 October 2002

Chapter 5 Funding - the need for transparency

We are also extremely concerned about accountability for the spending of those funds and at present we have very little information about where those funds actually go, which does not create a great deal of confidence that they are going to the right place.²⁷⁹

[Ms Roslyn Bragg, Deputy Director, Policy, NCOSS]

This report focuses on mental health service provision rather than funding of mental health services. Funding is nevertheless a component of health service provision and will be discussed in that context to provide an overview of funding allocations. This chapter will not provide detailed analysis of funding criteria or dissect the mental health budget in NSW in any great detail. The funding of health services by Commonwealth and State governments is often quite complex and shrouded in multiple interwoven initiatives. Mental health funding is indicative of the complex nature of health funding.

NSW funding model

- 5.1** The NSW funding model is a two-tiered system. With the exception of mental health, funds are distributed from NSW Health to Area Health Services in proportion to population need using a formula called the 'Resource Distribution Formula' (RDF). With the exception of mental health, it is recognised that NSW has done well in achieving population equity.²⁸⁰ NSW Health data suggests that all Areas will be within 2% of their RDF share by 2003.²⁸¹
- 5.2** The Centre for Health Service Development, University of Wollongong, stated that the Centre for Mental Health has historically resisted the introduction of formula-based funding, preferring a submission-based approach instead.
- 5.3** NSW Health informed the Committee that it has been developing an RDF for mental health, which specifically reflects mental health needs. In developing a draft RDF, NSW Health indicated that the formula would be used to guide the allocation of new resources, rather than be used to redistribute existing resources.²⁸²
- 5.4** NSW Health stated that the draft mental health RDF has been used to guide additional enhancement funding allocations to general acute funding for area health services, but not in relation to the allocation of funds for specialist statewide and non-acute services.²⁸³

²⁷⁹ Ms Roslyn Bragg, Deputy Director, Policy, NCOSS, Evidence 31 July 2002, p 38

²⁸⁰ Centre for Health Service Development, Submission 268 p 4

²⁸¹ *ibid*

²⁸² NSW Health, Submission 267, p C.8

²⁸³ *ibid*

Funding comparisons

5.5 According to the study *Mental Health in Australia Collaborative Community Practice*, NSW is the second lowest spending state per capita in Australia on mental health.²⁸⁴ For the 2000-2001 financial year, approximately 8% of the NSW Health budget (\$7.77 Billion) was spent on mental health.²⁸⁵ By international comparisons, the United States of America commits approximately 19% of its health budget to mental health, the Netherlands 23.3% and Great Britain 22%.²⁸⁶

Table 5.1 Selected key indicators of mental health services, NSW²⁸⁷

Indicator				National Avg.
	1992-1993	1997-1998	1999-2000	1999-2000
State Government Expenditure				
State spending on mental health services	\$388.7M	\$445.4M	\$495.1M	
State spending per capita	\$64.94	\$70.70	\$76.92	\$81.76
Service Mix				
% total service exp. – community services	29.9%	41.0%	44.5%	49.2%
% total service exp. – sep. psych hospitals	43.6%	32.4%	28.1%	23.3%
% total service exp. – collocated hospitals	26.5%	26.7%	27.3%	27.5%
Community Services (NGOs)				
% total service exp.	1.3%	1.7%	1.5%	5.4%
Per capita exp.	\$0.87	\$1.23	\$1.20	\$4.42

Source: *National Mental Health Report 2002*, Australian Department of Health and Ageing

5.6 Recent changes in the structure and mix of NSW public mental health services have seen an increase in community care and parallel reductions in inpatient services.²⁸⁸ By 1997-1998, 41% of expenditure was directed to community services compared with 30% in 1992-1993. By 1999-2000, 45% of mental health expenditure was directed to community services and spending on stand-alone hospitals had reduced to 28% of total service expenditure. Per capita spending on community services and general hospital units increased by 12% (\$46 million) between 1998-2000, taking the total increase in these services to \$132 million or 58% above 1992-1993 levels.²⁸⁹

²⁸⁴ W Weir & A Rosen, in G Meadows & B Singh (eds), *Mental Health in Australia Collaborative Community Practice*, Oxford University Press (Melbourne), 2001, pp 70-72

²⁸⁵ NSW Health, *Annual Report 2000-2001*

²⁸⁶ R S Murthy et al, *The World Health Report 2001 - Mental Health: New understanding, New Hope*, World Health Organisation (Geneva, Switzerland), 2001; Submission 182, St John of God Health Services, p 11

²⁸⁷ The Committee did not seek data earlier than 1992. The introduction of accrual accounting in all departments from 1990 to 1991 would make comparisons difficult with financial reports earlier than this period.

²⁸⁸ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

²⁸⁹ *ibid*

- 5.7** Section 129 of the *Health Services Act 1997* delegates the administration of funding for recognised establishments and recognised services of affiliated health organisations to the Area Health Services. In turn, section 130 provides the AHS with powers to set operational performance targets for the organisation, under a performance agreement. Section 127 refers to the determination of subsidies to be paid to AHS.
- 5.8** While this establishes the legislative role of the AHS in the determination of funding allocations, and hence service delivery, section 127 (4) of the *Health Services Act 1997* determines that “the Minister may attach to the payment of any subsidy such conditions as the Minister thinks fit”.

Table 5.2 Expenditure on mental health programs by Area

	1995/1996			1996/1997			1997/1998			1998/1999			1999/2000			2000/2001		
	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend	Total Programs	Mental Health Expend	% of Mental Health Expend
Central Sydney AHS	623,703	54,887	8.80	643,592	58,413	9.08	727,436	59,423	8.17	783,026	65,989	8.43	776,049	65,068	8.38	777,863	65,124	8.37
Northern Sydney AHS	525,005	57,535	10.96	547,296	55,711	10.18	611,574	60,446	9.88	631,301	67,221	10.65	689,030	77,398	11.27	704,922	74,477	10.57
Western Sydney AHS	607,185	54,706	9.01	567,332	50,156	8.84	668,138	51,870	7.76	717,954	55,620	7.75	766,647	58,648	7.65	812,583	76,433	9.41
Wentworth AHS	186,110	8,864	4.76	217,292	6,130	2.82	217,837	11,132	5.11	267,827	15,026	5.61	289,228	16,246	5.62	302,69	17,079	5.64
South Western Sydney AHS	414,308	18,810	4.54	427,226	21,466	5.02	564,103	25,284	4.48	615,190	29,727	4.83	645,729	32,633	5.05	673,844	34,858	5.17
Central Coast AHS	167,320	7,088	4.24	172,307	9,869	5.73	220,871	12,722	5.76	249,389	18,711	7.50	263,609	17,065	6.47	273,469	13,791	5.04
Hunter AHS	459,696	37,692	8.20	480,004	40,866	8.51	535,021	50,328	9.41	578,189	54,080	9.35	601,851	58,088	9.32	613,006	57,884	9.44
Illawarra AHS	205,904	13,132	6.38	216,816	16,345	7.56	275,569	19,254	6.99	303,103	19,509	6.44	315,065	26,073	8.28	345,844	28,965	8.38
South Eastern Sydney AHS	920,850	42,931	4.66	837,982	41,111	4.91	923,849	43,647	4.72	1,028,641	51,042	4.96	1,032,138	47,578	4.61	1,069,096	52,814	4.94
Northern Rivers	186,378	7,833	4.20	191,966	9,689	5.05	222,433	11,213	5.04	235,305	11,521	4.90	243,024	12,482	5.14	281,954	14,139	5.01
Mid North Coast	159,399	7,764	4.90	163,292	8,796	5.39	187,122	10,171	5.44	222,508	11,797	5.30	243,625	12,782	5.25	251,810	16,180	6.43
New England	153,965	6,558	4.26	159,110	7,326	4.60	176,149	9,121	5.18	197,599	9,520	4.82	203,234	9,764	4.80	209,236	11,716	5.60
Macquarie	98,626	2,556	2.59	99,471	2,900	2.92	115,626	3,241	2.80	123,675	4,034	3.26	132,507	4,372	3.30	137,779	4,638	3.37
Mid West	164,090	19,119	11.65	166,692	20,916	12.55	185,202	20,506	11.07	219,684	24,280	11.06	231,050	25,512	11.05	227,792	25,322	11.12
Far West	53,803	1,388	2.58	60,188	1,650	2.74	63,456	2,487	3.92	76,594	3,280	4.28	78,905	5,436	6.89	90,232	3,943	4.37
Greater Murray	209,146	5,285	2.53	232,219	5,911	2.55	231,808	8,878	3.83	249,934	9,826	3.93	253,187	9,623	3.76	290,546	10,705	3.68
Southern	132,354	18,561	14.02	130,584	16,858	12.91	146,293	18,671	12.76	167,606	24,762	14.77	175,081	24,023	13.72	229,653	22,961	10.00
New Children Hospital	135,930		0.00	150,960		0.00	165,008	325	0.20	176,568	350	0.20	171,763	872	0.49	185,810	1,559	0.84
Corrections	21,098	7,120	33.75	25,894	8,795	34.04	27,188	10,067	37.05	30,004	10,467	34.89	33,779	10,723	31.74	39,301	13,475	34.29
	5,423,870	371,829	6.86	5,489,459	382,908	6.98	6,264,663	428,786	6.84	6,874,077	486,772	7.08	7,149,501	512,296	7.17	7,517,430	546,083	7.26
NSW Department of Health Annual Report	6,013,513	375,327	6.24	5,973,131	384,604	6.44	6,493,604	428,736	6.60	6,978,379	479,877	6.88	7,193,294	509,996	7.09	7,506,070	549,692	7.32

- 5.9** Table 5.2 shows that between 1995-2001, while expenditure on mental health increased, there remains little change as a percentage of total health expenditure. As the cost of delivering services has increased, allowing for CPI increases, mental health expenditure may have actually decreased during this period.
- 5.10** The six National Mental Health Reports published to date have provided funding data under the National Mental Health Strategy, which monitors the progress of NSW in key policy areas. The *National Mental Health Report 2002* reported that NSW spent \$106 million more in real terms on mental health in 1999-2000 than in 1992-1993, representing a 27% increase or equivalent to a 18% per capita increase.²⁹⁰ Despite the significant growth, NSW investment in mental health remains lower than the national average over the course of the Strategy.²⁹¹ Per capita spending in NSW in 1999-2000 was 5.9% less than the national average.²⁹²
- 5.11** In April 2000, the NSW Government announced a mental health enhancement funding package totalling \$107.5 million to be delivered as recurrent funding over three years, up to the 2002-2003 financial year. NSW Health provided the following table to show how additional funding will be provided over the three-year period.

Table 5.3 Summary of Increases in Mental Health Funding 2000-2001 to 2002-2003

Year	Cost Escalation \$M	Enhanced Services \$M	Total Increase \$M
2000-2001	12.5	24.0	36.5
2001-2002	9.7	18.7	28.4
2002-2003	10.3	32.3	42.6
Total increase in annual allocation for Mental Health Services	32.5	75.0	107.5

Source: NSW Health, Submission 267, p C 6

- 5.12** As table 5.3 shows, the package comprises two parts: Cost Escalation of \$32.5 million and new real recurrent growth funding totalling \$75 million. \$28 million of this latter amount, however, is to support the operating costs associated with NSW Health's capital program.²⁹³ NSW Health explained the funding allocation:

The general enhancement funds for 2001-2002 and 2002-2003 have been allocated to area health services to enable them to develop their non-inpatient mental health services in priority areas. The area plans for 2000-2001 and 2001-2002 indicate that \$6 million in recurrent funds was allocated to specialist child and adolescent mental health services; \$17.2 million to adult mental health services; and \$2.5 million to mental health services for older people. A further \$2.5 million is being

²⁹⁰ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

²⁹¹ *ibid*

²⁹² *ibid*

²⁹³ Submission 267, NSW Health, p C 5

allocated by the areas from their enhancement funds to develop mental health services provided through non-Government organisations.²⁹⁴

- 5.13** The National Association of Practising Psychiatrists (NAPP) questioned the veracity of the additional funding and anticipated a lack of impact or improvement to services as a result:

Where has all the other mental health money gone over the last 13 years? Where has the injection of \$150 million disappeared to? NAPP believes that the short answer is that the AHS have subsumed it – a crucial issue for the Committee to address.²⁹⁵

- 5.14** The NAPP further queried whether or not NSW should return to centralised funding for mental health services. Referring to the fragmentation of responsibilities, notably alcohol and other drug services, and services for people with a developmental disability, the NAPP questioned whether or not these services should be reintegrated with mental health.²⁹⁶ (see Chapter 9, MISA)

- 5.15** While NSW Health contends that it is enhancing the accountability of the Area Health Services, the Director of the Centre for Mental Health, Prof Beverley Raphael, nevertheless acknowledged the practical difficulties:

The Areas are responsible for the delivery of services. That is their legislated brief. I cannot control that delivery of services.²⁹⁷

- 5.16** Prof Raphael stated, however:

I re-emphasise the fact that we recognise there is a need to do better. We are working actively with the area health services to deliver services to ensure this happens, but we will be very much looking for your recommendations to support our processes.²⁹⁸

- 5.17** With the 1999-2000 increase in per capita spending in NSW averaging 4.3%, by national and international standards, mental health funding in NSW does not reflect the demand currently being placed on services.

Recommendation 23

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

²⁹⁴ Submission 267, NSW Health, p C 7

²⁹⁵ Submission 189, National Association of Practising Psychiatrists, p 16

²⁹⁶ *ibid*

²⁹⁷ B Raphael, Evidence, 12 August 2002, p 18

²⁹⁸ *ibid*, p 4

Funding of community based services

5.18 Community based mental health services are managed by both the AHS and community or non-government organisations (NGOs). Community based services are the main method of mental health services delivery in NSW. Developments over the last twenty years have seen the decrease in inpatient services and an increased reliance on community based care.²⁹⁹ NSW CAG argue that the interaction between those with a mental illness and the hospital system is currently quite limited:

At any one time, a small percentage of those with a mental illness are in hospital. Yet the budgets for mental health do not reflect this.

NSW CAG's concern is not solely about not having enough beds in this state, (although there is no doubt that this is an important issue for acute and sub acute services), for most consumers are not in hospital. It is about the lack of funding for community-based services.³⁰⁰

5.19 In its submission to the Committee, the Mental Health Co-ordinating Council referred to the *National Mental Health Report 2000*, which detailed NGO funding data comparing 1992-1993 with the 1997-1998 financial year.

Table 5.4 Expenditure on community based mental health services per capita (ambulatory, residential and NGO) 1992-1993 and 1997-1998

	1992-1993		1997-1998	
	% of total mental health expenditure on mental health NGOs	Per capita expenditure on mental health NGOs (\$)	% of total mental health expenditure on mental health NGOs	Per capita expenditure on mental health NGOs (\$)
NSW	1.3	0.82	1.7	1.16
Vic	2.9	2.24	9.6	7.49
Qld	1.3	0.67	5.2	3.47
WA	2.4	1.55	5.6	4.86
SA	1.6	1.11	2.0	1.64
Tas	3.0	1.96	3.5	2.73
ACT	2.5	1.32	5.9	1.60
NT	1.0	0.54	5.1	3.78
Nat Avg	1.8	NA	5.0	3.66

Source: MHCC, Submission 218, p5 and Submission 192, NCOSS, p 6.

5.20 Table 5.4 shows that for these periods NSW allocated a significantly lower proportion of its total mental health expenditure, and a lower per capita expenditure, on mental health NGO services than most other states in 1992-1993 and the lowest in 1997-1998. Between

²⁹⁹ Submission 218, Mental Health Co-ordinating Council, p 6; Submission 192, NCOSS, p 5

³⁰⁰ Submission 162, NSW Consumer Advisory Group, p 35

1993 and 1998, the *National Mental Health Report 2000* notes that while grants to mental health NGOs in NSW increased by 48%, the average national growth was 201%.³⁰¹ It is apparent from the table that Victoria, Queensland, Western Australia and the Northern Territory have all significantly increased their expenditure on mental health NGO services between the two periods.

5.21 The MHCC noted in its submission to the Committee, that NSW Health reported an increase in funding to mental health NGOs in 2000-2001 of 2.1%. As the Consumer Price Index (CPI) for 2000-2001 was 2.5%, the mental health NGO sector sustained a cut in funding in real terms.³⁰²

5.22 The *National Mental Health Report 2002* noted:

Allocations to non-government organisations and spending on community based residential services showed little change when adjustments are made to account for the broader definition of residential services used in 1999-00.³⁰³

...NSW allocated a significantly lower proportion of its total mental health expenditure, and a lower per capita expenditure, on mental health NGO services than most other states in 1992-93 and the lowest in 1997-98.³⁰⁴

5.23 In contrast, the *National Mental Health Report 2002* noted that Victoria, which had the highest expenditure on NGOs:

continued as the leading State in the extent of structural reform, with resource distribution greater than all other jurisdictions combined. [There was a] 128% increase in expenditure on community based services since 1992-1993...[The] reduction in inpatient beds was more than offset by the development of alternative community based residential units.³⁰⁵

5.24 While acknowledging a lack of sufficient funding for NGO programs, the Committee is mindful that any increase in funding needs to be well coordinated and targeted. As Mr Robert Ramjan, Executive Director, Richmond Fellowship, stated:

there is no question that funding to NGOs should be increased in the mental health area, but if there is a sudden influx of money to the non-government sector, that would probably destroy a number of organisations. They would not have the infrastructure nor the expertise.³⁰⁶

³⁰¹ Commonwealth Department of Health and Aged Care (DHAC), *National Mental Health Report 2000*, p 51

³⁰² Submission 218, Mental Health Co-ordinating Council, p 6

³⁰³ Commonwealth of Australia, *National Mental Health Report 2002*, Chapter 4, p 49

³⁰⁴ *ibid*

³⁰⁵ *ibid*, p 58

³⁰⁶ R Ramjan, Evidence, 8 August 2002, p 21

Resource allocation between Area Health Services and NGOs

5.25 The Committee questioned Prof Beverley Raphael on whether or not NGOs in NSW are getting 68% less funding than the national average. Prof Raphael responded that this was attributable to various factors that increased the national average. For example, the national average for Victoria is particularly high because of the way NGO funding programs are structured:

There is no agreed national definition of what NGO charging is in the national survey data. So a range of different things come under NGOs. One of the things Victoria does, all its disability support comes under NGOs. We believe that NGOs have a major role in disability support, and our rehabilitation program identifies that. What we are trying to do now is look at where areas are providing that disability support which might be more properly provided by NGOs, as well as funding some of the strategies within NGOs...much of the work that Victoria identifies as NGO funding is being done by our Area Health Services.³⁰⁷

5.26 The Macksville Positive Living Skills Centre, currently under the Mid North Coast AHS (MNCAHS) expressed concern that their services are to be detached from the AHS and funded under the auspices of an NGO.³⁰⁸ This would indicate a shift towards a similar division of service to that of Victoria. The submission by the Macksville Positive Living Skills Centre continued:

Mental health services are currently provided by the MNCAHS, the expertise, knowledge base, experience and resources provided by the MNCAHS are crucial to the provision of high level of quality care. It is essential for Macksville Positive Living Skills to have good access to these services provided by the MNCAHS. Moreover, the shifting of responsibilities out of our region would certainly result in a deterioration of service provision. Therefore, it is essential that the provision of Positive Living Skills service remain a responsibility of the MNCAHS.³⁰⁹

5.27 The additional \$107.5 million for mental health announced in April 2000 was to include additional funding for the NGO sector. The MHCC informed the Committee that it had not been able to ascertain how the additional funds would be allocated, particularly for mental health NGOs. The Council of Social Service New South Wales (NCOSS) states that, despite assurances from both the Centre for Mental Health and a representative of the Minister for Health, it has seen no indication that NGOs were involved in a structured, participatory planning process for the rollout of the \$107.5 million.³¹⁰ In April 2002, the MHCC also informed the Committee that it was only aware of three NGO programs receiving funding, totalling around \$450,000 (0.4%).³¹¹

5.28 According to the MHCC, of particular concern to the mental health NGO sector is a perceived conflict of interest where AHS are both purchasers and providers of services:

³⁰⁷ B Raphael, Evidence, 12 August 2002, p 8

³⁰⁸ Submission 218, Mental Health Co-ordinating Council, p 6

³⁰⁹ Submission 64, Macksville Positive Living Skills Centre, p 2

³¹⁰ Submission 192, NCOSS, p 9

³¹¹ Submission 218, Mental Health Co-ordinating Council, p 6

Under the current system NGOs and Area Health Services compete for the same funds, but it is often Area Health Services who decide or influence decisions about whether or not NGOs receive any new funding. This occurs because NGOs are requested to submit funding applications through the Area Health Service.³¹²

5.29 NCOSS referred to the Area Health Service Agreements, which NSW Health uses to direct and monitor the performance of AHS:

These agreements contain targets for service delivery and service development, and are negotiated at Area Health Service board level. Neither the performance agreements nor the reporting against them is publicly available. NCOSS is extremely concerned about the secrecy attached to this important data on Area Health Service resources and activities.³¹³

5.30 The Committee is concerned that resource allocation appears to be a contest between 'hospital' and 'community', or between a relatively well-resourced area and another.

5.31 The Committee considers that AHS should not determine the allocation of funding for NGOs who coordinate programs across the State. Differentiation should be made between the interests of these large statewide NGOs and locally oriented and determined service delivery organisations. Statewide NGOs are currently restricted in implementing comprehensive statewide programs, as they must apply separately to each relevant Area Health Service. Similarly, locally oriented NGOs are forced to compete for funding with organisations which are far better prepared and experienced in seeking funding, though not necessarily more proficient at providing the required service in a specific area. The Committee calls on NSW Health to re-evaluate the funding determination for NGO programs and that funding allocation for statewide NGOs be allocated to and determined by the Centre for Mental Health.

Recommendation 24

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

³¹² Submission 218, Mental Health Co-ordinating Council, p 7

³¹³ Submission 192, NCOSS, p 8

Transparency

- 5.32** To determine whether mental health funding allocation is efficient, and that matching expenditure achieves desired outcomes, AHS need to adopt transparent reporting mechanisms. Public accountability can only be achieved through transparency.

Expenditure reporting

- 5.33** NCOSS, among its roles, has historically acted as a review body for government social issues policies and funding programs. NCOSS expressed concern that mental health funding lacked transparency:

To date there is little budget transparency and public accountability, and consumers and community organisations have little confidence in what financial information is available. This includes the funding of mental health services, particularly within the Area Health Services.

...Information on resource allocation and expenditure is available in NSW Budget papers, the NSW Health Annual Report and Area Health Service Annual Reports, however this information is of little use in determining actual expenditure on particular services on types of service, such as mental health services in the community.³¹⁴

- 5.34** NCOSS indicated that determining how, where and why funding is allocated by AHS is problematic:

It is an indictment on the lack of transparency in health funding in NSW that more information is available about spending on mental health services in NSW from reports under the National Mental Health Strategy than through the state's own public budgeting and reporting mechanisms.³¹⁵

- 5.35** NCOSS has consistently called for greater transparency of health service budget priorities, and in particular, “the publication of disaggregated data of actual expenditure according to service type”.³¹⁶

- 5.36** The Director of the Centre for Mental Health, Prof Beverley Raphael, asserted that the Centre for Mental Health requests “quite specific reporting on what has been spent and what it has been spent on”,³¹⁷ and that:

there are now active reporting frameworks to address what is done in the use of the funding for the services...That has been one of the complexities, because, as you would be well aware, the area health services act as autonomous bodies under the Health Services Act of 1997 and it is their job to deliver services. It is the

³¹⁴ Submission 192, NCOSS, p 8

³¹⁵ *ibid*

³¹⁶ *ibid*

³¹⁷ B Raphael, Evidence, 12 August 2002, p 6

central agency's job to influence that delivery of services as much as possible, and we work in close liaison with the area health services to try to facilitate and improve that.³¹⁸

- 5.37** Prof Raphael acknowledged, however, that she was not happy with the accuracy of the information often received from the AHS.³¹⁹ The Australian Salaried Medical Officers Federation (ASMOF) cited consensus among psychiatrists that 'quarantining' of mental health budgets is completely ineffective, but stated that:

the budget process is so opaque that there are some Area Directors of Mental Health who are not told what their budgets are.³²⁰

Use of mental health service funding for other purposes

- 5.38** Concerns raised in various submissions and by witnesses suggest that in some instances there is an incubation period for quarantined mental health funding between its dispatch to an AHS or hospital and its receipt.³²¹ In regard to a question from the Committee regarding the claimed use of 25% of the quarantined mental health budget for administrative and overhead purposes by AHS, Prof Raphael responded:

Budgets have an overhead proportion. We monitor that. We have had difficulties in the past, which we have now taken to get a much better handle in areas in the current planning being asked to identify exactly what the components of overheads will be. While that has been a problem that has been of concern to us, we have been attempting to actively pin down and get a consistent figure for the overhead budget.³²²

- 5.39** Later, Prof Raphael agreed that the figure could be more than 25% in some areas, and agreed with the general call for greater transparency:

What I would like to see is a clear delineation of the overheads and cost structures. Then we can all work together with transparency about what the elements are with respect to the budget and what is a proper charge against mental health.³²³

- 5.40** Prof Raphael indicated that the Centre for Mental Health was meeting with each AHS Chief Executive Officer to review their budget and to have any discrepancies explained and felt that information was "improving progressively".³²⁴ According to Prof Raphael, the critical issue is the need to develop a uniform process for the overhead component of the mental health budget:

³¹⁸ B Raphael, Evidence, 12 August 2002, p 3

³¹⁹ *ibid*

³²⁰ Submission 91, Australian Salaried Medical Officers Federation, Attachment A

³²¹ Submission 192, NCOSS, p 9

³²² B Raphael, Evidence, 12 August 2002, p 5

³²³ *ibid*

³²⁴ *ibid*

I would support a concept of the Area Directors having senior and direct reporting to the CEO so that governance can be stronger at an Area Health Service level.³²⁵

- 5.41** In June 2001, Mr Ken Barker, General Manager, Financial Commercial Services, NSW Health, highlighted to another Legislative Council Committee, the potential vulnerability of mental health funding, though commented that NSW Health was developing a process to monitor program movements and allocations within AHS. Mr Barker added that:

The monitoring arrangement will allow us to understand better what Areas are doing so that if they are moving money from one program to another there is a sound reason to it and it is not for something that you might say is not 100 per cent correct...³²⁶

- 5.42** The evidence provided by witnesses, including Prof Raphael, indicates that NSW Health is yet to implement an effective monitoring system to enhance transparency and allow greater public assessment of outcomes and efficiency. In response to a question from the Committee requesting whether this expenditure could be made public so people could determine the amount of money being spent, Prof Raphael stated:

I see no reason why it would not be possible...I understand that. I have had those concerns myself and have been trying to pursue them.³²⁷

- 5.43** The Committee questioned Dr William Barclay, Psychiatrist, whether he felt there is a need for transparency and greater accountability in the allocation of funding by AHS. Dr Barclay responded that:

A constant problem has been to do just that, be able to identify the budget and identify where all the money has gone. The short answer is yes.³²⁸

- 5.44** While recommending robust reporting processes, the Committee remains concerned over reports that a number of AHS have diverted funds intended for mental health to other activities.³²⁹ The Committee is informed that it is not uncommon for figures to be 'adjusted' to meet Departmental requirements.³³⁰ The number of reports of such incidents to the Committee, including confidential submissions, raises some serious questions over the publicly reported funding of mental health services.

³²⁵ ibid

³²⁶ Mr Ken Barker, General Manager, Financial Commercial Services, Evidence, GPSC2 hearing, 3 June 2001, p 7

³²⁷ B Raphael, Evidence, 12 August 2002, p 7

³²⁸ Dr William Barclay, Psychiatrist, Evidence, 30 May 2002, p 8

³²⁹ Submission 192, NCOSS, p 9

³³⁰ ibid

External auditing

- 5.45** To encourage transparency and achieve public accountability, a number of submissions advocated the need for appropriate external auditing processes to monitor expenditure.
- 5.46** The ASMOF advised the Committee that in June 2000 it had recommended solutions to the Minister for Health to address problems regarding the breach of quarantined mental health funding:
- the amounts provided to each area health service for Mental Health services must be published and the expenditure of those funds needs to be externally audited.³³¹
- 5.47** The NSW Nurses' Association argued that:
- Funding issues in mental health services are of paramount importance and auditing systems must be introduced immediately into all AHS. The Government has a commitment to guarantee a true quarantining of mental health funding with total transparency and accountability.³³²
- 5.48** Similarly, NCOSS called for the adoption of a statewide audit of mental health funding:
- to determine the current allocation of funds, and the distribution of mental health resources between acute and community care. NCOSS also urges that this auditing process be undertaken on a regular basis to ensure ongoing, accurate reporting from Area Health Services.³³³
- 5.49** The Committee supports these recommendations and agrees that a statewide performance audit would reveal the current funding environment. The Committee further considers that, following a statewide performance audit, NSW Health should establish a regular auditing plan, which includes both the current financial audits and also physical audits of hospitals and other service providers.

Key Performance Indicators

- 5.50** In health related health service areas other than mental health, such as Emergency Departments in public hospitals, Key Performance Indicators (KPIs) are assigned and monitored as part of NSW Health service agreements. In February 1999, NSW Health issued *A Framework for Managing the Quality of Health Services in New South Wales* (Quality Framework), which was designed to be an overarching policy for managing quality of health care in NSW. The Quality Framework outlined the need for indicators of health care quality.³³⁴

³³¹ Submission 91, Australian Salaried Medical Officers Federation, Attachment A

³³² Submission 212, NSW Nurses' Association, p 15

³³³ Submission 192, NCOSS, p 10

³³⁴ NSW Legislative Council, General Purpose Standing Committee No.2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, p 27

- 5.51** NSW Health advised that 27 Mental Health Quality Indicators, reflecting aspects of the quality of mental health service provision at a local level, would be collected for all mental health services in NSW. The indicators would be reported on a monthly, quarterly or annual basis from July 2002 to monitor a range of procedures including “the management of sentinel events, discharge planning and consumer/carer participation.”³³⁵
- 5.52** The Committee commends the introduction of mental health quality indicators. Specific KPIs must, however, be assigned to core mental health service evaluation components within public hospitals. The evaluation of performance improvement through a series of key indicators must feature in performance agreements at all levels of the health service, including funding allocation.
- 5.53** Under the Quality Framework, the implementation of an appropriate committee structure was an essential component of managing and monitoring quality of care delivered by AHS. A similar committee within each Area, such as a Mental Health Quality Care Committee, reporting to the AHS Board and the Centre for Mental Health, should be established to provide a means by which the quality of clinical and secondary care to consumers within the Area can be defined, measured, monitored, reported and improved. The primary activities of the Mental Health Quality Care Committee would be to collect, collate and analyse Area broad KPI data and report to the Area Board, and to the Centre for Mental Health.
- 5.54** The Committee is mindful that the assignment of KPIs alone, monitored by a Mental Health Quality Care Committee, cannot prevent ‘gaming’ where an organisation’s internal structures are designed specifically to meet a pre-determined outcome.³³⁶ The Committee is however confident that NSW Health and the Audit Office of NSW are aware of such practices and would closely monitor them.³³⁷

Recommendation 25

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

Recommendation 26

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

³³⁵ Submission 267, NSW Health, p E 2

³³⁶ Audit Office of NSW, NSW Legislative Council, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, p 32

³³⁷ NSW Legislative Council, General Purpose Standing Committee No 2, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW* – Discussion Paper, March 2002, pp 32-33

Recommendation 27

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

- a performance audit of mental health budget allocation and expenditure from July 2003 to 30 June 2004 in NSW, and that the performance audit report be tabled in Parliament
 - an audit plan designed for the annual audit of Area Health Services and service providers (hospitals and affiliated health organisations), that includes disclosure of mental health funding allocation and expenditure. Expenditure of mental health funding on non-mental health programs should be reported.
 - an on-going audit program to include both the current financial audit, as well as a physical audit of hospitals and other mental health service providers, to ensure that staffing, infrastructure and auxiliary budget costs are directly hypothecated.
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Recommendation 28

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

Recommendation 29

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

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

- 5.55** The Committee has determined that for mental health funding and services to be effective, they must be transparent. The Committee is not particularly critical of NSW Health mental health policy and has made no comment on clinical practices. The basis of the Select Committee's Terms of Reference was the provision of mental health services. Unfortunately, the policy initiatives developed by NSW Health and, in particular, the Centre for Mental Health, are not being adequately implemented. Revolutionary reforms are required to improve how mental health services are delivered, accessed and maintained. These reforms must be given priority status by the NSW Government. Cultural and community acceptance of poor access to and delivery of mental health services must not be allowed to develop.
- 5.56** The gaps between policy and implementation must not be permitted to continue, let alone widen. Bi-partisan commitment to change is required. The Committee is highly conscious of a statement by the NSW Nurses' Association regarding outcomes of previous inquiries:
- We find it curious the number of reviews, reports and recommendations that have been undertaken in mental health over the past twenty years and still very little has changed.³³⁸
- 5.57** The Committee noted previously that the deficiencies in mental health services reported over 150 years ago are similar to those that currently exist. Resolving these deficiencies cannot be achieved immediately but a resolve is required to commit to a managed and sustainable reform process. The Committee acknowledges that NSW Health and the Premier's administration must be presented sufficient time to ensure that change does occur. As reform cannot be further delayed, the Committee has recommended an Office of Mental Health be established within the NSW Premier's Department to support NSW Health and catalyse reform.

³³⁸ Submission 212, NSW Nurses' Association, p 2

