Briefing Note

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The Burdekin Report

Human Rights & Mental Illness
Report of the National Inquiry
into the Human Rights
of People with Mental Illness

No 004/93

New South Wales Parliamentary Library cataloguing-in-publication data

Australia. Human Rights and Equal Opportunity Commission. National Inquiry into the Human Rights of People with Mental Illness

The **Burdekin** report : human rights and mental illness : report of the National Inquiry into the Human Rights of People with Mental Illness. -- [Sydney, N.S.W.] : New South Wales Parliamentary Library, 1993. -- [vi, 42 p.] ; 30 cm. (Briefing note / NSW Parliamentary Library, ISSN 1321-2559 ; no.004/93)

ISSN 1321-2559

1. Insanity--Australia--Jurisprudence (LCSH)
2. Human rights--Australia (LCSH)
[1. MENTAL-PATIENTS-AUSTRALIA-LEGAL-ASPECTS-INQUIRY-REPORTS (Parliamentary thesaurus)]
[2. HUMAN-RIGHTS-AUSTRALIA-INQUIRY-REPORTS (Parliamentary thesaurus)]
[3. RIGHTS-OF-SPECIAL-GROUPS-AUSTRALIA-INQUIRY-REPORTS] (Parliamentary thesaurus)]
I. Burdekin, Brian
II. New South Wales. Parliamentary Library
III. Title
III. (Series) Briefing note (New South Wales. Parliamentary Library) ; 1993/4

346.940138 (DDC20)
[347.4152-94 (Moys classification)]

Published by the New South Wales Parliamentary Library.

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Acknowledgments

We would like to thank Theresa Papadopoulo for her efforts in quickly obtaining the Report for us; and Philip Dixon for his expert editorial advice and action which have resulted in a much more refined publication.

Contents

Abbreviations

CPI	Consumer Price Index
GDP	Gross Domestic Product
HACC	Home and Community Care
NGO	Non-Government Organisation
OECD	Organization for Economic Co-operation and Development
SAAP	Supported Accommodation Assistance Program
WHO	World Health Organisation

1 Introduction

In September, 1993, Mr Brian Burdekin, Federal Human Rights Commissioner wrote to the Hon Michael Lavarch, MP, the Attorney-General, enclosing a copy of his report *Human Rights & Mental Illness - Report of the National Inquiry into the Human Rights of People with Mental Illness*. The Report was released in October, 1993.

This *Briefing Note* summarises sections of the Report considered most useful to New South Wales Parliamentary Members. It does not attempt to summarise the entire Report which runs to some 1000 pages. It concentrates upon the general issues raised in the Report and those specifically relevant to New South Wales.

Part I: Background, Definitions, and Existing Services of the Report is summarised in the first half of this paper, with the exception of Chapter 7, a chronology of developments since the Inquiry began, which is appended to this document.

Part IV: Other Areas of Concern, constituting Chapters 26 through 29, is summarised in the second half of this paper, followed by *Part V: Findings and Recommendations*. Chapter 30 of this last part is summarised in detail, however, Chapter 31 is summarised in a more general fashion.

Parts II and III of the report have not been summarised in this document as the chapters in these sections deal primarily with extensive submissions made by particular groups to the Inquiry and issues specific to those groups.

2 The Report

Part I: Background, Definitions, and Existing Services

Chapter 1 THE INQUIRY PROCESS

In NSW there have been approximately 40 inquiries into psychiatric facilities and services since the first recorded case of mental illness in 1801. The only two which attempted to provide a national perspective ignored the issue of the rights of those affected.

Terms of Reference[1]

1 To inquire into the human rights and fundamental freedoms afforded persons who are or have been or are alleged to be affected by mental illness, having due regard to the rights of their families and members of the general community;

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[1] Pages 5-6 of the Report.

2 In particular, to inquire into the effectiveness of existing legislative provisions, legal mechanisms and other measures in protecting and promoting the human rights of such persons;

3 To examine the respective roles and responsibilities of Commonwealth, State and Territory Governments in these areas;

4 Without limiting the generality of the preceding terms, to consider:

(a) any discrimination on the basis of mental illness in Commonwealth laws or programs;
(b) any discrimination in employment, occupation, accommodation or access to goods and services on the basis of mental illness;
(c) human rights in relation to institutional and non-institutional care and treatment of persons with mental illness.

Commissioner Burdekin formally announced the Inquiry in June 1990 and public hearings commenced in Melbourne in April, 1991 and continued over the next 15 months in a selection of cities and regional centres across Australia. The Inquiry considered evidence from 456 witnesses during its formal hearings.

The incidence of mental illness in Australia has not been established definitively but it is clear that mental illness touches all socioeconomic groups in Australia and that there is growing evidence that its morbidity is greatest in the most productive working years when family responsibilities are also at their peak.[2]

It is estimated that at least 250,000 Australians (approximately 1.5%) of the population) suffer from major mental illnesses and approximately one in five adults have, or will develop some form of mental disorder.[3]

Chapter 2 RELEVANT HUMAN RIGHTS PROVISIONS AND INTERNATIONAL LAW

Australia, through successive Federal Governments, has committed itself to honour a range of international standards on human rights developed by the United Nations since 1945.

People with mental illness are human beings with human rights. This simple and fundamental point, which unfortunately still needs to be stressed, has been one of the fundamental tenets of this Inquiry.[4]

Principles for the Protection of Persons with Mental Illness and for the Improvement

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2 Page 13 of the Report. D T Richmonds (Chairperson) *Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled (Richmond Report), Part 3: Mental Services for the Mentally Ill*, NSW Health Department, Sydney 1983, p 17.

3 id.

4 Page 21 of the Report.

of Mental Health Care were adopted by the United Nations General Assembly in 1991. These Principles have not been formally incorporated in Australian legislation. However, they have been endorsed in the *National Mental Health Policy* released by the Minister for Health, Housing and Community Services in April 1992, which sets 1998 as a target date for ensuring full compliance by Australian mental health legislation with the standards set out in the Principles.

The Principles provide, *inter alia*, that:

- all persons have the right to the best available health care, which shall be part of the health and social care system;

- every patient shall have the right to receive such health and social care as is appropriate according to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.

There are now well-defined international standards applicable to a wide range of human rights problems confronting people with disabilities, and particularly those affected by mental illness.[5]

There is no need or justification for action in Australia to wait for further international standards to emerge. There is already in existence, and binding on Australia, a substantial body of international human rights law, recognising rights which must be respected and ensured on an equal basis to all Australians affected by mental illness.[6]

Chapter 3 DEFINITIONS AND CONCEPTIONS OF MENTAL ILLNESS

Changing Views of Mental Illness[7]

In the second half of the 20th Century, the medical model was reinforced by advances in research on the physiology of mental illness. Refinements in genetics, biochemistry and neurophysiology, particularly in relation to the understanding of abnormalities in the transition of electrical impulses in the brain, led to developments in the aetiology[8], therapy and management of mental illness. Modern anti-psychotic drugs have enabled maintenance on medication to largely replace long term institutionalisation of those with some of the most difficult mental disorders and have brought these conditions more clearly into line with physical illnesses.

However, the increasing dominance of the medical model of mental illness has been challenged in recent decades by some sociologists and others critical of the role of

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5 Page 34 of the Report.

6 Page 34 of the Report.

7 Pages 38-40 of the Report.

8 Aetiology is the cause or causes of e problem, be it biological or emotional.

psychiatrists. To these critics, what psychiatrists regard as symptoms of mental illness should be seen as behaviour deviating from social norms.[9]

Legal Definitions of Mental Illness[10]

The problem of defining mental illness for legal purposes has been approached differently in the various States and Territories. Some have not attempted a definition, leaving the matter in the first instance in the hands of medical practitioners who have the effective decision-making power under the legislation.

- The NSW *Mental Health Act 1990* contains a relatively comprehensive operational definition of mental illness as well as definitions of 'mentally ill person' and 'mentally disordered person';
- The Western Australian *Mental Health Act 1962* contains definitions of mental illness and mental disorder;
- The Tasmanian *Mental Health Act of 1963* also covers those with intellectual disability as well as those with mental illness;
- The ACT *Mental Health Act 1983* has no definition of mental illness but defines 'mental dysfunction';
- The South Australian *Mental Health Act 1977* covers people with intellectual disability as well as those with mental illness and defines mental illness simply as "any illness or disorder of the mind";
- Neither the Victorian *Mental Health Act 1986*, the Queensland *Mental Health Services Act 1974-1991*, nor the Northern Territory *Mental Health Act 1990* contain definitions of mental illness or of any equivalent term.

Cross Cultural Conceptions[11]

Recognition of the multicultural nature of Australian society requires an appreciation that people from different cultures do not simply speak different languages. They may also have very different ways of viewing the world; different systems of belief; and different values relating to certain forms of behaviour, social relationships and spiritual or religious obligations and relations. Distinctions drawn in contemporary western culture between such things as sickness and health or social and spiritual relations may be inappropriate in another cultural context. The concept of 'mental illness' in particular, may have no real equivalent, for example, in traditional Aboriginal culture.

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[9] Page 39 of the Report.

[10] Pages 40-44 of the Report.

[11] Pages 46-47 of the Report.

Conceptions and connotations of 'mental illness' and 'mental disorder' are significantly affected by individuals' experiences and expectations of the relative roles of the citizen and the State; the psychiatrist and the State and doctor and patient.[12]

Chapter 4 THE LEGAL FRAMEWORK

This chapter provides an overview of current Commonwealth, State and Territory Legislation governing or bearing upon the provision of mental health services in Australia. We will consider:

1 Commonwealth Legislation
2 New South Wales Legislation

1 Commonwealth Legislation[13]

Disability Services Act 1986

The *Disability Services Act 1986* covers persons with a disability that is attributable to a psychiatric impairment, provided the disability is 'permanent or likely to be permanent' and results in a 'substantially reduced capacity of the person for communication, learning or mobility; and the need for ongoing services'.

It replaced the *Handicapped Persons Assistance Act 1974* and Part III of the *Social Security Act 1947* with provisions that are more flexible and more responsive to the needs and aspirations of persons with disabilities.

The stated intention of the Act is that people with disabilities receive the services necessary to enable them to achieve their maximum potential as members in the community.

Financial assistance to a State or to an organisation is granted under the Act for the provision of 'eligible' (ie approved) services and also for services that were funded under the previous legislation - even if these services do not comply with the statutory objects and Ministerial objectives and principles of the Disability Services Act.

Aged or Disabled Persons Care Act 1954

For the purposes of the *Aged or Disabled Persons Care Act 1954* (as amended), a 'disabled person' is an individual who is either permanently blind or permanently incapacitated and unable to work.

The Act enables the Commonwealth to make capital and recurrent grants to

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[12] Page 47 of the Report.

[13] Pages 50-60 of the Report.

approved hostels as well as capital grants to nursing homes approved under the *National Health Act 1953*. The stated purposes of the *Aged or Disabled Persons Care Act* are to encourage and assist the provision of:

(a) suitable homes for those eligible to 'reside in conditions approaching as near as practicable normal domestic life'; and

(b) accommodation where 'care services and respite care services may be provided for eligible persons'.

The Act provides for agreements to be made between the Minister and an organisation which receives funding to operate a hostel. Under such agreements, the conditions of the grant may include giving priority access to specific classes of persons. Certain hostels specialise in caring for people suffering from dementia. However, the definition of hostel under the Act specifically excludes 'an institution carried on exclusively or primarily for the treatment of mentally ill or mentally defective persons, being an institution conducted by, or in receipt of a grant for maintenance from, a State'. This definition should not prevent the funding of hostels specialising in services for the mentally ill, provided the hostel was neither conducted by nor receiving a maintenance grant from a State Government.

The fact that the Commonwealth Government does not appear to have funded hostels specialising in care for people with mental illness appears to reflect the traditional view that mental illness services are the responsibility of State Governments - rather than any legislative limitation.

National Health Act 1953

The *National Health Act 1953* (as amended) provides for the payment of various pharmaceutical, sickness and hospital benefits. It also provides for the recurrent funding of nursing homes.

Home and Community Care Act 1985

The *Home and Community Care Act 1985* is brief enabling legislation which makes financial assistance available from the Commonwealth to the States through an agreement on the provision of home and community care services.

Home and Community Care (HACC) services include home help, personal care, home maintenance, community respite care, community nursing and paramedical services, education and training for service providers and users, and the provision of information and transport.

Services and facilities that are eligible for funding may be provided by State or local government; by a community organisation or by two or more of these acting jointly. Projects formerly funded by the Commonwealth may also be eligible where no alternative funding arrangements are available.

Health Insurance Act 1973

The *Health Insurance Act 1973* provides for payment of Medicare benefits for certain medical and hospital services and for provision of grants from the Commonwealth to organisations approved by the Minister for health services or health service development projects.

Social Security Act 1991

The *Social Security Act 1991* became operative in July 1991 and was substantially amended from the date of its commencement by the *Social Security (Job Search and Newstart) Amendments Act 1991* and others.

Disability Discrimination Act 1992

In October 1992, the *Disability Discrimination Act 1992* was passed by Federal Parliament prohibiting direct and indirect discrimination on the ground of disability, including physical, sensory, intellectual and psychiatric impairment. Harassment on the ground of disability is made unlawful.

The Act also complements legislation already existing in some States, in that it prohibits discrimination throughout Australia in employment, provision of foods and services (including transport and education services), accommodation, membership of clubs and the administration of Commonwealth programs.

2 New South Wales Legislation[14]

The New South Wales *Mental Health Act 1990* is the most recent State legislation in Australia and the most comprehensive. It forms a package with the *Mental Health (Criminal Procedure) Act 1990* and the *Guardianship Act 1987*. The *Mental Health Act* contains a detailed definition of mental illness, as well as definitions of 'mentally ill person' and 'mentally disordered person'.

Voluntary Admission

The Act provides for a person to be admitted to a hospital as an informal (voluntary) patient on an oral or written application to the medical superintendent made by the person concerned or, in the case of a person under guardianship within the meaning of the Guardianship Act, by the person's guardian with approval of the Guardianship Board.

Involuntary Admission

The Act states that a person must not be admitted or detained in hospital as an

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[14] Pages 61-72 of the Report.

involuntary patient unless the medical superintendent is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available.

The Act further requires that as soon as practicable after the medical superintendent has certified a person as mentally ill or disordered, the detainee must be examined by another doctor. If the medical superintendent is not a psychiatrist the further examination must be conducted by a psychiatrist.

Review, Discharge, Leave and Transfer

The Act contains detailed provisions for the conduct by magistrates of inquiries to review involuntary detention. Such inquiries must be open to the public unless the person detained objects and the magistrate upholds that objection. However, there are penalties for publishing the name of the detained person or any report of the inquiry which would lead to their identification.

Where the medical superintendent considers that a temporary patient should be detained beyond the period ordered by the magistrate, the superintendent is required to arrange for that patient to be reviewed by the Mental Health Review Tribunal.

The Tribunal must determine whether the patient is mentally ill and whether appropriate care of a less restrictive kind is reasonably available. The Tribunal may then determine that the patient be detained for a further period of observation or treatment as a temporary patient, or whether the person should be classified as a continued treatment patient. The Tribunal must review the detention of temporary patients at intervals of not more than three months. Continued treatment patients must be reviewed by the Tribunal every six months.

The Act also required the Tribunal to review, at least every 12 months, the case of each informal (voluntary) patient who has received care or treatment in hospital for a continuous period of 12 months or more.

Treatment

The medical superintendent of a hospital is authorised to give such treatment, including any medication, as he or she thinks fit where a person is detained involuntarily.

The superintendent is required to establish and maintain an internal review system to monitor and review the prescription and use of medication in terms of frequency of administration, dosage, intended and unintended effects and appropriateness of use.

The Act contains a general prohibition on administration to a person who is, or is suspected to be, suffering any mental illness or any mental condition, of ' a dosage (or dosages) of a drug or drugs, which having regard to proper professional standards, is excessive or inappropriate.'

There is also a prohibition on the administration or performance of deep sleep

therapy, insulin coma therapy, or any operation or treatment proscribed by regulation made under the Act.

The Act also contains elaborate provisions concerning electro convulsive therapy (ECT). The Act limits the use of ECT to gazetted psychiatric hospitals, authorised private hospitals, or other places authorised by the Director-General of Health.

Psychosurgery under the NSW Mental Health Act is subject to even more stringent controls. It requires not only consent by the person but also consent by the Psychosurgery Review Board, a body consisting of seven part-time members.

Treatment for mental illness outside hospitals is encouraged by the Act's provisions for community treatment orders and community counselling orders. These allow for treatment and care to be given entirely on an outpatient basis or following hospital treatment.

Forensic Patients

The *Mental Health (Criminal Procedures) Act 1990* contains provisions by which persons involved in criminal proceedings may be found unfit for trial and ordered to be detained in a hospital or other place. It also contains provisions for those found not guilty of an offence by reason of mental illness to be ordered to be detained in strict custody in a hospital or other place. It also provides for transfer to a psychiatric hospital of persons serving sentences of imprisonment who appear to the Chief Health Officer to be mentally ill.

The Mental Health Review Tribunal is required, at intervals of not more than six months, to review the case of each forensic patient and make recommendations to the Minister for Health concerning the patient's continued detention, care or treatment; the patient's release, either conditionally or unconditionally; and, in the case of a patient found unfit for trial, the fitness of that patient to be tried.

In contrast to the Tribunal's powers in relation to other patients, the Tribunal has no power to make final determinations in relation to forensic patients.

Administration, Monitoring and Complaint Handling

The NSW *Mental Health Act* provides for public hospitals or other premises to be gazetted as psychiatric hospitals for the purposes of the Act. Provision is also made for the Director General of Health to grant licenses for privately owned premises to be 'authorised hospitals' for the purposes of the Act.

Patients may only be admitted under the Act to a gazetted or authorised hospital. Unlike gazetted hospitals, authorised hospitals require an annual statement relating to the conduct of the hospital, the admission of patients and the care and treatment provided on the premises. The Act continues the use of official visitors to inspect hospitals and other health care agencies as a means of monitoring standards of service delivery.

Mental Health Review Tribunal

The Tribunal, established under the *Mental Health Act* consists of a President, Deputy President and other members (both full and part-time). They are appointed by the Governor and able to be removed by the Minister at any time.

The Tribunal's functions are to review the detention of temporary patients, continued treatment patients, informal patients and forensic patients at regular intervals, and to hear and determine appeals from temporary or continued patients whose applications for discharge have been refused or not dealt with by the medical superintendent.

Guardianship

The *Guardianship Act 1987* covers those who are 'intellectually, physically, psychologically or sensorily disabled' and specifically extends to a person 'who is a mentally ill person within the meaning of the *Mental Health Act*.' Application may be made to the Guardianship Board for a guardianship order. If the Board is satisfied that the person has a disability, is 'restricted in one or more major life activities to such an extent that he or she requires supervision or social habitation' and is 'in need of a guardian' it may make a limited or, if necessary, a plenary order on a temporary or continuing basis, subject to such conditions as it considers appropriate.

The Guardianship Board also has power, under the *Protected Estates Act 1983*, to make orders appointing financial managers for those incapable of administering their own property.

The guardianship legislation complements the *Mental Health Act* in several respects. It allows a person with a disability that is not a mental illness within the meaning of the *Mental Health Act* to be admitted to a psychiatric hospital as an informal patient where such care and/or treatment is in that person's interest. The *Guardianship Act* provides that in the event of an inconsistency between the provisions of that Act concerning medical consent and the provisions of the *Mental Health Act*, the latter shall prevail.

Anti-Discrimination Legislation

Under the *Anti-Discrimination Act 1977*, discrimination is prohibited on the grounds of physical or intellectual disability. The statutory definitions of these do not specifically include or exclude mental illness. It may be argued that conditions that have a physiological aetiology (as schizophrenia and manic-depression are now thought to) come within those definitions of intellectual or physical disability under the Act which refer to 'defect or disturbance of the structure and functioning' of the brain or body respectively.

Chapter 5 MENTAL HEALTH SERVICES

The Government Sector[15]

This century has seen a dramatic shift in governmental mental health policy and service provision. The 'asylum era' that dominated mental health policy in the nineteenth century has given way to less custodial and segregated approaches - culminating in the prevailing preference for community-based care. In the mid twentieth century, social pressure for reform - along with advances in medical technology and concerns about the financial burden imposed by large institutions - contributed to the major change in policy direction known as 'deinstitutionalisation'.

Unfortunately, hospital and community services have tended to compete for funds and have generally proved unwilling to co-operate with each other in service provision. In addition, the promise of more, and more effective, community-based services has yet to be realised.

The policy of 'mainstreaming' as espoused in the *National Mental Health Policy*, attempts to address this situation by ensuring that mental health services are co-located with general health services, while retaining the internal integration of specialised services to ensure continuity in clinical management.

The success of this policy shift to mainstreaming, and of the *National Mental Health Plan*, remains to be demonstrated in practice. However, it should be noted that the debate about distinctions in policy has tended to divert attention away from the endemic under-resourcing that has characterised mental health services. Resourcing and effective coordination are imperative if mainstreaming is going to work.

Funding

According to estimates for 1991-92, the Commonwealth spent $2,582 million on identifiable mental health services. Expenditure by the States and Territories in 1990-91 was $871 million. This is a total of $3,450 million, or $201 per capita.

Of the Commonwealth expenditure, $20.5 million is identified as funding through the Disability Services Program. A further $120 million is identified as expenditure through the Home and Community Care (HACC), Supported Accommodation Assistance Program (SAAP), and Housing Programs of the Commonwealth.

By far the greatest proportion of the Commonwealth's 'mental health' expenditure ($1,444 million) relates to income security payments. Other benefits to, or for, individual recipients include $79 million for pharmaceutical benefits, $405 million for nursing home benefits, and $14 million for 'emergency relief'.

In NSW spending on mental health services in 1990-91 was $266 million,

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[15] Pages 136-145 of the Report.

representing $46 per capita.

National Mental Health Policy Funding

The National Mental Health Policy and Plan were developed by the Commonwealth, State and Territory Governments over a three year period and launched in May, 1992.

The aims of the Policy are to:

- Promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders;
- Reduce the impact of mental disorders on individuals, family and the community;
- Assure the rights of people with mental disorders.

The Commonwealth is providing $135 million to implement the Plan over the next five years. (Additional funding has also been allocated for capital works.) Of the $135 million, approximately $106 million will be allocated directly to the States and Territories as part of the renegotiated Medicare Agreement - to assist with the policy of integrating mental health services with the general health system. The $10 million allocated during 1992-93 will be followed by:

1993-94	$14.1 million
1994-95	$19.1 million
1995-96	$19.6 million
1996-97	$20.7 million
1997-98	$22.8 million

The States and Territories are the primary providers of services for people affected by psychiatric disability. Most face significant difficulties in closing outmoded and expensive institutions, where most of their resources still lie, and developing an adequate level of community and acute hospital mental health services to accommodate patients currently in institutions.

Theoretically, the National Mental Health Policy funding will allow the introduction of additional services and facilitate the transfer of patients to community-based care. The intention is that this will facilitate further rationalisation of institutions and the release of funds which can then be redirected to the community sector.

Government Mental Health Services

Resource Allocation

In most States, particularly NSW and Victoria, there has recently been a significant

redirection of government effort. While mental health services are now much wider in range and impact than they were, State government funding is still largely 'institutionally based'.

While mental health services now offer specialised services, there is still a fundamental imbalance between the number and distribution of these services, the extent of community needs and the resources available to meet those needs.

Hospital Services

Due to a lack of uniform national data, it is not possible to accurately tabulate the provision of inpatient services on a State by State basis. However, the States and Territories are currently implementing systems to be linked into a national mental health minimum data set which will have the capacity to identify service patterns and costs.

The only hospital services provided by the Commonwealth, for people with psychiatric conditions, are those provided by the Department of Veterans' Affairs. A process of transferring these hospitals to the States is under way.

It should also be noted that private hospitals offer some beds to public patients with mental illness.

As previously mentioned, the policy of mainstreaming or amalgamating psychiatric inpatient services with general hospitals will have major implications for the future of hospital services for people affected by mental illness.

The Inquiry was presented with a wide range of views concerning the effects and desirability of mainstreaming public psychiatric services:-

- bringing acute psychiatric treatment into the mainstream of hospital services was seen as an essential way of improving the status of psychiatric medicine, and as a means of removing the stigma still associated with mental illness;

- potential for improvement in medical care for people affected by mental illness, as "roughly 30 per cent of patients in general hospital beds have co-existing psychiatric disorders. Likewise, 30-50 per cent of psychiatric inpatients show evidence of concurrent physical illness. It follows that integrated health care ought to improve the quality of care...";[16]

- concerns expressed that this shift in policy will result in mental health budgets being eroded and funds redirected to the larger and more expensive health services in general hospitals and could lead to diminished status and funding and even greater risks of discrimination and stigmatisation;

- psychiatric care could become more closely aligned with the 'medical model' of care, at the expense of broader psychological approaches to

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[16] Page 142 of the Report. Prof Vaughan Carr, submission to the Inquiry.

treatment.

With the introduction of mainstreaming, training must become a higher priority if general hospital staff are to adapt to the particular demands of dealing with people affected by psychiatric disorders in an appropriate, empathetic manner.[17]

Community Services

Notwithstanding the relatively slow reallocation of resources referred to above, submissions from State and Territory governments expressed a unanimous commitment to greater government involvement in direct service provision at a community level.

Government submissions received by the Inquiry clearly acknowledged that people with mental illness, like people with other illness, are best treated and cared for in a familiar environment, where they have access to both organisational and informal supports.[18]

From the evidence presented to the Inquiry there are a number of problems preventing the transition from institutional care to community care proceeding effectively:-

- failure to transfer financial resources to community mental health services;
- lack of staff in the community to care for people after discharge;
- inefficient organisational arrangements to integrate community services with hospitals;
- lack of retraining for hospital-based mental health professionals, particularly nursing staff;
- existence of industrial barriers to moving staff out of hospitals;
- lack of procedures to involve families in the community treatment process.

Specialist Services

This section is confined to clinical services - an area which is the exclusive preserve of government.

Concerns about the effects of mainstreaming are particularly pronounced in relation to specialist services. There is a chronic shortage of specialist services for particularly vulnerable groups such as children and adolescents, Aboriginal and Torres Strait Islander people, refugees, survivors of torture and trauma, the homeless and those with multiple disabilities.

Older Australians are particularly disadvantaged:

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[17] Page 143 of the Report. Refers to Chapter 6 - The Role and Training of Health Professionals and Others.

[18] Page 143 of the Report. Refers to NSW Mental Health Services Strategic Plan, *Leading the Way: A Framework for NSW Mental Health Services 1991-2001*, NSW Health Department 1992.

"As we get older we know there's a chance of having a psychiatric disorder. We know that 25 percent of people over the age of 75 can suffer from a depressive disorder and it can go unrecognised and therefore untreated..."[19]

The specialist services that do exist are currently concentrated in a handful of large cities - generally the State capitals. While this is understandable in a political and economic sense, the failure to provide even basic services outside our major urban centres must be a matter of serious concern in a country with such a widely dispersed population.

The Most Disabled

"Nowhere else in medicine does it occur that the sickest receive the least time of the most highly skilled. Have we largely abandoned these people?"[20]

As previously noted, reference has been made to the traditional concept of 'asylum' and the rapid decrease in the number of 'institutional beds' - from 281 per 100,000 people in the 1960s to 40 per 100,000 in 1992).

While few would oppose deinstitutionalisation as a concept, there are disturbing signs that some States may be on the verge of closing down all institutions without providing any viable alternatives for some of the sickest and most vulnerable in our society - those for whom some type of 'asylum' in the traditional sense is essential.

There are also a small number of individuals who are so dangerous to the community that there are compelling human rights arguments for their continued confinement. "These facts may be unpalatable - but they cannot be ignored. Nor can governments realistically look anywhere else but to government funded facilities for provision of the requisite care."[21]

Prevention and Early Intervention

Australian governments have committed themselves to promoting a better understanding of mental health issues and to secondary (early intervention) and tertiary (rehabilitation) prevention of psychiatric disability.

Little systematic attention has been given to this objective. While the Inquiry acknowledges the importance of specific programs (such as the Early Psychosis Centre at Parkville, Melbourne) the 'prevention' effort seems to have been directed at broader mental health issues.[22]

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[19] Page 144 of the Report. Prof Graham Burrows, oral evidence.

[20] Page 144 of the Report. Dr Norman James, quoted in 'Don't Crack Up', *The Bulletin*, Aug 3 1993.

[21] Page 145 of the Report.

[22] Page 145 of the Report. See Chapter 27 of the Report for further details.

The Private Sector[23]

A submission to the Inquiry included the following:

> "I would be quite happy to go on the record as being extremely critical of the role of private psychiatrists in the provision of services to psychiatric patients in the community. In our position we are frequently put in the situation where a psychiatrist will not see anyone after hours, even if it is their own patient....I would suspect that very, very few of them provide a locum service or an after-hours service, and...virtually none would ever visit a patient at home..."[24]

The Inquiry received very little evidence from the private sector. Publicly available information indicates that there are a significant number of private psychiatric services operating in the capital cities, particularly Sydney and Melbourne.

Private Sector Psychiatric Services

Outpatient Management

There are approximately 1800 psychiatrists in Australia and they see approximately 75 percent of patients in office-based private practice and 25 percent in public practice.

Psychiatrists in private practice are less likely to see people with severe mental illness and, according to government figures, approximately 60 percent of their patients suffer from neuroses or personality disorders.

However, there is considerable doubt that the remaining 40 percent are affected by what are clinically defined as 'mental illnesses':

> "A large number of psychiatrists have taken the soft option and set up a practice which discriminates against the seriously mentally ill. If someone really ill turns up, they're shunted off to the nearest government facility."[25]

When the figures for Commonwealth expenditure on mental health are analysed it can be seen that in 1990-91, the Federal Government paid out approximately $400 million in medical benefit rebates. This is a substantial sum and contrasts with the amount paid to support other important elements of the mental health care system.

In the context of governments closing institutions at an unprecedented rate and many psychiatrists declining to treat the most seriously ill, those professionals (and

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23 Pages 146-149 of the Report.

24 Page 146 of the Report. Dr David Wells, oral evidence.

25 Page 146 of the Report. Dr Jonathan Phillips, 'Don't Crack Up' in *The Bulletin*, Aug 3 1993.

the governments which substantially finance their practices through the rebate system) are fundamentally failing many who need them most.

Private Psychiatric Inpatient Services

Only 12 percent of acute psychiatric beds are in the private hospital system. In NSW, patients in private hospitals represented 13 percent of residents in mental health facilities at the 1990 Census. NSW private hospital psychiatric bed numbers have declined in recent years to 564 beds in October 1991 - a proportion of which are designated as drug and alcohol treatment beds.

Private inpatient psychiatric care is out of the question for people who do not have private health insurance. In addition, evidence to the Inquiry indicated that some major health insurance funds unjustifiably discriminate against people with mental illness, either by imposing special rates on patients admitted to private psychiatric facilities, or by establishing tables which exclude psychiatric hospitalisation.

These tables are often directed towards young adults on the basis that they will not need inpatient psychiatric care when they are in a high risk category:

> "Schizophrenia commonly starts between 15 and 25 years of age, and major mood disorders commonly between 25 and 45 years. To claim that psychiatric hospitalisation will be unnecessary is a fraud which can succeed because it caters to people's denial and prejudice."[26]

The Non-Government Sector[27]

Evidence presented to the Inquiry established that a wide range of non-government services (not-for-profit, non-hospital services) are central to effective realisation of the rights of people with mental illness. It was also established that such services are frequently regarded as incidental or peripheral to the 'real' effort of psychiatric treatment and rehabilitation. Indeed, the most recent comprehensive examination of psychiatric services in Australia confines non-government services to an essentially secondary role.

While there are substantial variations among Non-Government Organisations (NGOs), they share the following characteristics:

- The non-government sector does not provide medically based clinical or treatment services but offers a range of 'therapeutic' rehabilitation and support services;
- Many organisations have a major advocacy and lobbying role;
- In general, non-government organisations offer services that deal with disability - the functional consequences of an illness or impairment - and not

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[26] Page 149 of the Report. Dr Bill Pring, information provided to the Inquiry.

[27] Pages 149-165 of the Report.

with the illness or impairment itself;

- Many non-government services provide valuable links between public psychiatric services and community health sector, and the non-government community services sector.

NGOs tend to focus on providing support and rehabilitation. They give particular attention to group interaction and dynamics within a non-institutional setting to assist people to gain a sense of security and purpose and to become confident both within themselves and in their relationships with the wider community.

Despite the increasingly important role played by NGOs, the vast majority of resources are still devoted to public psychiatry. NSW provided a total of $2,330,550 to community organisations in 1991-92, amounting to 0.7 percent of its mental health budget. In NSW, 54 percent of its 1991-92 non-government organisation budget was allocated to accommodation and support services.

It was widely accepted by witnesses giving evidence to the Inquiry that secure, affordable accommodation, with support appropriate to the needs of individual residents - including access to complementary rehabilitation programs - is a fundamental right of mentally ill people.

Lack of secure accommodation and appropriate support was generally identified as a major cause of readmission to hospital.[28]

The next most common form of service in this sector is what NSW categorises as "support and self-help" which consumes 24 percent of the Health Department Budget for NGOs in 1991-92. In NSW, this category includes day programs of various types.

It should be noted that there are few non-government (or indeed government or private sector) services outside our capital cities.

Given the present poor status of mental health services throughout Australia, State and national mental health plans must urgently undertake:

(a) to substantially increase resources allocated to primary, secondary and tertiary non-government services;

(b) within these allocations, to ensure that there is a substantial increase of currently available 'places' (whether residential, day, or home support); and

(c) to substantially improve access to non-psychiatric government programs and services, such as HACC, Housing Agreements, SAAP etc, under which non-government bodies can improve their provision of services to people with mental illness and their carers.[29]

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[28] Page 157 of the Report.

[29] Page 165 of the Report.

Chapter 6 THE ROLE AND TRAINING OF HEALTH PROFESSIONALS AND OTHERS

The Views of Health Professionals[30]

Psychiatrists

Witnesses and submissions to the Inquiry expressed concern that no formal national mechanisms for the regulation and maintenance of standards of psychiatric care currently exist. This lack of self-regulation is due, in part, to the lack of regulatory powers enjoyed by the Royal Australian and New Zealand College of Psychiatrists. While the profession has made attempts to address the issues of psychiatric standards, quality of care and professional conduct, evidence to the Inquiry repeatedly emphasises that these issues need to be clearly articulated, reflected in appropriately defined standards and enforced in a nationally uniform fashion.

Witnesses and submissions to the Inquiry also indicated that working in a multidisciplinary community-based environment has caused, and still causes, certain psychiatrists some confusion and disquiet with other mental health professionals performing many of the functions that were formerly the domain of psychiatrists.

Because psychiatrists now treat the majority of patients in the community rather than in hospital, it is necessary to clarify the community treatment role and functions not only of psychiatrists, but also other mental health professionals.

The Honorary Secretary of the Royal Australian and New Zealand College of Psychiatrists suggested that to entice psychiatrists back to the public sector, their role needs to be reviewed and clarified:-

> "The role of the psychiatrist in the process of psychiatric treatment within the public sector is no longer clear and is constantly being challenged...To restore adequate participation of psychiatrists in Australian public psychiatric facilities a review of the role of the psychiatrist in those facilities is required, ensuring that there is sufficient job satisfaction, adequate financial incentives etc."[31]

Evidence to the Inquiry also indicated:

- that the recent movement of significant numbers of psychiatrists from the public to the private sector has restricted the access of many Australians affected by mental illness to effective psychiatric management, due to the substantially greater costs of private treatment;

- that public sector patients suffered from more serious mental illnesses than

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30 Pages 171-184 of the Report.

31 Page 173 of the Report. Dr B Kenny, submission to the Inquiry.

the private sector patients with approximately 60 percent of patients seen in private practice suffering from a neurosis or personality disorder;

- patients in the public sector were also twice as likely to be prescribed drugs - especially anti-psychotic medication - whereas private sector patients were twice as likely to be in psychotherapy. Private patients were seen twice as often and were expected to receive two and a half times as many consultation hours in the public sector; and

- some psychiatrists (in spite of their extensive training at public expense) have abandoned both the public sector and the treatment of patients with serious mental illness.

Nurses

Nursing requires extensive training, and understanding of human development and behaviour, diagnostic skills and therapeutic techniques. Nurses often work closely with clients and their families to achieve the best possible results. The role of nurses working within the mental health sector is fundamental in nurturing and caring for individuals affected by mental illness.

The following points are made in relation to nurses:

- the working environment can have an important impact on mental health nurses' roles and the discharge of their responsibilities and the Inquiry heard that the use of a formalised medical model in mental health settings can make it difficult to foster a sense of independence in patients and that management structures which support this traditional medical model may impede the development of wider roles for nurses;

- the level of staffing in mental health facilities clearly affects the role of health professionals and the quality of care and treatment;

- it was generally indicated at the Inquiry that work environments which do not sufficiently recognise or value the contribution of nurses to the delivery of an effective system of mental health care, promote poor work practices and undermine standards of care. In addition, the evidence suggested that in such working environments the potential for exploitation and abuse is increased.

Psychologists

The Inquiry found that the general public has little understanding of the various roles of psychologists and is confused about the distinction between functions performed by psychologists and those performed by psychiatrists.

Psychologists can provide three main intervention services to affected individuals and their families - assessment, therapy and counselling, and skills training.

Psychological assessment can assist individuals affected by mental illness by

identifying problem areas directly and indirectly associated with their illness - thus assisting development of the most effective intervention programs and maximising opportunities for reintegration into the community.

The development of psychology as a discipline and as a profession has seen the emergency of major specialisations, including clinical psychology, neuropsychology and counselling psychology, together with a number of specialist subdisciplines.

The specialisations of clinical psychology and counselling psychology are particularly relevant to the treatment of people with psychiatric disabilities. The Inquiry heard that both psychiatrists and psychologists are under-utilised in our mental health system.

In addition, rebates under Medicare are provided only for psychiatrists' fees. Services provided by psychologists and other qualified practitioners who are not doctors receive no rebates from Medicare and few from private funds.

Evidence to the Inquiry indicates that the restriction of access to psychologists results in important treatment options being denied to many individuals affected by mental illness and that preventative counselling and effective rehabilitation opportunities are being squandered.[32]

General Practitioners

General Practitioners (GPs) play a critical role in the treatment of mental illness because individuals affected by mental illness often consult them as their first point of contact with the health system and GPs then act as 'gate keepers' to specialist health services and treatment options.

Professional Training and Education[33]

The training and education of mental health professionals determines, to a large extent, the quality of care afforded Australians affected by mental illness.

Evidence to the Inquiry indicates that the education and training needs of many mental health professionals (and many health professionals routinely called upon to assist the mentally ill - particularly general practitioners) are not adequately met. Consequently, mental health services for Australians with a psychiatric disability are often sub-standard.

Inadequate access to education and training programs means that many mental health professionals are denied the opportunity to adequately establish and subsequently broaden their skills. Evidence to the Inquiry indicated that the priorities of their employers and the demands of their jobs frequently prevent mental health workers attending continuing education programs - this applies particularly to

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[32] Page 181 of the Report.

[33] Pages 184-202 of the Report.

professionals working in rural and isolated areas.

Consumer Concerns

The evidence from individuals affected by mental illness and their families indicated that many consumers had experienced insensitive and even callous treatment from mental health professionals.

Some witnesses suggested that consumers should participate in the development of training courses for mental health professionals and that programs should highlight what mental illness means to the individual, what it is like to be admitted to hospital and what individuals need from professionals when they are patients in hospitals. It was also suggested that mental health professionals need to work more closely with families to appreciate their needs and to explain aspects of each individual's illness and treatment.

Other Health Professionals

The Inquiry heard that other health professionals working in the mental health field - psychologists, social workers, and occupational therapists - have specific training needs, including in the field of community-based service delivery. The development of community-based educational programs and the promotion of continuing education courses in these areas were seen as essential.

Other Professionals Who work with People Affected by Mental Illness

The Inquiry heard that many professionals - including government employees, police and ambulance officers, teachers, lawyers and journalists - need training to deal with people affected by mental illness and issues relating to them in an appropriate manner.

School Children and Students

The Inquiry heard that educators are inadequately trained to identify mental health problems in childhood and adolescence. Teachers, lecturers, tutors and other education professionals often have inaccurate notions about mental illness and little understanding of the problems individuals face in coping with episodes of illness and trying to study. Beyond this, the potential of our schools for addressing the widespread ignorance which feeds discrimination against people affected by mental illness has, until very recently, been ignored.

The General Community

Evidence to the Inquiry confirmed that the level of understanding in the community about mental illness is abysmal. There is widespread fear about the behaviour of people affected by mental illness - based largely on ignorance, misconceptions and myths. This fear is sometimes reflected and reinforced by selective reporting in the

mass media, which contributes to stigmatisation, marginalisation and discrimination.

There is clearly an urgent need to effectively disseminate information about mental illness that dispels the common myths and misinformation.

It is an indictment of our lack of concern that such widespread ignorance still exists. A national campaign to effectively address and dispel it must clearly be a high priority.[34]

Chapter 7 DEVELOPMENTS SINCE THE INQUIRY BEGAN[35]

This chapter details significant developments which have occurred at Federal and State level since the Inquiry began.

For information detailing developments at the Federal and NSW State levels see *Appendix 1*.

Part IV Other Areas of Concern

Chapter 26 MENTAL HEALTH RESEARCH[36]

There is a relative paucity of mental health research in Australia and funding for such research is poor in Australian medical research funding terms and extremely poor in absolute terms and when compared to other OECD countries.

Medical research is important because it:

- Provides basic epidemiological data which can be used for identifying priorities for service provision and monitoring
- Assists in understanding aetiology and treatment of mental illness
- Enables determination of contribution of social factors to mental illness
- Enables determination of cost-effective mental health programs and services

There is basically no comprehensive data on the prevalence of psychiatric disorders or the availability or effectiveness of psychiatric treatments and this lack

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34 Page 202 of the Report.

35 Pages 210-224 of the Report.

36 Pages 821-842 of the Report.

constitutes a major impediment to our capacity to plan and deliver effective mental health programs.[37]

The lack of, and funding for, mental health research in Australia is due to a number of factors:

- The general low level of medical research funding in Australia
- Increased difficulties associated with getting public funding or funding from philanthropic organisations for psychiatric research
- Tradition of psychiatric research in Australia is relatively recent
- Most seriously ill psychiatric patients are treated in public hospitals where there is little or no research and where administrative demands impede the completion of research
- Obtaining informed consent for research is difficult
- Psychiatric research is often very complex and thus difficult to complete and also difficult to convince granting bodies to allocate funding
- Diverse settings in mental health between the States aggravate difficulties and, prior to the establishment of the National Mental Health Policy, there was little incentive and less action on the creation of a national data set
- Financially beneficial for psychiatrists to be clinicians rather than researchers
- Little effective lobbying occurred

Costs of Mental Illness in Australia

Four cost estimates are described.

(a) Eisen Wolfenden Report

Commissioned by the Commonwealth Department of Health, Housing and Community Services in 1988, this report estimated the overall cost of psychiatric illness at $2.74 billion per annum. Adjusted by the CPI in 1992 dollar terms this amounts to $3.53 billion per annum.

(b) Estimate of Total Costs from Direct Care Cost Data
(Report of the Mental Health Taskforce of the Australian Health Ministers' Advisory Council)

This 1991 report estimated:

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[37] Page 822 of the Report. Refers to *Report of the Mental Health Taskforce to the Overarching Committee on Health and Aged Care and to the Australian Health Ministers' Advisory Council*, AGPS, Canberra, 1991.

Combined State costs at $863 million
Commonwealth rebates on psychiatric consultations at $116 million
Cost of acute psychiatric care in public hospitals at $450 million and at private hospitals at $126 million
Expenditure via the Pharmaceutical Benefits Scheme at $60 million

Total cost at $1.615 billion.

As indirect costs of major psychiatric illnesses such as schizophrenia are estimated to exceed direct costs by a ratio of 3:1, indirect costs of psychiatric illness according to the aforementioned estimates would be of the order of $4.845 billion.

(c) Estimates from the National Foundation for Brain Research, Washington DC, USA

This organisation estimates the costs of psychiatric illness in the USA at 2.48% of GDP.

GDP in Australia totals $256.9 billion; the costs of psychiatric illness would therefore be around $6.36 billion (1992 dollars).

The average of estimates (a) to (c) above is $5.45 billion

(d) Estimates from the Australian National Association for Mental Health

Costs in 1988 were estimated at $3 billion in direct costs excluding pensions.

The Independent Commission on Health Research for Development[38] recommended the investment of at least two per cent of national health expenditure on medical research. According to the funding estimates available, less than one per cent of the identified direct costs of psychiatric illness are channelled into research. If the recommendation were followed, at least $32.3 million should be spent on psychiatric research per annum. Last years estimates are of the order of $10 million.

Neither Census nor National Health Surveys have collected much data on mental health. The Australian Bureau of Statistics has approached the Australian Society for Psychiatric Research to improve the quantity and quality of mental health data it is gathering. There are problems, however, with definitions, variations in data quality between States, confidentiality, funding constraints and the lack of morbidity data from psychiatric hospitals.

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[38] Independent Commission on Health Research for Development, *Essential Link to Equity and Development*, Oxford University Press, 1990.

Chapter 27 PREVENTION AND EARLY INTERVENTION[39]

Prevention is critical to the whole area of mental health.

The WHO has made repeated calls for recognition of the urgency of prevention initiatives in mental health.

Development of a National Health Strategy for Australia has, for the first time, incorporated systematic Goals and Targets for Mental Health[40] with a program for implementation under the National Mental Health Policy.

Although knowledge concerning the causes of many conditions is incomplete, the scientific advances of recent years have greatly helped.

Community Issues and Prevention in the Mental Health Field

There are substantial problems with:

- community understanding of mental illness
- media representation of mental illness
- stigma, associated with fear and misunderstanding
- social adversity, especially poverty and unemployment

which greatly impact upon the lives of those suffering mental illness.

More than 50% of unemployed young people suffer depression.

Mental illness may significantly impair the capacity of an individual to pursue education or training and thus equip themselves for later life. Mental illness may also inhibit maturation as the onset of mental illness is often in late adolescence.

Socio-cultural factors influence the perception and understanding of unusual behaviour and patterns of response. For example, Aboriginal and Torres Strait Islander people have totally different concepts of mental health and well-being, and ignoring those perceptions will perpetuate morbidity.

Certain groups, in particular women, the elderly, people from non-english speaking backgrounds, refugees and Aborigines and Torres Strait Islanders are especially vulnerable.

Opportunities for Prevention in Specific Contexts

Children and Adolescents

Approximately 15% of children and adolescents suffer significant psychological morbidity.

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[39] Pages 843-869 of the Report.

[40] D Nutbeam, M Wise, A Bauman, E Harris and S Leeder, *Goals and Targets for Australia's Health in the Year 2000 and Beyond*. Australian Government Printing Service, Canberra, 1993.

Emotional and behavioural problems in children are difficult to diagnose and may merge with distress related to experiences and family setting. Such problems significantly interfere with children's well-being and development, and may also continue into adolescence or constitute the basis for mental illness or disorder in adult life.

Social, behavioural, environmental and biological factors are important determinants of a child's susceptibility to mental illness.

There is growing recognition that there is a need for substantial preventative strategies to deal with mental illness in children and adolescents. Particular issues warranting special attention include:

- Youth suicide which is increasing alarmingly
- Depression which is increasingly frequent[41] and often poorly recognised.
- Conduct disorder and other disruptive behaviours[42], the prevention of which has become one of the primary aims of the National Goals and Targets for Mental Health.
- Youth homelessness which is associated with deprivation, violence and exploitation. The risk of homelessness is heightened with mental illness.
- Forensic encounters; "young people are particularly vulnerable in their early encounters with the criminal justice system" and every effort should be made to resist incarceration of young people and people with mental illness.[43]

Chapter 28 ACCOUNTABILITY[44]

Human rights violations perpetuated in New South Wales (Chelmsford), Queensland (Ward 10B, Townsville Hospital) and Victoria (Lakeside) have demonstrated the urgent need for appropriate mechanisms to prevent such abuses and provide an effective means of intervening if they do occur.

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41 Recent studies indicate 14.6% of adolescent males end 25.2% of adolescent females suffer from mild, moderate or severe depression (Adolescent Health Survey 1992: Depression. VicHealth, Melbourne, 1993).

42 According to one study in the *Australian and New Zealand Journal of Psychiatry* (Vol 24, pp 323-330), between 3.2 to 6.9% of young people demonstrate some form of conduct disorder or disruptive behaviour.

43 Page 856 of the Report. M Bashir, personal communication. Also reference to Chapters 20 and 25 of the Report.

44 Pages 870-882 of the Report.

The National Mental Health Policy recognises the importance of developing national standards for mental health services and methods of assessing whether standards are being met. This policy accords priority to the:

- implementation of quality assurance programs
- development of protocols for clinical treatment by appropriate professional bodies
- accreditation of mental health facilities
- development of nationally agreed measures of performance in relation to each of the above areas.

By endorsing the plan, State and Territory health ministers agreed to provide (subject to Commonwealth funding) the information required to enable program monitoring, to establish national service standards and to develop a strategy for nationally consistent mental health data.

Particular areas requiring attention include:

Quality assurance

The quality and appropriateness of patients' care and/or departmental performance needs to be documented and evaluated. Whilst there appears to be widespread support from State and Territory governments for this idea in principle, in practice very little has happened. In New South Wales, quality assurance is coordinated at an institutional level.

Standards

Compliance with standards is often voluntary although there may be funding implications associated with non-compliance.

Some of the most comprehensive standards for mental health services were published by the New South Wales Department of Health, Housing, Community Services and Local Government in 1991. Entitled *Standards of Care for Area Integrated Mental Health Services*, the standards were developed in consultation with experienced mental health professionals and representatives of consumer, family-support and voluntary care organisations. They focus on outcomes for service users and care-givers from initial contact through to long-term follow-up. These standards were designed for use, as a guide and as a checklist.

Other standards initiatives around Australia include the *Guidelines for Psychiatric Inpatient Services* published by the New South Wales Department of Health, Mental Health Services Unit in 1990. These guidelines were based on a seminar on quality assurance for inpatient services and although compliance is not mandatory it is strongly encouraged.

The Federal Department of Health, Housing, Local Government and Community Services has adopted a prescriptive approach by requiring nursing homes (since July 1987) and hostels (January 1991) to comply with standards including health care, social independence, freedom of choice, home-like environment, privacy and dignity, variety of experience and safety as a condition of Commonwealth funding.

The Report presumes that compliance with the National Mental Health Policy guidelines will be linked to funding although this has not been made clear.

There are problems also with disparate laws in each state. Following the Chelmsford Inquiry, New South Wales enacted the *Private Hospitals and Day Procedure Centres Act, 1988* which established stringent provisions for the maintenance of standards in such facilities. These provisions included licensing of private hospitals and day procedure centres and standards for patient safety, care, quality of life and quality and conduct of services.

The 1990 *Private Hospitals Regulation* (NSW) contains detailed provisions for staffing, facilities and equipment, record-keeping, clinical standards, professional accountability and quality assurance procedures. This regulation also requires the election of a medical advisory committee to advise the licensee regarding accreditation.

Peer Review

Peer review is basically an assessment by clinical colleagues of one another's handling of cases. Although it is widely regarded as desirable, there are problems with it as a method of quality assurance due to the lack of universally accepted parameters for making assessments and because there are no sanctions associated with either failing to implement good clinical practice or failing to make one's cases available for scrutiny.

Monitoring

In most States and Territories, powers of inspection and investigation apply only to hospital facilities. The exception is Victoria where such provisions are extended to all psychiatric services.

Accreditation

Accreditation is "an evaluation process which accords formal recognition to an institution or individual that complies with defined standards of service and care".[45] It is highly desirable that accrediting bodies have some public standing and are preferably independent.

Australia's primary hospital accreditation body, the Australia Council on Healthcare Standards, was established in 1974. It has since expanded to include under its auspices community health and day procedure facilities.

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[45] Page 877 of the Report.

Specific standards for psychiatric services were only developed in the late 1980s and more rigorous accreditation procedures should be imposed on psychiatric services.

Patients Rights and Patient Advocacy

Advocacy may be provided for patients by legislation or by community based or self-help groups funded under Commonwealth and State Disability Services Acts.

The Australia Council on Healthcare Services Accreditation Guide includes a statement of patients' rights and responsibilities and the Australian Health Ministers' Advisory Council adopted the *Charter of Consumer Outcomes* in May 1991 as the *Mental Health Statement of Rights and Responsibilities*. However, there are no direct sanctions attached to violations or failure to comply.

In New South Wales, there are statutory requirements for statements and rights to be made available to those subject to involuntary detention. However, in practice, even when such rights and statements do exist, they are not always made available to patients.

Complaints Mechanisms

New South Wales remains the only State to have specialised units established at an administrative level to handle complaints. The units have the power to investigate and to prosecute cases before relevant professional bodies.

Overall, in theory, there are controls and safeguards regulating mental health services, but:

There are no uniform national guarantees of individuals' rights.

There are no adequate mechanisms to ensure basic rights are protected.

There are inadequate or no resources to ensure the protection of individuals' rights and the implementation of various regulations.

Chapter 29 LEGISLATIVE PROPOSALS[46]

In most jurisdictions, mental health legislation has been under review. However, only South Australia and Western Australia have released draft bills.

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[46] Pages 883-892 of the Report.

Part V Findings and Recommendations

Chapter 30 LEGISLATION: FINDINGS AND RECOMMENDATIONS[47]

In its background paper - *Mental Health Legislation and Human Rights* - published in 1992, the Inquiry analysed mental health laws in each State and Territory in terms of the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

This analysis found widespread breaches of prescribed standards. One particular problem was the language of most existing laws; "both the form and substance of legislation work against assertion of rights by people with mental illness".[48]

The findings and recommendations pertaining to State and Commonwealth legislation are set out in the following paragraphs:

1 STATE LEGISLATION
2 FEDERAL LEGISLATION

1 STATE LEGISLATION

(a) Statutory Objects and Definitions

Findings

- Certain jurisdictions (not NSW) have no statements of principles or objectives in their mental health legislation.
- Laws in other jurisdictions are inadequate because they give insufficient weight to the 'least restrictive alternative' as regards care and treatment.
- In most jurisdictions, mental illness is inadequately or not defined in existing mental health legislation. There is also a lack of consistency between jurisdictions.

Recommendations

- The principles and objects of mental health legislation should be clearly set out giving emphasis to the least restrictive form of appropriate care.
- A clear and consistent definition of mental illness providing specific criteria should be defined in each mental health jurisdiction.

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47 Pages 895-907 of the Report.

48 Page 895 of the Report.

(b) Voluntary Admission

Findings

- Mental health legislation makes insufficient provision for the rights of voluntary (or informal) patients.
- A right of appeal against refusal of admission as an informal patient is not provided in most jurisdictions.
- The right to self-discharge by informal patient is often subject to significant restrictions and legislation fails to deal with the right of voluntary patients to refuse specific treatment.

Recommendations

- There should be provision for a right of appeal against refusal to admit an individual as an informal patient.
- Right of self-discharge by voluntary patients should not be limited except to provide sufficient notice to allow urgent action to detain them where it is justifiable under the involuntary treatment provisions.
- A clear statement concerning the rights of voluntary patients to refuse specific forms of treatment must be made.

(c) Involuntary Admission

Findings

- Criteria for detention are too broadly defined in most jurisdictions (including NSW).
- Procedures for involuntary admission in a number of States afford the exercise of a very wide discretion by police, magistrates and medical practitioners.
- There is often insufficient provision for assessment by appropriately independent and expert medical practitioners prior to detention.
- Emergency detention procedures are often inappropriately cumbersome.

Recommendations

- Emergency detention criteria and procedures should be clear and specified with clearly defined applications limits.
- Specific criteria for involuntary admission are required and should include a requirement that there be no less restrictive form of appropriate treatment available.

- Involuntary admission procedures should require independent assessment by expert medical practitioners with verification of the opinion of general practitioners by an expert as quickly as possible in emergency situations.

(d) Review

Findings

- Review provisions are non-existent or inadequate.
- Automatic review of patients is not always automatically required by independent review bodies where they do exist.
- Intervals for detention without review are often excessive and discharge may occur before review is required under legislation.

Recommendations

- Independent specialist review bodies should be established in every jurisdiction.
- Initial review of involuntary patients by these bodies should be required within a time limit that is less than average time of detention.
- Review of involuntary patients should be required at intervals of no more than six months and at intervals no longer than one year with voluntary patients.
- A guaranteed right to apply to the review body for discharge should exist for the individual patient or an authorised agent - relative or friend.

(e) Procedural Safeguards

Findings

- Statutory provisions for personal appearance or legal representation at review hearings are made by few jurisdictions.
- In no jurisdiction is there express provision for an interpreter.
- Access to information relevant to a case under review is not always made under legislation and where it is, it is not clearly defined.

Recommendations

- Statutory rights guaranteeing an individual the right to appear in person at hearings, to have an interpreter if necessary and to be represented by a lawyer or another person with leave of the tribunal should be established.

- The basic elements of natural justice, particularly access to relevant information, should be provided for.

- Individuals should have the right of appeal from decisions of the review body.

(f) Treatment

Findings

- Few jurisdictions provide for involuntary treatment without detention.

- Some jurisdictions have detailed requirements for administration of ECT or psychosurgery, others have none.

- In all jurisdictions, there is inadequate clarity of legislation relating to requirements for informed consent to general psychiatric treatment of voluntary and involuntary patients.

Recommendations

- Provision for compulsory treatment in the community should be legislated for in every jurisdiction and other safe-guards provided to prevent over-use or other forms of abuse.

- ECT and psychosurgery where permitted must be administered subject to stringent and clearly specified requirements for consent and independent specialist approval.

- Position of voluntary and involuntary patients regarding consent to general psychiatric treatment must be clearly set out in legislation.

(g) Confidentiality

Finding

- There are inadequate safeguards against breaches of confidentiality.

Recommendation

- Penalties for breaches of confidentiality in relation to personal information should exist in every jurisdiction.

(h) Forensic Patients

Findings

- Most jurisdictions do not adequately divert from the criminal justice system

individuals accused of crimes who require psychiatric treatment.

- Patients accused or convicted of a criminal offence have lesser rights concerning treatment, information and review than other patients in most jurisdictions.

- Decisions to discharge forensic patients are not made by an independent review body in most jurisdictions.

Recommendations

- Mental health and related legislation must ensure that any person accused or convicted of a criminal offence and in need of psychiatric treatment is provided with such treatment in an appropriate environment.

- Forensic patients should be accorded rights equivalent to those of other patients except in matters relating to leave and discharge.

- Decisions concerning discharge of forensic patients should be made by an independent body not at a political level.

(i) Legislative Controls

Findings

- Mental health legislation provides for standards and safeguards in hospitals designated involuntary treatment centres but does not systematically provide the same control in relation to community facilities.

- Criteria for monitoring standards in most psychiatric facilities are scarce or absent in most jurisdictions.

- Statutory mechanisms for consumer complaints and independent advocate monitoring of condition of treatment do not exist in most jurisdictions.

Recommendations

- Clear criteria for approval of all psychiatric facilities should be legislated for and the Commonwealth should adopt a monitoring role.

- Safeguards and controls concerning compulsory treatment would be equivalent in designated hospitals and community facilities.

- Statutory bodies to investigate and, if necessary, prosecute consumer complaints should exist.

- Independent advocates with statutory power and responsibility to monitor provision of services and maintenance of standards should exist in each State and Territory.

(j) Guardianship and Administration

Findings

- In some jurisdictions, there are no provisions for independent determination of the capacity of individuals with mental illness to make decisions regarding their personal and financial affairs and for appointment of substitute decision-makers.

- Provision for enduring power of attorney exist in some jurisdictions, but similar provision for self-determination and planning of guardianship are lacking.

Recommendations

- Independent statutory bodies with power to determine capacity regarding personal and financial matters and to appoint substitute decision-makers should be established in each State and Territory.

- Provision for individuals with (while they have) the capacity to do so to appoint a guardian nominee and to specify conditions of such guardianship should be provided for in each jurisdiction.

(k) Anti-Discrimination

Finding

- In some jurisdictions there is no prohibition in State or Territory legislation (this is often in contrast to the Federal situation) against discrimination on the ground of mental illness or psychiatric disability.

Recommendation

- Discrimination on the ground of mental illness or psychiatric disability should be illegal in every jurisdiction.

(l) Inter-State Co-operation

Finding

- Serious difficulties are caused by governments' limiting of recognition of orders and provisions under mental health, guardianship and administration legislation to their own State or Territory. Many individuals suffering mental illness are highly mobile and are sometimes transferred across State borders for treatment.

Recommendation

- Every jurisdiction should legislate to provide for reciprocal recognition of

orders relating to detention, involuntary treatment, guardianship and administration of property.

2 FEDERAL LEGISLATION

Findings

- Definition of "hostel" in the *Aged or Disabled Persons Care Act* specifically excludes institutions exclusively or primarily for people with mental illness and receiving funding from a State government.

- Criteria governing eligibility for hostel care under this Act discriminate against people affected by mental illness.

- Criteria under the *National Health Act* for classification of residents of nursing homes according to level of personal care they require, do not give sufficient weight to cognitive (intellectual) and/or affective (emotional) dysfunction.

- This criticism also applies to criteria governing eligibility for the Domiciliary Nursing Care Benefit. Furthermore, limitation of eligibility under this Act to carers who reside in the same abode as those for whom they care is unduly restrictive.

- Procedures for obtaining and maintaining eligibility for Disability Pension, Sickness Allowance and Job Search and Newstart Benefits are often difficult for people with mental illness to fulfil.

- Criteria for psychiatric impairment under the *Social Security (Disability and Sickness Support) Amendment Act* are too vague and lack specificity concerning the frequency of symptoms required.

- Categories of service eligible for rebates under the *Health Insurance Act* exclude many 'non-medical' services, eg psychological counselling and stress management, which may be important in preventing mental illness or its recurrence, or promoting rehabilitation.

Recommendations

- Exclusion from Federal government funding under the *Aged or Disabled Persons Care Act* because of receipt of State government funding should be removed for hostels accommodating people with mental illness.

- Criteria governing eligibility for care in hostels covered by this Act should be amended to avoid discrimination against those affected by mental illness.

- Criteria under the *National Health Act* should be amended to give greater weight to the personal care needs of those with cognitive and/or affective dysfunction.

- Procedures for obtaining and maintaining eligibility for various government

allowances, eg Disability Pension, should be made more flexible to accommodate difficulties encountered by people suffering mental illness.

- Criteria for psychiatric impairment should be made more specific and clear.

- A broader range of services should be eligible for rebates under the *Health Insurance Act*.

Chapter 31 GENERAL FINDINGS AND RECOMMENDATIONS[49]

General Conclusions

1 People suffering mental illness are amongst the most vulnerable and disadvantaged in the Australian community. "They suffer widespread, systemic discrimination and are consistently denied the rights and services to which they are entitled."[50]

2 Individuals with special needs - young people, the elderly, women, the homeless, Aborigines and Torres Strait Islanders, people from non-English speaking backgrounds, people with multiple disabilities, isolated and rural people, prisoners and refugees - "bear the burden of double discrimination and seriously inadequate specialist services."[51]

3 An unacceptable level of ignorance and discrimination are still associated with mental illness and psychiatric disability and must be tackled.

4 Savings resulting from deinstitutionalisation have not been redirected to community based mental health services which remain seriously underfunded. NGOs are also underfunded and whilst mainstreaming may remove stigmatisation associated with psychiatric care, the resources to make it successful do not seem to be forthcoming.

5 Despite the initiative of the *National Mental Health Policy* and *Plan*, major resources are required before Australia will be complying with international obligations under the UN Principles for the Protection of Persons with Mental Illness. There is a lack of cooperation between government agencies in the delivery of services, and poor inter-sectoral links and private sector inaction have contributed to the alarming state of mental health care facilities described in the Burdekin report.

The remainder of the Report, encapsulated in this chapter, details the main findings and recommendations of the Inquiry as they pertain to specific issues or groups. As would be expected in an Inquiry of this magnitude and importance, these

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[49] Pages 908-947 of the Report.

[50] Page 908 of the Report.

[51] Page 908 of the Report.

findings and recommendations are quite extensive. For the purpose of brevity therefore, a summary of some of the major themes and tenets of these findings and recommendations are summarised and the reader referred to the report for further clarification.[62]

- Deinstitutionalisation and mainstreaming of services for those affected by mental illness are worthwhile initiatives. However, resources - from State, Territory and Federal government sources - for the funding of these and community based facilities are woefully lacking and need to be freed and should include support for NGOs. The private sector also needs to become more involved in the delivery of services for the psychiatrically ill and private health funds should ensure that eligibility criteria are non-discriminatory.

- National standards for the provision of mental health care services and for the training and performance of mental health care professionals should be developed. Consideration should be given to the role of community groups in the provision of mental health care and coordination of services, standards and staffing organised in all domains - government, non-government and community.

- Education programs for health professionals need to be upgraded to include substantial, relevant and compulsory training in mental health issues. Universities and other educational institutions need to dedicate appointments to mental health disciplines and training programs need to be made more accessible.

- Appropriately trained crisis and emergency psychiatric teams should be on call, 24 hours per day, seven days a week in each health region in Australia. In remote or isolated areas, alternate after hours consultant services, for example telephone link-ups, should be established.

- Independent assessments of mental health and psychiatric institutions should be mandatory and measures taken to ensure the protection of the rights of involuntary, voluntary and forensic patients. Allegations of abuse or improper care should be investigated fully and quickly.

- "People affected by mental illness face a critical shortage of appropriate and affordable housing."[63] Standards governing accommodations such as boarding houses for those affected by mental illness urgently need to be established and regulated. Facilities for respite care need to be made available and various government support programs, eg Supported Accommodation Assistance Program, need to be expanded and upgraded to include support for people affected by mental illness. Special programs targeted at groups especially at risk, for example refugees, women, Aborigines and Torres Strait Islanders, need to be developed and implemented with sufficient funding support as quickly as possible. Such

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[62] Refer to pages 909 - 947 of the Report.

[63] Page 919 of the Report.

programs should include crisis, medium-term and long-term accommodation.

- Educational and employment opportunities for people affected by mental illness are often seriously reduced and add to the disadvantage and stigma suffered by these people. Vocational rehabilitation and educational programs need to be developed and an active community education campaign to reduce discrimination and ignorance concerning mental illness undertaken.

- Providers of goods and services, insurance companies and superannuation schemes must ensure that eligibility criteria do not discriminate against people affected by mental illness.

- Carers should receive the recognition and resources (including financial support) they merit to ensure that their crucial role in caring for the mentally ill does not result in undue and unrelieved burden.

- "Mental health professionals ... do not routinely inquire about the existence of any dependants when interviewing or admitting an adult with a mental illness."[54] This oversight should be addressed and adequate consideration given to the care of dependents of the mentally ill including notification of appropriate government departments and the provision of resources to NGOs who provide care for patients and their families.

- The needs of the elderly suffering mental illness are frequently unrecognised, unmet or under-resourced. Considerable research and training concerning mental illness in the elderly, the numbers of whom are increasing, needs to be undertaken and should include investigations of the requirements of the elderly from non-English backgrounds. Appropriate care facilities for those suffering dementia should be developed and the right to least restrictive treatment protected for this vulnerable group. Purpose built and properly maintained facilities for those suffering dementia should be funded by both State and Commonwealth authorities and a National Charter of Rights or Standards imposed on all such facilities. The Domiciliary Nursing Care Benefit should be increased and criteria loosened to make eligible carers of elderly people suffering mental illness.

- Links between violence, abuse and mental illness need to be investigated, particularly in relation to women. Consideration needs to be given to non-medical treatments and training in mental illness as it affects women so that tendencies to prescribe tranquillisers and to sex-role stereotype women who suffer mental illness can be avoided. The safety of women and children who have been the victims of abuse should be protected by hospitals and resources for crisis and long-term accommodation increased.

- The extreme shortage of specialist psychiatric services, practitioners and funding for children and adolescents needs urgently to be addressed. Educational, health and juvenile justice systems need to ensure coordination of services and communication between agencies to assure appropriate

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[54] Page 927 of the Report.

psychiatric assessment, ongoing treatment and review of young people with mental illness. A multi-agency youth suicide prevention task force should be devised nationally to counter the rising rate of youth suicide.

- "Specialist services for the many thousands of Australians affected by mental illness and some other form of disability are almost non-existent."[55] Misdiagnosis and shuffling of people with multiple disabilities from agency to agency are too common. Governments need to ensure protection of the rights of those with multiple disabilities including preventing sexual abuse and the use of chemical restraint, and "research into the aetiology, prevention, assessment and treatment of all areas of co-morbidity should be accorded a high priority."[56]

- Consideration of the basic rights of those affected by mental illness who are disadvantaged by rural or isolated location needs to be given higher priority than economic considerations in the provision of care and services.

- There is insufficient knowledge concerning the incidence and prevalence of mental illness amongst Aboriginal and Torres Strait Islander people. Resources for education, training and the provision of specialised services aimed at the mentally ill in this group need to be provided as a matter of high priority. Services should be developed in consultation with Aboriginal and Torres Strait Islander people and provision made for the treatment of patients within the community.

- Similar concerns pertain to the fate of people from non-English speaking backgrounds who suffer mental illness, and resources should urgently be directed towards the establishment of transcultural mental health services and appropriate cross-cultural training of staff and service providers.

- "Mentally ill people detained by the criminal justice system are frequently denied the health care and human rights protection to which they are entitled."[57] Distinctions between mental illness and criminal behaviour need to be made and the protection of the rights of forensic patients guaranteed across all jurisdictions.

- Funding for mental health research in Australia is "woefully inadequate"[58] and urgently needs to be increased. A national database concerning the prevalence of psychiatric disorders and the effectiveness of services must be established as a matter of high priority and general funding for mental health research increased to give incentive for young graduates to enter the discipline and address the serious shortage of trained psychiatric researchers.

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55 Page 935 of the Report.

56 Page 936 of the Report.

57 Page 940 of the Report.

58 Page 943 of the Report.

- Prevention and rehabilitation of mental illness is possible and should be encouraged not only in terms of increased funding for research and services in this area but also in terms of improving community understanding of mental illness and the problem faced by its sufferers.

- Across all jurisdictions (State and Commonwealth) and at all levels, controls and safeguards to protect the rights of people with mental illness must be established, maintained and monitored. Such standards must be consistent, properly resourced and developed in consultation with mental health professionals, community groups and government bodies.

Appendix 1
Chapter 7

DEVELOPMENTS SINCE THE INQUIRY BEGAN

A number of significant developments have occurred at both the Federal level and in individual States and Territories since the Human Rights Commissioner formally announced the Inquiry in June 1990. The most significant of those which the Inquiry has been able to identify are tabulated in this chapter.[1]

Many of these developments, incidentally or coincidentally, were closely related to evidence of serious deficiencies in legislation, policies and programs for the mentally ill presented to the Inquiry.

Federal

Policy

June 1990
- The Commonwealth and State Social Welfare Ministers establish a Working Party to develop a national framework for funding and operation of disability services.

Oct 1990
- A Special Premiers' Conference endorses the proposed national framework for disability services.
- Publication of a draft *Charter of Consumer Outcomes* — Report of the Mental Health Task Force to the Australian Health Ministers' Advisory Council (AHMAC).

March 1991
- AHMAC adopts the *Charter of Consumer Outcomes* as the Mental Health Statement of *Rights and Responsibilities*.
- The Commonwealth relaxes its discriminatory policy of denying patients who had been in a State psychiatric facility for more than twelve months access to Federally funded nursing homes.

[1] This chapter covers developments in the period from 1 June 1990 to 1 April 1993.

July 1991 • Heads of Government sign the Commonwealth-State Disability Services Agreement at a Special Premiers' Conference.

Aug 1991 • The Mental Health Task Force reporting to the Overarching Committee on Health And Aged Care and to AHMAC produces an initial report.

Oct 1991 • Mental Health Policy Section established in the Department of Health, Housing and Community Services.

Nov 1991 • Commencement of the Disability Reform Package. (Amendments to the *Social Security Act* 1990.)

Dec 1991 - Jan 1992 • National consultations held concerning the development of a National Mental Health Policy.

April 1992 • AHMAC adopts the National Mental Health Policy.

May 1992 • The National Mental Health Policy launched by the Federal Minister for Health, Housing and Community Services and the Victorian Health Minister.

Aug 1992 • Establishment of a National Consumer Advisory Group. (The title is subsequently amended, in 1993, to the National Community Advisory Group.)

Feb 1993 • Release of the Mental Health Workforce Committee's discussion paper on Mental Health Workforce Issues.

March 1993 • Reorganisation of the Health and Community Services portfolios. The Deputy Prime Minister and Minister for Housing, Local Government and Community Services retains responsibility for psychiatric disability and mental health issues. The Department of Health, Housing, Local Government and Community Services is created.

Legislation

Dec 1991 • Passage and part commencement of the *Health and Community Services Legislation Amendment Act*, affecting the approval of hostels and their funding.

April 1992 • Commencement of the rest of the *Health and Community Services Legislation Amendment Act*, amending the *National Health Act* 1953 and *Aged and Disabled Persons Homes Act* 1954.

Oct 1992 • Passage of the Federal *Disability Discrimination Act* (covering psychiatric disability).

Services

Sept 1990 • Launch of the *Statement of Rights and Responsibilities* for the Home and Community Care (HACC) Program.

March 1991 • Guidelines for approval of admission to nursing homes relaxed to cover people who have been residents of psychiatric institutions in certain circumstances.

Oct 1991 • Commencement of Vocational Rehabilitation Units for People with Psychiatric Disabilities within the Commonwealth Rehabilitation Service.

Dec 1991 • Launch of national service standards for HACC funded programs, developed by the Commonwealth in consultation with the States and Territories.

April 1992 • Introduction of a three-tiered hostel subsidy scheme involving higher subsidies for accommodating residents with dementia and the phasing out of the Dementia Grants Program.

Funding

May 1992 • Announcement of $52 million (over five years) from the Better Cities Program to upgrade mental health facilities in Victoria by providing new beds for psychiatric patients, primarily in general hospitals, and improved community services.

Aug 1992 Budget announcements -

• Inclusion of the National Mental Health Program funding arrangements in the new Medicare Agreements.

- $135.2 million to be provided over six years to implement the National Mental Health Plan. The funding initiatives include:

  a) $106 million to be paid directly to States and Territories to allow the introduction of additional services and facilitate the transfer of patients from institutional to community-based care;

  b) The balance of Program funds to be used to support a program of structural reform at the national level; mental health workforce training and redistribution; the development of a national mental health data collection strategy; innovation in service delivery; national service standards; education and promotion; evaluation; and research (including the establishment of a National Network of Brain Research). $17 million to be provided for projects of national significance in priority areas.

- An increase in the Domiciliary Nursing Care Benefit from $21 to $26 per week.

- Allocation of $150 million over three years (1992-1993 to 1994-1995) for a new community housing program.

- Allocation of $31 million over five years for the implementation of a National Action Plan for Dementia Care.

- Allocation of $17 million to encourage general practitioners to broaden their role beyond individual patient care, to improve access to after hours services and allied health services and to support the establishment of local networks or 'divisions' of general practice.

New South Wales

Legislation

Sept 1990 • Commencement of the *Mental Health Act* 1990.

Aug 1992 • The Committee appointed to monitor the implementation of the *Mental Health Act* 1990 reports to the Minister for Health.

Services

Sept 1990	•	A Mental Health Act training program commissioned through the Institute of Psychiatry for professionals and other interested groups, including consumers.
Oct 1990	•	Funds provided to establish or enhance Community Mental Health Services in Eastern Sydney, Southern Sydney, Wentworth, Western Sydney Area and North Coast Region, South Coast Region and New England Region.
	•	Funds provided to extend Community Child and Adult Mental Health Services in the Western Sydney Area.
	•	Funds provided to extend Psychogeriatric Outreach Services to the North Coast, New England, Orana and Far West Regions.
Dec 1990	•	Release of the final Report of the Royal Commission of Inquiry into Deep Sleep Therapy. (The Chelmsford Hospital Inquiry.)
	•	Ward 21 at Morisset Hospital (a ward for forensic patients) is closed and some patients transferred to the new Long Bay Prison Hospital.
April 1991	•	Funds provided to acquire additional supported accommodation for the mentally ill in Southern Sydney, South Western Sydney, Western Sydney, South West Region, North Coast Region and Wentworth.
	•	A 30 bed acute psychiatric admission unit opened at Nepean Hospital.
May 1991	•	The Department of Health releases a report on Aboriginal mental health in NSW.
June 1991	•	Special purpose units for the confused and disturbed elderly (CADE) opened at Wingham and Goulburn.
July 1991	•	A psychiatric suite opened at Broken Hill Hospital.
Aug 1991	•	A psychiatric suite opened at Dubbo Base Hospital.

- *Guidelines for the Integration of Hospitals and Community Mental Health Services* published by the Department of Health.

Sept 1991
- *Standards of Care for Area Integrated Mental Health Services* published by the Department of Health.

Nov 1991
- A new domestic cottage development (20 units) opened at Cumberland Hospital for the rehabilitation of patients back into the community.

Dec 1991
- The Western Sydney Regional Information and Research Service releases a report indicating a particular lack of mental health services in the western region of Sydney.

Feb 1992
- A 20-bed psychiatric rehabilitation unit opened at Shellharbour Hospital.
- The first Clinical Professor of Forensic Psychiatry appointed.

April 1992
- Opening of a 30-bed acute psychiatric admission unit at Manly Hospital.
- Opening of two psychiatric rehabilitation units at Kenmore Hospital.
- A new 20 bed hostel and acute admission unit opened at Macquarie Hospital.
- A new 40 bed acute psychiatric admission unit opened at Blacktown Hospital.
- CADE units opened at Mt Druitt Hospital and Lottie Stewart Hospital, Dundas.
- Release of the NSW Mental Health Strategic Plan for the development of services in the next two decades.

May 1992
- A CADE unit opened at Wagga Wagga.

July 1992
- Five cottages opened at Rozelle Hospital for the rehabilitation of patients back into the community.

Sept 1992	•	Amalgamation of Gladesville and Macquarie Hospitals under one administration.
	•	Release of a revised version of the computerised psychiatric client register (CRISP), incorporating an inpatient component.
Oct 1992	•	Release of *A Double Jeopardy* — a report on dementia in clients of non-English speaking backgrounds.
Dec 1992	•	Closure of two wards (72 beds) at Gladesville Macquarie Hospital.

Funding

Aug 1991	•	Removal of the specially guaranteed allocation of funding to mental health.
June 1992	•	Recommendation by the Northern Sydney Area Health Service that $2 million be cut from the budgets of Macquarie and Gladesville Hospitals, necessitating the closure of three wards at Gladesville and one ward and administration functions at Macquarie.