From: Philip Morris
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To: Mental Health Select Committee
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Attachments: The Australian Mental Health Crisis update.pdf; NAPP Submission to Engage Victoria, Dept of Health, Vic Gov - Response to the Update & Engagement paper for the proposed Mental Health & Wellbeing Act.pdf; 06226 Submission to the NSWLCSC Mental Health Services Inquiry-1.pdf; Suicide in ADF members and veterans Royal Commission-1.pdf

Select Committee on Mental Health

Please consider these submissions in your deliberations. I would be happy to give oral evidence too. Prof Morris AM (president National Association of Practising Psychiatrists and president Gold Coast Medical Association).

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The Australian Mental Health Crisis: A system failure in need of treatment

Australia has a mental health crisis. Despite a number of national mental health plans and a decade of changes to public mental health services, individuals, patients, families, carers and support groups from all around Australia are saying that the care of mentally ill individuals is a disgrace. The recent reports into the state of mental health nationwide (see recent "Not for Service" report and the Senate Select Committee report on mental health), and the Royal Commission into the Mental Health System in Victoria backs up the experience of these groups. This crisis primarily affects public mental health services.

Causes of the crisis

In my opinion the problems in mental health stem from the following difficulties.

Rationing

There are not enough mental health services to meet the needs of patients. This leads to rationing. In the current situation resources are so limited that rationing has to be tightened to extreme degrees and as a result only the most severely ill patients are offered treatment. Other patients who are very ill but fall under the rationing threshold may not get appropriate care. This rationing is most acutely felt when decisions are made to admit patients to psychiatric inpatient care from hospital emergency departments, when decisions are made to discharge patients from inpatient care, and when decisions are made to determine which patients are offered intensive case management by community mental health clinics.

The severity of rationing nowadays means that patients who need hospital admission may not get it, that patients who need longer stays in hospital may be discharged too early, and those patients who need intensive community case management and follow-up may not get it.

These flaws in the provision of treatment can have disastrous consequences; an article in The Australian newspaper drew attention to 42 suicide deaths in Victoria in young people under age 30 over a two-year period where inadequate treatment was linked to the suicide. Lack of mental health beds for high-risk patients, too rapid discharge, and lack of intensive treatment were problems identified. A Queensland Health report highlighted the problems for patients trying to access a health system under pressure. The report identified 140 unexpected deaths of patients treated by Queensland Health in the previous year. More than half of these deaths (86) were of mentally ill patients who accessed Queensland Health. Most of the deaths were by suicide; either within a week of a patient being assessed in Queensland Health emergency departments and not being admitted, or within a week of discharge from a psychiatric admission.

One of the major problems is the lack of acute psychiatric beds (and back-up extended care beds) across Queensland, making admission of very ill individuals difficult and

potentially forcing early discharge of inpatients. It is amazing that psychiatric inpatient units are continually at 100% occupancy, making them unable to meet the demands of fluctuating clinical pressures. Increasing inpatient bed numbers would allow inpatient units to operate at the more conventional 85% occupancy – allowing admission of patients when needed without rationing. Inadequate intensive community follow-up case management of these highly vulnerable individuals means that too few patients are managed closely in the community and are open to the possibility of self-harm.

New mental health acts and policies

New revisions of state mental health acts have been introduced around Australia over the past two decades. These acts are often more enlightened than the ones they replace in that they give more weight to patient autonomy and to the least restrictive forms of treatment being used. However, these acts can be misused because of the pressures of rationing that apply at the moment and this can lead to patients being treated inappropriately. The mental health acts may be used to cover inadequate inpatient beds, or mental health act provisions may be invoked for patients who do not need to be involuntary just in order to access community case management. Another article in The Australian highlighted psychiatrists needing to use these practices in order to get appropriate care for their patients.

Unfortunately, across the world the introduction of new mental health policies, acts and plans are associated with increased suicide rates compared with national drug policies that are associated with lowered suicide rates. Drug policies usually reduce drug supply and provide more rehabilitation treatment whereas new mental health acts and plans can make treatment more difficult to access.

'Mainstreaming' of mental health services

Over the past 20 years there has been a push by public mental health services to 'mainstream' the care of individuals suffering from mental illness. This means providing services for them within the general health system rather than a separate service for psychiatric illness. While this has emphasized the role of the general practitioner in providing treatment, and had some limited benefit of reducing stigma and curtailing the excesses of some treatment practices in the older, or more isolated, stand-alone psychiatric facilities, the policy more broadly has been a failure.

The unique needs of individuals suffering mental illness have not been fully appreciated and provided for and this has led to a secondary marginalization of mentally ill patients in general health services. One needs to look no further than the way patients with mental illness and substance abuse are treated in busy public hospital emergency departments to see evidence of this marginalization. Indeed, belatedly, there is now recognition that separate psychiatric emergency departments need to operate in public hospitals. But beyond the emergency department the mentally ill need inpatient units with plenty of space, sub acute and extended care treatment facilities, and properly supervised

community residential accommodation – all features that are not usually offered or supported by general health services.

Failure to publish mortality data

Mortality figures for individuals under the care of public mental health services are not easy to access. In NSW, for example, although figures for deaths occurring in people while theoretically under the care of the mental health services have been collected since 1992, systematic publication has been refused. A particularly alarming development was that the only paper published on the figures by NSW Health in 1995, covering a 39-month period from 1992 to 1995, had pooled these figures, giving an average of 76 such deaths per year. The paper failed to mention that, as eventually emerged in a 200-page report released later, the figures were actually 68 in 1993, 72 in 1994, jumping to 100 in 1995, i.e. a dramatic and alarming increase of 47% in just three years, which has continued subsequently to a total increase of at least 300% since 1992. Data and trends on mortality from natural causes (including a breakdown of causes of death), suicide, homicide, police shootings, and accidents are not readily available. Nor are data on the number of deaths and severe assaults that are caused by individuals under mental health care.

Limited training opportunities

Australia faces a looming crisis in training of psychiatrists and other mental health professionals. A large number of psychiatrists and psychiatric nurses are reaching retirement age and there are too few coming through to replace them. In addition, the training opportunities for a balanced, comprehensive training experience in psychiatry are limited. Public adult mental health services have gradually but progressively narrowed their clinical focus to patients suffering from drug induced and functional psychoses, patients on forensic orders, and the more severe (often Cluster B – antisocial, borderline) personality disorders. This is an important but very limited view of psychiatry.

Many of these services do not provide the breadth of clinical conditions and treatment environments and programs required to provide an attractive and comprehensive training experience for registrars and other mental health professionals. As most training positions are in the public sector (with some exceptions), this is causing serious problems for the training of the next generation of mental health professionals.

A recent study from the University of NSW shows that while medical students at the start of their training are favourably disposed to psychiatry, by the end of their clinical training they have a negative view of the discipline. Either the other medical and surgical specialities are better at attracting students, or the experience of clinical psychiatry in the current teaching settings is uninspiring. I suspect the latter. Students find it difficult to identify with aggressive, psychotic, heavily sedated, locked up and often forensic patients that populate public mental health units now. Lack of identification leads to a lack of potential interest in psychiatry as a career.

Having got to a 'mental health crisis,' what can be done?

Accountability

In my opinion the first action is to emphasize accountability at the point of the patient – clinician contact. The patient placing his or her care in the hands of a doctor, nurse or other mental health professional needs to know that that clinician has the patient's welfare at heart and that the treatment needs of the patient will not be inappropriately influenced by the demands of rationing or other bureaucratic impositions applied by the mental health service. This form of accountability will lead to a profound change in the way public mental health services are provided and resourced. Substantial staffing and facility enhancements and additional funding will be required to support this change.

An audit or standing commission of inquiry into all suicide deaths

An audit or commission of inquiry should be established to examine the pathways to death in all cases of suicide in Australia, whether occurring in hospital or in the community. The inquiry should have the power to call witnesses. The inquiry should be required to focus on the pathway to death of the individual and the nature of contact over the preceding three to six months between the individual and public (and private) mental health services. The inquiry should make regular comment about the quality of services and make recommendations about improving these services. The inquiry should also examine how the regulations of state mental health acts are being applied to see if they are affecting the provision of acute inpatient care and intensive community care.

The focus should be on the nature of the contacts with mental health services (and to a lesser extent with other practitioners) in the weeks and months prior to the suicide. Although suicide is a multi-determined behavior, surely the quality of mental health services for those who make contact with them prior to suicide has some role to play in preventing tragic outcomes - if not, then we should not be in the business of providing care. For example, the Brisbane Courier Mail reported on four suicides in far north Queensland where the adequacy of treatment by mental health services leading up to the suicide is being investigated by the Coroner.

A commission of inquiry will provide the opportunity to examine all evidence and witnesses (including health providers and mental health service managers) and to make recommendations about improving services. The advantage of a judicial commission is that it will be independent of government and health services and should be able to make findings and recommendations unbiased by outside influences.

Publish mortality data and number of mentally ill in prisons and homeless

It is important to publish mortality data from natural causes (including a breakdown of causes of death), suicide, homicide, police shootings, and accidents. Mortality data and operative complication rates are now becoming required even for individual surgeons. Anaesthetists for many years have provided a model of how to use their rare number of

peri-operative deaths to reduce mortality even further. If, as in all other life-threatening illnesses/procedures, we keep track of all the deaths, note whether the numbers are increasing, and look carefully at each one to see how, when and whether it could have been prevented, then that will tell us clearly how well the system is working. Data should be published on the numbers of deaths or serious assaults caused by individuals suffering from mental illness under care of public and private mental heath services, broken down by state and health service region. In mental illness we also have two other measures, which although social rather than medical, are nevertheless definite enough to be counted as clear indicators of how the system is working. These are the number of gaoled and homeless individuals with a significant mental illness.

Replace 'mainstreaming' with 'parallel but integrated' mental health services

Let us acknowledge that the 'mainstreaming' policy has its limitations and a move to another model is now needed. An alternate model would recognize the special needs of individuals with mental illness and build a system of care from there while utilizing the strengths and services that comes from close association with general health services. This change in direction would facilitate the development of community, emergency department, inpatient, sub acute and step-down, extended care, and residential supervised accommodation services that better meet the needs of the mentally ill. Parallel but integrated services should replace the 'mainstream' model. A major build of clustered 24-hour supervised accommodation around embedded rehabilitation and recovery services is urgently needed for longer stay patients.

Enhance training opportunities

A substantial increase in training opportunities beyond public mental health services is required for medical students, registrars, allied health professionals and nurses in order to provide comprehensive knowledge and skills in psychiatry. More training positions in the private sector (including office-based practices) and in other settings (such as non government organizations [NGO] services) are needed and should be affiliated with learning organizations such as universities and institutes. Methods of funding these positions will be a major challenge, but without this broadening of psychiatric training the profession will wither. With foresight and vision, regional medical communities might just provide the opportunities needed to overcome this looming crisis. The establishment of training positions for doctors, nurses and other mental health professionals in private hospitals and office-based clinics, and NGO services, all affiliated with local medical schools and educational institutes would go a long way to place mental health training on a secure footing. Even within the public sector a change in the teaching environment would help – dedicating some inpatient and outpatient services for voluntary patients only would expand the range of conditions seen and the types of treatment interventions able to be employed, thus offering a more satisfying learning experience.

Conclusion

While a major investment of public resources is required to deal with the mental health crisis, the money will not be well spent unless issues of accountability, service direction and training are addressed.

Prof Philip Morris AM

napp national association of practising psychiatrists

29.07.2021 Submission to Engage Victoria, Department of Health, Victorian Government:

Response to the Update & Engagement paper for the proposed Mental Health and Wellbeing Act

Introduction:

The proposed new Mental Health and Wellbeing Act in Victoria will guide the new Victorian public sector mental health service, consequent to the Royal Commission into the Victorian Mental Health System.

The main features are:

1. The fundamental perspective will be Human Rights.

2. Those with the lived experience are to take a major role at every level of the service.

3. The roles of families and carers is seen as fundamental.

4. The emphasis will be the provision of community services and hospital in the home. There is no mention of increased voluntary beds for adults. Young people and forensic services will obtain more beds, many refurbished from current adult beds.

5. The redesigned mental health system will employ significantly increased numbers of nurses and allied health. There will be an indeterminate number of positions for Junior Medical Officers (JMOs) to rotate through the new system. There is little mention of psychiatrists and their role throughout the public mental health system.

The Workforce fact sheet cites 22 professions that are involved in mental health services. Nurses are No 1. Telephone counsellors are no 5. Psychiatrists, Medical Officers, Registrars and General Practitioners are Numbers 19-22 respectively.

6. Compulsory treatment will be the last resort, and is to be phased out totally over 10 years. All possible non-compulsory community options will need to be exhausted first.

7. Non-legal advocates will be provided for every possible compulsory patient, on an “opt-out” model, to represent their plans and wishes.

8. Temporary treatment orders may be made by nurses and social workers, with new criteria.

9. Patients will have the right to withhold access to their clinical information.

10. Seclusion and restraint are to be phased out.

11. Meaningful Governance of the new service requires definitions of fundamental concepts and methods of monitoring performance that are as yet unclear.

The points below refer to specific sections of the Submission paper.

Objectives and principles of the new Act.

Question 1: Do you think the new proposals meet the Royal Commission's recommendations about objectives and principles of the new Act?

No.

Question 2: How do you think the proposals about objectives and principles could be improved? (Section 2.1 in the paper)

The fundamental conceptual frame of the Act is Human Rights.

The fundamental task of a public sector mental health service is to provide appropriate assessment and treatment of mental health conditions.

Yet the fundamental right to adequate treatment is not stated clearly.

There is inadequate focus on the role and impact of mental illness on mental health; yet this Act will guide a state-led health service.

A coherent and consistent definition of mental illnesses is not provided and is definitely required.

In the paper, mental health is stated as being more than the absence of mental illness. Most people accept that physical health is more than the absence of physical illness. It is self-evident that treating physical illness appropriately contributes to physical health. Mental health and mental illness require equitable consideration, attention and resourcing, including funding, to physical health and physical illness. The failure to ensure such equity contributes to worse mental health outcomes, discrimination and stigma. Mental illnesses need to be recognised and treated.

A fundamental health perspective required is the contemporary biopsychosocial knowledge base and clinical practice of Psychiatry, which needs to be embedded throughout the Act. This perspective is not in opposition to a Human Rights perspective. When adequately funded and facilitated at a systems level, a holistic biopsychososical psychiatric practice contributes to the upholding of human rights.

Mental illnesses are not necessarily equivalent to trauma, neurodiversity, emotional distress or mental health challenges, as defined in the proposed Act.

Mental illnesses can result in great distress and disability. A change of language will not change these experiences and outcomes.

Removing the term "mental disorder" will not cease the stigma of mental illnesses. It will simply push it underground.

Removing the bio-medical model will not assist the assessment and treatment of these conditions. It will not remove the existence of a range of mild-moderate-severe-extreme conditions. It will not remove the need for appropriately trained clinicians to conduct risk/benefit analyses when people present; and the need for evidence based clinical practice which is updated regularly for new advances.

There are no adequate definitions in the Proposed Act of: Mental illness; psychological distress; assessment; treatment; care; support; holistic treatment; high quality service; specialist mental health practitioners.

Diverse treatments are to be offered. What are they, and upon what are they based? How will clinicians' competence to provide specialist and diverse treatments be assessed or considered?

It is not clear where clinical accountability lies. Systems accountability, alone, will not be sufficient. Accountability for individual care must reside with the treating clinician.

The proposed principles for the new Act are described as "rights based" and as "prioritizing the views, preferences and values" of people living with mental illness. Proposed principle 8 lists a number of specific diversity-related

needs, such as age, gender, gender identity and sexual orientation. Currently it does not include 'sex'. Similarly, in proposed principle 9 it is written people may have "specific gender -related safety needs and experiences" and there is no mention of 'sex'. The characteristic of 'sex' is not equivalent to 'gender.' 'Sex' needs to be included, along with gender, in both point 8 and 9 to ensure the Act highlights that an appropriate balance is required in considering how best to meet the rights, dignity, preferences and well-being of a wide range of patients.

Non-legal advocacy:

Question 4: How do you think the proposals about non-legal advocacy could be improved? (Section 3.1 in the paper)

There is no mention of training of non-legal advocates. What training will be considered adequate? Who / which organisations will be responsible for adequacy of training and continuing professional development? To whom will the non-legal advocates be responsible in the event of a negative / adverse outcome, e.g., patient suicide?

It is unclear how their role fits with the views and roles of patients' powers of medical attorney/families/carers/nominated persons.

It is not clear how patients can opt out if they wish to do so, or how to give consent for information to shared, when they are too ill or lack capacity to make this decision / give informed consent or non-consent.

Non legal advocates are to be involved in decisions for seclusion and restraint. Some patients go in and out of seclusion and restraint repeatedly over many days. Will non-legal advocates be on call 24/7?

Supported decision making:

Question 6: How do you think the proposals about supported decision making could be improved? (Section 3.2 in the paper)

Second psychiatric opinions will be required to enhance supported decision making for all compulsory patients.

Currently the pressure for beds leads to patients being discharged before a second opinion can be performed. Currently, most admissions to public sector inpatient mental health units are compulsory admissions.

If there were more voluntary adult beds, many patients could be admitted earlier when their situation is less severe and they could give consent. Presumably in this situation, it would be expected there would be a decrease in the number of compulsory admissions.

How is the proposal for (increased) second psychiatric opinions to be enacted? Will there be an increase in staffing FTE (clinical employment hours) of psychiatrists in order to provide the required second opinions? How will the independence of the second opinion psychiatrists be guaranteed?

The views of patients, families, nominated persons/carers/spouses are essential components to supported decision making.

Many adults prefer to make their own decisions, and this needs to be acknowledged.

Information Collection:

Question 8: How do you think the proposals about information collection, use and sharing could be improved? (Section 3.3 in the paper)

It is not clear yet how informed consent applies, particularly with the provision of information about a patient across services.

There is no clarity about whether there is any level of safety considerations that may override a patient's wishes regarding the release of their confidential clinical information.

If a patient refuses to give consent for confidential information to be shared between services, how do they coordinate high quality treatment, support and care? How is this to be approached if the patient lacks capacity for informed decision making due to acute mental illness?

Section 4.1 Treatment, care and support:

Question 10: How do you think the proposals about compulsory treatment and assessment could be improved? (Section 4.1 in the paper)

Compulsory treatment should be a last resort in treatment. However, this principle in the Proposed Act does not address the situation that compulsory treatment may be required in the acute presentations of severe or extreme mental illness that require urgent assessment, treatment and risk management.

In the rest of medical practice, severe presentations can require voluntary inpatient treatment. Patients with severe conditions are not required to exhaust all community treatments first.

Mental health requires equity with the rest of medicine. Admitting patients voluntarily before they have deteriorated into crisis, worsening mental state, suicidality, self-harm or other risk could avoid an involuntary admission. There need to be more voluntary admission beds. This option is not adequately addressed in the Proposed Act. Compulsory treatment may then only be required for the most extreme or unwell patients; and, hopefully, less often due to early intervention.

Removing the bio-medical model will not remove the biological bases of serious mental illnesses, their complexity and co-morbidity. The bio-medical approach is required, integrated with psychological, social and cultural dimensions of mental health care, for truly holistic mental health care.

Making a temporary treatment order is a major responsibility and requires more than applying principles of human rights. A thorough understanding and competency in the assessment and treatment of serious mental illnesses is required.

The proposed new criteria for compulsory treatment are of concern.

Psychological distress is a poor criterion for involuntary treatment. It is subjective. Many serious mental health illnesses do not present with psychological distress: e.g., mania; suicidal people who have decided to kill themselves (ego-syntonic suicidality); schizophrenia with marked negative symptoms; mental illness in those with concurrent autism. These presentations could easily be missed.

This criterion could easily lead to more people becoming compulsory more often, rather than less. Psychological distress is very common.

Risk of imminent harm is also subjective and impossible to gauge accurately. The best way to reduce this risk is to acknowledge, and treat, any underlying mental illness.

Removing risk of physical harm as a criterion for compulsory treatment is a poor decision. Many complex scenarios are a mix of physical and mental illness. Both require concurrent assessment and management.

The new Act will impact upon seriously ill people, who are the most vulnerable of our community. A pilot study, incorporating the suggested changes, with a careful clinical outcome evaluation, is a minimal requirement to ensure that patient care is not adversely affected and that patients' human rights are upheld by the proposed changes before they are implemented.

Section 4.2 Reduce rates of restraint and seclusion:

Question 12: How do you think the proposals about seclusion and restraint could be improved? (Section 4.2 in the paper)

This is an important issue. No one wants any person to be secluded or restrained.

However, the bases of seclusion and restraint need careful analysis and address. These interventions do not occur for trivial reasons.

The safety of, and potential trauma to the patient, other patients and the family, and the mental health system workforce all have to be addressed.

How will these factors be addressed? The Proposed Act is silent on this matter.

Section 5.1 Governance:

Question 14: How do you think the proposals about governance and oversight could be improved? (Section 5.1 in the paper)

The current crisis-based mental health services in Victoria were set up by managers on neo-liberal principles. Neo-liberal principles are not the basis of contemporary biopsychosocial psychiatry. The managerial aim was to cut costs and to transfer public patients to community resources, which failed to be funded and eventuate. Only the most unwell were prioritised for public sector treatment. This has not only caused damage to the patients and their families, but also to the mental health workforce. This damage includes vicarious traumatisation, moral and emotional injuries for the staff, and particularly with the Ice epidemic, physical injury due to violence / assault. This has occurred at a time of increasing population without increase in the services' funding, staffing etc

The following questions are not answered in the paper.

What are the clinical characteristics of high-quality mental health and wellbeing services?

What is a safe service? How is 'safe' defined, for patients and for the workforce?

How is quality of service to be evaluated?

How will vicarious traumatisation, moral and emotional injuries and physical damage / injury sustained by the workforce be acknowledged, measured, reported and monitored and treated in the re-formed system, and by whom? Will there be overview beyond individual mental health services capturing potential outcomes of the Proposed Act? What is an adequate complaints process for the workforce?

Finally, surely a public sector mental health service must have, at its core, a commitment to providing vulnerable people with their human right to treatment?

How this is to be provided needs to be embedded throughout every aspect of the service and clearly documented in the Proposed Act.

Dr Philip Morris AM	Dr Vivienne Elton	Dr Melinda Hill
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National Association of Practising Psychiatrists

Submission to the

NSW Legislative Council
Select Committee on Mental Health:
Inquiry into Mental Health Services In NSW

Part I – Report

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Introduction

The National Association of Practising Psychiatrists (NAPP) has long advocated an inquiry into the provision of mental health services in New South Wales (NSW).

Since the adoption of the Richmond Report (1983) there has been a growing belief that de-institutionalisation of patients with mental illness has not been successful in achieving the objectives of more humane and improved treatment standards for people suffering mental illness in NSW.

Furthermore, there is evidence that the recommendations of the Richmond Report have been used by government as justification for radical cost reductions in the provision of mental health services in NSW.

The creation of Area Health Services in 1989 is seen by some as the method for creating the illusion that psychiatric beds were not being closed but merely "transferred" to modern local health facilities.

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

Furthermore, there is every reason to believe that this reduction in psychiatric beds and services has not resulted in any real cost savings but rather a "cost shifting" to other sectors of the community, namely; police, judiciary, corrective services, and general hospitals, many of which are not adequately equipped to cope with mentally ill patients.

Is our current situation a failure of government or is government simply reflecting the attitudes and priorities of its voting constituents?

Any attempt to examine the reality of mental health services in NSW is hampered by what can only be described as political self-censorship. Doctors and other insiders who speak out about deficiencies in the NSW mental health system, to which they are contracted, live in fear of career retribution. At best their evidence must be submitted to their political masters in order to be approved as stated, in regard to this Inquiry, in a Memorandum from the Acting Director-General, NSW Health, dated 5 January 2002.

Are we 25 years behind other States, as many professionals in mental health claim?

Have gaols become our new mental health institutions? Have we closed psychiatric beds to open prison cells?

Should we be alarmed when we hear that there were 248 probable suicides of NSW mental health patients between April 1992 to June 1995 for patients under the care of NSW Health? Why has this figure now increased to 177 suicides in 1999 and 166 in 2000? And if this is the suicide rate for patients in care, what is the homicide rate?

How do we differentiate between the criminally insane and the insane criminal? How do we provide for community expectations of punishment and the rights of the mentally ill to treatment?

What ever happened to the Statement of Rights and Responsibilities, Guidelines for Providers and Patients (1991), which was adopted by the Australian Health Ministers Advisory Committee as an adjunct to the National Mental Health Strategy?

Why is it that the much publicised Burdekin Report can raise so much awareness about deficiencies in mental health services but generate little action to fix it?

Why do policymakers in mental health find it difficult to understand the interrelationship between the provision of acute, non-acute, and rehabilitation psychiatric beds as an interrelated and organised system capable of providing for patients with overlapping and specialised needs, and in harmony with community based mental health programmes.

The answers to these and other questions require intellectual honesty and widespread community debate – free from fear and blame and directed towards the broadest agreement of what NSW should be providing, and can afford to provide, for those of us who are unfortunate enough to experience the pain of mental illness.

NAPP makes no apology for focussing particular attention in our submission to the Forensic area which not only highlights problems faced by forensic psychiatric services, but also highlights the neglect in general psychiatric services in the broader community. NAPP believes that the Forensic area needs special attention by this Inquiry.

NAPP welcomes this Inquiry as a first step towards the improvement of mental health services in NSW. History will judge whether it is simply a recycling of the problems or a watershed in improving the lives of people with mental illness.

This submission has been written and prepared on behalf of the National Association of Practising Psychiatrists by:

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with the assistance of many NAPP Members.

April 2002

Public mental health services in NSW

Acute services

There is a changing demand in mental health in more recent years. There's more violence, more suicide, more drug use, different drug use - and this creates a huge problem of increasing numbers of increasingly difficult patients. Bed numbers are insufficient to meet unusual demands on an already stressed system, and delays may, and do, result in injury or worse. Lack of beds places unintended strains on casualty departments, which in turn ties up police and nursing staff attempting to manage difficult patients.

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

Psychiatrists can, and often do, spend hours on the phone trying to locate any available bed. Patients are often admitted to a facility outside their Area Health Service (AHS), *sometimes travelling hundreds of miles* for a bed (both into and out of Sydney), and thereby dislocated from their family and social supports. This does not equate to best practice, and is detrimental to quality care.

An example of the number of bed days spent away from AHS of residence, by patients who have been sent as far as Queensland for treatment, can be seen in the following table from the Wentworth AHS :

Table 1: Psychiatric inpatient outflow destination data for Blue Mountains LGA population compared to all Wentworth resident adults eighteen years and over for the period Jul 2000 – June 2001

Hospital	No separations	No. of bed days out of AREA	Blue Mountains LGA No. Separations
Cumberland	28	1976	6
Westmead	19	149	3
Blacktown	11	60	1
Concord	33	170	0
Rozelle	6	21	1
Queensland Public	6	162	4
Royal North Shore	5	20	0
Campbelltown	4	21	1
Prince of Wales	4	57	2
Bloomfield	3	9	1
Liverpool	3	6	2
Other hospitals	41	623	9
Total	**155**	**3055**	**30**

One recent example is of a young woman with a 2 year old child, living in a caravan park in Port Macquarie who became psychotic. The local team couldn't get an acute psychiatric bed anywhere in NSW, and after a long relay of ambulances she was admitted to Royal North Shore hospital.

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

A 15 year study[1] on successful intervention on youth suicide, from Western Australia, concludes that when a young person is admitted to accident and emergency departments following self harm behaviours: *"...there were gross deficiencies in the kind of care being provided, not adequate assessments being made and the follow up tended to be woeful"* . The report showed that we can successfully intervene and dramatically reduce the suicide risk if *"...you actually take the trouble to spend enough time with the person to gain their confidence, take a good history and ensure that whatever treatment is provided is addressing some of their immediate needs. It was particularly important to improve the likelihood of decent follow up."*

The situation in NSW is grossly deficient in this regard. Because of pressure on beds, it is not possible to keep people in hospital long enough to ensure that their illness has stabilised. Very often the aim of treatment is acute suicide prevention, quickly, and as soon as they are deemed not to be acutely suicidal, they are discharged. Mistakes are made, and many psychiatrists report that patients often suicide after discharge because they still depressed or distressed. Despite repeated thwarted attempts to obtain the figures of suicides after discharge and during hospital admission the statistics are not being made available. (NAPP requests, under the FOI Act, oral and written requests to the Director, Centre for Mental Health, NSW.)

Data available from the NSW Mental Health Client Incident Monitoring System shows a rapid rise of suicides under the care of NSW Health, during 1992-1995. Since that time data has not been made publicly available.

Suicides under the care of NSW Health	
1989	10
1991	20
1992-1995	248 (89 in-patient)
1996	
1997	
1998	
1999	177
2000	166
2001	

[1] (Interview with Prof. Sven Silburn, Centre for Developmental Health, Curtain University and the Institute for Child Health Research, Perth, W.A. , Radio National, 4 February, 2002. Ref: Hillman SD et al. Suicide in Western Australia. Institute for Child Health Research UWA 2000).

Early discharge of patients in the acute phase of psychotic illness is now routine. Many patients are now discharged at a level of illness that once constituted criteria for admission. Rates of readmission are not published. For example, average length of admission is now 14 days, precisely the time antidepressants *start* to exert their effects in depressed patients - thus patients may be sent home *before any evidence exists* of treatment benefit.

"Create a bed quickly" *is not* "treatment" for patients, and it's soul destroying for staff. Care while in hospital is inadequate. If patients aren't discharged quickly it creates havoc in the system.

Sometimes these patients are put on "leave" to empty a bed, and relatives are often given little or no notice of patients being sent home. We do not have the statistics into the rate of domestic violence (including very serious assaults) in the case of patients being discharged to families and carers, or the community. We also do not have the statistics for homicide by psychiatric patients who are discharged into the community.

There is a difficulty in finding forensic beds for dangerous, aggressive mentally ill patients who remain in the acute unit. The shortage of acute psychiatric beds creates a serious problem in casualty departments of hospitals. Acutely disturbed psychiatric patients can spend 15 hours and upwards in casualty - they can abscond, might be suicidal, violent, or are disruptive to the other patients and staff.

To quote from a confidential draft report from NSW Health, dated June 2001:

> *"In the 30 years from 1965, overall psychiatric bed numbers (acute and non-acute) in NSW have reduced from over 12000 to about 2000 currently."*
>
> *"The pendulum has swung too far and that the number of beds, particularly non-acute beds, may not be sufficient to meet current needs."*[2]

The report quotes *a current shortfall of over 865 non-acute psychiatric beds*. The report also states that the decrease in beds *"...mostly reflects a very significant improvement in the quality of mental health services resulting from better treatments, an enhanced range of community services and changing community and professional attitudes"*.

The reality is few community facilities have been set up in their place. Long term treatment and support, as well as treatment for acute illnesses, is grossly inadequate to the need. To quote the report by the St Vincent de Paul Society, July 2001, St Vincent workers were helping a growing number of disadvantaged people with a mental illness, both in Sydney and in rural areas. The report states that about three-quarters of the homeless had some form of a mental disorder and the report identified a lack of acute care beds, inadequate hospital care and a lack of follow up after discharge.

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[2] NSW Health. Mental Health Non-Acute Inpatient Services Plan. 2001. pg 6

There's no way of identifying where available beds in NSW are. Hours and hours of expensive and valuable psychiatrists' time is repeatedly spent ringing around for a bed. Why is this? To get a centralised service, one that provides real time information, necessitates a salaried position, and this costs money. We were advised by the Director, Centre for Mental Health, NSW, that a centralised computer system was to be trialled to address this problem. Thus far this has not occurred and we have had limited information on its progress. NAPP is also interested to learn that this is one of the demands being made by the Australian Salaried Medical Officers Federation if threatened industrial action is to be averted (letter, ASMOF, 22nd March 2002).

Rural NSW

If a patient is acutely ill they often have to be cared for in a small facility, visited by a nurse and an on call GP. Since the commencement of the rotation of trainee psychiatrists to country terms, there is a small amelioration of a still very grim situation.

Subacute, longer term patients

There are fewer non-acute beds than 20 years ago, with huge waiting lists for patients needing longer hospital admissions that provide a program geared to their rehabilitation, perhaps lasting 6 to 24 months.

Some of these patients clog up acute beds or they live in substandard accommodation in the community. Some create an intolerable burden on the families that need to care for them and about three quarters of the homeless have some form of mental disorder. It is anti-therapeutic for such patients to remain in the turbulent atmosphere of the acute ward, and it's demoralising for the newly admitted patients when the acute wards are populated by chronic/subacute patients. Further, the presence of subacute patients may actually prevent admissions of acute cases, creating a downward spiral.

After discharge most patients with a mental illness get no treatment to speak of, perhaps occasional monitoring of their medication, and suffer from "revolving door" breakdowns needing readmission to hospital. This creates an enormous strain on families, on the patients themselves and on the health system generally. Families tell us that the mental health services don't keep following up patients for a longer term, often being told "we can't do any more" or "there are more acute cases and we don't have the resources".

Chronic and subacute patients need persistent long term care, sometimes rehabilitation. Mostly, this occurs in the community, if it occurs at all, but sometimes patients need an extended time in a place of asylum, away from the pressures of everyday living with which they are not coping. There is not an adequate number of chronic or longer term beds, and these patients are thus placed in danger of becoming "revolving door" readmissions unnecessarily.

Lack of Psychotherapeutic Service Provision

It is not possible (with very few exceptions) to get face to face psychological therapy as an inpatient or outpatient, though many patients and their family request this. They may, sometimes, get 1 or 2 counselling sessions with a nurse, or some occupational therapy, but not psychotherapy. This mode of treatment is essential in medication-resistant cases, cases of personality disorder which underlie depression, anxiety, or repeated suicide attempts.

Psychiatry espouses the biopsychosocial model of causation and treatment, but in effect the psychological and social dimensions of treatment are all but non existent in the public system. This is despite proven research benefit of psychotherapy in many conditions, such as borderline personality, depression and repeated self harm.

A long term study[3] in the USA, of over 20 years, linking personality disorders in adolescence with violent behaviour in early adulthood, found that this group, with the one exception among the personality disorders of the antisocial personality disorder, could be treated effectively with psychotherapy.

No treatment is available for these people in our public health system, and increasingly treatment is being curtailed in the private system, thus leading to increasing demoralisation of staff and poor retention rates of trained staff.

Supervision

There is virtually no supervision available for staff in the community and in hospitals dealing with mentally ill patients. They have an enormous responsibility and staff dealing with severely ill psychiatric patients need a regular and scheduled opportunity to discuss patients, so they can review their work.

In services where an experienced outside psychiatrist consultant who is trained consults regularly, the staff are more content and the patients less violent, less mad and less out of control. In the very few services where good supervision becomes available, the staff say the patients change and are easier to manage. This system existed in the past, and the demise of experienced consultants to supervise staff may partially explain why patients are more “difficult” these days.

Children and Adolescents

There was until recently only one designated residential unit, Redbank House (9 beds), now in disrepair, for acutely disturbed adolescents and children. A new 10 bed unit has just opened in Campbelltown. There is a long waiting time for admissions and psychotic, suicidal, or disturbed young people will sometimes be admitted to an adult ward or paediatric ward. *Despite this contravening their “duty of care” to this group, the authorities encourage this practice by ensuring their safety*. The staff are not equipped or trained to manage them, and the facilities are not secure or safe. Earlier this month,

[3] Johnson JG et al. American Journal of Psychiatry 2000; 157: 1406-1412.

allegations surfaced in South Australia that psychiatric patients admitted to general and surgical wards were being 'shackled to beds'[4]. An enquiry by the SA ombudsman is underway, but this is not an environment where children can be treated.

NAPP is aware that Psychiatrists in NSW have reported that when there is lack of adequate resources or facilities, desperate staff have tied young psychiatric patients down. There have been reports of injuries. We do not know the extent of such activities in NSW but we know it occurs.

Women

Women are particularly vulnerable in acute psychiatric wards. Younger women are frightened; they have to share common living areas where the most disturbed patients wander. Psychiatrists report that some female patients have been raped by other patients while in hospital.

While sexual activity between patients has always occurred in psychiatric hospitals, NAPP is concerned that the reports of rape on the young and vulnerable seem to be a more recent phenomena resulting from, in our view, the lack of staff and proper facilities to care for and protect patients.

Staffing problems

The recent practice of hiring "generic" health workers is compounding the problem of staff dissatisfaction and resignations. The family team at the Coral Tree House (formerly Arndell Children's Unit) which has instituted this policy, has had resignations of two thirds of its staff, both long standing and recent appointments, and is now virtually non functional. While superficially a cost effective way of filling vacancies, the assumption that everyone can do everything, regardless of training, leads to a situation where no effective treatment is on offer and staff, now mostly deskilled in their generic roles, have resigned in despair and continue to do so.

There is currently a severe shortage of medical and nursing staff - so severe in the case of nursing staff, that in many areas, despite budget cuts, there would be money to employ them, but they can't be found. Psychiatrists could however be found, relatively easily, but only if employed as VMOs. Few psychiatrists would be willing to work full-time in a system that has become so dysfunctional, hostile and unpleasant; but many would be willing to make a contribution, to teaching and clinical work, on a sessional basis. Because psychiatrists are relatively expensive, there has been increasing reluctance by AHSs to employ them at all. Hence, there would have to be incentives to do so, and/or perhaps penalties for failing to.

NAPP believes that the return to employment of psychiatric VMOs would be relatively inexpensive and simple; and would have great and immediate benefits in providing a living bridge between public and private sectors; a pool of experience and

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[4] The Australian newspaper: http://theaustralian.news.com.au/printpage/0,5942,3260020,00.html).

expertise which can be shared with new and less experienced staff; and an increase in status for the service, reassuring for patients and relatives. It would also help with recruitment of trainee psychiatrists, and nursing and other staff, to have a wider range of teachers, and knowledgeable support.

In general, it will be impossible to fix other staffing problems in isolation, particularly the shortage of nurses. The system as a whole has to be fixed, which means a very large and ongoing increase in funding. As well as that, the following need to be addressed:

(i.) Pay rates for nurses in general, including psychiatric nurses, have slipped to levels that provide little incentive for anyone with a choice, to remain in a hostile and increasingly dangerous system. This has to be addressed.

(ii.) Psychiatric nurse training was effectively abolished with the shift to university-based qualifications. This has to be fixed - possibly by introducing a part-apprenticeship, part academic system of training, where the apprenticeship portion is paid; and services are enabled to recruit according to their needs. Postgraduate qualifications need to be appropriately remunerated.

(iii.) Because of severe bed and other shortages, psychiatric nursing is currently an unacceptably dangerous occupation, and the staffing shortage has been compounded by the number of nurses off on extended leave following physical and/or psychological injury. Injuries at the current rate are completely unacceptable and have to stop. It would be worth asking for NSW Health records and reports on this issue. NAPP understands that CSAHS was recently fined $177,000 by WorkCover for breaches of OH&S at Rozelle, where a nurse was seriously injured; and there was a large payout a year or so ago in a claim by a nurse in WSAHS who was nearly killed by a patient in circumstances deemed negligent by the court.

(iv.) There is an enormous and costly problem looming in the NGO sector, where staff are commonly left on duty alone with a number of potentially dangerous clients. NAPP is aware of a number of court actions over this, and it is likely that they will soon be forced to have at least two staff on duty at all times - which obviously would double their costs.

Changes in the Medicare Schedule 1996

It has become increasingly difficult for community or hospital staff to refer patients to private psychiatrists since the restrictions on funding for long term intensive therapies. Not all patients are suitable for treatment in private practice. Many need multimodal services eg those provided by social workers, many are unreliable attendees and unattended sessions are wasteful when private resources are stretched, but some want and need an opportunity to work through their problems, understand their anxieties and conflicts. This treatment is cost effective in preventing readmission, enabling patients to resume studies and work, and prevents enormous disruption in families.

Quality Control and Recommendations

The basis of quality control is collection of data that can easily and effectively be used as outcome measures. But to be effective it has to be transparent. There is no point even trying if managers are able to continue hiding unpleasant facts. There has been a double standard that contributes to this - the implication that because mortality in patients with mental illness is so commonly caused by their own actions, that it somehow is unavoidable and therefore doesn't count; and the bureaucratic economic rationalism that seems to feel that death, particularly occurring early in a long and expensive illness like schizophrenia, is a desirable outcome.

But if we accept that people with mental illness are human beings; entitled to the best medical treatment available at the time, and not to be negligently allowed or encouraged to die; then measuring outcomes is easy. Death is a crude indicator; one we would prefer not to happen; but there is no argument about it. In other potentially fatal conditions - childbirth, for example - careful monitoring of the death rate, nationally and internationally, tells us when things are starting to go wrong.

Psychiatric Deaths Committee

NAPP believes that a Psychiatric Deaths Committee is required, analogous to the maternal deaths, and child deaths committees is required. The Committee would have to be chaired by someone with a known record of independence; contain experts independent of NSW Health, perhaps some being from interstate; should contain non-captive consumer representation; public health and other academic medical input; and perhaps some legal representation. It should report directly to Parliament, to avoid secrecy and interference as far as possible.

Its brief would be:

Suicide

- To monitor the client death reports already collected by the Centre for Mental Health, ensuring that these are regularly counted, and that ALL unexpected deaths are included - to look closely at a random selection (the numbers currently being far too great to look at them all, in contrast to maternal deaths, for example) to ascertain what could have been done differently to avoid that fatal outcome.

- It is vitally important to avoid a 'blame culture', adopting instead the aviation industry's highly regarded process of looking for mistakes, not to apportion blame, but to work out systemic ways of avoiding them in future. Examining samples of 'near miss' attempted suicides would also be instructive.

- To closely monitor trends, with a view to ensuring that the suicide and related death rate, which currently seems to be several times that of 13 years ago, and probably still rising, starts to steadily - and we hope rapidly - reverse down.

Homicide

- To monitor deaths from homicide, where either victim or offender is mentally ill. These statistics are not collected systematically at present, but could quite easily be included in the client death reports (where victims presumably would be picked up already). Patients known to mental health services who are charged with homicide would be no problem to add to the system; and liaison with the prison medical services could readily pick up the rest (those not known to mental health services before the offence.)

- To adopt the same 'no-blame' approach to assessing the whole group, (current numbers being probably a tenth of suicides, or less), with the same purpose.

- To monitor trends, again hopefully down.

The issue of homicide, and that of violence in general by people with mental illness, is a delicate one, in that it could at least in theory reinforce the stereotype of all people with mental illness being murderers. There has been a big effort by various bodies to reduce that perception, and stigma generally, over the past ten years.

However, this unfortunately has coincided with generalised cuts in services that have made dangerous and violent behaviour much more likely. In reality, although the great majority of people with a mental illness are never violent, and most of those who are will be a danger to themselves rather than others, severe mental illness IF UNTREATED is associated with a substantially increased risk of violence. This has probably increased further over the last 15-20 years as substance abuse in this group has become more frequent. If adequate and timely treatment is available, most of this risk disappears; but that is NOT the case at present.

It does people with mental illness, and the community in general, no favours to ignore this issue. The community needs to understand that lack of services not only commonly kills the patient, but also - albeit much less commonly - kills those around them: family, friends, fellow patients, and people who just happen to be in the wrong place at the wrong time. The patient who then ends up with a long gaol sentence for a crime that would not have happened if they had been able to get appropriate help, also obviously loses heavily in this unnecessary tragedy.

Mental Health Services Occupational Health And Safety Committee

This committee would have a similar brief to the Psychiatric Deaths Committee, but monitoring assaults and other violence to staff; physical and psychological sequelae, in terms of stress and other sick leave; Workers' Compensation claims; civil and industrial legal actions by injured staff; and injured staff being unable to return to any kind of work, or having to leave to work in an unrelated occupation.

Such data would mostly already be collected, one way or another, but probably in many different places, and with each separate AHS. It needs to be centralised, as does the committee. (Having AHS committees would not only multiply the work and

expense, but may leave committees susceptible to pressure from their AHS management.)

This committee should also report directly to Parliament, at least until the situation has greatly improved. Members should include union representatives, and independent medical, public health, legal, and industrial representation. Again, the intention would be to produce a downward trend, from 'no-blame' systemic precautions.

Consumer Satisfaction Surveys

If properly done, these would be a most useful adjunct to the committees recommended above. They would have to be done independently, by for example a university research department. Areas to be surveyed should be randomly allocated, probably on an annual basis; and should survey patients, their families and other carers, and professionals outside the system. The survey process, questionnaires, and (de-identified) results should be freely and publicly available. Again it would probably be necessary for the body doing the research to report directly to Parliament, to avoid the Minister of the day suppressing information, temporarily or permanently, for political reasons.

It should be noted that all the above measures are relatively inexpensive and easily implemented, and can be done immediately.

More Difficult, Important Issues

This inquiry should also look at the more long-term, difficult issues, which are crucially important, but more difficult and costly to implement. There is an obvious need to at least double the number of available psychiatric beds and community services in NSW. Apart from the cost, this could be easily done - or could it? Where has all the other mental health money gone over the last 13 years? Where has the recent injection of $150 million disappeared to? NAPP believes that the short answer is that the AHSs have subsumed it - a crucial issue for the Committee to address.

Questions to be answered:

1. Should NSW return to centralised funding for mental health services?

2. In addressing that instance of fragmentation, should at least some of a number of other services, notably alcohol and other drug services, and services for people with a developmental disability, also be reintegrated with mental health, and all again funded centrally? In an age when patients in general want to be treated holistically, is it reasonable to fragment the treatment of the groups least likely to be able to cope? Patients with mental illness, plus two or three other diagnoses, are never going to benefit from becoming the unwilling victim in games of 'pass the patient'. If services are not going to be reintegrated, it will be necessary to ensure that a service that refuses a patient with, say schizophrenia plus alcohol abuse, on the grounds

that the other issue is paramount, then has to take responsibility for obtaining the appropriate service for them.

3. If AHSs retain their present functions and funding, is it reasonable that patients should continue to be further fragmented by rigid catchment area restrictions, even when that is against their wishes, convenience, and where they happen to be when urgently needing a service?

4. If AHSs retain mental health, an issue that must be addressed is that currently all pressures on AHS CEOs are in the direction of their presenting the appearance of satisfactory performance regardless of substance. It is vital that staff whistleblowers are free to speak out, but this also has to apply to AHS CEOs. While they continue to be expected to do more with less, and are judged a failure if they say they can't, the current problems will inevitably continue.

5. Funding for mental health has to be open to full public scrutiny, whoever gets it, and some current anomalies must be removed. For example, new units at Tweed Heads and Campbelltown which were supposed to be open and functioning for six months of this financial year, and were funded for that, have not yet opened - fully or at all. Do the AHSs get to keep that money?

6. The incentives to 'realise assets' (ie sell hospital and other land) have to be removed if we are ever to have any hope of rational mental health services planning. A moratorium on any land sale would be a good start. The Callan Park Trust Bill - and the equivalent for other important heritage sites - should be passed as soon as practicable.

7. Health services planning in general has always tended to be done backwards, ie starting with a political decision, then finding figures to suit. It would be quite possible, particularly now the Mental Health Unit has produced its own planning instrument, to insist that this is used for mental health services. It would be a bare minimum; and would have to be adjusted to include regional and statewide services not currently covered (eg alcohol and other drugs, forensic and secure); but again would be a good start.

8. Currently we have much the same problem with mental health services as we have with modern warfare, in that those making the decisions to cut services are not directly confronted with the human tragedies that result. If AHS retain mental health, perhaps a panel interview between the AHS CEO and the bereaved family members within a specified - short - time after each psychiatric death? This may provide a direct incentive to reduce the extra workload by reducing the number of deaths.

Forensic Psychiatric Services - Introduction

This section is divided into two parts, each of which provides insights by specialists in the field who felt compelled to speak out under the auspices of NAPP. As mentioned in the Introduction, forensic services are in need of special and urgent attention and the particular problems highlighted here must be seen as part of overall service provision.

Many patients who offend end up in Correctional Services for want of better facilities, a situation which effectively fosters the imprisonment (*rather than treatment*) of the mentally ill in NSW with little by way of internationally recognised standards of care thereafter.

NAPP respectfully asks that the Select Inquiry understand that these two sections have deliberately not been conflated, but rather have been left separate to convey the strength of conviction based on experience behind the sentiments expressed.

Forensic Psychiatric Services – Section 1

The Scale of the Problem

- Because of the run-down and neglected condition of mental health services in NSW, a person suffering from an acute episode of mental illness may be more likely to be arrested than to be admitted into hospital for treatment.
- There were approximately 7750 prisoners in NSW in May 2001[5]; prisoner numbers in NSW have more than doubled over the past twenty years, from around 3,500 in the early 1980s, to the present figure of almost 8000.
- A survey carried out between January and May 2001[6] (incomplete at time of writing) suggested that there may be as many as 12% of NSW prison inmates with a psychotic illness.
- There are 90 psychiatric hospital beds in the NSW prison system, all at Long Bay. All beds are usually occupied as follows:
    - ‘A’ ward: 30 patients; all ‘Forensic’ prisoners under the NSW Mental Health Act
    - ‘C’ & ‘D’ wards: 60 beds:
        - 47 ‘Forensic’ patients
        - 13 other mentally ill prisoners
- There is a waiting list of 15-20 (sometimes more) mentally ill prisoners who are held in gaol, some in so-called ‘safe’ cells, awaiting a bed in the psychiatric hospital, sometimes for several days or weeks. Some are waiting so long they actually recover under treatment in spite of these substandard conditions.
- There are about 900 remand prisoners in Silverwater Reception and Remand Centre (MRRC) with more than 200 prisoners moving in and out each week, sometimes as many as 50 movements per day to and from the Courts and police cells.
- There are so many mentally ill prisoners in Silverwater that:
    - Psychiatric clinics are held six days per week utilising four consultant psychiatrists and a psychiatry registrar;
    - In spite of this service, there is a waiting list, sometimes almost 30 patients long, to see a psychiatrist;
    - The level of psychiatric disturbance amongst prisoners is such that at any one time, in Silverwater, as many as 20 mentally disturbed prisoners at any one time are held in so-called ‘safe cells’: isolation cells which are unheated unfurnished and in which patients may be inadequately clothed, in an attempt to prevent suicide attempts or self-inflicted injury. Such management techniques are never used in community psychiatric hospitals and probably represent a breach of the currently accepted standards of psychiatric treatment in developed countries.
- The recently proposed amendments to the New South Wales Bail Act will aggravate this situation even further. Because of illness or just poor

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[5] NSW Department of Corrective Services data supplied May, 2001.

[6] Informal Results, Personal Communication, May 2001.

organisation skills, mentally ill defendants are more likely to miss appointments at court and hence automatically lose the presumption of bail, *making gaol rather than proper treatment*, even more likely.

Analysis

Unethical Treatment

The current situation in relation to the treatment of the mentally ill in prisons in NSW is unethical. Since biblical times[7] it has been universally accepted amongst civilised communities that the mentally ill cannot be held morally responsible for crime and must be given treatment, not punished or imprisoned. This view is evident upon examination of a range of such legal codes such as the Talmud, the Hammurabi Code, Roman Law, Anglo-Norman Law, the Napoleonic Code and English Common Law.

Breach Of Accepted International Conventions

The failure to move mentally ill prisoners out of prison in NSW flouts international conventions and international law.

The United Nations Standard Minimal Rules for the Treatment of Prisoners adopted by the First United Nations Congress on the Prevention of Crime and the treatment of Offenders, held in Geneva in 1955 states:

- 82.(1) Persons who are found insane shall not be detained in prisons and arrangements should be made to move them to mental institutions as soon as possible.
- 82.(2) Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management
- 82.(3) During their stay in prison, such prisoners shall be placed under the special supervision of a medical officer.
- 82.(4)The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment
- 83. It is desirable that steps should be taken by arrangement with the appropriate agencies, to ensure if necessary the continuation of psychiatric treatment after release and the provision of social-psychiatric after-care.

United Nations Resolution 46/119, 17th December 1991 "The protection of persons with mental illness and the improvement of mental health care" states:

- All persons have the right to the best available mental health care which shall be part of the health and social care system.
- Every person shall have the right to be treated in the least restrictive environment.
- …persons serving sentences of imprisonment…should receive the best possible mental health care as provided in Principle 1.

[7] viz: Talmudic Law, Roman Law, British Norman Law, British Common Law, Australian Common Law, NSW Common and Statute Law.

Breaches Of Nationally And Internationally Accepted Standards For The Treatment Of The Mentally Ill

Mentally ill prisoners in the United Kingdom, Canada, New Zealand, Queensland, Victoria, South Australia, Western Australia and many other jurisdictions in developed countries are moved out of prison to a secure hospital as soon as practicable after they are identified[8].

The UK Royal College of Psychiatrists has recently condemned the use of 'safe cells' ("seclusion" and "stripped cells"):

> *"The use of seclusion and stripped cells for the management of suicidal prioress should be stopped".*[9]

In the same statement, the UK College also stated:

> *"Prisoners should have access to an equivalent level of health care as those outside of prison."*

In Breach Of The Recommendations Of The Burdekin Report

The Report of the National Enquiry into the Human Rights of People with Mental Illness, 1993 (*The Burdekin Report*) stated (p941):

- Mentally ill people in the community justice system must be provided with appropriate treatment
- Seriously mentally ill prisoners should generally be treated in health care facilities controlled and operated by the public health authorities
- Individuals in custody are appropriately assessed for mental illness or disorder
- Seriously mentally ill prisoners should be admitted to psychiatric wards in general hospitals or acute care wards in psychiatric hospitals [unless they] cannot be safely treated [in such facilities]
- Mentally ill prisoners who remain in gaol must have access to adequate treatment by mental health professionals
- Anyone ordered to be detained in custody after being found unfit….or not guilty on the grounds of mental illness should be detained in a health facility not a prison

Illegalities In New South Wales

S.32 of the NSW Mental Health (Criminal Procedure) Act provides for the magistrate to dismiss charges and direct towards treatment:

> *"If, …at any time during the course of the hearing, it appears to the magistrate that the defendant is developmentally disabled, is suffering from a mental illness or…a mental condition…"*

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[8] Dr Rosemary Wool, Secretary General, International Council of Prison Medical Services, former Director of Health Care of the Prison Services of England & Wales.

[9] Gunn, J Royal College of Psychiatrists, Annual Meeting, 9-13 July 2001.

S.33 of the same Act gives the magistrate similar duties for the most severely mentally ill who need urgent acute treatment.

S.35 of the same Act gives the Chief Health Officer the authority to transfer remand prisoners with a mental illness from a prison to a community (psychiatric) hospital after examination by a psychiatrist, under order of a magistrate.

Sections 97 & 98 of the NSW Mental Health Act (MHA) similarly provide for the transfer of mentally ill, sentenced prisoners to public psychiatric hospital wards.

In the general community, involuntary treatment of the mentally ill can take place under appropriate safeguards and care under the provisions of the MHA. The provisions of the NSW MHA do not extend to NSW gaols.

The consequence is that access to appropriate involuntary treatment is denied to mentally ill prisoners in NSW. 'One-off' episodes of involuntary treatment are available *in extremis* with the direct approval of the Corrections Health Service (CHS) CEO under the Correctional Centres Act. In practice, most mentally ill who need involuntary medication require several doses. This is impractical under the Correctional Centres Act. Thus mentally ill inmates are denied the standard of care available outside gaol, in breach of the standards referred to above (*The United Nations High Commissioner for Human Rights Standard Minimal Rules for the Treatment of Prisoners; The Report of the National Enquiry into the Human Rights of People with Mental Illness, 1993 (The Burdekin Report)*).

The failure to transfer mentally ill inmates to hospital for treatment, instead attempting to treat them in prison, represents a clear failure to follow the expressed intention of Parliament in drafting the NSW Mental Health Act, which states (Chapter 2, S4 2(a)):

> *"persons who are mentally ill or who are mentally disordered [should] receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given"*

and S4 2(b):

> *"in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances"*

Inadequate Standards Of Treatment Of Mentally Ill Prisoners

The rate of reception of inmates, particularly in the MRRC at Silverwater (up to 50 inmates per day, 200 per week) is extremely high. This workload means that, although inmates are screened for mental and physical illness on arrival and many mentally ill are identified, there is often no opportunity for mental health staff to assess and commence treatment before the inmate is moved.

Some inmates may be given bail and hence be free to seek or continue treatment in the community mental health system however, for this group, staff are often unable to find the opportunity to liaise with community health services before the inmate is moved. Staff may not be aware of the inmates' destination.

Other inmates may be moved to other gaols where re-engagement in mental health treatment will have to take place.

These factors raise the concern that the standards of mental health treatment for mentally ill inmates fall well below the minimum acceptable in the general community. If this were to be the case, such a situation would represent a failure to meet the standards set in:

- the United Nations High Commissioner for Human Rights' Standard Minimal Rules for the Treatment of Prisoners,
- the Report of the National Enquiry into the Human Rights of People with Mental Illness, 1993 (*The Burdekin Report*),
- S(4)(2) of the NSW Mental Health Act
- *and* standards generally prevailing for the treatment of mentally ill offenders in States such as South Australia, Victoria and Queensland and countries such as the UK, Canada and New Zealand.

Summary

The prevailing standard of mental health care available to mentally ill prisoners in NSW lies well beneath acceptable community standards. This level of care breaches a number of international standards and conventions, appears to flout the expressed intentions of the NSW Parliament as stated in the NSW Mental Health Act and represents, in NAPP's view, a discriminatory and possibly negligent standard of mental health care. Attention is drawn to these concerns in the hope that this will assist in remedial action being taken.

Some possible remedies have been suggested below.

Recommendations

Identification And Diversion Of Mentally Ill Defendants From Court

Mentally ill prisoners need to be identified before coming to gaol wherever possible. Court psychiatric services have been established in most developed countries including Australian States (except NSW), UK, Canada and New Zealand. Research has demonstrated such services to be effective in identifying mentally ill defendants and safely diverting them to community mental health facilities. Such services are effective in decreasing the number of mentally ill prisoners, finding and returning to

treatment individuals with whom the community health services have lost contact and decreasing the crime rate[10,11].

Court psychiatric services have been established on a pilot basis at a few locations and under a variety of different arrangements in a small number of centres in NSW. Court psychiatric services need to be established throughout NSW, under a single, state-wide Forensic Psychiatric Service, independent from the correctional system and the CHS, to assist the courts, to divert mentally ill remandees from prison back to their local Area Health Service (AHS).

Adequate Mental Health Treatment Facilities For Prisoners

The Department of Corrective Services is able to identify many mentally ill on their reception into gaol through their reception screening process but Corrections Health Service (CHS), the identified treating agency, has inadequate resources to treat these individuals.

There are at least three *clearly identifiable and serious deficiencies* in prison mental health service provision:

a. Prison mental health services are inadequately funded for the demand placed upon them. Prison numbers have increased from 3000 in the late 1980s to almost 8000 in July 2001 – an almost threefold increase. Interim results from the recent (and currently unfinished) prison mental illness prevalence survey revealed a point prevalence of:

Psychotic illness	11%
Depression	21%

   in prisoners, yet the CHS does not appear to have been allocated anywhere near the mental health resources needed to treat this level of psychiatric morbidity.

   Prison mental health services should be funded at a level sufficient to treat the measured level of morbidity within the population for which it is responsible.

b. With a population of 6.5 million, current practice would suggest that NSW needs a total forensic psychiatric inpatient capacity of approximately 350 beds, spread across the State. The acute and subacute psychiatric wards in Long Bay Hospital are gridlocked with forensic patients who should have been moved to forensic facilities outside prison.

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[10] James, ED et al, Outcome of Psychiatric Admission through the courts, Research Development & Statistics Directorate, Crime & Criminal Justice Unit, Home Office, UK, RDS Occasional Paper No 79, March 2002.

[11] Carne JM, Central Local Court Psychiatric Service, Results of the First Year of Operating: March 2000-Febraury 2001, Unpublished, July 2001

c. Heralded changes to the NSW Bail Act will only make matters worse. Mentally-ill offenders are likely to figure prominently amongst those denied the presumption of bail

Secure Psychiatric Hospitals (Community Forensic Hospitals)

A commitment has been made by NSW Health to a 105 bed forensic hospital. This capacity would need to be an addition to, not a replacement for, the current forensic facilities in Morrisset, Cumberland, Rozelle, Goulbourn and Long Bay if it is to make an impact upon this problem. It will take four to five years (at least) to have this facility up and running.

Alternatives, probably including the temporary re-use of unused facilities, are needed in the interim and arrangements should be made for site surveys to be undertaken to provide an inventory of potential locations for interim, forensic, medium - high security psychiatric wards to take the pressure off the Long Bay facility. Long Bay Hospital should be functioning (and was established to perform this) as an acute assessment unit for inmates suspected to be suffering from a mental illness. After diagnosis, mentally ill inmates should be transferred out of prison under S 35 of the MH(CP) Act or Ss 97 & 98 of the MH Act. In fact, patients are rarely transferred because of a shortage of community and forensic psychiatric beds.

Adequate Funding Of Community Mental Health Services

A major reason for the high numbers of mentally ill prisoners in NSW is the failure of AHS' to fund their mental health services even adequately. There are serious shortages and inadequacies in:

- The numbers of staff in community mental health centres
- The numbers of acute inpatient psychiatric beds. Inpatients are often discharged before recovery to make way for new patients, hence creating a 'revolving door' phenomenon. The new patients are often the recently discharged and incompletely treated.
- The numbers of long-term psychiatric rehabilitation beds for mentally ill individuals who cannot cope with independent or group living in the community.
- Drug and alcohol treatment and rehabilitation facilities for individuals with
    - drug and alcohol problems alone
    - mental illness compounded by D & A problems and which probably numbers up to a half of all individuals with serious mental illnesses

NSW Health must, as a matter of urgency, fund and build:

- A number, probably at least 120, of gazetted acute psychiatric inpatient hospital beds, around NSW according to the needs of local populations.
- Long-term psychiatric inpatient rehabilitation beds
- Adequate capacity of drug and alcohol treatment and rehabilitation facilities.

Such facilities would:

- relieve the pressure on the Long Bay facilities by properly treating mentally ill people in their homes or in hospital, markedly diminish the numbers of mentally ill becoming homeless, breaking the law and entering prison.
- take patients from Long Bay Hospital as forensic transferees under S 35 of the MH(CP)Act or Ss 97 &98 of the MH Act. This may require the imaginative temporary re-use of currently unused facilities. The site survey referred to above would assist in identifying these.
- unblock the Long Bay bed gridlock which, in turn would allow the movement of mentally ill prisoners from safe cells in Silverwater MRRC and elsewhere to more appropriate facilities in Long Bay prior to transfer out under S35 or Ss97 & 98
- relieve the pressure on the psychiatric staff of the CHS and enable them to do their proper job of identifying and assessing mentally ill prisoners prior to transfer to hospital or to the community as appropriate.

Statewide Management And Planning Of Psychiatric Services

The current perception is that AHS' do not act as if they have registered the importance of these issues. If they cannot identify a problem on their patch, eg, because the patient has been arrested or because they have instructed staff not to treat a certain category of patient, such as the violent mentally ill person, they ignore it.

A Properly Funded And Staffed NSW State Forensic Psychiatric Service

A NSW State Forensic Psychiatric Service, run from a centralised directorate at NSW Health (as Paediatric, Ambulance and Forensic Medicine) and planning and managing a State Forensic Psychiatric Service consisting of:

- Community Forensic Psychiatric Services
- Secure community (Forensic) Psychiatric hospitals
- Court Psychiatric Diversion Services

Training of community mental health and psychiatric hospital staff in the relevant forensic psychiatric issues is also needed. There is an additional stigma suffered by mentally ill individuals with a criminal record as a result of untreated mental illness; community staff often fear this category of patient, viewing them, usually mistakenly, as presenting a threat to the staff who treat them. This view has been effectively discredited by the recent research in the UK.[12]

[12] James, ED et al; op. cit.

Conclusion

The prevailing standard of mental health care available to mentally ill prisoners in NSW lies well below acceptable community standards. This level of care breaches a number of international standards and conventions, flouts the expressed intentions of the NSW Parliament as stated in the NSW Mental Health Act and represents, in NAPP's view, a discriminatory and possibly negligent standard of mental health care.

Inadequate community mental health services (inpatient psychiatric beds and community mental health services) lead to the unnecessary criminalisation and imprisonment of the mentally ill. Yet facilities for the treatment of mentally ill prisoners are woefully inadequate; leading to standards of care amounting to, in NAPP's view, negligence within NSW prisons.

Attention has been drawn to these concerns in the hope that this will assist in remedial action being taken.

Forensic Psychiatric Services – Section 2

Introduction

NAPP members feel that we have a duty to alert this inquiry to the serious plight of the mentally ill in NSW in both the Forensic area and in the general community. All of us have had extensive experience both locally and some overseas.

We would like to deal with the problems that have arisen since the Richmond Report regarding Forensic Mental Health Services, General Mental Health and other areas of concern.

Our members have expressed the frustration and sense of abandonment that we and our patients have felt by the Authorities as the conditions for treatment of the mentally ill have steadily worsened over the years.

Nurses

As it was with the Royal Commission into Deep Sleep and other inquiries, so it is for those giving evidence in this inquiry - nurses run a serious risk of loosing their job or of being ostracised in many subtle ways if they give evidence. Some of us have enquired of nurses about their opinions and they will express significant opinions privately but unless they are about to retire will not speak out.

In the Forensic and General mental health service they have been in an intolerable position struggling to look after their patients in the best tradition of nursing. They watched patients who they knew were dangerous go back into the community and return completely psychotic, on drugs or found out later they had killed or assaulted and had been arrested by the police. Very often no one had asked them their opinion or even had time to discuss the outcome. They often felt there had been inadequate discharge planning and saw administrative decisions made that they knew were untenable and likely to lead to suicide, homicide or worsening of the patient mental state.

The sad thing for them was that these very inappropriate decisions had sometimes been made by administrative staff with nursing background who had put the economic rationalist philosophy above their nursing ethics. In some cases the decisions could only have led to high risk of death and morbidity. (See Pod 16 below).

Suggestions

It should be possibly for those who are in some way threatened to give evidence to this inquiry confidentially "In Camera".

Forensic Mental Health Services

Introduction

There seems to be wide acceptance amongst forensic psychiatrists that NSW is about 25 years behind other states and countries except Tasmania, which is also seen as problematic.

An opportunity was missed when Prof P Mullins decided he could work in a prison-based system and went from NZ to Victoria and established Forensicare. It is not for lack of advice, as we have had the "father of forensic psychiatry", Prof Bluglas write a report for the NSW Government, as well as the Barclay Report and others.

Another rare chance of developing a rational and experienced forensic mental health team for NSW was missed when Prof Carolyn Quadrio was not supported in her demanding job and resigned. As a result there have been a stream of resignations and general withdrawal from active participation by highly qualified forensic psychiatrists.

There has been an arguably all pervading influence by Corrections to maintain control of the Correction Health Services. Although the Corrections Health Service is funded by the Health Department and answerable to Director of Mental Health, the real control is in Corrections who control which prisoners are seen, when they are seen, what psychological treatment is given and exercise many other subtle controls as well.

NAPP has heard it said that if beds were produced they would be filled and that the best thing is not to produce the beds and have the staff simply "manage" the patients in the community. It is this seemingly simplistic philosophy that we feel guides planning.

Suggestions

That the inquiry look at what has motivated the possible negligence which has caused this lack of effective forward planning resulting in the NSW being 25 years behind the comparable jurisdictions.

Pod 16

An example of the ill-informed, and damaging attitudes arguably affecting the Corrections administration was seen in **Pod 16**. In this situation, nursing trained administrators decided to put 40 prisoners with serious mental illness into a prison wing at the MRRC section of Silverwater complex. This was called "Pod 16" which then changed name to an "assessment centre", and then again to "an accommodation wing". Prof Quadrio agreed that this arrangement may be better than having prisoners spread all over the prison causing difficulties in getting mentally ill prisoners to the clinic for assessment and treatment (there are often long gaps in seeing patients in prisons due to their incarceration for various reasons by Corrections).

However, it was soon realised that there would *only* be Corrections Officers looking after them and that they would be locked up for 16 hours at night with no supervision

at all. All psychiatrists objected and most refused to go back to Silverwater prison because to do so would be seen to be co-operating with a highly dangerous move. The Forensic Registrar was not allowed to resume work at the MRRC complex for safety reasons and to avoid any appearance of accepting the arrangements in this complex. Pod 16 (Assessment Unit) was not to be changed in the eyes of Corrections administration despite strongly worded objections and vigorous complaints. No explanation was offered for this seemingly rigid stance.

As further evidence of the decline that is consequent to such policies, we note that :

- Dr Rosen has been commissioned to do a report for CHS but this has not been released.

- Dr Boettcher discussed matters with highly respected UK Forensic Psychiatrist, Dr Martin Donovan, who agreed there would be suicides and that Pod 16 is *inhumane*.

- Dr Carne resigned from his position as Director of Forensic Mental Health in the Western Region because of Pod 16, as has Dr Ahmed, a most experienced psychiatrist.

- Prof Quadrio resigned because of a perceived lack of support. Her position of Director of CHS has been taken by a nurse, as has that of Dr Carne.

Suggestions

That Forensic Psychiatrists have a greater influence into the management decisions and are seriously listened to. NSW is blessed with a reasonable pool of very high quality and experienced psychiatrists most of whom have been forced to work full time in the private sector. They would be prepared to work part time in the public sector if it was operating in a professional and safe manner which respected their expertise

There has been a seemingly deliberate attempt to get rid of psychiatrists out of administrative positions. Is there any rationale for this?

The position of Professor of Forensic Psychiatric should be properly established. (See Prof Robert Bluglass's report page 30 No 8). The report by Dr Rosen into Silverwater Assessment Unit should be read by the inquiry.

Media and Political Involvement

The press attended an RANZCP Forensic Branch conference held in Sydney and were briefed about the situation. There were a series of articles in the Sydney Morning Herald (2001) and an editorial (3 September, 3 October, letter 5 October). Soon thereafter, on about 4th October Dr Boettcher and Dr Giufredda attended a meeting about the staffing of the assessment units in the male and female prisons at Silverwater and the meeting was asked, "How many staff do you need in the unit".

These two psychiatrists told them that their opinion had not changed and that the staffing should be the same as in Victorian prison assessment unit (2.5 prisoner/ mental health worker) - the meeting then agreed that this would be their target.

It is noteworthy that authorities had until this time *refused to even discuss* the number or type of staff.

It would appear that the administration has little idea of the seriousness of a psychotic state and so it became a source of amazement and concern that they would be prepared to sanction management by Corrections Officers which included being locked up 16 hours a day.

Patients in this state need constant attention and observation to treat, supervise and prevent suicide and homicide and only mental health trained nurses are capable of carrying this out.

Suggestions

Inexperienced administrators arguably have no place running Forensic Mental Health facilities - this discourages many forensic psychiatrists from being involved with public mental health. The practice should be stopped immediately. This discouragement comes in various guises but seems to be the result of the narrow view of service provision *only,* with little encouragement for academic achievement. The involvement of media and politicians came only after years of attempts to improve the attitude in Corrections.

NAPP urges this committee to make certain that their findings do not just gather dust the way previous enquiries have. (See Prof Robert Bluglass's report page 30 No 9)

Court Liaison

Court liaison services are being established in most States of Australia but in NSW there is only one in central Sydney and in Newcastle operating satisfactorily.

After much persuasion from Prof Quadrio, Dr Carne and others it has been suggested that another 5 court liaison services be established as part of the diversion program around Sydney. The successful Drug Court should be expanded to other areas of NSW and perhaps within the court system greater use made if it. (See Prof Robert Bluglass's report page 30 No 7).

However, the composition of the Steering Committee is significantly lacking in not having any Sydney psychiatrist as part of its team. There is one South African psychiatrist who has been appointed as Director of Court Liaison in NSW. This is despite the availability of a number of suitable Sydney based psychiatrists.

Suggestions

That the 5 Court Liaison services be established as quickly as possible and that staff are carefully selected on merit and not political affiliations or other reasons and that they are given a 6 months initial contract. NAPP is given to understand that Prof Greenberg from Perth is to be the new Director of Court Liaison but he has had no apparent influence of selection of suitable staff. It was the poor selection of staff that caused the downfall of Parramatta Court Liaison Service. There has been no effort to involve psychiatrists who, after all, have to supervise the Court Liaison Staff. (See Prof Robert Bluglass's report page 30 No 7)

Long Bay Prisons Complex

The Forensic Hospital costs $18 million to run with $8 million being the cost of the Corrections component. It would be more cost effective if the Correction were removed and the hospital was run the way other countries and States of Australia run their Forensic Hospitals.

Prof Bluglas realised for the first time*, about 25 years ago*, that to treat mentally ill prisoners they had to be *removed* from the prison environment. He orchestrated the building of Reaside Clinic next to the prison in Birmingham in UK and was the first to organise this experiment. It was highly successful and it has been rebuilt away from the prisons complex now in another part of Birmingham.

Surely we can learn from this and build the planned new Forensic Hospital for Sydney away from the prison complexes *and not as planned* next to the Long Bay prison complex. There is a site in Parramatta in the present Cumberland Hospital in North Parramatta where it could be built as part of a medical complex with Westmead Hospital. One potential disadvantage is that some developers have planned a residential development there.

Currently, the running of forensic mental health is mainly done from the Long Bay Prison Hospital, which is old, dangerous and under funded for such things as secretarial assistance, and other basic facilities. Corrections officers control the physical environment and CHS staff have to fit in with all the rules and regulations of Corrections, which do not relate to Health. The current Hospital is quite unattractive for nursing and medical staff to work in - the inquiry should note that there is a worldwide shortage of these staff.

Suggestions

The new Forensic Hospital should be built away from Long Bay and near the source of nurses, which are the southern and western suburbs of Sydney. It also needs to be near transport routes to court facilities and prisons. It must continue to be independent of Corrections Service.

To staff it with nurses and doctors it is essential to *change the name and ethos* of CHS to "Forensic Mental Health Service". (See Prof Robert Bluglass's report page 30 and 31, No 1, 2, 3, 4 and importantly, 11).

Silverwater Prisons Complex

This has a number of prisons in it. The problem is that there are few psychiatrists willing to work in such a depressing environment. The MRRC section has been built along US prisons lines and is very oppressive. Prisoners are assessed by nursing staff and psychologists as to whether they have mental illness and referred to mental health clinics if thought to need psychiatrist assessment. There is a high throughput and the assessments are all done under pressure. Part of the problem is that the mentally ill prisoners are spread around the prison and hard to locate when mental health workers want to see them.

Seclusion is freely used and the conditions are *brutal* especially in winter as there is no heating in the cells. Prisoners are often *naked* and they react to the barbarism by becoming *more disturbed*. Because of the shortage of nurses and doctors there is a constant feeling of crisis and these staff can become quite distressed. The main problem is the high numbers of prisoners needing attention. It was in these chaotic circumstances that the idea of warehousing the mentally ill in one wing was born.

Suggestions

NAPP makes no suggestions about Corrections Services. However, it does underline the *absolute need* to separate the mentally ill from prisons and to follow Queensland's example.

Rural Prisons

The staff in Rural Prisons seem to be more humane and we would include Parramatta Prison in this statement. Rural Prisons are however isolated from psychiatric expertise and in Bathurst Prison for example there is only one mental Health Nurse employed part time for a very large number of prisoners. He is hard pressed to carry out his job with the skill he possesses but he does an excellent job under the circumstances.

An example of the lack of frequency of services can be seen in how Dr Boettcher visited Bathurst Prison one day *a month* and earlier in the year had a registrar visiting once a month also to ensure that there was one visit every *two weeks*. Video-conferencing is used in Bathurst prison but it cannot replace a visit and live assessment. However in an emergency it is worth having this facility available although there has been *concern about the legal status* of such an assessment.

Suggestions

One part time mental health nurse is inadequate to carry out the duty of care for the 30-40% of mentally ill patients overall present in the prisons population. There are studies that have been carried out, which seem to have been withheld, indicating that 30-40 % is the rate of serious mental illness in this population.

Victoria

The main facility in Victoria is the new Thomas Embling Hospital and we would strongly suggest the inquiry visit this facility and talk to Prof Paul Mullens about the matters they are considering, as he is a world authority.

This hospital has 90 beds and due to go to 120 shortly. The facilities are well staffed and standards of care very high. *There are no corrections staff involved.* There are clinics in the prisons for assessment and one long stay area but it would be better for the inquiry members to see for themselves. In Victoria Prof Mullens has ensured that their Prison services exist with adequate conditions, community Forensic mental health teams exist for follow up, and that there are Court Liaisons Services and adequate teaching.

There is a continuous assessment of the "Forensicare Services" and planning for the future in conjunction with the Government which is a completely different attitude and far more progressive management style than is currently the case in NSW.

Queensland

Extraordinary advances in Queensland in Forensic Mental Health have occurred. They seem to lead the world and great attention should be paid to their progress. Without doubt it is the best way to handle forensic mental health problems *by removing all the 30%* of prisoners who have serious mental illness from the criminal Justice system. In our view, these prisoners are unable to be handled in a fair and reasonable manner in an adversarial system or a prison system run by the Corrections Mental Health Service. A Forensic Mental Health system is needed to manage and treat these prisoners in a decent and humane manner outside the prison system.

Suggestions

Look at and obtain advice from the Queensland system. The Director of Mental Health (Dr Peggy Brown) and the Director of Forensic Mental Health (Dr Bill Kingswell) are very able to give excellent advice. Increase the level of mental health spending to over 7.5% as in Queensland from 2.5% in NSW

United Kingdom

The United Kingdom (UK) was where Forensic Psychiatry really developed and they have a very extensive coverage of this discipline with facilities of varying types right across the country. In recent years the financing of continuing development has been driven by a number of truly horrific killings and other major incidents by psychiatric patients.

We believe that unless NSW pays more attention to the proper development of Forensic Psychiatry facilities history will repeat itself in NSW.

The aim of forensic mental health services is to divert seriously mentally ill before, during, and after the court process. To do this the UK has the full range of interventions and treatment facilities. They also provide a Forensic Psychiatry service to the general psychiatric services. Forensic Psychiatrists are accredited after about a 5 year training programme.

An example is the Reaside Clinic based on a large Regional Secure Unit with 92 beds. It is situated in Birmingham Great Park, Rubery, Birmingham. The Clinic and the Academic Department have a multi-disciplinary emphasis. Full-time academic staff carries out teaching and staff from the clinic teaches on a variety of courses. For example undergraduate teaching has a MbChB Psychiatry Module and a Special Study Module on Psychiatry, Ethics and the Law. Postgraduate course information on the MSc/Postgraduate Diploma in Forensic Mental Health Care can be found on the university of Birmingham website (http://www.bham.ac.uk/psychiatry/mscfmhc.htm).

Research Interests include:

- Mental health legislation.
- Relationship between mental disorder and violence.
- Pathways through medium security.
- Long-term medium secure provision and other service related areas.
- Statutory follow-up of mentally disordered offenders.
- Prison psychiatry.
- Professional knowledge of mental health law.
- Children who kill.

Further information can be obtained from contact Dr M. Humphreys, The University of Birmingham, Department of Forensic Psychiatry, The Reaside Clinic, Birmingham Great Park, Bristol Road South, Rubery, Birmingham B45 9BE.

A paper on Forensic Psychiatry development can be found in the Institute of Australasian Psychiatrist web page on http://www.iap.org.au/boe-qld-psych.pdf

A search of the Internet will produce the many and varied Forensic psychiatry facilities and training available in the UK. We estimate that we are about 25 years behind these developments.

Suggestions

NSW would do well to look at the models of forensic mental health facilities, structure and philosophy set up in UK. We have already had one eminent UK professor do a thorough assessment of facilities etc in NSW and *largely had his findings ignored*. (Prof. Robert Bluglas). See Prof Robert Bluglass's report page 1 Preface.

United States

The USA has a patchy Forensic Mental Health Service. However recently there has been progress with the evolution of the term "Therapeutic Jurisprudence" and the successful use of Drug Courts there.

Medium Secure Units

These units' main aims are rehabilitation and crime prevention by stopping recidivism. One of the problems with Kestrel and Bunya, the two Medium Secure Units in NSW at Morrisett and Cumberland Hospitals respectively, are that they are being used to *warehouse dangerous patients*. This is caused in part by the "log jam" of patients that occurs because of the outmoded legal regulations in moving patients through these programs.

In NAPP's view, there is no need for the Minister of Health and the Governor of NSW to have to review all the changes to a patient's security status. Every time a patient gets an increase in leave they have to go through the very time consuming process of having the Mental Health Review Tribunal (MHRT), the Minister and the Governor agree to the change of status. It is quite ridiculous and merely obstructing the Teams in the medium Secure Units from doing their job. Other states and countries have the review process handled by a body such as the MHRT, or in the case of South Australia the original sentencing court deals with this review.

These facilities have been called the most efficient psychiatric facility in NSW and they should be allowed to do their job unimpeded.

More of these highly efficient and extremely cost effect units should be created. There are hundreds of these units in the UK. Victoria has several that fit into this type of unit inside the Thomas Embling Hospital.

Suggestions

The law should be changed so that an independent and non-political MHRT should be the only reviewing body for Medium Secure Units and more Medium Secure Units should be created.

Forensic Community Services

There is only one Forensic Community Psychiatric nurse in NSW that NAPP is aware of. She works in conjunction with Bunya Medium Secure Unit. It is a disgrace that we have no Forensic Community Psychiatric Teams as do all other states and countries that have Forensic Mental Health Services.

The staff in current Forensic Mental Health, whether in the prison or other facilities, have great difficulty in placing prisoners with serious or not so serious mental illness

into community care. These staff are not trained to handle forensic patients and often the community teams when contacted simply refuse to have anything to do with forensic patients. NSW Corrections simply push such prisoners out their front door often at very inappropriate times, such as Friday evenings with no hint of follow up.

In Queensland any offending (restricted or non restricted) prisoners with mental illness are seen in follow up by the Forensic Mental Health Services, which exist in all areas. (See Prof Robert Bluglass's report page 30 No 6 and 7). These forensic mental health teams in Queensland can refer patients to the normal community teams but will review the teams actions and treatment periodically, perhaps asking to interview the patient themselves.

For the first time ever two Forensic Staff members from Bunya are taking a Forensic patient to a country town in March 2002 to meet the Mental Health Community team who will be looking after him. These staff members are the ONLY Forensic Mental Health Social Worker in NSW and a Forensic Mental Health Psychologist. The fact that this is the first time this has been done is a reflection of the abysmal state of Forensic Mental Health in NSW given that this has been standard practice for at least 25 years in UK.

Suggestion

Establish Forensic Mental Health Teams covering all areas of NSW. These teams will assist in reducing recidivism and are thus *very cost effective*.

Court Liaison Services

Court Liaison Services (CLS) have again been used in NZ, UK for about 15 years or more and in Queensland for about 6-10 years. Again, NSW is very slow in adopting these services. There have been moves in 2001 following prodding by a number of psychiatrists who were in the CHS to get more going. There has been a service in Central Sydney and of course they are most impressive in the way they streamline the diversion of mentally ill people from the court system and identify the mentally ill. Court and police gain relief because the Court Liaison Officer is able to indicate to them not only that the person is mentally ill and needs a full psychiatric assessment but also advise the court of what alternatives there are in the way of treatment facilities etc. Usually the CLS has one nurse and a supervising psychiatrist.

There are finally now moves to establish another 7 services across the Sydney region.

Allied Professions

There is only one Forensic Mental Health Social Worker in NSW working in Bunya Medium Secure Unit. This speaks volumes about the attitude of the administration in Corrections Health Service.

Other members of allied professions are also in very short supply with the possible exception of psychologists many of who run programs inside prisons and who are employed by CHS. Unfortunately, the evidence of effectiveness for some of these programs is difficult to obtain, especially the programs for sexual offenders.

Suggestion

All teams treating mentally ill patients should have the option to have their patients becoming involved with a social worker. There should thus be many more Forensic Mental Health Social Workers recruited and trained. Forensic mental health should be made far more attractive to allied professions than the current dysfunctional organisation currently is.

NAPP is of the opinion that the programs for sexual offenders should be reviewed by psychiatrists who are expert in this area.

Teaching and Training

Most staff of CHS are struggling to manage their own survival in the dangerous environment of CHS with little emphasis given to training. Registrars in Long Bay are so busy that they complain of not having time to adequately participate in training activities and at Silverwater psychiatrists had to struggle to get any co-operation to have times set for nurses to attend even a one-hour training session.

Corrections staff were felt to be so uncooperative that training started at Bunya Medium Secure Unit. However, the administration would not allow them to attend more than once a month. This is typical of the stories that surround any attempt to train staff. Unfortunately, the psychiatrist has since resigned.

Suggestions

It should be clearly indicated that all *staff have the right to have continuing education* and training and time should be put aside for this. The ethos in this regard needs to be greatly improved. One of the problems is that with the denuding of academic positions and psychiatrists there is no real academic emphasis.

Danger of Assaults to Prisoners and Staff

Very few of the prisons give the impression of being safe and assaults are “managed” so that *the true rate of assaults is difficult to ascertain*. In forensic health facilities, such as Bunya, the assault rate is low and risk assessment is an important part of the program. In prisons and in general psychiatric facilities this ethos is lost in the mêlée of pressure of work and under staffing. Most prisons are poorly designed to handle violence.

Dr Boettcher has been assaulted twice in one year. Both times when there was no staff of any kind around.

The first incident was when the staff became distracted by a large scale fight in the indescribably small and poorly designed clinic in the MRRC. The second in Parramatta prison (this was only a verbal assault with threats of death and destruction etc). This occurred in a clinic with a long corridor and offices off this corridor. The Corrections officer was up at the other end and could not hear the noise the prisoner was making. The alarming thing is that *more clinics are being built like this* at Parklea Prison. NAPP understands that the corrections Department had refused to supply more than one corrections officer to these clinics even though there was more than one activity going on in the clinic.

Suggestions

That treatment and management of mentally ill offenders be removed from CHS for the safety of staff and patients who are very disturbed by having been violent. Corrections Services should get independent advice on the safety of the prisons they are building and planning.

UN Directives and Other Inquiries into the Lack of Forensic Mental Health Services in NSW

The Centre for Mental Health seems to place Forensic Mental Health on the bottom of their list of considerations. Until Prof Quadrio emphasised the need for change they were apparently happy to go along 20 years behind the rest of the world and ignore the UN directives and other enquiries mentioned above. What mystifies psychiatrists from other States and overseas *who see our lack of service* in the forensic system is how this state of affairs came to exist. How did we get so far behind?

There are in fact some very experienced forensic psychiatrists in Sydney but they are now excluded from the decision making process. The turning point could have been when Prof Mullens was appointed to Victoria from NZ. He claimed at that time that the main thing that turned him away from NSW was the firmly entrenched lack of will to change.

Other States' psychiatrists have watched with dismay each year at Forensic Conferences as NSW psychiatrists describe the steady decline in Forensic Services compared to other places.

Illicit Drugs

NAPP is informed that illicit drugs are easily available to prisoners in prison and *there are often positive tests* for them. In Bunya this is not a problem and positive drug screens are very rare. It would take a very determined investigation to show why there is such a difference.

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Nine steps that will halt suicide in Australian Defence Force members and ex-ADF members

by Philip Morris AM |
Nine steps that will halt suicide in Australian Defence Force (ADF) members and ex-ADF members

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1. Publish annual suicide and attempted suicide statistics for Australian Defence Force members and suicide statistics for ex-ADF members

Before changes can be made to influence the rate of suicide in serving members of the ADF or ex-serving members of the ADF it is essential to know what the extent of the problem is. Who would consider making interventions to reduce the Australian road toll without knowing what the road toll is and how it is changing? The same applies to suicide in current and ex-ADF personnel. Annual statistics of suicide for ex-ADF personnel and both suicide and attempted suicide (as attempted suicide is a powerful predictor of completed suicide) for current ADF personnel must be made public. The data should be stratified by state and territory, age band, gender, service type (Army, Navy Air force), and deployment history. These data should be readily available for current ADF personnel. The information will be harder to obtain for ex-ADF personnel but all coroners and other officials dealing with suicide should be asked to note if the individual has a service history. Trends in the raw numbers and standardised rates of suicide and attempted suicide in ADF and ex-ADF personnel should be made available over 5 and 10-year periods. This information can then be used to assess the impact of interventions to reduce suicide in these populations. I am aware that the Australian Institute of Health and Welfare has produced a report on completed suicides over the past decade in the ADF and among veterans. This is a good start but ongoing surveillance of suicide statistics will need to continue.

2. Provide a medical treatment Gold Card equivalent to all ex-ADF members as they leave military service

The equivalent of Gold Card access to medical (and psychiatric) treatment should be a mandated benefit (entitlement) of ADF service following discharge. Psychiatric illness still carries significant stigma that prevents individuals accessing treatment. Many ADF personnel are not recognised at discharge as having a mental illness, which often becomes overt later, and frequently service-related mental disorders take years to develop. While treatment for certain psychiatric and substance use disorders is supported by the Department of Veterans' Affairs (DVA) (non-liability health services) and is accessed by ex-ADF personnel (over 10,000 occasions of service in a recent year illustrating the depth of demand) the affected individual has to be considered as a 'case' before funding flows. This is a disincentive to early treatment. Providing all ex-ADF personnel a Gold Card treatment equivalent will eliminate this barrier to treatment – physical health problems and mental health problems will be regarded equally. The reallocation of Medicare funds that would otherwise be used to subsidise the physical and mental health care of ex-ADF members to a seamless specialised system of health care for ADF and ex-ADF personnel would also encourage the aggregation of ADF and DVA medical services to allow the development of a critical mass of health providers in different regions coordinated to establish programs of care. The earlier treatment and more effective social and vocational rehabilitation of mental health disorders are likely to be a net financial benefit to the overall DVA budget.

3. Fast-track pension and compensation entitlements with a minimal adversarial approach

The perception of some ex-ADF personnel is that the DVA 'fights' eligibility for pensions and juxtaposes readiness for work as evidence for pension review. While this perception is frequently inaccurate, the impression of an adversarial approach does little to improve functioning, and does not address or support the social, family and personal factors that augur well for recovery. A minimum fuss, fast-track approach for valid and reliable assessment for eligibility for pension and other benefits needs to be developed. Individuals with special needs generated by the claims process such as those with psychiatric disorder and personality difficulties should be offered additional

support during and after the determination of their claims. Claims staff needs to become more attuned to the effects of the decision-making process on these vulnerable potential beneficiaries.

4. Establish networks of clinical excellence among health care providers funded by ADF and Department of Veterans' Affairs in high density ADF and ex-ADF member locations

   Before the mid 1990's the DVA had a network of Repatriation Hospitals and outpatient clinics dedicated to the physical health and mental health care of ex-ADF personnel. In the mid 1990's these facilities were transferred to state and private health services. With some notable exceptions the level of mental health services dedicated to ex-ADF personnel has declined over the past two decades. To redress this change and to improve the availability, access, and quality of mental health services we need to establish networks of clinical excellence specialising in the mental health care of ADF and ex-ADF personnel. Initially these networks should be established in areas of high ADF and ex-ADF personnel density such as Townsville, Darwin and the state capital cities. Given the small proportion of defence-related population in Australia (compared with the USA for example) it would be advisable to join clinicians caring for the mental health needs of ADF personnel with those caring for ex-ADF personnel. This would mean bringing together general practitioners, psychiatrists, psychologists, allied health professionals and social and vocational rehabilitation specialists involved in the treatment of Army, Navy and Air force personnel with similar professionals treating ex-ADF personnel in the community in the same geographic region. Networks developed in this way would have sufficient numbers of clinicians to be viable arrangements for collaboration, training, sharing knowledge and skills, and acting as referral networks for the special needs of ADF and ex-ADF patients. Phoenix Australia (Centre for Posttraumatic Mental Health) and the Centre for Traumatic Stress Studies University of Adelaide may have a role in establishing and supporting these networks of clinical excellence. Providing a seamless health care system as outlined above will facilitate this process of mental health care service enhancement.

5. Make transparent the career implications for ADF members acknowledging mental health problems

   The onset of a mental health disorder in a serving ADF member has serious consequences for the career prospects for this person. Despite progressively more informed attitudes in the ADF to mental illness, stigma persists and there are real practical limitations for career progression for ADF personnel suffering from mental illness – particularly for future deployments. This should be acknowledged openly and alternate career paths developed to allow ADF members to continue serving and advancing in their careers where ever possible. This approach should reduce the proportion of ADF personnel who delay acknowledgement and treatment of a mental illness, but there will continue to be members who deny or conceal their problems – and this situation should be openly recognised. ADF personnel who 'suffer in silence' like this are likely to be missed as needing support when they are discharged and will be unknown to the DVA until their mental health problems bring them to attention later. At that stage treatment and rehabilitation may be much less effective. The ADF and DVA should work in unison to transition individuals who would be disadvantaged by continued trauma exposure as part of their military careers.

6. Enhance the transition and follow-up process from ADF member to ex-ADF member status

   The transition process from serving member of the ADF to ex-ADF status is a vital opportunity to identify and support personnel who have developed mental illness in the ADF or who are at increased risk of doing so following discharge. For those who have developed mental health problems, the prospect of leaving the ADF can have both positive and negative effects. For some leaving the ADF means 'leaving their problems behind'. Unfortunately for many individuals mental health problems do not go away when they are discharged from the ADF. Leaving service life also means leaving an organised social and work environment. The loss of this support can worsen the mental health problems of ex-ADF personnel. Although some ex-ADF personnel may want nothing to do with the DVA at this time, none-the-less the transition period is an important time for clinical relationships to be established and regular supportive follow-up to start. Most important is the pre-discharge medical and psychological review. A medical practitioner proficient with mental health screening assessment should conduct the review. While questionnaires and checklists can accomplish a lot, they do not replace the value of a personal examination by a physician. This assessment can identify current problems and anticipate future mental health risks and treatment needs and develop a plan of appropriate referral and follow up to address them. A six to 12-monthly physical/mental health follow-up review with a mutually agreed local doctor with expertise in the care of ex-ADF members for the first five years would be helpful, with one to two yearly follow-up after that. Ongoing physical and mental health surveillance is crucial for service improvement. Giving all ex-ADF personnel a Gold Card treatment entitlement equivalent as outlined above would facilitate this level of post-discharge support and allow more detailed monitoring of health status and service usage.

7. Refocus vocational rehabilitation to how work (or other productive activity) can help recovery from mental health problems

   Many ADF personnel discharged from military service will be in their mid careers. They will have two to three decades of working life ahead of them. Ex-ADF personnel suffering from mental illness and their physicians need to be encouraged to see work (or other productive activity) as part of the recovery process rather than an end in itself. The question should be 'how can work aid recovery?' rather than 'when will the patient be fit to return to work?' This change in attitude requires a new approach to vocational rehabilitation (individual placement and support, or supported employment methods) and improved flexibility in workplaces to accommodate the special needs and part-time working schedules of recovering patients. DVA compensation and pension arrangements need to take this situation into account. Pension payments should be flexible in order to encourage part-time return to suitable work without the recipient losing the pension or having to re-qualify for it. Making vocational rehabilitation a positive experience rather than a source of adversarial tension should improve the treatment environment for ex-ADF personnel with mental health problems.

8. Provide all ex-ADF members and their immediate family specific training in mental health first aid as they leave military service

   An important way of empowering ex-ADF personnel and their families to deal with mental illness and suicide risk is to provide them with training in mental health first aid. This will have the additional benefit of further de-stigmatising mental illness. At the point of discharge from the ADF the leaving member and his/her immediate adult family should be provided the 'Mental Health First Aid Course' suitably modified to take into account common conditions suffered by ex-ADF personnel as well as how to respond to potential and real suicide risk situations. In a similar way an occupational health intervention of mental health first aid training should be introduced for all individuals in leadership positions in the ADF.

9. Overcome isolation of distressed ADF and ex-ADF members

   Isolation from others is a powerful risk factor for suicide. Perhaps the most important thing that can be done to prevent suicide is to connect the person at risk with individuals from caring networks of peers, family, and professionals. Personal contact with the person at risk by one or more of the individuals from the caring network reduces isolation and improves self-esteem – both likely to increase the threshold against self-harm. The ADF and DVA should be doing all they can to identify individuals at risk (see above points) and to encourage and support the building and maintaining of carer networks. This will mean a more accepting attitude of veteran-based rehabilitation programs that focus on social inclusion and participation.

Taken together these nine steps will help reduce suicide and self-harm behaviour in ADF and ex-ADF personnel. Monitoring the suicide statistics mentioned in step 1 will provide proof of the effect of these interventions.

Prof Philip Morris AM.