LEGISLATIVE ASSEMBLY FOR THE
AUSTRALIAN CAPITAL TERRITORY

Report on the inquiry into

The Adequacy of Mental Health Services

REPORT NO. 6

STANDING COMMITTEE ON SOCIAL POLICY

September 1997

Committee membership

Ms Kerrie Tucker MLA (Chair)
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Resolution of appointment

The following general purpose standing committees be established to inquire into and report on matters referred to them by the Assembly or matters that are considered by the committee to be of concern to the community …

… a Standing Committee on Social Policy to examine matters related to health, hospitals, nursing homes, welfare, employment, housing, social security, the ageing, people with a disability, the family, Aboriginal people, youth affairs, the status of women, multicultural affairs, industrial relations, occupational health and safety, education, the arts, sport and recreation.

***Minutes of Proceedings,* No. 1, 9 March 1995, p 7.**

Terms of Reference

On 1 December 1995 the Standing Committee on Social policy adopted the following resolution.

> Inquire into the adequacy of mental health services with particular reference to:
>
> - coordination of service provision and issues surrounding continuity of care;
>
> - the interface between mental health services and other services (especially police and housing); and
>
> - any other related matter

Preface

Mental health is an issue of great importance and touches many people personally in the ACT community. The statistics show that twenty percent of adults will experience mental health problems in their lifetime and between ten to fifteen percent of children and adolescents in one year. We define mental health in a rather narrow manner at present but it is my belief that mental health is actually about broader social and emotional well-being as much as it is about mental illness. Surveys of young people are consistently showing a lack of optimism about the future, a sense of alienation from community and a lack of meaning and purpose in their lives. As a civil society we must address these broader issues and examine ways to develop the community and to improve social cohesion.

In this report we have looked at ways to improve services for people who are experiencing mental illness. The Committee was disturbed to find that provision of services to treat and support people with mental illness was very inadequate. While there have some improvements, services in the ACT are still under-developed and under-resourced.

The National Mental Health Strategy has resulted in dramatic changes in how we support people with mental illness. We are moving away from institutional care to a community support model and to an integrated approach of service delivery. While this change is welcomed, it is alarming that there is no clear policy framework or strategic plan in place in the ACT to guide this transition. The Committee's first recommendation addresses this issue and it must be acted upon urgently by the Government.

It is also very important that this move into the community is supported by appropriate resource allocations. The cost of mental illness in terms of human suffering is significant. The financial costs associated with provision of adequate care services are an issue for government, but must always be considered in association with the social costs of failure to provide these services.

The Committee's recommendations come under the categories of: planning; services for children and adolescents; forensic facilities; community based assessment treatment and support; supported accommodation; services for Aboriginal and Torres Strait Islanders; interface between mental health and other services; continuity of care; advocacy; complaints mechanisms; and monitoring of service delivery. Each of these areas requires significant attention from government.

Mental health service delivery in the ACT has suffered a benign neglect for many years. While the issues are complex, if all stakeholders are involved and there is a genuine commitment from government we should be able to develop and implement responsive and comprehensive mental health support and treatment services.

Kerrie Tucker MLA
Chair
19 September 1997

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Overview and recommendations

The adequacy of mental health services is an issue of great concern to the ACT community. In the last few years there have been some very unfortunate and tragic incidents that have revealed serious deficiencies in both the availability of services and the way services are provided. In the last year the Government has made some welcome changes to the way some services are delivered and coordinated. This is a start, however there is much more to be done before services for people with a mental illness are considered adequate.

Planning

The Committee was astonished to learn that major changes are taking place in an unplanned manner. At present there is no Territory-wide mental health policy or strategic plan in place. ACT Mental Health Services, the largest provider, is in the process of developing its own plan. However this and any other plan being developed by a service provider is being done in a vacuum.

The Government has not developed a strategic policy framework to guide service provision. As the recently appointed Executive Director of ACT Mental Health Services said:

> *… the ACT has, in fact a lot of good resources but many of them are not being pulled together and, many of them do not necessarily work cooperatively … There are actually lots of bits but there is not a mechanism that pulls them together so that you have a full spectrum that avoids overlap, ensures that there are not gaps in the system and that we get better utilisation of resources by getting the people to work together.*[1]

The Committee considers a Territory-wide strategic plan to be fundamental and this must be addressed as a matter of urgency.

The Committee recommends that:

- **as a matter of high priority the Department of Health and Community Care in partnership with stakeholders develop a Territory Mental Health Policy and Strategic Plan which includes clear policy guidelines for all aspects of mental health services as well as evaluative mechanisms**. (Recommendation 17, paragraph 6.54)

[1] Transcript, p 389.

Gaps in services

In the last few years a number of studies into the need for various mental health services have been undertaken. However the Committee was very surprised to be told that at present there is no system which captures much of that information. There is no accurate data on who is receiving care and whether services are meeting community need. While the Government advised that it is working towards improving this situation the Committee considers that at present another fundamental aspect of planning service delivery has been overlooked.

The Committee identified a number of serious gaps in services, many of which have been reported in previous studies over many years. These gaps need to be addressed in a planned manner in the context of the development of an integrated system of service delivery. The Committee made thirteen recommendations concerning gaps in services as outlined below.

Services for children and adolescents

The Committee recommends that:

- **the ACT Government provide an accessible and age appropriate inpatient facility for young people with a psychiatric illness.** (Recommendation 1 paragraph 4.14)

Services for people with dual or multiple diagnosis

The Committee recommends that:

- **as a matter of urgency the ACT Government in collaboration with non-government service providers develop an action plan to address the issue of the lack of services for people (including those under 18) with dual or multiple disabilities especially those with substance abuse and mental illness.** (Recommendation 2, paragraph 4.45)

Early onset psychosis

The Committee recommends that:

- **the ACT Government urgently develop and implement a comprehensive strategy to provide early intervention services to adolescents and young people at risk of or suffering from early onset psychosis. This strategy should also include prevention measures**. (Recommendation 3, paragraph 4.54)

Secure facility

The Committee recommends that:

- **the ACT Government establish a secure facility for people with a mental illness who require involuntary accommodation**. (Recommendation 4, paragraph 4.65)

Forensic psychiatry services at Quamby

The Committee recommends that:

- **a strategic plan and policies for forensic psychiatry services at Quamby be developed as a matter of urgency**. (Recommendation 5, paragraph 4.70)

Belconnen Remand Centre

The Committee recommends that:

- **strategies be put in place to improve:**
    - **the linkages between the Belconnen Remand Centre and ACT Mental Health Services; and**
    - **the level of psychiatric service at the Belconnen Remand Centre.** (Recommendation 6, paragraph 4.76)

Forensic facility

The Committee recommends that:

- **any assessment of the need for an ACT jail should consider inclusion of a best practice forensic psychiatry facility to be administered by the health portfolio.** (Recommendation 7, paragraph 4.82)

'Step down' facility

The Committee recommends that:

- **the ACT Government establish a 'step down' facility in a community environment to provide 24 hour care including respite care for people with a mental illness not requiring hospitalisation.** (Recommendation 8**,** paragraph 4.98)

Community-based assessment, treatment and support

The Committee recommends that **the ACT Government:**

- **expand the range of community-based clinical services to include a mobile treatment and support service with similar functions to such services operating in the regions in Victoria and South Australia and that these be in addition to the Crisis Assessment and Treatment Team; and**
- **further fund and support non-government agencies to provide non-clinical community-based services to people with a mental illness.** (Recommendation 9, paragraph 4.108)

Supported accommodation

The Committee recommends that:

- **the ACT Government ensure that community-based supported accommodation options in the future continue to include a range of levels of support from 24 hour support to minimal support; and**
- **the level of support required by each consumer be based on continuing thorough assessments of need, which include measures to ensure quality of life.** (Recommendation 10, paragraph 4.123)

The Committee recommends that:

- **as a matter of urgency the ACT Government develop and implement a strategy which addresses accommodation and support needs of young people with a mental illness.** (Recommendation 11, paragraph 4.128)

Clubhouse

The Committee recommends that:

- **in consultation with the local mental health community and relevant experts the ACT Government conduct a feasibility study on the establishment of a Clubhouse.** (Recommendation 12**,** paragraph 4.139)

Services for Aboriginals and Torres Strait Islanders

The Committee recommends that:

- **the ACT Government acknowledge the special circumstances surrounding the provision of mental health services to the Aboriginal and Torres Strait Islander community:**
    - **by working towards a partnership arrangement which gives greater community control in the delivery of services; and**
    - **through increased resourcing.** (Recommendation 13, paragraph 4.154)

Interface between mental health services and other services

In the last few years there have been several incidents which revealed serious problems in communication between ACT Mental Health Services and other Government services. The Committee acknowledges that in the last year considerable action has been taken to improve the situation. Memoranda of Understanding have been established between the Australian Federal Police and ACT Mental Health Services and ACT Housing and ACT Mental Health Services. These have resulted in clarification of roles and responsibilities and greater liaison between the agencies and improved service delivery. An Internal Standing Committee on Mental Health has also been established. This Committee's role is to monitor mental health issues which affect all agencies including legislation, complex clients and accommodation services.

The Committee has identified the need for processes to be put in place to improve the interface between the Australian Federal Police and ACT Housing and the Australian Federal Police and some non government agencies. There are serious deficiencies with liaison processes between the Belconnen Remand Centre and the Government health services.

Memoranda of Understanding

The Committee recommends that:

- **Memoranda of Understanding to provide for effective management of situations involving persons with a mental illness be developed between:**
    - **the AFP and ACT Housing; and**
    - **the AFP and relevant non government agencies.** (Recommendation 14, paragraph 5.9)

Corrections Health Services Board

The Committee recommends that:

- **the ACT Government establish a Corrections Health Services Board.** (Recommendation 15, paragraph 5.27)

Coordination of services and continuity of care

The Committee found serious deficiencies in continuity of care and the manner in which services are coordinated both in hospital and community settings. ACT Mental Health Services, the largest provider acknowledged that at present its services do not function in a coordinated way.

Some changes and new initiatives have been instituted resulting in improvements in some areas such as consultation liaison and the management of extremely difficult cases.

However there is much work to be done beginning with the development of a Territory-wide strategic plan mentioned above. The following three recommendations also address coordination and continuity of care.

Continuity of care

The Committee recommends that:

- **in consultation with key stakeholders including consumers, ACT Mental Health Services develop and implement a strategy that ensures continuity of care for its clients**. (Recommendation 16, paragraph 6.44)

Advocacy

The Committee recommends that:

- **the ACT Government ensure:**
    - **consumers of mental health services have access to advocacy services as needed; and**
    - **adequate funds are provided to advocacy services to enable them to deal with any increased demand as a result of the changes in the delivery of mental health services.** (Recommendation 18, paragraph 6.62)

Complaints systems

The Committee recommends that:

- **the Department of Health and Community Care require all funded mental health services to develop effective internal complaints systems and grievance procedures and to make information on these readily available to consumers, carers and advocates**. (Recommendation 19, paragraph 6.72)

Monitoring progress

This inquiry has identified serious gaps in services, fundamental problems with planning of services on a Territory-wide basis, some improvements needed in the interface between agencies and serious deficiencies in coordination and continuity of care.

Moreover mental health services are undergoing considerable change, particularly in the area of community-based care. As people are moved from the hostels to the community it will be crucial that sufficient clinical and non-clinical support is available.

The Committee therefore believes that the Social Policy Committee, or its equivalent in the Fourth Assembly, should continue to take an active role in monitoring the provision of services and progress with the changes.

The Committee recommends that:

- **the ACT Government continue to provide to the Social Policy Committee (or its equivalent) regular six monthly reports on:**
    - **the need for and provision of services including legal services for people with a mental dysfunction; and**
    - **progress with the implementation of recommendations of this report**. (Recommendation 20, paragraph 7.9)

1. Introduction

1.1. Mental health services in the ACT have come under intense scrutiny in the last two years following some tragic and highly publicised incidents.

Prevalence of mental illness

1.2. Mental health is an area of great importance to the community. It is estimated that mental health problems will affect more than 20 per cent of adults in their lifetime and between 10 and 15 per cent of children and adolescents in any one year. The *National Mental Health Policy* reports that it has been estimated that at any one time 3 to 4 per cent of all Australians will experience severe mental disorders that will significantly interfere with their mental well-being and reduce their capacity to participate fully in community life. Many will recover spontaneously and, of the remainder, the vast majority can be treated and will fully recover. A small number however will experience longer periods of distress and disability.[2]

Context of the inquiry

The National Mental Health Strategy

1.3. This inquiry was conducted during a time of great change in the way mental health services are provided.

1.4. In 1992 the Australian Health Ministers adopted a National Mental Health Policy and Plan, which together with the earlier endorsement of a Statement of Rights and Responsibilities form the National Mental Health Strategy.

1.5. The National Mental Health Strategy set clear directions for the future provision of mental health services in Australia.

1.6. It acknowledges that priority in allocation of resources should be given to people with severe mental health problems or mental disorders who, because of their condition require ongoing and sometimes intensive treatment. It also recognises the impact of mental health problems on the community and outlines measures to reduce this impact.[3]

[2] Australian Health Ministers, *National Mental Health Policy,* AGPS, Canberra, 1995, p 7.
[3] Australian Health Ministers, *National Mental Health Policy,* AGPS, Canberra, 1995.

1.7. It promotes an integrated approach to service delivery and argues that mental health services will be better provided within the general health system rather than in separate institutions. The policy states:

> *in order to ensure continuity of care and a balanced mix of services, there needs to be an integrated mental health program covering the full range of services in each region or area.*[4]

1.8. The specific aims of the National Mental Health Strategy are to:

- promote the mental health of the Australian community and, where possible, prevent the development of mental health problems and mental disorders;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental disorders.[5]

1.9. The Strategy provides a national framework to achieve mental health reform. It addresses key issues such as:

- consumer rights;
- the provision of integrated mental health services;
- intersectoral links;
- legislation;
- workforce reform;
- monitoring and accountability procedures; and
- the requirements of special needs groups such as people from a non-English speaking background or of Aboriginal or Torres Strait Islander descent.

1.10. A focus of the mental health reforms across the country has been the development of systems that enhance the control of consumers and maximise continuity of care. Key features are:

- integration within mainstream health services of an identifiable mental health program;
- a balanced mix of community and inpatient services;
- consumer rights are guaranteed and protected;
- the use of case management;
- multi-disciplinary approaches to service delivery;
- assessment which offers a single point of entry into an integrated service; and
- information and systems that support continuity and integration of service delivery.

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[4] Australian Health Ministers, *National Mental Health Policy,* AGPS, Canberra, 1995, p 17.
[5] Australian Health Ministers, op cit, p 11.

1.11. The shift to community oriented mental health care has revealed a need to raise awareness and improve community attitudes by increasing knowledge and understanding about mental illness so that people with mental illness, their families and carers are able to live in the community free from stigma and discrimination.

1.12. Each State and Territory is in the process of making major changes to the way it delivers mental health services. The focus of support has changed. Asylums and institutions are no longer accepted as the main focus of mental health care. There is now a strong emphasis on treating people with a mental illness in the general health system and on community-based and consumer run mental health services. Although some people, with severe mental illness will still require hospitalisation, the emphasis is more on treating and supporting people with a mental illness in their own communities. The success of these changes requires the provision of an integrated network of different services.

Reviews and changes in the ACT

1.13. In the ACT a number of other reviews were initiated during the timeframe of this inquiry. In 1996 a review of the Crisis Team was conducted resulting in a refocus of the service to provide community-based crisis intervention and acute psychiatric treatment as well as assessment for acute admission.

1.14. Also in 1996 Fjeldsoe et al was commissioned by the ACT Government to conduct a review of public and private sector mental health services. The reason for the review was to provide core data for the development of a draft purchasing agreement between the Department of Health and Community Care and the relevant providers of mental health services.

1.15. A review of the *Mental Health (Treatment and Care) Act 1994* was undertaken in 1997. The Committee was briefed by the Department of Health and Community Care on this review and had opportunity for input.

1.16. Two inquests into deaths of people with a mental illness commenced during the inquiry. One related to the police shooting in November 1995 of a man suffering from schizophrenia. The other concerned the death at the Belconnen Remand Centre in April 1996 of a young person with a mental illness.

1.17. A purchaser/provider model was implemented in 1996, with ACT Mental Health Services becoming separate from the Department of Health and Community Care. The Department of Health and Community Care is responsible for policy development, planning, funding and accountability. An annual report on all mental health services in the ACT will be produced from September 1997.

This report will:

- provide public information about the operation of all services;
- act as a focus for improving client outcomes;
- provide information about the financial resources dedicated to services;
- provide longitudinal data;
- include the report of the Director of ACT Mental Health Services.[6]

1.18. ACT Mental Health Services, a part of the Canberra Hospital is the government provider of mental health services and also the largest provider of these services in the Territory.

1.19. ACT Mental Health Services is itself undergoing significant change in an effort to provide a more integrated, responsive, client focussed service with expanded community-based treatment care and support. In April 1997, ACT Mental Health Services circulated a Draft Development Plan for community comment. This plan, which will set the direction of the Service for the next three years is now being finalised. The Committee was disappointed that the original timeframe proposed for input would not have given the community adequate time for a considered response. Following representations from the Committee the timeframe was extended. The Committee has received positive feedback from the community on the proposed changes as outlined in the plan and welcomes the changes implemented to date.

Conduct of inquiry

1.20. The inquiry was advertised in local newspapers in June 1996. In addition letters inviting submissions were sent to a total of 51 individuals and organisations known to have an interest in the subject of the inquiry.

1.21. In response, 54 submissions were received and the Committee held nine public hearings. Details of submissions received are at Appendix 1 and of witnesses who gave evidence at public hearings at Appendix 2.

1.22. The Committee was briefed by the Department of Health and Community Care and ACT Mental Health Services.

1.23. The Committee visited a range of mental health programs in the ACT. It also held informal discussions with government officials in New South Wales, Victoria and South Australia and visited a number of government and non-government programs in these states. A list of these visits is at Appendix 3. The Committee also attended the Australian and New Zealand Conference on Mental Health Services held in Brisbane in September 1996.

[6] *Moving Ahead - Mental Health Care in the ACT,* ACT Government, November 1996.

2. Current services

2.1. Mental health services in the ACT are provided by ACT Mental Health Services (the government provider, which provides the majority of services), Calvary Hospital, private practitioners and a small number of non-government organisations. Unlike the services in some other States, it has been openly acknowledged that mental health services in the ACT are not well coordinated and integrated. As the Director of ACT Mental Health Services said:

> *I think it is reasonable to say that there are pockets of the Mental Health Service which function quite well, but as a system it does not function particularly well as an integrated service.*[7]

2.2. The ACT is the only State/Territory that has all its public sector mental health services independently accredited.

2.3. This chapter outlines the services currently available.

The Canberra Hospital

2.4. The Psychiatric Unit of the Canberra Hospital provides an acute and sub-acute inpatient service consisting of 32 designated beds, nine of which are dedicated high dependency. The primary function of the unit is to provide care and treatment for people experiencing acute symptoms of psychiatric illness. One of the key aims of the inpatient service is to return people back to the community as soon as possible with the support of regional teams where appropriate.[8]

2.5. The Psychiatric Unit, a new building, was designed as a 40 bed unit. However as the Committee observed on its visit to the Unit the building is poorly designed and it would be impossible to fit in 40 patients without considerable overcrowding.

Calvary Hospital

2.6. The hospital has a 20 bed public unit that provides acute and sub-acute care services for mentally dysfunctional patients. It is not a designated unit under the *Mental Health (Treatment and Care) Act 1994.*

2.7. Services at Calvary also include a clozapine clinic, general and specialised day programs such as the Anorexia Group and individual outpatient services.[9]

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[7] Record of discussions, 4 February 1997, p 3.
[8] *ACT Mental Health Services Draft Development Plan*, April 1997, p 17.
[9] *Submission* 26.

Residential services

Watson Hostel

2.8. Watson Hostel is a residential setting that provides accommodation for 40 people with a range of mental illnesses and dysfunctions. The function of the hostel is to provide accommodation, rehabilitation, extended care, respite, sub-acute and psychogeriatric care for it's residents.

2.9. The residents are housed in 4 villas with each resident having their own private room with shared facilities. The hostel is staffed 24 hours by nursing and allied staff and has access to a psychiatric registrar for 16 hours a week and a consultant psychiatrist for 4 hours per week.

2.10. The hostel has a community focus with residents encouraged to establish links with the neighbouring community, including their own GP, dentists, podiatrists etc. It runs a living skills program for individuals and small groups on a needs basis. There is a two bedroom flat in the grounds of the Hostel that is used for a staged rehabilitation program. It also includes one designated respite bed that is available to clients of ACT Mental Health Services.

2.11. Watson Hostel's population is on average older than that of Hennessy House, however the age ranges are similar.

Hennessy House

2.12. Hennessy House is a residential setting for 20 people housed in two villas. Each resident has their own room with shared facilities. The hostel provides residential rehabilitation, extended care, respite and subacute facilities for people with a mental illness.

2.13. One villa provides long term care for people with a mental illness who, in the past, have been unable to function in a less structured environment. The residents of this villa are responsible for attending to their own activities of daily living. The other villa operates a structured rehabilitation program that revolves around activities of daily living as well as shopping, budgeting, meal planning and meal preparation. Residents of both villas are encouraged to develop and maintain links with the community either by attending appointments, recreation and leisure activities or through pursuing vocational activities.

2.14. The hostel is staffed 24 hours a day by nursing and allied staff and has access to a psychiatric registrar for 16 hours a week and a consultant psychiatrist for 3 hours a week.

Residential services provided interstate

2.15. The ACT Government submission reported that there are approximately 16 residents of the ACT who are inpatients at Kenmore Hospital in Goulburn. There seems to be some confusion about whether the ACT is responsible for these people. According to ACT Mental Health Services, it is yet to be established if those at Kenmore are permanent residents of the ACT.[10] In addition there are two secure extended care beds provided by Morrisset Hospital at Morrisset.[11]

Community Mental Health Program

2.16. The Community Mental Health program consists of: adult mental health services provided by teams from four regional health centres; a 24 hour Mental Health Crisis and Assessment Team; the Child and Adolescent Mental Health Service; and Forensic Services.

Adult Community Mental Health Services

2.17. Adult Community Mental Health Services are located at the following Health Centres: Tuggeranong, Woden, Belconnen and Civic. They aim to provide timely and effective mental health services in the community by providing assessment and treatment to individuals over 18 years of age.

2.18. Services mainly comprise individual counselling and case management to clients suffering moderate to severe psychiatric, emotional and behavioural disturbances, and support to the families and carers of these clients. Each regional team operates Monday to Friday between the hours of 8:30 am and 5:00 pm and includes an "intake" service between the hours of 1:30 - 4:30 pm Monday to Friday. These teams meet weekly to discuss intake and other clinical issues as well as for allocation of new referrals. Referrals are made through the Mental Health Services Triage.

Crisis Assessment Service

2.19. Since February 1997 the role of the 24 hour Crisis Team has been expanded to provide both mental health assessments and treatment across the ACT.[12] It attends to the urgent presentations that cannot be dealt with by the intake worker at the regional teams and provides support for existing ACT Mental Health Services' clients on a needs basis.

2.20. The Crisis Team also provides an after hours generic crisis service, providing assessment in relation to a range of clients in crisis including clients of drug and alcohol and intellectual disability services.

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[10] *ACT Mental Health Services Draft Development Plan*, April 1997, p 19.
[11] *Submission* 44, p 15.
[12] Chief Executive, ACT Mental Health Services, Transcript of Discussion, 4 February 1997, p 3.

Child and Adolescent Service (CAMHS).

2.21. The Child and Adolescent Mental Health Service is located in the Phillip Community Health Centre with satellites at Tuggeranong and Belconnen Health Centre. The Service is open from 8:30 am to 5:00 pm and includes an 'intake service' from 10:00 am to 1:00 pm Monday to Friday. CAMHS provides assessment and treatment to people under 18 years of age using a multidisciplinary framework. An adolescent outreach program provides direct clinical services to the homeless adolescent population, with mental health issues and consultation with other youth agencies. Other programmes include, 'open day' which provides brief intervention/assessment sessions to families, and CAMHS Ed which liaises with the Department of Education, Employment and Training on mental health issues.[13]

Forensic Service

2.22. The Forensic Service provides assessment, advice and treatment for people involved in the criminal justice system who also have some mental health needs.

2.23. This includes: assessment of those before the courts and advice to the courts; treatment of persons in custody (police cells, remand, prison and youth detention centres); secure hospital treatment services; specialist clinical services eg sexual offender management and treatment and violent offender treatment; establishing service linkages with corrective services, intellectual disability services, drug and alcohol services, child and adolescent mental health services; and buying bed days from the NSW service due to lack of secure beds in the ACT.[14]

Forensic services provided by NSW

2.24. Because there is currently no jail in the ACT, people who receive prison sentences from ACT courts serve their sentences in NSW jails. At any one time there are approximately 100 ACT prisoners in NSW jails[15] and a small percentage of these require forensic services at some time during their sentences.

2.25. Forensic services in NSW jails are provided by the Corrections Health Service and funded by NSW Health. The largest clinical facility is in Long Bay Hospital which has three psychiatric wards. A Ward is a 30 bed unit primarily for forensic patients, persons detained while fitness to be tried is being assessed, those found not guilty due to mental illness and prisoners transferred to hospital

[13] *ACT Mental Health Services Draft Development Plan*, April 1997, p 20.
[14] *ACT Mental Health Services Draft Development Plan*, April 1997, p 42.
[15] At 31 March 1996 there were 88 ACT prisoners in NSW prisons, *Debates of the Legislative Assembly for the Australian Capital Territory, Weekly Hansard*, Vol 5, 1996, p 1430.

under the provisions of the NSW Mental Health Act. C Ward is a sub-acute ward for persons who have been acutely psychotic or those who have threatened suicide or repeatedly display self-harm behaviours. D ward is an acute ward for persons experiencing psychosis and those with personality disorders.

Psychiatric Rehabilitation Service

2.26. The Psychiatric Rehabilitation Service (PRS) was under review during the inquiry. ACT Mental Health Services Draft Development Plan states that the PRS provides psychiatric rehabilitation services to the seriously mentally ill, through a clinical program, community access, pre-vocational and community activities. Referrals to PRS are usually secondary via a primary clinician within and outside the service (for example GPs). Each client is allocated a clinical coordinator to facilitate the client's progress through the rehabilitation service. The staff meet each week to discuss clinical issues and to allocate new referrals. The Intensive Rehabilitation Team, which is currently a part of PRS, provides intensive rehabilitative and clinical services to 40 clients across the ACT.

2.27. PRS provides different programs at several locations. These include TASC (Technical and Skills Centre) at Bruce; Haydon Offices at Bruce; Stage One at Civic; Throsby Place, at Griffith Shops; Work Program; Welfare Services; Supported Accommodation Program; Community Access Program; Intensive Rehabilitation Team; and The Young Ones.

2.28. Together with the Canberra Schizophrenia Fellowship, the PRS operates registered businesses that provide vocational rehabilitation through paid work experience to prepare people to work at a standard that allows them to access mainstream training and employment opportunities. These businesses are Cafe Pazzini and Northside Contractors.

Services provided by non Government organisations

2.29. A small number of services are provided by non-Government organisations. These services include the Special Care Unit at Ainslie Village; the supported accommodation provided by Richmond Fellowship and the Mental Health Foundation Inc; the Mental Health Resource; GROW, a community mental health movement; EXPAND which provides post and ante natal depression support; services provided by the Canberra Schizophrenia Fellowship; Transact, a service for survivors of torture and trauma; and some services offered to women by Inanna.

3. Funding

3.1. The *National Mental Health Report 1995* states that the ACT has a higher proportion of spending on resources for community mental health services than other states and the Northern Territory. In 1994/95 the ACT spent $30 per capita on community mental health residential services compared with the national average of $21. On the other hand the report notes that, based on 1994/95 spending, the ACT rates sixth on total per capita spending on all mental health with an expenditure of $51.8 per capita compared with a national average of $58.[16]

3.2. It should be noted that the ACT has never had any large institutions and would therefore be expected to have a higher proportion of spending on resources for community mental health residential services than many other jurisdictions. A significant program of deinstituionalisation has been implemented in many states in the last three years which could result in a different picture in 1997. Further there are definitional problems with 'community residential services'. The National Health and Medical Research Council regards the ACT hostels as community-based, but according to the ACT Mental Health Advisory Council they correspond to institutional beds in other States. [17] The Committee understands there is ongoing debate about which services are defined as institutions.

3.3. The Minister for Health and Community Care[18] advised the Committee that the estimated per capita expenditure on mental health services in the ACT is $59 for 1997/98. The Minister stated that this appears broadly consistent with the per capita expenditure of $51.8 for 1994/95 as noted in the *National Mental Health Report 1995*.

3.4. The cash allocation for mental health services identified in the 1997/98 budget for the Department of Health and Community Care is $18.2m.[19] The allocation incorporated in the 1996/97 budget was $17.4m, the figure reported in Walter and Turnbull's independent audit report.[20]

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[16] Department of Health and Family Services, *National Mental Health Report 1995,* AGPS, Canberra 1996.
[17] Mental Health Advisory Council, *Response to the Purdon Report: ACT Review of Accommodation for People with Psychiatric Disabilities,* July 1995, p12.
[18] Minister for Health and Community Care, Question on Notice, Select Committee on Estimates 1996-97, 29 May 1997.
[19] *Budget Paper No 4*, Volume 1, p 188-189.
[20] Walter and Turnbull, *Independent Audit Report,* 18 November 1996.

3.5. The 1997/98 financial year is the first year that funding for mental health services has been separately identified and pooled. The Minister[21] advised that during 1997/98 the funding models used to determine the various elements of the pool will be further refined and the costings validated. These will include:

- the adequacy of overheads incorporated in the Casemix (diagnosis related groups) payments for inpatient services;
- the appropriateness of the inclusion of some services (for example psychogeriatric) in the mental health category through the Casemix based funding model; and
- the cost of mental health 'outliers' ie inpatients staying longer in hospital than the average length of stay plus seven days.

3.6. The breakdown of projected payments for mental health services for 1997/98 provided by the Minister is as follows:

The Canberra Hospital	$14.74m
The Calvary Hospital	$ 2.55m
Non Government agencies	$ 0.65m
Funds to be allocated	$ 0.25m (for community-based support)

Funds allocated to the Canberra Hospital include the following services: inpatient services; outpatient services; community mental health and extended care services; and funds allocated from the National Mental Health Strategy.

Funds allocated to the Calvary Hospital cover inpatient and outpatient services.

3.7. The Committee notes that currently in the ACT only 3.6 per cent of the mental health budget is allocated to non-government organisations. This is a small proportion compared to some of the more progressive States which have contracted out more services to the non-government sector. For example in 1995/96 non-government services in Victoria made up 5 per cent of the total budget or 10 per cent of the Adult Mental Health Budget. In 1996/97 this was increased to approximately 12 per cent of the Adult Mental Health Budget.

[21] Minister for Health and Community Care, Question on Notice, Select Committee on Estimates 1996-97.

3.8. The Canberra Hospital is in the process of establishing accrual cost centre budgets for all services for 1997/98. However indicative cash allocations for community mental health services[22] which total $8.59m are:

Community Mental Health Centres	$1.73m
Child and Adolescent Unit	$0.91m
Forensic Mental Health Services	$0.10m
Mental Health Crisis Team	$0.67m
Psychiatric Rehabilitation Services	$1.11m
Extended Care Services	$2.98m
Education and Training	$0.43m
Administration	$0.44m
Accommodation	$0.22m

3.9. The Territory received $1.047m in 1996/97 under the National Mental Health Strategy. The same amount was included in the 1997/98 ACT Government Budget but the Government reported that it has since received advice that this will rise to $1.071m in 1997/98. Projections in May 1997 indicated that expenditure would fall short of the 1996/97 allocation by $277,000 and this would be 'rolled-over' into the 1997/98 Mental Health budget.

3.10. Projects funded through the National Mental Health Strategy in 1996/97, and estimated expenditure against these projects is as follows:

Connections Volunteer Program	$49,500
Mental Health Awareness Education	$68,800
Trainee Psychiatrist	$61,500
Case Management	$128,600
Cafe Pazzini	$39,600
Reporting & Information Development	$80,900
Implementation Director	$104,000
Crisis Team	$79,700
Intensive Extended Rehabilitation	$90,600
Clozapine Drug Program .	$59,700
Best Practice Review	$6,800

At the time of printing projects to be funded in 1997/98 had not been determined.

[22] ibid.

3.11. The ACT will receive funds under the National Youth Suicide Prevention Strategy, from the Commonwealth Department of Health and Family Services, for a stocktake of youth suicide prevention activities; and a training project for professionals.

3.12. As part of the cross-border funding arrangements between States/Territories, the ACT receives payments for the provision of inpatient and outpatient services to people resident outside the ACT. Similarly, it must pay other States/Territories for Territory patients receiving inpatient and outpatient services outside the ACT.

3.13. The ACT incurs costs in relation to services provided by New South Wales for hospital inpatient and outpatient services and for forensic psychiatric services for people with a mental illness imprisoned in NSW. The Territory does not incur any other direct costs for mental health services provided by NSW.

3.14. The Commonwealth Grants Commission, in advising the Commonwealth Government on per capita relativities for distributing general revenue grants among the States and Territories, takes into account cross border influences in reaching its Expenditure and Revenue assessments.

3.15. The Committee observed some community concern about the lack of transparency in reporting mental health funding. The Committee awaits with interest to see if transparency is improved with the new reporting arrangements which will include an annual report on all mental health services to be tabled in the Assembly in September 1997. Several witnesses expressed the view that there is no transparency about the mental health budget and fear that any savings from, for example, a decrease in acute care beds as a result of more and better community-based services, will not be put back into the mental health budget. The Committee would also be extremely concerned if this happened. The Committee understands that any savings generated by efficiencies in some aspects of mental health services will be used to support other sectors of mental health.

4. Gaps in services

4.1. In the last few years a number of studies into the need for various mental health services have been undertaken. However the Committee was advised that at present there is no system that captures much of that information. There is no accurate data on who is receiving services and care and whether services are meeting community need.[23] The Committee considers that accurate data on where services are provided and where there is unmet need is fundamental to planning and delivering mental health services. The Committee heard from the non-government sector that there is indeed a crisis in certain areas and unmet need is a serious problem. The Department of Health and Community Care and ACT Mental Health Services advised the Committee that they are working towards improving this situation.

4.2. This chapter outlines gaps in services which were drawn to the Committee's attention and makes recommendations to address some of the issues. In doing so the Committee is mindful of the fact that the mental health system is a complex and interdependent system and that changing parts of the system in isolation will not work. Any proposed changes must be considered in the context of the development of an integrated system of service delivery and the identified needs.

Services for children and adolescents

4.3. The Committee found gaps in services for children and adolescents to be a widespread concern.[24] The Government has also made it clear that it is particularly concerned about mental health service for children and adolescents.[25]

4.4. Youth refuges reported serious difficulties in negotiating the system and accessing services for their clients. Youth refuges accommodate many adolescents who exhibit mental health problems. One refuge estimated that in the last 18 months 50 per cent of its household at any one time has comprised people with a mental illness.[26] The staff of the refuges claim they frequently have detailed information on a young person's background and medical history as well as information based on direct observation of the young person which is rarely sought let alone taken into account by clinical staff. This often results in a young person seeking help from a clinical service being sent back to the refuge without having undergone an assessment or receiving any ongoing treatment.

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[23] Transcript, p 382. Minister for Health and Community Care, *Third Report to the Standing Committee on Social Policy on the Need for and Provision of Services, including Legal Services for People with a Mental Dysfunction*, p 11.
[24] For example *Submission*s 6, 9, 20, 21, 23, 25. 48, 49, 51. Transcript, p 96, p 362, p 408-431.
[25] *'Ministerial Statement on Mental Health Services in the Australian Capital Territory', Debates of the Legislative Assembly for the Australian Capital Territory Weekly Hansard*, Vol 2, 1997, p 571.
[26] Transcript, p 408.

4.5. Other youth services such as the Woden Youth Centre are extremely concerned about the lack of services for adolescents who exhibit suicidal tendencies.

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4.6. The consequences of reluctance to offer ongoing treatment to some young people have been quite alarming. For example, recently a 14 year old whose psychiatric condition was not taken seriously and who despite concerted attempts by the refuge involved received no treatment, committed a serious crime. This young person's condition was subsequently taken seriously and the young person was put back on medication and stabilised.

4.7. In its Shared Care project the ACT Division of General Practice Inc identified child and adolescent mental health care as a priority area of concern in the ACT. A survey conducted as part of the project identified as a high priority: education and training in the areas of emotional and behavioural problems of childhood; adolescent mental health care; and the prevention of self harm and suicide by young people.

4.8. In addition, recent national strategies such as the National Mental Health Strategy, the National Health Strategy and the National Health Goals and Targets stressed the need for increased early intervention with children and the further development of specialist mental health services for young people.[27]

Inpatient services

4.9. As ACT Mental Health Services[28] acknowledges currently public psychiatric inpatient services are limited for children and adolescents in the ACT posing a significant gap in services. The ACT Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) submitted that the most serious lack of specialist services relates to child and adolescent mental health services. No specialist inpatient or day patient services for children and adolescents exist beyond consultations by psychiatrists in the paediatric wards and admission to adult acute units.[29] There are no beds dedicated to child and adolescent psychiatry. Moreover there are no specialty trained mental health nurses dedicated to child and adolescent inpatient services. With the exception of a small proportion who can be successfully managed in the adolescent ward, children and adolescents requiring hospitalisation are either placed in a general ward or in the Psychiatric Unit.

[27] ACT Division of General Practice, *Enhancing Mental Health Care through General Practice*, Report on the Shared Care Project, April 1996.
[28] *ACT Mental Health Services Draft Development Plan*, April 1997, p 17.
[29] *Submission* 21.

4.10. The Committee was told by numerous witnesses that this situation is totally unacceptable and unsatisfactory.[30] As one parent stated:

> *This means that adolescents are taken to the Psychiatric Unit at Woden …where they mix with adults. The age gap creates added strain for all patients and staff. Additionally, young patients are exposed to more pronounced psychotic behaviour, which may slow the effects of therapy and may also lead to competitive copycat behaviour.*[31]

4.11. One submission[32] reported the case of a young person under 18 who spent four months in the Acute Psychiatric Unit at the Canberra Hospital, because there was nowhere else for him to be placed. According to the submission, the Mental Health Tribunal had to constantly put him on a mental health order because he needed accommodation, drug and alcohol counselling and psychiatric care and nothing was available.

4.12. In discussing this issue the President of the Mental Health Tribunal told the Committee:

> *There is no doubt about the horror that I have in making orders in respect of a psychotic young person, say at 15 or 16, and saying, "The only option we have is to keep you in hospital for 28 days at the Canberra Hospital Psychiatric Unit with everyone else".*[33]

4.13. Clearly this situation is untenable and must be addressed urgently. One way of addressing the issue would be the establishment of a special secure psychiatric unit for young people. However as the President of the Mental Health Tribunal pointed out there are questions of scale and expense which must be considered and creative solutions need to be found. Other options include making some arrangements with New South Wales or establishing a regional unit. Ensuring that these young people are not separated from their families by long distances is a key consideration.

Recommendation 1

4.14. The Committee recommends that the ACT Government provide an accessible and age appropriate inpatient facility for young people with a psychiatric illness.

[30] For example *Submission*s 6, 9, 20, 21, 23, 25. 48, 49, 51. Transcript, p 96.
[31] *Submission* 11.
[32] *Submission* 51.
[33] Transcript, p 349.

4.15. As mentioned above a small proportion of young people with a psychiatric illness can be successfully managed in the adolescent ward or other parts of the hospital. For example a child and adolescent psychiatrist told the Committee that he had cared for a 13 year old who was very ill with schizophrenia in the isolation ward.[34] However under these arrangements, apart from a visiting psychiatrist there are no other specialist staff. The Faculty of Child and Adolescent Psychiatry believe that with skilled nursing such as a mental health nursing position there is a range of young people who could be managed in the adolescent ward.

4.16. The Committee considers the provision of a mental health nursing position as part of the adolescent ward staff would be of benefit to young people with a diagnosed mental illness as well as those at risk of developing a mental illness as a result of trauma or other conditions.

4.17. Parents and carers of young people between 16 and 18 years of age felt left out of the decision making processes about their child's treatment and care in hospital. One parent told the Committee that she was not given answers about her seventeen year old's condition because 'it is confidential …you are only the parent'.[35]

4.18. Another witness was extremely critical of the system which considers a young person of 16 to be an adult and expects that young person to be in charge of their mental health and make decisions about such matters as discharge from hospital and who could talk to the parents about the young person's mental health. This witness was astounded that a young person could be given such responsibility. The witness equated this as meaning the system is not going to do anything for the young person because 'you are an adult and you should be able to negotiate the system and you should be able to make these decisions'.[36]

4.19. The legislation is silent on whether a young person under 18 years of age can make a decision about their medical treatment. However under common law if a young person is mature enough and able to understand the nature of the treatment they can give consent and the parents cannot override the decision. For example if a young person decides that they do not want psychiatric treatment while the parents feel the young person should have it, the young person is entitled to have his/her wishes met. Under the UN Convention on the Rights of the Child this is appropriate, however obviously in the best interests of the child it would seem reasonable that parents/carers are given an opportunity for input so that decisions are based on broader information. When carers/parents of a person under 18 are denied input they and the medical profession are faced with a dilemma. The only avenue open to parents or doctors in these cases is the Mental Health Tribunal.

[34] Transcript, p 360.
[35] Confidential evidence.
[36] Confidential evidence.

4.20. The Tribunal may make a mental health order on the referral of a doctor or parent if: having regard to an assessment and after holding an inquiry, the Tribunal is satisfied that the young person is mentally dysfunctional and that the person's health or safety is or is likely to be substantially at risk; or the person is or is likely to be a danger to the community.

4.21. The disclosure of medical information about a young person aged 16 to 18 years to a parent without the young person's consent is proscribed by Commonwealth legislation which also applies to the ACT. There is an exception where non disclosure may lead to harm to some party. Parents who really feel they have an interest in knowing can take the matter to the Administrative Appeals Tribunal.

4.22. The Committee received some confidential evidence from both individual parents and community organisations which questioned the quality of the psychiatric care available for children and adolescents in the ACT.

Child and Adolescent Mental Health Service

4.23. A lack of suitable inpatient facilities for children and adolescents with a mental illness is only one aspect of the issue of gaps in services for this group. The RANZCP told the Committee that the Child and Adolescent Service is 'drowning' and has extensive waiting lists for appointments.[37] This view was reflected by many other organisations and individuals.

4.24. In February 1997 the Minister told the Assembly that as a result of revised intake procedures, waiting times for an initial assessment had been reduced from eight weeks to two weeks.[38] However this does not appear to have been the situation later in the year. The Committee received correspondence[39] from a parent whose child was referred to CAMHS by a General Practitioner and the school psychologist in August 1997. The parent phoned the Crisis Line to seek an appointment. After listening to a recorded message and music for 15 minutes the call was answered. The parent was required to describe the child's symptoms, behaviour and previous counselling and then told there was a case for a referral, which the Crisis Line would put through to CAMHS. The parent was also told that CAMHS would make contact within a few days. Four days later CAMHS phoned and asked the parent to describe all the symptoms again. The parent was then told that an appointment would be arranged following a meeting two days later. Nothing was heard for five days when the parent phoned the Crisis Line to ask for the CAMHS number. Again there was a long wait for the call to be answered (12 minutes). CAMHS advised that the child had been put

[37] Transcript, p 362.
[38] *'Ministerial Statement on Mental Health Services in the Australian Capital Territory', Debates of the Legislative Assembly for the Australian Capital Territory Weekly Hansard*, Vol 2, 1997, p 571.
[39] Correspondence dated 15 August 1997 and 5 September 1997, name withheld.

on the priority list and that the parent would be notified of the appointment date in two or three weeks. The parent was contacted after two weeks and given an appointment for a date four weeks from the initial call to the Crisis line.

4.25. The Committee believes that this is unacceptable. Most people do not seek help until the situation is almost at crisis point. In the case described above the child had already been assessed by both the General Practitioner and the school psychologist as needing specialist care.

4.26. This case also conflicts with the advice received in September 1997 from the Minister on waiting times and procedures at CAMHS. In a letter to the Committee the Minister stated that a response to Category 3 referrals to the Triage (Crisis Line) is provided in 24 to 48 hours and there is a 1 to 2 week waiting time for assessment.[40] The letter also stated that there is a 6 to 8 week waiting time for non urgent cases and for specialist psychological assessments.

4.27. Clearly access to CAMHS is a major problem.

4.28. In the report *Mental Health in the ACT*[41] it is generally agreed that the number of children and adolescents suffering from some form of mental disorders to be between 10 and 18 per cent in inner cities both internationally and in Australia. For the ACT this equates to between 5,800 and 8,600 children in the 5 to 17 year age group. Further, recent research has indicated that those who develop mental disorders at an early age become more severely impaired and are more likely to have comorbid diagnoses.[42]

4.29. The Faculty of Child and Adolescent Psychiatry claimed that the amount spent on child and adolescent mental health services in the ACT is disproportionately low. It reported that seven per cent of the Mental Health budget is allocated for child and adolescent mental health services, [43] yet according to ACT Mental Health Services this group represents 32.23 per cent of mental health clients in the ACT.[44] By comparison in 1996/97 Victoria dedicated a minimum of 10 per cent of area mental health services' budgets to the Child and Adolescent Mental Health Service.[45] Victoria is reviewing the adequacy of this level of expenditure. The Faculty of Child and Adolescent Psychiatry also claimed that over the past decade resources have been redirected

[40] Minister for Health and Community Care, correspondence dated 9 September 1997.
[41] White U, Gilbert C and Johansen G, *Mental Health in the ACT*, Epidemiology Unit, ACT Department of Health and Community Care: Health Series No 11, ACT Government Printer, ACT, p 29.
[42] Newman D L, Moffit T E, Caspi A, Magdol L, Silva P A, Stanton W R, 'Psychiatric disorder in a birth cohort of young adults: prevalence, comorbidity, clinical significance, and new case incidence from ages to 11 to 21', *Journal of Consulting and Clinical Psychology*, Vol 64;3: p 552-62, June 1996.
[43] Transcript, p 358.
[44] Minister for Health and Community Care, correspondence dated 9 September 1997.
[45] Department of Health and Community Services, *Purchasing Better Mental Health Services in Victoria: 1996-97*, Psychiatric Services Division, April 1996.

from child and adolescent mental health services to the needs of the chronically mentally ill.[46]

4.30. The RANZCP reported that the problems are exacerbated by the staffing situation in the existing child and adolescent mental health services. It stated that in the near future there will only be one child psychiatrist practising at CAMHS and over the last two years there has been an unacceptable level of movement of other professional staff with 26 staff moving through 12 positions. Many of these people have been on six month contracts. The College asserts that this is totally unacceptable in an area where children need to be seen often over two years.[47] The Committee also considers this unacceptable as being required to deal with new professionals continually can be detrimental to a young person's recovery.

4.31. The evidence before the Committee indicates that the Child and Adolescent Mental Health Service is not meeting the needs of the community.

Services for young adults

4.32. This is another area of serious deficiency. The Committee was told[48] that young adults, that is, those aged between 18 and 25 are falling through the net. Woden Youth Centre advised that most of its clients in this age group with mental health problems are not able to access treatment or support from ACT Mental Health Services. The Committee also received confidential evidence from several parents of young people with a mental illness, some of whom had attempted suicide This evidence detailed the parents' horrific experiences in trying to obtain help for their son or daughter.

4.33. In some cases where young people have been admitted to the Acute Psychiatric Unit they have not been able to access the support needed after discharge. Woden Youth Centre reported that many patients discharged from hospital cannot get the help they need when they seek it and many suffer a rapid decline in their condition. Some have attempted suicide.

4.34. Woden Youth Centre also told the Committee that some young people who have no one to pick them up on discharge from hospital are left to find their own way home and often arrive at the Centre in a heavily medicated state.[49]

[46] *Submission* 23.
[47] *Submission* 21.
[48] Transcript, p 112, *Submission* 25, Confidential evidence.
[49] Transcript, p 109.

Services for people with dual or multiple diagnosis

4.35. Related to services for adolescents and young adults is the issue of services for people with dual diagnosis. While there are several forms of dual diagnosis such as mental illness and intellectual disability; mental illness and acquired brain injury; and mental illness and substance abuse; the evidence presented to this inquiry was largely concerned with the latter, namely mental illness and substance abuse. A large proportion of this client group is in the under 25 age group.

4.36. Many individuals and organisations[50] informed the Committee that there are no services for people with dual diagnosis. The Woden Youth Centre asserted that the ACT is outdated in its approach to dual diagnosis. It said:

> *If we have a mental health system that refuses to acknowledge that people are using other drugs to self medicate, then they may as well give up now.*[51]

4.37. The Alcohol and Drug Foundation of the ACT (ADFACT) provides a service to adults ie people over 18 years of age. It estimates that 30 to 90 per cent of clients served either by Alcohol and Drug or Mental Health Services are in the dual diagnosis category. Research has shown that up to 80 per cent of all problematic drug users experience mental health problems at some time during their using life and 50 per cent of people with a mental illness will experience alcohol and drug related problems.[52]

4.38. The Alcohol and Drug Foundation stated that its workers are reluctant to deal with clients with dual diagnosis where there is some uncertainty about the appropriate treatment and a concern that the client's condition may unwittingly be aggravated. ADFACT asserted that the mental health worker has similar concerns and as a result a dual diagnosis client may receive little or no treatment, being 'disowned' by both services.[53]

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[50] For example *Submission*s 18, 24, 25, 27, 41, 45.
[51] Transcript, p 115.
[52] First M B and Gladis M M, "Diagnosis and Differential Diagnosis of Psychiatric and Substance Use Disorders", *Dual Diagnosis: Evaluation, Treatment, Training and Program Development.* Solomon J, Zimberg S, and Schollar E (eds), Plenum Medical Book Company, New York, 1993.
Kosten T R and Kleber H D, 'Differential Diagnosis of Psychiatric Comorbidity in Substance Abusers' *Journal of Substance Abuse Treatment, 5 (4): 201-206, 1988.*
[53] *Submission* 24.

4.39. Services for people under 18 years of age with dual diagnosis are also non existent. One submission detailed the problem of a young person under 18. This submission stated:

> *There is nowhere for him to live in safety and no program which will accept a young person with drug and alcohol problems and mental health problems.*
> *The Detox Unit at the Canberra Hospital will not have him because of his mental health problem;*
> *The Psych Ward will not treat him because of his drug and alcohol problem;*
> *Marlow is not a safe place for him and certainly is not able to handle his problems;*
> *All other youth refuges choose to turn away difficult cases.*
>
> ***There is no place and no program for young people in the ACT with combined mental health and drug and alcohol problems and in fact no place and no program in the whole of the country.***[54]

4.40. ACT Mental Health Services stated in its Development Plan that mental health services on their own have neither the skills nor the facilities to treat, manage or rehabilitate people with drug and alcohol dependencies.[55]

4.41. ACT Mental Health Services[56] acknowledges that no specialist service exists to deal with people with mental illness and substance abuse. It contends that mental health services for this group need to be provided in collaboration with other services such as drug and alcohol.

4.42. In Western Australia a proposal based on the shared care model has been developed to deal with dual diagnosis. This proposal was reported at 'Winter in the Sun' a major Drug and Alcohol Conference held in Brisbane in July 1997. In his paper Gerry Chandler stated:

> *Shared care is not about sharing all the information given to individual service providers by clients. It is about sharing relevant information, with a client's knowledge and permission, to maximise the services being provided to the client. It is about service providers acknowledging their areas of expertise, their skills and their limitations, and working together with others who*

[54] *Submission* 51.
[55] *ACT Mental Health Services Draft Development Plan,* April 1997, p 43.
[56] *ibid.*

have different areas of expertise, different skills and different limitations. It is about not allowing their limitations to prevent them working with clients. It is about starting to meet the needs of a specific, dislocated client group.[57]

4.43. In New South Wales, the Royal North Shore Hospital has reported considerable success in developing programs for people with dual problems of serious mental illness and substance abuse. Between 1994 and 1996 it conducted a project to develop strategies to deal with the problem. The project's report noted that it is possible to improve the cooperation between mental health services and drug and alcohol services within the existing system. The report recommended:

adapting existing systems to encourage the development of combined teams of mental health and drug and alcohol professionals to support cross training initiatives and to supervise mental health and drug and alcohol case managers of people with a serious mental illness and problematic substance use.[58]

4.44. Dealing with dual diagnosis is a major problem for the ACT as well as other jurisdictions. The Committee is extremely concerned that people with a mental illness who also have drug and alcohol problems are not able to access appropriate services and believes that the issue must be addressed urgently. Some work has been done in other States which could inform the ACT's approach.

Recommendation 2

4.45. The Committee recommends that as a matter of urgency the ACT Government in collaboration with non-government service providers develop an action plan to address the issue of the lack of services for people (including those under 18) with dual or multiple disabilities especially those with substance abuse and mental illness.

Early onset psychosis

4.46. In addition to the problems identified with the current services for children and adolescents and young people there appears to be little in the way of services for those at risk of developing a serious psychotic illness, those people who are prodromal or who have experienced an initial acute episode.

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[57] Chandler Gerry, *When lifestyle is confounded by mental health issues and alcohol or other drug related problems*, Paper presented to 'Winter in the Sun' conference, Brisbane, July 1997.

[58] Clenaghan Paul, Rosen Alan, Van Bysterveld Mieke, Friel Oisin and Spilsbury Georgina, *Developing Effective Treatment Strategies for People with a Serious Mental Illness and Problematic Substance Abuse*, Project Report.

4.47. In March 1997 the Committee visited the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne and received a briefing on the program. EPPIC is an integrated and comprehensive psychiatric service aimed at addressing the needs of older adolescents and young adults with emerging psychotic disorders in the western metropolitan region of Melbourne. EPPIC's services include the Early Psychosis Assessment and Community Treatment Team - a mobile team which is the first point of contact with EPPIC; an outpatient case management program; an inpatient service; research and evaluation; family work comprising a range of specialist services to provide information and support to families; and Statewide Services which assists services outside the western metropolitan region.

4.48. The Committee received a number of submissions[59] which reported that there is no early intervention program in the ACT to identify young people at risk of mental illness, to alleviate early symptoms and minimise disruption to social functioning and careers.

4.49. The ACT study released in May 1995 entitled 'First Onset Psychosis Project - Final Report' documented the need for resources to be provided for early intervention. The Committee was advised by a practising psychiatrist that:

> *there are no resources to implement the recommendations arising out of that study and as a result there will continue to be an unnecessarily high level of disability and chronicity amongst these young people with much increased likelihood of suicide.*[60]

4.50. The Committee also heard from a number of witnesses, mainly parents, who felt that their concerns about the deteriorating mental health of young family members were not listened to and effective intervention or treatment was not offered. Several cases were reported to the Committee where parents (even some who are very familiar with the system) were unable to satisfactorily negotiate the system to obtain suitable services for their children or young people. As one parent said:

> *…I am a very articulate and probably pushy person, if I find difficulties trying to get help…God help anybody else out there - I mean even to deal with the hospital nearly killed me. I could not believe, with my skills and my knowledge of the system and my understandings of what went on, that they almost beat me.*[61]

[59] For example *Submission*s 6, 11, 19, 20, 41. Transcript, p 96.
[60] *Submission* 20, p 4.
[61] Confidential evidence.

4.51. A strong feeling emerged from witnesses that professionals tended to dismiss the signs of mental illness in children and young people as being manipulative on the part of the young person. Yet the medical evidence indicates that the longer the illness is left unrecognised the greater the disruption to a person's family, friends, study and work. According to EPPIC other problems can occur or intensify such as substance abuse, self inflicted injury, depression and breaking the law. In addition delays in treatment may lead to slower and less complete recovery.[62]

4.52. *Mental Health in the ACT*[63] points out that the National Health and Medical Research Council (NH&MRC) has identified circumstances in which a child or adolescent is more likely to develop a mental disorder. The factors identified have been confirmed in a review of the epidemiology of psychiatric disorders in children and adolescents. Most of these factors tend to be generic and include:

- familial factors, ie parental discord, parental difficulties through alcoholism and parental psychiatric disturbance;
- emotionally stressful life event ie bereavement, loss through separation or divorce, physical illness, witnessing violence;
- genetic factors, ie development of central nervous system and biological assaults through pregnancy, birth and later life; and
- social factors.

4.53. The Committee notes that in its 'Draft Development Plan', ACT Mental Health Services stated that it is committed to providing services to this client group. As well the ACT has a representative on the National Early Psychosis project. However clearly at present there is a major gap in services for early onset psychosis. Further, more attention also needs to be given to preventative measures which promote mental well being along with the projects in place to prevent youth suicide. While the ACT could not support a comprehensive research early intervention and treatment facility such as EPPIC there is a need for the ACT Government to develop and implement strategies to target specific high risk children and young people and their families.

Recommendation 3

4.54. The Committee recommends that the ACT Government urgently develop and implement a comprehensive strategy to provide early intervention services to adolescents and young people at risk of or suffering from early onset psychosis. This strategy should also include prevention measures.

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[62] Department of Health and Community Services, *EPPIC Information Sheet No 3.*

[63] White U, Gilbert C and Johansen G, *Mental Health in the ACT*, Epidemiology Unit, ACT Department of Health and Community Care: Health Series No 11, ACT Government Printer, ACT, p 29.

Services for women suffering from post natal depression

4.55. The Royal Australian and New Zealand College Psychiatrists, individual medical practitioners, the Post Natal Depression Support Group, the Post Natal Depression Resource Network and Inanna[64] submitted that there needs to be an appropriate inpatient facility for mothers suffering from a mental illness where mother and baby can be accommodated.

4.56. Both the Psychiatric Units at Calvary and at the Canberra Hospital admit women (with their babies) who are suffering post natal depression. This is not considered a satisfactory arrangement. Women often feel that other patients may harm their baby.

4.57. This unsatisfactory situation was acknowledged by Calvary Hospital[65] in its submission to the inquiry. Further Fjeldsoe et al[66] also noted this gap in service and recommended that a proposal be developed for the delivery of inpatient services for women with post partum mental illness.

4.58. The inpatient issue was only one of the issues raised. The Committee was told that across the board current services do not have processes for dealing with the specific needs of women who suffer from post natal depression. Women from diverse cultural and linguistic background are especially disadvantaged. There is a lack of knowledge and diagnosis of puerperal mental disorders, differing methods of treatment and very limited affordable long term counselling. Further, concerns were expressed about the way some women with post natal depression are treated when Family Services becomes involved.[67]

4.59. The Division of General Practice Inc recently completed a project aiming to encourage a multi-disciplinary, multi-level approach to the management of post natal depression by focusing on the integration of GPs into postnatal services. Some of the initiatives developed included establishing referral protocols, establishing networks between GPs, government and non-government service providers, and the involvement of GPs in ante natal care.[68]

4.60. This initiative together with changes to the Crisis Assessment and Treatment Team and improved liaison between the QE2 and ACT Mental Health Services has recently resulted in more accessible services for women with post natal depression.[69] However further improvements are needed.

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[64] *Submissions* 4, 21, 36, 40.
[65] *Submission* 26.
[66] Fjeldsoe K., Spencer D., Jones A., op. cit., p 45.
[67] *Submission* 36.
[68] White U, Gilbert C and Johansen G, *Mental Health in the ACT*, Epidemiology Unit, ACT Department of Health and Community Care: Health Series No 11, ACT Government Printer, ACT, p 40.
[69] Confidential evidence.

Secure facility

4.61. Many submissions[70] expressed serious concerns about the problems associated with the lack of a secure facility for people who require involuntary accommodation. This has been an issue for many years. For example, the May 1993 Report of the Interdepartmental Working Group on Mental Dysfunction identified as a gap appropriate facilities (outside the criminal justice system) and effective community facilities and services for people with behavioural disorders who are dangerous to themselves or others. Since then an acute behavioural management program has been established, however as the Government acknowledged[71] the service does not include a secure facility and thus fails to address the needs of people in crisis episodes.

4.62. The Committee was most concerned about the reported practice of placing people (often young people under 25) considered to be a danger to themselves or others in the Remand Centre because there is no alternative. According to the Legal Aid Office the police, while extremely well intentioned, have to resort to charging such people with an offence to get them some help. What is questionable is the vague community expectation that if such people are placed in the criminal justice system something will be done, somehow this will activate services and the problem will be addressed. This practice overlooks the critical fact that the criminal law system is a punishment regime.

4.63. Grave concerns were expressed about this practice by the ACT Legal Aid Office, which pointed out three years ago that the practice is intolerable and people would die. Since that time three people have died. In commenting on the practice the Chief Executive of the Legal Aid Office said:

> *It is intolerable, I would have thought, for a decent community like ours to be sitting back watching us send people into systems where they will die or they will go to prison and be brutalised horrendously. Just to watch the appearance of a mentally ill person who goes into our Remand Centre and then on to Silverwater, or wherever, you can see that very aggressive haircut for example.*
>
> *If they are males, they spend a lot of time pumping weights. All that image is a progression to thuggery. This is in people who are, basically, very injured people to start off with; very ill people, to start off with. So, there is the dying; the brutalising; and there is the general abuse which we dish out because we are not putting services to people appropriately.*[72]

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[70] For example *Submissions* 14,18, 19, 20, 33, 44.

[71] Minister for Health and Community Care, *Report to the Standing Committee on Social Policy on the Need for and Provision of Services, including Legal Services, for People with a Mental Dysfunction,* December 1995.

[72] Transcript, p 28.

4.64. The Committee considers that urgent action must be taken to provide a more suitable facility for people with a mental illness who are considered a danger to themselves or others and require involuntary accommodation. The Remand Centre is totally inappropriate. Such a facility must be a safe non criminal facility which is able to provide the appropriate treatment and care for these people.

Recommendation 4

4.65. The Committee recommends that the ACT Government establish a secure facility for people with a mental illness who require involuntary accommodation.

Forensic psychiatric services

4.66. Forensic psychiatry is a speciality in psychiatry which deals with the mental health needs of prisoners and others involved with the criminal justice system. There are six categories of people who are within the criminal justice system and who may need forensic services. They are: people appearing before ACT courts; prisoners on remand at Belconnen Remand Centre; detainees of Quamby; detainees on weekend detention; detainees in police cells; and ACT prisoners serving sentences in NSW. The first five categories are serviced by the ACT Government, while the ACT prisoners in NSW are looked after by NSW Corrective Services and NSW Health.

4.67. The committee noted that the ACT Mental Health Services Draft Development Plan only includes a summary of the activities of the Forensic Service but does not include any strategies, visions or objectives for future improvements of the Service. The committee noted the lack of a strategic vision and lack of performance indicators to enable evaluation of the service.

4.68. A review of ACT Forensic Services was undertaken earlier this year by an external consultancy (Stephen Kerr). He observed ‘disturbing problems in the provision of services to those in custody’ and noted that ‘both of ACT's recent suicides in custody had a strong psychiatric element'. He recommended ‘a modest increase in resources immediately to improve basic forensic services.'

Quamby

4.69. The committee was also concerned about the adequacy of psychiatric service provision at Quamby. In the past year there has been a number of incidents and one suicide. A recent evaluation of the service reported:

> *Psychiatric provision to Quamby appears to be disorganised and no clear policy as who is responsible has been developed by MHS. Consequently the inpatient unit, community teams, child and adolescent, FPS and the crisis team are called at various times.*
>
> *The Casemanagement by MHS of mentally dysfunctional detainees is not evident and major problems were evident in the Casemanagement of a number of detainees discussed in this review.*
>
> *…Discussions need to occur to ensure that the specialist skills of C&A[73] are available to children in custody as this surely represents a high priority for publicly funded services.*[74]

Recommendation 5

4.70. The Committee recommends that a strategic plan and policies for forensic psychiatry services at Quamby be developed as a matter of urgency.

Belconnen Remand Centre

4.71. Forensic services at the Belconnen Remand Centre (BRC) have been a long standing problem.

4.72. The Government has provided reports every six months to the Social Policy Committee on the implementation of the interim mental health legislation. The report[75] for the period 1 January 1996 to 30 June 1996 noted that ACT Corrective Services identified a difficulty in accessing psychiatric intervention for remandees. Delays of up to 4 to 6 weeks have been experienced in having an assessment conducted by a psychiatrist when these assessments were recommended by a psychiatrist or general practitioner or ordered by the Mental Health Tribunal. There was also a problem identified where BRC staff were not

[73] C&A refers to the Child and Adolescent Mental Health Service.
[74] Kerr, Stephen, *Forensic Psychiatry Services*, Report to the Australian Capital Territory - Mental Health Services, February 1997.
[75] ACT Government, *Second Report on the Need for and Provision of Services, Including Legal Services, for People with a Mental Dysfunction*, December 1996.

always provided with information arising from an assessment which would assist in the care of the remandee.

4.73. In June 1997 the President of the Mental Health Tribunal told the Committee:

> *… if someone is taken into custody and then becomes psychotic, either at the police cells or the BRC, we have a problem. I really think addressing forensic cases of people in custody is an issue we have yet to come to grips with.*[76]

4.74. A Special Care Unit was established some years ago to accommodate detainees likely to commit acts of self harm, however it was never staffed properly or adequately equipped and has now been decommissioned. As acknowledged by the Government the BRC is severely limited in its capacity to provide observation and care to detainees who are assessed as likely to harm themselves.[77]

4.75. The employment of a psychiatric nurse early in 1997 is a much overdue reform. The role of the psychiatric nurse is to screen all detainees for their level of risk of self harm behaviours or suicide at induction to provide ongoing monitoring and care. The Committee visited BRC and became concerned about the professional and physical isolation of this position which is a Corrective Services rather than a Mental Health Services position. The Committee noted the professional isolation of the position and the view expressed by BRC staff that the position should be a Health position rather than a Corrective Services position. The Committee supports that view and believes that the matter needs to be addressed urgently.

Recommendation 6

4.76. The Committee recommends that strategies be put in place to improve:

- **the linkages between the Belconnen Remand Centre and ACT Mental Health Services; and**
- **the level of psychiatric service at the Belconnen Remand Centre.**

ACT prisoners in NSW jails

4.77. At any one time there are approximately 100 ACT prisoners in NSW jails. Recently there has been considerable discussion about the need for the ACT to have its own jail. Following examination of the issue the Legal Affairs Committee of the Assembly presented a statement supporting the ACT having its own jail. The Legal Affairs Committee did not address the issue of forensic psychiatric services. However the Committee understands that before any

[76] Transcript, p 345.
[77] Attorney General, correspondence dated 23 June 1997.

decision is made more detailed studies will be undertaken.

4.78. The number of ACT prisoners requiring forensic psychiatric services is difficult to determine. Monthly reports detailing the current location of ACT prisoners indicated that from 1 July 1996 to 30 April 1997, six ACT prisoners spent time in the Psychiatric Wards at Long Bay Hospital. Of these two were identified as forensic patients, that is referred to under the *Mental Health (Treatment and Care) Act 1994* as 'mentally dysfunctional offenders' and the remaining four may have received some treatment in the acute or sub acute psychiatric wards. There may be a small number of other prisoners who were not identified on the monthly reports. As the Attorney General noted in his letter to the Committee, the ACT Corrective Services administration is not notified when ACT prisoners move into psychiatric facilities so that it is difficult to estimate the numbers.[78] The Committee believes ACT Corrective Services should be advised of these moves when they occur.

4.79. The Committee is also concerned about the poor psychiatric facilities in NSW jails. The most recent evaluation of these services conducted by Professor Bluglass[79] made some serious criticisms of the service provision for example: poor hospital facilities (stark and unwelcoming); high staff turnover; low staffing levels; limited opportunities for therapeutic intervention; limited training in mental illness for prison officers; oppressive domination of the hospital by the prison culture; and limited input by psychologists. Bluglass noted that the 'primary aim is supervision, the prevention of suicide and self-harm and the containment of patients rather than a focus on treatment and rehabilitation.' He also pointed out the lack of services for discharged forensic patients and mentally ill prisoners and the lack of diversion schemes.

4.80. The Committee noted that ACT prisoners using the NSW psychiatric facilities in prisons face additional burdens by being isolated from visits from family and friends and this isolation can be especially traumatic for people suffering from mental illness. The Committee is of the view that it would be preferable if such prisoners had access to a psychiatric facility in the ACT. Such a facility should aim to provide a best practice treatment and rehabilitation service. It should also follow up services for prisoners on their release from prison. The Committee acknowledges that it would not be viable for an ACT forensic facility to provide the whole range of forensic psychiatry services and treatment as some of the more severe mental illnesses would occur infrequently in the small ACT prison population. In such cases it would be necessary to send ACT prisoners to another facility with the appropriate level of psychiatric expertise.

[78] Attorney General, correspondence dated 23 June 1997.
[79] Bluglass, R. *Review of Forensic Mental Health Services NSW*, March 1997.

4.81. After extensive discussions in New South Wales, Victoria and South Australia on the provision of forensic psychiatry services the Committee is of the view that any forensic psychiatry facility is best managed and administered by the health portfolio.

Recommendation 7

4.82. The Committee recommends that any assessment of the need for an ACT jail should consider inclusion of a best practice forensic psychiatry facility to be administered by the health portfolio.

Secure hospital service

4.83. The Kerr[80] review noted problems with the provision of secure hospital services and confusion regarding the transfer of patients from custodial institutions.

4.84. The Committee agreed with the consultant on the need for further study of the nature and level of demand for secure hospital services, hospital admission policies, transport arrangements and case management. The Committee also suggests that consideration be given to alternative treatments to hospitalisation eg in the prison or in the community whilst on bail or community order.

Court assessments

4.85. The Kerr review of the Forensic Service noted that 'the current services to courts are reasonable in quality and responsiveness' and that the reports are usually written by allied health staff of the Forensic Psychiatry Service. The review noted the Chief Magistrate and others had supported the need for on site or on call forensic psychiatry support to give advice to courts.[81] The Committee notes that in his report Kerr recommends immediate action be taken to provide an on site forensic psychiatry service for peak court sittings.

Community-based services

4.86. Other gaps identified with the Forensic Psychiatry Service[82] were a general lack of housing, community-based treatment options and residential drug and alcohol treatment to meet the needs of offenders experiencing mental dysfunction. There is also extremely limited availability of community-based services for mentally ill people who have committed more serious crimes.

[80] Kerr, Stephen, *Forensic Psychiatry Services,* Report to the Australian Capital Territory - Mental Health Services, February 1997.
[81] ibid
[82] ACT Government, *Second Report on the Need for and Provision of Services, Including Legal Services, for People with a Mental Dysfunction*, December 1996.

Acute inpatient beds

4.87. The Committee heard from a range of organisations and individuals that there is a shortage of acute care beds. Several witnesses and submissions reported difficulties in getting urgent cases admitted to the Acute Psychiatric Unit.[83] These cases included young people, people with a known psychiatric illness and people judged by the police to be in need of urgent psychiatric care. The Committee witnessed this problem when it visited the Canberra Hospital in March 1997. There is a total of 52 acute public inpatient beds, which are operational. Thirty two of these beds are at The Canberra Hospital and the remaining 20 at Calvary. The beds at Calvary Hospital are not 'gazetted' under the legislation, which means that the Mental Health Tribunal and the courts are not able to refer people to Calvary for assessment and treatment.[84]

4.88. The Director of the National Health and Medical Research Council Social Psychiatry Research Unit submitted that the standard of inpatient care is not satisfactory. One reason for this is that there are insufficient registrars and very often registrars do not have enough time to make a comprehensive assessment. He was particularly critical of the locked ward at The Canberra Hospital and maintains that with proper psychiatric and nursing care it is no longer necessary to treat a great majority of patients in locked premises.[85]

4.89. The Committee noted that several other mental health areas of equivalent size to Canberra manage with fewer acute inpatient beds. For example each of the metropolitan regions in South Australia has 40 beds serving a population of 300,000. In Victoria the Committee visited the Central East Area Mental Health Service, which serves a population of 350,000 with 16 acute beds. Both Victoria and South Australia have implemented major reforms in the delivery of mental health services resulting in a strong focus on regionally based services providing care and support in the community. Both these States have developed an integrated mental health program with mental health services based in the general health system rather than in separate institutions. Each region has a range of community-based clinical and non-clinical services which provide assessment, treatment and support. More time and further evaluation will be needed to determine the long term effects of these changes.

[83] For example *Submissions 9, 19, 25, 39*, Transcript, p 31.
[84] *Moving Ahead - Mental Health Care in the ACT*, ACT Government, November 1996.
[85] *Submission* 6, p 1.

4.90. Fjeldsoe et al[86] reported that a series of reviews and reports had identified several problems accessing acute services at The Canberra Hospital. These problems resulted from: difficulty in accessing extended care places; lack of supported accommodation; absence of dedicated child and adolescent beds; and absence of private beds. Canberra does not have an integrated mental health program with a full range of services. Community-based clinical and non-clinical support is not well developed.

4.91. The Committee is of the view that the answer to the current problems in accessing acute inpatient beds may not necessarily lie in providing more beds but rather in considering the gazettal of the beds at Calvary Hospital and the development of community-based clinical and non-clinical support, which would enable more people to be treated in the community rather than in hospital. An evaluation of the impact of the proposed increased community-based services on the demand for acute care inpatient beds will be necessary.

'Step down' facility

4.92. Another significant problem reported to the Committee is inadequate 'step down', half way accommodation. According to the Canberra Schizophrenia Fellowship Inc [87]people needing managed accommodation after hospital do not have enough options.

4.93. As Calvary Hospital[88] advised there are some clients who are not able to live independently in the community due to their mental illness and resulting disability either in the short term following an acute episode or in the long term as a life plan. At present many patients who are very slowly improving can only be accommodated in an acute inpatient unit when a less intensive setting would suffice.[89] This has the effect of tying up an acute inpatient bed, sometimes for months. The situation is further complicated because vacancies are not readily available in facilities such as Hennessy House and Watson Hostel. These hostels although staffed at intensive levels also function as long term placements because they are unable to move their sub-acute patients to adequately supervised and assisted accommodation.

4.94. The Executive Director of ACT Mental Health Services acknowledged that unlike other jurisdictions the service does not have the capacity at present to provide support and care for people in a 'half way house' type environment. The needs of people either beginning to become unwell who can be managed outside hospital or who would benefit from a short period of less intensive care and

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[86] Fjeldsoe K., Spencer D., Jones A., *Australian Capital Territory, Mental Health Services Review and Schedule to Accompany Purchasing Agreement*, May 1996.
[87] *Submission* 19.
[88] *Submission* 26, p 3.
[89] *Submission* 21.

support after hospitalisation, or who need a break away from their family are not being met at present.

4.95. ACT Mental Health Services asserted[90] that in the short term such a service is needed, however it should not be in an institutional environment but rather in a more normal environment such as a house or flat in the community.

4.96. The Committee notes that the need for respite care, already inadequate, may in fact increase as more community-based treatment and care is provided. As the Canberra Schizophrenia Fellowship told the Committee:

> *…treatment in the home might be very good for the person …but you have to think of the effect on the people in the house…spouses and siblings have rights to harmony, some attention to sleep.*[91]

4.97. The Committee considers that until community-based treatment and care is well developed and can deal effectively with people in the community a 'step down' facility must be provided.

Recommendation 8

4.98. The Committee recommends that the ACT Government establish a 'step down' facility in a community environment to provide 24 hour care including respite care for people with a mental illness not requiring hospitalisation.

Community-based assessment, treatment and support

4.99. Services to provide community-based assessment, treatment and support are currently very limited in the ACT. As reported above, in some other parts of Australia where such services are much more highly developed the demand for acute inpatient beds has decreased considerably.

4.100. The Committee had some discussions with regional Mental Health Services in Victoria and South Australia. While the models vary both these services have a strong focus on community-based treatment and support with mobile teams playing a crucial role. In both these States mental health services are structured on a regional basis with each metropolitan region serving a population approximately the size of the ACT.

4.101. In South Australia each mental health region offers the following community-based services:

[90] Transcript, p 267.
[91] Transcript, p 122, 123.

- Assessment and Crisis Intervention Service (ACIS)

This is the 24 hour crisis service. All admissions to the acute inpatient unit are channelled through ACIS. It does not provide treatment.

- Mobile Assertive Care (MAC)

MAC provides clinical support in the home to clients with long term, severe mental illness with significant disability who require continuous and accessible, intensive support. The MAC provides an alternative to hospitalisation. MAC services are provided in close cooperation with rehabilitation and accommodation support services.

- Continuing Care Team

The continuing care teams provide a range of community-based services including assessment, treatment, and consultancy services in addition to continuing care and case management. Case Management services focus on the seriously mentally ill who require ongoing monitoring and support in the community. Close links are maintained with inpatient services and the broad range of community support services.

- Community Support

Community support is the least intensive service. Community-based non government services are funded to provide a range of non-clinical services such as accommodation support and day programs. There is a move to engaging generic services to provide these services rather than just relying on organisations which only provide services to the mentally ill such as the Schizophrenia Fellowship. This is in line with the current thinking that services to people with mental health problems should be based in the general health and community system rather than being segregated.

4.102. Victoria's mental health services operate under a slightly different model. The services which provide support in the community are:

- Crisis Assessment and Treatment Service (CATT)
  This is a 24 hour service which provides both assessment and treatment. All admissions to the inpatient units are referred through the CATT.

- Mobile Treatment and Support Service
  This is a mobile, intensive, assertive case management and disability support service for people with severe and persistent psychiatric illness, who are not in an acute episode of their psychiatric illness. It provides a full range of services on an outreach basis. Services include assessment, individual service planning, treatment, unplanned responsive intervention, medication administration and management, housing support and rehabilitation. Contact is not dependent upon clients maintaining appointments.

- Continuing Care, Clinical and Consultancy Services
  These services operate in a similar manner to those in South Australia described above.

- Community support
  As in South Australia a range of non-government organisations are funded to provide a variety of non-clinical services such as support with daily living, day centres, training and psychosocial rehabilitation.

4.103. In both Victoria and South Australia there is a strong emphasis on the separation of clinical and non-clinical services, with clinical services in general provided by the public sector and non-clinical services by the non-government sector. Case management and coordination of services play a significant role in the delivery of mental health services in these States. The Committee sees merit in the separation of the provision of clinical and non-clinical services when there is effective case management ensuring a holistic approach.

4.104. The Government has acknowledged that community-based clinical and non-clinical treatment and support need to be developed. At present community-based clinical and non-clinical services cannot meet the demand. In the ACT there are currently several stand alone services providing support in the community. They include:
- the Crisis Assessment and Treatment Team, which was reformed early in 1997 and now offers assessment and treatment;
- the Psychiatric Rehabilitation Service (currently under review), which offers a centrally based rehabilitation service;
- the Intensive Rehabilitation Team (currently under review) which is part of the Psychiatric Rehabilitation Service and includes a Mobile Domiciliary Service for chronically mentally ill clients; and
- a community mental health service.

4.105. The Intensive Rehabilitation Team including the Mobile Domiciliary Service has been well received by the community. The Canberra Schizophrenia Fellowship[92] reported it has proved valuable in helping people who are avoiding contact with mental health services. However its case load is restricted and there is a long waiting list. Clearly there is a need for much greater access to mobile teams if the ACT is to provide an effective community-based service.

4.106. The Committee supports the Government's intention to provide more community-based mental health services. There are a number of successful models operating in other States. Some are based on discrete teams for example a crisis team; a mobile team; and a community mental health team. Others are based on a combined area-based team model where each clinician within the

[92] *Submission* 19, p 6.

team has a turn at doing crisis intake work for one or two days a fortnight and intensive case management for the remainder of the time.

4.107. Changes must be made in the context of the development of a fully integrated service in full consultation with consumers, staff and the community. Moreover planning must ensure that adequate and effective support systems are in place before people are moved from the hospital or any of the hostels into community settings.

Recommendation 9

4.108. The Committee recommends that the ACT Government

- **expand the range of community-based clinical services to include a mobile treatment and support service with similar functions to such services operating in the regions in Victoria and South Australia and that these be in addition to the Crisis Assessment and Treatment Team; and**
- **further fund and support non-government agencies to provide non-clinical community-based services to people with a mental illness.**

Supported accommodation

4.109. The issue of adequate supported accommodation options for people with a mental illness is closely related to the availability of support in the community.

4.110. An insufficient range of suitable, affordable housing options and disability support services for people with mental illness in the ACT was reported by many individuals and organisations submitting to the inquiry.[93] This deficiency has also been reported in a number of other studies over the last few years. These include Purdon (1995)[94], Burdekin (1993)[95] and the Interdepartmental Committee Review of Services for People with a Mental Dysfunction (1995).[96]

4.111. Further, the Richmond Fellowship, a significant provider of supported accommodation has for some time not been able to accommodate people without a considerable wait. In May 1997 the waiting time was seven months.[97] One of the reasons for the long waiting time provided by Richmond Fellowship is that a higher proportion of the clients currently in its houses require longer periods of support. These people are more suited to hostel accommodation, however due to a shortage of beds they are unable to be accommodated in one of the hostels.

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[93] For example *Submission*s 2, 13, 18, 19, 20, 21, 33.
[94] Purdon Associates Pty. Ltd, *A Review of Accommodation for People with Psychiatric Disabilities,* April 1995.
[95] Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness,* AGPS, Canberra 1993.
[96] As reported in Fjeldsoe et al, op cit p 30.
[97] Transcript, p 140.

4.112. On the other hand, according to ACT Mental Health Services there are a number of residents at Hennessy House and Watson Hostel who could be accommodated in the community if adequate and suitable support options were provided. The Committee understands that by August 1997 the movement of some residents into the community had begun.

4.113. The Committee heard from a number of individuals and organisations[98] who stressed the need for continual provision by Mental Health Services of 24 hour supported accommodation for the group of people who would not be able to live independently in the community. According to the Mental Health Council[99] there is a core of mental health consumers who need ongoing, 24 hour supported accommodation for various reasons such as lack of insight into medical condition leading to lack of compliance in taking necessary medications or regular urges to commit suicide. This accommodation need not necessarily be in an institutional setting such as Hennessy House, but could be in a small community setting. The Government should examine suitable models operating in other States that would be appropriate for the ACT.

4.114. Representatives of St Albans Church who work closely with residents at two ACT Housing complexes, told the Committee that many people with a mental illness who are currently living in or are moved into the community are not receiving the level of support they need.

4.115. Many do not have the skills to enable them to function effectively on their own. They cannot budget and prioritise their needs, do not understand nutrition, cannot cook, and are unable to manage their medication. As Father Peter Guy said:

> *The things we take for granted so quickly and so easily are simply not there.…*
> *They do not have the skills to manage their time…*
> *They do not know how to prioritise needs…*
> *You are putting people in the community who simply do not have the skill or the discipline to handle medication programs…*
> *They do not have decent meals…*
> *In interpersonal relationships, they lack skills, as individuals and groups.*[100]

4.116. Moreover, because of the lack of skills in managing access to support many people with a mental illness do not seek support services. The Committee was told that what are seen as simple issues such as getting to a service, dealing with the staff and having to wait their turn can be a major barrier to using services for some people with a mental illness. In many cases these experiences

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[98] For example *Submission*s 2, 14, 19, 33.
[99] *Submission* 33.
[100] Uncorrected proof transcript, 29 August 1997, pp 2-10.

lead to a build up of frustration and anger and the client either loses their temper or simply will not go.

4.117. Another significant barrier to accessing services is the unavailability of public telephones in some of the complexes as a result of continual vandalism. Residents often do not have their own phone because of difficulties in making payments. This situation makes accessing crisis services impossible.

4.118. St Albans also stressed the view that 24 hour support is required for some people. In discussing the plans to move people out of the hostels and the possibility of them going into ACT Housing flats one of St Alban's representatives said:

> *If we talk about a level of community support we have to get out of this silly pattern we are in that we are all educated, middle-class, competent people when we are not. If these people are going to be cared for, you have got to have someone 24 hours a day, manning a crisis centre in the flats. You have got to have people on call that they can walk to.*[101]

4.119. At present adequate support is not available for people with a mental illness living in these ACT Housing flat complexes and the Church is doing its best to fill the gap. However as Father Guy said:

> *We are reaching breaking point. It is not that we have ever broken down but I can see it coming if more and more is put on us to handle with our current resources.*[102]

4.120. An amount of $150,000 was allocated in the 1996/97 budget to increase community-based accommodation. In the 1997/98 budget the Government announced the allocation of a further $250,000 to establish more community-based residential places for Canberrans with a mental illness, mainly for some of the current residents of Hennessy House and Watson Hostel.

4.121. The Committee is most concerned about the adequacy of this level of funding when there is considerable evidence that adequate support is not available to those already living in the community. Over the last two and a half years the Committee has been continually told that support is inadequate or non existent for these people currently living in the community. The Committee would be most concerned if the funds to provide additional support were required to be generated by savings from within ACT Mental Health Services. The Committee urges the Government to continue to expand the support available to people with a mental illness living in the community.

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[101] Uncorrected proof transcript, 29 August 1997, p 9.
[102] Op cit, 29 August 1997, p 21.

4.122. The Committee believes that it is critical that adequate support structures, including advocacy are in place before any people with mental illness currently in hospitals or hostels are moved into the community.

Recommendation 10

4.123. The Committee recommends that:

- **the ACT Government ensure that community-based supported accommodation options in the future continue to include a range of levels of support from 24 hour support to minimal support; and**
- **the level of support required by each consumer be based on continuing thorough assessments of need, which include measures to ensure quality of life.**

Accommodation for young people

4.124. Young people with a mental illness were reported as being particularly poorly serviced. Barnardos[103] representatives told the Committee that there is a lack of appropriate accommodation services for young people with a mental illness. Many stay in services that are for mainstream young people who cannot live at home but rapidly exhaust their options in these services because of their behaviour, which may be a threat to others or difficult to live with. These young people tend to end up in flats. There are young people with a mental illness aged 15 and 16 living in ACT Housing flats without adequate support. Staff of the mainstream services are not trained to deal with such cases and cannot provide the required level of support.

4.125. Moreover, a delegation of youth refuges told the Committee that there are many times when they simply cannot manage a client because of the client's condition. Yet the refuges have huge problems in either having the young person admitted to hospital or obtaining clinical support from the CATT. When told that the CATT will visit up to four or five times a day the delegation told the Committee:

> *Yes, but it does not happen. It does not happen.*[104]

4.126. These are further examples of the serious deficiencies in services to young people with a mental illness. The Committee considers it extraordinary that research evidence strongly demonstrates the benefits of early intervention, yet young people with a mental illness are left unsupported. The Committee believes that it is critical that accommodation options and support services for young people with a mental illness are improved.

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[103] Transcript, p 95.
[104] Transcript, p 409.

4.127. There are a number of options which could be considered. One would be the establishment of a dedicated community house/s for this group with specially trained staff. Another would be to provide some training and a high level of clinical support to existing youth services on an on call basis from the proposed mobile team.

Recommendation 11

4.128. The Committee recommends that as a matter of urgency the ACT Government develop and implement a strategy which addresses accommodation and support needs of young people with a mental illness.

Separation of property management and support functions

4.129. During the course of the inquiry the Committee visited a number of non-government services in South Australia and Victoria which provide accommodation support. Without exception these services had devolved or were in the process of devolving the property management role to another organisation such as a housing cooperative. There was a general view in both these States that there is a conflict of interest in undertaking both the support and property management functions.

4.130. In most instances non-government agencies in the ACT are performing both these functions. While some agencies claimed that such an arrangement gave them more flexibility in dealing with problems such as rent arrears or property damage, the Committee is not convinced that one agency performing the dual role is satisfactory. As more people are accommodated in the community, the Committee would like to see a clear separation of the property management and support functions.

Clubhouse

4.131. A number of organisations and individuals drew the Committee's attention to the fact that the ACT does not have a Clubhouse. The Clubhouse model is a model of psychosocial and vocational rehabilitation that is to be found in a number of countries worldwide. The model is predicated on recognition of the fact that the ability to live and work successfully in the community is improved by being treated as a valued and needed contributor to society. It recognises that confidence, self-esteem and functionality all improve when the client is treated as a person with something to give, not as a passive recipient of social services.[105]

[105] Morgan Paul, *The Clubhouse Report - An Evaluation of Bromham Place Clubhouse Program 1991-1994,* SANE Australia.

4.132. Clubhouses operate in accordance with agreed program standards which are accepted by all Clubhouses worldwide. The Clubhouse model is founded on the premise that all people no matter how severely disabled by mental illness have the potential to be productive and the right to dignified satisfying work and relationships.

4.133. The Clubhouse is structured around various work units such as kitchen, employment, maintenance and communications units. The kitchen, communications and maintenance units generally support the daily operations of the Clubhouse. The kitchen unit prepares meals and snacks for members to buy. It is usually based on a commercial kitchen model and provides members with training which can equip them for work in the catering and hospitality industry. The communications unit covers much of the clerical and administrative work required to keep the Clubhouse going. Involvement in this unit develops a range of skills including keyboarding and computer skills.

4.134. The aim of the employment unit is to help ease members back into the workforce and support them in their jobs. Members and staff work together to find transitional, supported and group work placements. The transitional employment program provides a range of work placement types and support, offering a continuum of options from pre-vocational training through to independent employment. Group work placements include one off jobs such as packing and mailouts, for which the Clubhouse is contracted. When it takes on a job or places a member in a transitional employment program the Clubhouse guarantees the job will be done. In instances of absence due to illness the Clubhouse provides another trained person to stand in.

4.135. Clubhouse members participate actively in decision making and in all administrative and operational functions of the Clubhouse. These responsibilities include staff recruitment, board participation, Clubhouse correspondence and financial management.

4.136. The Committee visited two Clubhouses during the inquiry, namely Diamond House in Adelaide, a recently established program and Bromham Place in Melbourne, the first Australian Clubhouse. Bromham Place is sponsored and managed by the Schizophrenia Fellowship, while Diamond House is managed by a community board comprising people with a range of relevant qualifications and expertise.

4.137. The Committee discussed the possible establishment of a Clubhouse in the ACT with several witnesses. There was no opposition to the concept. The Canberra Schizophrenia Fellowship however cautioned the Committee about misunderstandings in the ACT community about the Clubhouse model. They

pointed out that some proponents of the model seem to think it is a drop in centre or leisure centre run by people with a mental illness for people with a mental illness. The Clubhouse model does empower people with a mental illness, but it does this through the use of highly skilled professional staff and needs a substantial and professionally managed budget. It is essentially a multi-faceted rehabilitation program.[106]

4.138. The Committee believes that the Clubhouse is a valuable model and supports in principle the establishment of a Clubhouse in Canberra. The Committee was told that financial and professional support from the Government would be required to set up one in the ACT. The Committee understands that other Clubhouses in Australia would provide support on a consultative basis. The Committee is not aware of any substantive work which has been done to investigate the extent of the need for such a program, the costs involved and the most suitable management structure and considers these issues need to be investigated before proceeding.

Recommendation 12

4.139. The Committee recommends that in consultation with the local mental health community and relevant experts the ACT Government conduct a feasibility study on the establishment of a Clubhouse.

Services for deaf people

4.140. It is estimated that there are 200 people in the ACT who identify themselves as members of the deaf community, by virtue of its unique culture and language, Australian Sign Language. For these people English is a second language. Further it is estimated that 15 of the 200 deaf people in the ACT require ongoing support for mental illness.[107]

4.141. The ACT Deafness Resource Centre told the Committee that there are no mental health services in the ACT which are linguistically and culturally sensitive to the needs of the deaf community. Service providers are uneducated about the needs of deaf people and misdiagnosis often occurs. For example deafness itself has been misdiagnosed as a psychiatric illness, mental illness has been diagnosed where none exists and poor language skills have been perceived as thought or language disorders.

4.142. The ACT is not alone in not having specific mental health services for deaf people. The Committee was told that there are only two psychiatrists in Australia who can use Auslan. One is practising in Sydney and the other from Western Australia has recently retired. Some Canberra residents are being treated by the Sydney psychiatrist, however travel and accommodation costs are

[106] Transcript, p 129.
[107] Transcript, p 296.

a barrier. The use of Auslan interpreters who are specially trained in mental health can facilitate access to generic mental health services. However there is a critical shortage of appropriately qualified and trained Auslan interpreters available for mental health work.

4.143. The Committee endorses the call by the Deafness Resource Centre for appropriate training in dealing with deaf people to be provided to mental health service providers.

Services for Aboriginals and Torres Strait Islanders

4.144. In 1996, as part of its Strategic Plan, ACT Mental Health Services completed a project on the mental health needs of Aboriginals and Torres Strait Islanders in the ACT. The project was supported by Reform and Incentive funding provided by the Commonwealth.

4.145. The report identified a number of service deficits for Aboriginals and Torres Strait Islanders. These include:

- a lack of culturally appropriate services;
- poor identification of Aboriginal and Torres Strait Islander people accessing ACT Mental Health Services;
- barriers to access to the mainstream mental health services such as: culturally inappropriate services; no Aboriginal staff to relate to; and lack of information in the community about available services and their location.

4.146. The report made a series of recommendations aimed at improving mental health services. Some relate to the employment of Aboriginal Mental Health Workers within ACT Mental Health Services and the filling of the designated position in the Aboriginal Medical Service. Others focus on education and training of staff on Aboriginal mental health needs and the importance of developing and distributing information on services of particular relevance to the local Aboriginal community.

4.147. However as the Director of ACT Mental Health Services told the Committee there has not been full agreement with the report. ACT Mental Health Services indicated that further discussions will be held with the Aboriginal community to ensure they are comfortable with the recommendations and the direction to be taken before any changes occur.[108]

4.148. The Committee also had discussions with some members of the Aboriginal community as well as some service providers who have a large number of Aboriginal and Torres Strait Islander clients.

[108] Transcript, p 403.

4.149. One women's refuge, Inanna,[109] which has a high proportion of Aboriginal clients identified a range of problems with mental health services to Aboriginal and Torres Strait Islander people. Inanna reported that existing services tend to focus on single issues and individual problems and do not recognise the need for a response which recognises the history and social context of people's lives. There is an urgent need for cross cultural awareness training for health professionals concerning contemporary aboriginal health status.

4.150. The submission from the Aboriginal and Torres Strait Islander community made similar points. It stressed the need for a holistic approach and for the system of care to be more responsive and appropriate to the needs of indigenous individuals or their families. It also stated that mental health services have little knowledge or understanding of the needs of the community or how the community works.[110] One consequence of this lack of understanding is that workers are not receiving cross cultural training which equips them to understand the context of how the Aboriginal community dealt with the traumas experienced by its members such as being taken away from the family.

4.151. Another issue of grave concern is the effect of what can be seen as tokenistic acknowledgment of Aboriginal health matters by employing a small number of Aboriginal people in health services. These people quickly become overburdened by increased demand.

4.152. The Committee believes that there is a number of critical issues which must be addressed when planning and delivering mental health services for this client group. They are:

- the definition of mental health needs to be addressed from an Aboriginal and Torres Strait Islander cultural point of view, not from a Western medical model;
- the role of kin relationships and social relationships and responsibilities in Aboriginal culture;
- the impact of kin relationships on funding needs of services;
- recognition that a holistic approach needs to be taken to address emotional and social wellbeing;
- the accuracy of current data;
- the development of a partnership relationship between the ACT Government and Winnunga Nimmityjah Aboriginal Health Service;
- the workload of Aboriginal staff in health services;
- ensuring cross cultural awareness training develops an understanding by service providers of their own culture and the impact of cultural differences on service delivery; and

[109] *Submission* 40.
[110] *Submission* 54.

- the timeframe; the far reaching changes required to address the emotional and social wellbeing of the Aboriginal and Torres Strait Islander people must be considered as a long term plan and realistically could not be accomplished in less than five years.

4.153. Further, negotiations must begin between the Aboriginal and Torres Strait Islander community and the Government to develop a true partnership relationship which is based on understanding and acceptance of the cultural differences and defines the roles and responsibilities of those involved in providing mental health services.

Recommendation 13

4.154. The Committee recommends that the ACT Government acknowledge the special circumstances surrounding the provision of mental health services to the Aboriginal and Torres Strait Islander community:

- **by working towards a partnership arrangement which gives greater community control in the delivery of services; and**
- **through increased resourcing.**

4.155. The Committee's attention was drawn to the fact that the ACT does not receive funds for Aboriginal housing under the Commonwealth/State Housing Agreement. Adequate and appropriate housing for Aboriginal and Torres Strait Islander people is something which must be addressed in the context of holistic care. Given the reported increase in the Aboriginal population of the ACT the Committee understands there may be a case for reassessment by the Commonwealth of the provision of funding under the Agreement.

Services for older people

4.156. The ACT Council on the Ageing (ACTCOTA) identified a number of issues concerning older people which need addressing. These included

- access to services and the identification of services;
- the appropriateness of the available services especially the tendency of some providers to dismiss depression as a normal part of the ageing process;
- support for older people who are carers of people with a mental illness;
- the need to offer alternatives to home based assessment and extended care for some older people with a mental illness; and
- the tendency for some providers not to distinguish between mental illness and dementia (loss of mental capacity).[111]

[111] Transcript, p 207-210.

4.157. ACTCOTA told the Committee that most of its concerns were addressed in ACT Mental Health Services' Draft Development Plan. ACTCOTA supported ACT Mental Health Services' proposal to establish a designated specialist psychogeriatric service as part of an integrated mental health service. It also supported the proposal for an education and liaison project saying:

> *The proposal for an education and liaison project is exactly what is needed to ensure that not only people in the mental health area but people in the aged care area, people working at home, people working in HACC services and people working in nursing homes and hostels, recognise the problems when they arise.*[112]

4.158. One issue which ACTCOTA cautioned the Committee about was conducting assessments and extended care in the client's home. ACTCOTA'S view is that in general this practice is fine, however there are times when it is not appropriate, for example when it places too much stress on a carer. There must be provision for the consumer to be given care in another setting. In such cases access to the proposed designated short-term assessment beds for older people would overcome the problem.[113]

Services for people of non English speaking background

4.159. The Committee received very little evidence about services for this group. ACT Mental Health Services' Draft Development Plan has highlighted services for people from non-English speaking backgrounds as an area it needs to deal with.

4.160. The major issues identified to be dealt with are:

- the provision of services that ensure equity of access and recognise cultural and linguistic differences; and
- the need to address the fact that people of non-English speaking background may face increased risk of mental health because of their isolation and dislocation.

4.161. Transact, the ACT counselling service for victims of torture and trauma highlighted the issues which need addressing for its client group as:

- recognition that 80 per cent of people coming to the ACT under the Humanitarian and Refugee programs are highly traumatised and need help;
- the importance of early intervention in preventing the later development of mental illness among victims of torture and trauma;
- the critical importance of health professionals engaging qualified interpreters when dealing with people who are not fluent in English; and

[112] Transcript, p 209.
[113] Transcript, p 210.

- training for health workers in understanding the cultural background of this client group and how that impacts on service delivery.[114]

Alternative treatment

4.162. Two people drew the Committee's attention to the need for the provision of services, treatments and therapies not available in the ACT public system and suggested that a regional 'Centre for Wholistic Healing' be established in the ACT to accommodate these services.[115]

4.163. The Committee was told[116] that in mental health services there is a lack of commitment to the biological and biochemical approaches to treatment of mental illness. For example in the ACT the important disciplines of orthomolecular psychiatry and clinical ecology are not practised.

4.164. Orthomolecular medicine refers to the treatment of medical conditions with 'right molecules' emphasising diet, vitamins and minerals in preference to drugs, although more conventional medicines may be used by orthomolecular physicians.

4.165. Clinical ecology is concerned with environmental illness, illness caused by what we breathe, eat drink or absorb through the skin.

4.166. Other treatments which were reported by these witnesses as not available in the public health system include some different massage therapies and stress reduction techniques, chiropractic care, orthomolecular nutrition and special counselling techniques.

4.167. These are important issues which should not be discounted. However the Committee does not have the resources to evaluate the merits of these suggested alternative treatments. The Committee suggests that the Government investigate alternative treatments for people with a mental illness.

Private hospital

4.168. At present there is no private psychiatric facility and ACT residents wishing to obtain treatment in a private hospital need to travel to Sydney or other cities. This has been acknowledged as a gap by the ACT Government. A private psychiatric hospital to be run by Calvary Hospital is currently under construction and is expected to be completed in February 1998. This will be a 20 bed unit which will provide both inpatient and day hospital services.[117]

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[114] Transcript, p 71-77.
[115] *Submission* 15.
[116] *Submission* 15.
[117] Transcript, 239.

5. The interface between mental health services and other services

5.1. The interface between various services has become a serious issue in the last two years. There were several widely publicised incidents which revealed serious deficiencies in communication between mental health services and other services. By the end of 1996 considerable action had commenced to improve the situation with the signing of a Memorandum of Understanding (MOU) between the Australian Federal Police and ACT Mental Health Services and the initiation of strategies to improve communication between ACT Housing and Mental Health Services. A description of these initiatives and their impact is outlined below.

5.2. Also at the end of 1996 the Government established an Internal Standing Committee on Mental Health to provide a regular forum at a senior officer level for the discussion of mental health issues across all agencies. This committee is tasked with monitoring mental health issues that affect all agencies, including legislation, complex clients and accommodation services.[118]

Australian Federal Police and other agencies

5.3. A Memorandum of Understanding (MOU) is in place between the Australian Federal Police (AFP) - ACT Region and ACT Mental Health Services. The aim of the MOU is to provide for effective management of situations involving persons suffering from a mental dysfunction. It details when and how police are to refer to Mental Health Services; procedures to be followed when police are called to assist Mental Health Services staff; and procedures for joint management of incidents. The AFP has also developed a MOU with the Canberra Hospital (formerly known as Woden Valley Hospital). These MOUs are reviewed regularly.

5.4. To facilitate ease of contact the AFP- ACT Region has appointed a Mental Health Liaison Officer at each of the policing patrols and with the Police Negotiation Team.

5.5. The AFP is usually the first agency to be called to provide assistance when an organisation or an individual is experiencing difficulties in dealing with a person with a mental illness. For example between 1 July 1996 and 30 June 1997 the AFP responded to 644 tasks which it considered to be mental health responses. Of these there were only 74 instances where the CATT called for police assistance.[119]

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[118] *Moving Ahead - Mental Health Care in the ACT*, ACT Government, November 1996.
[119] AFP, Correspondence dated 11 September 1997.

5.6. Evidence from the AFP indicated that the police are required to deal with many of the same people time after time. In one case the police were called to deal with the same person 108 times in one year.[120] The fact that the police are frequently called to support people with a mental illness begs the question as to how these people are being supported in the community. Why do people need to call the police rather than the Crisis Assessment and Treatment Team? The Committee is concerned that the police often have to take on the responsibility of being the first point of contact for people requiring assistance with a mental health problem. For example, when the Crisis Line (Triage) is overstressed and cannot answer a call immediately, the recorded message suggests the police be called if the matter is urgent.

5.7. At present there is no MOU between the AFP and ACT Housing or the AFP and the Mental Health Foundation. The need for MOUs between the police and these organisations has been acknowledged by the AFP. The Committee believes that this is essential.

5.8. At present there is a number of other non government agencies involved in the provision of accommodation and support for people with a mental illness. This number could expand as more community-based services are developed. The Committee considers that it would be useful for MOUs to be developed between the AFP and all relevant non government agencies.

Recommendation 14

5.9. The Committee recommends that Memoranda of Understanding to provide for effective management of situations involving persons with a mental illness be developed between:

- **the AFP and ACT Housing; and**
- **the AFP and relevant non government agencies.**

5.10. There has been strong community support for the procedures that have been put in place by the AFP. The Canberra Schizophrenia Fellowship[121] told the Committee that it was very impressed with the procedures put in place by the AFP and their training program. As the AFP[122] advised it has instituted a five day training course to better equip its officers to deal with people with a mental illness. By August 1997, 75 per cent of police officers had completed the training.

[120] Uncorrected proof Transcript, p 13, 14 August 1997
[121] Transcript, p 129.
[122] Uncorrected proof Transcript, p 5, 14 August 1997.

5.11. The Canberra Schizophrenia Fellowship was concerned about one recent case of inappropriate police behaviour in dealing with a man with a mental illness who was in the police cells. The Committee heard of another case of most inappropriate police handling of a person with a mental illness, who was charged and placed in Belconnen Remand Centre.

5.12. While it is pleasing to see many positive steps being taken by the AFP in dealing with people with mental illness, the Committee acknowledges that it will take time and effort to ensure all police officers handle people with a mental illness in an appropriate manner. These efforts must continue.

ACT Mental Health Services and ACT Housing

5.13. Late in 1996 operational protocols were put in place between ACT Housing and ACT Mental Health Services. The purpose of the protocols is to facilitate operational effectiveness between the two agencies in the delivery of housing and housing-related services to people with a psychiatric disability or apparent psychiatric disability. Contact officers have been appointed at a regional level in each agency to deal with issues related to this client group. The protocols set out procedures to be followed taking into account the provisions of the *Privacy Act 1988*.

5.14. The Acting Commissioner for Housing[123] reported that since the protocols have been in place ACT Housing has not experienced any serious occurrences or occurrences that it has not been able to address. He defined 'serious occurrence' as 'becoming aware of a problem for the first time because of police involvement'.

5.15. This is a major improvement. Certainly before the protocols were in place the Committee is aware of several cases where neighbours and carers received no assistance with concerns about a person with a mental illness from ACT Housing.

ACT Department of Education and Training and ACT Mental Health Services

5.16. In 1996 a pilot study was conducted involving the ACT Department of Education and Training and the Child and Adolescent Mental Health Service to facilitate a unified treatment approach for primary school aged children with emotional/behavioural problems. The aim of the project was to improve intersectoral links between schools and the Child and Adolescent Mental Health Service (CAMHS) by developing protocols for joint management of children and adolescents with emotional and behavioural problems. The project was successfully trialed in the Woden/Weston region.

[123] Transcript, p 310.

5.17. The Committee sought an update on progress since the completion of the pilot and was advised that 'following from the pilot CAMHS continues to have an ongoing working relationship with ACT schools; and it also works with the Youth Connections Service.'[124] This response leaves the Committee uncertain if any system-wide changes have been implemented such as the adoption system-wide of the protocols for joint management.

5.18. The Committee was interested to hear about an initiative in Victoria to develop and evaluate a school based mental health promotion strategy which aims to reduce the incidence of common emotional problems experienced by young people. The project called the 'Gatehouse Project' is a cooperative venture between the Centre for Adolescent Health and several schools in the Melbourne area. The project recognises that promotion of mental health is dependent on other people involved in that setting. It has a strong focus on both the personal and professional development of teachers and on promoting links with parents and community groups. It is planned as a three year project with overlapping yearly stages. The first phase of the project involved three schools and concentrated on: locating the project in the curriculum in each school; conducting professional development; and identifying strategies and designing materials which could be used with year 8 students. The later years will focus on: research and evaluation; curriculum development and implementation; whole school development; the development of school-community links; professional development; and publicising the project.

5.19. The Committee is of the view that much more work needs to be done around adolescent mental health and wellbeing. Research has demonstrated clear continuities between adolescent and later adult mental health problems. [125] Mental health problems have been linked to a number of health damaging behaviours such as alcohol and substance abuse, eating disorders, suicidal behaviour and smoking. Improvement in adolescent mental health is therefore likely to result in a range of other health, educational and social benefits.[126] The Committee believes that projects such as the Gatehouse project where schools and mental health professionals work together to promote mental wellbeing among adolescents through the normal school curriculum have significant potential as a public health measure. The Committee urges the ACT Government to monitor developments and to consider introducing this approach in the ACT.

[124] Minister for Health and Community Care, Correspondence dated 21 July 1997.
[125] Harrington 'The natural history and treatment of child and adolescent affective disorders (review), *Journal of Child Psychiatry and Psychology*, 1992, 3:1287-302.
[126] Centre for Adolescent Health, *The Gatehouse Project: Engaging with Schools, Report on the Developmental Phase: 1996.*

The Canberra Hospital/Calvary Hospital

5.20. Early in the inquiry the Committee heard from both ACT Mental Health Services and the Calvary Hospital that liaison between the two hospitals was not satisfactory. Some of the liaison problems seem to stem from the fact that Calvary is not a scheduled hospital. A patient presenting at Calvary who is subsequently placed under a schedule, cannot be admitted at Calvary and must be transferred to The Canberra Hospital.

5.21. The Committee was advised later in the inquiry that liaison between the two hospitals was improving.[127] The Committee observed that Calvary Hospital seems unsure of its future as a provider of mental health services. In the future if public bed usage is reduced due to better community-based treatment and support, Calvary could be in a position to offer a range of subspecialty psychiatric services such as services for people with post natal depression, eating disorders or suicidal tendencies. The Committee found that Calvary is providing its services based on its historical role and not as part of an overall plan. If the ACT is to provide a fully integrated mental health service, the services that the Government purchases from Calvary need to be part of the overall plan. At present there is no fully integrated Mental Health Strategy for the ACT. This matter is discussed in greater detail in the next chapter.

Correctional Services, the Department of Health and Community Care and ACT Mental Health Services

5.22. Discussions with staff of ACT Corrective Services at the Belconnen Remand Centre and evidence provided by the Chair of the Mental Health Tribunal[128] revealed deficiencies in the interface between ACT Corrective Services and the health bureaucracies namely the Department of Health and Community Care and ACT Mental Health Services. There is confusion over roles and responsibilities in relation to policy development and service provision. There is no group or organisation responsible for coordinating the health services and correctional effort in the delivery of health and medical services for offenders. In addition as Kerr[129] pointed out there are no clear policy guidelines about the provision of psychiatric services at the juvenile corrections facility, Quamby.

[127] Transcript, p 241.
[128] Transcript, p 345.
[129] Kerr, Stephen, *Forensic Psychiatry Services,* Report to the Australian Capital Territory - Mental Health Services, February 1997.

5.23. Further at present there is no comprehensive set of policies and protocols for all aspects of medical and health care for offenders. In relation to mental health care at the Belconnen Remand Centre, access to psychiatric assessments and treatment is difficult and slow. The mental health nurse does not have immediate access to ACT Mental Health Service patient records and referrals to a psychiatrist must be requested through the private General Practitioner which also leads to delays.

5.24. The need to improve the interface between correctional services and the health bureaucracies will become even more critical if the ACT decides to establish its own prison.

5.25. Other jurisdictions such as NSW and Victoria have a structure in place to ensure broadly based policy advice and management of all correctional facilities. In NSW this organisation is the Corrections Health Service Board, which comprises representatives from the Department of Health, NSW Department of Corrective Services, the Corrections Health Service, community representatives from the indigenous community, industry and universities. Appointments are made by the Minister for Health.

5.26. The Committee believes that the establishment of a Corrections Health Service Board would result in significant improvements in addressing the mental health needs of all offenders and detainees including juveniles. A Corrections Health Board would not be confined to mental health issues but cover all aspects of health.

Recommendation 15

5.27. The Committee recommends that the ACT Government establish a Corrections Health Service Board.

6. Coordination of services and continuity of care

6.1. At present ACT Mental Health Services is the major provider of mental health services. It comprises a number of different services such as the Acute Psychiatric Unit, Watson and Hennessy Hostels, the Crisis Assessment and Treatment Team, the Rehabilitation Service, the Child and Adolescent Mental Health Service and a separate community mental health service for each region.[130]

6.2. In addition, Calvary Hospital, GPs, private psychiatrists and the small number of services provided by non-government organisations have a significant role in providing mental health services. These services interact frequently with ACT Mental Health Services and are often dependent on particular services within ACT Mental Health Services for specialist support.

6.3. The ACT Department of Health and Community Care has a major role in funding, policy development, planning and assessment of outcomes of mental health services.

Deficiencies identified

6.4. The Committee received considerable evidence which indicated serious deficiencies with service coordination and continuity of care across hospital and community-based settings.

6.5. The ACT Division of General Practice Inc in collaboration with ACT Mental Health Services undertook a Shared Care project over the last two years. The project aimed to enable the Division to develop strategies to increase the effectiveness of GPs in mental health care and to establish more cooperative working relationships between GPs and mental health services. The results of this project offer some useful insights into current deficiencies in coordination and continuity of care.

6.6. The project found:[131]

- there is a need for the further development of effective protocols for referral and feedback between GPs and any of the mental health services;
- there is a need to improve liaison and coordination with public crisis and non-crisis mental health services, hospital out-patient services and with private psychiatrists; and
- there is a need to enhance the skills and knowledge of GPs in some areas of mental health.

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[130] Transcript, p 264.

[131] ACT Division of General Practice, *Enhancing Mental Health Care through General Practice*, Report on the Shared Care Project, April 1996.

6.7. The Committee also heard of many specific cases describing the current problems.

6.8. The Executive Director of ACT Mental Health Services told the Committee:

> *that while component parts of the system are functioning quite well, the system as a whole does not seem to pull together and function in a coordinated way.*[132]

He reported that there have been instances where a single person has made contact with three different parts of the service on the same day and has not received an adequate response from any of them because each service thinks somebody else is acting on the case.[133]

6.9. The Canberra Schizophrenia Fellowship[134] presented a case study which highlighted a serious lack of coordination and communication between the four groups involved in the case, namely the Mental Health Tribunal, the police, the Canberra Hospital and the doctors. This case describes the experiences of a mother in trying to get support for a 20 year old assessed as probably being in the prodromal stages of a psychotic illness. Her attempts to have her 20 year old agree to voluntary treatment were unsuccessful. She then sought a hearing with the Mental Health Tribunal which decided that there should be a three day in-patient assessment. Several weeks after the hearing a warrant was issued to take the young person to hospital for an assessment. On arrival the duty doctor was not aware of any arrangements for an in-patient assessment and the young person was sent home. The following day the mother enquired about when the assessment was to take place. She was told it was to be in six days time. Before the day was over she received another call to say the assessment was not in six days time but that the doctor had requested it be in 13 days time, which was a time when the doctor would be available to keep a close eye on all the tests. Nevertheless the police arrived with a warrant to take the young person to hospital six days later. The young person was admitted and assessed. However the young person continued with bizarre behaviour and was not compelled to accept help. The mother and her children continue to live in fear.

6.10. Parents and carers of children and adolescents reported that there are too many players in each case which can result in a frustrating and unsatisfactory situation of having to speak to someone different each time an issue arises. One

[132] Record of discussions, 4 February 1997, p 3.
[133] Transcript, p 264.
[134] *Case Study*. Paper tabled by the Canberra Schizophrenia Fellowship, 29 April 1997.

person[135] told the Committee that at present parents and carers and sometimes the young consumer have to go from one place to another to beg for help. Further the submission pointed out that a young consumer is often unwilling to seek help. These frustrations are exhausting even for the most willing carer.

6.11. The Post Natal Support Group submitted that services are not fully briefed about the agencies in the Territory which inhibits appropriate referral of clients. Further information needs to be available to clients so that they can have some choice in the manner of their care and gain some control of their treatment. [136]

6.12. The Committee was advised that coordination of service provision and continuity of care in case management usually does not take a holistic view and total care approach.

6.13. Inanna[137] reported that current interventions appear too often to be a 'bandaid' treatment of diagnosis, medication and short term crisis management. Treatment is focussed on the presenting problem and often does not extend to dealing with life experiences such as trauma, sexual assault and domestic violence which could be linked to the mental illness or impact on mental wellbeing. Inanna quoted the case of a woman who received psychiatric treatment for five years before someone suggested that the Rape Crisis Service may be able to assist her resolve her problems.[138]

6.14. The Aids Action Council[139] also reported experiences of poor case management and coordination of services for some of its clients. In one instance of an HIV positive man suffering from manic depression and schizophrenia, the client's case manager failed to assist in finding suitable accommodation, in seeking rehabilitation or activities and accessing further psychiatric help. No supported accommodation was available and the client was forced to live in an ACT Housing flat where he proved unable to care for himself properly.

6.15. In another instance the Aids Action Council claimed that the needs of a client with AIDS Dementia Complex admitted to the Acute Psychiatric Unit were not met. The AIDS Action Council stated:

> *There was a general lack of understanding of both health and social issues relating to HIV. The client was stabilised on psychiatric medications and then transferred to the Oncology Ward where his psychiatric problems were not well managed. On several occasions the client was found wandering in various states of nakedness in other areas of the hospital and on one*

[135] *Submission* 51.
[136] *Submission* 36.
[137] *Submission* 40.
[138] Transcript, p 193.
[139] *Submission* 37.

> *occasion was discovered trying to catch a taxi outside the hospital. Hospital staff claimed that they did not have the resources to properly supervise the client, so the AIDS Action Council was approached to put in place a team of volunteers on the hospital ward to supervise his daily activities.*[140]

6.16. A number of other organisations and individuals also expressed serious concerns about the boundaries between the Acute Psychiatric Unit and different parts of The Canberra Hospital and the resulting poor continuity in care and coordination of services.

6.17. Woden Youth Centre asserted that once someone enters the hospital system all hope of continuity of care is lost.[141] The centre which supports many young people through crises, reported great difficulties in being allowed to continue that support to any of their clients who were hospitalised.

6.18. The Woden Youth Centre[142] related the difficulties encountered in obtaining psychiatric assistance by the family of a young man critically injured in a stabbing. This young man spent many months in hospital recovering from the attack without any psychiatric support. Despite concerted attempts by his family or advocates to negotiate to have psychiatric support to help him deal with severe post traumatic stress this support was not provided. The reasons given were that he was not to receive any psychiatric assessment or support until he was physically well.

6.19. Woden Youth Centre was also very critical of discharge procedures at the Acute Psychiatric Unit. It told the Committee that when they refer someone to the ward not only do they get no response to any request for progress, they are not told what is to happen when the patient is discharged. At times they have found people released from hospital who have no one to pick them up wandering near the centre in a very heavily medicated state.[143]

6.20. The President of the Mental Health Tribunal expressed concerns about people being discharged from the Acute Psychiatric Unit without support. Many people in this situation live alone in ACT Housing flats and without support are at risk of having another episode and requiring readmission.[144]

6.21. The Acting Commissioner for Housing also stressed the importance of recognising that people with a mental illness need support in the community on an ongoing basis. He pointed out that in large flat complexes it is easy for people without disabilities to become isolated; it is doubly so for people with disabilities

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[140] *Submission* 37.
[141] Transcript, p 113.
[142] Transcript, p 113.
[143] Transcript, p 109.
[144] Transcript, p 348.

and whose behaviour may be aberrant. He suggested that a non-government organisation be funded to provide support based on a case management plan for the individual which recognises not only the psychiatric disability is episodic on occasion but also that the support needs vary through time and that sometimes the individual does not need anything more than somebody dropping in once a week for a short time.[145]

Case management

6.22. Case management is considered to be an effective way of utilising and coordinating resources and services to meet the individual needs of the client. Case management manages a client's entry into the service, coordinates the client's movement through the service and assists with discharge.

6.23. The Committee received much evidence indicating the need for improved case management to assist better continuity of care.

6.24. Inanna submitted that the current lack of coordination, case supervision, needs analysis and case management handover means that agencies potentially double up on service provision, have to gain a history of previous interventions and judge independently how best to step into a case management plan.[146] In Inanna's view, in terms of case management an impediment to collaborative, multidisciplinary service provision is restrictive networking between services especially between ACT Mental Health Services and the community sector.

6.25. The Richmond Fellowship reported that at present the effectiveness of case management is largely dependent on the skills and dedication of the individual case manager. The role played by the Intensive Rehabilitation Team was seen as critical in case management of Richmond Fellowship clients[147]

6.26. The President of the Mental Health Tribunal told the Committee that unless there is a case plan and a case manager in place the efficacy of the Tribunal's orders must be questioned.[148]

6.27. 'Major problems with the case management of some Quamby detainees' were noted by the consultant engaged to review ACT Forensic Services. The report recommended the introduction of a visiting psychiatric nurse to be supported by a psychiatrist and integrated with court advice and Belconnen Remand Centre sessions.[149]

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[145] Transcript, p 312.
[146] *Submission* 40.
[147] Transcript, p 148.
[148] Transcript, p 347.
[149] Kerr, Stephen, *Forensic Psychiatry Services,* Report to the Australian Capital Territory - Mental Health Services, February 1997.

6.28. According to ACT Mental Health Services the case management role of each regional community mental health team tends to be defined by the clinician involved rather than the use of a standardised system. Integration between the regional teams and the inpatient unit is enhanced by staff attending weekly clinical meetings at the Psychiatric Unit at The Canberra Hospital.[150] Yet the evidence before the Committee suggests that this approach is not always effective.

6.29. Similarly the evidence provided about coordination of services and continuity of care in the hospital setting suggests more effective systems need to be put in place.

6.30. One of the reasons given for poor case management and coordination of services is the structure of some aspects of mental health services. ACT Mental Health Services at present is set up as separate services such as the Child and Adolescent Mental Health Service (CAMHS) and the Psychiatric Rehabilitation Service (PRS). In the case of the PRS at present in addition to having to wait to access the service some programs which could be offered on a regional basis are centralised. The Executive Director ACT Mental Health Services told the Committee:

> *One of the problems when you have a stand alone rehabilitation program is that rehabilitation becomes something that that bit of the program does, where my view is that everybody who has a case manager should have a rehabilitation plan in place, so as part of their treatment and management there is a rehabilitation approach to how they are being managed. So that virtually everybody has a rehabilitative approach taking into account their needs and what can be done, hopefully on a local basis and hopefully using where possible generic services with our support to get into those programs.*[151]

[150] *ACT Mental Health Services Draft Development Plan,* April 1997, p 20.
[151] Transcript, p 265.

Recent initiatives to improve service coordination and continuity of care

Shared Care Project

6.31. As a result of the Shared Care Project the Division of General Practice and ACT Mental Health Services are working together to improve links and to promote continuity of care. The Committee is strongly supportive of this initiative and expects it to result in better coordination and continuity for some consumers.

6.32. GPs are increasingly being called upon to play a crucial frontline role in mental health care and there is strong recognition of the significance of mental health care within general practice. Research both in Australia and overseas indicates that the establishment of direct links between mental health services and general practitioners leads to improved cooperation and to improved coordination of care.

Crisis service

6.33. As part of the reforms to ACT Mental Health Services, in February 1997 the Crisis Service underwent major changes. The service is now a crisis assessment and treatment service rather than just a crisis and referral service. It operates on a triage system where a qualified practitioner takes the calls, makes an initial assessment and directs the Crisis Team in how it responds and the time limits for a response. Eight additional staff including a psychiatrist and a medical registrar have been added to the team. The team is taking on more responsibility in continuity of care and this will increase as more people are managed and treated in the community by the Crisis Team and the Community Mental Health Teams. The Crisis Service is now the preferred point of entry into all services provided by ACT Mental Health Services.

6.34. The Committee was disturbed to hear from three witnesses recent serious difficulties in contacting the Crisis Service. One a medical practitioner told the Committee that when he phoned the Crisis Service he received a recorded message. He gave up and reluctantly called the police.[152] Another stated that she was put on hold for half an hour and finally gave up.[153] The third case involved a parent, with a referral from her child's GP and school psychologist, wishing to make an appointment with the Child and Adolescent Mental Health Service (CAMHS).[154] The Crisis Line/Triage number is the also the contact point for CAMHS. When she called the number she was put on hold for 15 minutes and

[152] Transcript, p 373.
[153] Constituent complaint to the Chair.
[154] Correspondence dated 15 August 1997, name withheld.

then had her conversation interrupted while the triage officer answered another call. The information she gave was assessed as sufficient for a referral to CAMHS and she was then told that the triage officer would put the referral through to CAMHS, who would contact her in a few days with an appointment time.

6.35. The Committee observed that such teams in other States are more generously staffed. The Committee was assured by the Executive Director ACT Mental Health Services[155] that present staffing levels in the ACT are adequate, however they will need to be reviewed as more people are managed in the community. The Committee finds this assessment difficult to accept in the light of the problems cited above and wonders whether staffing levels should be reviewed as a matter of urgency.

Consultation Liaison Psychiatry Service

6.36. For some time there was no consultation liaison psychiatry service at the Canberra Hospital. Consultation liaison psychiatry refers to the management of psychiatric problems associated with medical presentations and problems. The fact that there was no liaison psychiatry service created major problems in the coordination of services and continuity of care as well as problems for the training program. The position has recently been filled which should result in an improvement in continuity of care at the Canberra Hospital.

Management Assessment Panel

6.37. A Management Assessment Panel (MAP) was established earlier in the year. It is located in the Office of the Community Advocate. Its function is to promote and facilitate coordination and cooperation between all service providers in the ACT and enable those with a mental dysfunction or other eligible individuals to access an integrated package of support and resources.

6.38. Membership of the MAP varies according to the case, however the Chair is a continuing member. Panels are constituted by invitation to the agencies already involved in the cases referred, together with representatives of other agencies (government and non-government) thought to be likely to have the potential to contribute to new solutions.

6.39. The most usual referrals to the MAP are when complex and challenging service provision needs exist and when there are personal risks or dangers. The MAP is available to both children and adults. The MAP is not available to everyone with a mental dysfunction. Strict eligibility criteria apply. The MAP will only consider those situations where the eligibility criteria are met and when no other solutions exist.

[155] Transcript, p 266.

How can coordination of services and continuity of care be improved?

6.40. The initiatives to improve the interface between agencies described in the previous chapter together with the recent initiatives to improve coordination of services and continuity of care described above should result in some improvements. However much more needs to be done to ensure seamless service delivery right across mental health services.

ACT Mental Health Services

6.41. According to ACT Mental Health Services continuity of care is promoted by:

- case management;
- an assessment program with a preferred point of entry into an integrated service;
- information systems which facilitate continuity and integration; and
- a multidisciplinary approach.[156]

6.42. The evidence presented to the Committee indicates that service providers, carers and consumers are not satisfied with current efforts to coordinate service provision. While ACT Mental Health Services has undertaken a case management project which according to the Government submission has resulted in improvements to the system of clinical case management for clients, until very recently (July 1997) there was not a consistent and well documented policy on case management. Further the service is not a fully integrated service, information systems appear to be unsatisfactory and a holistic approach is often not taken.

6.43. ACT Mental Health Services has identified continuity of care as one of the issues it will address in the future organisation of its services. The Committee is alarmed that such a critical aspect of support is not well developed and strongly supports ACT Mental Health Services' intention to do something about it. It must be done in the context of the development of an integrated service.

Recommendation 16

6.44. The Committee recommends that in consultation with key stakeholders including consumers, ACT Mental Health Services develop and implement a strategy that ensures continuity of care for its clients.

[156] *ACT Mental Health Services Draft Development Plan,* April 1997, p 29.

Policy development and planning

6.45. The Committee gained an impression that the Government is relying on ACT Mental Health Services, the largest provider, to solve all the Territory's problems with mental health services. The Government's public statements since November 1996 have largely focussed on the changes in ACT Mental Health Services. Moreover when the Committee requested information on mental health policies for specific groups such as people from non-English speaking background and children and adolescents the Committee was referred to the Draft Development Plan of ACT Mental Health Services. Little has been said about the initiatives in policy, planning and outcome measurement.

6.46. The recently appointed Executive Director of ACT Mental Health Services observed that:

> *… the ACT has, in fact a lot of good resources but many of them are not being pulled together and, many of them do not necessarily work cooperatively … There are actually lots of bits but there is not a mechanism that pulls them together so that you have a full spectrum that avoids overlap, ensures that there are not gaps in the system and that we get better utilisation of resources by getting the people to work together.*[157]

6.47. In the last year the functions of policy, planning and outcomes and service delivery have been separated with the introduction of a purchaser provider model.

6.48. The Committee noted that in Victoria and South Australia much emphasis was given to policy development, planning and outcome measurement. The equivalent of the Department of Health and Community Care in those States had a very clear view about the changes which were required, how these changes were to be achieved and their expectations of funded services. These are detailed in a series of policy documents.

6.49. In its submission of September 1996, the Government stated:

> *The current structure of public mental health services does not enable coordination of Territory wide mental health strategic planning and development which can limit outcomes in relation to coordinated care.*[158]

[157] Transcript, p 389.
[158] *Submission* 44, p 18.

6.50. In July 1997, the Committee raised the matter of the existence of a Territory-wide strategic plan on mental health with officials of the Department of Health and Community Care and was told that there is none. The development of a whole of Territory policy and strategic plan will be the Department's next major task after the review of the mental health legislation has been completed.[159]

6.51. The Committee is astonished that significant changes are being implemented without any overall policy and strategic plan in place. It is fortunate that, according to the officials, there are no major differences between what ACT Mental Health Services is doing and what the Department wants it to do. Policy should drive service delivery not vice versa.

6.52. The lack of any overall policy and strategic plan has meant that service providers and consultants such as Fjeldsoe et al have been working in a policy vacuum.

6.53. The Committee believes that the Department of Health and Community Care, as a matter of priority, must develop a Territory mental health policy and strategic plan with input from relevant stakeholders including service providers, potential service providers, carers, consumers, non-government organisations and the community.

Recommendation 17

6.54. The Committee recommends that as a matter of high priority the Department of Health and Community Care in partnership with stakeholders develop a Territory Mental Health Policy and Strategic Plan which includes clear policy guidelines for all aspects of mental health services as well as evaluative measures.

Advocacy and complaints mechanisms

6.55. The Committee heard some disturbing accounts about the effects of the lack of coordination of services, poor continuity of care and poor or non-existent information systems. These problems ranged from consumers being given the 'run around', to over-medication, lack of informed consent and a serious allergic reaction to medication.

6.56. Consumers and key community organisations discussed with the Committee the importance of advocacy and the need for improved complaints mechanisms.

[159] Transcript, p 377.

6.57. The National Mental Health Policy states:

> *Consumers must have access to information on their rights and to advocacy services to ensure their rights and to mechanisms for complaint and appeal.*[160]

6.58. Advocacy takes many forms. It includes self advocacy, advocacy by a parent or carer, and independent advocacy. As Conroy[161] points out, while self advocacy may be the most desirable form of advocacy because it is the most empowering there are times when service users are not able to act for themselves. Then independent advocacy is the most appropriate alternative. Independent advocacy can be provided by an advocacy organisation such as People First or ADACAS. It can also be provided by consumer advocates.

6.59. The availability of advocacy services is critical at all times but especially during times of change. The Committee is concerned that some people with a mental illness are not given full opportunity and information to access an advocate.

6.60. Over the next few years mental health services in the ACT will undergo considerable change. In accordance with the National Mental Health Strategy plans are underway to move people living in hostels into more homelike accommodation in the community with opportunities for greater independence and integration. This will require significant adjustments for some people. For the process to be as least disruptive as possible and to provide the necessary support, all affected people must have access to the support of an advocate.

6.61. To enable this to occur advocacy services must be adequately funded to deal with any additional workload. The Committee acknowledges that this may require the Government to provide additional resources.

Recommendation 18

6.62. The Committee recommends that the ACT Government ensure:

- **consumers of mental health services have access to advocacy services as needed;**
- **adequate funds are provided to advocacy services to enable them to deal with any increased demand as a result of the changes in the delivery of mental health services.**

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[160] Australian Health Ministers, *National Mental Health Policy,* AGPS, Canberra, 1995, p 15.
[161] Conroy Catherine, *Report on the South Eastern NSW Mental Health Consumer Advocacy Project,* October 1996, p 4.

6.63. Consumer advocates are an emerging form of advocacy. Mental Health Consumer Advocate positions have been established in some States, for example in New South Wales and in Victoria. The Committee met with one of these advocates in Victoria. In general the role of the Consumer Advocate is to provide help and support to clients of the mental health service, to support consumers attending tribunal and guardianship or court hearings and network and negotiate with government and non-government organisations regarding mental health issues.

6.64. The Committee was told that there is a need for a consumer advocacy system to be initiated in the ACT to ensure the rights of people with a mental illness are respected.

6.65. Often parents and carers are overlooked as advocates. While they are not independent they frequently have a wealth of background information and knowledge about the needs of the client. This can include knowledge which can be critical such as medication needs or allergies.

6.66. The Committee was also told that complaints procedures in mental health services in the ACT are not satisfactory. Effective complaints systems do not merely rely on external mechanisms but also include good internal complaints mechanisms and grievance procedures.

6.67. Consumers of mental health services in the ACT can lodge a complaint with the Commissioner for Health Complaints, an independent external body. However the Committee found many consumers were unaware of this mechanism. Others simply did not have the energy to pursue this avenue themselves.

6.68. Government officials advised that discussions[162] have also begun on the feasibility of creating a position of Official Visitor to hear complaints about mental health services. The Committee has been advised that this system works well in some other states. The Committee is interested in this concept and looks forward to further discussion.

6.69. The Committee believes that good internal complaints systems are essential for all services. Such a system must have clearly enunciated processes, be well advertised and be viewed as part of a continual improvement process rather than in a negative way. In relation to complaints systems the recently released *National Standards for Mental Health Services* states:

> *The MHS has an easily accessed, responsive and fair complaints procedure for consumers and the MHS informs consumers and carers about this procedure.*[163]

[162] Transcript, p 380.
[163] *National Standards for Mental Health Services*, p 8.

6.70. The Standards should be incorporated into service/funding agreements and achievement of the Standards regularly monitored. The Committee understands that the ACT Government[164] is committed to these standards but that they have not all been implemented yet.

6.71. Further, there must be clear service agreements in place between the provider and the consumer so all involved are aware of their rights and responsibilities.

Recommendation 19

6.72. The Committee recommends that the Department of Health and Community Care require all funded mental health services to develop effective internal complaints systems and grievance procedures and to make information on these readily available to consumers, carers and advocates.

[164] Transcript, p 378.

7. Monitoring progress

7.1. During the course of this inquiry some progress has been made towards restructuring mental health services, addressing the gaps in services, encouraging consumer input in planning and policy development and issues related to coordination and continuity of care. However there is still much to be done.

7.2. As long ago as May 1993 an Interagency Working Group identified the following gaps in service delivery for people with a mental dysfunction:

- *appropriate and effective community facilities and services;*
- *secure treatment facilities for medium to longer term mentally ill;*
- *services for children and adolescents requiring psychiatric intervention;*
- *services for young children requiring psychological intervention;*
- *services for mentally dysfunctional people to meet the needs of Aboriginal Peoples and Torres Strait Islanders;*
- *accommodation options for intellectually disabled;*
- *emergency back up system;*
- *acute beds for people with a mental illness;*
- *services for mothers with small children;*
- *appropriate facilities for inebriates;*
- *services for babies and young children.*[165]

7.3. Most of the gaps noted above still exist and have been identified again in this inquiry.

7.4. A number of submissions to the inquiry expressed concern that current services cannot now meet the demand placed on them by consumers in the community.

7.5. As more emphasis is placed on community-based treatment there will be a critical need to ensure sufficient clinical and non-clinical support is available. It is imperative that the gaps in services are adequately addressed and that further community-based services are instituted in the context of the development of an integrated mental health service.

7.6. Moreover, as more community-based services are established and the non-government sector is expanded issues of coordination and continuity of care will become more important.

[165] Interagency Working Group on Mental Dysfunction, *Final Report*, 1993, p1.

7.7. For these reasons the Committee considers it essential that the provision of mental health services continue to be monitored on a biannual basis.

7.8. The Committee notes the Government's wish that reports be provided to it annually in the form of the Annual Report on Mental Health Services. However as most providers are required under their purchase agreements to report at least six monthly to the Department of Health and Community Care, the Committee wishes biannual reporting to continue.

Recommendation 20

7.9. The Committee recommends that the ACT Government continue to provide to the Social Policy Committee (or its equivalent) regular six monthly reports on:

- **the need for and provision of services including legal services for people with a mental dysfunction; and**
- **progress with the implementation of recommendations of this report.**

Kerrie Tucker MLA
Chair
19 September 1997

Appendix 1 Submissions

1. Katrina Higgins
2. Canberra Schizophrenia Fellowship
3. Ms Patricia Landers
4. Post Natal Depression Support Group (ACT) Inc.
5. Confidential
6. ANU, NHMRC Social Psychiatry Research Unit
7. Confidential
8. Work Ways
9. Dr Brian White
10. Confidential
11. Mr Cornelis Reiman
12. Australian Psychiatric Disability Coalition Inc.
13. The Richmond Fellowship of the ACT Inc. - ACT Chapter
14. Mr John Rowland
15. Mr Doug McIver
16. National Association for Loss and Grief (NSW) Inc.
17. Mr Kevin Dutton
18. Centacare
19. Canberra Schizophrenia Fellowship Inc.
20. Dr L.R.H. Drew
21. The Royal Australian and New Zealand College of Psychiatrists, ACT Branch

22. Mrs E Batterham

23. Dr Terry Heins

24 Alcohol & Drug Foundation of the A.C.T.

25 Woden Youth Centre

26 Calvary Hospital

27 Mental Health Tribunal

28 Community Information and Referral Service of the ACT Inc.

29 Libby Steeper

30 Confidential

31 The After Suicide Support Group

32 Transact

33 Mental Health Council

34 Respite Care ACT Incorporated

35 ACT Division of General Practice Inc.

36 Post Natal Depression Support Group (ACT) Inc

37 AIDS Action Council of the ACT Inc.

38 Ms Lynda Napier

39 Confidential

40 Inanna

41 Youth Coalition of the ACT

42 Mental Health Foundation (ACT) Inc.

43 Suicide Prevention Group

44 ACT Government

45 Phelps Reid, Barristers and Solicitors

46 Mrs Barbara Tonge

47 Schizophrenia Fellowship of NSW Inc.

48 ACT Ombudsman

49 Marymead Child and Family Centre and the Richmond Fellowship of the ACT

50 Child, Youth and Family Agencies of the ACT

51 Veronica J Barbeler

52 Confidential

53 Paul Hill

54 Aboriginal and Torres Strait Islander Community of the ACT

Appendix 2 Public hearings

Monday 21 October 1996

For the Mental Health Foundation of the ACT
Mr Brian I'Anson, Patron
Ms Maureen McInerney, Senior Vice President
Mr Michael Fowler, President

For the ACT Mental Health Council
Mrs Gillian McDonald
Cinmayii
Mr Robert Linford

As an individual
Mrs Patricia Napier

Wednesday 23 April 1997

For the ACT Legal Aid Office
Mr Chris Staniforth, Executive Director
Ms Jennifer Saunders, Solicitor
Mr Jason Lee, Solicitor

For the Special Care Unit, Ainslie Village
Ms Janice Kostantinidis, Manager

For the Australian Psychiatric Disability Coalition
Mr David Plant,

Thursday 24 April 1997

For TRANSACT
Ms Michele Harris, Director

For Work Ways
Ms Brenda Field, Manager

For Barnardos Australia
Ms Jennifer Kitchin, Executive Director
Ms Siobhan Cosgrave

Tuesday 29 April 1997

For the Woden Youth Centre
Ms Kim Sattler, Coordinator
Ms Anna Hamers, Youth Worker

For the Canberra Schizophrenia Fellowship
Mrs Pat Linford, Secretary
Mrs Sheelah Egan, President

For the Richmond Fellowship
Ms Heide Seaman

For ACT Disability Aged and Carer Advocacy Service (ADACAS)
Mr Michael Woodhead

For the Alcohol and Drug Foundation of the ACT (ADFACT)
Mr Bob Budd, Executive Director
Mrs Kim Fleming, Coordinator Family Program

For Inanna
Ms Winsome Willow,
Ms Jane Bullen

As a carer
Ms Libby Steeper

Thursday 1 May 1997

For the Council on the Ageing
Mr Jim Purcell, Executive Director

For the Mental Health Foundation of the ACT
Mr Michael Fowler, President
Mr Doug McIver, Vice President
Mr Michael Alexander, Residents Representative, Friendship House
Ms Jennifer Ward, Friendship House Support Coordinator
Mr Rupert Gerritsen, Warren I'Anson House, Respite Coordinator
Ms Lesley Hyndal, Administrative Support Worker
Ms Dianne Murgatroyd

For Calvary Hospital
Dr Rob Griffin, Medical Director

For GROW
Mr Des Goddard, Fieldworker

Wednesday 11 June 1997

For ACT Mental Health Services
Mr Richard Clarke, Executive Director

For the ACT Department of Health and Community Care
Dr Penny Gregory, Executive Director, Health Outcomes, Policy and Planning
Mr Des Graham, Manager, Mental Health and Drug Strategy Unit

Thursday 12 June 1997

For ACT Deafness Resource Centre
Mrs Mandy Dolejsi, Member

For ACT Housing
Mr Tim Tench, Acting Commissioner for Housing

For the Office of the Public Trustee
Mr Doug Gillespie, Acting Public Trustee

As individuals
Mr Doug McIver
Mrs Jan McIver

For the Mental Health Tribunal
Mr Ron Cahill, President
Mrs Alison Perrau, Deputy Registrar

For the Royal Australian and New Zealand College of Psychiatrists - ACT Branch and the Faculty of Child and Adolescent Psychiatry
Dr Don Lawrence, Chairperson, ACT Branch
Dr Terence Heins, Faculty of Child and Adolescent Psychiatry

Thursday 31 July 1997

For ACT Mental Health Services
Mr Richard Clarke, Executive Director
Ms Deborah Inge, Team Leader Child and Adolescent Mental Health Service

For the ACT Department of Health and Community Care
Dr Penny Gregory, Executive Director, Health Outcomes, Policy and Planning
Mr Des Graham, Manager, Mental Health and Drug Strategy Unit

For Youth Refuges
Ms Jenny Walker, Coordinator, Southside Youth Refuge
Ms Lucinda Renfree, Youth Worker, Southside Youth Refuge
Mr Malcom Barlow, Youth Worker, Southside Youth Refuge
Mr Robert Large, Senior Worker, Tumladden

Thursday 14 August 1997

For the Australian Federal Police, District Operations
Commander Denis McDermott
Sergeant Garry Fulton

Friday 29 August 1997

For St Albans Church, Woden

Father Peter Guy
Rev Salma Colless
Mr Patrick Russell
Mr John Brummell

During the inquiry a number of organisations and individuals including consumers, carers, parents and neighbours gave evidence in camera.

Appendix 3 Programs visited

ACT

The Crisis Assessment and Treatment Team
The Canberra Hospital, Acute Psychiatric Unit
Hennessy House
Watson Hostel
Belconnen Remand Centre
Copland College Mental Health Foundation School Education Program

South Australia

Diamond House Clubhouse
Northwestern Adelaide Mental Health Service
Supported Housing Options Program
James Nash House
Services to the Elderly, Hillcrest Campus

Victoria

Central East Area Mental Health Service

- Upton House, inpatient unit
- Crisis Assessment and Treatment Team
- Koonung Community Mental Health Centre
- Mobile Support and Treatment Team
- Canterbury Road House

Prahran City Mission
Bromham Place Clubhouse
Early Psychosis Prevention and Intervention Centre (EPPIC)
North Eastern Alliance for the Mentally Ill (NEAMI)

New South Wales

Long Bay Hospital

Appendix 4 Acronyms

ACIS	Assessment and Crisis Intervention Service
ACTCOTA	ACT Council on the Ageing
ADFACT	Alcohol and Drug Foundation of the ACT
AFP	Australian Federal Police
ADACAS	ACT Disability Aged and Carer Advocacy Service Inc
BRC	Belconnen Remand Centre
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment and Treatment Team
EPPIC	Early Psychosis Prevention Intervention Centre
FPS	Forensic Psychiatry Service
MAC	Mobile Assertive Care
MHS	Mental health service
MOU	Memorandum of Understanding
NH&MRC	National Health and Medical Research Council
PRS	Psychiatric Rehabilitation Service
RANZCP	Royal Australian and New Zealand College of Psychiatrists

Appendix 5 Dissenting Report by Mrs Littlewood

Overview

I have to express my dissatisfaction at the outset with the timeframes under which the Committee decided to finalise its report. It should be noted that this inquiry was commenced in December 1995, more than 21 months ago, yet I was faced with the task of having to submit a dissenting report within only 6 hours after discussing the final report.

There is no doubt that mental health is one of the key challenges facing the community today and for this reason, an inquiry by an Assembly Committee has been a worthwhile exercise.

However, I am concerned that this report does not reflect the enormous effort that has been made by the ACT Government and its agencies in working to improve the quality and availability of services for people with a mental illness.

The report also fails to acknowledge the significant problems that have been associated with the delivery of mental health services in the ACT since self-government. The current government inherited a fragmented, reactive system that was inadequately resourced and almost entirely focused around hospital-based, clinical treatment.

My dissenting report therefore, attempts to present a true picture of the substantial improvements that have occurred since the government was elected in 1995, and reasons for my decision to disagree with several of the Committee's recommendations.

Under the theme of "Moving Ahead," the government announced major reforms to mental health service delivery in 1996, with the aim of redirecting the focus of services increasingly towards community-based support and intervention.

It is recognised that this kind of fundamental change will not occur overnight and it will not take place without difficulty. But the willingness of this government to push for this kind of fundamental reform, which simply has to happen, should be commended.

The result of this renewed effort has seen the following results:

- An increase in funding for mental health services amounting to more than $1.5 million or almost 10 per cent during the past three years.

- Additional funding of $400,000 over the past two years to expand community-based residential support for people with a mental illness. This has created an additional 45 supported accommodation places in Canberra.

- An increase of more than $150,000 a year in funding for mental health projects via Healthpact, the ACT's independent health promotion agency set up by the government.

- Independent accreditation of all public mental health services in the ACT, the only state or Territory to achieve this.

- Expansion of the Mental Health Crisis Team which has resulted in a vast improvement in levels of service and responsiveness. A total of eight new positions have been created to enable the team to broaden its role to include treatment as well as assessment in the community. The 22 member team now operates a 24 hour 1-800 contact number and has introduced a new triage service, and computerised tracking system to more quickly respond to clients.

- The creation of an intensive care management team operating out of the Accident and Emergency Department and the Psychiatric Ward at The Canberra Hospital. Two extra specialist nurses have been employed to provide better treatment and discharge planning for clients who present at A and E.

- Re-establishment of the position of liaison psychiatrist at The Canberra Hospital to ensure all patients, particularly those in the geriatric ward, can access this service.

- The establishment of a specialist mental health nursing position at the Belconnen Remand Centre.

- Ongoing funding to help establish the Warren I'Anson Memorial Respite House, which is managed by the Mental Health Foundation.

- Approval for the construction of a new, $2.5 million, 20-bed private psychiatric facility, Hyson Green, by Calvary Hospital, the first private unit to open in Canberra. This will expand the number of acute beds in the ACT by 30 per cent.

- Additional, one-off funding to provide respite care for children with mental health problems or for children whose parents have mental illnesses.

- New memoranda of understanding between the ACT Mental Health Service, the Australian Federal Police, and ACT Housing to improve the co-ordination of responses and services.

- Establishment of a new Management Assessment Panel to better assist in meeting the needs of people with complex cases.

- Production of the first ever annual report specifically about mental health services in Canberra.

Many of the issues raised in the Committee's report are either already being addressed or are soon to be examined. All are complex. None are easy. I fully expect that the kind of changes I have supported in this report will take months and even years (in some cases) to come about.

The report refers to mental health services in other states that were visited by members of the Committee, eg, Victoria and South Australia. It should be noted that these states have significantly larger populations, cover a wider geographical area and therefore are likely to have different political, social, economic and demographic variables from those present in the ACT. It is equally important to note that the principles which underpin these services are similar, if not the same, as those which underpin mental health services in Canberra.

I am also concerned that the Committee's report pays little, if any attention to the resource implications of the recommendations that a majority of members have endorsed. They represent, in one sense, a 'wish list' that has been generated from interstate observations without any thought being given to the fact that the ACT does not have the same economies of scale or resources.

By even the most conservative estimate, the adoption of all the recommendations would commit a Territory government to additional recurrent expenditure of at least $5 million per annum. This report does not identify where this funding would be obtained or what services in other areas of government would have to be de-funded.

I have specifically disagreed with seven recommendations contained in the Committee's report. My reasons for doing so are outlined below.

Recommendation 4
The government has already given an undertaking in its 'Moving Ahead' statement on mental health that the establishment of a secure facility would be investigated. The Committee was advised of this.

Recommendation 8
The National Mental Health Strategy clearly states that each jurisdiction must meet the service needs of its population and not develop service components around models which are inappropriate for the population.
The ACT does not have the resources to support such models as outlined in this report, nor is it likely to be appropriate to the needs of the local population. In relation to the second part of the recommendation, the government has demonstrated its ongoing commitment to non-clinical support through announcements of $150,000 funding in 1996/97 and $250,000 funding in 1997/98 for these services. These funds are recurrent and future years will see these support services become increasingly comprehensive.

Recommendation 9
The government has already demonstrated its commitment in this area.

Recommendation 10
I am concerned that it may not be a cost-effective measure for the ACT to sustain a separate accommodation and support strategy for young people experiencing mental illness. As noted in my comments concerning Recommendation 8 the government has significantly expanded support for community accommodation options in the last two budgets. The services that have been made available through this funding are open to clients of all ages.

ACT Mental Health Services has also improved its responsiveness to the needs of young people. Services are delivered in an interdisciplinary framework in close collaboration between the MHS and other community agencies. There are also major changes occurring to the operations of the Child and Adolescent Mental Health Services, and significant improvements in other areas such as the development of an ACT Youth Suicide Prevention Strategy.

Recommendation 11
I believe that the implementation of current reforms to ACT Mental Health Services will, in all likelihood, obviate the need for such a short term and therefore potentially costly solution. The need for respite services is extremely variable with the result that there needs to be a creative and flexible means for addressing this need, such as rental of self contained units for families/carers.

Recommendation 17
The Committee has already been advised that work has commenced on the development of a Territory Mental Health Policy and Strategic Plan which will include clear policy guidelines for all aspects of mental health services as well as evaluative mechanisms.

Recommendation 19
The government has provided a wealth of information to the Social Policy Committee and to the Assembly about the progress of reforms to mental health services. The compilation of six-monthly reports would, in my view, place an unnecessary burden on the agencies which are involved in implementing these changes. Having to constantly prepare updates for committees takes these officers away from the real task of improving service delivery and achieving better outcomes for clients. I believe that annual reports, in line with the government's commitment to produce a separate statement about mental health every year, would be a far more sensible option.

Conclusion

There is a still a long way to go and much to be done to improve mental health services in the ACT. I believe that together with disabilities, this sector presents probably the greatest challenges and complexities faced by governments.

However, mental health services in Canberra today are a far cry from those which existed only a few years ago. With continued emphasis on reform and adequate resourcing, I am confident that the level, availability and quality of services for clients and those who care for them will improve very quickly.

In conclusion, if ever there was an area of service delivery and policy making that would benefit from a non-partisan approach in this Assembly, it would have to be mental health. I am disappointed therefore, that this has not been apparent during my time as a member of this Committee and as a MLA.

Louise Littlewood MLA
19 September 1997