

National Association of Practising Psychiatrists

Submission to the

NSW Legislative Council

Select Committee on Mental Health:

Inquiry into Mental Health Services In NSW

Part I – Report

National Association of Practising Psychiatrists Inc

ARBN 076 781 854

PO Box 12 ARNCLIFFE NSW 2205

Telephone: 02 9556 2534 Facsimile: 02 9567 4681

E-mail: napp@milgate.net Web: www.napp.org.au

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Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Dr Gil Anaf, President
Dr Rachel Falk, NSW Representative
Mr Glen Ramos, Assistant National Co-ordinator*

with the assistance of many NAPP Members.

April 2002

Public mental health services in NSW

Acute services

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

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

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

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

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

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

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

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

A 15 year study¹ on successful intervention on youth suicide, from Western Australia, concludes that when a young person is admitted to accident and emergency departments following self harm behaviours: *"...there were gross deficiencies in the kind of care being provided, not adequate assessments being made and the follow up tended to be woeful"*. The report showed that we can successfully intervene and dramatically reduce the suicide risk if *"...you actually take the trouble to spend enough time with the person to gain their confidence, take a good history and ensure that whatever treatment is provided is addressing some of their immediate needs. It was particularly important to improve the likelihood of decent follow up."*

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

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

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

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

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

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

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

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

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

“In the 30 years from 1965, overall psychiatric bed numbers (acute and non-acute) in NSW have reduced from over 12000 to about 2000 currently.”

“The pendulum has swung too far and that the number of beds, particularly non-acute beds, may not be sufficient to meet current needs.”²

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

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

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

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

Rural NSW

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

Subacute, longer term patients

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

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

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

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

Lack of Psychotherapeutic Service Provision

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

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

A long-term study³ in the USA, of over 20 years, linking personality disorders in adolescence with violent behaviour in early adulthood, found that this group, with the one exception among the personality disorders of the antisocial personality disorder, could be treated effectively with psychotherapy.

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

Supervision

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

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

Children and Adolescents

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

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

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

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

Women

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

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

Staffing problems

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

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

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

⁴ The Australian newspaper: <http://theaustralian.news.com.au/printpage/0,5942,3260020,00.html>.

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

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

- (i.) Pay rates for nurses in general, including psychiatric nurses, have slipped to levels that provide little incentive for anyone with a choice, to remain in a hostile and increasingly dangerous system. This has to be addressed.
- (ii.) Psychiatric nurse training was effectively abolished with the shift to university-based qualifications. This has to be fixed - possibly by introducing a part-apprenticeship, part academic system of training, where the apprenticeship portion is paid; and services are enabled to recruit according to their needs. Postgraduate qualifications need to be appropriately remunerated.
- (iii.) Because of severe bed and other shortages, psychiatric nursing is currently an unacceptably dangerous occupation, and the staffing shortage has been compounded by the number of nurses off on extended leave following physical and/or psychological injury. Injuries at the current rate are completely unacceptable and have to stop. It would be worth asking for NSW Health records and reports on this issue. NAPP understands that CSAHS was recently fined \$177,000 by WorkCover for breaches of OH&S at Rozelle, where a nurse was seriously injured; and there was a large payout a year or so ago in a claim by a nurse in WSAHS who was nearly killed by a patient in circumstances deemed negligent by the court.
- (iv.) There is an enormous and costly problem looming in the NGO sector, where staff are commonly left on duty alone with a number of potentially dangerous clients. NAPP is aware of a number of court actions over this, and it is likely that they will soon be forced to have at least two staff on duty at all times - which obviously would double their costs.

Changes in the Medicare Schedule 1996

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

Quality Control and Recommendations

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

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

Psychiatric Deaths Committee

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

Its brief would be:

Suicide

- To monitor the client death reports already collected by the Centre for Mental Health, ensuring that these are regularly counted, and that ALL unexpected deaths are included - to look closely at a random selection (the numbers currently being far too great to look at them all, in contrast to maternal deaths, for example) to ascertain what could have been done differently to avoid that fatal outcome.
- It is vitally important to avoid a 'blame culture', adopting instead the aviation industry's highly regarded process of looking for mistakes, not to apportion blame, but to work out systemic ways of avoiding them in future. Examining samples of 'near miss' attempted suicides would also be instructive.
- To closely monitor trends, with a view to ensuring that the suicide and related death rate, which currently seems to be several times that of 13 years ago, and probably still rising, starts to steadily - and we hope rapidly - reverse down.

Homicide

- To monitor deaths from homicide, where either victim or offender is mentally ill. These statistics are not collected systematically at present, but could quite easily be included in the client death reports (where victims presumably would be picked up already). Patients known to mental health services who are charged with homicide would be no problem to add to the system; and liaison with the prison medical services could readily pick up the rest (those not known to mental health services before the offence.)
- To adopt the same ‘no-blame’ approach to assessing the whole group, (current numbers being probably a tenth of suicides, or less), with the same purpose.
- To monitor trends, again hopefully down.

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

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

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

Mental Health Services Occupational Health And Safety Committee

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

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

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

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

Consumer Satisfaction Surveys

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

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

More Difficult, Important Issues

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

Questions to be answered:

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

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

3. If AHSs retain their present functions and funding, is it reasonable that patients should continue to be further fragmented by rigid catchment area restrictions, even when that is against their wishes, convenience, and where they happen to be when urgently needing a service?
4. If AHSs retain mental health, an issue that must be addressed is that currently all pressures on AHS CEOs are in the direction of their presenting the appearance of satisfactory performance regardless of substance. It is vital that staff whistleblowers are free to speak out, but this also has to apply to AHS CEOs. While they continue to be expected to do more with less, and are judged a failure if they say they can't, the current problems will inevitably continue.
5. Funding for mental health has to be open to full public scrutiny, whoever gets it, and some current anomalies must be removed. For example, new units at Tweed Heads and Campbelltown which were supposed to be open and functioning for six months of this financial year, and were funded for that, have not yet opened - fully or at all. Do the AHSs get to keep that money?
6. The incentives to 'realise assets' (ie sell hospital and other land) have to be removed if we are ever to have any hope of rational mental health services planning. A moratorium on any land sale would be a good start. The Callan Park Trust Bill - and the equivalent for other important heritage sites - should be passed as soon as practicable.
7. Health services planning in general has always tended to be done backwards, ie starting with a political decision, then finding figures to suit. It would be quite possible, particularly now the Mental Health Unit has produced its own planning instrument, to insist that this is used for mental health services. It would be a bare minimum; and would have to be adjusted to include regional and statewide services not currently covered (eg alcohol and other drugs, forensic and secure); but again would be a good start.
8. Currently we have much the same problem with mental health services as we have with modern warfare, in that those making the decisions to cut services are not directly confronted with the human tragedies that result. If AHS retain mental health, perhaps a panel interview between the AHS CEO and the bereaved family members within a specified - short - time after each psychiatric death? This may provide a direct incentive to reduce the extra workload by reducing the number of deaths.

Forensic Psychiatric Services - Introduction

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

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

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

Forensic Psychiatric Services – Section 1

The Scale of the Problem

- Because of the run-down and neglected condition of mental health services in NSW, a person suffering from an acute episode of mental illness may be more likely to be arrested than to be admitted into hospital for treatment.
- There were approximately 7750 prisoners in NSW in May 2001⁵; prisoner numbers in NSW have more than doubled over the past twenty years, from around 3,500 in the early 1980s, to the present figure of almost 8000.
- A survey carried out between January and May 2001⁶ (incomplete at time of writing) suggested that there may be as many as 12% of NSW prison inmates with a psychotic illness.
- There are 90 psychiatric hospital beds in the NSW prison system, all at Long Bay. All beds are usually occupied as follows:
 - ‘A’ ward: 30 patients; all ‘Forensic’ prisoners under the NSW Mental Health Act
 - ‘C’ & ‘D’ wards: 60 beds:
 - 47 ‘Forensic’ patients
 - 13 other mentally ill prisoners
- There is a waiting list of 15-20 (sometimes more) mentally ill prisoners who are held in gaol, some in so-called ‘safe’ cells, awaiting a bed in the psychiatric hospital, sometimes for several days or weeks. Some are waiting so long they actually recover under treatment in spite of these substandard conditions.
- There are about 900 remand prisoners in Silverwater Reception and Remand Centre (MRRC) with more than 200 prisoners moving in and out each week, sometimes as many as 50 movements per day to and from the Courts and police cells.
- There are so many mentally ill prisoners in Silverwater that:
 - Psychiatric clinics are held six days per week utilising four consultant psychiatrists and a psychiatry registrar;
 - In spite of this service, there is a waiting list, sometimes almost 30 patients long, to see a psychiatrist;
 - The level of psychiatric disturbance amongst prisoners is such that at any one time, in Silverwater, as many as 20 mentally disturbed prisoners at any one time are held in so-called ‘safe cells’: isolation cells which are unheated unfurnished and in which patients may be inadequately clothed, in an attempt to prevent suicide attempts or self-inflicted injury. Such management techniques are never used in community psychiatric hospitals and probably represent a breach of the currently accepted standards of psychiatric treatment in developed countries.
- The recently proposed amendments to the New South Wales Bail Act will aggravate this situation even further. Because of illness or just poor

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

⁶ Informal Results, Personal Communication, May 2001.

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

Analysis

Unethical Treatment

The current situation in relation to the treatment of the mentally ill in prisons in NSW is unethical. Since biblical times⁷ it has been universally accepted amongst civilised communities that the mentally ill cannot be held morally responsible for crime and must be given treatment, not punished or imprisoned. This view is evident upon examination of a range of such legal codes such as the Talmud, the Hammurabi Code, Roman Law, Anglo-Norman Law, the Napoleonic Code and English Common Law.

Breach Of Accepted International Conventions

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

The United Nations Standard Minimal Rules for the Treatment of Prisoners

adopted by the First United Nations Congress on the Prevention of Crime and the treatment of Offenders, held in Geneva in 1955 states:

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

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

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

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

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

Mentally ill prisoners in the United Kingdom, Canada, New Zealand, Queensland, Victoria, South Australia, Western Australia and many other jurisdictions in developed countries are moved out of prison to a secure hospital as soon as practicable after they are identified⁸.

The UK Royal College of Psychiatrists has recently condemned the use of ‘safe cells’ (“seclusion” and “stripped cells”):

“The use of seclusion and stripped cells for the management of suicidal prisoners should be stopped”.⁹

In the same statement, the UK College also stated:

“Prisoners should have access to an equivalent level of health care as those outside of prison.”

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

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

Illegalities In New South Wales

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

“If, ...at any time during the course of the hearing, it appears to the magistrate that the defendant is developmentally disabled, is suffering from a mental illness or...a mental condition...”

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

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

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

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

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

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

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

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

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

and S4 2(b):

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

Inadequate Standards Of Treatment Of Mentally Ill Prisoners

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

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

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

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

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

Summary

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

Some possible remedies have been suggested below.

Recommendations

Identification And Diversion Of Mentally Ill Defendants From Court

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

treatment individuals with whom the community health services have lost contact and decreasing the crime rate^{10,11}.

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

Adequate Mental Health Treatment Facilities For Prisoners

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

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

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

Psychotic illness	11%
Depression	21%

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

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

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

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

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

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

Secure Psychiatric Hospitals (Community Forensic Hospitals)

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

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

Adequate Funding Of Community Mental Health Services

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

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

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

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

Such facilities would:

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

Statewide Management And Planning Of Psychiatric Services

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

A Properly Funded And Staffed NSW State Forensic Psychiatric Service

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

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

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

¹² James, ED et al; op. cit.

Conclusion

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

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

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

Forensic Psychiatric Services – Section 2

Introduction

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

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

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

Nurses

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

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

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

Suggestions

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

Forensic Mental Health Services

Introduction

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

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

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

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

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

Suggestions

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

Pod 16

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

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

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

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

- Dr Rosen has been commissioned to do a report for CHS but this has not been released.
- Dr Boettcher discussed matters with highly respected UK Forensic Psychiatrist, Dr Martin Donovan, who agreed there would be suicides and that Pod 16 is *inhumane*.
- Dr Carne resigned from his position as Director of Forensic Mental Health in the Western Region because of Pod 16, as has Dr Ahmed, a most experienced psychiatrist.
- Prof Quadrio resigned because of a perceived lack of support. Her position of Director of CHS has been taken by a nurse, as has that of Dr Carne.

Suggestions

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

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

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

Media and Political Involvement

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

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

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

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

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

Suggestions

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

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

Court Liaison

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

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

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

Suggestions

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

Long Bay Prisons Complex

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

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

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

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

Suggestions

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

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

Silverwater Prisons Complex

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

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

Suggestions

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

Rural Prisons

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

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

Suggestions

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

Victoria

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

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

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

Queensland

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

Suggestions

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

United Kingdom

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

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

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

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

Research Interests include:

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

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

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

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

Suggestions

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

United States

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

Medium Secure Units

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

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

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

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

Suggestions

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

Forensic Community Services

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

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

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

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

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

Suggestion

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

Court Liaison Services

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

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

Allied Professions

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

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

Suggestion

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

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

Teaching and Training

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

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

Suggestions

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

Danger of Assaults to Prisoners and Staff

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

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

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

Suggestions

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

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

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

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

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

Illicit Drugs

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