Australian Senate

Select Committee on Mental Health

Submission

by the

Public Advocate

Prepared by John Harley - Public Advocate
and the staff at The Office of the Public Advocate

Contents

To: The Secretary,
Select Committee on Mental Health
Parliament House
Canberra ACT 2600

1. Introduction

Thank you for the opportunity to make submissions to the Committee.

Time and lack of resources necessitate that I limit my comments to only a few areas covered in your comprehensive terms of reference.

This submission is primarily based on my *impressions* and those of my staff from our day-to-day work and feedback from the community. Unfortunately we have little opportunity to systematically collate information provided to us.

2. Background to the Office of the Public Advocate ('OPA')

My position and my office which is an independent statutory office have been in existence in South Australia for over 10 years. My functions are outlined in section 21 of the Guardianship and Administration Act 1993, my primary role being to promote and protect the rights and needs of people with mental incapacity and of their carers. This is achieved primarily through our roles as:

- statutory guardian of last resort;
- individual and systemic advocates;
- investigators; and
- providers of education, information and advice on the legislation relevant to people with mental incapacity. (The Mental Health Act, Consent to Medical Treatment and Palliative Care Act and Guardianship and Administration Act).

33% of our guardianship clients (known as "protected persons") have primarily mental health issues with a further 40% having dementia as their primary diagnosis. The picture is similar for advocacy and investigation clients. It is estimated that a further 10 % would have mental health issues as their secondary presenting diagnoses.

14% of enquiries to the OPA relate to clients with identifiable mental health issues, with a further 20% relating to people with dementia. *(source: Office of the Public Advocate Annual Report 2003-04)*

3. Submission Summary

Despite the Burdekin Report recommendations and the National Mental Health Strategies, it is our impression that, at least in South Australia, there has been a deterioration in service availability and access, particularly for those clients who have chronic and multiple mental health problems and who now reside in the community.

We still appear to be struggling with the practical application of collaborative models of clinical and support services and lack the range of programs necessary to meet the needs of people with chronic mental health problems. This is most evident in the lack of accommodation and support packages for those with moderate to high support needs.

Case management appears to have been almost entirely abandoned in favour of clinical management (often interpreted as and being merely medication management in the community). Where case management does exist, there is inconsistency across the mental health regions as to who receives services and the quality of them.

It is rare nowadays to find clients with comprehensive holistic management plans developed and coordinated by mental health workers. Whilst this may be in line with the reform agenda of mainstreaming non-clinical responses, by and large, the non clinical responses are not put in place (sometimes not even thought of) making relapse prevention mere rhetoric.

Some clients have non-clinical service coordinators who look at social, recreational and support needs. It is our experience that many of the people employed to provide the non-clinical responses lack the training and support to confidently undertake their roles with the most complex of clients. This is

reflected in their comments about a sense of abandonment by clinical mental health systems.

It is our belief that state mental health systems do have a responsibility to provide ongoing holistic case coordination/management for clients with the most multiple and complex needs. In addition, these providers must be available to assist with responsive consultancy and direct intervention to backup non-mental health providers in playing their part in appropriate service responses. Whilst we acknowledge that resourcing of mental health remains a critical issue in delivering such services, the appropriate training of mental health personnel to work effectively, collaboratively and in a holistic way is critical.

My office tends to see the "more difficult situations" in mental health. None-the-less, I am disturbed by the amount of time and effort that this office is required to commit to ensuring that services talk to each other, coordinate their work and demonstrate proactive planning. This problem is not unique to the state's mental health system. However, the culture and morale of many mental health workers in South Australia reflects a siege mentality and a long history of operating within a silo.

South Australia is criticised at the national level for its lack of progress against the reform agenda. Our observations would support this. However, I express my sympathy for the leaders and staff in this state who I am sure currently feel under enormous pressure. Reform cannot be achieved without difficulty; it certainly cannot be achieved without financial and philosophical commitment by the government of the day. The building blocks for reform have been under funded, poorly cemented together and significantly affected by inconsistent leadership.

Workers are exhausted and have become cynical by lack of resources, constantly changing reform agendas to satisfy immediate political demands and

a lack of commitment by and a failure of successive governments to match their rhetoric with financial support.

4. Deinstitutionalisation, Funding and the Impact of Contractual Processes

The SA Department of Health plan to further deinstitutionalise people with mental health disorders currently resident in Glenside Hospital which is our only residential/treatment facility devoted exclusively to adults with mental health disorders. While Hillcrest Hospital still maintains care for the aged with mental health disorders, the adult mental health residential treatment service closed in the 1990's.

This latest plan for deinstitutionalisation is both welcomed and bemoaned by many in the field.

The following factors are generally seen as contributing to the policy rationale for deinstitutionalisation :

- concern to extend the legal and civil rights of people with mental illness
- the effectiveness of the newer pharmacological agents in controlling the more severe manifestations and behavioural disturbance of mental illness
- real and perceived abuses existing in the institutions, including custodial approach to treatment, social under stimulation and loss of independence
- a growing awareness of the values of personal autonomy and equality
- a community mental health philosophy that it is better to treat people in the community in which they live; and
- the increasing financial burden on a health system of maintaining large institutions.

(Source: Mechanic and Aiken (1987))

OPA believes that the concept of deinstitutionalisation should refer primarily to changing the way in which we engage and work with people. The downsizing of the bricks and mortar that we call "institutions" will not automatically lead to

deinstitutionalised thinking. What will be achieved (given the paucity of alternative community responses) is a lack of appropriate safe places or asylums in which people with mental illness, their families and the community can be afforded some safety and dignity at times of maximum disturbance.

The following factors particularly concern us in the South Australian situation:

- The significant reduction in beds in psychiatric hospitals has not been accompanied by an increase in the numbers of beds in the community. This has led to inappropriate increased admissions of mental health clients to already overloaded emergency wards in acute hospitals.

  The solution most often mooted is that funding for the community services be redirected from the psychiatric institutions or psychiatric wards in acute hospitals. However, this does not recognise the need for a successful transition phase. A well funded transition period, will increase the overall costs for a significant period of time. OPA endorses ongoing concerns about the lack of appropriate funding strategies in South Australia to enable sound community based alternatives to develop before stand alone inpatient focussed programs are reformed. Much is made of the disproportionate expenditure on inpatient facilities in this state in comparison with other states in Australia. We are also concerned that this discussion has not taken into account the increasing demand for services, including inpatient services, to which mental health is required to respond.

- We believe that "hump" funding is necessary to prevent the creation of additional or new problems that, in the long term, will cost the state more financially. We already see this in the criminal justice system and public housing for example.
- At present there is a chronic lack of appropriately trained government and non-government workers and accommodation in the community.

- A side effect of deinstitutionalisation and mainstreaming appears to be a threat to funding stability. Psychiatric institutions have had a significant power base within the mental health system which has ensured the protection of funding to their facilities. We accept that such power bases intent on retaining funding do not necessarily lead to a "quality of service". With decentralised community services providing generic treatment in smaller accommodations within the community, the power base is likely to be lessened, and the funding is therefore more dependent on the goodwill of the government of the day and of the commitment of the regional host organisations. If mental health services do not feature highly, then small programs are likely to lose funding, particularly where it is linked to temporary contractual arrangements (eg non-government sector programs are particularly vulnerable to political whim).

- Service providers in the non-government organisation (NGO) sector are often contracted to work in the community for people with a mental illness on an "as needs" basis. Agreements between government agencies and the NGO's do not take into account the conditions of the workers in those agencies. They particularly do not consider well the tenure of workers, their wage structure, or their training needs in order to equip them for the job type. Recruitment and retention is difficult. Workers with insecure positions are unable to make long term plans and are therefore more likely to be less satisfied in their jobs and less in control of their own lives. This leads to a much less stable work force impacting negatively on the client group receiving their services. OPA has examples of NGO service providers, unable to retain staff due to the prevalence of casual and short term contracted work, which has clearly impacted negatively on some of our client group.

- It appears to us that tendering for services in the community contributes to an ad hoc way of working with needy client groups, and involves a competitive environment that is at odds with the collaborative models that are touted as the successful way forward in the health and welfare fields. Contracts that run from month to month are common and again contribute to a lack of accountability of contracted service providers. If we are to provide successful community care for people with mental illnesses, tendering of service provision should not be the only process for contracting services. Agreements between government and NGO's should promote program continuity (staffing stability in particular), create collaborative working environments and ensure adequate continuous funding.

5. Culture and Acceptance

Community Culture:

It would appear that education strategies and media focus have raised community sensitivity to mental health issues. However, in a community culture which is increasingly concerned about personal safety and conformity, this sensitivity centres around issues of the dangerousness of people with mental illness and ambivalence about the increasing expectation of communities embracing the mentally ill.

This culture is reflected in current government/community priorities of law and order, harsher penalties for offenders and so on. The current government mindset and response to a perceived community pressure for personal safety is well illustrated by the attached photograph of barbed wire adorning the external courtyard fences in the state's intensive care unit for mentally ill people. (attachment 1.)

Whilst the media have played a significant role in informing the public on mental health issues, it is unfortunate that some of their strategies serve to reinforce community fears. Public policy is also confusing. On the one hand, the state through its children's education system, promotes respect and concern for the wellbeing of disadvantaged people. In contrast, society appears to be promoting intolerance, for example, of refugees, of offenders, of the disabled of the unemployed and so on.

It seems to this office that community attitudes and expectations and the drivers for mental health reform are still significantly in conflict. In South Australia, the inability of the mental health system to reassure the public that help is available

to the mentally ill (and lack of funded community support alternatives) serves to reinforce the very fears which the reform process seeks to overcome.

Systems culture

I find the current culture surrounding mental health confusing:

- Many non-mental health personnel still appear to be reluctant participants in service responses for the mentally ill and their families.
- The occupational health and safety issues and responses to protect staff seem to drive considerations of service responses (at times appropriately) which may serve to further traumatise and alienate already severely disturbed people (eg the use of security guards to guard detained patients in general hospitals).
- There are conflicting beliefs from site to site about the nature, scope and service responsibilities and ethos that mental health services should be providing.

6. Human rights and the Mentally Ill

Whilst mental health reform has sought to enhance the human rights of the mentally ill, there are a number of problems which appear to have been exacerbated during the reform period.

Examples include:

- physical restraint/shackling strategies used to manage an acutely mentally ill patient in a public hospital environment eg in emergency departments and as overflow patients in medical wards;
- detained patients waiting for days under guard in emergency departments waiting for access to an appropriate bed;
- acutely/chronically ill people remaining in their community whilst their behaviour significantly jeopardises their own wellbeing and their future relationships with landlords, neighbours and family members-we lack safe havens to preserve not only their safety but also their dignity and relationships; and
- increased disputes around public safety and public housing, identifying the mentally ill as a "problem" group which increases the stigma associated with it.

7. Service Access and Focus

Narrowed focus of mental health to acute emergency and clinical services

There is and apparent narrowing focus of state mental health providers towards acute short term intervention for people with treatable psychiatric disorders. People with chronic mental health problems are the most vulnerable because of their inability to make their wishes known and to make their own day to day decisions. They, however, seem to be the most neglected and disadvantaged of all.

South Australia has not matched their reform process of the mental health system with sufficient complementary programs to support those with chronic mental illness and their carers.

The OPA recently participated in an advocacy project pertaining to residents with mental disabilities of privately managed supported residential facilities under threat of closure. The lack of externally provided advocacy and support and clinical management for these residents from mental health services was of concern.

Dual and multiple disabilities

People with dual and multiple disabilities still remain the subject of dispute between mental health and other service providers eg a problem may be defined as "behavioural" by mental health and "psychiatric" by disability providers. Complimentary and collaborative programs are rare and we find ourselves

repeatedly involved in negotiating/advocating for such strategies around individuals.

People with "personality disorders" or "conduct disorders" appear to receive very patchy services and eligibility rules for provision of services seem to fluctuate often in accordance with the degree of difficulty that the client presents to the system. In the adult arena at least, one can form the view that those with the most challenging of behaviours are less likely to receive a service despite the fact that they are more likely to be rejected/ exported to the criminal justice system for management which essentially means containment. It would appear that we are getting more people with multiple and complex disabilities, particularly those with drug induced problems. (Attachment 2)

Service integration and collaboration

There are some excellent examples of good work where services have joined forces to deliver a program. However in the main programs still appear to operate in isolation.

In particular, the isolation of drug and alcohol services from mental health services continues to present a major problem given the numbers of psychiatric presentations that are based on drug or alcohol induced psychoses.

Whilst we recognise that services must be clustered according to some rationale, the move towards mainstreaming mental health has not substantially assisted in areas such as:

- inter region mental health management of itinerant clients and acceptance of other regions' assessments for like programs;
- seamless transition from youth to adult to aged services;

- inter sectoral client management within family systems with a view to family preservation (eg collaboration between education, youth services, mental health and guardianship; and
- integration between diagnostically streamed services.

8. Prison Mental Health Services

Studies both locally and interstate indicate that approximately 7% of prisoners have schizophrenia or related psychotic conditions (not including substance related psychosis) and an additional 10% suffer from depressive disorders, post traumatic stress disorder or anxiety disorders. Substance abuse by this 17% is also the norm.

The South Australian Prison Health Service and the Department of Correctional Services provide primary care for prisoners with these problems. However, there is also a responsibility for specialist services to provide both direct care and to support primary care services in their management of prisoners with complex and serious mental disorders.

The *United Nations Basic Principles for the Treatment of Prisoners (1990)* provide, inter alia:

"1. All prisoners shall be treated with the respect due to their inherent dignity and value as human beings."

"4. The responsibility for prisons ... shall be discharged in keeping with the State's other social objectives and its fundamental responsibilities for promoting the well-being and development of all members of society."

"9. Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."

The *International Covenant on Civil and Political Rights (1966)* provides, inter alia:

"Article 10

1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

Over the past decade the real level of specialist mental health services available for prisoners on a per capita basis has declined markedly. This has resulted in a significant service deficiency for prisoners. Those individuals who are incarcerated quite possibly have poorer access to services than mentally ill people residing in the community.

At present non-violent offenders with obvious mental health problems are kept in prison whilst waiting for assessment of mental impairment for the courts. They should be placed in suitable health facilities or their assessments arranged in the community.

Violent offenders with the same mental health problems should be placed in a secure health facility, such as James Nash House, pending assessment. This frequently does not occur due to a lack of bed space. However, if the offender is kept in prison, then the assessment should be expedited so that the time in prison is minimised before a return to court.

The current level of specialist psychiatric face to face consulting services also reflects the service needs of a decade ago. Currently prisoners access 40 hours per month of face to face consultations. The average length of consultations is 20 minutes. The current level of service must be regarded as inadequate and borders on the dangerous. This service shortfall is across all prisons but is particularly acute at Port Augusta Prison.

The current access by prisoners to James Nash House is inadequate. Over the past decade effective numbers of available beds has declined from 30 down to 8 whilst numbers of prisoners have increased by 30% and the proportion of major behavioural problems has increased.

As prisoners' mental health problems have been inadequately dealt with whilst in prison they experience significant problems in their transition into the community.

There is frequently inadequate discharge planning whereby clinical information and responsibility for care is handed over to community based services. These deficiencies in services increase the likelihood that, upon their release, they will re-offend and fall into the correctional system once more with further harm to the prisoner and society in general.

9. Things That Are Working

The Office of the Public Advocate provides guardianship for adults across a broad range of sectors, and also divisions within services.

For example, OPA is guardian for approximately 12 individuals deemed to have "exceptional needs". Typically, these are people living with co-morbid illnesses who fall between eligibility criteria for services and have a level of need that no one service can meet alone.

South Australia is one of a small number of states that offers a holistic resource stream to clients deemed to live with exceptional needs. It provides a model of service delivery that is genuinely holistic, dedicating resources to the individual person, targeted to the key domains of their lives. Commonly, this combines issues of housing, daily support, case management and therapy. The success of this program is that it is well resourced, allows resources to follow needs rather than diagnostic or multiple eligibility criteria and it's commitment to clients is strong.
This stands in stark contrast to the more typical picture, where housing, health and welfare services are discrete entities that create a degree of inertia that can mitigate against positive outcomes for clients.

The Exceptional Needs Program offers a model of successful multi-sectoral intervention in mental health. The Office of the Public Advocate strongly recommends that further opportunities for multi-sectorial intervention be sought in mental health service delivery, particularly in terms of forging a direct link between housing and community supports.

We also commend the efforts of the South Australian Government for its Social Inclusion initiatives. A Thinker-in-Residence program has recently promoted

debate on the issue of how services can follow client need as they move through accommodation and support programs as their needs change.

We are also seeing an increased recognition of mental health and related issues in the legal system through the establishment of court diversion programs. Here, mentally ill clients are being linked with service providers in an attempt to achieve optimal mental health. In addition there are a range of advocacy services that assist mentally ill people and their families with their legal rights.

Collaborative clinical and support programs do exist in some areas. For example Collaborative Action is a partnership between state mental health services, district nursing services and a non government direct care provider to managing older people with complex mental health issues.

10. Mental Health of Detainees

I have been heavily involved in trying to redress the injury and injustice experienced by individuals whose mental health has been severely affected by their life experiences and their detention firstly in Woomera Detention Centre and now in Baxter Detention Centre in South Australia.

A recent High Court decision highlights the negligence of the government with respect to the mental health care of 2 detainees who have been unable to access appropriate responses to ameliorate their distress. This is not an isolated problem. (The summary of this judgment is in attachment 3.)

The OPA has adopted the role of guardian for a small number of detainees who have subsequently been released into the community. I have no right of access to detainees within Baxter and therefore cannot afford them any individual support or advocacy to have their needs mental health needs met.

It is well validated that refugees are likely to have mental health issues arising from situational trauma which cause them to flee their countries of origin. Extended periods of incarceration when there is no certainty about the future can only serve to exacerbate or create mental health problems potentially resulting in longer term or permanent disability.

We urge this Senate enquiry to advise the government to provide more humane responses to detainees, particularly those exhibiting mental health problems. In the short term this should include improved access to local/state mental health programs and community based accommodation that sustains family and cultural ties.

11. Information and Privacy

Privacy, confidentiality and sharing information with carers and family members remains a confusing area. Some time ago, I participated in a mental health working party whose objective it was to produce a balanced set of guidelines on this issue. We are still awaiting the release of the documentation. In the meantime, carers still express frustration about the difficulties that they experience in engaging help, being kept in the communication loop and being expected to act as primary carer without due consideration of their needs in the discharge planning and case management processes.

12. Miscellaneous Issues

Recognition of state laws by commonwealth entities:

All states and territories have experienced difficulties with Centrelink accepting the authority of an administrator appointed under state law. Private administrators in particular have experienced unnecessary delays and flat refusal to accept their authority. Such action or inaction on the part of the Centrelink places mentally incapacitated persons, whose inability to manage their affairs has been determined through a legal process, at financial risk.

Cost of administration

In South Australia, the Public Trustee is the default administrator of the financial affairs of protected people. This organisation receives no government funding for undertaking this role and charges all but the poorest for its services. In so doing people with more than $2,000 to their name receive less income than any other citizen just because of their incapacity. (This is sometimes called a tax on lunacy).

Community Visitors Schemes

In all other states, residents of long term hospitals or institutions, disability housing and privately run supported accommodation are visited by volunteers or community visitors to establish their wellbeing and needs. South Australia has no such scheme to supplement and complement the work of mental health and disability workers.

Mental Incapacity and Justice Processes

People with mental illness or other forms of mental incapacity find themselves as parties to some form of legal process either as perpetrator, defendant, victim, witness or interested party. The Courts system has gone some way towards recognising alternative ways of dealing with defendants through diversion programs (Mental Impairment Diversion Program).

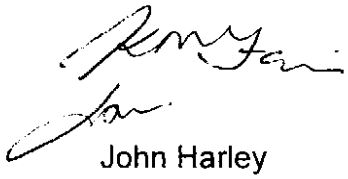
The OPA and the state Public Trustee become involved in a small number of civil litigation non criminal matters where an individual lacks the competence to instruct legal counsel. This work is essential for the protection of the rights of those individuals and to enable the courts to respond appropriately to their circumstances. This work is poorly resourced at present and warrants expansion to assist in addressing human rights issues.

In some states of Australia programs have been established to ensure that mentally incapacitated people involved in police and court processes are supported by third parties to ensure their understanding of the process. South Australia has developed a proposal but this has not been funded.

Rural and Remote issues

South Australia is a large state but most of the population is centred around Adelaide.

- Rural and remote areas lack the centres of population to develop the full range of mental health services.
- There are now no resident rurally based practising psychiatrists and no approved treatment centres for the purposes of treating detained patients within their local community.
- Country mental health providers still struggle with engaging primary health care practitioners in a commitment to mental health service.
- Recruitment and retention of workers in this area remains a problem.



John Harley

Public Advocate.

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Advertiser 16 December 04

Ring of steel at Glenside

By MILES KEMP

GLENSIDE hospital's "Spider-Man fence" is being reinforced for security.

Workers yesterday attached prison-style steel rolls along the top of about 50 metres of fencing at the rear of Glenside's most secure ward, Brentwood. Such rolls make climbing over security fences much more difficult.

The fence was nicknamed when Mental Health Services chief executive Jonathan Phillips declared a patient would need the skills of Spider-Man to scale the structure.

Australian Nurses Federation secretary Lee Thomas said the 4m structure had previously had rolled steel at the top, but it was removed years ago because it made the ward look prison-like.

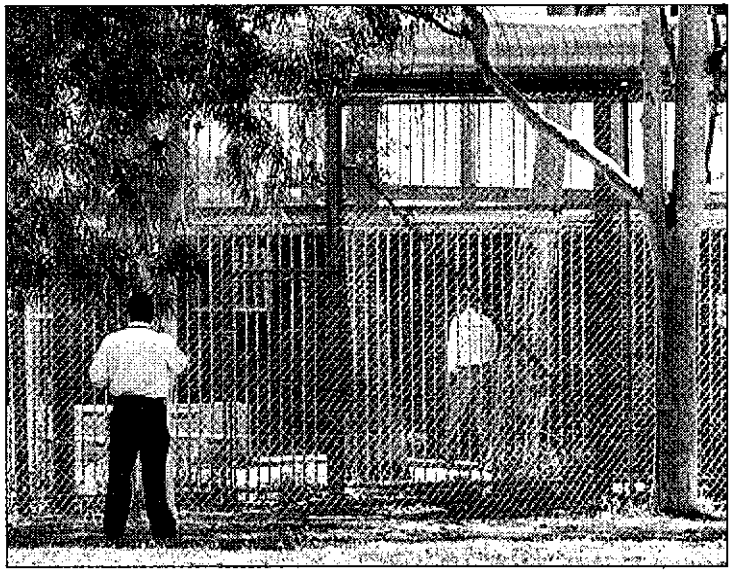
"It is something the staff (of the hospital) have been keen on for some while, because it gives them greater security," she said.

"The roll was removed because of what it looked like and there have been moves for some time to have it put on."

She welcomed the return of the steel and said union members were happy with the work.

A Glenside nurse who told *The Advertiser* of the security work yesterday said staff were happy management had relented.

Nurses had demanded the fence be reinforced following a series of escapes and the failure of perspex sheeting which was designed to stop patients reaching the top of the structure.



FENCED IN: The fence around the Brentwood ward yesterday.

Doctors who fear for the mental health of patients and those who advocate greater security at Glenside have been at loggerheads over increased security.

But a spokesman for the Royal Adelaide Hospital, which runs Glenside, said staff were generally happy with the security upgrade. "It will make that area totally and absolutely secure," he said. Brentwood is the most difficult ward to manage at Glenside. In August, staff from Brentwood, which houses around 20 of the hospital's most acutely ill patients, imposed a ban on personal items which could cause harm.

The ban followed an attack on a staff member, who suffered broken ribs when he was kicked by a patient with heavy boots.

Norwood developer wins $1.1m payment

By GREG KELTON

A DAMAGES claim involving Labor MP Vini Ciccarello and her local council over a Norwood building development was settled yesterday for $1.1 million.

The consent order for payment, including costs, to Boscaini Investments was handed down in the Federal Court. The claim will be paid by the Local Government Association Mutual Liability Scheme which provides cover for councils.

Boscaini had originally sought $3.3 million over the handling of the development on The Parade and George St intersection.

Ms Ciccarello, the Labor member for Norwood and former mayor of Norwood, was part of a group accused of deliberately delaying an application by Boscaini Investments for its development to promote a rival proposal on council-owned land.

Boscaini claimed details of a rival bid for the council-owned Growers' Market had been deliberately withheld to give the council a commercial advantage.

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Attachment I

Cemetery, brothels and night soil dump drags the West End down - Page 10

System failing to cope

By LOUISE RUSSELL

THE state's stretched mental health services are failing to adequately cope with people suffering from personality disorders, the Public Advocate **John Harley** says.

He says people with often destructive disorders are not receiving treatment as they are not properly recognised by health professionals because their problems are not classified as strict mental health issues.

At a justice forum in Parliament House last week, Mr Harley called on the State Government to better recognise and treat personality disorders.

Mr Harley gave several examples of people with personality disorders who could not get any help:

- An Adelaide woman with a personality disorder who made 700 visits to emergency departments at public hospitals.
- A southern suburbs man who had a "habit of trying to demolish" his Housing Trust home. He could not get treatment until "he burnt his house down, so now I can get a medical report on him so we can determine what we can do".
- A woman in her mid-20s who also suffered post-traumatic stress after being raped. After being turned away from the Royal Adelaide Hospital's emergency room, she tried to kill herself. She then spent two months in the RAH intensive care and is now undergoing rehabilitation.

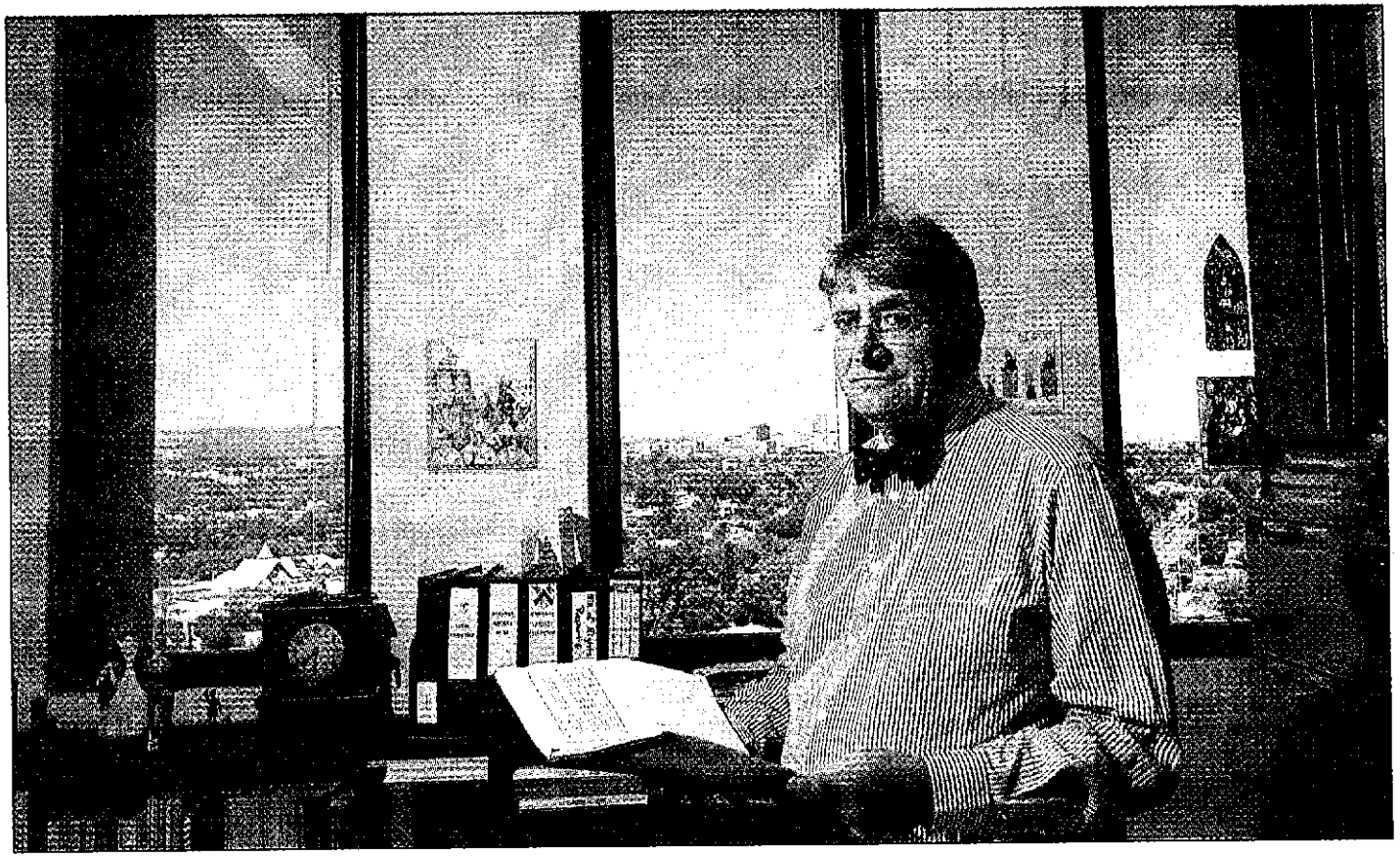
"When these people are rejected by acute care hospitals they go back on to the street and it's up to the ambulance and the police," Mr Harley said.

He said a personality disorder was basically a "dysfunctional personality" with such traits as lying, stealing, running away from home and committing crime. "Very often people are turned away and refused services because they say it's a 'personality disorder', the person is 'acting out', they are just trying to seek attention and there is nothing they can do for them," Mr Harley said.

"They say the person is not psychotic and therefore there is no available treatment for them in an approved treatment centre, or psychotic hospital."

Mr Harley said the situation was "grossly inadequate". He said providing better services for people with personality disorders would save lives and the state in terms of intensive care costs, prison costs and emergency room visits.

A spokesman for Health Minister **Lea Stevens** said mental health services staff had started training to treat personality disorders. He said the Health Department had specifically incorporated borderline personality disorders into future mental health services, including the budget process.



PUBLIC Advocate **John Harley says people with personality disorders are falling through the cracks in the mental health system.**

Attachment II

Attachment 3 - Judgment of the Hon Justice Finn May 2005:

"CONCLUSIONS

257 In each of these matters the facts speak for themselves. It was the Commonwealth's duty to ensure that reasonable care was taken of S and M who, by reason of their detention, could not care for themselves. That duty required the Commonwealth to ensure that a level of medical care was made available to them which was reasonably designed to meet their health care needs including psychiatric care. They did not have to settle for a lesser standard of mental health care because they were in immigration detention.

258 Given the known prevalence of mental illness amongst the over 100 long-term detainees at Baxter, and the likely needs of S and M in particular at least since their participation in December 2004 roof top protest and hunger strike, the level of psychiatric service made available to S and M was, and remained, clearly inadequate. Where there was an obvious need to take steps to provide timely psychiatric service after the protest, none were taken. The Commonwealth ought to have appreciated that to rely upon the two monthly visits of Dr Frukacz resulted in inadequate service provision in the circumstances. This was no fault of Dr Frukacz. The Commonwealth neglected to take steps to inform itself of this inadequacy. Its conduct contributed to the progressive deterioration of the applicants over several months.

259 The Commonwealth entered into a complex outsourcing arrangement for the provision of mental health services which left it to contractors and subcontractors to determine the level of services to be supplied. The hallmarks of these arrangements were devolution and fragmentation of actual service provision. The service provision was so structured that there was a clear and obvious needs for regular and systematic auditing of the psychological and psychiatric services provided if the Commonwealth was to inform itself appropriately as to the adequacy and effectiveness of these services for which it bore responsibility. There has to date been no such audit. The Commonwealth has put into place monitoring and working procedures to deal essentially with the immediate and the ad hoc, though these did not avail S and M up to these hearings. The Commonwealth now foreshadows more by way of auditing and monitoring. Nonetheless, it is difficult to avoid the conclusion that the Commonwealth's own arrangement for outsourcing health care services itself requires review. Its aptness is open to real question.

260 At the times relevant to these proceedings, Commonwealth officers at Baxter entertained a significant level of trust and confidence in the various health service providers, in their professional competence and in the adequacy and effectiveness of the services they provided to detainees. On the material before me I can only conclude that that confidence was founded more on faith than on informed knowledge in relation to some matters critical to the health care of S and M.

261 I have found, particularly in the case of S, continuing failures both to take appropriate steps to arrange psychiatric assessments after medical referrals and to implement adequately treatment plans that had been prescribed. Notwithstanding the receipt of medical opinions from two outside psychiatrists and a GP challenging the treatment plans prescribed at Baxter for S and M, the Commonwealth continued to rely upon the latter without, on the evidence, feeling it necessary to obtain competent, independent, third party advice that it was reasonable to continue to do so. Importantly the outside opinions were to the effect that the conditions at Baxter were themselves a contributing cause of the mental illness of S and M; that Baxter was unable to provide the level of care now required by S and M given their conditions; and that Baxter was an inappropriate treatment environment for them.

262 Those opinions could not be said to be unreasonable. They put the Commonwealth on notice that it needed to take reasonable steps to satisfy itself that it remained reasonable and appropriate to continue to rely upon the treatment plans prescribed at Baxter. This necessitated in the circumstances that independent advice be obtained. This was not done. The consequence was that the Commonwealth was aware that, without properly informing itself as to the reasonableness of its so doing, it continued to commit itself to treatment plans that may have been exacerbating, or else inadequately or inappropriately treating, the very conditions of the two applicants for which it was required to provide health care.

263 I would have granted injunctive relief against the Commonwealth to prevent exposing S and M to that likelihood of harm. Their transfer to Glenside has rendered this unnecessary. I need not in consequence consider the appropriate form of such injunctions. The transfers so late in the day may practically have brought these two applications to an end. They in no way addressed the regrettable need for the applications to be made.

264 I will order in both proceedings (SAD 21 of 2005 and SAD 22 of 2005) that the application against the first respondent be dismissed and that the second respondent pay the applicants' costs of the application.

I certify that the preceding two hundred
and sixty-four (264) numbered
paragraphs are a true copy of the Reasons
for Judgment herein of the Honourable
Justice Finn.

Associate:

Dated: 5 May 2005"

(source. www.austlii.ed.au/au/cases/cth/federalct/2005/549.html)