Senate Select Committee on Mental Health
Questions on notice from Monday 4 July 2005 hearing in Canberra
Catholic Health Australia

Question 1 (Senator Humphries to Mr Sullivan) (page 33, *Proof Hansard)*

Senator HUMPHRIES—Wouldn't it be the case—I have not checked the source that you quoted—that that seven per cent of health expenditure is a reference to total expenditure by Australian governments generally, not by the federal government? I would be surprised if the federal government spent seven per cent of its health expenditure on mental health.

Mr Sullivan—I will take it on notice to get the proper reference for you and give you the answer to that question.

CHA Response:

The reference in the CHA Submission refers to expenditure by Commonwealth and State and Territory governments and the source is provided in the submission:

Mathers, C., Vos, T., Stevenson, C. *The Burden of Disease and Injury in Australia. AIHW Cat No PHE 17.* 1999. Canberra: Australian Institute of Health and Welfare - in Groom, G., Hickie, I. & Davenport, T. (2003) *Out of Hospital, Out of Mind: A Report Detailing Mental Health Services in 2002 and Community Priorities for National Mental Health Policy for 2003-2008.* Canberra: Mental Health Council of Australia.

Question 2 (Senator Scullion to Mr Sullivan) (page 35, *Proof Hansard)*

Senator SCULLION—Thank you for your submission, Mr Sullivan. I noted that as part of your submission you touched on areas that you thought were underserviced in the mental health system. There were two principal areas—one that dealt with remote areas, particularly Indigenous communities, and one that dealt with mental health settings or incarceration of some type in prisons or detention facilities. I am not sure if you have seen the recommendations of the Palmer inquiry.

Mr Sullivan—No.

Senator SCULLION—Perhaps on notice you may wish to peruse those and give me a response about how far you think they go towards meeting some of those concerns in detention facilities.

CHA Response:

CHA welcomes the findings of the Palmer Inquiry into immigration detention particularly the recognition that detention centres are ill-equipped to deal with the mental health needs of detainees.

The situation in Australian detention centres had become so disgraceful and appalling, yet the government had been unwilling to listen to the concerns expressed by church groups and advocacy groups about conditions in the centres. It is unfortunate that it took the tragic cases of Cornelia Rau and Vivian Alvarez to put the issues into the public spotlight and for the government to commission an inquiry such as the one conducted by Mick Palmer.

If the Palmer recommendations are implemented, CHA believes that the mental health of detainees will improve and their needs will be more appropriately addressed than they have been over the past few years. There are a lot of recommendations to work through and it will require the full commitment of all levels of government to action the recommendations in full to ensure people are genuinely cared for and their needs met. There is a risk that the recommendations will simply be used as a 'tick-a-box' exercise for reporting rather than a key step in the process of changing cultures and attitudes about meeting the mental health needs of people who have experienced the trauma of seeking asylum in another country.

CHA will reserve full judgement about how far the Palmer Inquiry goes toward meeting the concerns raised in our submission about detention facilities until it is clear how seriously the Australian and state and territory governments are taking these recommendations and acting on them and what impact this is having on improving the mental health needs of people facing the immigration detention regime.

Question 3 (Senator Moore to Mr Sullivan) (page 37, *Proof Hansard)*

Senator MOORE—At the end of your submission you have a summary of recommendations. You have touched on a lot of the funding ones but the bottom one looks at another category of people—those in middle age—who miss out. That has not been picked up in other submissions we have had. Would you give us a bit of information about what that recommendation refers to?

Mr Sullivan—In part, this came from some of our more community based services which are dealing specifically with men at risk of homelessness. The particular service we have been talking about is where we got most of our information from, but I would be happy to give you some more written information about that—

Senator MOORE—That would be good.

CHA Response:

The service that originally raised this issue with CHA about middle-aged people works in the inner city of Sydney. The issues they raised however are likely to be reflected more generally in cases across the country.

The service stated that prior to deinstitutionalisation the typical client was elderly, living in poor inner city rooming houses and suffering from chronic illness, mainly due to alcoholism. Over the past 20 years the client profile has changed. The typical client now is male – aged 35 to 60 years, living in rooming house accommodation, public housing or homeless, has a dual diagnosis (primary diagnosis of mental illness combined with drug and alcohol misuse, intellectual disability and/or acquired brain injury).

As stated in our submission, one of the key reasons these people are missing out on services is because they are not the priority for early intervention and rehabilitation services (which are mostly targeted to younger people where they exist) and they are too young to be eligible for aged care services including home and community care packages.

There are a number of other factors which exacerbate the problems for this group.

Many of the people in this group have chronic conditions. They may not have episodes which require acute care and therefore the only medical attention they might receive is through a visit to a GP who is willing to see them. The GP might offer some assistance but is often not in a position to provide the ongoing support needs for their chronic conditions and will often refer them to non-government organisations that can provide food, clothing, shelter and companionship etc but may not be resourced to provide medical care. These people are often not a priority for inner city mental health teams who may be committed to responding to acute episodes and providing services and support for younger people as their key priorities.

Further, many of these people in the middle-aged group have had previous exposure of the mental health system through being institutionalised in the past or with medications that were prescribed in past years that had serious side effects (in many cases these medications have more recently been superseded and/or more is known about the risks of medications and how to address them). Many people who had bad experiences in the past are now reluctant to approach the mental health system for help because of this ongoing fear. The style of treatment they experienced in the past may have been traumatic and in many cases did not focus on educating people about their mental illness. In these cases, people have no sense that there are other options available for treatment and management of their illness.

In many cases, people in this group have both chronic mental and physical health conditions. Often, because of the difficult life they have led, they have physically aged with chronic health conditions such as chest infections, hepatitis, rotting teeth etc. In many cases they need just as much physical care as would an older person in an aged care hostel or nursing home but their age precludes them from eligibility for aged care services.

Many of the strategies to address the needs of this group will have already been recommended to the Senate Committee. In particular, there needs to be much better coordination between drug and alcohol, mental health and disability services together with housing and supported accommodation programs. Mental health services need to be tailored to respond to the needs of inner city dwellers (often people who have a dual diagnosis, are homeless and who have no family support). A Catholic provider has stated that 'truly' mobile mental health teams are needed which visit the places where the people actually spend their time (not just set locations at certain times). In addition, there needs to be better collaboration and partnership between non-government organisations and mental health services so that mental health clients are not referred to welfare services without appropriate supervision and back-up support.

The issue of dual diagnosis is one that has been raised during this Inquiry and is certainly an area where further work could be done. Sr Myree Harris RSJ who works with the Gethsemane Community in Petersham, Sydney, a house for a small group of men and women who have mental illness was the recipient of a Churchill Fellowship in 2002 to study this area. Sr Myree's studies included investigations of models of treatment and rehabilitation for people who have a dual diagnosis of mental illness and substance abuse in the USA, Canada and Britain with an emphasis on the care of homeless people.

CHA recommends that the Committee examine this report which was produced as an outcome of this Churchill Fellowship. The report provides examples of services and treatment models being used in other countries to determine whether some of these models would also be successful in the Australian context with appropriate support and financing. The report can be found at the Winston Churchill Memorial Trust website:

http://www.churchilltrust.com.au/Fellows Reports/Harris Myree 20022.pdf

Mr Sullivan—and also to go back to Senator Humphries's question about clarifying the funding relativities.

CHAIR—Thank you. That would be useful.

CHA Response: see response to question 1

Question 4 (Senator Webber to Mr Sullivan) (page 37, *Proof Hansard)*

Senator WEBBER—I will see how we go. One of your recommendations refers to the need to 'support innovative service models which will ensure rural and remote hospitals are fully funded to provide mental health care'. I was wondering if you could expand on the kinds of models you think they would be.

Mr Sullivan—I cannot give you a list of models here. Again, I will take it on notice and give you one, because we do have a major unit of rural hospitals within Catholic Health.

Senator WEBBER—You are the only service outside Perth other than the public health system.

Mr Sullivan—Exactly, so they will have a system of best practice. I think it goes to a deeper issue, though, and this is where I was trying to answer Senator Scullion's first question—that is, if you do not live in metropolitan Australia, your access to mental health services is very poor in real terms, and this goes to the whole question of Medicare entitlements. The entitlement is based on geography more than anything that we have previously understood. Simply having Medicare coverage does not mean that you are going to be adequately covered for mental health care. It may be the case in some metropolitan cities, if you are lucky, but it is certainly not the case in many country towns. Unfortunately, it is certainly not the case in those country towns, even if you have private health insurance.

This is not an argument about public and private insurance; it is an argument about the capacity to deliver any entitlement to anybody, because it is about infrastructure, in the first instance. Secondly—and it has not been asked here but I am going to jump in on this anyway—under the present state and territory mental health acts, the definition of an acute in-patient is so tight that many people do not qualify for admission under that category. We are finding that this particularly applies to younger people. I noticed one of your questions in the previous round was about people with a dual diagnosis, people who may be involved in chemical and substance abuse and who have a fundamental mental disorder.

The third area is this: if a person is in a public hospital but they are not, under the definition, suitable for involuntary admission to, say, a forensic unit because for some reason they do not meet the full criteria of the category and yet they cannot remain in the community because, frankly, they put other people at risk, we have found that a major cost falls back to the hospital system—and we had a glaring case of this recently, where they said that people needed to be 'specialled' 24 hours a day, seven days a week. An enormous amount of resources are placed on one person. One of the reasons is that the

legal categories do not adequately apply and, secondly, there is no service where the person can be placed that also means that the community will be safe.

I am loath to bring that up because that immediately brings up issues of law and order, and that is not within the spirit of this inquiry—I hope—but the point is that we are finding that many services are lumbered with a very resource intensive circumstance simply because the legislation at the state or territory level is not adequate. I would encourage you to look into that further. **We will also try to give you more information on that**. It becomes a huge burden on the work force. As for people in country towns and so on in similar situations, I do not know where you go with that.

CHA Response:

The first part of this question sought further information about innovative models of mental health service delivery particularly in rural and regional Australia. I am attaching to this response the Mental Health Strategy of one of the largest providers of Catholic Health in Australia, St John of God Health Care. This health system is a major provider of health services including in rural and regional Western Australia and Victoria. They have developed a number of innovative service models across the spectrum of rural health including mental health service provision. St John of God Health Care's Mental Health Strategy provides examples of some innovative models of service provision in both metropolitan and rural and regional locations.

For further information, I am also attaching a short document prepared by St John of God Health Care which provides background information on the development of two community mental health services recently established in Ballarat, Victoria and Fremantle, Western Australia. It re-traces the process for the planning and implementation of these services, and the associated liaison with partner groups and community agencies. The comparison in services may also be of interest to the Senate Committee.

The last part of this question on notice sought further information about cases where people have been inappropriately housed in public hospitals for extended periods of time because other suitable options are not available for their care. The following provides further background to this issue.

Firstly, there is the issue of patients who are deemed 'at risk' to the community and admitted and detained in the mental health unit under the Mental Health Act. Ideally these people should be placed in a high level care environment such as secure extended care units or forensic units. However, due to bed shortages and the patient's diagnosis, such units are often unable to be found or are not suitable and these patients are left in a general inpatient unit as there is nowhere else to care for them. These inpatient units are not resourced to meet such

intensive care requirements. The patients are usually very difficult and in the case cited by one Catholic hospital in Victoria, a patient caused permanent harm to a staff member and threatened other patients. In such cases, the hospital has to special the patients 24 hours per day. In the case cited, this patient was specialled for almost four months until an appropriate bed became available.

Of further concern is that when these patients arrive and there are no mental health beds, they are maintained in an acute hospital or emergency department until the first inpatient bed becomes available (which can take up to 3 days). They are then placed in the first bed available rather than the most appropriate placement which is clearly not in the best interests of the patient or other mental health patients.

The hospital group that raised this particular issue has defined the problem as two-fold. One, there are not enough secure extended care beds (ie long term secure accommodation) and two, the move to community care (from the institutional model) has not worked for all people. Some patients with extreme and complex mental health illness require a permanent, secure and supported living arrangement as they may be dangerous to themselves and to others. As referred to in the response to the question about the issues for middle-aged people, there is also a significant gap in the mental health system for supporting people with chronic and complex mental health needs in the community. In the move to full deinstitutionalisation, it could be the case that we have lost sight of the fact that some people need to be in supported accommodation with people they can relate to. This should not be a hospital environment with wards and clinical surroundings but rather supported accommodation for the long term so that people be can be housed and supported to prevent inpatient admission and readmission.

A further issue about specialling patients raised by a Victorian hospital is that when a patient turns up to an Emergency Department and they are kept there with a ‘special’, this treatment is unfunded until a bed can be found. This can be 3-4 days and emergency departments are simply not the place for people with mental illness. Two strategies to deal with this would be to have designated mental health staff as part of the treatment teams (not just crisis response workers) who can assist staff in the treatment and management of mental health patients. Secondly, separate areas are needed in emergency departments where these patients can be cared for until a longer term bed can be found. It is unacceptable that some hospitals consider that their only option in these situations is to keep patients on a trolley with either physical or chemical restraint which is undignified and clearly inappropriate.