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Our ref Jane Sanders

Doc no Sydney\004530340

The Hon Dr Brian Pezzutti MLC
Chairman
Select Committee on Mental Health
NSW Parliament
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Sir

Inquiry into Mental Health Services in New South Wales

We welcome the opportunity to provide a submission to this inquiry. We thank you for giving us an extension of time to lodge our submission.

The Shopfront Youth Legal Centre is a free legal service for homeless and disadvantaged young people aged 25 and under. It was established in 1993 and is now staffed by four solicitors and two legal assistants.

The Shopfront advises and represents clients on a variety of legal issues, including criminal law, victims compensation, family law, discrimination, tenancy and debt. It is based in the inner city but works with clients all over the Sydney metropolitan area.

A significant proportion of our clients have a mental illness. Some of these clients also have an intellectual disability, a personality disorder and/or a dependency on alcohol or other drugs.

In working with our clients, we have come into contact with a number of the mental health services. Some of these services respond well to our clients' needs. However, for many young people (especially those who are itinerant or who suffer from "dual diagnosis"), there is an acute lack of appropriate services.

1 Client case studies

Below are some case studies which illustrate some of the problems with mental health services in NSW. Each case study describes the experiences of a particular Shopfront client. The clients' names have been changed and some identifying details withheld to protect their confidentiality.

1.1 Steve

Steve is 22 and has a long history of mental illness and substance abuse problems. He has been involved in the criminal justice system since his mid-teens. At the age of nine, Steve was hit by a car and suffered a traumatic brain injury. According to a psychological assessment, this affected his cognitive, emotional and executive functions. He is impulsive and prone to sudden alterations of moods. His capacity to plan and to choose alternatives has been impaired. Recently Steve was also diagnosed as suffering from clinical depression and a psychotic illness.

For the last couple of years Steve has lacked stable accommodation. Although he had a flat provided by the Department of Housing, he lacks the skills and support needed to live independently. Steve has also spent periods of time living with his grandparents, who are elderly and have difficulty coping with him. He has also had several psychiatric admissions and has spent time drifting around temporary accommodation or living on the streets.

When Steve was living in his Department of Housing flat, his local mental health service was not very helpful. We understand this is largely because they see his primary problem as being drug-related. On one occasion a neighbour saw Steve running in front of traffic in his street, and called the police. When the police came, Steve struggled with them. Police took him to the local psychiatric unit, who refused to admit him, stating that he would be more appropriately dealt with by the criminal justice system. As a result, Steve was charged with assaulting police and initially refused bail.

Steve tends to gravitate towards the King Cross/Darlinghurst area, especially when he is homeless. He obtains some assistance from our service and from a youth outreach service in the area. He has also received assistance from the Program for Early Intervention and Prevention of Disability (PEIPOD) which is run by St Vincent's Mental Health Service. PEIPOD have engaged with him in a way that other services have apparently failed to do. They have been working to organise some stable supported accommodation for Steve, and have secured a place in a local youth accommodation service once a vacancy becomes available.

However, PEIPOD's capacity to work with Steve is limited by the fact that they are area-based. If Steve moves outside the inner city area, he has to be referred to another area-based mental health service, who may or may not provide services which meet his needs. Steve's experiences with the mental health services on the Northern Beaches and elsewhere suggest that he will again fall through the gaps in services if he does not remain in the inner city area.

1.2 Barbara

Barbara is in her mid-twenties and has been a client of the Shopfront for several years. She suffered from physical and sexual abuse in her childhood. Not surprisingly, she became homeless, opiate-dependent, and involved with the criminal justice system. She has served several terms of imprisonment, mainly for property offences.

Several months ago, when Barbara was released from custody, she was extremely depressed and suicidal. She attempted suicide on at least one occasion by slashing her wrists, and was admitted to the emergency department of her local hospital. She was discharged a couple of days later without any apparent follow-up.

After this hospital admission, Barbara continued to harm herself by slashing her arms. She confided to us about her fear that she would either kill herself or someone else if she didn't get help. She said she felt she really needed to be admitted to a psychiatric ward in order to feel safe.

We accompanied Barbara to the local community mental health centre to have her assessed for possible admission to hospital. Barbara was frank with the intake worker about her suicidal feelings, and her fears that she may seriously harm herself or others if not treated. The intake worker was very dismissive, saying that a psychiatric admission would not assist Barbara with her problems. She said that Barbara needed long term psychotherapy, which the community mental health service was unable to provide. She suggested that Barbara go to a detoxification centre or, if there were no vacancies in detox, to a refuge. The intake worker then asked Barbara if she would like a dose of anti-psychotic medication to "calm her down", and arranged for a doctor to prescribe this.

Fortunately, Barbara has not yet committed suicide (or seriously harmed anyone else) but she is still struggling with depression, suicidal ideation and substance abuse problems. It appears that there are no services which will address her needs in a holistic way.

1.3 Tony

Tony is now 27 years old and has been a client of the Shopfront since he was 19. He was diagnosed with schizophrenia at age 16 and has had numerous involuntary admissions to psychiatric hospitals over the years.

In many ways, Tony has been well served by the mental health system. Although he can become violent or threatening during psychotic episodes, for the most part he has been dealt with by the mental health system rather than the criminal justice system. However, on occasions the mental health system has failed Tony - and it has failed spectacularly.

In the past, Tony's periods in hospital were generally followed by Community Treatment Orders. His compliance with these orders was not always satisfactory (which is not uncommon for people with schizophrenia, who often have little or no insight into their illness and their need for medication). Nevertheless, his local mental health team persevered with him and he was able to remain in the community and function reasonably well for long periods.

A couple of years ago, while Tony was an involuntary patient at his local psychiatric unit, he had a violent outburst and broke a nurse's jaw. Understandably, this hospital is now reluctant to admit him. We understand that his violent reputation has spread to other hospitals and to his local community mental health team. It has become difficult for him to find appropriate treatment when he needs it.

Tony had two lengthy hospital admissions in 2000 and 2001 respectively. Both times, he was discharged without a Community Treatment Order. We understand that this is because his local community mental health team indicated they would not enforce a CTO (presumably because of the likelihood of non-compliance and the risk of violence).

Tony is relatively fortunate in that he has supportive parents, who were able to assist him obtain a Department of Housing flat. However, his relationship with

them is not always cordial, and Tony believes their intervention is an attempt to "run my life".

Tony also has access to some money apart from his disability pension. He was sexually abused as a child and received a substantial victims' compensation payout in early 2000. Because of his mental illness, the compensation money was placed under the administration of the Public Trustee. The Public Trustee paid his rental bond and ensured his rent was paid regularly. They also released funds to allow him to purchase a car and necessary household and personal items. However, the staff at the Public Trustee's office were ill-equipped to deal with Tony's frequent requests for extra money.

Even though Tony was financially provided for, his living skills were poor and he had no social worker to assist him. The staff at the Shopfront reluctantly became his de facto social workers, assisting him with all manner of day-to-day tasks. We attempted to secure him some assistance from his local community mental health team, but to no avail. It seems that unless Tony was prepared to see a doctor and take his prescribed medication, he could not get any social work assistance.

Tony was not taking any medication and became increasingly unwell. His relationship with his family also deteriorated, to the point where his parents took out an Apprehended Violence Order against him.

Early this year, Tony went to his parents' house (in breach of the AVO) and allegedly assaulted his parents. His parents called the police but Tony ran away before they arrived. Tony was arrested several weeks later. He was charged with breach AVO and two counts of assault. He was also charged with resist police (because he struggled with police when they were arresting him) and with carrying a cutting weapon (because a hunting knife was found in his bag).

Even though Tony was acutely psychotic, and would have met the criteria for involuntary admission, he was not admitted to hospital. Instead he was refused bail and spent a week in prison.

We did not find out about the charges until a prison welfare officer telephoned us. We then made an application to the court under 33 of the *Mental Health (Criminal Procedure) Act*. After reading a report from Tony's psychiatrist, the court made a section 33 order, with a condition that he should be brought back to court if found not to be a "mentally ill person". Tony was taken to Rozelle Hospital and admitted as an involuntary patient.

That should have been the end of the matter. However, when Tony appeared before the visiting Magistrate at the hospital several days later, the Magistrate saw the words "bail refused" on the section 33 order. This was obviously a clerical error, as a person subject to a section 33 order cannot be bail refused. Instead of recognising this, the Magistrate sent him back to court, on the grounds that he was bail refused and therefore should be in prison and not in a hospital.

We appeared for Tony at court that afternoon (which was a Friday). The Magistrate made a new section 33 order, again with the condition that he be brought back to court if not found to be a "mentally ill person". Tony was taken back to Rozelle Hospital, who refused to admit him on the grounds that he was no longer a "mentally ill person", because he had been medicated for the last 10 days and no longer presented an acute danger to himself or others. Tony was therefore taken back to the court cells in the custody of the police. The police had no power

to grant bail, or even to place him before the weekend bail court, so Tony spent the entire weekend in the Waverley police cells before appearing at court on Monday morning.

On the Monday, the Magistrate refused to make another section 33 order because he feared the hospital would not admit Tony. Having received an indication from Rozelle Hospital that they would accept Tony as a voluntary patient, we submitted to the Magistrate that Tony should be granted bail on condition that he accept treatment voluntarily. However, the Magistrate refused bail, believing that Tony still presented a risk to his parents and could not be trusted to accept treatment voluntarily even if it was a condition of his bail.

Tony was therefore remanded in custody for several weeks until someone was able to arrange a bed for him at Morriset Hospital. We then made another section 33 application, which was granted, with the result that Tony was admitted to Morriset.

At Morriset, Tony has been held in a locked ward with forensic patients whose violent behaviour and criminal activity is far more serious than Tony's has ever been. Arguably it is not the most appropriate place for him, but it is one of the few places that would accommodate him. Additionally, Morriset has a rehabilitation program which may be of benefit to Tony if he agrees to participate.

2 Problems with mental health services in NSW

2.1 Lack of appropriate accommodation

A common complaint about the implementation of the Richmond Report recommendations is that "deinstitutionalisation" took place without ensuring adequate accommodation was provided in the community. Many people with mental health problems are homeless or are living in sub-standard accommodation (such as boarding houses) where they are not adequately supported and may be exploited.

There are some very good youth refuges and supported accommodation programs for young people. Many of these services do their best to accommodate young people with mental health problems. However, their funding does not permit them to provide the high level of supervision and support that is often required, nor does it enable them to employ highly-qualified specialist staff.

We know of at least one youth service which can find no appropriate accommodation for young people with mental illnesses. Its only option is to refer them to a service which houses them together with people in their 40s.

We are aware of a few supported accommodation services that target mental illnesses, but these are few and far between and do not provide enough places to accommodate the demand.

Although people with mental health problems are usually given priority by the Department of Housing, a lack of adequate support services in the community means that this housing is often jeopardised. Obtaining accommodation is one thing; maintaining it is another. Even if the tenant keeps up to date with their rent, they may lose their housing because they are absent for long periods (due to being in hospital, prison or just going “walkabout”), or because neighbours complain about unusual or difficult behaviour.

2.2 Services are area-based

A problem illustrated by the case study of Steve, and common to many of our clients, is that mental health services are generally only available to people who live in their catchment area. Many of our clients, who are homeless or have frequent changes of accommodation, are therefore unable to establish a relationship with any mental health service. Or they do establish a good relationship with a doctor or caseworker, only to be forced to sever the connection when they move to a different area. People like Steve may be met with inconsistent approaches from different area health services - some being very supportive and others being unwilling or unable to assist them.

It must be borne in mind that most of our clients have little or no choice as to where they live. In some of these cases, a move to a different area results in a total cessation of contact with any mental health services.

2.3 Inability to deal with dual diagnosis

The problems of "dual diagnosis" clients are well-documented and very difficult to resolve. We have numerous clients with substance abuse problems and mental health problems, who are unable to access mental health *or* drug and alcohol services. The case studies of Steve and Barbara are just two examples.

We acknowledge that there may be genuine therapeutic reasons why people with dual diagnosis cannot be treated by mainstream services. However, we refuse to accept that it is impossible to treat dual diagnosis clients. There is a glaring need for a spectrum of services targeted at this group of people. We are aware that there have been some attempts to address the issue, through pilot programs and the like, but to our knowledge there are very few services which adequately tackle the problem.

2.4 Inadequate recognition and treatment of non-psychotic illnesses

The case study of Barbara illustrates an apparent lack of response to people whose mental illnesses do not fall into neat categories.

The New South Wales mental health system seems to be geared towards people with recognised psychotic illnesses which respond to medication. We do not suggest it is inappropriate that these people be given high priority, but we suggest that there are other people with non-psychotic illnesses who also need help.

For people like Barbara who are depressed, suicidal and in need of long term psychotherapy, it seems that the mental health system has little to offer apart from "band-aid" measures such as a dose of medication.

Although people are frequently involuntarily admitted to hospital after suicide attempts, they are generally admitted as "mentally disordered" patients and are discharged after a day or two, often on to the street. Some people are not even admitted to a psychiatric unit, but are admitted to a general ward. In this situation they receive treatment for their physical injuries but do not always receive any treatment for their mental health problems.

We do not necessarily support an extension of the time for which a “mentally disordered” person can be involuntarily detained under the *Mental Health Act.* However, we believe there is a need for more follow-up and support in the

community (after discharge from hospital or, better still, before a hospital admission becomes necessary).

We would also like to see more resources available so that people like Barbara who are depressed and suicidal could receive treatment as *voluntary* patients. In our experience, people who seek to be admitted (or to remain after the end of an involuntary admission) as voluntary patients are often unable to do so due to a lack of beds in the public system.

2.5 Inability to deal with violent or "difficult" behaviour

The case study of Tony illustrates the inability or unwillingness of some mental health services to deal with people whose behaviour is violent or challenging.

We acknowledge that there are very real concerns about occupational health and safety. Mental health workers, whether in hospitals or in the community, should not be forced put their personal safety at risk every time they go to work.

People with mental illnesses are often stereotyped as inherently violent. We know this is not the case. However, many people with mental illnesses *do* engage in violent behaviour, especially if they are psychotic. To be admitted as an involuntary patient, a person must be a "mentally ill person". Not only must the person have a mental illness, but there must be grounds for believing that care, treatment or control is necessary to protect them or others from serious harm. In these circumstances, we would expect that many involuntary patients would have tendencies towards violent or challenging behaviour at some stage. We are therefore concerned about the apparent inability of certain psychiatric hospitals to admit patients like Tony. We suggest that staffing levels must be enhanced so that these patients can be effectively managed.

It also appears that some patients are placed in the "too hard basket" because they repeatedly fail to comply with Community Treatment Orders and other attempts to treat them. This results in a lack of follow-up and repetition of the cycle involving deterioration in mental health, escalation of psychotic symptoms, and involuntary admission to hospital.

We do not pretend there are any easy solutions to this problem - it is of course very difficult to treat an unwilling patient, especially in the community. However, given that non-compliance with treatment is common among people with schizophrenia, we suggest that more needs to be done to ensure that people like Tony do not remain totally untreated and unsupported for long periods.

2.6 Interaction with criminal justice system

In our experience, clients with mental health problems are often involved with the criminal justice system. Sometimes the mental health and criminal justice systems work well together, so that the person’s mental illness is treated and managed appropriately. However, sometimes these systems do not interact well, and people with mental illnesses are subject to inappropriate criminal sanctions, including imprisonment.

In some cases it appears that mental health professionals consider the clients to be too difficult to manage, and decide that they would be more appropriately managed in the criminal justice system. We see this as inappropriate for people like Tony, whose criminal activity is clearly related to his mental health problem and who does not receive adequate treatment in jail. The prison environment is

likely to aggravate rather than control his mental illness. He poses far more of a risk to the community if imprisoned and subsequently released than if managed by a mental health service.

2.7 Shortage of adolescent mental health facilities

Although this is not covered by the case studies, we would also mention the lack of appropriate mental health services for adolescents.

In our experience, the problem seems to be mainly with acute or crisis care. Although there are hospital and residential facilities for adolescents, many of these are not equipped to deal with patients who are acutely psychotic or actively suicidal. We have worked with several adolescents (some in their early or mid teens) who have had to be confined in acute adult wards because there are no appropriate adolescent wards.

Adolescents may also have difficulty accessing mental health services because they have not been diagnosed with a mental illness. During adolescence, it can be difficult to separate mental health problems from normal behavioural changes or substance abuse. There is also a reluctance by some professionals to "label" a person at a young age. This diagnostic difficulty or reluctance is recognised by some adolescent mental health programmes, which are able to work with young people despite the lack of a clear diagnosis. However, we suggest that there is room for improvement in this area.

3 Conclusion

Although our clients are a very marginalised group of people, their problems are not unique. It is well-established that homelessness, dual diagnosis and interaction with the criminal justice system are common among people with mental illnesses (see, for example, the 1993 report of the Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness*).

Clearly, there are no cheap and simple solutions to the problems highlighted in this submission. Many of the problems could of course be ameliorated by an increase in funding. However, we suggest that there are some measures that could be taken without substantial funding increases. This may necessitate a redistribution of existing funds or a philosophical shift.

In addition to this submission, we would welcome the opportunity to give evidence at the inquiry.

Yours faithfully
SHOPFRONT YOUTH LEGAL CENTRE

Jane Sanders
Principal Solicitor