INQUIRY UNDER SECTION 47 OF THE HEALTH AND DISABILITY SERVICES ACT 1993 IN RESPECT OF CERTAIN MENTAL HEALTH SERVICES

Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley

May 1996

INQUIRY UNDER SECTION 47 OF THE HEALTH AND DISABILITY SERVICES ACT 1993 IN RESPECT OF CERTAIN MENTAL HEALTH SERVICES

REPORT OF THE MINISTERIAL INQUIRY TO THE MINISTER OF HEALTH HON. JENNY SHIPLEY

MAY 1996

Mental illness is different from physical illness. Mental illness is a very personal thing, a personal experience. You can't see it, so you can't distance yourself from it. It's you. It's for life. It takes your soul. Sometimes it's like dying. No one else sees it, so they often don't believe you or they don't understand. You don't understand it yourself; often you don't understand yourself. The health professional can't really explain it, except in vague or incomprehensible terms of chemical imbalance. So relief is in the personal care and attention and time that are offered to you. They are just as important as the medications.

Dr Don Quick, Psychiatrist

Christchurch
23 May 1996

HON. JENNY SHIPLEY
MINISTER OF HEALTH
PARLIAMENT BUILDINGS
WELLINGTON

Dear Minister,

Greetings to you, the Minister of Health. We have pleasure in handing you our report relating to certain Mental Health services.

The recommendations contained in this report are few in number but significant in their potential impact.

The best available evidence suggests that in any one year 25% - 30% of our population have symptoms that meet criteria for a mental disorder and that approximately one third of these people have a disorder which is serious or chronic.

That simple statement is sufficient to demonstrate the need for a service which is readily accessible, professional, user friendly and mindful always of the needs of that group which it is designed to serve - the consumer.

We believe that our recommendations, if implemented, will raise the New Zealand Mental Health Service to a position of international excellence.

We thank you Minister for the opportunity to be of service.

KEN MASON
CHAIRMAN

.....

JUNE JOHNSTON

.....

JIM CROWE

.....

TERMS OF REFERENCE

Government has established a sharply focused Inquiry into the availability and delivery of those aspects of Mental Health Services in New Zealand relating to semi-acute and acute mental disorder.

It is proposed the panel will consult with those they deem appropriate and that the Inquiry be established pursuant to Section 47 of the Health and Disability Services Act 1993. This will establish a Ministerial Inquiry and provide all the powers to complete the job without impediment.

DETAILS OF TERMS OF REFERENCE

1. Previous Inquiries

a. To review recent recommendations from New Zealand Mental Health inquiries to report on the extent to which those recommendations have been implemented or actioned.

b. Make further recommendations associated with these reports on:

- priority given to recommendations to date; and
- additional changes required to previous recommendations.

c. To review any recent international reports which are considered to be significant and applicable to New Zealand.

2. Legislation

Consider amendments already identified or that may be approved or require attention in the Mental Health (Compulsory Assessment and Treatment Act 1992).

3. Privacy Concerns

a. Review and provide comment on how the Health Privacy code is being used by Mental Health Service providers.

b. Make particular comment and recommendations on how and when family members associated with the care and treatment of mental health patients should be provided with information concerning that patient's treatment and care.

4. The Rights of Family Members

To report on what consultation and consideration is given to the views of close family members in determining the treatment and care of those with semi-acute and acute mental disorders.

5. Drugs and Alcohol

Comment on the extent that non-prescription drugs and alcohol are known to contribute to acute and semi-acute mental disorders.

6. Provision and Co-ordination of Services

a. Review the services, including crisis support, assessment, treatment and continuing support for those who are suffering from an acute or semi-acute mental disorder.

b. Identify and recommend where improved co-ordination procedures between providers of services are required and how particular problems may be overcome.

7. Consultation

The panel is to consult with those who they deem to be appropriate to complete this task.

8. Time Frame

It is proposed the Inquiry report to the Minister of Health no later than 30 April 1996.

GLOSSARY

The following abbreviations are used in this report:

ACT:	Mental Health (Compulsory Assessment and Treatment) Act 1992 (No. 46)
CHE / CHEs:	Crown Health Enterprise(s)
CCMAU:	Crown Company Monitoring & Audit Unit
CONSULTANT:	Consultant Psychiatrist
DAMHS:	Director of Area Mental Health Services
DAO / DAOs:	Duly Authorised Officer(s) designated and authorised pursuant to Section 93 Mental Health (Compulsory Assessment and Treatment) Act 1992
HRC:	Health Research Council
NGO / NGOs:	Non-Government Organisation(s)
PDN:	Psychiatric District Nurse
PRIVACY ACT / PRIVACY CODE:	Privacy Act 1993 / Health Information Privacy Code 1994
RHA / RHA(s):	Regional Health Authority(ies)

CONTENTS

APPENDICES

CHAPTER ONE

INTRODUCTION

In the latter part of 1995 two young men in possession of firearms were shot dead by Police. In Wanganui the activities of an individual alleged to be suffering from a personality disorder attracted media attention. The common feature in all cases is that each person had been involved with Mental Health services during the months immediately preceding the events which brought them to public notice.

Yet again the media, talk back hosts and the Parliament debated the quantity and quality of Mental Health services, and in particular the issues of dangerousness, public safety and the inaccessibility of services. A high level of public concern was generated. The term "ex-psychiatric patient" assumed a place of notoriety on the airwaves.

We are unable to say whether those events precipitated our Inquiry but it was against this background that we were invited to consider the various matters set out in our Terms of Reference.

We were briefed by the Minister and Ministry of Health officials on 29 November 1995.

Thereafter we established an office in Christchurch and advertised in all metropolitan and several provincial newspapers inviting written submissions by 15 January 1996.

Mary Coatman was appointed as Secretary to the Inquiry Team.

Within days of our initial briefing we received 67 reports from the Ministry of Health followed, at varying intervals, by additional information relating to our Terms of Reference. In total, we received in excess of 150 reports from that source.

On 12 December 1995 we met with officials from each of the four RHAs. We were anxious to obtain a general overview about purchasing practices and procedures.

Ministry officials anticipated, on 29 November 1995, that we may receive about 200 written submissions. That figure proved to be an underestimate, so much so that the closing date for written submissions was extended to 5 February 1996. In total, we received and considered 720 written submissions.

It will be noted that we were to be "... a sharply focused inquiry into the availability and delivery ... of Mental Health services in New Zealand relating to semi-acute and acute mental disorder". Almost without exception those who made submissions did not confine their remarks to that group of people.

One Psychiatrist observed:

> **70% of people who present to the Mental Health services with semi-acute and acute mental disorder do so in the context of having chronic or lifelong vulnerability to recurrent persistent mental disorder. To focus merely on mental health services relating to semi-acute and acute mental disorder would be to act on a misunderstanding of the nature of severe mental disorder. The aim of a good Mental Health service is to prevent the worst consequences of acute mental disorder by targeting it's services to those most vulnerable, the severely and persistently mentally ill. The aim is not the other way around.**

It was obvious that those who made written submissions and those with whom we met were concerned that Mental Health services were not being delivered as efficiently and effectively as they should be. They were anxious to ensure that we examined the Mental Health sector in wide terms rather than confine our enquiries to those services which affected a select group of consumers.

A list of those who made written submissions is annexed as Appendix 1.

We met with or consulted those individuals and organisations referred to in Appendix 2. They included Psychiatrists, Psychologists, Nurses, Social Workers, families, consumers, RHA and CHE officials, representatives from intersectoral agencies, NGOs and Maori and Pacific Island representatives. It was a matter of considerable regret that we were unable to meet with all those who wished to make oral submissions. Time constraints meant that we had to decline many such requests.

We visited Dunedin, Invercargill, Auckland, Whangarei, Rotorua, Hamilton, Christchurch, Thames, Hokitika and Wellington. We also spent four days in Melbourne examining several models of service delivery particularly those relating to early intervention. In the process we had the opportunity to study the Victorian Mental Health System which caters for a population similar in size to that of New Zealand.

Such was the interest in our Inquiry that the reporting date was extended to 23 May 1996.

In writing this report we have adopted the practice of allowing the participants to tell their own stories. We make no apology for not substituting our words for those of the submitters - that would be tantamount to sanitising the objectivity of the submissions.

It would be fair to say that the time frame within which this Inquiry was conducted was less than we would have wished - given the large number of oral and written submissions. Nonetheless we are satisfied that we have had sufficient time and information to consider how best to advance the cause of Mental Health services and to recommend the method by which that goal can be achieved.

Within three weeks of our initial briefing by Ministry officials, and having had the opportunity to read several of the numerous reports before us, one significant feature emerged. We were surprised that no one organisation appeared to have a mandate to drive the National Mental Health Strategy (Strategic Directions For Mental Health Services) outlined by the Minister in June 1994. We were impressed by the vast amount of information about services which had been collated but found it difficult to see any practical application of that information. Before Christmas 1995 we had formed the tentative view that more than anything else the Mental Health strategy needed to be moved forward by some organisation which had an unequivocal mandate to do so.

Some months later a clinician commented:

> **The Mental Health strategy is basically a fairly good document but it has no legs. If it remains standing still it is nothing more than a vision statement. That strategy now needs to be put into practice but no one seems capable of driving it forward.**

Our early tentative view was reinforced during the following months and indeed, the lack of national leadership and planning in the Mental Health sector emerged as one of the most predominant features of the Inquiry.

Later in this report we recommend the establishment of a three person Mental Health Commission and a seven person Advisory Board. The function of that Commission, in simple terms, will be to advance the cause of Mental Health and to translate the national strategy into a fully functioning quality Mental Health service.

Acknowledgements:
We acknowledge with thanks the assistance and encouragement of many people throughout New Zealand and Australia during the course of this Inquiry. We particularly thank:

- Mary Coatman who so cheerfully carried out her secretarial duties and who organised our travel, accommodation and meetings
- Linda Leaf who so competently typed and collated this report
- Dianne Williams for undertaking typing and secretarial duties at short notice

- Associate Professor Jeremy Anderson for organising our visit to Melbourne
- David Curry and staff at the Ministry of Health
- Schizophrenia Fellowship (Otago branch) who were kind enough to release Jim Crowe from his duties as Senior Field Worker for the duration of the Inquiry
- Those individuals and organisations who thought that this Inquiry was important enough for them to take the time and trouble to write submissions and / or appear in person before us
- Our families who cheerfully tolerated prolonged absences from our homes
- Those families and consumers who allowed us to intrude into their lives and for whom that experience was often a painful one
- Our kaumatua John Turei for his encouragement and support

CHAPTER TWO

PREVIOUS INQUIRIES

We were uncertain as to which "recent ... NZ Mental Health Inquiries" should be reviewed under this Term of Reference. On 22 January 1996 we wrote to the Ministry of Health:

> **"Would you please provide a list of recent New Zealand Mental Health Inquiries referred to in Term of Reference 1 (a), i.e. what previous Inquiries should be dealt with under this head? Would you please itemise those recommendations referred to in the "recent ... Inquiries" (referred to above) which have been implemented or actioned and those which have not been implemented or actioned".**

On 24 January we were advised that the information would be forthcoming no later than 2 February 1996. There was no further response until we met with the Director General of Health and her officials on 27 February 1996.

On that day we informed officials that the information we sought was exclusively within the knowledge of the Ministry of Health. We asked:

> **Please provide us with information as to those recommendations which have been made in respect of Inquiries from 1987 onwards. Advise us which recommendations have been implemented and those which have not been implemented or actioned, and if not, why not. We assume that people involved in Inquiries, whether they be Commissions or Committees ... make recommendations after ... considerable thought, and the Minister and the public will want to know why recommendations have not been implemented. The grounds for not doing so may be perfectly legitimate - we make no judgment about that - but it would be helpful to know the "why not" part.**

The Ministry pointed out that many Inquiries since 1987 had been conducted by District Inspectors, and asked how they should treat such Inquiries. We invited them to deal only with **SIGNIFICANT** Inquiries, and indicated that we would be content to let officials make a judgment as to which Inquiries might be regarded as significant.

We received an interim report in March and a final report on 2 April 1996. The final report is a 191 page document and, for obvious reasons, it cannot be included as an appendix to this report.

We set out below the more important comments and conclusions in that report.

A REVIEW OF THE IMPLEMENTATION OF RECOMMENDATIONS FROM MENTAL HEALTH SERVICE INQUIRIES 1987-95

INTRODUCTION

This report is provided in response to a formal request for information by the Inquiry into Mental Health Services at its meeting with Ministry staff on 27 February 1996.

Since 1987, 67 inquiries, including the Inquiry into Mental Health Services, have been held or are being conducted into aspects of mental health services. In each inquiry, some incident or set of circumstances has been of sufficient concern or significance to some person or body authorised to initiate independent investigation. The Ministry respects the judgment of those who have initiated inquiries or investigated matters which have sometimes involved human suffering or tragedy, the rights and dignity of people with mental illness or disability, suspected deficiencies in standards of professional practice, procedures or service provision. All inquiries are considered of equal significance.

DEFINITIONS

An Inquiry can be defined as an independent investigation by a person or body, authorised by the state and acting on behalf of the community, to consider facts and evidence, draw conclusions, make recommendations and to report on an event or events. This may be undertaken informally or by using formal procedures.

The report presents the recommendations of inquiries in the area of Mental Health services since 1987. These services include psychiatric hospitals, psychiatric units in general hospitals, and community-based psychiatric services.

SCOPE OF THE REVIEW

Sixty-seven inquiries, including 4 possible inquiries about which there is insufficient information, come within the definition of mental health services. A further 6 inquiries concerning intellectual handicap hospitals were undertaken by district inspectors or involved specialist psychiatric expertise.

> **The jurisdiction of district inspectors included intellectual handicap hospitals until the Mental Health (Compulsory Assessment and Treatment) Act 1992 came into effect. It is not possible to distinguish between inquiries into the care of or services for patients with intellectual handicap and / or a psychiatric diagnosis for whom services have traditionally been provided by psychiatric hospitals.**

The Ministry then described the classification of Inquiries in terms of their status and origin. They are:

1. Royal Commissions
2. Commissions of Inquiry
3. Parliamentary Select Committees
4. Inquiries under particular statutes, e.g. the Hospitals Act 1957 and the Health and Disability Services Act 1993
5. Advisory and Technical Committees
6. Inquiries by District Inspectors
7. Coroner's Courts
8. Administrative Reviews by Central Agencies of Government
9. Investigations and inquiries by other bodies, e.g. Health Professional Disciplinary Committees or the Police Complaints Authority

In respect of Inquiries by District Inspectors the report notes:

> **This has been the most frequently used form of Inquiry and the basis of classifying Inquiries by origin. Investigative powers available to district inspectors fall within two main categories:**
>
> **a. Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 enables a District Inspector, on his / her own authority or upon direction by the Ministry's Director of Mental Health, to enquire into any breach of the Act, breach of duty by any officer or other person employed in a hospital or Mental Health service, or "such other matters as the District Inspector or**

Director thinks fit to be inquired into respecting any patients, or the management of the hospital or other service." This authority is comparable to the previous mandate under s.58 of the Mental Health Act 1969 except that the scope of a District Inspector's authority and powers of inquiry are confined to persons under compulsory care and treatment, and are not restricted to psychiatric hospitals.

b. Section 75 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 empowers District Inspectors to investigate complaints of breach of rights, to report and to make recommendations to the DAMHS.

The distinction between Inquiries which have been self-initiated by District Inspectors and those which they have been directed to undertake has important implications for the scope of this report. Self-initiated inquiries cover:

a. those Inquiries where the seeming formality of a Section 95 Inquiry (or its equivalent under the previous legislation) has been demonstrated by e.g., a District Inspector advising that his / her Inquiry is taking place under Section 95 provisions; or the existence of formal terms of reference, and the mention of any recommendations or suggestions;

b. requests by hospital or service management for an independent Inquiry by the District Inspector into a specific situation; and

c. reports which the District Inspector has described as an "Inquiry." It is appreciated that the exercise of statutory authority and powers by a District Inspector may not need to be explicitly stated when the roles, responsibilities and relationships of District Inspectors are understood and accepted by staff. Thus an Inquiry must refer to whatever a District Inspector calls an Inquiry. In a number of instances, this includes complaints investigations under s.75 of the Act.

STATUTORY AND ADMINISTRATIVE BASIS

Tables 1 and 2 show the general statutory authority and administrative basis for the 67 Mental Health service Inquiries.

The great majority (78 per cent) were undertaken using provisions of Mental Health legislation and a further 18 per cent using other health legislation (such as the Hospitals Act 1957, the Area Health Boards Act 1983 or the Health and Disability Services Act 1993). Inquiries under Mental Health legislation of 1969 or 1992 can be further categorised into those which were initiated by district inspectors (45 per cent of the total or 58 per cent of the sub-total) and those referred by central agencies or health service management (52 per cent of the total or 42 per cent of the Mental Health legislation sub-total).

These figures indicate firstly, the ongoing importance of an Inquiry system which is flexible enough to respond to deficiencies reported through political, statutory and managerial processes to the Minister or the Ministry. Secondly, they underline the role of a system of locally based district inspectors who can be expected to know services, staff and clients in an area and who have the statutory authority to investigate deficiencies on their own account.

Although all Mental Health services and all of the country are covered by district inspectors, Table 3 shows that Inquiries are not evenly distributed across regions or services.

This may reflect such factors as the nature and level of involvement by individual district inspectors, the relationship between District Inspectors and service managers, the particular stresses in traditional services, and the historic role of district inspectors in intellectual handicap hospitals from the time when their clients were subject to provisions of the Mental Health Act 1969.

Fifty-one (or 76 per cent) of Mental Health service Inquiries involved care or services in psychiatric hospitals.

RECOMMENDATIONS FROM INQUIRIES

The recommendations from all Inquiries are provided later in this report, along with schedules which show the implementation on Inquiries related more specifically to Mental Health services as defined above.

A limited number of Mental Health service Inquiries (3) contained no recommendations. The number of recommendations from other Mental Health service Inquiries ranges from 1-81. These vary from broad principles for policy development to highly specific operational details and procedures. Because of the multiple and interlocking effects of many recommendations, the classification in Table 4 should be regarded as indicative only. Numerical strength is not necessarily an indication of the influence of a recommendation.

Recommendations and implementation details from the 6 intellectual handicap hospital Inquiries have been included for information where immediately available from the Ministry's files. A glance at these shows how such Inquiries often mirror recommendations and suggestions made by other Inquiries.

IMPLEMENTATION OF RECOMMENDATIONS

Table 5 summarises the implementation status of the recommendations from Mental Health service Inquiries. Further detail is provided in Table 6.

A search has been made of the Ministry's records, and the assistance of DAMHS sought to track down the follow-up to Inquiries. In those cases where follow-up is primarily local, the Ministry's files may not include correspondence regarding the implementation of recommendations. Sometimes further information can be obtained from local hospital files or patient correspondence files. This is not always possible, however, because of reconfiguration of service management in the transition from hospital board to area health board to CHE administration. Hospital closure (e.g. Carrington) and management changes have also made it difficult to track records and to identify the extent to which recommended changes in procedures continue to be implemented or monitored.

The extent to which an Inquiry has been instigated from the centre or the emergence of a pattern among recommendations may well denote the nature of the Ministry's follow-up. Where Inquiries have occurred because of local management referral or where they have been initiated by district inspectors, local action is more appropriate. Those recommendations which are described as having been implemented include those which have been fully implemented, those recommendations whose intent has been acknowledged but which have been implemented in some other way, and those which have been adopted as statements of broad principle.

The high level of overall implementation (78 per cent) suggests the importance of the Inquiry procedure in providing an agenda for action. Indeed, the highest rate of implementation has been achieved in those areas which are more operational in nature (e.g. service liaison, quality of care, the physical environment, work force, and policies, procedures and systems, and immediate follow-up to Inquiry reports).

Although the Inquiry process plays an important role in policy development, the high number of operational type recommendations underlines the value of retrospective external review in the maintenance and development of standards of care and service. This occurs in two ways.

First, there can be a direct cause and effect relationship between a recommendation and the management response. Secondly, the cumulative impact of Inquiries enables national patterns to be observed, may activate statutory intervention, or prompt the development of national standards and guidelines.

CONCLUSIONS

This review of Mental Health service Inquiries focuses upon those initiated under legislation administered by the Department / Ministry of Health and about which information is most readily obtainable within the Inquiry's time frames. Although this undoubtedly includes the great majority of Inquiries since 1987, there are obvious, and in some cases, noted exceptions.

The review highlights the extent to which Mental Health legislation remains the authority for the great majority of Inquiries. District inspectors, whose administrative origins are to be found in the era of lunacy reform in early nineteenth century Britain, continue to play a significant part in the Inquiry process. Investigation or Inquiry was a notable element in Mental Health service reform before New Zealand was annexed as a British colony. As suggested in the Ministry's submission to the Inquiry into Mental Health Services, Inquiries accompanied the stresses of establishing a national network of psychiatric hospitals in New Zealand. A high proportion of Inquiries covered by this review have also originated in such services at a time when their role has been challenged and their services diversified.

Formal Inquiries contribute to the process of policy development but they also play a very effective role in shaping and monitoring standards of care. Inquiries are thus a very old method of facilitating quality assurance. This is apparent from the extent to which Inquiries included within this review have led to operational change or improvement. The figures indicate firstly, the ongoing importance of an Inquiry system which is flexible enough to respond to deficiencies reported through political, statutory and managerial processes to the Minister or the Ministry.

Secondly, they underline the value and role of a system of locally based "watch dogs" who can be expected to know services, staff and clients in an area and who have the statutory authority to investigate deficiencies on their own account.

TABLE 1

STATUTORY AUTHORITY AND ADMINISTRATIVE BASIS OF MENTAL HEALTH SERVICE INQUIRIES, 1987-1996

	No.	%
Mental Health Legislation	52	77.6
Other Health Legislation	12	17.9
Other Legislation	1	1.5
Not Known	2	3.0
Total	67	100.0

TABLE 2

ADMINISTRATIVE BASIS OF MENTAL HEALTH SERVICE INQUIRIES, 1987-1996

	No.	%
Mental Health Legislation		
Referred	22	32.8
Initiated by District Inspectors	30	44.7
Other Health Legislation		
Referred	12	17.9
Other Legislation		
Referred	1	1.5
Not Known	2	3.0
Total	67	100.0

TABLE 3

REGIONAL AND FUNCTIONAL BASIS OF MENTAL HEALTH SERVICE INQUIRIES 1987-1996

Region	Total	%	Psychiatric Hospital Linked Inquiries
		No.	
Auckland	17	25.3	11
Waikato	8	11.9	8
Bay of Plenty	1	1.5	-
Hawkes Bay	1	1.5	-
Wanganui	10	15.0	9
Wellington / Hutt	12	17.9	10
Nelson	3	4.5	3
Canterbury	8	11.9	6
South Canterbury	1	1.5	-
Otago	5	7.5	4
Southland*	1	1.5	-
Total	67	100.0	51

* The Inquiry into Mental Health Services is assumed to have arisen in part from events in Invercargill.

TABLE 4

SUMMARY OF RECOMMENDATIONS FROM MENTAL HEALTH SERVICE INQUIRIES 1987-96 BY TOPIC

	Total	%
Follow-up Inquiry Report	38	8.8
Improve Management	28	6.5
Improve Service / Intersectoral Links	18	4.2
Amend Legislation	14	3.2
Enhance Patients' Rights	14	3.2
Funding	14	3.2
Research	4	0.9
Service Development	41	9.4
Improve Quality of Care	34	7.8
Improve Physical Environment	14	3.2
Work force	84	19.4
Change Policies, Procedures & Systems	131	30.2
Total	434	100.0

TABLE 5

SUMMARY OF RECOMMENDATIONS FROM MENTAL HEALTH SERVICE INQUIRIES 1987-96 AND IMPLEMENTATION STATUS

Note: A = Accepted and adopted fully or partially
X = Not adopted
? = Implementation status unclear
S = Superseded by administrative change
C = Currently under review or action pending

	A	X	?	S	C	Total
Follow-up Inquiry Report	23	4	11	-	-	38
Improve Management	23	-	3	-	2	28
Improve Service / Intersectoral Links	18	-	-	-	-	18
Amend Legislation	6	2	3	-	3	14
Enhance Patients' Rights	7	-	7	-	-	14
Funding	8	-	5	-	1	14
Research	-	-	4	-	-	4
Develop Services	32	2	1	-	6	41
Improve Quality of Care	31	-	2	1	-	34
Improve Physical Environment	10	1	1	-	2	14
Address Work force Issues	68	3	6	1	6	84
Change Policies, Procedures /Systems	112	3	10	1	5	131
Total	**338**	**15**	**53**	**3**	**25**	**434**
%	77.9	3.4	12.2	0.7	5.8	100.0

TABLE 6

SUMMARY OF RECOMMENDATIONS FROM MENTAL HEALTH SERVICE INQUIRIES 1987-96 BY TOPIC AND IMPLEMENTATION STATUS

Note: A = Accepted and adopted fully or partially
X = Not adopted
? = Implementation status unclear
S = Superseded by administrative change
C = Currently under review or action pending

	A	X	?	S	C	Total
Follow-up Inquiry Report						
Distribute Report	7	-	3	-	-	10
Implementation Mechanism	-	-	2	-	-	2
Further Investigation, Discipline, Prosecution	6	2	4	-	-	12
Individual Patient Care	9	-	4	-	-	13
Other	1	-	-	-	-	1
Sub-total	**23**	**4**	**11**	-	-	**38**
Improve Management						
General Issues	11	-	3	-	1	15
Service / Unit	4	-	-	-	-	4
Professional Leadership	6	-	-	-	-	6
Change Management	2	-	-	-	1	3
Sub-total	**23**	-	**3**	-	**2**	**28**
Improve Service / Intersectoral Links						
Police	6	-	-	-	-	6
Penal Services	3	-	-	-	-	3
Other Intersectoral	2	-	-	-	-	2
Intra / Inter Mental Health-Service	7	-	-	-	-	7
Sub-total	**18**	-	-	-	-	**18**
Amend Legislation						
Mental Health	6	2	-	-	1	9
Criminal Justice	-	-	2	-	2	4
Other	-	-	1	-	-	1
Sub-total	**6**	**2**	**3**	-	**3**	**14**

Table 6 continued	A	X	?	S	C	T
Enhance Patients' Rights						
Informed Consent	-	-	4	-	-	4
** DI / Official Visitors	2	-	-	-	-	2
Other	5	-	3	-	-	8
Sub-total	**7**	**-**	**7**	**-**	**-**	**14**
Funding	**8**	**-**	**5**	**-**	**1**	**14**
Research	**-**	**-**	**4**	**-**	**-**	**4**
Develop Services						
Forensic	5	-	-	-	-	5
Secure	7	1	-	-	-	8
Penal	5	1	-	-	-	5
Other Specialist Mental Health	3	-	1	-	3	7
Community Services	5	-	-	-	3	8
Bicultural	1	-	-	-	-	1
Process of Development	6	-	-	-	-	6
Sub-total	**32**	**2**	**1**	**-**	**6**	**41**
Improve Quality of Care						
Individual Treatment Plans	3	-	-	-	-	3
Assessment	5	-	-	-	-	5
Appropriate Placement	6	-	-	-	-	6
Continuity of Care	6	-	-	-	-	6
Activation	2	-	-	-	-	2
Cultural Responsiveness	2	-	-	-	-	2
Treatment	4	-	1	-	-	5
Other	3	-	1	1	-	5
Sub-total	**31**	**-**	**2**	**1**	**-**	**34**
Improve Physical Environment	**10**	**1**	**1**	**-**	**2**	**14**
Address Work force Issues	**68**	**3**	**6**	**1**	**6**	**84**
Numbers and Deployment	17	1	3	-	-	21
Multi-disciplinary Basis	10	1	-	-	-	11
Appointment Criteria / Processes	3	-	1	-	-	4
Rostering	7	-	-	-	-	7
Roles / Responsibilities	4	-	-	1	-	5
Key Workers	2	-	-	-	-	2
Support	1	-	-	-	-	1
Training Models	2	1	-	-	2	5

** DI = District Inspectors

Table 6 continued	A	X	?	S	C	T
Skills Development	3	-	-	-	1	4
Calming / Restraint	4	-	-	-	-	4
Forensic	3	-	-	-	-	3
Bicultural	3	-	-	-	-	3
Resuscitation	3	-	-	-	-	3
Legislation	2	-	1	-	3	6
Treatment Modes	2	-	-	-	-	2
Documentation	1	-	-	-	-	1
Incident Handling	1	-	-	-	-	1
Communications	-	-	1	-	-	1
Sub-total	**68**	**3**	**6**	**1**	**6**	**84**
Change Policies, Procedures /Systems						
Documentation	28	1	3	-	1	33
Admission / Accessibility	7	-	1	1	-	9
Transfer / Discharge	10	1	-	-	2	13
Medication	17	1	-	-	1	19
Information Systems	4	-	-	-	-	4
Crisis Response / Incident Investigation	13	-	-	-	-	13
Risk / Harm Prevention	14	-	1	-	-	15
Communication with Relatives	4	-	3	-	1	8
Quality Systems	12	-	1	-	-	13
Legislation	2	-	-	-	-	2
Complaints	1	-	-	-	-	1
Other	-	-	1	-	-	1
Sub-total	**112**	**3**	**10**	**1**	**5**	**131**

Although it is not entirely clear from the documentation, it appears that at least fifty five Inquiries were undertaken by District Inspectors, one by the Controller and Auditor General, two by DAMHS while four were of uncertain origin and appear to be local in character. There were only seven which might properly be regarded as having some national significance. They were:

- Committee of Inquiry into procedures used in certain psychiatric hospitals (Mason Inquiry) 1988
- Inquiry into the use of "deep sleep therapy" (Ministerial Task Force) 1991
- Committee of Inquiry into the circumstances of the treatment and death of DJP at the psychiatric unit of Rotorua Hospital 1991
- Committee of Inquiry into the death, at Carrington Hospital, of Michael Watene 1991
- Committee of Inquiry into Mental Health services provided for MT 1994
- Commission of Inquiry into the circumstances surrounding the death of Matthew Francis Innes 1994
- Inquiry concerning deaths by suicide in Health Link South Services April 1994 - April 1995

We note the Ministry comment that of the 338 recommendations from Inquiries between 1987 and 1996, almost 80% have been accepted and adopted, fully or partially. Allowing for the unclear implementation status of 12% of the recommendations, it follows that only 3.4% of all recommendations have not been adopted. That latter figure came as a surprise to us since it did not accord with the expressed views of many people who bemoaned the fact that so many recommendations from recent Inquiries had simply not translated into a more efficient and effective Mental Health service.

Whatever the statistics may disclose we noted a very strong perception in the sector that if recommendations of previous Inquiries had been implemented the Mental Health services would not still be in a state of crisis. In particular, many submissions commented that significant recommendations in the Psychiatric Report (1988) and the Matthew Innes Inquiry (1994) had not yet been implemented, or at best, had been implemented to a minimal extent only. In fairness, submitters acknowledged that major improvements had come about in the Forensic Service.

We sought comment on the Ministry Report. Representative views by those to whom it was referred were:

> **It's just possible that 80% of all recommendations have been adopted fully or partially, but I suspect that the vast majority would be partially adopted - I would use the term "minimal". It makes no sense to say that a recommendation has been adopted because it is now handled through RHA purchasing. What does that mean?**
>
> **If all the recommendations of the Mason Inquiry (1988) had been adopted we wouldn't be in the mess we are in today. Although that Inquiry dealt with forensic matters, it gave a very comprehensive view of what a total Mental Health service should look like.**
>
> **If the figure of 80% is correct why are we still in such a mess? And why are you people involved in yet another Mental Health Inquiry. If things were going well you wouldn't be needed.**

We hasten to add that those views should not be taken as reflecting on the integrity of the author of the Ministry's report. We acknowledge his efforts in compiling such a comprehensive document.

COMMENT: No useful purpose would be served by engaging in a semantic argument as to the extent to which previous recommendations have been implemented or actioned.

During the past few years widespread change has occurred in the delivery of Mental Health services. We now have a funder / purchaser / provider split. RHAs, CHEs and NGOs are creatures of recent health reforms and management structures have changed significantly. There is an escalating move towards de-institutionalisation and, in general terms, the climate which may have allowed for the implementation of recommendations some years ago no longer exists. For this reason alone, we see no purpose in recommending additional changes to previous recommendations. That would be tinkering with the system. Many of the problems which existed in 1987 have not yet been resolved and the intervening nine years have raised additional issues which must be confronted.

Rather than dwelling on what might or might not have been done between 1987 and 1996, we believe it is more profitable to tackle those matters of serious concern which still pervade the Mental Health sector, and to suggest how those concerns, past and present, might be resolved.

We attach as Appendix 3 a list of recent international reports which we considered significant and applicable to New Zealand. Several reports from Great Britain and Australia were especially helpful since some of the problems we presently experience have been or are being confronted in those countries.

Where it is appropriate and relevant we have referred to the British and Australian experience during the course of this report. It will be obvious from the foregoing that there is a genuine concern about the non-implementation of recommendations of previous Inquiries. Many submissions considered by this present Inquiry expressed cynicism about the outcome of our proposed recommendations. To allay those concerns we have one recommendation to make.

RECOMMENDATION: That this present Inquiry Team be invited to monitor the implementation of the recommendations contained in this report as and when required, but at intervals of not less than three months, and that it report progress to the Minister of Health.

CHAPTER THREE

LEGISLATION

We have been asked to consider amendments already identified or that may be approved or require attention in the Mental Health (Compulsory Assessment And Treatment) Act 1992.

Following the death of a patient at Oakley Hospital in 1983, the Gallen Inquiry advocated better protection of patients' rights.

The 1992 Act came into force on 1 November 1992. This Act dealt with patients who would be compulsorily assessed and treated, special and restricted patients and the rights of all such patients.

The Act provided a new definition of mental disorder, it set out patients' rights and provided processes, reviews and inquiries to protect such rights.

The intent of the Act was to ensure treatment for those who needed it in the least intrusive and restrictive way. For the first time assessment and treatment could be provided in the community with access to in-patient facilities as a backup. Mental Health professionals would see patients in their homes and manage them there provided that could be done effectively and safely.

Such changes clearly required training and retraining for all those involved in this new mode of service delivery, particularly frontline workers. Resources were needed for their training and education about the new requirements of the Act, and for services to be set up, mobilised and relocated in the community.

Unfortunately the training and resourcing did not happen and crisis services continued to be associated in the minds of the public, with hospital admissions.

Although not directly connected, the commencement of the Act coincided with "the Health Reforms" which brought in new management structures and systems of accounting and accountability. De-institutionalisation which began in the 1950s continued with the closure or downsizing of large psychiatric institutions.

All these changes impinged on each other and in turn, this resulted in a public perception that services were being reduced and becoming less accessible.

Not surprisingly the Act was seen by many as part of a change in the health sector which resulted in help being "too little and too late".

We received submissions expressing numerous concerns about the Act from all sections of the community:

- mental health professionals
- lawyers
- patients, or former patients
- families and caregivers
- service providers
- victims
- members of the public such as landlords
- neighbours of the mentally ill
- the Police

It would be difficult to reflect the high level of concern without quoting from some of the submissions. In some cases names have been changed to maintain confidentiality. Some submissions have been edited but in all cases the integrity of the submission has been preserved.

FAMILIES:

Families felt it was increasingly difficult to get access to psychiatric services. The threshold or test of "serious danger" made it almost impossible to get in-patient care until there had been a major catastrophe.

This from the relative of a mentally ill mother:

> **I do not believe that any New Zealander should be reduced to the state of being socially isolated, filthy, totally alone, living out of a public toilet, and seriously ill before medical care is given.**

The evidence of a Social Worker to a Coroner:

> **I found Mr B. to be extremely frustrated by the situation and conflicted about reports from mental health professionals who stated G. did not suffer from a major mental illness and the "evidence" he saw vis-a-vis G's demeanour behaviour and chaotic lifestyle.**

Further evidence:

> **D. detailed the impact of G's behaviour on his life explaining that whilst he felt obliged to take care of him he felt it was "beyond him".**

Families saw themselves as standing by helplessly watching their family member deteriorate with the knowledge that further deterioration would mean more prolonged treatment and less likelihood of recovery.

An elder sister talks about her younger sister:

> **It took two years for my sister to be assessed and diagnosed. I do not think the level of attention she received was enough. Certainly I believe she could have been treated a lot sooner than she was (and may be she would not be as bad as she is now). Crisis support for us has been non-existent. When my sister was threatening to take her own life, the quickest appointment she could have was over a week away.**

A mother-in-law:

> **All of J's symptom's were present on 2 December 1993. The fifteen week's delay in getting treatment resulted in the stress of arrests and overnight stays in police cells for J, her children's increasing pain and confusion, the family's substantial fear and stress, financial costs in the loss of J's money and car, property damage and legal fees, and most significantly, J's complete mental deterioration. Also she is now "street-wise" and this has serious implications if she relapses. All of this and more could have been avoided, if the Team had accurately assessed J. and admitted her to hospital on 2 December 1993, or had provided us with proper assistance after that time.**

Families also expressed concern that their family member would be discharged as soon as he/she was no longer "a serious danger" whether or not they were still very ill. There were a number of submissions from families who were not notified or consulted when their family member was discharged whether or not the family was expected to take over their care.

A representative of Schizophrenia Fellowship:

> **This is often due to a shortage of beds, and as there is also a shortage of 24 hour supervised accommodation, the still unwell person is sent home to their family. I believe that most of the decision-makers cannot conceive of the stress and disruption to a family caused by having a seriously mentally unwell person living in the home 24 hours a day, 7 days a week. We no longer have dark attics with barred windows where we lock our mentally ill relatives - and thank heavens for that! - but families are torn apart by having a seriously unstable person with a major mental illness in their midst. The stress and distress caused to parents, siblings and also to extended family, is incalculable. Families must be involved in the ongoing planning for the person's future. They must be consulted and take part in the discharge planning, which must begin early enough to enable support systems to be in place for the person with the disability, and if necessary for the family. If the support is not there before the person is discharged, it is almost impossible to implement it afterwards. There is also need for more respite care; but instead of increasing, it is diminishing.**

Many families experienced difficulties with the legal procedures set out in the Act. They found themselves in adversarial conflict with their family member they were trying to help and care for. Often the review and inquiry processes became very painful and expensive experiences for families who were already emotionally and financially stressed.

Schizophrenia Fellowship:

> **Families, neighbours and friends of the person who is becoming ill are often reluctant or even afraid to apply for a compulsory assessment order, because frequently the person hires a good lawyer and is back in the community within a very short time without adequate treatment, and in an angry, paranoid state, and may seek revenge on the person who has signed the order.**

This can be verbal or physical abuse, or complete withdrawal and blaming of the family or caregiver. The family or caregiver can then no longer support or care for the ill person, and if the state will not - we have a recipe for disaster.

Families felt their role undermined and undervalued by the legislation. There is no requirement that they be involved in any of the procedures from assessment to discharge even though they have the most knowledge and concern about the patient and are the most constant people in the patients' lives. Their right to be heard in reviews is not expressly protected and their involvement depends on the approach or whim of the particular "professionals".

A father speaks of his mentally ill daughter:

Family rarely walk away from unwell relatives. When overworked health professionals fail to maintain contact with psychiatrically disabled people living in the community, family again takes over.

Some families questioned whether ill patients should be given "choices" as to whether they receive treatment particularly if such patients are behaving in threatening, bizarre or abnormal ways.

A relative:

K, in his final year as an undergraduate lawyer began suffering dramatically from positive, or active, schizophrenia. He was 23 years old. His illness was severe and he hated the side effects of the medication, which to suppress the symptoms, turned K into a virtual zombie. When K was not on medication he was a danger to himself and others and there were incidences of this (some very serious) over the course of his illness. He had in one instance held our elderly aunt and uncle hostage for several hours one evening with a large carving knife. They have never really recovered from this trauma. K's Mum, a widow in frail health was stretched trying to care for K and with little professional help, it took its toll on her. When K died, she had a mental breakdown and remains in hospital to date.

The circumstances of his death are as follows:

> **Hope came in the form of the new drug Clozapine (I think it is). K was able to function again, almost as he once had. However, one of the side effects of this drug, for some people is an increase in white blood cells and in K's case this was so. He was unable to continue with this drug and he was devastated. K was given the *choice* about returning to the former medication which though he hated it, kept him and others safe. The mental health authorities gave him the *choice* and allowed him *to go without* any medication even though K was at risk of hurting himself or others. K returned to his flat with no support or oversight, on no medication. His psychosis returned with a vengeance, as indeed was predictable, with this illness. K with his hallucinations, stripped naked, burst through a plate glass window and ran as though he was hunted from one suburb to another. He ran through traffic, sections, industrial areas terrified of whatever he imagined was pursuing him. He than climbed on to the roof of an elderly woman's garage. She was alarmed and frightened and called the authorities.**
>
> **Sadly it was too late. K leapt from the building and suffered serious head injury, which he subsequently died from in hospital, 4 days later.**

We now refer to evidence in a recent Coroner's court hearing. This hearing followed the death / suicide of a father / son.

> **D contacted me again shortly after. He reported that he recognised G would benefit from psychological treatment, but was at a loss as to how he could facilitate this. His concerns were centred predominantly around G's refusal to get out of bed, except to have cigarettes, meals and attend to toileting requirements. He admitted to frustration and diminishing tolerance of G's presence in the house and asked if it was possible for him to reside in a supported environment .... I reiterated to D our inability to action any appropriate treatment options in the face of G's reluctance to accept any recommendation of his case manager and psychiatrist.**

The issue then for families is whether Mental Health professionals, with their expert knowledge, should take a more assertive approach to compulsory treatment and override a patient's wishes more often?

The lack of appropriate training of Judges and Lawyers worried many families. They were concerned that legally trained persons were, at times, making clinical decisions and were unable to see when they crossed the boundary between legal and medical matters.

A wife speaks about her husband:

> **Before 1992 the hospital believed the Doctors and the family that he needed treatment again, but now that Judges make that decision, it is nearly impossible.**
>
> **I will only tell what happened after 1992. All the time my husband was committed and had to have injections. At the review the judge said that the medication should be halved. Not long after he took an overdose, he survived and was 6 weeks in hospital. When his case came up again, the judge decided that it was for the patient's good, not to be committed any more and to stop the injections. For more than a year we lived with a man who was in mental agony. The nurse who still came to see him now and then, tried to get him in hospital, for he knew how worried I was. But when the judge saw him two days later, he decided that it was not the right time. He came home the next afternoon and that night, about 2 am. he went to the house of a good friend of mine and threatened her with a steel bar. He was arrested in May and is still in hospital. This time they are more careful.**

Some families believed some lawyers were unnecessarily adversarial and as they had no understanding of mental illness, they were more concerned about civil liberties than proper care and treatment for those they represented.

Dr Dick Burrell:

> **The emphasis in the 1992 Mental Health Act is upon danger to self or others, with no attention being given to the right to treatment of people who because of the nature of their illness are unaware that they need it. Some have to be allowed to deteriorate over weeks or months until they do or say something which can be construed as dangerous which then brings them into the ambit of current legislation. This is admittedly a thorny issue which has led to the catchphrase of people being allowed "to die with their rights on" – a situation which has led to a number of tragedies.**

> **My personal experience of many patients over many years is that when they finally recover and come to realise how unwell they have been they are grateful for what has been done for them and that someone stepped in and took control even though they objected strongly, and often threateningly at the time.**

Because they were not familiar with their clients and knew little about the effect of mental illness, some lawyers were unable to ascertain whether their clients were capable of giving instructions. Families believed that often, inadequately trained lawyers would "hype" up the patient, make them treatment-resistant and unrealistic, and then take their fees, walk away and leave families to pick up the pieces.

Questions were raised about the use of public monies through legal aid particularly if lawyers who take on the work receive so little training and have so little understanding of the needs of their clients. Such lawyers put at risk the therapeutic relationship between the patient and clinician and the committed and supportive relationship between the patient and the patient's family. At times such damage is irreparable. Do lawyers want to see their clients "die with their rights on"?

Lawyers should be aware of s.66 of the Act which provides "every patient is entitled to medical treatment and other health care appropriate to his or her condition".

Families were also concerned about the expensive legal procedures set out in the Act. Many had to engage lawyers so they could be heard at inquiries or reviews and some gave examples of bills of $2000 - $3000. In some instances the outcome was almost inevitable but their concern and care for their family member made them feel the risk of taking no action was too great. Such costs are especially burdensome. Quite often these families are already financially disadvantaged by giving up employment to care for their family member or have already incurred costs of subsidising their family member's accommodation, living costs or bailing them out of various situations. One submission estimated costs over the years to be about $240,000.

The father of a mentally ill daughter:

> **I would hate to count up the actual costs over the years, but taking into account vehicle running expenses, disruption of work, handouts, phone, electricity, air fares, holidays, food, meals, clothes, furniture, furnishings, cigarettes, tobacco, fruit, bills and loss of jobs through a pre-occupation with the problems she has caused, raising and educating her son, interest on over-drafts.**

> **(THESE ARE ONLY SOME OF THE THINGS I CAN THINK OF). These have cost us conservatively $8,000 per year x 30 years = $240,000 which should have been invested in our retirement fund. I only know for certain that I have been forced to extend my working life for as long as possible, having passed the normal age of retirement with just over $4,000 as reserve, an old but mortgage-free house, a 16 year old car, and NOTHING to look forward to except constant worry about her future.**

Many parents continued to work beyond the usual retirement age to provide for their mentally ill children. Incurring costs in what they see as misguided legal processes therefore have an extra sting.

PATIENTS, FORMER PATIENTS AND CONSUMERS:

The 1992 Act makes no reference to voluntary patients. It provides a regime for **COMPULSORY** assessment and treatment and it seems to have set standards for access to mental health services. A number of persons with mental illness, now living in the community, were worried about the difficulty in obtaining respite care in those cases where they had insight about their illness and were able to judge when they were becoming unwell. If respite care would enable them to make a quick recovery, they were concerned that this would be denied as they were not a "serious danger" to themselves or others given that they were aware of their illness.

A health professional:

> **In the case of a compulsory presentation the definition of mental disorder provides a standard which must be applied. Clinicians assessing people who are brought before them compulsorily have principally to decide whether or not they are mentally disordered, within the meaning of the Act. If so, they will almost certainly be admitted to an in-patient unit for assessment and treatment. There is no such standard set for those who seek voluntary admission.**
>
> **Pressure on acute beds is often extreme and there is an observable reluctance by clinicians to allocate this scarce resource to those who seek assistance when it is a perceived necessity to reserve beds for those who may present under compulsion. The voluntary patient, however unwell, is a relatively unassertive competitor for the bed against the rigours of legal obligation.**

The decision faced by the clinician assessing a person appearing before him or her voluntarily is likely to be influenced by a judgement as to whether or not the case can be managed, or continue to be managed, on an outpatient basis. The absence of any statutory responsibility to decide positively on issues of dangerousness in particular might incline clinicians to be more prepared to refuse admission to a voluntary patient. The decision as to whether or not to admit a voluntary patient rests with the clinician, who has no standard to be guided by, bears no *statutory* responsibility to assess mental disorder and has no *statutory* accountability for a decision to refuse admission. Thus there is greater latitude for variation in intake criteria and less protection for the person who seeks appropriate help.

The patient who is a voluntary patient while in hospital may continue to be relatively disadvantaged by virtue of not "being under papers". There is competition for resources (e.g. staff time) with those who are compelled to be there and for whom hospital staff have clearly defined legal responsibilities. The series of requirements of staff which the 1992 Act lays down has no equivalent for the voluntary patient. For example, there is no legislative provision requiring psychiatric hospital authorities to provide voluntary patients with a statement of rights, as is mandatory for those compelled to accept treatment. Similarly, there is no requirement for the appointment of a Responsible Clinician.

A consumer:

Drugs *aren't* and *can't* be the only solution to mental illness. Doctors, psychiatrists, counsellors should find the root of people's problems and help them out there before even considering to put them on drugs.

I heard in hospital that you cannot be admitted involuntarily to hospital unless you are a danger to yourself or others, well none of the times I was involuntarily admitted to hospital was I a danger to anyone at all. I also think psychiatrists, nurses and all workers within the mental health system should be more sensitive to people who are unwell by not saying "you're sick", "you're unwell", "you've got an illness".

Many times other people and I have found Emergency Psychiatric Services to just say things like "Go make yourself a cup of coffee" when they are suicidal or not feeling well. This is ridiculous. What they need is someone who can listen to their problems and why they are feeling that way in a caring, compassionate, interested way not the cold hard way the people at E.P.S. I've talked to have been. Once I attempted suicide (which is a serious matter and should never be taken lightly) the lady at E.P.S. said "how many pills did you take?" and I said seven paroxitine and she said "well I hardly think you're going to kill yourself on seven paroxitine" implying I was stupid and should've taken more. What absurdity!! Lucky for me I didn't go and take some more pills, (luckily for her job also) but someone else had every chance of doing so. That was disgraceful! That same lady has been always very uncaring, misunderstanding and unhelpful. People should not work at E.P.S. unless they have a compassionate heart, or the good sense to know what would best help the person in trouble. Another time I rang E.P.S. hysterical, I was crying and breathing really loudly, I was having a horrible panic attack and all the man said was "we'll send someone out to see you" and that was it. If E.P.S. helpers cannot ask and listen to the person's problem they shouldn't be there.

One time I heard the voices for 5 hours and I was not only uptight, tense, anxious and panicking but my eyes were rolling back and they would not come down, it was another one of the most terrifying experiences of my life but that is not the worst part. The worst part is that once I had arrived at E.P.S. I had to just sit on a chair for FOUR hours (I am not exaggerating) to see a doctor, then to be told I could not go into hospital. The shortest time I've had to wait at E.P.S. is one and a half hours. That alone is FAR too long for a person in my state to be waiting but FOUR hours is again disgraceful.

Dr John Crawshaw:

> **The utilisation of the compulsory assessment and treatment provisions of the Act can from time to time depend on the availability of services. The unavailability of in-patient beds has been widely reported from time to time and as a consequence clinicians have to prioritise access to acute hospital services. In these circumstances, those persons committed under the Act receive a higher priority for acute admission than do those who seek admission on an informal basis. For this reason, some consumers who are quite capable of understanding their illness and know when they need admission cannot access services on an informal basis. This is inevitable where the legislation provides access as of right to patients committed under the Act but not to informal patients.**

A Mental Health professional:

> **Since the inception of the Mental Health Act in November 1992, it has become increasingly difficult for an individual to be admitted to a Mental Health Unit for treatment on an informal basis.**
>
> **Often a well timed short admission can prevent more serious problems developing. This would provide a more efficient and cost effective service for individuals, who recognise their need for treatment and are therefore taking responsibility for maintaining wellness.**

Many consumers considered the legislation promoted "a quick fix" approach to treatment and did not, given the time constraints, allow for any type of treatment apart from the "medical model". Some consumers felt that large doses of medication were forced on them without a proper assessment as to whether or not that was the most effective or appropriate treatment regime. Some who had suffered sexual abuse or death of close family members or other trauma regarded counselling, psychological services or psychotherapy as being more appropriate.

Although consumers identified several shortcomings in the Act the majority did not want to see it amended. In particular, they did not want to see the threshold for admission and discharge altered by removal of the word "serious". Nor did they want to see the protection of patients' rights altered. Some considered there should be more training and education for all persons involved with the legislation.

Submissions were received from patients who commented that had there been earlier or better intervention on their behalf, they would not have squandered assets or alienated friends and family during the onset of their illness.

The Wairarapa Mental Health Consumers Union:

> **Our members feel it should be written into the Act that consumers can appoint an advocate for say 2 years when they are well, and cannot revoke that authority when they are semi-acute or acute. The problem at the moment is getting help early with such cases and results in consumers getting a bad name for themselves in the eyes of the community.**

CLINICIANS:

Several submissions noted that some clinicians had given up working in the Mental Health system because of their frustrations with the Act.

Many clinicians consider compliance with the Act extremely burdensome. Some say they now spend about one third of their time on paperwork which would include also compliance with new management structures. They regarded this as a waste of valuable expertise.

They received no extra resources when the Act came into force and they see the paperwork as being done at the expense of their clinical work. For clinicians who chose and saw their career as caring for patients the paperwork involved is an anathema.

PSA members of Healthcare Otago:

> **Since the changes to the Mental Health Act, there has been a dramatic increase in the documentation required of staff. For example, a patient in an acute unit became very disturbed and unsafe, the staff were required to fully restrain and seclude the patient. Because the patient was voluntary the nurse responsible for her care initiated section 111 under the Mental Health Act. The documentation required:**

i. for restraining the patient the staff nurse filled out an incident report;

ii. for secluding the patient the staff nurse filled out a seclusion form;

iii. the duty psychiatric registrar filled out a seclusion form and documented the incident in the progress notes;

iv. to detain a patient under the Mental Health Act;

v. the staff nurse filled out a section 8 (section 111) Certificate;

vi. the Duly Authorised Officer (duty manager) filled out a section 9 Certificate;

vii. the duty psychiatric registrar filled out a section 8 certificate;

viii. the psychiatrist filled out a section 10 and 11 certificates;

ix. minute and 2 hourly visual observations for the period of seclusion documented in 2 separate places; and

x. the staff nurse also recorded the incident in the progress notes.

In total four different staff assessed the patient, who documented the incident in ten different places and two types of visual observations were carried out. It is important to document the care of a patient but it is quite astonishing how much a nurse wastes time if the excessive documentation reduces contact time with the patient.

Many clinicians are not at ease with some of the legal terminology set out in the Act, e.g. the definition of "mental disorder" including "volition' or "cognition". They say that legal terminology does not correspond with medical diagnoses.

Dr Erihana Ryan is the DAMHS at Healthlink South. We quote part of a recent Coroner's decision:

> **Dr Ryan gave examples of how the term "disorder of volition" can be demonstrated in major psychiatric disorders. She pointed to the example in schizophrenia of the negative symptomatology being an example of loss of volition. She also pointed to the example of mania, where as a result of the sufferer's illness, the choices the sufferer makes are directed by the perception of self and the world (of the sufferer) as determined by the activity of the illness. As an example, it is not uncommon for the sufferer of an acute mania to spend thousands of dollars, thereby showing a disorder of volition.**
>
> **Dr Ryan pointed out there is controversy about the application of the terminology ("disorder of volition") where there is no major psychiatric disorder (as in G's case) and psychiatrists are left to apply a term, which is poorly defined, to the choices that people make. The definition shows itself to be unclear about impulsive behaviours, for instance, or behaviour which might be identified by other people as abnormal.**
>
> **Dr Ryan said that a disorder of volition in this context may exist where there is a failure to an abnormal extent by a person to learn to adjust or control that person's impulsive behaviour. This raises some degree of interpretation as to what constitutes "an abnormal extent to learn to adjust or to control". The term "disorder of volition" is not a term otherwise used in psychiatry and it is difficult to apply legally and clinically.**

Clinicians also referred to the often uneasy relationship which existed between themselves and some Lawyers. For clinicians, a therapeutic relationship or alliance with their patient is critical to the outcome of their treatment and care. It is an essential "tool" and as important to the mental health professional as technological devices are to surgeons. Yet this relationship is put at risk by the review and inquiry processes which can cast them into an adversarial role against their own patient. They find they have to give evidence against their own patient.

Clinicians want their patients to receive treatment and that is their main focus. They see themselves as providing treatment with humanity and to the best of their ability and consider that emphasis on civil liberties and safety of others is misplaced in these circumstances.

Clinicians are concerned at the lack of understanding shown by some members of the legal profession for mental health matters. They were also concerned that some lawyers and Judges were not clear where the limits of their expertise lay. The adversarial approach of some lawyers caused added difficulties. The readiness of lawyers to involve themselves inappropriately with reviews or other hearings which were "hopeless" placed further demands on clinicians' time and even worse, gave patients unrealistic expectations and caused them to resist treatment to their detriment. This then resulted in more clinical work for the clinicians as well. Their patients were more difficult to treat.

Professor Sarah Romans:

> **Where an inexperienced lawyer, with no knowledge of the ravages of mental illness, fights the committal in a combative and aggressive manner, all except s/he may lose; the patient does not get the treatment and protection they need, the therapeutic alliance between patient and treatment team is undermined and the time consuming nature of some hearings results in other patients being deprived of the psychiatrist's time.**

A Community Mental Health Nurse:

> **I have worked as a Community Mental Health Nurse in my area for five years. My concern is that for the second time in two weeks I have had to drive for two hours accompanied by two witnesses to attend a review for a Community Treatment Order for a person with a thirty year history of mental disorder. He has had many and frequent admissions to hospital.**
>
> **I'm angry because last week a District Court Judge, his secretary, the District Inspector, a Psychiatrist, another Community Mental Health Nurse, ward staff and my two fellow travellers and I gathered in Tauranga for a hearing. My client had requested legal representation but his lawyer was unable to attend. As a consequence the hearing was adjourned for another two weeks so we all have to reassemble again then, at what cost???!!**
>
> **My complaint is with the process rather than the client that allows a person with serious mental disorder to demand a judicial review at any time and demand the services of a lawyer (paid by legal aid) to contest a clinical decision.**

This means that a judge is deciding the fate of a person with chronic mental illness without the required clinical experience. In other words our role as clinicians is only one of advice to a judge who then makes the decision as to whether they stay on a Community Treatment Order.

This particular client has had three admissions since October 1995 all involving the police, the GP, the community mental health team and the psychiatric emergency team. On each admission he has been discharged from compulsory status.

Not only is the cost of these hearings astronomical but if a clinician had been able to make a decision about his compulsory status in October then my client would be in a settled state. Of course he remains grossly insightless and each time he is discharged he refuses medication and so we're on the roundabout again.

THE COMMUNITY AND THE POLICE:

The Police cited numerous incidents which suggested that the definition of mental disorder for the purposes of compulsory assessment and treatment appeared to provide such a high threshold or test that it defied common sense or belief. They saw themselves as propping up a failing mental health system and spend countless hours dealing with mentally ill persons.

NZ Police National Headquarters:

It seems incongruous to police with their daily duty to prevent danger to life and their focus on pro-active policing that under part (a) of the definition they must wait for someone to become a serious danger to either him or herself or others before action can be taken. The attached written submissions from Senior Sergeant H to a District Court Judge graphically demonstrate this problem. In a 28 hour period the defendant attempted suicide four times and yet in that same period mental health professionals twice refused to admit her to an institution stating on one occasion that she was not mental but on another saying she was "less likely" to commit suicide out of an institution.

Sunday 22 October 1995 : 1430hrs - Police investigate nuisance phone calls which had started at 8 am that day. Offender ... located at her residence and spoken to but she maintained that she would keep making the calls until she received help.

1559hrs - Police respond to a call to attend ... address as she had attempted to commit suicide. On arrival Police assisted ambulance staff in removing a bathroom door and found ... had tried to strangle herself. As a result of this ... was admitted to the Unit pursuant to Section 11 of the Mental Health Act 1992.

23 October 1995 : 1330hrs - Police attend the Unit in response to nursing staff having problems discharging ... On arrival Police found that ... had attempted to hang herself at the entrance to the hospital. Hospital staff informed Police that ... was not mental and that if she wished to take her life that was entirely her right. It was alleged that she had assaulted a Doctor and damaged a motor vehicle prior to the attempt on her life. Police did not feel it proper to release her for her own safety and she was placed under arrest.

1630hrs - ... was seen by a Police doctor and shortly after attempted to hang herself with a shoelace behind a door in the interview room. Quick action by Police staff prevented this attempt being successful.

1640hrs - Police contact the Director of Mental Health who informed us that she would not be admitted and that this was "Therapeutic Risktaking" which meant that she would be less likely to commit suicide out of an institution. "If she does actually commit suicide and calls our bluff, so be it." Police were not prepared to take this risk.

1850hrs - ... (who is also bulimic) was found to have squeezed her entire body minus her head through the bottom of the cell door. This required the Fire service to attend to assist with the release.

1950hrs - ... attempts to choke herself by stuffing paper down her throat.

The Crisis Support team were contacted and after consultation it was agreed that she would have to be kept in the Unit overnight.

If Your Honour pleases, I have attempted to set the entire events out in sequence to show that this defendant obviously needs help but is unfortunately unable to get it through the Health system. I would with respect submit that this defendant be remanded in custody for a Psychiatric Report to enable her to receive the help she obviously needs.

The Act was seen as allowing or forcing too many dangerous people to stay in the community, thereby putting at unreasonable and unnecessary risk, their own lives and the lives of others.

For the same reasons the Act was seen to establish a regime of neglect. Mentally ill persons were reported to live in squalor, to be taken advantage of by being robbed of their drugs or their money. The test of "serious" lack of capacity for self care was seen to be under utilised.

Police on occasions felt so concerned about the lack of response from the Mental Health services that they would lay charges against the person in order to obtain help for him / her through the criminal justice system.

RURAL COMMUNITIES AND RURAL DOCTORS:

Compliance with the Act is difficult in rural areas. There are few or no Mental Health professionals and facilities for treatment. Heavy reliance is placed on the local general practitioners, many of whom have responded admirably to the tasks imposed upon them. Difficulties arise if the GP has no desire or skills to work with mentally ill patients. For those who do the work it is time consuming and puts them at considerable risk, especially if they work alone and have no accessible back up from Mental Health professionals or Police. Trying to restrain a patient or transporting one to be assessed is problematic to say the least. No treatment, including sedation, may be given before a patient has been assessed. To assist rural doctors or health professionals the Act may require amendment to enable some treatment such as sedation to be given to a "proposed" patient to facilitate transporting that patient to a place of assessment. Guidelines for rural doctors who find themselves in this situation may also be helpful. Such guidelines would include matters such as ready avenues of assistance, appropriate procedures and medications and availability of technological or mechanical restraints. Rural doctors could be encouraged and financially supported to undergo additional training or education in mental health matters. Some of the difficulties also arise from lack of resources in rural areas.

Dr Helen Kingston is a General Practitioner in Golden Bay:

> **My own situation is that I am in an area where the Mobile Community team does not operate - we are too distant. It is therefore almost always the general practitioner's responsibility to be the first professional called for mentally disturbed people in crisis. We then have to fulfil the requirements of the Mental Health Act, usually as the provider of the supporting Medical Certificate for Sect. 8, but we also have to provide care for the patient as we would in any other emergency. Dr Wilson suggests in her letter that a "short acting sedative" might be used (there is no question in my mind of this being a "routine" treatment - every person is different and every case unique). She also suggests that we consult a psychiatrist at the time. In most cases this would not be practicable - what we are talking about is taking control in a very difficult situation (for example the patient physically escaping), and as I have mentioned we may well be the first professional on the scene, or have few skilled resources. In Golden Bay we have 2 policemen, not always on duty, and the next nearest are in Motueka an hour away. The ambulance is staffed by volunteers, none of whom would have much experience with these patients.**
>
> **We are intrigued by what might be considered an effective short-acting sedative. And, if we give something effective, we then have the double bind where the patient may be much more lucid when reaching the psychiatrist for assessment than when we saw him/her. In my case any sedation has to be effective for 5 hours or so; it is a 2 to 3 hour journey to Nelson depending on where in Golden Bay they live, but it takes much longer than that to get everything organised. The draft Memorandum of Understanding with the Police mentions that an ambulance or CHE vehicle with appropriate restraints should be used; in our case, as mentioned, the CHE mobile team does not come to us and our ambulance is a volunteer staffed one. The draft also expects that, having been sedated, a health professional should accompany the patient, possibly the medical practitioner concerned. Again in my case, when I am on call, I am on call for the whole practice area and cannot leave it for 5 or 6 hours without cover. Many other rural GPs are in the same situation, or worse - at least I get time off, as there are three doctors on the roster.**

Who will provide the back-up for our practices. A second on call at all times is not feasible, and certainly not economical for such infrequent (but devastating) circumstances.

LAWYERS AND JUDGES:

Lawyers were concerned about the adversarial approach taken by some of their colleagues and most advocated for a more inquisitorial approach.

Lawyers and Judges are aware of the difficulties the Act imposes on them. Judges acknowledge they do not have the training or expertise to "examine" patients. Lawyers acknowledge difficulty knowing when they can confidently and properly follow their patient / client's instructions. Do they act as their client's advocate or in their client's best interests?

Some lawyers and Judges have questioned whether or not there are too many provisions for reviews. Some reviews are unrealistic and unsettling for everyone involved not least the patient. They are also not a sensible use of scarce clinical, judicial and financial resources. No doubt families and clinicians would agree with these concerns.

The respective roles and the professional expertise of the Review Tribunal and the Judges may need further consideration. The Review Tribunal has a psychiatrist member and a lay member and is chaired by a lawyer. A Judge sits alone. The question arises as to which should be the tribunal of "first" instance. Currently a patient may apply to the Review Tribunal for a review of a Compulsory Treatment Order at any time even if at the same time the responsible clinician is applying to a Judge to extend the Compulsory Treatment Order. Neither decision takes precedence but an appeal from a Tribunal decision is directed to the Court. This makes little sense when the Court may have made a decision to the opposite effect.

There were further concerns about Community Treatment Orders.

i. If a patient on a Community Treatment Order requires hospital admission a new assessment process is initiated. It is unclear whether the Community Treatment Order ends on admission. Lawyers, Judges, and clinicians suggested that a Community Treatment Order should remain extant even if there has been a brief hospital admission.

ii. There is no written plan of treatment so it is difficult to ensure that care has been undertaken in terms of the information given to the Court. There is no provision for Judges to impose conditions on Community Treatment Orders such as directing where or with whom a patient is to live or associate (or not associate). Nor is there any requirement on the patient to abstain from alcohol and / or cannabis.

PROPOSED CHANGES

We attach as Appendix 4 a list of proposed amendments identified by the Ministry of Health and made available to the Social Services Select Committee when the Committee considered the Mental Health (CAT) Amendment Bill. We do not propose to discuss each of those amendments as some are relatively minor or technical or are designed to correct, clarify or enhance existing provisions. Clearly many of the proposals should be considered further and appropriate amendments to the Act may result. The proposed amendments relating to treatment for "proposed patients", powers of detention, the use of force and the power to enter, delegation of functions by the Director of Area Mental Health Services, and the issue of civil liability for health professionals and other officials operating under the Act may require special attention.

By necessary implication our Terms of Reference require us to consider whether the Act makes access to Mental Health Services too difficult and whether it releases into or retains in the community persons who are dangerous and who have a potential to commit serious crimes.

The Mental Health (Compulsory Assessment and Treatment) Amendment Bill:
The Bill was introduced by the Minister of Health on the 30th May 1994. It was prompted by concern over serious offending by two former psychiatric patients both of whom had been special patients after having been found unfit to plead under the Criminal Justice Act 1985. They were among some persons who were released from mental health institutions when the 1992 Act came into force. The status of these individuals did not fall within the definition of "mental disorder" as set out in the Act even though they were considered dangerous. It was initially thought there were 37 such persons in the community but further enquiries resulted in this figure being reduced to 24. To protect the public from the dangerous but not mentally disordered persons the Bill set out procedures to detain persons with "a specified condition" who are likely to commit a "serious offence" if released.

"Specified condition" was defined as "a state of arrested or incomplete development of mind involving severe impairment of intelligence and social functioning and associated with abnormally aggressive or seriously irresponsible conduct on the part of the person", or "a persistent disorder or disability of mind (whether or not involving significant impairment of intelligence) associated with abnormally aggressive or seriously irresponsible conduct on the part of the person".

"Serious offences" are those set out in Section 105(9)(b) Criminal Justice Act 1985.

The Bill proposed that before a patient is released from compulsory status, the patient be reviewed by the Review Tribunal which will decide whether the patient is "mentally disordered" or "has a specified condition" and is likely to commit "a serious offence" if released. If the patient is found to be "mentally disordered" he or she will remain subject to a Compulsory Treatment Order.

If the Tribunal finds the patient is not mentally disordered but has a specified condition and is likely to commit a serious offence if released the patient will be subject to a Compulsory Care Order.

If the patient is considered fit for release, the Review Tribunal or the Clinician may direct the patient to be held for a further month and this would allow time for the transition into the community to be planned.

The Bill also provides for the persons who came into the Mental Health System through the Criminal Justice System and who were released when the 1992 Act came into force to be assessed to see if they had the "specified condition". Any person can apply to the Director of Mental Health for the assessment of one of those persons who would be assessed by a competent clinician and if the clinician found the person to have the specified condition and likely to commit a serious offence if released, the clinician can apply to the District Court for a Compulsory Care Order.

The Bill also proposed that the word "serious" be deleted from the current definition of mental disorder. "Mental disorder" means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:

i. poses a serious danger to the health or safety of that person or others; or

ii. seriously diminishes the capacity of the person to take care of him/herself.

The Minister of Health in introducing the Bill referred to the definition "being interpreted in an overly legalistic way by a number of lawyers and Judges". She was concerned they were importing into the concept of "serious" the words "imminent" or "demonstrable". Such interpretation was seen to exclude many persons from mental health services.

"Dangerous", in the proposed Amendment Bill, was to be defined as "a potential to commit a serious offence as set out in Section 105 Criminal Justice Act."

A further significant shift was to change the definition of "unfit to plead" in the Criminal Justice Act so that it would cover a broader range of persons than those who were "mentally disordered" within the meaning of the 1992 Act. An example would be someone who was intellectually disabled but not "mentally disordered".

COMMENT: The Amendment Bill is still with the Select Committee some two years later.

It is our view that the provisions of the Amendment Bill should not be enacted without further careful consideration. The Bill is a reaction to the manner in which the 1992 Act was being interpreted and is in fact, considerably less deficient than has been widely perceived.

The definition of persons who may be mentally disordered is not narrow and restrictive. The various conditions which may constitute a mental disorder are expressed in the alternative by the word "or" being used seven times. Some criticism has been made that the definition excludes persons with personality disorders. While it is not for us to attempt a comprehensive or authoritative definition of the term "mental disorder" we are of the view the definition can include some types of personality disorder. We deal with the issue of personality disorder later in this report.

Concerns about the interpretation of "serious" may have been dispelled to some extent by recent decisions which are more in line with the legislation's intention, i.e. to provide treatment in the least restrictive manner. We agree with Principal Family Court Judge P. D. Mahony that there must be more education and training for lawyers working in the Mental Health sector and that there may have been a misguided emphasis on getting clients "off" rather than into treatment.

Many Counsel lack the skill to know whether or not their clients are fit to instruct them and appear to be unclear about where clinical and legal boundaries lay. Protecting a client's liberty is a concept with which lawyers are comfortable. In-patient care is likened to imprisonment. Section 66 of the Act provides for a patient to receive "medical treatment and other health care appropriate to his or her condition". That concept poses a difficulty for some lawyers. Lawyers need to be aware that untreated mental illness can pose a serious danger to the patient's own health or safety.

Only a few cases have created the impression that the "serious danger" must be physical danger and be "grave, demonstrable or imminent". It seems to us that the remedy is not to amend the definition forthwith, but rather to allow further time for its interpretation to be worked through and clarified. Guidelines as to its interpretation should be compiled and published and this will then enable the Act to fulfil its intended function of providing timely and humane intervention. The Act needs to be understood with some confidence particularly by those who are regularly confronted by it such as patients, families, "frontline workers" and clinicians.

The Inquiry team received many submissions which suggested the "strict" interpretation of the Act was not exclusively the work of lawyers and Judges but was also "resource driven". One submission noted:

> **The danger may have been considered not sufficiently "serious" if there was no bed available to admit a person to in-patient care or a patient was no longer "serious" enough to retain in hospital if his/her bed was needed for someone more "serious".**

Many submissions referred to the enormous difficulties in accessing acute services and, more often than not, the interpretation of the term "serious danger" was referred to as the reason.

The Ministry of Health has identified those sections of the Act for which guidelines should be available. These are set out at the end of this chapter as Table 1. If such guidelines are to be authoritative and workable, it will be necessary for all sectors of the Mental Health service to be involved in their preparation.

The lack of clarity and effectiveness of Community Treatment Orders requires particular attention.

The Act came into force on the 1st November 1992. There is a widely held perception in the Mental Health sector that almost all the above shortcomings which have been attributed to the Act have come about because of inadequate training and resourcing. We agree.

Few resources have been provided to train Mental Health professionals about the Act.

Few resources have been allocated to Mental Health professionals to enable them to carry out the new workload imposed on them by the Act. Paperwork and the time spent attending inquiries and reviews have meant less time for clinical work

Insufficient resources have been allocated to set up effective community care services so treatment in the community has been less successful than intended. This has caused in-patient facilities to be overloaded. If the Act is to provide a responsive, humane service it must be properly resourced with a much larger, properly trained work force. Models and guidelines for good practice should be established and followed. All this can be achieved under the present legislation.

Resourcing the Mental Health service so as to enable the Act to function as was intended, must be a priority. Some provisions of the Act are yet to be fully utilised. That part of the definition of "mental disorder" which refers to the seriously diminished capacity for self care is rarely invoked.

The provisions for "restricted patients" may be used more frequently to prevent dangerous patients returning to the community. Patients who become dangerous while subject to compulsory treatment may be made restricted patients on application by the Director of Mental Health, on the basis such a patient "presents special difficulties because of the danger that he or she poses to others".

Education about the meaning and use of the Act is also a matter of some urgency. Inconsistent interpretation, misuse and misunderstanding renders the Act ineffectual and is often used as an excuse to deny services. There must be a better understanding about what the Act can do before it is amended.

In considering the legislation and suggested amendments, we were mindful that our role is not that of an appellate court or legislator. The proposed Mental Health Commission should be invited to provide leadership and oversight to ensure that the Act functions as was intended. It can do this by:

i. providing education and training so that the purport and intent of the Act are well known;

ii. ensuring that the functions of the Act are well understood and properly applied. It should facilitate the work necessary to complete and publish clear guidelines relating to the clear interpretation of the Act;

iii. considering what amendments are necessary. If any lesson has been learnt from the advent of this Act, it is that before legislation comes into force, there should be a common understanding by the different professions involved as to what the Act is all about. There must be clear guidelines, sufficient resources, appropriate training and an acceptance and commitment from all involved to make the legislation work. For example, the concept of "specified condition" as proposed in the Amendment Bill should be understood by medical, legal and lay persons. The concept of "secure care" needs to be closely examined. What is it, who may need it, who is able to provide it, what resources are needed, what will it achieve and who will benefit from it? It is pointless passing an amendment if there are few facilities and a depleted work force, insufficiently trained, to provide the care.

iv. ensuring that the services intended to be provided are properly resourced so that the interpretation of the legislation is not distorted by inadequate facilities. There may be less need for hospital admission while subject to Community Treatment Order if community treatment services were more readily available and responsive. There is a lack of back-up acute services. Caseloads are unrealistically high so follow-up is not particularly effective. Non-compliance is frequent especially if a patient moves from one region to another.

The Act came into force amid a host of other changes. The health reforms and the managerial restructuring which accompanied them and the advent of the Privacy Act, all created difficulty in trying to come to grips with a complex new Act. Resources and work force were already scarce and it is therefore hardly surprising that the Mental Health sector felt battered or besieged by the various new demands made on it from different directions.

Now that the interpretation of the legislation is better understood and "settling down" it would be unwise to make further sudden far-reaching changes.

During the past few years the Mental Health sector has been functioning at a frenetic pace. Proposed amendments to the Act must be considered in an atmosphere of relative calm. It will be essential to ensure that resource implications are resolved contemporaneously with any further amendments to the act. That is an issue, amongst others, which should be dealt with by the Mental Health Commission.

TABLE 1

PROPOSED GUIDELINES (Compiled by the Ministry of Health)
Mental Health (Compulsory Assessment and Treatment) Act 1992

Guidelines are intended to suggest how the Act may be most appropriately interpreted, or in cases where the wording of the Act is unclear, provide definitive guidance as to what is intended. Guidelines are proposed to cover the following sections.

Section 2 : Definitions

- "Fit to be released"
- "Principal Caregiver"
- "Mental Disorder" including "Abnormal State of Mind"
- Disorder of Volition
- Disorder of Cognition
- Interpretation of the degree of disorder, i.e. seriously diminished capacity to take care of self, serious danger to the health or safety of self or others

Section 5:

Respect for cultural identity

Section 6:

Use of interpreters

Section 9(1):

The arrangements that the DAMHS or DAO "shall make" for the assessment examination to be conducted

Section 9(3)(b):

What is meant by "reasonably available"?

Section 10(3):

- Reassessment may be requested at any time
- Responsibility for further action, including transport from the place of assessment

Sections 11 and 13:

Definitive advice on the proper way to measure the time periods of 5 and 14 days

Sections 11(6), 13(6), 14(3) and 35(1):
Paperwork to be completed by use of assessment certificate - to ensure that the patient and other parties are informed and the records are clear

Section 14(4)(a):
The application should include a medical report

Section 29:
Community treatment orders:

- When an application is made this should define the terms and scope of the proposed order. The court should specify the conditions of the order

- Criteria for when it is appropriate to have informal admissions during the term of a community treatment order, duration of admission, and requirement for review by district inspector

If the patient is required to undergo reassessment under s29(3) should the existing order lapse, or be suspended?

Section 31:
Guidance on when a written leave form is required

Section 38:
What action a DAO should take if the person is not mentally disordered

Section 44:
Clarification of issues of treatment of special patients, particularly those under Section 121(2)(b)(ii) of CJA.

Section 47(3):
Clarification of status pending transfer back to prison

Section 60(a):
Consent for electro-convulsive treatment: all patients should have a second opinion

Sections 64-75:
"Proposed patients" should be accorded the same rights as "patients"

Section 87:
Consent should be sought from parent or guardian, but is insufficient alone

Various Sections:
Clarification of what powers the police have throughout the Act, and in what circumstances.

CHAPTER FOUR

PRIVACY

We have been asked to review and comment on how the Health Privacy Code is being used by Mental Health Service Providers and to make particular comment and recommendations on how and when family members associated with the care and treatment of mental health patients should be provided with information concerning the patient's treatment and care.

The Health Information Privacy Code and Privacy Act are not the only statutes or codes which regulate how information is to be used, other examples being the Health Act, Official Information Act and Professional Codes of Ethics.

Submissions to us made it clear that the Privacy Act or Health Information Privacy Code are being used or misused by some Mental Health professionals in ways which have caused grief, feelings of absolute helplessness and despair to both families and consumers.

A mother speaks of her daughter:

> **The week before our daughter took her own life, I phoned the psychiatrist to say that she had put up a "noose". The psychiatrist asked if I had my daughter's permission to call.**

Many families told us that the Privacy Act or Code has been a barrier preventing them from providing vital information relating to the assessment and treatment of a family member. In some cases the survival of a person may have been at risk.

A sister speaks of her brother:

> **In summary, I believe M's immediate death was preventable. I believe that the Privacy Act was inappropriately invoked in M's case. As a result, staff inadvertently facilitated his suicide by releasing into the community a man who had for months had a plan to kill himself by his 25th birthday on the eve of that birthday, despite being advised of its significance by the referring psychologist before and during M's admission. They released him without any significant other knowing where he was and without advising the psychologist. In doing this they prevented family from supporting him at this critical time, and from informing staff that M was deliberately misleading them about his level of risk in order to be released.**

Parents speak of their daughter:

> **It was agreed by all parties when we relocated to T in December 1994 that we would hold and apportion J's medication to ensure she took the prescribed dosages regularly. Previous experience had shown that she, in common we understand with most schizophrenics, could not be relied upon to take such medication regularly. If her "voices" told her to stop, she would stop. In both February 1995 and July 1995 medication was altered by two psychiatrists. Neither informed us of his change, leaving the communication to J who, on the former occasion, had not grasped that a change had been made. On questioning both practitioners quoted the Privacy Act for the lack of communication.**

On occasions misuse of the Act or Code has placed families in very difficult situations. A family member may be discharged without any notice to the family and without any information being given to them about the family member's care, needs or medication or nature of the illness.

In some cases the family has been unable to locate their family member or has found him / her living in conditions of squalor.

There are exceptions permitting disclosure which appear not to be well known. They are set out in Rule 11 of the Health Information Privacy Code. Disclosure may be made if it is authorised by the person concerned or by his representative if the person is unable to give his authority. It may be made if it is for one of the purposes for which it was obtained and this includes further treatment. If the family are to be the caregivers such information should be given to them. Disclosure is permitted if it is necessary to prevent a threat to public health or safety or the life or health of the person himself or of another person. Even if disclosure is made beyond these exceptions it will only be an interference with privacy if it causes loss, detrimental damage or injury or adversely affects rights or interests of the person or causes significant humiliation, loss of dignity or injury to feelings.

Problems have arisen largely from a lack of knowledge and understanding and misinterpretation of the Act and Code. On some occasions they have been misused or misquoted by over-extended mental health professionals to avoid spending time communicating.

The Mental Health sector must be better educated about the Act and Code. Properly interpreted, the Act and Code should not be obstacles to good service delivery.

The Privacy Commissioner has provided a commentary to Rule 11, that being the Rule listing the grounds on which a health agency may disclose health information. That commentary is recorded as Table 2. We have also included, as Table 3, an article by the Privacy Commissioner entitled "Resolving Conflicts Regarding Privacy". Both articles will be of assistance to the Mental Health sector.

Families or caregivers should be aware that there is no restriction on their giving information to mental health professionals. Such information may of course find its way on to the patient's records and be made available to the patient at the patient's request.

Clinicians also need to be aware that they are entitled to receive such information without breaching the Act or Code. This will avoid any repetition of the situation referred to in the first quote in this chapter.

In addition to further education and training, there are other concerns which will merit consideration.

a. ***A patient's express instruction not to disclose any information (patient veto):***
Such an instruction may be given when a patient is clearly unwell and has lost the insight to act in his or her best interests. Further there is no minimum age for rights to privacy. The express instruction may be given by a child who does not have the maturity to understand the effects and implications of such an instruction. It may be given by a "difficult" adolescent intent on behaving in an oppositional or confrontational manner towards his/her parents. There may need to be a specially designated person or office holder who could adjudicate or decide in any of the above circumstances as to whether or not there should be disclosure and if so to what extent. Another possibility may be a provision that disclosure of particular information to a particular class of persons would not constitute an interference with privacy under the Privacy Act 1993.

b. ***A patient's request for information held on file:***
Some families were concerned about information which they supplied to Mental Health professionals being given to the patient. Some clinicians were concerned about being involved in litigation if they kept full notes on patients. Some said they took a "conservative" approach and committed as little as possible to writing even though they were aware that that may not be helpful to the patient's treatment. Mental health professionals also expressed concern at the time and expense involved in supplying the information. No resources have been allocated for such attendances and there is no provision to charge the patient or former patient.

c. ***Should there be a set of national guidelines?***
The difficulty with a set of guidelines or rules is that it may be inconsistent with a particular type of service delivery or service provided. The Act and Code set out objectives and principles on handling information to avoid interference with privacy. However there are several different ways or means to achieve those objectives. A service provider using an integrated family model would handle issues of privacy differently from a service providing psychotherapy or counselling to a patient who had been abused by a family member.

It is suggested however that service providers make known to patients how privacy issues are handled, and explain policy openly and tactfully to patients and families before collecting information. Such an approach may go a considerable way to avoiding difficulties at a later stage. If the reason and purpose for collecting the information is made known, explained and discussed there is more likely to be assent.

Some of the above difficulties may have resulted from ignorance or poor communication and may in time as everyone becomes more familiar with the Act and Code, disappear or reduce to the extent no changes are required.

COMMENT: Education and training, resources for training and compliance must be made available to Mental Health professionals.

Service providers should be invited to prepare a set of clear guidelines as to what the Act and Code may or may not permit as far as their particular service is concerned, and those guidelines should be made available to staff, patients, families and caregivers.

Privacy Officers must be properly trained and readily available for consultation by families, caregivers, patients, clinicians and Mental Health workers.

The Privacy Commissioner's phone hotline number should be widely publicised.

Consideration should be given to an express provision that disclosure of certain health information to family or principal caregivers will not constitute an interference with privacy under the Privacy Act 1993 or the Health Information Privacy Code.

TABLE 2

Rule 11 : Extracts From A Commentary By The Privacy Commissioner

(1) (a) & (b) Disclosure is to, or authorised by, the individual concerned:
If disclosure is to the individual concerned privacy issues are unlikely to arise. However, care must be taken in disclosing information to ensure that information about other individuals is not disclosed.

Disclosure authorised by the individual, or by his or her representative, is almost always to be preferred to relying on some other ground for disclosure in rule 11.

(c) Disclosure is a purpose for which the information was obtained:
This would include instances where information is required for the further treatment of the individual or where the information is required for the administrative aspects of care and treatment, or the monitoring of that care and treatment.

(e) Disclosure of general information about hospital patient on particular day:
Many hospitals have operational procedures for the disclosure of this type of general information about an individual's presence and location in hospital and condition. The general information conveyed may amount to confirmation that a named patient is admitted and that he or she is comfortable, stable, has not changed etc. but not detailed particulars. Location information will assist visitors. The individual may veto the disclosure of such information. For most non-urgent admissions, hospitals should make their policy known in advance, perhaps through their admission forms, so that a patient can exercise the right to veto the disclosure of the information.

Disclosure is also allowed under sub-rule (2) in certain circumstances where it is not desirable or practicable to obtain individual authorisation.

(2) (a) .....

(2) (b) Disclosure of information to nominated person, principal caregiver or near relative:
Health agencies will need to have in place clear operational procedures to ascertain the identity of the person to whom the information in being disclosed. Regard must be had to any express wishes of the individual concerned.

(2) (c) .....

Difficulties may arise with patients who move in and out of psychiatric institutions and the care of a family member or caregiver. Often at the time of readmission such people may be hostile to their caregivers and veto the giving of any information to caregivers.

There is no easy solution to this issue but the rule does require respect for clear instructions of the patient. It is suggested that difficulties may be minimised by the exercise of discretion and skill by agencies as to the timing of broaching the subject (e.g. obtaining "standing" instructions during a calm lucid period rather than in the heat of an angry readmission) and discussing the limits of any "veto" (e.g. acknowledging the patient's right to keep details of treatment private while negotiating to seek permission to tell a family member at least that the patient is okay). Even where the patient does "veto" disclosure, the matter should be raised again and not left in an unsatisfactory state beyond the initial anger.

Where a clinician considers a psychiatric patient does not have the current mental capacity to give or withhold consent, disclosure may be made to, or with the authority of, a representative (see rule 11(1). See useful discussion in: A. M. Zipple et al, "Client confidentiality and the family's need to know: strategies for resolving the conflict" 26/6 (December 1990) *Community Mental Health Journal*, 533.

(2) (d) Disclosure necessary to prevent or lessen a serious and imminent threat to public health or public safety or the life or health of an individual:

In order to disclose under this exception, the agency would need to believe on reasonable grounds that it is not necessary or desirable to obtain individual authorisation and:

i. that there is a *serious threat* to public health, public safety or the life or health of an individual;

ii. that the threat is **IMMINENT**;

iii. that the disclosure of the information would *prevent or lessen* that threat; and

iv. that the disclosure of information is *necessary* to prevent or lessen the threat.

Even if disclosure is warranted, it should be only to the extent necessary to prevent or lessen the threat - rule 11(3). A decision to disclose does not justify the disclosure of information other than that which is necessary to prevent or lessen the threat.

Generally if there is a statutory official with powers to deal with such a threat, then disclosure to that responsible authority may be an appropriate response. The purpose of the disclosure should be made clear so that the person receiving the information knows the limited purpose to which it can be put.

TABLE 3

RESOLVING CONFLICTS REGARDING PRIVACY
(Advice from the Privacy Commissioner)

The Privacy Commissioner, Mr Bruce Slane, says that the failure of some mental health agencies to listen to families may be "a problem with the delivery of health services rather than a problem with the collection or disclosure of personal information". Different approaches from doctors to the involvement of family members in treatment, or the supply of information about a relative may lead to difficulties. These problems should not be attributed entirely to "patient confidentiality" or "privacy", but often have just as much to do with family dynamics, the doctor's view of the best way to treat a person, and the best use of the doctor's time.

According to Mr Slane, "Present legislation and practice recognises a much greater degree of family involvement in treatment than was formerly the case, but personal styles, resources and available time can all limit the degree of involvement of family members".

Q. Can I phone a mental health worker, and express my concern about the way my son is failing to look after himself?

A. The Privacy Act places absolutely no barrier in the way of a family member ringing or writing to volunteer information about an individual's mental state to a health agency. Neither the family nor the agency could be said to be breaching the Health Information Privacy Code. However, the use to which the agency puts the information, and the weight it gives to it remain within the professional discretion of the agency.

Q. Is the family entitled to be notified before a relative is discharged from psychiatric hospital care?

A. At the point of discharge from hospital, if an individual is to be placed in the care of a family member it is obvious that personal health information will have to be passed to those people in order to provide that care. It is interesting that when discharging other types of patients, no problem seems to be encountered in giving health information to caregivers to ensure that medication is taken or further risks are minimised.

If an individual is not to be discharged into the care of the family itself, it would nonetheless be a sensible matter for the hospital to expressly address whether or not there is any need to notify family members. When a patient refuses to authorise notification, the hospital would need to consider its options.

If there was a serious and imminent threat to family members, the hospital would have grounds to disclose discharge information to the family, however, it is hardly conceivable that a hospital would knowingly discharge a patient in such circumstances. If a threat manifests itself later a warning can be given.

Q. Are family members allowed to phone a hospital psychiatric unit and inquire about a relative who is being treated in the unit?

A. There's nothing to stop a family member enquiring; the real question is how much information the hospital staff can give. Brief information in general terms about the presence, condition and progress of the hospital patient on that day can be given to any caller if the disclosure is not contrary to the express request of the patient. Disclosure of more detailed information generally requires the authorisation of the patient (or their representative if they are too unwell to exercise their own rights).

Q. What if my relative refuses to authorise any release of his or her health information?

A. If an individual issues clear instructions that information is not to be disclosed (a patient veto), then the health agency cannot release any information. This is an essential privacy safeguard, and absolutely consistent with traditional notions of medical confidentiality. If a person has the mental capacity to express views on the subject, and expressly asks that the information not be disclosed to a family member, it does not seem appropriate to override those clear instructions.

The Health Information Privacy Code allows information to be disclosed without the patient's authorisation and even in the presence of a patient's veto, when that disclosure was one of the purposes for which the information was obtained. Although this situation will rarely arise in a health care context it may sometimes occur, at the discretion of professional staff, in relation to passing information to a particular caregiver.

Q. My relative has a history of becoming deeply suspicious of her family when she is acutely mentally disordered. Upon entering a hospital, the first thing she tells the staff is "don't tell my family anything!" Yet we are her main social and emotional support when she is living in the community. How do we find out how she's getting on in hospital?

A. There is no easy solution to this issue, but difficulties may be minimised by staff exercising discretion and skill when broaching the subject. The existence of a patient veto does not prevent health staff from raising the information issue again and seeking new instructions at an appropriate interval, which may be hours or days later, and which might find the individual in a calmer mood, or responding to treatment. Also, the veto does not prevent the doctor, consistent with good medical practice, from negotiating with the individual about what the family may be told.

For instance, the person may agree that relatives can be told general information, but that details of treatment will be kept private.

If a patient does not have the current mental capacity to give authorisation, then their "representative" can authorise disclosure. This representative is often a family member or the Public Trustee who could authorise information being released to another family member. It may be argued that a person who is very disordered would not be in a position to "veto" the release of information, although this point is not so clean-cut.

Q. My nephew lives with me, and would not be able to cope in the community without the support of his relatives. However, when he requires acute psychiatric treatment, or has his medication altered, mental health staff are unwilling to tell me how to cope with my nephew's changing behaviour, or what to expect from the new treatment.

A. Section 22F of the Health Act may have relevance here. When a family member has some formal role in the care of a patient, then they may be "providing health services" to the individual. The caregiver may have standing to seek information under the Health Act, or to be a "representative" of the individual. This may allow the caregiver to obtain details that may otherwise be withheld. The Privacy Commissioner may review a decision to withhold information under Section 22F.

Q. I suspect that the doctors and nurses consider me a "busybody" when I inquire about my son's mental health status, but I am genuinely concerned about his wellbeing. I am sure I would not be denied information if he was suffering from cancer - why are psychiatric illnesses any different?

A. The involvement or non-involvement of families in mental health treatment can be a vexed issue. There are inherent difficulties in these areas. However, the Privacy Act ought not to exacerbate these difficulties.

It should be recognised that there is often a difference of opinion between medical professionals and family members. The health professional may feel that particular family members have no right to certain details about their relative, and would never, due to patient/doctor confidentiality, release any information. The professional may find it easier to "blame the Privacy Act", rather than upset the family member with the true reasons why an individual has requested no contact with them. This may avoid alienating a family member whose involvement with the patient is acknowledged to be important, but it is more a matter of clinical judgement and family dynamics than a privacy issue.

Q. Who should I go to if I feel that health agency staff are being unreasonable about releasing information about my relative?

A. Ask to speak to the Privacy Officer at the CHE. All hospital Privacy Officers are trained in the interpretation of the Privacy Act and the Health Information Code, but difficulties seem to arise more in some parts of the country than in others. All Privacy Officers have been encouraged to network among themselves and share practical ways of dealing with problems.

Reprinted from an article from *Schizophrenia News*

CHAPTER FIVE

RIGHTS OF FAMILY MEMBERS

We have been asked to report on what consultation and consideration is given to the views of close family members in determining the treatment and care of those with semi-acute and acute mental disorders.

For obvious reasons the identities of those who made submissions under this head must remain anonymous and, in some cases, submissions have been edited without compromising their integrity. The common feature in all submissions was that families were rarely regarded as a valuable source of information during the assessment, planning and review and discharge stages of a family member. We received hundreds of submissions from family members.

A typical comment:

> **The family is the only group which knows patients when they are well and unwell. We know the idiosyncrasies and foibles of our family members. The family usually knows when something unusual is about to occur, that is not explainable and is beyond the usual experience of people. Families have a sixth sense. We have an empathy with the person who is unwell. A Clinician with little information as to what caused the problem - can he possibly work out what treatment may be required? Often we have the information which can assist in that treatment. A patient cannot be treated in isolation. The patient's wellbeing and behaviour affects the whole family and it is therefore necessary to involve the whole family in the process, from assessment right through to discharge and beyond. We admire the Maori approach to this matter - the whanau is regarded as being part of the patient.**

Another family member:

> **Most families will learn to cope. Some have better personal resources than others. However it will be at a cost to all. It will cost money. It will cost in terms of general health. It will cost in terms of consequent and reactive maladies affecting other family members and requiring medical and / or psychiatric intervention. It will cost in terms of disruption to work or profession. It will cost in terms of heightened stress. It will cost in terms of strain on family relationships.**

It will cost sleep. It will cost tears. It will cost the frustration of helplessness and hopelessness. And through these costs to each family and family member, there will be a cost to the community as a whole.

In determining the treatment and care of a Mental Health client it is clearly imperative that the views of such close family members are given utmost attention. Moreover it is imperative that, when the client is residing in the community in circumstances such that the family will be required to continue to relate to and be directly involved with the client, the Mental Health authorities charged with care for the client must take close account of the family dynamics, resources and capacity to cope. The family is not a surrogate Mental Health hospital; the family is no substitute for trained professional care; the family is not a de-facto facility of community Mental Health care. Although by default all these demands and circumstances are indeed placed implicitly, if not explicitly, upon the families of Mental Health clients. And to the extent that this does occur, then the rights of family members are curtailed and compromised. From the perspective of the rights of family members, Mental Health is not something that is being adequately or competently dealt with in the community. Rather it is being simply transferred into the community arena, there to spread and exacerbate effects rather than, as the governing policy would intend, to be ameliorated and counteracted by virtue of being situated within a more "normal" community environment.

Where families are effectively required to play an active support role in respect of the care of a member suffering semi-acute or acute Mental Health disorder, it is important that such families are offered assessment and assistance, ranging from appropriate financial subsidy to regular visits by a professional who will assist with the direct care of the client.

Parents speak of their son:

We feel that parents must be consulted before their son or daughter is released into the community after being a patient in a Mental Health hospital. Our son was a committed patient (committed by us).

We understood that he was in the care of the hospital when, one morning he rang to say he was in a motel in the city. He had been released the previous afternoon, given $300.00 of social welfare money and left on the streets. He was most upset and by morning was psychotic and most disturbed when he rang for help. We should have been informed of his impending release.

Parents know their sons' and daughters' histories and should be listened to. For example we asked for help because our son was becoming increasingly disturbed whilst living in a half way house and was not taking his medication. We were told, "forget your son and get on with your lives". As a result of this advice (from a professional) our son landed in Mt Eden Prison after robbing a service station and threatening the attendant with a knife. This need never have happened and the stress on the robbery victim, the patient and the patient's family could have been totally avoided.

A husband speaks about his wife:

On the whole I have made a point of being present during significant issues relating to my wife's situation. Not withstanding this, we have experienced a time when she has been sent home from hospital without consultation with me (the primary caregiver) as to my ability to cope with ongoing care.

A husband:

While my wife received care, my family (aged 8 to 2 years) and I were left to fend for ourselves without support of any kind.

... there was virtually no consultation until my wife announced to me, with the support of the staff, that she needed a period of separation to get her life in order. This came as a terrible shock for me personally. Apart from my personal heartache, I was concerned that my wife was "released" to take over the responsibility of caring for our four children. How "one of the most severely depressed women" one Psychiatrist had ever met could be encouraged to undertake care of four children alone, I have no idea!

Another concerned parent:

> **Family members are often acutely perceptive and can recognise symptoms on a particular pattern of behaviour which precedes an acute phase, and they feel resentful when their concerns are simply waived aside, or they are told that nothing can be done until the position becomes acute.**

Healthlink South submission:

> **Family members are often acting as unpaid professionals in the care of their family member. The benefits of this help, to the patient and to the health service, cannot be underestimated in terms of their input and free labour.**
>
> **Family members who are not the primary caregivers need to have clear agreements with the health service so that they know which information will be shared and which will not. For example, will the family automatically be notified on their relative's admission to hospital? If these things are clear at the onset, then everyone knows what to expect.**

Sisters speak of an uncle:

> **Families should be more involved through regular meetings with psychiatric services so full consultation and open dialogue between all parties can be fully beneficial to the patient, i.e. past history, present care and up to date information on the illness, can be passed on to the families or caregivers. This is necessary to empower the family or caregiver who, because of the nature of the privileged relationship between patient and Psychiatrist, are often left to feel totally excluded. The illness already isolates the family from their loved one. What we are advocating is that where families are willing, these people must have an involvement in the care, the progress and the overall treatment of their family member. This will help them to feel a part of that person's life again, to be of use, to help and be helped.**

Parents speak of their son:

> **It was some three months ago before we, as caregivers, were properly informed about our son's condition - and this came about only after we had initiated a family meeting with professionals and other staff at the hospital. Even then, it was the Consulting Pharmacist rather than the Doctor, Psychiatrist or regular professional staff member who gave us the information**
>
> **We would have been told very little indeed about our son's treatment / care at the hospital had we not visited regularly (once, and often twice, a week) and asked questions. But even then we often found ourselves at a loss because there was a complete lack of desire / climate to stimulate an exchange of views.**

Dr Wayne Miles is the DAMHS at Waitemata Health. We set out below an article written for a staff magazine:

> **The new year brings with it the need to tidy up from the last, a chance to catch up and review. One such review for me was to look at last year's complaints.**
>
> **A remarkably common thread through many of these complaints was the expression of concern by family members, caregivers or close friends, that they had not been listened to or consulted by the various Mental Health teams. Frequently they describe experiences ranging from "kind dismissal" to "blatant rudeness and ignore". It is perhaps no coincidence that the Inquiry into Mental Health Services has, as a term of reference, the review of the involvement of families and the effect of the Privacy Act.**
>
> **Mental Health services should be grounded in the bio-psychosocial approach. The importance of the relationship of one's family and / or close friends to one's mental wellbeing is well acknowledged in that approach. Why then should we be seeing so much discontent from the significant others of our clients?**

Some would contend that we only pay lip service to the relationship issues, that we are not at all interested in the family, at best seeing them as "necessary baggage", at worst as "the cause of the problem". The only family intervention is parentectomy. I have little evidence that such attitudes prevail in Waitemata Mental Health. So ... how come some of our clients get that impression?

In discussions related to the complaints, a common feature is the time pressure that workers are under. The very nature of the relationships and their distortion when mental illness interferes makes for difficulties in understanding and communicating. Again that will not be news to any of you. What it means however, is that in order to successfully communicate, to have the family believe they have been heard, time needs to be spent with them. That time is a precious commodity and, as you have the next ten requests for help stacking up, time is what you have not got.

A second component may be expertise and confidence. While working with the family does not mean you are expected to be a White, Minuchin or Epstein, it does require skill that is different from that of every day conversation. Understanding the dynamics and processes always leaves you in a better position to affect the outcome of the interaction.

I am hopeful that the Inquiry, taking a note of the findings of the New Zealand Workforce Committee, will stress the need for both an increase in the absolute number of workers in Mental Health as well as an expansion of the skill base through training. There needs to be a balance in that training between the academic and experiential. Many of you will be aware from your own training that the balance is often absent. Some training is all theoretical and when the individual comes to practice their book learning, they cannot translate it to the real world. At the other end of the spectrum is the situation where hands on is the all. The practitioner never gets to understand the reasoning behind the practice, can become method bound, inflexible and, in the worst case, endorses bad practice "because that's the way we've always done it". Maybe our recent success with the Cognitive Therapy course might expand new horizons and include courses in Working With Families.

A second contributing area is the conflict between the rights of the individual for privacy compared with the rights and benefits of others being informed and involved. The Privacy Act can become a millstone around the usually communicating Clinician's neck. It is my strong belief that the best path is usually taken when the Clinician, well informed, decides the path that is likely to have the best outcome for the patient. This may mean that family members are involved without the expressed authority of the patient. It is possible to explain why you are talking to others, better still you can involve the family AND your patient in the dialogue. Many families believe that the Act has been used as a convenient way for the Clinicians to avoid talking to them. They cite knowledge or suggestion that would clearly have had a contribution to outcome. If you reach a situation where you see a clear conflict between talking with and involving family, and the expressed or assumed wishes of your client, then you should seek the advice of colleagues. The best way through most difficult decisions is the peer process.

I know that the situations can become very difficult but then we are experts in the area of Mental Health and that should include working with families.

COMMENT: In an Inquiry of this nature it is only to be expected that we will be alerted to the negative aspects of the Mental Health service. Those families who have been consulted and listened to are unlikely to bring that to our notice - it is something they would expect to happen. Nonetheless, the overwhelming evidence suggests that the views of close family members are not being considered to the extent that they would wish. Families do not wish to interfere unduly in the therapeutic process, but they have a justifiable concern for the welfare and wellbeing of their family member. They should be recognised as a resource and be consulted whenever a family member is being assessed or considered for discharge, and when the planning and review of treatment is being contemplated.

We heard of many occasions where patients were discharged, without prior consultation, into the care of family members who then found themselves unable to cope. At the other end of the scale, several parents told us they were forced to stand by helplessly while a family member deteriorated to the stage where hospitalisation became inevitable.

We have some sympathy for the views expressed by Dr Miles. We acknowledge the enormous stresses under which Clinicians work and the almost frenetic pace at which the system appears to be operating.

It is hardly surprising, in an age of staff shortages and poor resources, that some Clinicians will take the shortcut and dismiss the family consultation as an unnecessary impediment. In fairness however, we detected a fairly firm resolve by those Clinicians who met with us, to remedy something which they regarded as an unsatisfactory state of affairs:

> **Families are the only constant factor in the life of a patient. Clinicians come and go, but families are involved twenty four hours each day. That is a good reason for listening to them.**

We have given careful consideration as to whether that consultative process should be mandatory or whether it is something which can be achieved by additional resources and further training. We note that in some regions Clinicians are obliged to share already overcrowded office space and we note, with regret, that some institutions are devoid of adequate facilities for the conduct of a meaningful family consultation.

Later in this report we will refer to early intervention programmes being undertaken in Melbourne, Australia by Associate Professors Pat McGorry and Jayashri Kulkarni. The evidence shows that such programmes have the potential to produce far better results than a system which allows an individual to disintegrate to the point where hospitalisation becomes inevitable. One of the most significant elements in the early intervention programmes is that they would fail in the absence of family or caregiver involvement. It is our expectation that such programmes will be replicated in New Zealand and that noticeable benefits will then be seen for patients, Clinicians and families alike.

June Read is a well respected educator in the Mental Health sector. She suggests that education must be aimed at attitudinal changes. Formal and informal carers and the people for whom they care, need to become aware of each others view points, consider the advantages and disadvantages of working in partnership, and discover what each has to contribute to such a partnership. There must be opportunities for all parties to meet together at regular intervals to problem solve and plan and review treatment, care and rehabilitation of the consumer. That is an approach which we prefer - at least on an interim basis.

We have also considered whether there should be a formal Code of Family Rights. In our view, this approach would be premature. We believe that a well planned Mental Health service, properly funded and resourced, will include consultation with family members as an essential component in that service. If all else fails the Mental Health Commission, after a reasonable period, should give consideration to a Code of Family Rights.

- We agree with the Framework Trust:

> **If people with mental illness are to receive optimal care, family and carers need to be given the opportunity to be consulted and to contribute to that care. To achieve this, resources and services need to be developed to assist families in this process.**

CHAPTER SIX

DRUGS AND ALCOHOL

We have been asked to comment on the extent to which non-prescription drugs and alcohol are known to contribute to acute and semi-acute mental disorders. Our response may be stated in two sentences. Drug and alcohol abuse is a major exacerbating factor for such people and over 50% of forensic psychiatric patients are noted to have this factor as a contributor to their risk management. Although there is no hard evidence as to the number of dual-diagnosis patients in New Zealand, the problem is substantial and estimates range between 35% and 85% of psychiatric patients also having alcohol or other drug problems.

The Royal Australian and New Zealand College of Psychiatrists:

> **The relationships between substance use / abuse and psychiatric phenomena are multiple. There are a wide range of problems and difficulties. The frequent co-existence of substance use disorder with mental illness can often lead to speculation on cause and effect. Does substance use / abuse cause mental illness? Does mental illness lead to substance use? Does the social stigma of mental illness encourage the use and abuse of substances? Are substance use and mental illness the result of some other factor, e.g. social deprivation?**
>
> **Such extreme attitudes are unhelpful to the person with co-existing mental illness and substance use disorder. Those attitudes do explain however the present major split between Substance Abuse services and Mental Health services. That is particularly damaging for the mentally ill person with substance use disorder, the so-called dual-diagnosis patient.**
>
> **The care of the mentally ill will be greatly enhanced by the fostering of closer links between Substance Abuse services and Mental Health services. For many patients concurrent treatment is necessary for effective management, and it is our belief that this best takes place in a specialised setting rather than within the general psychiatric unit, as the structure of such units is rarely conducive to dealing effectively with the substance use disorder.**

Dr John Turbott is the Director of Psychiatric Registrar Training in Auckland:

Undoubtedly drugs and alcohol make a major contribution to the occurrence and presentation of acute and semi-acute psychiatric illness.

Firstly, intoxication with drugs or alcohol temporarily affects mental function; severely intoxicated people may be distressed, dysfunctional or dangerous to the point they require restraint or treatment. Psychiatrists are familiar with these states (from clinical observation of course) and sometimes may play a part in their acute management. On most occasions psychiatric hospitalisation is not required for acute intoxication alone.

Secondly, drug and alcohol withdrawal states may give rise to disturbance of mental functioning. Similar comments apply as to acute intoxication. Sometimes withdrawal is a planned procedure ("detoxification") which often is done in community settings but may require admission to a specialised unit and medical management.

Thirdly, many people with psychiatric illness are chronically distressed and dysfunctional, and use drugs and alcohol, in some respects, as self medication - in an attempt to help their condition. This is well known to all experienced clinicians and may or may not cause additional significant problems. Most psychiatrists would counsel their patients to minimise or cease such practices. Some may require specific long term treatment in a "dual-diagnosis" service.

Fourthly, in some cases drugs and alcohol may have a specific effect in precipitating or worsening attacks of mental illness. This may lead to diagnostic difficulties, i.e. what type of condition is it; is it a relapse of psychiatric illness, withdrawal or intoxication; is it both? This is a regular challenge to psychiatrists working with acute psychiatric disorder. Sometimes prolonged alcohol or drug abuse may lead to brain damage and to ongoing mental illness.

The diagnosis and management of these so called "dual-diagnosis" situations requires a high level of expertise and training, and usually is not done well in drug abuse services where the clinicians do not have psychiatric training.

Dual-diagnosis facilities have not been well developed and supported in New Zealand, particularly in Auckland where, for some time, the substance abuse service has been entirely separated from mainstream psychiatry. The result of this is that, while dual-diagnosis patients continue to turn up at already overloaded psychiatric facilities, they also occur in the drug treatment stream where they are not well managed.

Fifthly, there is a component of drug and alcohol management which genuinely straddles the border between psychiatry, general medicine and society. This is the treatment and prevention of excessive and continuing drug or alcohol abuse which has become a personal, family, financial, legal or social problem to the individual concerned, but which has not caused psychiatric illness. This is the area which often is claimed by non-medical people as their own (Wodak, 1994). There are strong arguments either way, i.e. for seeing alcoholism and drug abuse as an illness requiring medical approaches to treatment, or as a social and behavioural problem. Most would agree that these conditions are multi-factorial and that their best assessment and treatment requires a genuinely multi-disciplinary approach.

We heard of many examples of the "ping pong" effect. Alcohol and drug treatment centres are often unwilling to accept patients with co-existing psychiatric problems. When they do accept them, they often have few or no staff who are adequately trained to deal with the complexity of issues for these patients. Most residential treatment centres have a focus of abstinence, which includes an expectation that the patient will be drug free, including medication free, on admission. Patients on essential psychiatric medications are told that they must stop them before admission, or at least work towards withdrawing them during admission.

Conversely we were told of some people who were denied admission to a psychiatric facility on the grounds that they must first be "clean", i.e. sober or drug free. The inevitable consequence is that such people spent their time "bouncing" between services.

COMMENT: Clearly a multi-disciplinary approach is called for. There must be a closer working relationship between the drug / alcohol sector and the Mental Health sector. There needs to be greater integration between Drug and Alcohol services and Mental Health with more co-operation in terms of joint assessment for those with dual-diagnosis. A significant proportion of Mental Health consumers would fall into a dual-diagnosis category.

Co-ordination of the Mental Health strategy and a Drug and Alcohol strategy must be a high priority with specific purchasing arrangements to ensure integration of the services and integration of funding.

Without effective treatment co-morbid patients will remain chronically psychotic and actively drug dependent. Adequate community services, to deal with this difficult and problematic group with a high rate of hospitalisation, simply do not exist. In many cases one disorder is "treated" at the cost of the other. Models of treatment for such people are only gradually being developed. There is a lack of specialised facilities for such patients and the advent of such units would be an advantage.

Cannabis intake amongst Maori is a matter of concern. There is much we can learn from overseas research, but we must also have our own indigenous overview. Research and planning must co-exist.

Dr John Adams is the Clinical Director of Ashburn Hall:

> **At Ashburn Hall we have been arguing for some time against the "splitting off" of Alcohol and Drug services from other Mental Health services.**
>
> **It is clear to us that many people (particularly young people) who present with psychiatric symptoms such as depression, anxiety or even repeated psychotic episodes, have an underlying alcohol and drug addiction problem. Also, many have combined problems. Often those with past histories of sexual abuse have multiple difficulties with eating, self harm and substances. Many other patients have vulnerabilities to using substances to escape from the pain of their emotional difficulties.**
>
> **Substances cause psychiatric symptoms. Almost all alcohol and drugs have psychiatric syndromes associated with their use, and intoxication and withdrawal states that may need psychiatric attention.**
>
> **The methods used in treating addictions are not distinct from those used in other psychiatric disorders. Although often a very clear addiction focused approach is needed, the treatment methods with social feedback, "holding" and individual and group psychotherapeutic treatment are similar to the treatment of many other difficulties. The skill base is virtually the same.**

We treat our addicted people together with all other patients although we also provide a special Substance Abuse Group. The issue is that the problems are not necessarily distinct, and when divisions and demarcations start to appear in treatment services a danger of people "falling between two stools" is created.

We would submit that the splitting of Alcohol and Drug and psychiatric services is unrealistic, and that both should come under the same structure. More attention should be given to purchasing services for those with co-morbid diagnoses.

CHAPTER SEVEN

PROVISION AND CO-ORDINATION OF SERVICES

We have been asked to:

a. review the services, including crisis support, assessment, treatment and continuing support for those who are suffering from an acute or semi-acute mental disorder; and

b. identify and recommend where improved co-ordination procedures between providers of services are required and how particular problems may be overcome.

John (not his real name) is the father of a nineteen year old son who first came to the notice of Mental Health services in 1985:

> **The singular problem with the provision of Mental Health services would have to be the re-active mode upon which they are premised and by which they are constrained. The adage "no news is good news" does not hold true for Mental Health. Out of sight out of mind, can only be a temporary expediency; the Mental Health client, unsupervised, unchecked, with no "minder", no guide and mentor, will inevitably drift on a sea of unknowing until dashed against the rocks of confusion, distress and despair. Mental Health professional caregivers, forced to spend time plucking from the rocks, are rarely able to steer their clients into calm and safe waters, will ever be swamped and the tide of Mental Health disorder will never abate.**
>
> **The single requirement for the provision of Mental Health services is that they be pro-active. Unless there is an adequately resourced programme designed to effect beneficial outcomes, current Mental Health services will remain inadequate to meet real need.**
>
> **Mental Health is the Cinderella of medical services. It really requires to be the Prince. Rather than existing on lean resources, the nature of the care required demands a high level of human (and therefore concomitant financial) input. To be effective, Mental Health therapies must, of necessity, be highly labour intensive.**

Although somewhat lyrical, that description is by no means untypical of the hundreds of submissions presented to us. Many submissions referred to the nationwide shortage of acute beds.

Catherine MacKirdy is a Consultant Psychiatrist at Western Bay Health:

> **The most serious problem affecting Mental Health services at the present time is the lack of acute beds in Regional Hospital Units following the down sizing and closure of the old mental hospitals. Over the past year our own acute unit at Tauranga Hospital has repeatedly been in crisis through lack of beds in which to place acutely ill people. The back up from Tokanui Hospital has not been reliable. It (Tokanui) has also been repeatedly in crisis through lack of acute beds. There have been times when we have approached Tokanui to accept a transfer of a patient who cannot be safely managed in our own unit at Tauranga Hospital, only to be told that they too do not have the facilities to manage them. We have been told that in their Intensive Psychiatric Unit they have been looking after as many as thirty people in nineteen beds. I am aware, from talking to other senior psychiatrists from around the country, that this is by no means a localised problem. I have heard senior psychiatrists from Auckland and Wellington complain that they are wasting large amounts of clinical time trying to admit severely ill people, when there are no beds available.**

An Auckland Consultant Psychiatrist continues the theme:

> **In my opinion there is little doubt that the acute and sub-acute services for patients with severe psychiatric illness are not functioning as well as they should. The process of rapid de-institutionalisation has resulted in the loss of large numbers of psychiatric beds, sub-acute and long stay.**
>
> **Because of the greatly reduced numbers of acute beds and the scarcity of sub-acute and medium stay beds available in the Auckland area, acute wards frequently are overfilled. Patients, not infrequently, have difficulty in gaining admission when this clearly is indicated. Equally, patients who are not properly settled are returned prematurely to the community, leading inevitably to a revolving door situation.**

I would suggest that one of the major guiding principles of this Inquiry should be the recognition *that effective acute and sub-acute services are absolutely essential for the well functioning of a Mental Health system.* The resources which have been put into better support, accommodation and rehabilitation in the community are welcome, if still insufficient. However, *unless the acute and sub-acute services are functioning effectively, the whole system is in a constant state of tension and dysfunction.*

Politicians should be aware that if the acute and semi-acute services are not functioning, the consequences of untreated and uncontrolled mental illness in the community will continue to be seen, to the ongoing delectation of the media and the alarm of the community.

Jean Haslam is the Secretary of the Western Bay of Plenty Mental Health Trust:

Shortage of beds is very serious. Our psychiatrists are constantly hunting for beds as Tokanui and Kingseat Hospitals are relentlessly downsized. Hotbedding, as seen in the UK and the USA has arrived in New Zealand. Recently patients have been moved into a local redundant Nurses' Home as there was nowhere else for them to go. This is neither safe nor suitable for patients or staff. Also recently, acutely ill people were housed in the psychiatric unit, which has no secure wing. Patients walked out and caused Police alerts until they were found. One at large patient was armed with a knife. There were no beds in Tokanui for people on a Section.

Acutely ill people should not be mixed with fragile recovering patients. There must be secure units in place before downsizing proceeds. People are discharged too soon and too often to give up their urgently needed bed to someone even more ill! So heavily medicated, and physically unwell, they are put out into the community before they are ready. Inevitably, days or weeks later, these people need to be readmitted, acutely ill again. *Every admission lessens their chances of making a good recovery.* There is an unrealistic management expectation that the acutely psychotic person *must get well quickly!*

Non-medical Managers do not seem to understand the complexity of psychiatric illnesses and the need for asylum and convalescence. Nor do they seem to understand the cyclical, seasonal nature of the illness.

They do not grasp the severity of the post-trauma symptoms following a terrifying psychotic episode. The speeded up process for human repair does not apply to mental illness. The community (that nebulous identity) does not know how to care for emotionally fragile, exhausted people. It is very specific work and the funding allocated has never recognised this fact.

An experienced nurse:

Bed numbers have been reduced to such an extent that most services now "run on the seat of their pants", are expected to manage larger numbers of admissions and also have to manage a proportion of continuing care patients with chronic mental illness, who are unable to be placed in any other facility - either public or private.

In the unit in which I work for example, a constant 10% - 12% of beds are occupied by these continuing care patients whose behaviour, or the chronic nature of their mental disorder, requires a high level of psychiatric care and psychosocial support. Previous attempts have failed to secure suitable accommodation or the patients themselves have simply refused to be moved.

The utterly unreasonable circumstances under which staff must work on occasions is best described by Dr Christine Perkins:

Tonight I am the Consultant Psychiatrist on call for Central Auckland. It is Friday 26 January, the beginning of a long weekend.

- **Connolly Unit, the acute unit, is full - in fact "one over numbers". Fortunately a patient has gone AWOL so we could fill this bed. Hopefully he won't return and expect to sleep there. There are no intensive care beds.**

- **Taharoto, the North Shore Mental Health unit, is full**

- **Te Atarau in the West has one empty female bed**

- **Kingseat has some beds in the open units but no intensive care beds**

- **The private hospital often used for respite psychiatric patients is full**

Four Policemen have just spent two hours waiting with a violent, mentally ill man outside the Connolly Unit while an intensive care bed was organised. For this to happen, a person nearly due for discharge has been sent out on extended weekend leave (we hope he lasts it out), a patient from the intensive care unit has been moved in to the "open" ward with a "special" Nurse to constantly observe him, and the man with the Police is now (hopefully) in intensive care.

With all this demand on acute beds you would expect there to be chaos in the wards. This is not so because the wards are full of people who are well, or nearly so, but cannot be discharged because they have nowhere to go. The lack of *rehabilitation beds, supervised board and supervised or unsupervised and affordable flats* in Central Auckland is a major problem. We have nowhere to send people once they are treated. We have not got to the point yet of discharging people into the street, but this is the option favoured by the US Mental Health authorities who allow Doctors to treat the illness but ignore the fact that homelessness is likely to precipitate another admission. We desperately need suitable accommodation and rehabilitation options for people with mental illness. We also need more intensive care beds.

Starting the long weekend with no empty beds is not encouraging. Some people on weekend leave will have their beds filled over the weekend. We will have to sort out what to do with them on Tuesday. I hope no one needs a bed tonight. It is difficult transporting people to Tokanui or Northland (if they have suitable beds) in the middle of the night. The patients and their families find this situation very confusing. They are already enormously stressed by the mental illness itself.

It is now 27 January. Often you can get away with no beds overnight but last night wasn't one of those nights. A twenty year old man, presenting psychotic for the first time, was seen by the crisis team. Because he was threatening to damage his home and himself, he should have been admitted. He refused medication. Fortunately the neighbour, who has some medical experience, was able to sit with the family all night until this morning.

I thought this situation was quite dangerous. Our only alternative, if things went wrong overnight, was to ask the Police to care for him. To arrange a bed we have transferred yet another not-quite-ready patient out of the intensive care unit and arranged for two patients to go and stay in a motel. They can be supervised by the crisis team. One patient thought it was a great idea, the other was upset but accepted the situation. So now there is one free open ward male bed!

I talked to some other patients about extending their leave in the weekend but they didn't want to. One was very distressed about the idea of changing plans and started to express psychotic beliefs she had not been previously voicing. We have to remember how extremely fragile psychiatric patients can be in the "convalescent" stages. Discharge too early often results in the patient decompensating and having to return to the ward.

As I went in to organise things this morning I met Nurses escorting the second to last patient discharged from the intensive care unit back to the open ward. She had absconded in her nightie.

This is a typical weekend scenario. I don't believe we can tell whether we need additional general acute beds until we have the problem of *outflow* sorted out.

Rehabilitation and convalescent beds and long term supervised accommodation need to be available for consumers of Mental Health services. We cannot separate their physical, environmental and spiritual needs from the Mental Health needs. Each influences the other and unless all issues are addressed, our clients will be unable to maintain wellness and will continue to put enormous pressures on this already stressed system.

We hasten to add that when we sought Dr Perkins' permission to reprint her submission she emphasised that nothing in it should be construed as a criticism of staff. They were, she said, working under difficult circumstances.

The fact that acute services are in a chaotic state is a sign that support and treatment services in the community are inadequate or non-existent. Another alarming spin-off from this situation is that often, clinicians will make a judgment based on the availability of resources rather than the needs of the patient. Often staff have been advised to "discourage" admissions due to lack of beds.

Sometimes a less acute patient will be discharged so that the bed space may be utilised by someone who is "more acute" than the patient being discharged.

We believe these practices to be ethically unacceptable and, in making that observation, we express considerable sympathy for clinicians and staff who should never be confronted by that ethical dilemma.

Two District Inspectors in the Wellington region write of similar concerns:

> **We should say that the present acute in-patient unit at Pineview Clinic functions highly. However its functioning is compromised by a lack of access to step-down units closer to home communities. Its functioning is also compromised by what we consider to be an improper use of the facility. For example, we have seen a number of persons coming into the unit with a primary diagnosis of intellectual disability, or who are psycho-geriatric, or who are disturbed adolescents (some as young as fourteen years old). The unit meets the needs of these disparate groups as best as it can, but there are neither the specialist resources nor the training available to provide appropriate treatment or specialised assessment for these patients.**
>
> **We see many patients on a cycle whereby they are acute in-patients for a relatively short period, are discharged into the community and are readmitted some weeks or months later. This may occasionally be the optimal management for such patients, but it often reflects a lack of crisis support and insufficient continuing support. The constraints in in-patient acute beds mean that respite beds are rarely available and so a person is not readmitted until matters have escalated. The difficulties in continuing support have a number of aspects. One is the caseloads of community based Mental Health workers. Another is the apparent lack of social workers with relevant Mental Health training.**

> **Another is that the fragmentation of service delivery which the shift to the community entails, means that it is harder to ensure consistent standards of delivery of service, it becomes more necessary to co-ordinate service delivery with other State and private agencies, and it is harder to provide clinical leadership.**

The District Inspectors noted that their submission was not to be taken as a criticism of the DAMHS in the Wellington region.

A wide range of services attracted unfavourable comment. We can do no better than to quote the submissions directly.

A group of in-patient nurses:

> **While functional assessments may reveal the need for twenty four hour care, there is no access to this level of care in the Wellington region. Boarding houses offer a poor physical environment with shabby decor, tiny bed space and shared kitchen facilities. That results in clients having to dine out at the soup kitchen or at McDonalds. Many boarding houses have become backpackers and clients have had their food stolen from the fridge. Many of our revolving door clients require Levels 3 and 4 accommodation. Lack of availability of this level of accommodation has led to some clients occupying an acute bed for three months. In some cases they have been discharged back to the night shelter.**
>
> **Changes in accommodation impact on Mental Health service provision because staff need to do more extensive budget checks, set up auto payments to help clients manage what little money they have, act as advocates with rent evictions and support clients applying for assistance from Income Support - these are often factors that precipitate admission. It is significant that the winter months, August - September, are the peak admission times for in-patients and the time of greatest pressure on beds. The contracting out of accommodation to private individuals or organisations has led to poor continuity of care management, particularly where the staff involved have no training / experience in Mental Health. One 15 bed hostel was converted to an 8 bed medium term rehabilitation facility staffed by workers with no Mental Health qualifications or experience. Clients still must have a Mental Health key worker who must provide or organise care if the person deteriorates.**

Waiting lists are long. A client admitted to hospital for medication adjustment has needed re-referral to return there.

A client on compulsory treatment and hospitalised for nearly three months intensive treatment (including depot medication because of repeated non-compliance) was being encouraged to change to oral medication shortly after arrival, undermining his in-patient care.

Dr John Adams:

We would submit that the environment for providers of psychiatric services is not supportive. The work is very hard with few rewards, services are vulnerable to economic pressures and patients cannot be powerful lobbyists themselves.

We believe that the Ministry and RHAs should have a more active role in supporting, protecting and encouraging service providers. We would also submit that patient choice in psychiatric services is inadequate.

Dr Dick Burrell of South Auckland, Consultant Psychiatrist:

Many psychotic episodes are already manageable "at home" but a safe community service can only be run if there is sufficient back up in the form of available respite or acute admission accommodation. This is clearly not the situation in New Zealand at the present time as is evidenced by the difficulty in obtaining admission to hospital, even for the acutely mentally ill, resulting in suicides and other matters leading to the present Inquiry.

Recent newspaper publicity about the suicides of young people for whom family members were unable to obtain safe accommodation, is a national disgrace. Anecdotally, I have been Consultant on call for South Auckland at the weekend when there has been only one acute bed available in the entire Auckland region. Scuttlebut has it that, on a recent weekend, there was no acute psychiatric bed available in the North Island! One can only think that "heads must roll".

There may well be enough accommodation for the strictly acute psychiatric admissions, but all do not recover in the notional three weeks allotted, and may require many weeks or months. Most acute units become clogged with longer stay patients whom they cannot move on. Some patients remain chronically disabled and need structured care. One hopes that future developments in psycho-pharmacology will reduce and even eliminate this group, but at this time, they exist in reality and will not simply disappear, as much as the planners and administrators wish they would. In summary then, urgent needs are:

- **Early and unfettered availability of new anti-psychotic drugs as these are developed**

- **Respite beds in the community which are available in the catchment area of each CHE**

- **Asylum-type care for those who cannot exist safely in the community, even with much support. Unfortunately there are still people who need such care in the proper sense of the word "asylum". At present we are seeing a return to the community neglect which led to the development of asylums in the first place.**

- **More structured in-patient beds for assessment and rehabilitation both in the CHE and forensic services. Some will need to be closed wards. Forensic services' current fifty nine beds, fewer than recommended in 1988, are clearly insufficient in 1996**

NZ Police National Headquarters:

Police feel frustration at dealing with the same mentally disordered person on several occasions. One salient case involved a patient who was taken off bridges on some seven occasions by Police, several of whom put themselves at risk and were formally commended for their actions. The patient eventually "fell" to her death from a motorway overbridge. Apart from the above case, four patients "fell" on to the Auckland motorway system and died between September and December 1995 - three in fourteen days and two in twenty four hours - from the same psychiatric institution.

Police believe that a greater level of security, coupled with less emphasis on returning patients this ill to the community, may prevent further tragedies of this nature.

A nurse comments:

There are a variety of shortages of community resources, ranging from simple boarding houses and rest homes to specialised units. In addition, other resources are needed, such as adequately funded community Mental Health centres. They need adequate space for interview rooms instead of talking to people in corridors and waiting rooms.

They need twenty four hour crisis coverage; the current system doesn't work because people don't answer their pagers. They need increased funding for Psychologists so that people don't have to wait months for counselling. And they need higher staffing levels so that case load numbers can be lowered, to the benefit of consumers who will then be able to see their key worker when they need to, not when they can be fitted in.

Brent Doncliff is the Manager of the Community Mental Health Service at Timaru:

In many smaller areas there are only on-call DAOs available to respond to crisis calls. With the increasing pressure on in-patient beds, there are many people who are being prematurely discharged from hospital psychiatric units. Mostly they go back home, rather than into supported accommodation, as there is none or very little available.

It is a big step to go from a twenty four hour acute care facility back home, where you may only be visited by a health care worker once or twice per week, depending on Clinician work loads. There is a desperate need for twenty four hour staffed, supported accommodation in the community and the RHAs need to allocate funding for such services. Continuing care services in this area are stretched. We in South Canterbury cater for a population of 68,000 people, and have travelling times of over two hours to the most remote parts of our catchment.

The West Auckland Shared Vision group note:

> **The integration of statutory services and Levels 3 and 3+ beds provided by NGOs needs to better co-ordinated. There is currently a disincentive within the funding system for clients to move through the Level 3 beds when they no longer require that level of input. This is caused by funding being on a *per client* basis rather than on a capacity model. There is a disincentive for people to access very difficult clients, because of the funding implications, or to move settled clients through to a less supported environment. There needs to be more work done on the needs of the long term mentally ill, a small group of whom will require beds for life.**
>
> **Current practice is that people from this group end up either within acute services, blocking an acute bed, or commit some crime and end up within forensic services. This creates massive bed blocking within both forensics and acute services, and clogs the whole system. Greater flexibility needs to be developed in terms of contracting to ensure that adequate residential accommodation can be purchased for these individuals.**

The Hutt Mental Health network submitted:

> **The policy of providing a minimal number of acute beds for those most seriously ill, not only pre-supposes a range of alternative services for those not so ill, but in need of some help, it also means that consumers usually, or often, have to be eligible for compulsory treatment before they can gain access. The lack of alternatives can sometimes lead to an "all for nothing" situation for many who seek voluntary treatment and have significant needs, but may miss out on any service because they are "not sick enough".**
>
> **Imagine orthopaedic patients with simple fractures being denied treatment because there are only enough resources or beds for those with compound fractures. We support the development of acute day hospital services and community treatment options, but they still do not provide enough services to meet the needs. The solution is to match acute services with current demand and apply the beds : population ratio only when a comprehensive range of services is available.**

Restricting acute services before this point is reached is premature and leads to significant service gaps.

Nurses working in the community:

Community Mental Health teams are not sufficiently resourced to meet the demands. Acceptable standards of care require that community team members have reasonable case loads (maximum of 20 - 25). This ensures that team members have some response capacity in a crisis. It also means that cover can be provided where a team member is on leave or sick. Staff are being asked to take twice that number, an amount that precludes assertive follow up. In order for there to be continuity of care, there needs to be a prompt pick up of clients referred from the acute in-patient area.

At present our community teams require a one year history of mental illness from the first contact with psychiatric services. The out-patient units, who pick up more short term clients, have lengthy waiting lists. Examples from last year were an average eight week delay, twelve weeks for a psychologist and six weeks for occupational therapy.

Delays can be attributed to the slow replacement of staff who leave, e.g. an Occupational Therapist resigned in March, the position was advertised in July and readvertised in December. Community teams have been informed that two Nurses who transferred to an emergency team will not be replaced. Staff from the out-patient unit have been anticipating joining the community teams but the setting up of bases has already been deferred from September to February. Delays have been attributed to funding difficulties as well as problems in finding suitable bases. In the meantime, uncertainties have led to staff resignations.

A nurse:

The respite service offers an alternative to hospitalisation when patients or their families are in need of respite, and when the illness has not progressed to the extent of needing admission. Of course this is not always possible and admissions are arranged if the respite option doesn't work.

It was not intended that this service offer some sort of de-facto admission service but recently, patients from our unit have been discharged into the care of the respite team to allow bed space to be created for those more in need of in-patient care? The respite service has become the crisis team for our own service.

The Auckland Council of Psychiatrists expresses its concerns:

Of real concern is the fragmentation of service provision. There is a plethora of different organisations providing services. This greatly increases the time and effort required for communication and co-ordination. In Auckland, NGOs may have to negotiate with three different CHEs. NGOs tend to cope poorly with the severely ill, especially if their behaviours are disruptive or dangerous. CHE services thus manage these people, often without adequate resources, e.g. long term CHE-provided accommodation, combined treatment and rehabilitation facilities. There is a completely artificial division between clinical services and accommodation, and this is most noticeable where people are most disturbed and unco-operative. Offering non-clinical providers more money is simply not the answer.

Accommodation which has adequate clinical input to manage and contain the most difficult people must be provided. In this situation solely focussing on their "disability" is irresponsible. They need treatment and accommodation concurrently for a prolonged period. NGO services are unevenly spread geographically, therefore certain CHEs have easier access to them than others. (The NGO may also put a greater work load on community teams in their area).

Boarding houses and supported homes are often poorly monitored and abuse of their residents occurs, not infrequently. There is extremely poor accountability to the purchasers. In addition stressed, overworked CHE services have had to erect barriers around themselves. This has resulted in people having difficulty accessing necessary services, and in sub-optimal co-ordination of both individual care and overall service provision. With better resourcing, this is improving but still remains an issue. Blaming Mental Health services will not solve the problem.

While services must develop better accountability, the community has to decide what level of adequacy of Mental Health service it is willing to purchase. We experience a philosophical rift between clinical staff and the purchaser (North Health). It is our opinion that North Health has an oversimplified, ideology-driven view of people's treatments and personal needs. We think they are minimising the expertise required to assess a person's mental state accurately and to develop a treatment and rehabilitation strategy. Our concern is that less adequately trained personnel will be employed instead of appropriate clinical staff.

The Aotearoa Network of Psychiatric Survivors:

There is a remarkable consistency in service users' views about the services throughout the world and between cultures. People want services that will restore them to full citizenship and enable them to participate in the community of their choice. We want services to facilitate opportunities to regain the social and material opportunities we have lost, rather than to just treat our illness. Most of our needs are identical to anyone else's - a liveable income, secure housing, work, friends, intimate partners and self esteem.

People want voluntary services, not coercive ones. We want the power to decide, or at least influence, government policy, purchasing processes and the actual delivery of services. We want the skills and resources to run our own services. Many survivors find that Mental Health services are over medicalised. Most experience medication to be of limited, or no help. There is a great demand for counselling and psychotherapy which are not often freely available to Mental Health service users, despite the fact that people who use Mental Health services have frequently suffered trauma, both as a cause and as a result of their psychiatric condition.

Outcome measures for people using Mental Health services are important. There is a danger though that the desire to match outcomes to dollars will mean that outcome measures are over standardised and do not fit all individuals. We believe that outcomes need to be generated by individuals and their unique set of needs and wishes, not by generalisations about peoples' needs or by what services are willing, or able, to deliver.

The health reforms have created, or at least aggravated regional inconsistencies in the kinds of services to which people have access. A blatant example of this is the fact that Clozapine is not subsidised in all parts of the country. Consistency should be one of the major objectives for a taxpayer funded health system - it is even more important than choice. We note that choice has been one of the values that have driven the health reforms, but these days there is very little talk about consistency.

We think the lack of consistency has been, in part, generated by the weak accountability processes in the new health system, from the Ministry of Health down.

The Ministry's policy guidelines to the RHAs, on which they base their purchasing plans, are too vague to enable much meaningful compliance or accountability. We understand that the Ministry then negotiates their funding agreements with the RHAs, based on the purchasing plan and that the funding agreements also lack sufficient detail. We are also concerned that purchasing decisions do not appear to be monitored by the Ministry and that the Tenders Act prevents the RHAs from giving the public any details about prospective providers who have submitted proposals, thus denying the public input into who should provide services. We are also concerned that not all of the RHAs are actively monitoring the quality of the services they purchase.

There are also indications that some of the Crown Health Enterprises are using some of the new Mental Health money for other services.

In addition to the weak accountability processes, there is a lack of useful, quantifiable information on the use of Mental Health services on which to base policy directions and purchasing processes. The Ministry of Health needs to take more leadership and, if necessary, become more directive with the RHAs. For instance the Ministry should be empowered to tell the RHAs to ensure Clozapine is subsidised in all regions, rather than to just recommend it. The Ministry also needs to monitor RHA purchasing and monitoring processes. If this does not happen, services throughout the country will continue to be of varying quality and quantity.

Framework Trust:

> **Mental Health services are under resourced and under co-ordinated. Increased resourcing needs to be focused on the facilitation of staff training, and include the development and the prioritisation of social, activity and vocational services. Co-ordination of care for people who are most seriously ill or whose illness is compounded by addictions or difficult behaviours, is required.**
>
> **There needs to be a consistent national policy and guidelines to ensure that RHAs and CFA can purchase prioritised services. An integrated approach is required that includes the patient, family and others involved in providing care. Such an approach must ensure better communication between agencies. More staff are required in Mental Health services, and more pre-acute and forensic beds are needed. There is also a need for more accommodation that is responsive to consumer need and based in the community. It needs to be provided at all levels and, in particular, for people who have addiction and behavioural problems. Specialist services need to be developed for the treatment of dual diagnosis. When addressing Mental Health problems it must be recognised these issues do not occur, and cannot be treated, in isolation but are symptoms of wider social ills.**

The method by which services are purchased aroused much comment. The Association of CHE Mental Health Managers noted that the concept of purchasing and providing, with the associated idea of competition and market forces, was not a helpful one to Mental Health services at this stage of their development.

The submission continues:

> **Individuals often have multiple problems and require multiple interventions - some of which may be provided by other agencies, other CHEs or other providers. One of the key requirements to providing good quality care is a high level of co-operation and working together by all parties involved with an individual, including families and carers. Co-ordination of these efforts is a major task already fraught with difficulty. Superimposing the idea of competition between providers makes the good co-ordination of services even more difficult.**

The short nature of most contracts introduces a level of anxiety amongst providers that is not healthy, and does not encourage a provider to either invest in relationships with other providers or in its work force. There needs to be recognition of this by RHAs and Government with the awarding of longer term contracts and increased use of the concept of "preferred provider".

The relationship between purchasers and providers appears to be poor. The respective roles, constraints and expectations are not understood and there is a real antipathy developing between the two sets of organisations. Providers believe they are neither listened to nor their needs understood by the purchasers. Purchasers, on the other hand, appear to believe that providers are institutional in their thinking and only interested in the dollar. The differences between policy and delivery of services is either not understood or ignored. There appears to be a predominant view among purchasers that the private and NGO sector is to be developed whilst the CHEs are sidelined. Instances have occurred where services are purchased that clearly have an impact on what a CHE is already doing, and yet no consultation is even attempted.

Peter Browning of Homes commented on the number of problems which exist between community providers and the RHAs. He believes that this is generally due to poor consultation on behalf of some RHAs. He continues:

For some reason the RHAs seem reluctant to involve providers in their planning issues. We have felt this to be because the RHAs believe providers will look after their own interests. Given that most providers are in fact not-for-profit and have set up for philosophical reasons to benefit consumers, this is false reasoning and the lack of consultation leads to many frustrations because providers are continually in the dark as to RHA intentions.

Access to RHA staff is a problem for providers outside of the main centres. Their staff do not visit provider sites very often and providers are concerned that the RHA is therefore unaware of the quality of the services they are providing. This has spin-offs when contract pricing arises. The typical model is to be told the price you receive for a service.

It is our view that this is often done on inadequate information, though we believe the information is reasonably readily available. While the RHAs often base their tenders on the competitive model, the truth of the matter is that community providers have been underfunded for numbers of years and cannot offer services at lower prices than they currently receive. We are unable to provide figures but we are aware of a large number of providers going out of business over the last few years because of financial difficulty. This was not because they were poorly managed, but the funding base was inadequate for the task. Even now many trusts survive by fundraising and applying to philanthropic trusts for vehicles and funds to meet refurbishment or operating costs.

The nett effect of all this will be an increased need for basic financial support of providers. There is real concern that price is playing too large a part in the picture and that the RHA is seeking to obtain services a a price well below that which is considered reasonable to provide a quality service.

Dr Dick Burrell also criticised the lack of consultation:

The purchaser / provider split does not allow competition from the private sector and the provision of a range of options, so does have some advantages over provider monopoly.

Its successful operation in Mental Health services depends upon the competence of the purchaser in knowing what should be purchased. To this end, consultation with community groups and clinicians should take place in reality and with more than mere lip service being given to the process. It is noteworthy that the South Auckland Division of Psychiatry, comprising the Psychiatrist Clinicians in the district, has not met with the RHA in more than two years, despite the Division's request for such a meeting. The consequence has been that decisions are made and clinicians often told afterwards.

A Community Health Manager notes:

> **The attempt to create a competitive market place flies in the face of services which, in the past, have worked co-operatively, collaboratively and with a great deal of good will. There is an inter-dependency, at both local and national levels, that is essential to effective service development and must be acknowledged by the Ministry and the RHAs.**

Ken Whelan is the Manager of Mental Health Services in Whangarei:

> **Currently there is no requirement for the RHA to enter into a consultative process with the DAMHS when planning services or funding services in a particular region. If the DAMHS feels that more resources are required for patients covered by the Mental Health Act, he / she has no direct recourse to the RHA for such services to be established. On the other side, if the DAMHS feels that a given service in the community is inadequately serving compulsory patients, he / she would appear to have no authority over local service providers except a complaint to the RHA. DAMHS are frequently in the best position to evaluate the quality of local services being provided, yet are rarely, if ever, consulted by the RHA about funding or refunding decisions. One solution would be to require the RHA to consult with the DAMHS and for the DAMHS to have a role in approving local contracts for Mental Health services.**

Dr Irving Baran practised adolescent and adult psychiatry in the USA before coming to New Zealand four years ago. He is the DAMHS with Good Health Wanganui:

> **Consultation regarding community needs continues to be inadequate. Methods of consultation and assessment of needs have been superficial, arbitrary or reactive to extraneous pressures and unsubstantially based. Clinical Directors of Mental Health services and DAMHS have, by and large, not been consulted. Purchasing indicators as well have been poorly based and defined. For example, so called "contacts" for community Mental Health are poorly defined and do not take into account degrees of complexity, collateral involvements with other than the patients and the varied Clinicians, as to who is making the contacts. Documentation and clinical meetings are not realistically considered.**

> **One of the major problems with the RHA is that it contributes to a general sense of instability and insecurity because of their contracting process. Not only are contracts for an unrealistic short term, which calls for spending a large portion of the year in negotiation and keeping people and programmes up in the air, but results in an excessive amount of time taken away from providing needed services. Very often contracts are given for various community services to agencies outside of the CHEs and without adequate assessment of the capabilities of these agencies to provide the necessary services that are contracted for. There is need for overall co-ordination to provide continuity of services, particularly with the main Mental Health services in a region, that of the CHE's. Inadequate provision of care in the services results in the Mental Health service of the CHE having to provide care for patients who decompensate or regress in their condition. Although the ultimate responsibility will fall back on the Mental Health service, their involvement or authority for the care of these patients in these agencies is limited or nil.**

The Catholic Commission for Justice and Peace assert that:

> **It is also the Commission's view that the current system of purchasers and providers, with its associated ideas of market forces and competition, is not conducive to ensuring a comprehensive and holistic Mental Health service. Most people accessing Mental Health services present with multiple and complex needs, requiring a wide range of co-ordinated interventions. Superimposing the idea of competition between providers detracts from the high level of co-operation needed to provide good quality care, and makes the co-ordination of services even more difficult.**

The joint submission of the PSA and the New Zealand Nurses Organisation expresses a similar sentiment:

> **The system of RHA purchasing, combined with contestable contracting in the Mental Health field, has led to a fragmented service. Fragmentation occurs at local, regional and national levels. Fragmentation leads to a lack of communication between different providers of services and to poor co-ordination of services.**

James (not his real name) is a consumer of Mental Health services. He works for a small organisation, the purpose of which is either misunderstood or regarded as irrelevant:

> **This group has been functioning on the sole purpose of trying to meet consumers' endless needs, which range from requests over the telephone to people in genuine distress in their homes and even traumatised by the "system" in hospital (whom we visit).**
>
> **Over the years we have repeatedly made numerous requests for funding assistance to our local RHA and local branch of the New Zealand Community Funding Agency, but to no avail. They not only don't recognise the desperate need for our group in this city, but they don't even appear to know its purpose.**
>
> **Because of this, in a way I feel maybe we are victimised because we are a totally consumer driven organisation.**
>
> **At the moment our staff only consists of two and we work consistently without any lunch or tea breaks, weekends and after hours, on wages that certainly don't suit our qualifications, work conditions or hours of work.**

The National Association of CHE Mental Health Managers told us that the lack of national co-ordination and uniformity of service delivery is particularly apparent in four specific areas:

i. Recruitment, training and retention of a highly skilled work force.

ii. The lack of information systems which identify, on a national basis, what needs to be done and to whom.

iii. An unco-ordinated administration approach at national level which results in a duplication of resources, little or no audit and monitoring, inconsistent interpretation and implementation of the various Acts and guidelines and lack of standardisation of forms. They note that monitoring a service is difficult because an overall implementation system does not exist.

iv. There is poor, if any, benchmarking taking place. Outcomes are not clear and services are not focused on them.

We agree with the Mental Health Foundation who note that the need for a vastly improved Mental Health database has clicked away like a broken record.

The inadequacy of audit and monitoring procedures attracted comment from other sources.

The Schizophrenia Fellowship (Nelson branch):

> **Many family members, Mental Health workers and other service providers are concerned about the lack of monitoring of services, service quality and service achievements. Many new ideas are being trialled, but it is difficult to make comparisons as there is no data about success rates. CHEs are not monitored for service provision or financial accountability. Has the extra money that has been provided by RHAs for Mental Health services actually resulted in an improvement in those services? It is not possible to quantify any changes due to lack of meaningful data. An audit system should be established to ensure that their purchasing guidelines are being followed.**

Dr David Chaplow of Auckland gives another slant on accountability:

> **Out of the three main players, the Ministry, the RHAs and providers, only the providers are held accountable for their actions, vis a vis, the patients. In spite of this, the provider groups have minimal say in what is to be purchased, particularly the CHE providers, on the grounds of fear of "provider capture". System changes occur through the lengthy process of the contracting cycle, policy decisions or Court directives.**

A Psychiatrist in a metropolitan region is also concerned about the lack of accountability:

> **There should be a better form of accountability than currently operates between the CHE, which is spending public money, and the public who are, in truth, funding them. The RHAs are not seemingly in a position to assess the quality of the services they fund and, in reality, no one is (apart from the Clinicians and clients) because data collection focuses only on quantity. In the past, the Clinicians themselves saw to the quality and were able to do so because they had a measure of control over the resourcing. Now that this is so emphatically not the case, it seems that no one is interested in quality, i.e. no one who can have any real influence on it.**

This can be changed only by manipulating incentives via structural changes which should include direct public representation on the Boards of the CHEs and RHAs.

Implicit in much, but not all of the above, is the huge need for more expenditure within the health care delivery agencies - not the RHAs and the CHE bureaucracies, but where the work of caring for the mentally ill is done. For example, in our centre we need twice as many Clinicians and five times the floor space to delivery a truly excellent service.

My fear is that given the current structures, even if the Government were to give the RHAs more, very little of that would emerge at the other end, actually improving patient care. Nevertheless, more money is definitely needed.

We leave the last word on this topic to a Mental Health worker in a provincial centre:

There is an audit system but flaws are clearly apparent. This is demonstrated by a local house receiving an "excellent" rating despite:

i. having no qualified staffing policy;

ii. having a harsh employment contract with no sick leave for part time supervisors and 0.25 pay for sole charge night supervisors; and

iii. having Level 3 category patients when only set up to care for Levels 1 and 2.

This type of thing is precisely why we are finding patients out on the streets, unsupervised and in the news headlines, often in tragic circumstances.

Several submissions also noted the lack of interface between Mental Health services and others involved with the sector.

The Children and Young Persons Service, Police, Corrections, Ministry of Education, Housing organisations, Inland Revenue Department, Community Funding Agency, ACC and others were cited as organisations with whom the Mental Health sector should have a closer and more responsive interface. Several submitters noted that quite often people need co-ordinated and multi-agency assistance by people who are highly trained and experienced. They emphasised the need for widespread co-operation.

One CYPS official noted that his was a service of last resort:

> **In our region we have found it too difficult to access Mental Health services. We have no expertise or facilities to cater for mentally ill young people. It's a disaster.**

A mother caring for children with mental health difficulties best captures what happens when services are fragmented or unco-operative:

> **Providers of Mental Health services must not engage in games of power with one another. The client and his family end up being worse off. Services must not be in competition; they must complement each others roles, not compete against them.**
>
> **In our case, the Children and Young Persons Service and the Child, Adolescent and Family Mental Health Services were openly antagonistic toward each other. CAF criticised CYPS verbally to me, deliberately withheld critical information CYPS had requested and told me they were intending to withhold it. CYPS criticised CAF, also to me.**
>
> **I had enough to deal with without being involved in their stupid, pointless power games. I have copies of both the CAF and the CYPS file notes, and both services have documented antagonistic comments towards each other in their own notes.**
>
> **There was no consultation between CYPS and CAF regarding CAF's presence being required for the first Family Group Conference.**
>
> **When FGC invitations were being prepared, I asked CYPS to consult with and invite CAF to be present. Shortly before the FGC date I checked with CAF that they would be there. They said they hadn't been invited. I then asked CYPS again to contact CAF. When they finally asked them to be present, no consultation took place regarding the time or date.**
>
> **CAF told me they would not be attending as CYPS had "not bothered to consult with them on the timing of the meeting" and that "Thursday was their team meeting day so they couldn't possibly attend".**

COMMENT: Anyone reading this chapter might be excused for believing that we have set out to highlight the absurd, the unusual or the bizarre. That is not so. During the course of this Inquiry we read over 700 submissions and we met with large numbers of Mental Health workers, consumers and their families from Bluff to Kaitaia.

The descriptions referred to in this chapter were repeated, with variations, throughout the country. We acknowledge that in some places there are pockets of excellence which may not fall within some of the scenarios described above, but in general we have represented the state of Mental Health services in New Zealand. We make no attempt to summarise the contents of this chapter. What can be said for certain is that all services including crisis support, assessment, treatment and continuing support are fragmented and under resourced, both in skills and size. Co-ordination, in many services, is non-existent.

Dr Sandy Simpson correctly noted that:

> **Any service which has any pretence to quality for those with chronic mental illness and provides key workers with caseloads in excess of twenty and Psychiatrists, caseloads in excess of sixty, does not understand the needs of these people and their carers for assertive and committed follow up.**

The comments made in the numerous submissions quoted in this chapter will come as no surprise to those who work in or access Mental Health services. The deficiencies have been recognised for years, and that poses the question as to why they have not been remedied. No doubt there are varying inter-related reasons as to why this state of affairs should have been allowed to persist. We accept that inadequate funding and the advent of the health reforms accompanied by a new model for purchasing services have been significant contributors, but we cannot avoid the simple conclusion that the answer is a lack of leadership at national level.

Two DAOs informed us:

> **Where are we going in Mental Health? We don't know and we wonder if anyone does. As a consequence of the lack of a clear national vision, we have a range of piecemeal initiatives.**

Dr David Chaplow is the Director of Regional Forensic Services in Auckland:

> **In operating a service over a region as our service does, it is very clear that *no one is in charge* for the supra-region, i.e. no one is accountable for the cohesion of services. No one is responsible for plugging the gaps as they invariably appear from time to time. While the Ministry will advocate (strongly) on behalf of certain matters, they have limited jurisdiction, apart from the MHA, accepted policies, the contracting cycle and the prerogative of the Director making a directive.**

We are reluctant to dwell at length on this subject, but it must be recorded that the lack of leadership at a national level was one of the two topics, above all others, which permeated this Inquiry. Persistently and consistently the criticism was directed at the seeming inability of any one organisation to translate the National Mental Health strategy, which was widely approved by the sector, from a vision statement into a fully functioning, prestigious service.

It is hardly surprising, in the absence of some visionary leadership, that services have developed in an ad hoc fashion. Providers are entitled to know what type of service they are expected to provide. They are entitled to know the benchmark levels of service, the time frame within which those benchmarks should be achieved and they must also be prepared to have those national benchmarks evaluated and monitored. Not to do so - as a matter of urgency - will result in a continuing disintegration of the Mental Health service.

The Service is entitled to better. It is entitled to a greater priority and level of commitment from Government, the Ministry of Health and the RHAs. Above all else it is entitled to a new organisation, clearly mandated, which will deliver a quality service within five years.

CHAPTER EIGHT

A NEW ORGANISATION

As we indicated earlier in this report, there is a need for Mental Health to be given a greater sense of commitment and priority by Government, the Ministry of Health and the four RHAs. There need to be incentives, including increased funding, to improve performance, and sanctions if that performance is defective. There is an absence of positive innovative leadership in the Mental Health sector. No one organisation appears to have the mandate to implement Government's Mental Health Strategy.

We believe it is now necessary to establish a new organisation that can act as a catalyst to improve performance and lift the priority given to Mental Health in New Zealand. That organisation should provide the necessary leadership for creating a culture of good Mental Health services in New Zealand. For that to be achieved, the organisation will need to be independent, well resourced and have sufficient powers to make a difference. The organisation needs to be one that can infuse the whole sector with a sense of vision and purpose.

Functions the new organisation should not have:

The new organisation ought not to be one that is the receptacle for complaints about the system. If that occurred, it would become diverted from what we consider to be its prime purpose.

This point is of some importance. The Health and Disability Commissioner Act 1994 defines health as "human health". All aspects of Mental Health are embraced within this definition and the complaints procedure erected in that statute would apply to the Mental Health sector. In addition the Act extends to hospitals within the meaning of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and thus sufficient scope already exists for members of the public to complain if they so wish. Separating out Mental Health complaints would be problematic.

Furthermore, we believe that the legislative checks and balances afforded by the Mental Health Act should remain intact. Ample scope exists to ensure that legitimate complaints may be dealt with.

We note that:

- There is a National Strategy for Mental Health. In June 1994 Hon. Jenny Shipley outlined the goals, principles and national objectives in "Looking Forward : Strategic Directions For The Mental Health Services"

- Many of the shortcomings and defects in the delivery of the Mental Health services have already been identified

- The Ministry of Health has issued policy guidelines to the four RHAs for the purchase of Mental Health services

- The Ministry of Health have issued several guidelines relating to good clinical practice

- There are several models of good service delivery, both nationally and internationally to which the Mental Health sector has ready access

- What is now required is the efficient and effective implementation of all these matters and the other components in the Mental Health strategy to ensure the delivery of a world class Mental Health service

- Mental Health services are often insufficient or inadequate, and always under funded. In some areas services are non-existent. They are frequently inconsistent with one another and inaccessible to those whom they are designed to help. There is a high degree of fragmentation in the field. Often inappropriate treatment or the refusal to treat, result in outcomes which consumers and families regard as inhumane. The lack of national leadership, inadequate resources and underfunding has resulted in many of the services being poorly planned.

In our view there are a number of significant elements in the Mental Health sector which must be attended to if we are to have even an adequate Mental Health service. These include:

A. Leadership and Setting Priorities

1. The provision of national leadership and direction in the delivery of Mental Health services which will include:

   i. the development of a nationally standardised system for needs and service assessment; and

ii. the review and implementation of "Looking Forward : Strategic Directions For The Mental Health Services"

2. The promotion of research to enable planning on an informed basis for Mental Health needs in New Zealand

3. The identification of priorities which will result in an efficient and effective Mental Health service, and a plan of action for the implementation of those priorities

4. Promoting a unity of purpose and vision in all parts of the Mental Health sector so as to provide better Mental Health services for those who need them

B. Co-ordination of Mental Health Services

1. The co-ordination of services to ensure that people do not "fall through the cracks"

2. Avoiding duplication in services

3. Ensuring that both providers and purchasers consult so that appropriate services are made available to those who are mentally ill

4. Ensuring the equitable distribution and availability of Mental Health services throughout New Zealand

5. The promotion of a positive image of Mental Health by public education and better community understanding

C. Oversight and Monitoring

1. The promulgation of national standards and guidelines and common purchasing definitions for an optimum Mental Health service

2. Ensuring compliance with Mental Health, Privacy and other legislation by appropriate education and training

3. Ensuring that funds allocated for Mental Health services are appropriately spent on those services and that such expenditure is monitored

4. Ensuring all services are user friendly and humane

5. Ensuring that Mental Health services are responsive to the cultural needs of those who use the services

6. Ensuring the meaningful participation in the planning and delivery of Mental Health services by consumers and families

7. Ensuring that the best use is made of the available resources and personnel

D. Mental Health Staff

1. The oversight of recruitment, training and retention of a highly qualified work force in the Mental Health sector

2. Advocating to improve working conditions in the Mental Health services

E. Promoting Mental Health

1. Promoting and encouraging initiatives, models of excellence, innovative ideas and practices

2. The promotion of co-operation and mutual respect among all sections of the Mental Health community

F. Legislation and Policy

1. Scrutinising legislative proposals and policy changes that may affect those who are mentally ill, and acting as an advocate for such persons within the policy making establishment

2. Ensuring co-operation and co-ordination with those sectors which may be used by Mental Health consumers, e.g. Justice Department, Police, Children and Young Persons Service, Housing, Community Funding Agency, Inland Revenue Department, etc.

3. Providing policy advice to the Minister

G. Parliament

1. Making an annual report to Parliament on the provision of Mental Health services

Sunset Clause:

The objectives set out above are wide-ranging and extensive. They will not be easy to achieve and the resources necessary to do so must be substantial. It is not desired to set up an extensive new bureaucracy, but rather our intention is to establish a small dedicated organisation that is committed to making substantial progress in delivering a world class Mental Health service in a short time.

For that reason, we recommend a sunset provision for the new organisation. It should have a life limited to, say, five years. At the end of that period, it should be reviewed to see whether it needs to continue, should be altered, or be allowed to lapse. It should be established to carry out its work rigorously, change the system if necessary, establish the new priorities and then cease if its mission is accomplished. The legislation could provide for a legislatively determined review date and cessation date for the new organisation. The benefits of such an approach is that the community may be more inclined to support the new organisation, funding may be more readily available and, in turn, the organisation may stay truer to its intentions if it is not designed to become part of the organisational furniture within government.

The design of the new mechanism:

A number of options for the design of the new mechanism have been considered by us. They are:

- A new department of state
- A single purchaser for Mental Health services
- An individual commissioner based along the lines of the Commissioner for Children
- A Mental Health Commission
- A Committee along the lines of the Core Services Committee established by the Health and Disability Services Act 1993

We review each option below.

Government Department

We recommend against a new department on the grounds that it will be expensive to operate and take far too long to establish. It would also require major surgery to be performed on the structure of government within the health sector. A new department would not fit well into existing health care structures. It would be seen to be in the shadow of the Ministry of Health and would undermine our objective of creating an enhanced status for Mental Health.

Single Purchaser for Mental Health Services

The option of a single purchaser for Mental Health services has considerable attractions as this would enable common consistent purchasing definitions to be established. It is the absence of clear definitions which has caused many of the problems experienced by providers. The single purchaser concept received strong support from the Mental Health sector including all twenty two CHE Mental Health Managers.

It is with some hesitation that we reject the concept at this stage. We are concerned that a single purchaser would have a lesser raft of functions than we envisage and we note also that CHEs would be required to deal with two purchasers. We believe that the disadvantages in operating under that system outweigh the advantages.

Mental Health Commissioner

In our view there is merit in the appointment of a sole Commissioner along the lines of the Commissioner for Children established under Part IX of the Children, Young Persons and Their Families Act 1989. In some ways the functions of the Commissioner for Children are analogous to the types of function that we want carried out in the Mental Health sector. The Commissioner:

a. could provide leadership;

b. would be independent; and

c. could be vested with statutory functions.

On the other hand, a single Commissioner in the Mental Health sector might be thought to represent one segment of a complex scene at the expense of others and this could result in a lack of confidence from some sectors of the Mental Health community.

National Advisory Board

It would also be possible to set up a National Advisory Board on Mental Health utilising sections 6 and 46 of the Health and Disability Services Act. This option has few attractions. The Board would lack potency and would not be able to accomplish all of the goals that we wish to see achieved.

OUR PREFERRED MODEL:

New Commission

In order to achieve maximum impact within a five year time frame we recommend that a Commission with three Commissioners should be established. The Commission will comprise:

a. a full-time chairperson;

b. a second commissioner who would be an experienced Mental Health professional and who may be appointed on a part time basis; and

c. a third Commissioner drawn from the lay public, but with an interest in Mental Health. Our preference would be a consumer / family representative. That Commissioner may be appointed on a part time basis.

A Commission of this nature would, in our view, pack the necessary punch bureaucratically to achieve the objectives we have outlined.

Servicing

The Commissioners will have statutory independence from Government. The Commission should be able to select the services it buys within its budget and must have the necessary flexibility to make a difference. It must have sufficient funding to enable it to purchase expertise and research. It may prove convenient, in order to carry out the necessary administrative functions, for the Commission to enter into a purchase agreement with the Ministry of Health. Considerable synergies should be available under such an arrangement which will allow the new Commission to focus its energies on achieving the objectives outlined.

Powers

We have given considerable thought to the powers that will be needed by the Commission in order to successfully discharge its functions successfully. In our view the main requirement will be power to get information and find out what is really going on. It will need power to investigate and to enquire. The powers should be limited to what is necessary. The powers ought not to be overly intrusive, coercive or broad, but they need to be sufficient for the Commission to get to the bottom of things.

We think the best available precedent are the powers given to a Proceedings Commissioner under the Human Rights Act 1993 and we have modelled the provisions relating to the powers of the proposed Mental Health Commission on that modern statute.

Separate provision should be made in the Estimates of Appropriation each year for the Mental Health Commission in a similar manner to that which is provided for the Health and Disability Commissioner.

It is essential to set out in legislative form the nature of the arrangements we recommend. The draft will require further attention from Parliamentary Counsel should our recommendation be adopted by Government but what is included here allows people to see what is intended. We have decided against including a definition of Mental Health, preferring to leave that expression to receive its broad, ordinary meaning.

HEALTH AND DISABILITY SERVICES AMENDMENT BILL 1996

An Act to Amend the Health and Disability Services Act 1993

BE IT ENACTED by the Parliament of New Zealand as follows:

1. **Short Title** (1) This Act may be cited as the Health and Disability Services Amendment Act 1996, and shall be read together with and deemed part of the Health and Disability Services Act 1993 (hereinafter referred to as the principal Act)

   (2) This Act shall come into force on the day on which it receives the Royal Assent.

2. **New Part V inserted** - The principal Act is hereby amended by inserting after Part IV the following part:

Part V

Mental Health Commission

53. Commencement and Expiry - (1) This part of this Act shall commence on 1 August 1996 and shall expire on 31 July 2001.

(2) On or before 1 April 2001, the Minister shall table a report in Parliament reviewing the work of the Mental Health Commission established under this part and making recommendations as to the future of the Mental Health Commission for consideration by Parliament.

(54) Establishment of Mental Health Commission - (1) There is hereby established a Commission called the Mental Health Commission.

(2) The Mental Health Commission shall be a body corporate with perpetual succession and a common seal and shall have and may exercise all the rights, powers and privileges, and may incur all the liabilities and obligations, of a natural person of full age and capacity.

(3) The Mental Health Commission is a Crown entity for the purposes of the Public Finance Act 1989.

(55) Membership of Mental Health Commission - (1) The Mental Health Commission shall comprise three Commissioners:

a. One full time or part time Commissioner will be an experienced Mental Health professional and a second full time or part time Commissioner with an interest in Mental Health will be appointed from the lay public.

b. A third full-time Commissioner shall be appointed as Chairperson of the Commission.

(2) Members of the Mental Health Commission shall be appointed by the Governor General, on the recommendation of the Minister of Health.

(3) The term of each Commissioner shall be five years.

(4) Any member of the Commission may resign office at any time by written notice to the Minister.

(5) Any member of the Commission may be removed from office at any time by the Governor General for disability, bankruptcy, neglect of duty or misconduct proved to the satisfaction of the Governor General.

(6) The remuneration of the Commissioners shall be determined by the Higher Salaries Commission.

(7) Any extraordinary vacancy that occurs may be filled by a further appointment under subsection (2) of this section.

(56) Functions of the Mental Health Commission - (1) The functions of the Mental Health Commission are:

a. to provide policy advice on Mental Health services to the Minister of Health;

b. to provide an annual report to Parliament on the provision of Mental Health services in New Zealand;

c. to inquire into, investigate and monitor matters relating to the provision of Mental Health services, to identify Mental Health needs and to ensure that those needs are met;

d. to purchase, or arrange for the purchase of Mental Health services, by means of purchase agreements or otherwise when authorised by the Minister of Health in writing to do so; and

e. to carry out such further functions as are necessary to give effect to the objectives set out in the Third Schedule to this Act.

(57) Appropriation - The Commission shall be funded from an appropriation by Parliament.

(58) Meetings of the Mental Health Commission - (1) Meetings of the Commission shall be held at such times and places as the Commission or the Chairperson from time to time appoints.

(2) At all meetings of the Commission the quorum necessary for the transaction of business shall be two members.

(3) The Commission may regulate its procedure in such manner as it thinks fit.

(59) National Advisory Board of Mental Health Commission - (1) A National Advisory Board of the Mental Health Commission shall be established to advise the Mental Health Commission on matters thought to be appropriate by either the Commission or the Board.

(2) The National Advisory Board shall consist of up to seven members who shall be appointed from time to time by the Minister by notice in writing after consultation with the Commission.

(3) The members of the National Advisory Board shall be persons who, in the opinion of the Minister, will assist the Mental Health Commission in achieving its objectives.

(4) There may be paid out of money appropriated by Parliament to the members of the National Advisory Board appointed by the Minister under this section remuneration by way of fees, salary and allowances and travelling allowances and expenses in accordance with the Fees and Travelling Allowances Act 1951.

(60) Evidence - (1) The Commission may from time to time, by notice in writing, require any person who in its opinion is able to give any information relevant to an investigation or inquiry being conducted by the Commission to furnish such information, and to produce any such documents or things in the possession or under the control of that person, as in the opinion of the Commission are relevant to the subject-matter of the investigation or inquiry.

(2) The Commission may summon before it and examine on oath any person who in the Commission's opinion is able to give any information relating to the matter under investigation or inquiry, and may for that purpose administer an oath to any person so summoned.

(3) Every such examination by the Commission shall be deemed to be a judicial proceeding within the meaning of section 108 of the Crimes Act 1961 (which relates to perjury).

(4) Nothing in this section shall limit any powers that the Minister of Health or the Director-General of Health has under any other enactment or rule of law.

Cf. 1993, No. 82, s. 127

(61) Protection and privileges of witnesses, etc. - (1) Every person shall have the same privileges in relation to:

a. the giving of information to the Commission; or

b. the answering of questions put by the Commission; or

c. the production of documents or things to the Commission, as such persons would possess if they were witnesses in judicial proceedings.

(2) No person shall be required to supply any information to or to answer any question put by the Commission in relation to any matter, or to produce to the Commission any document or paper or thing relating to any matter, in any case where compliance with that requirement would be in breach of an obligation of secrecy or non-disclosure imposed on that person by the provisions of any Act or regulations, other than the Official Information Act 1982.

(3) No person shall be liable to prosecution for an offence against any enactment, other than under section 64 of this Act, by reason only of that person's compliance with any requirement of the Commission under section 60.

(4) (a) Where any attendance of any person is required by the Commission under section 60 of this Act, that person shall be entitled to the same fees, allowances, and expenses as if the person were a witness in Summary Proceedings before the District Court and, for the purpose:

a the provisions of any regulations in that behalf under the Summary Proceedings Act 1957 shall apply accordingly; and

b the Commission shall have the powers of a District Court under any such regulations to fix or disallow, in whole or in part, or to increase, any amounts payable under the regulations.

Cf. 1993, No. 82, s. 128.

(62) Disclosure of certain matters not to be required - (1) Where the Attorney-General certifies that the giving of any information or the answering of any question or the production of any document or thing might:

a prejudice the prevention, investigation, or detection of offences; or

b involve the disclosure of proceedings of Cabinet, or any committee of Cabinet, being matters of a secret or confidential nature, where the disclosure would be injurious to the public interest,

the Commission shall not require the information to be given, or, as the case may be, the document or thing to be produced.

(2) Subject to the provisions of subsection (1) of this section, the rule of law which authorises or requires the withholding of any document, or the refusal to answer any question, on the ground that the disclosure of the document or the answering of the question would be injurious to the public interest shall not apply in respect of any investigation by the Commission.

Cf. 1977, No. 49, s. 129.

(63) Proceedings privileged - (1) This section applies to the Commission and every person engaged or employed in connection with the work of the Commission.

(2) Subject to subsection (3) of this section:

a No proceedings, civil or criminal, shall lie against any person to whom this section applies for anything he or she may do or report or say in the course of the exercise or intended exercise of his or her duties under this Act, unless it be shown that that person acted in bad faith:

b No person to whom this section applies shall be required to give evidence in any court, or in any proceedings of a judicial nature, in respect of anything coming to his or her knowledge in the course of the exercise of his or her functions.

(3) Nothing in subsection (2) of this section applies in respect of proceedings for:

a An offence against section 78 or section 78a(1) or section 105 or section 105a or section 105b of the Crimes Act 1961; or

b The offence of attempting or conspiring to commit an offence against section 78 or section 78a(1) or section 105 or section 105a or section 105b of the Crimes Act 1961.

(4) Anything said or any information supplied or any document or thing produced by any person in the course of any inquiry or investigation by the Commission under this Act shall be privileged in the same manner as if the inquiry or investigation or proceedings were proceedings in a Court.

(5) For the purposes of clause 3 of Part II of the First Schedule to the Defamation Act 1992, any report made by the Commission or a Commissioner under this Act shall be deemed to be an official report made by a person holding an inquiry under the authority of the Parliament of New Zealand.

Cf. 1993, No. 82, s. 130.

(64) Offences - Every person commits an offence against this part of this Act and is liable on summary conviction to a fine not exceeding $3,000 who:

a without lawful justification or excuse, wilfully obstructs, hinders, or resists the Commission in the exercise of its or his or her powers under this Act:

b without lawful justification or excuse, refuses or wilfully fails to comply with any lawful requirement of the Commission under this Act:

c makes any false statement knowing it to be false or intentionally misleads or attempts to mislead the Commission in the exercise of its or his or her powers under this Act.

Cf. 1993, No. 82, s. 143.

(65) Consequential Amendments - (1) Section 16 of the principal Act is hereby amended by inserting, before the phrase "every regional health authority", "The Mental Health Commission".

(2) Section 17 of the principal Act is hereby amended by inserting, before the phrase "every regional health authority", "The Mental Health Commission".

Section 21(2) of the principal Act is hereby amended by inserting after "the Ministry of Health", "The Mental Health Commission".

Third Schedule

Section 56(e) Objectives:

A. Leadership and Setting Priorities

1. The provision of national leadership and direction in the delivery of Mental Health services which will include:

   i. the development of a nationally standardised system for needs and service assessment; and

   ii. the review and implementation of "Looking Forward : Strategic Directions For The Mental Health Services"

2. The promotion of research to enable planning on an informed basis for Mental Health needs in New Zealand

3. The identification of priorities which will result in an efficient and effective Mental Health service, and a plan of action for the implementation of those priorities

4. Promoting a unity of purpose and vision in all parts of the Mental Health sector so as to provide better Mental Health services for those who need them

B. Co-ordination of Mental Health Services

1. The co-ordination of services

2. Avoiding duplication in services

3. Ensuring that both providers and purchasers consult so that appropriate services are made available to those who are mentally ill

4. Ensuring the equitable distribution and availability of Mental Health services throughout New Zealand

5. The promotion of a positive image of Mental Health by public education and better community understanding

C. Oversight and Monitoring

1. The promulgation of national standards and guidelines and common purchasing definitions for an optimum Mental Health service

2. Ensuring compliance with Mental Health, Privacy and other legislation by appropriate education and training

3. Ensuring that funds allocated for Mental Health services are appropriately spent on those services and that such expenditure is monitored

4. Ensuring all services are user friendly and humane

5. Ensuring that Mental Health services are responsive to the cultural needs of those who use the services

6. Ensuring the meaningful participation in the planning and delivery of Mental Health services by consumers and families

7. Ensuring that the best use is made of the available resources and personnel

D. Mental Health Staff

1. The oversight of recruitment, training and retention of a highly qualified work force in the Mental Health sector

2. Advocating to improve working conditions in the Mental Health services

E. Promoting Mental Health

1. Promoting and encouraging initiatives, models of excellence, innovative ideas and practices

2. The promotion of co-operation and mutual respect among all sections of the Mental Health community

F. Legislation and Policy

1. Scrutinising legislative proposals and policy changes that may affect those who are mentally ill, and acting as an advocate for such persons within the policy making establishment

2. Ensuring co-operation and co-ordination with those sectors which may be used by Mental Health consumers, e.g. Justice Department, Police, Children and Young Persons Service, Housing, Community Funding Agency, Inland Revenue Department, etc.

3. Providing policy advice to the Minister

G. Parliament

1. Making an annual report to Parliament on the provision of Mental Health services

COMMENT: We are confident that the establishment of a Mental Health Commission and a National Advisory Board, properly resourced, will see sustained development in the provision of Mental Health Services. The composition of the National Advisory Board will depend, to some extent, on the qualifications of those appointed as Commissioners. It is imperative that consumers and / or families be involved, at the highest level, in planning for services of which they are the ultimate recipients. There should be no room for tokenism. We envisage that representation may include Maori, Pacific Island peoples, Mental Health professionals, NGOs, consumers, families, managers, people with business skills, and "wise people" who have demonstrated an interest in Mental Health.

We express the hope that appointees will not see themselves as necessarily representing the interests of the faction from which they were selected, but rather as one contributor amongst others in the development of a quality Mental Health service.

We acknowledge that under the Mental Health Act the Director of Mental Health is vested with certain statutory rights and obligations. It is imperative not to isolate that office holder. The responsibilities of the Director are manifold and onerous, and it would be important for the Commission to maintain a cordial and co-operative relationship with the Director and the Ministry of Health.

We urge that the Commission be funded at a level which will enable it to purchase staff, expertise and research. We envisage the Commission being a prestigious organisation whose sole objective is to create a quality Mental Health service within five years. It must not be allowed to fail because of inadequate resources.

WE RECOMMEND:

1. The establishment of a Mental Health Commission and a National Advisory Board in terms of the draft legislation above

2. That the Minister of Health request the Mental Health Commission to prepare a national blueprint for the development of Mental Health services. That blueprint will:

i. outline a strategy for implementing "Looking Forward - Strategic Directions For The Mental Health Services" (1994);

ii. outline the manner in which it will action the various concerns highlighted in this report;

iii. include a timetable within which the goals referred to in (i.) and (ii.) above will be achieved;

iv. as a matter of priority, give particular attention to:

A. the identification of benchmark levels of service and the time frame within which those benchmarks will be achieved;

the development of common purchasing definitions for Mental Health services;

the development of outcome definitions for Mental Health services;

the development of audit and monitoring processes;

the development of a comprehensive information system.

B. work force development;

C. the development of services for Maori and Pacific Island people;

D. the development of Child and Adolescent services; and

E. the development of Early Intervention programmes.

v. report on funding and resource issues for Mental Health services; and

vi. be compiled on or before 1 December 1996.

NOTE: The purpose of this recommendation is to ensure that the Mental Health Commission reacts promptly to address the more significant concerns raised in this report. Clearly it will be impracticable for it to solve all, or even some of those problems before 1 December 1996. The development of a Child and Adolescent service, for example, may take many months, perhaps several years, before it becomes part of a truly integrated service. It seems to us however, that the Minister and the Mental Health sector are entitled to be assured that the Commission is not only fully appraised of the major issues, but also that it has a progressive, systematic, timetabled plan to achieve the goals which it sets. We believe that, in the short term, those who work in Mental Health services may be prepared to further extend their tolerance if there is a clear indication from the Commission that positive action is being taken to develop a quality service.

Needless to say, we would expect the Commission's blueprint to be actioned after 1 December 1996.

CHAPTER NINE

WORK FORCE

No discussion on Mental Health services makes sense if attention is not paid to work force, employment and training issues. This is probably the most significant concern in the Mental Health sector. It is a service which is understaffed in some disciplines, inadequately trained and in most regions morale is at a low level. At the risk of sounding alarmist, we believe that many staff are demoralised. On many occasions during the course of this Inquiry the comment was made:

> **If this Inquiry doesn't achieve something worthwhile I shall be putting up my hand and taking off. I've had enough.**

All the discussion in the world about funding, restructuring or reconfiguration of services cannot disguise the fact that unless people with skills, ability and an empathy towards the mentally ill are available in sufficient numbers, then the Mental Health service runs the real risk of disintegrating.

A joint submission from the PSA and the New Zealand Nurses' Organisation captures their concerns:

> **Almost without exception our members reported that morale in the Mental Health services is low. Again, there are exceptions to this but these appear to be pockets and do not contradict the overall picture. Low morale is both cause and consequence of the serious work force issues besetting the Mental Health services. One comment on morale was:**
>
> ***So low, burn out is causing open antagonism in previously cohesive teams. Uncaring attitudes are occurring because of lack of support. There is a combination of causes - high workloads, low value by management, attempts to lower wages and conditions, non-listening by superiors, poor quality of medical staff generally, and new staff due to lack of experience.***
>
> **Other comments included:**
>
> ***Morale is fairly low. Mental Health has a long history of living off the goodwill of its staff, however the staff retention problems highlight this. It seems that people are only just able to take care of the safety issues - hold people and treat them when we have time.***

Rock bottom. I have never worked anywhere with such low morale. A lot of community Mental Health staff have left due to dissatisfaction with management and health reforms. Productivity seems very low due to low morale.

It is clear that recruitment and retention, serious problems in the past, are now exacerbated in the Mental Health services. Major factors include:

- **Burnout and loss of experienced staff. There are many unfilled vacancies and shortages of staff including experienced Registered Nurses**

- **Lack of support from management. There are exceptions but management is often seen by staff as uninformed and uncaring in relation to the Mental Health services**

- **Terms and conditions of employment. Pay, conditions and attempts by management to reduce conditions of employment are all serious issues for the staffing of Mental Health services**

- **The burdens placed on the remaining core of experienced staff in an environment of high turnover, in which induction training for new staff is widely viewed as inadequate**

- **Short staffing and the high work loads, lower quality of service and lesser job satisfaction that arise from this**

- **Safety of staff at work. Members report considerable violence against them and this has increased in recent years**

On a more personal level, one Nurse commented:

Another reason I believe Mental Health services are not performing adequately is the extremely low morale of the people working in them. We have had seven years of radical change by two governments.

We have not had a pay increase in five years and my current employer is probably, in the new year, going to lock me out as I and a number of my colleagues refuse to sign a contract which is inferior in wages and conditions to what I am on now. In fact, for District Nurses this means a drop in salary of $7,000.00.

I should add that I am reluctant to bring the industrial issue into this submission but I feel very strongly that our (Mental Health professionals) welfare is important because if we are feeling undervalued and stressed, we are going to find it difficult to give our best to clients and their families.

Another factor I believe is the type and style of management currently running Mental Health services.

A comprehensive submission was received from a multi-disciplinary team who described the frustrations of those who work in an in-patient setting. They first reaffirmed that the quality of care offered in acute in-patient service is directly related to the adequacy of staff resources. They note that staff must be valued and that more effort must be put into recruitment and retention of staff and especially, experienced staff. The submission continues:

Problems have been experienced in the following areas relating to staffing:

- **Restructuring and low staff morale are leading to a high staff turnover. Experienced staff are either leaving the Mental Health service completely or leaving New Zealand for overseas positions. As these are usually experienced workers, this represents a serious loss to the service. All staff who leave should have an exit interview with action being taken to redress issues raised. During the last year, management here refused to take any action about exit interviews as they were "too negative"**

- **Slow replacement of staff. Before vacant positions a proposal (approval to appoint) must be submitted to Service Managers, Division Managers and then for the personal signature of the Chief Executive. This can result in vacancies being open for several months. In a service whose strength is continuity of care, this puts stress on co-workers and clients, but does help the budget.**

- **The use of casual pool Nurses may compromise quality of care and may increase the stress on regular nursing staff who must supervise the pool Nurses. Slow replacement of nursing staff has, at times in the past year, led to this in-patient ward using casual pool staff. On some days, three out of five staff have been casual pool staff. These Nurses are usually new graduates without any psychiatric experience; they may only work one day. In one month last year, some two hundred and fifty five uses of casual staff were recorded. Some of the casual pool Nurses are Nurses on days off from another hospital, working (4 & 2 shift).**

- **Shortage of Consultants. There are ongoing vacancies within the service which makes it difficult to organise cover when medical staff take leave. Shortages last year resulted in the employment of American Psychiatrists on three month contracts. This involved high expense (air fares, rental cars, paid accommodation) and had a detrimental effect on the service, as they had no knowledge of the Mental Health Act or the New Zealand Health system.**

- **Multi-disciplinary Staff shortages which have resulted in lower standards of care. Our unit has had to make do with .5 occupational therapy time, no social worker, .5 psychotherapy and .2 psychology. An acute service with such low hours for its multi-disciplinary team cannot work effectively. There are delays (wait lists) until the clients can be seen by the Occupational Therapist, there is no cover when staff go on holiday and there is an inadequate programme of rehabilitation. There have been examples of people who have had a longer hospital stay because of lack of social work time to facilitate placement. Requests for an increase in staff numbers have been ignored for years.**

- **Poor clerical and administration support services. The new Mental Health Act has involved an enormous increase in administrative, legal and court liaison work. The ward is provided with only .5 clerical time. In the afternoon all staff have to spend time answering phones and doing reception.**

- **Typing is done by one person who covers outpatients and day hospital as well as in-patients, and one other person is available for three half days. Delays in getting discharge summaries occur despite a quality assurance standard that requires them to be completed in seven days.**

The introduction of a career structure within the different disciplines is an important part of recruitment and retention of staff for the Mental Health service.

Internships should be offered at entry level where there is considerable supervision and education, especially in occupational therapy, psychology and nursing, where there are recruitment problems.

To assist retention, clinical staff need a career structure that offers recognition of clinical experience without people needing to move into management. An example of this is the occupational therapy career path which allows the appointment of advanced practitioners (four years or more experience) who have peer supervision responsibilities and clinical specialists (more than seven years experience) who have education and research responsibilities. For the first time, there is recognition of the in-service education a Clinician does.

A Consultant Psychiatrist, in this edited submission, describes the staffing situation in his unit:

This hospital has experienced a gradual "leaching out" of experienced registered nursing staff over the last several years. This process has accelerated in the last two years, predominantly in response to the expansion of the community Mental Health services, which has allowed Registered Nurses to leave the less desirable clinical field of in-patient nursing (run down facilities, lack of support services, higher risk of violence, long term shortages of experienced medical staff) for the advantages of the multi-disciplinary field of community Mental Health care (high levels of support services, ability to practice autonomously, reduced violence risk, enhanced work environments).

Community based Mental Health services have a necessary expectation that their Nurses be able to practise safely in an antonymous, self reliant manner, therefore their selection processes tend to exclude those nurses who are either new to the field or who do not demonstrate high levels of skill and motivation. The result of this is that they both seek and attract many of the most valuable staff from the in-patient service, i.e. those who are both highly skilled and motivated.

As a result of the ongoing nationwide shortage of experienced Registered Mental Health Nurses (Registered Psychiatric Nurses or Registered Comprehensive Nurses practising in the Mental Health field), those experienced Nurses who leave the in-patient service have tended to be replaced by Nurses with reduced levels of experience in Mental Health nursing. The emerging pattern for these newer graduates follows the same pattern as their more experienced peers. Once they have established a skill base for their practice, those of them who show potential are likely to be quickly snapped up by community based or alternative services.

There are, of course, many motivated Nurses with advanced skill levels who choose to work within the in-patient service at this hospital. However it is this group which has grown smaller over time and now increasingly find themselves being clinically supported by an ever increasing number of staff who either lack experience in the field or who, while having experience, do not or are unable to apply this in a manner that enhances or advances patient care.

Increasingly the basis of care at the hospital has become safety rather than development, which has seen the growth of a deep seated defensive mentality among many staff in response to resource shortages, degenerating facilities, future service uncertainty and burn out in the face of rising workloads and the high risk of violence.

One outcome of these various influences on the work force has been the development of two tiers of nursing practice within the hospital Mental Health units. One is built around "centres of excellence" where peer pressure and individually motivated staff have maintained care standards to the best of their ability (often well in excess of what could be reasonably expected). The other, areas where staff are burnt out, under skilled or unmotivated, have tended to cluster.

Much of the above scenario is simply a result of forces beyond local clinical / managerial control, including:

- **The cumulative effects of years of service run-down**
- **The constant and inherent pressures of the Mental Health environment (including the risk of aggression)**
- **The historical background to the high ratio of unqualified staff on this site. As legislative, ministerial and managerial requirements for qualified staff have increased (MH CAT Act, MOH requirements, increased unit "autonomy"), the workload pressure has increasingly and disproportionately fallen on the numbers of staff with qualifications, with less of the caregiving role being able to be safely delegated to untrained staff**
- **The natural desire of motivate staff to move into more autonomous practice fields**

On this site the workload is high and stressful. Assaults on staff have long been a concern by Health and Safety. Overcrowding on wards (not necessarily in terms of numbers, but in terms of patient mix and acuity) has lead to many highly volatile situations. The staffing levels on some of the wards, whilst improved over past years, is barely more than minimal level and certainly no more than custodial care level. Health and Safety have expressed concerns and are working with us to try to minimise our risk. Staff feel that management do not care about their plight and it is out of sight, out of mind. This feeling has been reinforced by the difficulty in getting any capital expenditure for even basic things such as electrical repairs and overflowing drain pipes. Even getting windows cleaned was a major exercise. This has improved over the past year, but for the previous year the only way to get things done was to take it out of the wards operating budget. This caused a massive loss of confidence in the CHE.

The picture, as far as medical staff goes, is even worse. We will have two permanent Psychiatrists on this site, one of whom has been with us for about a month (and who is already dissatisfied), and one who wants to leave but as yet, has not been able to.

The rest of the staff (apart from two MOSS) are Americans on short term (three to six month) contracts. Whilst some provide a good short term cover, some are obviously here for the holiday and really do not add value. They do however enable us to remain open and comply with the Mental Health Act. The Mental Health Act places real demands on medical staff and is partially responsible for at least one of the best Psychiatrists leaving.

I have also been told by another Psychiatrist, who is leaving, that one of the reasons he is leaving is that it looks bad on his CV to be associated with our unit - so badly is it viewed outside. He also worries that something terrible will happen soon and he does not wish to be associated with that.

The outcome of this is a staff who are in siege mentality and who are sick of not being able to provide a quality service. They would like to be able to treat clients to good health instead of having to discharge, at a moment's notice, the least ill client so that they can provide a bed for an even sicker person requiring admission.

The staff do a good job in spite of the above. They have few suicides and they do provide an environment in which people get better. However there is a trend which is not the fault of any one individual, but is a trend of declining quality.

The only way I can see to reverse this trend is to try to provide a realistic service from this hospital.

We cannot be all things to everyone, yet that is the service we provide. We need to be clear about the number of beds we have and not go over these beds.

We need to resource the unit so that there is a safe number of staff on each ward, i.e. enough workers to enable staff to have time to get involved in training and quality matters.

The scenario described above is representative of many submissions we received.

COMMENT: There is no doubt that the shortage of Psychiatrists, Psychologists, Nurses, Social Workers, Occupational Therapists, Maori Mental Health Workers and others has reached a critical level. Dr Richard Mullen of Dunedin notes that the absurd consequence of New Zealand's failure to dedicate resources to training Psychiatrists is the appointment, at premium rates, of foreign locums. He told us that although often highly qualified, such locums are usually in New Zealand briefly and have little or no investment in the establishment or continuation of high quality services, and are indeed only just getting used to local law and facilities by the time they leave. This, he says, is an ineffective and staggeringly expensive way of staffing a health service.

Another Psychiatrist, after two years in the New Zealand Mental Health service, has recently departed for an overseas posting:

> **Most Psychiatrists are very frustrated, and so are Nurses working in psychiatric wards and hospitals. Morale is rapidly deteriorating. Rapid changes in the health system and new legislations compound the problem. Psychiatrists are leaving either for overseas positions or centres with more tolerable working conditions. Auckland is having a serious shortage of psychiatric beds, probably much worse than anywhere else in the country. Personally, I believe Auckland has the highest "potential" for a major disaster to happen.**

If the current downward trend is to be halted, working conditions that will entice and encourage staff to remain in the system must be constant throughout the country. The Mental Health sector is a high stress environment and if staff can get better conditions elsewhere, they will not remain. To quote a new graduate:

> **Who wants to work in an environment where you get verbally abused and are expected to put up with it.**

There must be change in management practices so that staff are consulted and involved in changes in the working environment, and are acknowledged for their increased responsibility and accountability.

The PSA comment that staff will only remain in a job if:

- **they are valued for their skills and experience;**
- **they have enough resources to fulfil all expectations;**
- **they have safe and comfortable working conditions;**

- **there is a career path to follow;**
- **they are encouraged to improve their skills service without being penalised by the cost of education, and get financial recognition for developing new skills;**
- **the environment is pro-active and not using those at the bottom of the ladder as whipping boys when things go wrong; and**
- **they are fairly recompensed for work done and for their skill.**

After preparing this section of this report we were handed a copy of the report of the National Working Party on Mental Health Workforce Development.

Frances Hughes is a Professional Nursing Officer in the Mental Health service. We invited her to critique that report:

> **After reading this report it is easy to see how the Mental Health work force in New Zealand has been allowed to deteriorate. How can you plan for a work force without a strategic plan? How can sectors work together when there is no requirement to work together? We have an environment of short term contracting, unclear accountabilities and boundaries between agencies, and we have health professionals oriented in different educational environments where, at its best, Mental Health is still viewed as a "Cinderella"? Client outcomes are also not centralised in these trainings. Research is lacking and we need a mechanism to foster it in the area of work force planning.**
>
> **With duplication, fragmentation, little linkages between agencies, plenty of streets without a map and unclear formulae for determining the work force, it is frightening that this has been allowed to go on for so long. We should be learning from the primary school teachers of today. We have new graduates coming out in nursing. How do we know we are training the right amount for the future? We know they often cannot find work and we know they often do not choose Mental Health. Let us now begin to unpick the poor knitting and weaving that has occurred and find the dropped stitches.**

I believe a rationalisation process should occur so that we get some overview or central control back until such time as we have an agreement of a master plan. Immigration should never be seen as the answer to work force planning.

It is but one strategy. Immigration brings with it the baggage of another culture, of different standards and of different places. It is only ever a short fix measure and I'm pleased that this report has not highlighted immigration in any other way than as a quick fix. I do not think devolvement and deregulation will assist in this process at all and I'm quite convinced that we should not throw the baby out with the bath water. I think clear direction and planning must first come from the Ministry of Health and the Ministry of Education. This relationship must be closer. The proliferation of agencies stems from both these fund holders.

We acknowledge the considerable work and expertise which has gone into the Work Force Development report. Some managers have suggested to us that critical shortages have arisen because of the change from care in the hospital to care in the community. We reject that notion. It can hardly be said that de-institutionalisation crept up on the sector overnight - it has been an ongoing phenomena for many years.

The simple fact of the matter is that no one organisation has accepted the responsibility to prepare a strategic plan for work force development, and then make it work. That should be the first priority for the Mental Health Commission. The Workforce Development report provides an excellent resource for a push forward.

CHAPTER TEN

CHILD AND ADOLESCENT SERVICES

It is a matter of real concern that no national plan exists for the development of child and adolescent services. That must be a priority.

Professor John Werry has been a long term advocate for the advancement of Mental Health services. He has a particular interest in child and adolescent services. He captures the sentiments expressed in numerous submissions:

> **Children and adolescents make up about a third of the population. The frequency of major psychiatric disorders in this group requiring professional care is approximately the same as in adults (benchmarked at 3% by the Ministry). All adult disorders occur in this age group though those that consume most of the public Mental Health resources in NZ, schizophrenia and bipolar mood disorder are uncommon until adolescence when they increase rapidly to assume adult incidence. There are however, three major handicapping disorders which are more prominent in this age group than in adults (autism/Asperger's disorder, conduct disorder and attention deficit hyperactivity disorder). These disorders impose huge burdens on families and schools.**
>
> **Government and the people of NZ have been particularly concerned about youth (15-24) suicide which is currently the highest in the Western world. However, the Ministry of Health (MOH) aggregates suicide statistics into deciles (15-24) and figures from overseas suggest that most suicides are from age 18 though most high schools in NZ are having about one suicide in their pupils every 1-2 years.**
>
> **The main cause of suicide in youth is major psychiatric disorder. Among the most important of these are conduct disorder (anti-social personality) responsible for most suicides in jail, schizophrenia and major depression especially bipolar mood disorder. Contributory factors which increase the risk in those with mental disorders are male gender, alcohol and drug use, use of highly lethal methods (hanging, falls and firearms) and some major personal stressor.**

While suicide before age 18 is infrequent, the most common cause of psychiatric emergencies in adolescents is attempted or threatened suicide. Unlike completed suicide, most attempted suicides are in females.

The other main causes of psychiatric emergencies are from out of control children and adolescents. Most of these have conduct disorder. This problem in NZ is enormous beside which most Mental Health problems pale into significance. This problem is largely hidden first because these problems are considered due to faulty or negligent parenting and viewed moralistically and second because the burden falls on families, schools, welfare agencies, health facilities who lack political clout.

Mental Health services for children and adolescents are widely acknowledged to be grossly underfunded and underdeveloped and have been designated as high priority in the Government's strategic plan. There is wide variation in services throughout NZ. The only in-patient unit for adolescents is at the Starship children's hospital in Auckland. Most other adolescents with major psychiatric disorders are put in adult units which are quite unsuitable for unemancipated adolescents since they rarely provide schooling, their ambience is adultocentric, staff are unskilled in diagnosis and frequently miss or confuse major disorders which have somewhat different presentations at this age. Adolescents are also exposed to sexual harassment and to drugs which commonly circulate in most psychiatric units (despite the best efforts of staff).

The unit at Auckland has been under increasing pressure to take older and more disturbed adolescents because of shortage of adult beds. We have responded to this as best we can, but we lack *sufficient staffing, male staff* and *intensive care facilities* to provide a complete service. Also taking adolescents from much of the North Island exposes the *shortage of proper continuing care facilities* in the communities from which the children come.

Obstacles to the Implementation of Services:

- **Ignorance and antagonism. This is widespread throughout the Health Service. The Ministry for example was most reluctant to accept the benchmark figure for services as the same as for adults despite the fact that good epidemiological research shows the prevalence is actually around 7%!**

- **Lack of *clear prescriptive direction from MOH to RHA and from RHA to CHE.* As noted the McGeorge Report is prescriptive and hence has found little favour with RHAs.**

- **Adultocentrism of most Mental Health management. The power and resources are controlled by adult psychiatrists for adults. However, some of this is historical in that most services were set up solely for adults and the problems of the large population of chronically disabled adults is overwhelming.**

- ***Lack of trained staff in child and adolescent Mental Health.* Child psychiatrists are currently the nation's most scarce medical specialists. *There are no training programmes for psychologists, social workers, occupational therapists, nurses or community workers specifically in child Mental Health.* A recent informal survey for example conducted by Mr Tom Guild, showed that *none of the training programmes in NZ for social workers addressed the issues needed for residential or in-patient care of disturbed children.***

- **Boundary problems between health education and welfare services. This affects most particularly children and adolescents with psychiatric disorders who cannot live at home. There is disagreement between CYPS and Health about who is responsible for children and adolescents with behaviour problems (conduct disorder).**

- ***General shortage of facilities for caring for disturbed or at risk children. This increases attempts to offload cases.***

- **The state of the CYPS. It is impossible to overestimate the internal and policy problems that CYPS is facing. The General Manager of that organisation recently described his service as "dysfunctional". Head office of CYPS and field staff are at odds and government is generally unwilling to invest sufficient resources especially for out of control children where costs of such services are very high. Families, schools and communities are forced to bear the cost of these children and youth by an apparently uncaring government and a Head Office of CYPS whose ideology is contrary to fact and at odds with the opinions of field staff.**

- **As a result, field staff who are poorly trained to cope with very difficult children are overloaded, demoralised and leaving in large numbers.**

- **The downgrading of Special Education Service and support services to schools such as central registers of children and truant officers. This at a time when schools are experiencing more and more difficult children makes the situation alarming.**

- **Administrative problems. Most management policies are geared to the needs of medical and surgical services where market forces are very different. This is most particularly true of personnel policies. Auckland Healthcare, for example, requires hiring *to be at such low levels in the salary scale* that recruitment of scarce professionals in the child and adolescent Mental Health area becomes almost impossible. This is placing the first attempt in NZ to *establish a forensic Mental Health service for adolescents in jeopardy*.**

Lesley Westwood presents a similarly distressing picture about the state of child and adolescent services:

> **We have many referrals for suicidal adolescents. We are not resourced or set up in any way to provide such an acute service. The child is often handled initially by the Adult Mental Health Service and referred on to us.**

We are an outpatient service. All clinicians have full ongoing caseloads and therefore cannot practicably respond on an immediate basis to referrals for suicidal adolescents. We do not have an after hours service. We do not have beds available.

When an adolescent has to be hospitalised he / she has to be accommodated in the adult Mental Health service or paediatrics, or wherever a bed is available. None of these options is really suitable for teenagers in crisis, or for the staff who care for them.

Our inability to respond to other than semi-acute or acute situations arises from reduced resources in staffing and the changing climate under the RHA and the services which they are prepared to purchase.

Physically and psychologically healthy children and adolescents grow into productive and healthy adults. I would like the resources to assist families to the maximum, in the early years, to be increased, not reduced.

In January 1995 Dr Peter McGeorge produced a report aimed at providing information and preliminary views on models of service provision and resources for Mental Health services to children and young people. We acknowledge the need to consult further on that report but we are concerned that sixteen months down the track no discernible progress has been made in implementing its recommendations. For planning purposes Dr McGeorge conservatively estimated that 5% of the New Zealand child and adolescent population have a serious psychiatric disorder. At any point in time therefore, around forty thousand young New Zealanders would require specialised psychiatric services.

COMMENT: Given the extent of the problem it is alarming that Mental Health services for children and adolescents still lag far behind those for adults. It is the adult services which consume most of the Mental Health budget spent in New Zealand.

The best evidence available suggest that the 5% benchmark in the McGeorge report is too low. We agree with Professor Werry that the figure is probably closer to 7%. For planning purposes we support the 5% benchmark. In our view it would be wrong to reduce the benchmark - however tempting that may be in financial terms. Given appropriate funding and resourcing we believe that the 5% benchmark is an attainable level and is one which acknowledges the realities of an already desperate situation.

We leave the last word to Professor Werry:

There is a need for the Government to adopt a prescriptive plan for children and adolescent services (such as the McGeorge report) and require RHAs to implement this plan.

There is a need for some adequate oversight of implementation of any such plan. No such oversight currently exists in other than rudimentary and ineffectual form.

The problems of providing adequate services for children and adolescents with major psychiatric disorders is hampered by territorial disputes among and shortfalls in health education and welfare services.

In particular, the inability of the Children and Young Persons Service to service the Children, Young Persons And Their Families Act, and by inadequate funding of the Special Education and school base services for disturbed children.

The shortfall in services for children and youth is further restricted by grave shortages of trained child and adolescent Mental Health professionals.

This is largely a result of a lack of training programmes for these professionals (except Child Psychiatrists and Child Therapists) in New Zealand. However, even where such professionals may be available, there is a reluctance by RHAs and CHEs to meet market rates.

In order to raise the profile of child and adolescent Mental Health, increase the standard of clinical programmes, promote research relevant to New Zealand needs and to provide a matrix for training specialised professionals, it is recommended that an Institute for Child and Adolescent Mental Health be established as a joint venture between a CHE, one of the universities and selected other tertiary institutions concerned with the training of health professionals.

CHAPTER ELEVEN

MAORI

One of the national objectives of "Looking Forward : Strategic Directions For The Mental Health Services" is encouraging Maori involvement in planning, developing and delivery of Mental Health services. In terms of poor mental health Maori face an appalling situation. In 1991 one of the authors of this report (KM) spoke to a retired Maori Psychiatric Nurse:

> **I worked at Oakley Hospital in the years shortly after the Second World War. There were just a handful of Maori Nurses at the institution and we all kept in touch with each other. There were more than one thousand patients in the hospital - I think that was the figure - of whom only six were Maori. Four Maori patients were members of the one family. We used to get alongside the Maori patients and I'm sure they felt much more comfortable being with us.**

During the course of this Inquiry we met with a senior Maori Mental Health worker who commented:

> **I have a vivid recollection of the first Maori who came into our hospital - and that wasn't so long ago. I remember it well because I had never previously seen a Maori in a psychiatric hospital. And he wasn't there because he was mentally ill - he had alcohol problems.**

Maori now make up a significant proportion of consumers of Mental Health services. Professor Mason Durie notes that they are more likely to be admitted involuntarily, have poor outcomes after first admission and their readmission rates increased by 40% over the last decade. He also comments that there is also the possibility that a high acceptance of abnormal behaviour leaves illness undetected and untreated.

This leads to the view that:

a. there are insufficient culturally appropriate community services to prevent admission;

b. current services are not designed to meet the needs of Maori people; and

c. the social and economic environment is hostile to Maori people.

In "Nga Ia O Te Oranga Hinengaro Maori" (Te Puni Kokiri 1993) it was recommended that the following issues be addressed:

- **Greater Maori control of Mental Health services**
- **Better funding of services with a specific Maori mental health focus**
- **The provision of accurate and up to date service information on Maori mental health and treatment outcomes**
- **The development of community based, hospital and advocacy Mental Health services that meet Maori needs**
- **Research identifying Maori mental health needs and effective treatments**
- **Training programmes to rapidly increase the number of qualified Maori available to work in Maori Mental Health services**
- **Education programmes targeting specific areas for Maori such as drug abuse, young mothers and school aged children**
- **Reviews of the impact of legislation on Maori such as the Mental Health (Compulsory Assessment and Treatment) Act 1992 and the Criminal Justice Act 1985**

Those issues remain extant. An equally important issue is the provision of a mechanism by which these goals may be attained. Earlier in this report we commented that consumer / family representation, at the highest planning level, must not result in mere tokenism. The same is true for Maori if the objective of "by Maori for Maori" is to be translated into reality.

We received several submissions from Maori providers who were distressed at the apparent inability of some RHAs to understand the true nature and content of a Mental Health service "by Maori for Maori". Some of their concerns were:

> **Holistic health is acknowledged but not implemented. The measuring of a service is still done by "Pakeha" tools and this does not equate to or satisfy the Maori kaupapa. Maori delivery is being choked in order to respond to reporting formats.**

Maori wish to deliver a service which is appropriate to Maori, as Maori have requested. However we cannot get acceptance or Requests for Proposals in kaupapa Maori form. We cannot get a total holistic contract. We must accept the components of service set out by the RHA (which is Pakeha) and we, the service deliverer, must compromise our delivery. The alternative is not having a service. Therefore our needs as Maori are not met, nor are they equivalent to those of Pakeha.

We have clients on our books who wish and choose to move to the next stage of being well, but we cannot deliver. They lack a service and they are now being readmitted into the hospital system.

We are not permitted to develop or push for development; we are threatened with no funds or contracts.

It is evident that there is a push by the RHA for our organisation to deliver Iwi support and whanau education only. Other parts of our service are ignored. When we choose to deliver 1:1 client care or to further enhance their wellbeing, the strong arm tactics appear.

The reporting formats should be developed by the provider and the purchaser on an equal platform to satisfy the funders' accountabilities, but more importantly to capture accurate data to enable more informed decisions to be made for the future for Maori health. The current formats for reporting are Europeanised.

There is a population of Maori in the community who are not captured in any health organisation records and who are using this Maori Mental Health service to cope with the stresses of today's living. Without this service this population of people would be entrenched in the institutionalised system.

Alternative healing and rongoa are acknowledged but not implemented, due to the lack of an evaluation tool.

> **Our organisation has progressed through year one successfully. The bother here is that if we are unable to complete the year two phase, the label of "another Maori organisation" will be attached through the lack of efficient management skills within the RHA.**
>
> **We are constantly reminded to operate a cost effective, almost commercial, profit making business with stringent rules and regulations. We have no problem with being accountable and being audited.**

Fairly obviously the RHAs have not yet come to grips with what is required in terms of purchasing Mental Health services for Maori. Nor has there been any recognisable improvement in Maori being involved in planning services, at national level, in a meaningful way.

COMMENT: We are hopeful that the establishment of the Mental Health Commission, with its responsibility to set common purchasing definitions, will provide a more exact measure as to what can be purchased by Maori Mental Health providers. We direct the Commission's attention to "Guidelines For Purchasing Personal Mental Health Services For Maori" (by Te Pumanawa Hauora Ki Manawatu) as a valuable resource document. We expect the Mental Health Commission and / or Advisory Board to have Maori representation in sufficient numbers and expertise "to make a difference".

Maori have suggested four options for the delivery of Mental Health services by Maori, for Maori:

- By Iwi
- By a regional organisation
- By a Maori Mental Health Commission which would have functions similar to those of our proposed Mental Health Commission
- By establishing a Maori Mental Health Advisory Group which would be one of the "core functions" of a National Mental Health Board.

In our view there is scope for a flexible and co-operative approach. We would be concerned to see a duplication of the functions of our proposed Mental Health Commission, but we do not rule that out as an option which ought to be considered. Further consultation with Maori will be necessary.

CHAPTER TWELVE

PACIFIC ISLAND PEOPLE

Pacific Island people appear to have become the forgotten group by those who plan Mental Health services.

In 1994 the Ministry of Health, with the support of the Ministry of Pacific Island Affairs, consulted with various Pacific Island communities throughout New Zealand. The fundamental principle behind that project was to ensure the provision of Mental Health services which were both appropriate to the communities they serve and receptive enough to accommodate cultural differences. A total of nineteen regions were visited during that consultative process which, in March 1995, resulted in "Strategic Directions for the Mental Health services for Pacific Island people".

One of the main conclusions in that report was:

> **Pacific Island people who live in New Zealand have a right to health services that reflect their needs. Pacific Island people, as a group and as individuals, have been and will continue to be, major users of the health systems. After extensive consultation with Pacific Island communities this report has recommended that a National Advisory Council for Pacific Island Mental Health be established along with a Cultural Advocacy Service. It is further recommended that these and the other inter-related policies be incorporated in the *Strategic Directions for Mental Health Services 1994*.**
>
> **In essence, the proposals identify the need for Pacific Island people to be involved in formulating policies for their own health and, in particular, the need for mental health services to respond to factors which are part of a Pacific Island individual's cultural and ethnic background in order that the services and treatment provided are effective.**

COMMENT: Fuimaono Karl Pulotu-Endemann was one of the authors of that report. He is best qualified to comment. He expressed his concern and frustration in this way:

> **In March 1995 the document "Strategic Directions for Mental Health Services for Pacific Island People" was released by the Ministry of Health. I was one of the authors of this document.**

This letter relates to the recommendations and content of the document but more specifically, I am asking what is happening to the document? I personally have heard very little concerning any "actioning" of some of the recommendations.

My concerns relate to the following issues:

The Strategic Directions for the Mental Health Services for Pacific Island People document was the result of consultation with Pacific Island communities throughout New Zealand. We were reporting on what the people had said and wanted to happen for them.

Many people have contacted me to enquire about the outcome of what was said in the document. I can only comment on a few services like A+ Mental Health Service in Auckland who have established a Pacific Island Mental Health service.

I am very concerned that Mental Health services for Pacific Island people, yet again, will be defined and determined by non-Pacific Island people without any consideration of what was said in the document.

In 1988 you released the Psychiatric Report which was, of course, the result of many things, but in particular an incident in Ponsonby with a Samoan man. That report also looked at the inadequate care for people like that Samoan man. As a Samoan and a health professional, I work with Pacific Island people throughout New Zealand and I am amazed that we have not had another incident like the one in Ponsonby. Something must happen before it happens. I believe this Inquiry is a vehicle for change and for "doing something".

CHAPTER THIRTEEN

EARLY INTERVENTION

It's very difficult to express the anguish of schizophrenia. It's so bizarre and beyond the imagination of most parents seeing their child in difficulty. I will be plagued to my death bed by the thought that I saw things going wrong, and had we intervened appropriately early on the outcome may not have been inevitable.
A mother speaking about her son.

The Royal Australian and New Zealand College of Psychiatrists informed us that in the USA the National Advisory Mental Health Council estimates that 2.8% of the adult population and 3.2% of children and adolescents experience a severe mental disorder in a one year period. In this context the definition of ***severe mental illness*** is based not only on diagnosis but also on other criteria, including duration, danger to life (self or others), interference with function and interference with emotional and mental development. At least another 20% of the population suffer from mental disorders and Mental Health problems which impair functioning and cause significant distress and anguish to sufferers and their families. We were told that these conditions are treatable and that early intervention can prevent the development of severe mental illness.

Dr Dick Burrell is a long serving Consultant Psychiatrist in South Auckland:

It should be remembered that effective early treatment at the first presentation of a psychotic illness lessens long term disability.

There is evidence that each psychotic break facilitates the next. This makes treatment more difficult and contributes to the development of deficit or negative symptoms of the disorder. Repeated episodes of psychosis serve to alienate friends and family, and periods of hospitalisation lead to general dysculturation, employment prejudice, etc. In addition there are quality of life issues since a psychotic state often produces a tortured existence and lead many sufferers to take their own lives. The suicide rate among people with schizophrenia is of the order of 10 - 15%, and so is that for major depressive disorder.

Lesley Westwood is currently the intake worker for the Child, Adolescent and Family Service for Hutt Valley Health. She noted that:

The benefits of early intervention work, at the stage when families are beginning to experience difficulties, include:

- **Shorter term therapy**
- **More likelihood of lasting effects**
- **Less likelihood of repeat referrals**
- **Less likelihood of escalation of the presenting symptoms, which can lead to an acute presentation at a later stage**
- **Less likelihood of the development of other symptoms in the child or other family members**
- **Less likelihood of the situation becoming more complex, involving other agencies, therefore more demanding of time and resources. This affects the likelihood of a therapeutically satisfactory outcome**
- **More effective use of therapy, therefore better cost effectiveness and a more efficient use of shrinking resources**

In moving away from doing preventative early work with families to a situation where we are only able to see serious presentations, we are increasing the stress on the children and their families, and increasing the need for complex, time consuming and costly interventions with decreased chances of satisfactory outcomes

What does this say to families and the community about the value placed on the wellbeing of children and their families?

We have many referrals for suicidal adolescents. We are not resourced or set up in any way to provide such an acute service. The child is often handled initially by the Adult Mental Health Service and referred on to us.

Several submissions noted that although more trained staff would be needed to implement early intervention programmes, such a move would be cost effective in the long run and beneficial to the mentally ill person who may have a shorter hospital stay, or may not be admitted at all. One submitter commented that a hospital admission is always a very traumatic experience for both patient and family, especially if Police or a Crisis Team is involved.

Associate Professor Pat McGorry of Melbourne has an international reputation in the early management of psychotic disorders. He describes early intervention in these terms:

> **Early intervention involves diagnosis of psychotic disorders at the earliest possible time and ensuring that appropriate specialist treatment is initiated. This should be at the first sign of positive psychotic symptoms, but it may also be possible to intervene during the pre-psychotic, prodromal phase.**
>
> **Achieving early intervention requires increasing community understanding of these disorders through raising awareness of early signs and decreasing the stigma which can sometimes delay people from seeking help. It also requires improving skills and knowledge amongst health professionals in a position to be able to detect these disorders.**
>
> **The initial episode of psychotic disorders can be particularly confusing and traumatic for the person and the family. Apart from the concern caused by the change in the person's behaviour, distress occurs because the person, the family and peers may not understand what is happening. This lack of awareness often leads to delays in seeking help. As a result these treatable illnesses are left unrecognised and untreated. Even when appropriate help seeking does occur, there are often further delays before the right diagnosis is made, because the recognition of these disorders can at times be difficult, and specific skills and knowledge are needed.**
>
> **Several studies have shown that there is often a major delay in initiating treatment for people affected by a psychotic disorder.**
>
> **These delays vary widely from person to person, but in many studies the interval between onset of psychotic symptoms and commencement of appropriate treatment is more than one year.**

As a consequence of these delays, significant disruption can occur to the person's family, social, educational and work life at a critical developmental period. Secondary problems such as employment, substance abuse, depression, self harm or suicide and law breaking can also occur or intensify.

The longer the period of untreated illness, the greater the risk of this psychosocial disruption and secondary morbidity for the person and the family. Also, the illness may become more deeply entrenched, as it has been found that delays in receiving treatment are associated with slower and less complete recovery, and that a long duration of psychotic symptoms before treatment appears to contribute to poorer prognosis.

Delayed treatment can result in:

- **Interference with psychological and social development**
- **Strain on relationships or loss of family and social supports**
- **Disruption of parenting role in young mothers / fathers with psychosis**
- **Distress and increased psychological problems within the person's family**
- **Disruption of study**
- **Disruption of employment and unemployment**
- **Slower and less complete recovery**
- **Poorer prognosis**
- **Depression and suicide**
- **Substance abuse**
- **Law breaking**
- **Unnecessary hospitalisation**
- **Increased economic cost to the community**

Benefits of early intervention are:

- **Reduced morbidity**
- **Preservation of psychosocial skills**
- **Preservation of family and social supports**
- **Decreased need for hospitalisation**
- **More rapid recovery**
- **Better prognosis**

Psychotic disorders include syndromes such as schizophrenia, bipolar disorder, schizophreniform disorder, schizoaffective disorder, drug induced psychosis, brief reactive psychosis, organic psychoses and delusional disorder.

As with most mental illnesses, the onset of these disorders is typically in adolescence or early adult life.

The development of a psychotic disorder appears to relate to a specific vulnerability. Vulnerability has been defined as the propensity to develop specific syndromes in the face of stress. The stress-vulnerability model proposed for the psychoses integrates biological and environmental influences to account for onset and course. The major determinants of this vulnerability are biological and its expression as frank disorder is influenced by stressors and triggers, both psychosocial and biological.

A positive family history of psychosis and particular personality types, e.g. schizotypal personality, are associated with an increased risk of vulnerability to psychosis.

COMMENT:

We were impressed by the enormous advantages to be gained in developing early intervention programmes. We met with Associate Professor McGorry and Associate Professor Jayashri Kulkarni in Melbourne. We attach as Appendix 5 a description of a home based treatment programme of first episode psychosis initiated by Associate Professor Kulkarni.

We commend the development of early intervention programmes and acknowledge the need for additional staff, resources and funding in order to reach that objective. We are in no doubt that a sound base of expertise and research already exists within Australasia to the extent that pilot programmes in the near future should be established.

CHAPTER FOURTEEN

PERSONALITY DISORDER

Dr John Turbott has described *personality disorder* in this way:

> **Personality disorder is a psychiatric concept. It refers to a disparate group of conditions. The common factor is that the individual affected has deeply ingrained, maladaptive ways of thinking, feeling and behaving, present from adolescence and continuing, in most cases, throughout life. These conditions do not arise as a result of brain damage (like most cases of mental retardation) or as the result of psychiatric illness. They may in part be genetic or, to a substantial degree, may arise as the result of adverse upbringing experiences, but once established are very difficult to change. People with personality disorder may be more vulnerable to psychiatric illness. They may be violent and antisocial, BUT NOT INVARIABLY SO. Most authorities with significant clinical experience of these conditions believe them to be very difficult and often impossible to change. This applies particularly to antisocial personality disorder (the so called "psychopaths"). Personality disorder usually is not amenable to biological psychiatric treatment although supervening psychiatric illness (to which such people are vulnerable) may be.**
>
> **I would emphasise that very few Psychiatrist would claim to be able to treat effectively most cases of severe personality disorder. That is not to say that such people should not be treated with compassion or that they may not benefit from NON-SPECIFIC help such as appropriate social support and stress management. Nor is it to say that they will not require psychiatric attention - quite frequently they will because of their added vulnerability to psychiatric illness - but it is the ILLNESS mainly which is treated, not the underlying personality disorder.**

John Gunn of the Institute of Psychiatry in London has an international reputation in Forensic Psychiatry. He has strong views as to whether people with personality disorders will benefit through psychiatric intervention. We produce an edited version of a paper in Criminal Behaviour and Mental Health, 2, 202 / 211 1992:

PERSONALITY DISORDERS AND FORENSIC PSYCHIATRY

Personality problems of various kinds make a significant impact on the practice of forensic psychiatry. Clusters of personality problems that amount to clinical syndromes should be treated as such and not discriminated against. Treatment for personality disorders is akin to treatment for other chronic disabling disease such as schizophrenia. Patients with severe personality disorders should have just as much access to in-patient services as patients with other diseases. Such access should include access to compulsory care as well as to voluntary care. British Mental Health law allows, indeed encourages, such an approach. Prison care for personality disordered patients has an important role to play in their management, but prison management should not be the mainstay of treatment for personality disorders any more than it is for any other disease. The task for forensic psychiatry is to conduct research into personality disorders and to reduce the negativity associated with this term.

Personality disorders are an ill-defined, yet substantial group of diseases which are the concern of all branches of psychiatry. Their lifetime prevalence has been variously estimated as between 2% and 18% of the general population (Casey, 1988). They are a contentious aspect of modern psychiatry. They are of particular importance to forensic psychiatry because they are, by definition, chronic in nature and are usually manifest by behaviour disturbances. Patients with personality disorders are thus likely to be unpopular and to get into trouble. To some extent they provide the drive for the development of forensic psychiatry; medicine seems to need a separate sub-specialty that will deal with behaviourally disturbed people. At times the term "personality disorder" is part of the language of rejection.

Patients with schizophrenia, for example, may be labelled as personality disordered, not because of conceptual similarities, but when they are about to be rejected because of their unpleasant behaviour.

Treatability:

In considering treatability, schizophrenia provides a useful model. Schizophrenia is not usually thought of as a personality disorder, although it is one. ICD-9 defines schizophrenia as "a group of psychoses in which there is a fundamental disturbance of personality". The behavioural abnormalities listed include oddities of conduct, an inability to meet the demands of society, self absorption, idleness, aimlessness, solitariness, vagrancy, irresponsible behaviour and unpredictability. In other words, there are marked similarities between schizophrenia and other personality disorders, the common feature including chronicity, behavioural abnormalities and significant management problems. Schizophrenia can be, and is easily, relabelled as personality disorder if the patient gets destructive aggressive, or otherwise difficult to manage, and such relabelling is a political device leading to rejection.

How are the personality features of schizophrenia treated? First a detailed assessment is required, an assessment that gives a symptom profile and lists both strengths and weaknesses. Next, specific symptoms are targeted with, for example, medication, behaviour therapy, psychotherapy. Then an appropriate environment is provided, either in hospital or at home, using the skills of nursing, social work and occupational therapy. Skills deficits are remedied if possible using education, occupational therapy and psychological techniques. Last, support and counselling are provided. This strategy is also entirely appropriate for other forms of personality disorder.

Part of the treatment of any chronic disease, be it physical or psychosocial, is the provision of an appropriate environment. Patients with arthritis may need hand tools, adapted cars, ramps, etc. Patients with personality disorders may require therapeutic communities such as the Henderson Hospital, Grendon Prison or Barlinnie Special Unit.

It is sometimes implied that, because a patient requires a special psychological environment on a long term basis, that means that the environment does not work. It is difficult to conceive of anyone arguing for the abolition of nursing homes for patients with dementia because nursing homes do not cure the dementia!

A serious difficulty in the field of personality disorder is that the concept of treatability is frequently equated with curability - which is totally inappropriate.

Insight:

Informal or voluntary in-patient treatment for patients with personality disorders, although rarely provided, is generally accepted in principle. Compulsory treatment poses extra difficulties. This must turn on the concept of insight. A patient with schizophrenia suffering from a variety of behavioural problems is more easily conceived as having poor insight and thus more eligible for the compulsory powers of a mental health act.

Insight is a difficult problem for psychiatry. It is a much used but ill-defined term. In casual terms, patients with personality disorders are often referred to as "having no insight" and yet there is a reluctance to use the concept technically in such people. It is almost as if insight difficulties have to be linked to just a few diagnoses such as schizophrenia, mania and depression.

Gelder, Gath and Mayou (1989) define insight in terms of four questions:

1. **Is the patient aware of the phenomena noted by others?**
2. **Does he recognise these phenomena as abnormal?**
3. **Does he consider they are caused by illness?**
4. **Does he think he needs treatment?**

If these questions can be applied in measurable terms to patients with schizophrenia or depression, so they can for patients with say, borderline personality disorder, and some such patients will have scores at the low insight end of the spectrum.

Should they be deprived of compulsory treatment just because of contemporary nosology? Certainly the layman, who may be a good judge of insight, will often quarrel with the Psychiatrist's view of the patient's insight saying something like, "I don't care what you say, anyone can see he is mad".

It would be wrong to hand over treatment criteria entirely to laymen, but our Mental Health legislation, in various ways, insists that the Psychiatrist considers the layman's perspective, and that makes good sense as well as good medicine.

Prisons Versus Hospitals:

An aspect of the treatability debate, in respect of the personality disordered patient who offends, is location, especially if the patient is an offender. Such patients are frequently dealt with differently from patients with other diagnoses. Such diagnostic discrimination is unjust. Whether the diagnosis is schizophrenia or borderline personality disorder, the clinical judgment should be made in terms of clinical needs and facilities available. One attempted justification is the shortage of appropriate facilities, but in the current political climate this amounts to self-fulfilling prophecy. "We can't take Mr X because we have no facilities for him", quickly becomes "we don't develop facilities for personality disorder patients because we don't have many!" Other attempted justifications depend on the mistaken assumptions mentioned above, that personality disordered patients always have full insight or are untreatable, so in fairness they must be refused. This fairness often results in a penal disposal, usually imprisonment, where facilities are much worse. A refinement of this argument is that once in prison, the potential patient can then put his hand up for treatment if he wishes and effect a transfer to the hospital system which will now be more ready to receive him because they have a prison to return him to if they cannot manage him. This is both flawed and discriminatory. Assessment services are very deficient in prison and the patient is unlikely to be identified as a therapeutic prospect; the prisoner may have little insight and not volunteer. Such an escape route may be convenient for hospitals but it is hardly an appropriate clinical response, and although it is also occasionally applied to patients with other diagnoses, it is never advocated for other patients as a matter of health policy.

Prisons are forced into providing therapeutic environments for a wide range of personality disorders. At centres like Grendon Prison they do it very well. This however should not exonerate health services from trying to do just as well.

Furthermore, prisons are NOT established primarily as therapeutic institutions; that is a role for hospitals. Clearly functions of institutions overlap, but it is inappropriate for health service personnel to try and shift therapeutic burdens entirely into a service that has other roles and where, for much of the time, the therapy will be flowing against the tide.

A final but powerful reason for preferring hospital to imprisonment concerns the welfare of bystanders. Some patients, especially those for whom prison is considered to be an option, pose a threat to others. This threat is almost never reduced by imprisonment; it may be increased. In the UK health disposals under Mental Health legislation give opportunities for long term management and control. For example, after discharge from hospital, a patient will usually be under compulsory supervision and is liable to recall to hospital if things go awry. Imprisonment frequently means incarceration without treatment followed by release without strings, or supports, attached. All cases in which a health facility has declined to assist with a difficult patient suffering from a recognised disease, and which ultimately goes wrong, for example by a serious attack or homicide following release from prison, should be regarded as a medical failure.

<u>The Task For Forensic Psychiatry:</u>
The first medical task in relation to any disease which creates problems is to acquire knowledge about it. As far as personality disorders are concerned, we need to know a lot more about their phenomenology, their aetiology, their epidemiology and their treatment. Personality disorder may well be a very expensive disease in terms of its secondary effects and in terms of the resources it consumes. Personality disorders may be self-perpetuating in that patients with such disorders victimise others, especially children, who then develop further personality disorders. Management research should include experiments within existing structure and the experimental provision of new structures (such as therapeutic communities in the NHS) so that these can all be evaluated.

A further task is to reduce the negative power of the term psychopathic disorder. The medical profession should not collude with the public instinct to use this term as a device for rejection.

The diseases identified as sub-categories of personality disorder are legitimate concerns for a comprehensive psychiatric service and, as already suggested, are of particular interest to the Forensic Psychiatrist. Other diseases, e.g. schizophrenia, will also be, from time to time, included under the political / legal category of psychopathic disorder when it seems expedient or convenient to do so. The practical problem which needs addressing is that very few facilities for the treatment and management of patients who can, one way or another, be classified as "psychopathic" usually exist.

It is worth considering that if medicine / psychiatry abdicates its responsibilities to this group of diseases they will not simply fade away. The problems will remain and others in other disciplines, sometimes others without any scientific training, or others with less regard for rigorous ethics, may try to respond to the self-evident needs of a problematic group of patients. It could be, in the longer term, that if psychiatry gives up all its difficult patients, society will give up psychiatry. Forensic Psychiatrists are well placed to see that this does not happen.

COMMENT: We respectfully adopt the views expressed by Professor Gunn. If psychiatry has something to offer those with personality disorder it would be ethically wrong to give up on this difficult group. The "management" of such persons requires a disproportionate expenditure in time and resources. The Mental Health Foundation has drawn our attention to the US Patuxent Model as one which has had some success for anti-social personality disorders. A description of that programme is as follows:

Successful in-patient programmes involve long term, strictly structured, hierarchical settings in which every aspect of the patient's life affects, and is affected by, his progress. Some, like the Patuxent Institute in Jessup, Maryland, control the patient's administrative status as well as other parts of his life from the day he enters the hospital. He begins with very few privileges except that of being treated as a human being.

He slowly moves through a four or five step hierarchy of privileges, he acquires more and more self-esteem, awareness of his emotional life and his social and interpersonal competence, leading to less need for the anti-social character style.

In addition to the rigorous structure there should always be time for reflection during which, particularly in the early stages, the patient may become "emotional" without exposing himself completely to others (although sharing one's feelings with others is a necessary later part of the treatment programme).

Such in-patient / residential programmes take years to complete, are moderately expensive (although far less so than ineffective incarceration) and tend to have good results, particularly if the patient receives community follow-up by the same team which treated him as an in-patient.

The long standing debate about those individuals who have a personality disorder must be resolved. It would be fair to say that on occasions the activities of such people have created real concerns about public safety. We have reprinted the article by John Gunn in the expectation that it may explain the issues and assist in their resolution.

We respectfully adopt the approach suggested by Professor Gunn. If, as we believe, a service must be provided for this group that proposition must first be subjected to further research and evaluation.

CHAPTER FIFTEEN

PRIMARY MENTAL HEALTH SERVICES

During the latter stages of our Inquiry we were invited to consider a submission from the National Advisory Committee on Health and Disability (National Health Committee).

The committee noted that the focus of development in the Mental Health sector has been on the 3% of the population who experience a serious mental disorder, or on the 1% for whom access is increasingly defined in narrow terms under the Mental Health Act. It commented:

> **There is little policy emphasis on the development of Mental Health services at the level of primary health services where the majority of people with Mental Health problems first present and are treated. Recent estimates from Australia suggest that at any time, an additional 5% of the population suffer from chronic mental disorders (especially disorders of depression, anxiety and substance abuse), and a further 18.8% have mild and transient problems. The treatment needs of these two groups, especially those with chronic disorders, should also be addressed. However, it is important that the greater share of resources should go to those with the most disabling disorders.**

It noted that people with ongoing or unremitting Mental Health disorders, less severe immediately although nonetheless serious, seem to be getting decreased access to publicly funded treatment. It continues:

> **It is imperative that any future development in Mental Health services should lead to a comprehensive and co-ordinated network of services which range from in-patient services to primary Mental Health services. The services should include appropriate community based support services for patients and carers, diagnostic services, treatment services, advocacy, counselling and referral services, emergency / crisis intervention services (for all age groups including adolescents) and habilitation / rehabilitation services for Mental Health and Drug and Alcohol use disorders. Access to these services should be based on the severity and / or disability of the individual and the optimum likely benefit from the most cost effective treatment that is available.**

The Committee then presented us with a proposal strengthening the capacity of the primary Mental Health sector in treating depression, and noted several points:

It is essential to take a co-ordinated approach to Mental Health service delivery, across the range of services to be offered. Secondary and forensic Mental Health services are important, especially for long standing, severe disabilities. Equally important however, are effective primary Mental Health services - especially those which allow for early detection, effective diagnosis and management of conditions before those conditions become so severe that specialist treatment is necessary.

Adequate resourcing for, and delivery of, co-ordinated primary Mental Health services will lead to the better management, at an earlier stage, for people who have developed Mental Health disorders. In the past, some people with depression for example, have received no treatment at all, and others have become so severely depressed that admission to hospital has been necessary when it could have been avoided.

A primary care Mental Health focus needs to be supported by better funding arrangements (especially long consultation GMS or capitation payments) to encourage primary health providers to deliver more Mental Health services. Competencies and skills among primary Mental Health workers can also be improved to support the delivery of effective, timely, Mental Health services.

Depression is treatable. The treatments we recommend are effective for most people in the primary care setting. Full implementation would cost about $30 million per year.

In our view, strengthening the capacity of the primary Mental Health sector in treating depression and related disorders will result in a reduction in admissions for acute services for depression and for readmissions to secondary care, associated with depression. This will lessen some of the pressures on secondary care facilities.

Importantly however, it will also improve equity of access to services for people with Mental Health problems.

The guidelines are almost immediately implementable through appropriate information for the existing primary care work force.

Depression affects a large number of people in society (one in seven people will, at some time, experience a depressive disorder), and it causes significant distress and impairment.

People with depressive illnesses often do not seek help for their depression. When they do seek help it is likely to be from their GP.

The primary sector is the main and often sole source of treatment for people with depressive illnesses, consequently the primary sector has the opportunity to play a significant role in the detection, diagnosis and treatment of depression.

The early recognition and treatment of depression by GPs can result in decreased morbidity and mortality. This has been demonstrated by the Gotland Studies where an education programme for GPs resulted in more appropriate prescription of medication for depression, decreased use of in-patient services and a decrease in suicides associated with depression.

COMMENT: Unfortunately time does not permit us to record the Committee's proposal in detail. We acknowledge the care and expertise involved in preparing the guidelines, and confirm that any proposal that achieves a health gain is to be commended. We acknowledge that depression is a significant and under treated Mental Health disorder.

For this Inquiry team however, the dilemma is one of resources. Later in this report we comment on present and future funding for Mental Health services. In simple terms, the present Mental Health budget provides services for approximately 1.2% - 1.5% of the 3% population referred to in "Strategic Directions for Mental Health Services". A significant increase in funding is warranted if the 3% group is to be appropriately managed. We are not qualified to comment on the Committee's submission that implementation of the depression guidelines would cost about $30 million per year. That may require further examination.

However, accepting for the present that the figure is correct, we would not wish that sum to be allocated towards the primary services if that were to occur at the expense of an already under funded secondary service.

It may be however, that there is scope for both services to benefit by adopting a collaborative approach. We note that the Committee intends producing further guidelines later this year about anxiety disorders and drug and alcohol use disorders, and it makes sense for the Mental Health Commission to examine the present proposal further. Ultimately the outcome will hinge on how much New Zealand is prepared to pay for a comprehensive Mental Health service.

CHAPTER SIXTEEN

STIGMA : EDUCATION AND PUBLICITY

The Framework Trust note that it is easy to place all the "blame" for inadequate Mental Health care at the feet of the Mental Health service community, families and consumers themselves. A factor which compounds the difficulties of Mental Health consumers and service providers is the sensationalist view of Mental Health perpetrated by the media and self interested lobby groups.

The Association of CHE Mental Health Managers comment:

> **There is general misunderstanding about the nature of mental illness and disability. There has been a tendency to simplify the health care provision to those with psychotic or severe mood disorders. This neglects the terrible legacy left by those with severe anxiety disorders, e.g. phobic, obsessive compulsive disorders, post-traumatic stress disorders, and the problems associated with severe personality disorders. On the other hand there is too much willingness to extend the coverage to those with behaviours and problems that society is troubled by, e.g. sexual offending, anti-social behaviour, various criminal behaviours and out-of-control aggressive behaviour. All too often with these individuals, we have neither therapeutic strategies that have proven effectiveness nor the willing participation of the individual with the problem. Mental Health services cannot afford to be society's panacea for all ills.**
>
> **There needs to be a specific community education and media education programme. Mental Health stories sell papers (because of) the way the media currently handle the topic. They also intensify the stigma and hinder the development of good services. There needs to be a deliberate strategy to address this and to ensure that the general public will not prevent a person obtaining accommodation or a job because they have a psychiatric disability. A greater willingness to seek help early in the onset of an illness is important and is not helped by current media reporting.**
>
> **There is real confusion as to what is happening as well as a lack of understanding of the differences between mental health and those people with either intellectual disability, head injury or personality disorder, and who also have an associated behavioural difficulty.**

It also appears difficult for someone who has once used Mental Health services to ever move away from an identity of "psychiatric patient".

This is not usually the case with other medical conditions. There is an increased public expectation of services when they are developed. Somehow it needs to be clearly stated what these additional services can expect to provide and what they can't.

Nor do politicians escape criticism. The Association of CHE Mental Health Managers:

It is incumbent upon politicians to avoid using Mental Health as a political football. What New Zealand needs is a multi-party accord on a Mental Health strategy. This is essential if we are to address the long standing systemic problems in Mental Health care delivery. There are real issues in this most difficult of areas and they require the involvement and support of all parties rather than it being seen as a means of political point scoring. This high profile attention makes those who work in Mental Health understandably anxious - particularly worried about being scapegoated in an issue that is more than any one person's responsibility. There is little recognition by society and politicians of the extreme difficulty posed to professionals working with the more challenging patients. The judgment calls are complex. The behaviours shown often take their emotional toll. The job is often not very rewarding and requires great dedication, whereas the response from the public and politicians is often to blame the staff who are struggling with the complex demands of the situation. This in turn leads to problems with staff recruitment and high turnover. Professionals are prepared to accept responsibility when it is fairly theirs and when all aspects are considered, but do not wish to do so where the issue is one of lack of service or resources, or an unreal expectation of what can be provided for an individual.

The press and politicians also have a tendency to extrapolate from one individual instance that has, or appears to, have gone wrong, to a general conclusion that all is wrong or in chaos or crisis. This makes it more difficult for clinicians to do their already difficult job.

There is also some concern that the media and political portrayal of psychiatric patients as offenders, paedophiles, etc. will deter some people from using the service when needed - either because of fear of other patients or of being seen as one of that group.

Negative publicity commonly leads to a breach of clients' rights in that they are discriminated against (often not intentionally) due to the anxiety provoked within the public.

Major investigations and inquiries frequently result in clients ringing up in distress, anxious about what is going to happen to them. Additionally, it can take up enormous amounts of time and energy and divert Clinicians and others from the real job of improving the services on offer.

There is no doubt that the feeling of alienation created by stigma is one of the significant reasons cited for loss of hope and relapse by those who experience mental illness.

The Framework Trust:

This issue is significant given that many people who experience mental illness are often more sensitive to criticism and the judgment / opinions of others. Mental Health promotion is an important ingredient to reduce stigma, and must be regarded as a high priority if changes to the current pattern of inadequate adjustment to community settings is to be tackled effectively.

COMMENT: Clearly there is a need for a public awareness campaign which aims at educating the general public on Mental Health and mental illness. One submitter commented:

Public education has been shown to be successful in reducing stigma. Two recent examples in New Zealand were violence in the home (this is now not viewed as being acceptable behaviour). The other area where there has been significant change is in the public campaign for cycle helmets to be worn. With a concentrated effort on advising the general public on safety issues, it is now rare to see cyclists not wearing safety helmets.

If a concentrated effort was made around de-stigmatising mental illness it is unlikely we would continue to have the knee-jerk reactions we have from some politicians and the media.

We note that the Australian government recently embarked on a comprehensive, three year campaign promoting its National Mental Health Strategy - $8.5 million has been allocated to that project.

We support a public awareness campaign - it is a must. It is fundamentally wrong that a vulnerable group in our society should be continually subjected to the comments and actions of those who possess an outcast mentality. We believe that a well directed publicity strategy would bring success. We are optimistic enough to believe that a well informed New Zealand public will then realise that the mentally ill are people whom we should nurture and value.

We have been informed that a small steering group of Mental Health personnel in Auckland is presently working on a publicity strategy. We have insufficient information about that proposal upon which to make a sound judgment as to its effectiveness but, in general terms, we applaud the direction in which that steering group is heading.

It is important to note however that the effectiveness of such a campaign must be well researched in order to obtain maximum impact.

We have no wish to diminish the enthusiasm of the Auckland steering group - we acknowledge their commitment - but it seems to us that the implementation of a national publicity campaign must inevitably have resource implications at a national level. That, in turn, must necessarily implicate the Mental Health Commission to whose attention the steering group will do doubt direct its proposal.

CHAPTER SEVENTEEN

RESEARCH AND DEVELOPMENT

Dr George Salmond is the Director of the Health Services Research Centre. He is concerned about the lack of formal research and development programmes impacting on Mental Health Services:

> **In the 1994 - 1995 year the Health Research Council expended roughly 10% of its available funds in the Mental Health area. Of those funds, half was spent on neuroscience and neurology. Nothing was spend on Mental Health services research.**
>
> **The Ministry of Health expends small amounts on information support of its policy development function but has no formal research and development programme. Neither the RHAs or the CHEs have any research and development obligations. The conclusion that must be drawn then, is that there is no organised Mental Health research and development activity in New Zealand.**
>
> **A direct consequence of this lack of a research and development effort is that very little reliable information is available about any aspect of the provision of Mental Health services in New Zealand. What information exists is mainly about the institutional care of patients, not the medical care and social support of people with mental illness in the community. Rapidly changing organisational arrangements and patterns of service delivery make it difficult, if not impossible, to draw soundly based conclusions about how resources are, or could, or should be used. The result is that policy makers and managers at all levels are ill informed and have little other than self-interest advocacy to call upon. This situation is totally unsatisfactory, but need not be so.**
>
> **Example of possible research objectives:**
>
> - **To identify what range and mix of knowledge and skills is required to deliver cost effective care**

To assess the training requirements of members of specialist Mental Health teams and Primary Care teams, in order to establish ways in which professional development might be delivered to the team as a whole, rather than according to a professional background. This might include training in relation to diagnosis, treatment, service delivery, policy and legal aspects. Training requirements for those whose task it is to purchase Mental Health services might also be considered

- **To investigate the relative proportion of time spent by members of multi-disciplinary teams (including those based in primary care settings) using so called "generic skills", and that spent using skills specific to their professional background and training**

- **To test the hypothesis that the desirable membership of multi-disciplinary teams differs according to geographic, socio-demographic and ethnic characteristics of their catchment populations**

- **To investigate whether routine provision of psychological support specifically tailored to the needs of Mental Health workers is necessary, desirable or cost effective**

- **To establish the basic and continuing training requirements of professionals such as General Practitioners, Midwives, School and Practice Nurses and others not formally trained in psychiatry, who might be expected to identify, treat or provide continuing care for people with mental illness. What training and support from specialist workers is required?**

The following is a preliminary list of priority research themes developed by an informal group of people interested in Mental Health research.

- **The development of outcome measures for use in Mental Health services in New Zealand**

- **Studies of the interfaces between the various components of health and social services which bear upon Mental Health, Welfare Services, Housing, Self Help Groups, etc.**

- **Recognition of and response to Mental Health problems presenting in primary care settings**

- **Strategies to develop support systems for consumers and their families**

- **Reduce stigma and promote better understanding of all aspects of mental illness in New Zealand communities**

- **Develop evaluation models of acute services / systems and their delivery for use in New Zealand**

- **Develop evaluation models of culture specific services / systems and their delivery for use in New Zealand**

- **Look specifically at the interface between primary and secondary services**

- **Look at the impact of consumer participation on the acceptability and effectiveness of services**

- **Look at what keeps people with chronic mental illness well and what precipitates breakdown**

Subsequent to that submission it was pleasing to note that the Health Research Council has granted $1 million for Mental Health research projects which may extend over a three year period. Several of the themes outlined by Dr Salmond have been incorporated in Council's request for proposals.

Although there is much we can learn from overseas research, New Zealand cannot expect to rely almost exclusively on those sources for the continuing development of a Mental Health service which has numerous features peculiar to this country.

COMMENT: We support the move towards the development of a comprehensive and well resourced research and development programme. We envisage that RHAs and CHEs will become partners in that programme and, in so doing, they will assist in funding the research and sharing in its benefits.

We have considered how much funding would be required to establish and maintain a comprehensive research programme. We note that in the UK the benchmark level is 1% of the Mental Health budget, rising to 1.5%. Given the present state of research in New Zealand, that benchmark is excessive. New Zealand has a fairly small base of highly qualified researchers and it seems to us that the first requirement is to enlarge the skill base and then support it with appropriate funding. We believe that a modest start in the early stages is a desirable objective.

We regard research as a necessary adjunct to the development of a progressive Mental Health service. A benchmark funding base of about 0.7% of the Mental Health budget might not be an unrealistic target.

CHAPTER EIGHTEEN

FUNDING

As might be expected, the funding issue permeated this Inquiry. We find it difficult to recall one occasion on which a submission was not accompanied by a call for additional resources.

On 3 May 1996 we were advised by the Ministry of Health that, in real terms, expenditure on Mental Health services has grown by 5.9% per annum since 1990 / 1991 - albeit from a relatively small base. We were also informed that, on a real per capita basis, expenditure on Mental Health rose from $83.00 in 1990 / 1991 to around $99.00 per head in 1994 / 1995. This was said to be real growth of 4.6%.

Time and resources did not allow us to validate these figures but, for the moment, we accept they are correct. We acknowledge that any increase in funding is to be welcomed, but be that as it may, statistics cannot camouflage a few simple conclusions which have arisen out of this Inquiry. In no particular order they are:

- Mental Health services are in disarray. Those who work in the Mental Health sector are undervalued and underestimated for the notable contribution they make towards achieving a healthy community

- The recent increases in funding for Mental Health services are but an inadequate "catch up" to compensate for decades of financial neglect. The current level of funding, if maintained, will see the stagnation of a service which has been described by some as "barely adequate"

- We commented earlier in this report that, in some areas, Mental Health services are virtually non-existent. It may be argued that all but the most inaccessible regions have Mental Health cover and this proposition would be difficult to refute. The point we make is that when a service is so infrequent or under-resourced to the extent that the outcome is less than optimum then, for practical purposes, the service may as well not exist at all

- New Zealand must wake up to the fact that, for decades, Mental Health services have been delivered "on the cheap". This has resulted in the gradual disintegration of systems, a flight of expertise, a loss of morale by those who remain within the system and a potential loss of confidence by the community. Mental Health must not be at the end of the pecking order when funding for general health services is being decided. It must be regarded as a prestigious service if only because, in one form or another, 30% of New Zealanders will access the service. Although Mental Health has now been designated a funding priority it needs to be clearly understood that vision and reality must merge if progress is to be made

- A serious investment in the Mental Health sector must involve the provision of certain basic services, some of which are presently regarded as "add on extras". We note for example that in some areas maternal mental health, child and baby units, medical psychiatric units, chronic rehabilitation beds, day hospital, out-patient psychotherapy and brain injury units are regarded as supplementary services. This must not be so. If basic services do not exist it is a nonsense to implement initiatives such as community support workers and respite care services - desirable though these may be. We anticipate that the Mental Health Commission will undertake a comprehensive review of basic service needs.

- There must be a corporate and personal attitudinal change by those who purchase Mental Health services. At the risk of appearing offensive - that is not our intention - we suggest that, in some regions, Mental Health is regarded as a service which can cope on minimal funding. That attitude should long ago have been discarded. Clearly the Mental Health sector does not have the priority rating of other services.

  During the course of this Inquiry we heard, anecdotally, of Mental Health funding being diverted to some other sector "because that was more urgent". Comment was also made about the disproportionate corporate overhead paid by Mental Health services. We acknowledge the need for Mental Health to pay its fair share of administrative overheads, but if the fairly substantial anecdotal evidence is to be believed, then it would appear that the Mental Health sector - perhaps inadvertently - is being asked to account for more than its fair share.

  We express no decided view on the matter but we are led irresistibly to conclude that it will be difficult to alter attitudinal thinking in the short term. That observation should not be taken as reflecting on the integrity of those who allocate funds for Mental Health services. Realistically, we do not believe that even a modest attitudinal change will translate into the increased funding level which we believe is necessary.

  Accordingly, we will recommend that all Mental Health funding be ring-fenced at both RHA and CHE levels

- The Mental Health service survives because of the goodwill and expertise of those who remain within the sector. That goodwill has almost expired and when that happens there will be yet another Inquiry as to why the service has fallen to such a low level - yet again. The reality of course is that New Zealand has never had a comprehensive, fully integrated Mental Health service, and if it wants one it must be prepared to pay for it. Dr Ian Goodwin of Auckland expressed his concerns in this way:

At present the situation of psychiatry in New Zealand may be likened to that of surgeons being asked to perform surgery without operating theatres. It can be done, but it is not particularly pleasant and probably is quite dangerous for the patient.

- The Mental Health budget is aimed at providing services for that 3% of the population benchmarked in "Strategic Directions For Mental Health Services" (June 1994). The best evidence indicates that current funding is capturing 1.2% - 1.5% of that population. However, it would be wrong to conclude that a 100% increase in funding will provide a sufficient service for the benchmark population. That would clearly be excessive.

  We have given careful consideration as to the amount of additional funding which may be required over, say, a five year period in order to provide a comprehensive service for those for whom treatment is mandated. We express our thanks to Dr Sue Hallwright, Healthlink South (Paul Wylie), Southern RHA (Dr Karleen Edwards) and Derek Wright of Waitemata Health Ltd. for their assistance in this regard. In our view the additional figure would lie between $124.2 million and $140 million. Our resources were insufficient to validate the information supplied to us, but the general tenor from all four sources would indicate that the range we have suggested is a realistic one. We note that in two cases the indicative figure exceeded $140 million.

  We set out below an extract from the report of Dr Sue Hallwright.

COSTS OF A COMPREHENSIVE, INTEGRATED MENTAL HEALTH SYSTEM FOR ALL AGES

Per capita costs:

As detailed in this report, the cost to the Government in five years' time of a comprehensive and integrated mental health system for all age groups is estimated at $146.06 per capita (GST exclusive), of which $123.57 is for mental health services, $12.49 for drug and alcohol services, and approximately $10.00 is for improved access to expensive pharmaceuticals.

The $123.57 per capita for mental health services is based upon a 3% per annum population coverage for all age groups. The costing methodology used for mental health services is based upon the services required by people in the different population groups defined in Appendix I. The basis of the $123.57 per capita figure for mental health and the $10.00 per capita for expensive pharmaceuticals is shown in Appendix II.

Total annual sum:

Information received from the four Regional Health Authorities suggests that New Zealand falls $124.2 million per annum short of having sufficient money for a comprehensive, integrated mental health system for all age groups that could achieve a 3% per annum population cover. The sum would be substantially higher if the Government are seeking to achieve 3% population cover at a single point in time. Of the $124.2 million per annum, $80.9 million is for mental health services, $8.2 million for drug and alcohol and $35.1 million is to boost access to expensive pharmaceuticals (see Appendix III).

Additional work force development:

Experience from the recent past suggests that additional money for mental health would need to be introduced incrementally in order to ensure appropriate services are developed. It is also recommended that the sum to be spent on additional services each year for the next five years is augmented by a further sum for the purposes of work force development (without which services of excellence are unlikely to be developed). The appropriate sum will depend to some extent on the approach to work force development that is adopted, but a minimum of $6.2 million per annum (5% of the total additional money needed for mental health) is likely to be required. This sum would be over and above the expected investment by service providers in the development of their work force.

Services excluded:

The sum of $124.2 million per annum cited above would not cover:

- education, promotion, prevention (for the population)
- primary mental health care

Both of these areas are currently substantially under-resourced for mental health and together are likely to add in excess of $15 per capita to the above estimated cost to the Government (i.e. over $50 million per annum in addition to the $124.2 million cited in this report). Accurate assessment of the costs of more adequately addressing these additional areas has yet to be undertaken. The full amount of shortfall for all mental health services (from public health through primary and secondary services) is therefore likely to be over $175 million.

COMMENT: It should be noted that the following are excluded from the above analysis:

- Education, promotion, prevention

- Primary mental health care

- Work force development

We hasten to add that as part of her analysis, Dr Hallwright provided us with a comprehensive set of tables and a methodology explanation in support of her conclusions.

For immediate purposes, the most significant exclusion is that of work force development. We are unable to indicate a figure for this purpose and ultimately it may be difficult to quantify the amount until the proposed Mental Health Commission has decided how it will tackle the work force issue. We support the notion that additional funding be introduced incrementally over a five year period, rising to $125 million - $140 million in year four or five.

Finally, we acknowledge that Government is entitled to know how its money is being spent. If a serious health need exists then it is our respectful view that Government has a responsibility to fund it. We believe that this Inquiry has demonstrated a profound need for more and better co-ordinated Mental Health services. We believe that the Mental Health Commission will have no difficulty in reaching a similar conclusion. We urge Government to predicate its funding on a five year timetable - that being the life span of the proposed Mental Health Commission. The need for some immediacy was drawn to our attention by one consumer who noted:

> **Someone who is mentally ill or in need of Mental Health services is here and now. We cannot afford to wait another ten years.**

We acknowledge that Mental Health, like all other sectors, must be one of several competitors for taxpayer resources, but it seems to us that the issue of additional funding might well be approached from two directions. They are:

i. direct additional funding from vote:health; or

ii. a re-allocation of resources from each RHA plus additional funding from vote:health.

We invited each RHA to provide us with information about the expenditure on Mental Health services, including Drug and Alcohol services, for the current year. We note that expenditure by the Central RHA, at $125.54 per capita, was higher than in each of the remaining three regions.

If the notion of a national, comprehensive, integrated Mental Health service is to have any meaning at all, we see no reason why Government should not insist upon each RHA funding to the level of the highest current purchaser, i.e. Central RHA at $125.54 per capita. On that basis the additional RHA contribution would be approximately $53 million and the additional Government contribution, from vote:health would be approximately $72 million. More precise figures are set out in the graph below.

See page 176 for recommendations.

RHA	POPULATION	RHA TARGET 1	ACTUAL	RHA CONTRIBUTION 2	GOVT CONTRIBUTION 3	TOTAL
SOUTHERN	777,782	$97,647,770	$86,188,488	$11,459,282	$15,958,718	$27,417,999
CENTRAL	860,000	$107,970,000	$107,970,000	$0	$17,645,695	$17,645,965
MIDLAND	714,000	$89,640,209	$78,560,000	$11,080,209	$14,650,030	$25,730,240
NORTHERN	1,157,236	$145,286,943	$115,600,000	$29,686,943	$23,774,458	$53,431,400
TOTAL	3,509,018	$440,544,922	$388,318,488	$52,226,434	$71,998,901	$124,225,335

1 Based upon each RHA equalling the Central RHA in per capita expenditure

2 Additional expenditure required by each RHA to equal Central RHA per capita expenditure (to be sourced from internal re-allocation of funding from other health areas)

3 Government contribution toward sufficient expenditure for the proposed Mental Health services at $20.52 per capita, if each RHA were to equal the per capita contribution of Central RHA to Mental Health

WE RECOMMEND:

1. That current expenditure on Mental Health services, including Drug and Alcohol services, be increased incrementally over a five year period. The level of additional funding in year five will be not less than $125 million - $140 million per annum

2. That expenditure on Mental Health services, including Drug and Alcohol services, be ring fenced at RHA and CHE levels

CHAPTER NINETEEN

SOME FINAL THOUGHTS

This Inquiry has four objectives:

- To respond to our Terms of Reference
- To provide an overview of Mental Health services in New Zealand and, in particular, to highlight those services which are less than optimum
- To recommend a mechanism for the delivery of Mental Health services
- To highlight funding and resource concerns

This report is unusual in that it contains only five recommendations. However, if implemented, those recommendations will have a profound effect on the future development of services. We have deliberately avoided making further recommendations for reasons which are probably apparent from a reading of this report. It makes no sense to draft recommendations about clinical, legislative, management, administrative, work force and other issues unless there is a real expectation that they will be implemented.

We may be criticised for not having done so and that is a criticism we are prepared to accept. To some people a raft of recommendations may be seen as an indicator that the Inquiry team has been doing its job in the sense that the numerical value of the recommendations is in direct proportion to the time, energy, study and expertise involved in their creation.

Given the current state of Mental Health leadership in New Zealand, we believe that such an approach is illusory. It would create an expectation in the Mental Health sector and amongst families and consumers, which could not be met. That would be devastating.

Above all else it is imperative to establish an organisation which will take control of the existing fragmented services, and develop a quality service within five years. In our view the Mental Health sector is now looking for certainty and consistency in its future development. A nationally recognised leader, clearly mandated, is necessary if those goals are to be achieved.

We are confident that appointees to the Mental Health Commission and the Advisory Board will be people of vision, wisdom and expertise and will have an empathy towards the mentally ill and those who access Mental Health services.

We have no wish to stifle the Commission in deciding for itself how best to tackle the many problems outlined in this report, and we are concerned that any recommendations we make might be seen as a firm direction to follow the course we suggest.

That would remove flexibility of thought and action by the Commission which, when confronted by additional information, may well adopt an approach contrary to our own.

In writing this report we have opted to comment on each of the main problem services brought to our notice. We have underscored the features in each of those services, which demand resolution and, where appropriate, we have indicated the priority which should be accorded to that service. A plethora of recommendations would be of little assistance to the Commission. We are hopeful that those who read this report will have little difficulty in identifying the defects in the Mental Health sector - most are already well known - and we are content to rely on the Mental Health Commission to take note of our views, to recognise the general direction in which that service should be moving and to turn words into action.

We now comment briefly, and at random, on other matters which have not been touched on in this report. Because of time constraints we have been unable to give as much attention as we would have wished to other features of the Mental Health service. Services for the elderly, refugee services, services for mothers and babies, the difficulties in accessing certain medications, the inequity of benefit payments for mentally ill consumers, training for NGOs and services for those who sustain head injuries were just some of the many aspects we were asked to consider. Those submissions, although few in number, deserve further consideration by the Mental Health Commission.

On several occasions during the course of this Inquiry we were told that some improvement has occurred in the delivery of Mental Health services. It was generally acknowledged that a substantial improvement had occurred in the Forensic Service since 1988 but, in our view, the so called improvement is a philosophical improvement rather than one which directly affects the wellbeing of the consumer and his / her family or caregiver. More often than not, the response from those who suggested an improvement in services was "well, we don't have the large crowded psychiatric hospitals and that's got to be a real improvement". We applaud the move towards care in the community, but if the closure or rundown of large psychiatric institutions is to be regarded as the litmus test or "improvement", then it would seem that the improvement has been more illusory than real.

On 1 May 1996 the Ministry of Health sent us a copy of a statement on the Mental Health Services Strategy from the Mental Health Services Strategy Advisory Group, chaired by Dr Thakshan Fernando. We agree with the general thrust of that statement and note, that in several respects, its findings are similar to those of this Inquiry.

In general terms that statement identifies some of the key issues which must be resolved before the National Mental Health Strategy can be fully implemented. We commend that statement for further consideration by the Mental Health Commission. It will be a valuable resource document.

With the advent of this report, the Mental Health sector will have completed yet another cycle of Inquiry fatigue. That process does little for the dignity of those who are mentally ill or who access Mental Health services.

We leave the last word to the Wellington branch of the Schizophrenia Fellowship:

> **Mental illness, in all its various forms, is a normal part of society. It is found in roughly the same proportions all around the world and in all societies, be they modern industrial societies or mountainous village communities. Given that we do not as yet have the ability to prevent these illnesses, or the knowledge to provide a complete cure, mental illness cannot be eliminated. People who suffer from such cruel and, at time debilitating, disorders must be fully supported and adequately resourced so that life for them can be "the best it can possibly be" - whether that is in a secure, protected, safe, humane, residential setting (asylum in the very best sense of the word), or living a healthy contemporary life of their choice in the community. There should not have to be this fight over resources. Can a society that considers it places value on human rights and democracy do anything less than fully support and value its most vulnerable?**

APPENDIX 1
LIST OF WRITTEN SUBMISSIONS

Accident Compensation Corporation

Accommodation for Mental Health Society (North Shore) Inc.

Aitchison, Angus

Aitchison, A.L.

Alcohol Advisory Council of New Zealand, (Dr Mike MacAvoy)

Aldred, Helen M.

Alexander, Graham

Alliance Party, (Jim Anderton M.P.)

Alo-O-Tuatagaloa, (Fuimaono Karl Pulotu-Endemann)

Amani, Margaret

Amos, Murray

ANOPS

Anchorage Trust

Anderson, Margot

Anderton, Jim M.P.

Aotearoa Network of Psychiatric Survivors, (Mary O'Hagan)

Ashburn Hall, (Dr John Adams)

Ashton, Lois

Association for Allergy Hyperactivity & ADD (Brenda Sampson)

Association of CHE Mental Health Managers

Atley, Sarah

Auckland Council for Civil Liberties

Auckland Council of Psychiatrists, (Dr Chris Perkins)

Auckland District Law Society - Mental Health Committee

Auckland Healthcare Services Ltd

Auckland Hospital Mental Health Services

Auckland Mental Health Association Inc., (Suella Sturm)

Auckland Public Service Association

Auckland Regional Parents/Care Givers Support Group, (Robyn Ford)

Avery, K.H.

Bailey, Karen E.

Bain, Beverly and Allan

Baptist Mental Health

Baran, Dr., Irving

Barlow, R.B.

Barry, Mary

Barry, Vince

Barton, Dr., Yvonne

Bateman, Robyn

Beard, Mr and Mrs, D.G.

Bebarfald, David

Bebarfald, S.H.

Belcher, A.J. & P.J.

Belcher, Eric W.

Beltowski, Dr, L.

Benland, Catherine

Bent, W. John

Benton, Michael Ann

Better Futures, (Chris Sides)

Birt, Gail

Bishop, Athol L.

Black, Anne

Blackwell, R.M.

Boddy, Gill

Booth, Graham and Patricia

Bowden, Muriel

Boyd, Stephen

Braams, Gaynor and Bill

Bracey, O.

Bradford, Bill and Sue

Bradley, Peter

Bradshaw, Peter

Breeze, Paul

Bridgeman, Jocelyn

Bridges Consumer Support Network Incorporated

Brines, James and Jan

Broad, Joanna

Brockway, Dr, Raewyn Alice

Bruce, Richard R.

Buller District Council

Burrell, Dr, Richard H.

Cabral, Len and Noeline

Cairns, M.M.

Calder, Vivienne

Campbell Home Trust

Campbell, Kevin

Campbell, Lorraine

Capital Coast Health Ltd., (Dr. Bridget Taumoepeau)

Capital Coast Health Ltd, (Dr John Crawshaw)

Capital Coast Health Ltd, (Mental Health Resource Centre Staff)

Capital Coast Health Ltd, (Ward 27 - Multidisciplinary Team)

Capital Coast Health Ltd.

Caring Communities Incorporated

Carlyon, Noeline and Robert

Carr, Patrick

Carrell, Martin

Carruthers, Ellen

Cathie, T.

Catholic Commission for Justice and Peace

Central Regional Health Authority, (Martin Hefford)

Challenge Trust, (John Wade)

Chappell, James

Chignell, Mr and Mrs

Ching, Cheryl

Christian Social Services

Citizens Advice Bureaux, (Margy-Jean Malcolm)

Citizens Commission on Human Rights

Coast Health Care Ltd, (Community Mental Health Services, Greymouth)

Coast Health Care Ltd, (Hecta Williams)

Coast Health Care Ltd, (Tom Groot)

Coast Health Care Ltd.

Coast Health Care Ltd., (Dan Brizzell)

Colegate, Ann and Brian

College of Nurses, Aotearoa (N.Z.) Inc.

Collier, Janice

Comber, P.J.R.

Conn, Stephen

Coppin, Wendy and Bill

Cottage Mental Health Unit, (Raewyn Stutterd & Mary Stanners)

Cotton, Lawrence

Craig, Dr., Brian J.S.

Crawford, Dr, Robert

Creighton, Gillian

Cressford, M.

Cross, Valda and Ron

Crowe, Janet

Crowley, Dr., John

Cunningham, Marjorie

Cutelli, Bernadette, and others

D'Postine, M.E.

Dalton, Beth M.

Dalziel, Lianne, M.P.

Davidson, Christine

Davidson, Christine and Brian

Davis, The Most Reverend, Brian

Department of Corrections

Derry, Phil and Margaret

Dexter, Judith

Dick, J.M. **and Dick,** D.F.

Dickson, P.M.

Dimensions Consultancy, (Edgar B. Smallwood)

Ding, Dr, Les

District Inspectors of Mental Health, Wellington

Doherty, Patrick and Helen

Dore, Dr., Glenys

Downtown Community Ministry Wellington Inc.

DPA (New Zealand) Inc.

Drury, Nick

Duff, Maera

Dunsford, Esther A.

Dyall, Lorna

Dyer, Mary

de Jong, Maxine **and Tait,** Tahi

du Fresne, Dr., Stephanie

East Community Mental Health Sector Base

East Mental Health Sector Team - Day Programme Clients

Eastbay Health Ltd, (Pam Greenaway)

Eastbay Health Ltd., (Eddie Smith)

Eastbay Health Youth Mental Health (Kevan McConnell)

Eating Disorders Association (NZ) Inc.

Elder, R.A.

Elliott, Christine

Elliott, Dr., Roger

Ellis, Rosemary

Ellis, Shirley

Emery, Michael John

Emery, Maureen

Eriksen, Sonja

Evans, David

Evans, Jacqueline

Eves, W.

Family Health Counselling Service, Healthlink South

Farquhar, C.

Feist, Margaret

Fenlon, Mr, F.

FIRST Group, (Dr Stephanie du Fresne)

Fisher, Mark

Fitzgerald, Dr., Paul

Flahive, Russell

Fleischer, Henriette

Flynn, Cathy

Foreman, Paula

Forsyth, Chaz

Foster, Barbara

Foster, Gladys

Framework Trust, (Katherine Fell and Chris Harris)

Fraser-Wood, Natalie

Fredericks, Mary

Frew, Christine

Gawith, John

Gayford, J.

George, Timoti

Gibb, L. J.

Gibson, Gloria

Gilchrist, Melanie

Gilchrist, J.

Gilmore, Harry L.

Goldsack, Murray and Maxine

Goode, Brian and Cushla

Goodwin, Dr, Ian

Goodwood Park Trust

GROW NZ Inc., (Annie Cripps)

Grace, Adrienne

Grebenar, Catherine Mary

Green, E.

Greenwood, Alexander R.

Greer, Judy

Gregory, Robert J.

Grigor, Dr, John

Groenewegen, Linda

Grubbs, Dr., James H.

Hakiwai, Laurie

Hall, Dr, Anne

Hall, Karen

Halley, Craig

Halley, Rosemary

Halligan, J.

Hamilton City Council

Harding, J.R.

Hargreaves, Alfred E.E.

Harris, T.R.

Harrison, Linda

Harrison, A.M.

Hartshorn, Dr., Mary

Hartshorn, Jackie

Hathaway, Rebecca

Hauoro Waikato (Rae Wirihana)

Hay, Roger

Hayward, Judy

He Putea Atawhai

Head Injury Society of New Zealand Inc.

Health Services Research Centre

Health South Canterbury Ltd, (Brent Doncliff)

Health Waikato Ltd, (Dr. Malcolm Stewart)

Health Waikato Ltd, (Dr. Simon Eminson)

Health Waikato Ltd, (Ellie Wellington and Jeff Symonds)

Health Waikato Ltd, (PSA Sub-Group - Tokanui Hospital)

Health Waikato Ltd, (Dr. Roy Krawitz)

Health Waikato Ltd., (Dr. John Gleisner)

Health Waikato, (Dr. Satvir Singh)

Healthcare Hawkes Bay, (Sue Ward)

Healthcare Otago, (Dr Richard Mullen)

Healthlink South, (Paul Wylie)

Healthlink South, (Community Drug & Alcohol Service)

Healthlink South, (Dr Erihana Ryan)

Healthlink South, (Health Promotion Public Health Service, Sue Dewe)

Healthlink South, (Jane Cartwright)

Healthlink South, (Jonathan Morgan and Murray Walker)

Healthlink South, (Psychiatric Service for the Elderly)

Healthlink South, (Te Kahui Pou Hauora Maori, Dr Erihana Ryan)

Healthlink South, (West Mental Health Centre)

Hemus, C.R.

Hewland, Dr., Robyn, QSM

Hibbs, Dr., D.J.

Hickman, Airdrie Drysdale

Higgs, Graeme

Hill, A.E. and R.J.

Hill, Tony

Hillyer, Hon., Peter G.

Hinde, G.W.

Hinds, Pauline

Hobbs, John

HOMES, (Peter Browning)

Hoffman, Jeanette

Hokianga Health, (Roy Johnson and Kirsten McCullum)

Holthouse, John

Hopewell, Mary

Hopkins, Dr, John

Hopkirk, Kathy

Horan, Dr., J.J.

Hosford, Dr., Ian

House, Sheila

Hucklesby, Nigel

Hughes, Frances

Hulme House, (Staff)

Human Rights and Disability Lobby Group, (John Forman)

Human Rights Commission

Humphries, Hilary

Hunt, James

Hurst, Sue

Hutt City Council

Hutt City Council City Environment Group, (Sandy Beath-Tatam)

Hutt Community Psychiatric Nurses, Hutt Valley Health, (Debbie Gell)

Hutt Mental Health Network, (John Forman)

Hutt Valley Health: (Kathy A. Korth)

IHC New Zealand Inc.

Inches, Stuart

Inside Out

Invercargill Community Mental Health Team

Jackson Y.L.

Jacobs, Maureen

Jameson, Diana

Jarvis, Felicity, **and Parnell,** Catherine

Jeffcoat, Richard

Johnston, Graham

Joseph, C.E.

Joyce, Patricia Josephine

Joyce, Professor, Peter

Justice Action Group, (C.R.Burgering)

Kan, Timothy

Keatinge, W.

Keen, Patricia

Kemp, Bernard

Kennedy, Colleen

Kenny, Gerard

Kent, Hugh

Kenworthy, Dr., Gordon

Kerr, Garry and Denise

Kingston, Dr, Helen

Kirby-Barr, Maggie **and Henderson,** Rose

Klinger, Dr., Jeremy

Kneebone, Jean and Clarrie

Knight, Ron and Alice

Kulkarni, Associate Professor, Jayashri

Kydd, Professor Robert

Lakeland Health Ltd., (Mental Health Service)

Lakeland Health, (Phyllis Tangitu and Ray Watson)

Lamb, Thomas L.

Lambe, Dr., John

Laracy, Eugénie

Larsen, Kathleen

Larsen, Win

Laurie, Anne

Lawler, Cicely M.

Lee, Mrs

Leonard-Taylor, S.

Levin Obsessive Compulsive Disorder Support Group

Limmer, Joan

Lin Naili

Linklater, Jack

Llewellyn, Richard

Love, Jean

le Fleming, F.M.

M.A.S.H. Trust

MacClure, Ruth

MacDonald, Dr., A.D.

MacDonald, Graham and Sandra

MacKay, Libby and Dougal

MacKenzie, Judith

MacKirdy, Dr. Catherine

Macquarrie, W.N.

Mahony, Judge, P.D.

Mallard, Trevor, M.P.

Malley Mahon & Co., (Ernest J. Tait)

Maloney, Judith

Mannering, Rosemary

Maori Women's Welfare League, Rata Branch

Map, Peggy

Mariner, Brian E.

Marshall, J. and G.D.

Marsland, Cathy and Roger

Mason-Rogers, Caroline

Mates, Dr., Jacob

McCormack, Janet

McDonald, Wiremu J.

McElrea, Judge, F.W.M.

McGaw, J.D.

McGaw, Sue

McGeorge, Dr, Peter

McKewen, Shirley

McLauchlan, Ian

McNeil, Kathryn

McVeagh, John D.

Mellsop, Prof., Graham

Mental Health Foundation of New Zealand

Mental Health Rehabilitation Team

Mental Health Service, Hutt Valley Health, (Dr. John Lambe)

Metcalfe, Rose

MidCentral Health Ltd, (Sue Wyeth)

Midland Regional Health Authority

Miles, Dr., Wayne

Mills, Stewart

Milne, Duncan

Ministry of Health

Mitchell, Tom

Moller, Dr. P, **and Nicholls,** Prof. M.G.

Moore, K.W.

Moran, Cherie

Morgan, L.A.

Mossman, Pauline

Muir, Marjorie

Munce, Louise

Munro, Cheryl

Murfitt, Robert

Narbey, Nick

National Advisory Committee on Health and Disability

National Council of Women of New Zealand (Inc.)

National Mental Health Media Strategy Group, (Janet Peters)

National Union of Public Employees Inc.

Nau Mai Whare, (Vivienne Calder)

Neal, Tracy J.

Neame, Peter

Neame, Rosalie

Nelson-Marlborough Health Services

Nelson-Marlborough Health Services, (Keith Rusholme)

Nelson-Marlborough Health Services, (Ashley Koning)

Nelson-Marlborough Health Services, (Mobile Community Team)

New Zealand Association of Occupational Therapists (Inc.)

New Zealand Association of Social Workers (Inc.)

New Zealand Association of Social Workers, (Val McKenzie)

New Zealand Children & Young Persons Service

New Zealand First, (Patra de Coudray)

New Zealand Medical Association

New Zealand Medical Association, Canterbury Division

New Zealand Police Association

Wellington Mental Health Consumers Union Inc.

New Zealand Police National Headquarters

New Zealand Prisoners Aid & Rehabilitation Society (Inc.)

New Zealand Public Service Association, (Peter Neame)

New Zealand Public Service Association, (Anthony Rimmell)

New Zealand Public Service Association, (Grant Duffy)

New Zealand Public Service Association, (Good Health Wanganui Ltd)

New Zealand Society of Physiotherapists Inc.

Nicholls, E.A.

Nicholls, Jennifer

Nixon, Curtis A.

Nolan, Chris

Nom, Tony and Janette

Northern Mental Health Review Tribunal, (Kristy P. McDonald)

North Health, (Garry Wilson)

Northland Health: (Ken Whelan)

Nursing Council of New Zealand

NZ Branch Training Committee, Royal ANZ College of Psychiatry

NZ Police (Avondale)

O'Connor, J.R.K.

O'Connor, T.J.

O'Sullivan, Peggy

Office of the Privacy Commissioner

Ogle, Ross and Lee

Olsen, Daphne

Oranje, Lana **and Ledger,** Linda

Orovwuje, Reg

P.S.A. Otago (Members Healthcare Otago Psychiatric Services)

Page, Jennifer

Page, Sylvia

Paget, Joan

Parham, Helena

Parr, Jean E.

Patient Rights Advocacy Waikato Incorporated

Pearcy, Brian E.

Peddie, Esme

Penney, M.J.

Penny, Linda

People Relying On People, (Eve McCarthy)

Perkins, Dr, Christine

Pharmacy Care N.Z. Ltd.

Philp, Christine

Phobic Trust, (Marcia Read)

Pipe, Christine

Polaschek, Devon

Pollard, Joan

Porirua ADD Parent's Support Group

Porirua Community Health Group, (Don Borrie)

Porirua Community Health Group, (Mental Health SubGroup)

Pou Kaha Support Group, (Tony Butler)

Powell, Raymond

Pratt, Dr., Douglas

Presbyterian Support Services, (Jocelyn Wilson)

Psychiatric Consumers Support and Advisory Trust, (Gary L.Watts)

Psychiatric Rights and Information Network, (Rodney Davis)

Psychiatric Survivors Trust, (John)

Psychiatric Survivors Trust, (Lynette Neill)

Psychiatric Survivors Inc., (Rodney Davis)

Psychiatry Consultancy Services, (Dr Stewart Roberts)

Public Service Association and NZ Nurses Organisation

Public Service Association, (Porirua Hospital Sub-Group)

Pugmire, Neil McIntyre

Purdey, Lesley

Queen Mary Centre, (Gerald A. Bunn)

Quick, Dr., Don

Race, Marilyn

Rae, Dr Alma

Manawatu Schizophrenia Fellowship Carers Group, (Dorothy Alley)

Rapua te Oranga Hinengaro Trust

Rauschenberger, Lou

Ravlich, Anthony

Read, June E.

Read, Dr, John

Recordon, Philip

Reddell, Rev., Graham H.

Regional Forensic Psychiatry Service: Porirua

Rescare Auckland Inc.

Rescare New Zealand Inc., (Bill McElhinney & Val Newman, QSO)

Reynolds, Judith

Rice, Stephen

Richardson, Paula

Richmond Fellowship New Zealand, (Gerry Walmisley)

Richmond Fellowship, (Michael Jones)

Riley, Elizabeth

Robertson, Diana

Robertson, Irene and Donald

Robertson, Jenny

Robinson, Elspeth

Roche, Dr. R.A.

Rogers, Carmel

Romans, Prof. Sarah E.

Roopu Tane Taranaki

Ross, Alisdair

Rushworth, Kathleen

Committee of Concerned Citizens for Hospital Services

Russell, Alasdair J.

Ruth, Sally

Rutherford, J.

Ryan, Tom

Sadler, Mark D.

Salvation Army Invercargill, (Major Gerald Thorner)

Samson, Elaine

Sanderson, Ray

Sara, H.S.

Sara, Shirley

Savory, S.J. and L.W.

Schimmel, Dr., Paul

Schizophrenia Fellowship (Auckland) Inc.

Schizophrenia Fellowship (Auckland) Inc., (Cindi Wallace)

Schizophrenia Fellowship Canterbury Branch Inc.

Schizophrenia Fellowship Canterbury Inc., (Judy Tait)

Schizophrenia Fellowship Central Otago Sub Group

Schizophrenia Fellowship Hawkes Bay Branch

Schizophrenia Fellowship Manawatu Branch Inc.

Schizophrenia Fellowship Nelson Branch Inc.

Schizophrenia Fellowship New Plymouth Branch

Schizophrenia Fellowship NZ Inc.

Schizophrenia Fellowship Otago Branch Inc., (Heather Ottley)

Schizophrenia Fellowship Southland Branch Inc.

Schizophrenia Fellowship Waikato Branch

Schizophrenia Fellowship Wairarapa Branch

Schizophrenia Fellowship Wellington Branch Inc.

Scobie, Dr., Brian

Scobie, Fairlie

Scoles, Dennis K.

Scott, Howard

Scrivens, Ruth

Service, Scott

Sheenan, Alva

Shelley, Ann-Marie

Shurrock, Janet

Simpson, Dr, A.I.F.

Simpson, Kathy

Singh, Dr., Satvir

Single, Mike

Smagge, Charles

Smith, Kevin L.

Snoep, Maree

Solutions, (J. Oldbury and P. Kempton)

South Auckland Greypower Superannuitants Association

South Auckland Health, (Ingrid Thomas)

Southern Regional Health Authority, (Dr. Karleen Edwards)

Southland Mental Health Community Committee, (Margaret Klemick)

Sporting Shooters Association of New Zealand Inc.

St Anne's Anglican Church, Porirua, (Rosemary Robinson)

St. Johanser, Christopher

Standards and Monitoring Services, (Marilyn Craig)

Staniforth, Christine

Stepping Out Hauraki, (Lisa Fulton and Marie Reilly)

Stevens, Wayne

Stevenson, Fay

Stiles-Dawe, Elizabeth

Suburban Care, (Trevor J. Humphre)

Sutich, Joseph

Symmans, Mary

Tairawhiti Healthcare Ltd., (Dr. Noel Fernando)

Tait, Judy

Tangiora, Pauline

Tangitu, Phyllis

Taumata Rest Home, (S. Burton)

Tauranga-Western Bay Health Community

Taylor, J.W.

Taylor, Lorraine

Te Aratu Trust - Associates, (Geoff Harman)

Te Aratu Trust, (Karel Hartemink)

Te Kotuku Ki Te Rangi

Te Puni Kokiri

Te Whanau o Maori Mental Health Services, (Chas McCarthy)

Templeton, David and Gillian

The Avenue Counselling Centre, (Irene Deliefde)

The Manic Depressive Society Incorporated

The National Association of Support & Housing Services

The Royal Australian and New Zealand College of Psychiatrists

The St Lukes Centre (Inc.), (A. Jones, J. Tolmie, B. Hall)

Thompson, Gail

Tod, Peter G. and **Tod,** J.L.

Tohovaka, Te Aniwa

Anglican Social Justice Commissioners, (Rev. Jim Greenaway)

Tuakimoana, Tamaleti

Turbott, Dr, John

Tuwhare, Jean

Tuwharetoa Health Roopu, (Frances Ketu and Kamiria Gosman)

Van Alkemade, Elizabeth

Van der Hulst, C.

Van der Klift, Dr., Derek

Vaughan, Jo-Anne

Verhoeven, W.

Versandvoort, C.J.

Victim Support Group Palmerston North

Victoria Corner, (John Fallon)

Vietnam Veteran's Association of New Zealand Incorporated

Viitakangas, Gloria and Jouni

van der Sluis, Dr, J. D.

Wahitapu, Valerie

Wairarapa Health: (C. Clarke, N. Worrall, D. Arya)

Wairarapa Mental Health Consumers Union, (T.E. Ward)

Waitemata Health Ltd, (Dr. D.G. Chaplow)

Waitemata Health Ltd, (Derek Wright)

Waitemata Health Ltd, (Mental Health Services for Older People)

Waitemata Health Ltd, (Occupational Therapists)

Waitemata Health Ltd, (Simon Baxter)

Walby, James

Wallace, Cindi & **McGill,** Sandra

Wallace, Glenys

Ward, Mr and Mrs, R.B.

Ward, W.

Wareing, Dr Christopher R.

Warren, Jenny and Roger

Waugh, John

Weintraub, Dr., Dan

Weir, Lyndsay

Wellington Gay Welfare Group Inc., (Ian MacEwan)

Wellington Mental Health Consumers Union Incorporated

Wellington Psychiatrists, (Dr. Rebecca Denford & seven others)

Wellington, Ellie and **Lindsay,** Jan Maree

Wells, G.

Welsh, Barry

Werry, Prof., John S.

West, Jane

West, Steve

West Auckland Shared Vision for Mental Health, (C.C. Hullett & others)

West Christchurch Women's Refuge

Western Bay Health Community Mental Health Services

Western Bay Health, (Beryl Riley)

Western Bay Health,(Dr. Pey-Chyou Pan)

Western Bay of Plenty Mental Health Trust, (Jean Haslam)

Westwood, Lesley

Whangarei Mental Health Caregivers Support Group

White, Isabella W.

White, Malcolm and Beryl

Whitehead, G.B.

Whitehead, Peg

Wiffin, Lyn

Wijohn, Leon and Julie

Wild, Necia T.

Wilhelm, Fran

Wilkie, D.

Williams, Mike, **O'Donnell,** Eamonn and **Smith,** Bethne

Williams, Sheryle

Willy, Madeline & Christopher

Wilson, E.G. & B.R.

Winn, Kathleen

Winter, Carol

Wisely, Dr., Chris

Womens' Division of Federated Farmers of New Zealand (Inc.)

Wong, Dr, Sai

Wood, Dr., Kate

Wood, Margaret

Workplace Learning Consultancy

Worthington, Sonja

Wright, G.D.

Young, Dr. B.

Zinzan, Robin

APPENDIX 2

LIST OF INDIVIDUALS AND ORGANISATIONS WHO MADE ORAL SUBMISSIONS OR WHO WERE CONSULTED

This list is not exhaustive. It does not include the names of some who appeared in support of a group submission.

Adams: Dr. John	Baran: Dr. Irving
Adlam: Gilbert	Barclay: Louise
Aitken: Michael	Barclay: Margaret
Alami: Dr. Mark	Barker: Nigel
Allan: Cath	Barltrop: Peter
Allan: John	Barry: Sandy
Allnut: Dr. Steve	Barsby: Glen
Amos: Murray	Barter: Dr. Jim
Anderson: Barbara	Barton: Yvonne
Anderson: Dr. David	Bathgate: Dr. David
Anderson: Prof. Jeremy	Baxter: Dr. Joanne
Anderton: Jim (MP)	Bayne: Steve
Ankcorn: John	Beattie: Andrew
Antcliff: Dr. Debbie	Belcher: Eric
Arthur: Pikau	Bell: Sylvia
Ashford: Pauline	Bennett: Dr. Win
Ashley-Jones: Cathryn	Bensemann: Dr. Clive
Atkinson: George	Bernhardt: Mary
Auimatagi: Epa	Berwick: Roger
Autumn: Jan	Betageri: Ravindra
Ayling: John	Biddington: Eric
Bain: Allan	Bills: Dr. Jan
Bain: Beverly	Birt: Gail
Bale: Ian	Black: Angus
Ball: Gregory	Booth: Graham
Balzer: Mere	Booth: Patricia
Banga: Franceska	Bos: Valerie

Bradburn: Glenn	Chignell: Graham
Bradford: Bill	Chignell: Yvonne
Bradford: Sue	Chiplin: Jo
Bradley: Louisa	Chisholm: Olive
Bradshaw: Peter	Christie: Julia
Brankin: Kathryn	Clark: Bill
Breeze: Paul	Clarke: Carol
Bridgman: Dr. Geoff	Coats: Robert
Brinded: Dr. Phil	Cochrane: John
Brizzell: Dan	Cochrane: Rene
Broadbent: Dr Robert	Cockburn: Stuart
Brokenshire: John	Cole: Andrew
Broome: Victoria	Comber: Phillip
Browing: Peter	Compain: Tipa
Bruges: Graeme	Conaghan: Debbie
Brunton: Warwick	Connor: Jacqui
Buist: David	Cooper: Joy
Bunkle: Phillipa	Cosgriff: Kate
Burrell: Dr. Richard	Craig: Dr. Brian
Burt: Martin	Craig: Terry
Byers: Mark	Cranefield: Harry
Cadogan: Christine	Cranstoun: Lorrima
Calder: Vivienne	Craven: Karen
Campion: Peter	Crawford: Barbara
Carroll: Sandy	Crawshaw: John
Carter: Peter	Cressy: Shirley
Cartwright: Jane	Cripps: Annie
Casey: Andrea	Croft: David
Casey: Cathy	Crofts: Ruahine
Casey: Sarah	Crosswell: Gaye
Casley: Bill	Crowther: Liz
Cate: Irene	Curry: David
Cessford: T.	Curtis: Corinne
Chaplow: Dr. David	Dalziel: Lianne (MP)
Chappell: Allison	Dara: Lynne

Davies: Alan	Eminson: Dr Simon
Davies: Dave	Epstein: Dr Michael
Davies: Marie	Farrell: Kath
Davis: Rod	Farrell: Michelle
Davis: Trish	Faville: Cathy
Davison: Joanna	Fell: Katherine
Devcich: Phyl	Ferguson-Smith: John
Deverell: Neil	Filipo: Rossana
Ding: Dr. Les	Finlay: Peter
Disley: Dr. Barbara	Fitzgerald: Dr. Paul
Dixon: Annette	Fletcher: Kay
Dobson: Ella	Flynn: Cathy
Doolan: Mike	Forbes: Lesley
Dore: Dr. Glenys	Forley: Peter
Douglas: Candy	Forsyth: Charles
Douglas: Tom	Fraser: Dr. Allen
Drysdale: Dr. Douglas	Fraser: Ngaire
du Fresne: Dr. Stephanie	Fulton: Lisa
Duffy: Grant	Fyfe: Harriet
Duffy: Steve	Gallen: Ted
Duggan: Robyn	Gamby: John
Duncan: Sandra	Gawith: John
Durham: Dr. Gillian	Gay: Maxine
Dyall: Lorna	Gedye: Robyn
Edgar: Wendy	Geer: Bryan
Edmond: Graeme	Gerken: S.
Edwards: Dr. Karleen	Gibb: Dr. Ian
Edwards: Erika	Gillespie: John
Egerton: Geoff	Gilmore: Sean
Elborn: Ann	Glasson: Sharon
Elder: Geoff	Gleisner: Dr. John
Elley: Lauraine	Glendinning: Debbie
Elliott: Bob	Gloistein: Joyce
Elliott: Christine	Goode: Cushla
Emery: Maureen	Gordon: Dr. Bill

Graham: Cheryll	Hetherington: Robyn
Grebenar: Catherine	Hibbs: Diane
Green: Les	Hibbs: Dr. Doug
Greer: Barbara	Hibbs: Lyn
Greer: Belinda	Hieatt: Tangiwairua
Grey: Gerald	Hinds: Pauline
Grieve: Allison	Hines: Peter
Groot: Tom	Hita: Dason
Guilder: Terry	Hitchcox: Dorothy
Haines: Stephen	Hobbs: John
Hakiwai: Laurie	Hocking: Barbara
Hall: Anne	Hodgkinson: V.
Hall: Dr. Ann	Holley: Trevor
Hall: Ken	Holman: Linda
Hall: Sheila	Honeychurch: Malcolm
Hallwright: Dr. Sue	Hooker: Chrissy
Hamer: Derick	Hooker: Pat
Hampton: A.	Hooper: Eve
Handley: Richard	Hopkins: Rosalie
Hannifin: John	Hopkinson: Ian
Harman: Geoff	Hore: Stephanie
Harris: Chris	House: Sheila
Harrison: Alva	Howison: Chris
Harrison: Henry	Hudson: John
Hartigan: John	Huggins: Maurice
Hayden: Helen	Hughes: Frances
Healey: Brad	Hughes: Peter
Hefford: Martin	Hullett: Clive
Helen: Madeline	Hussey: Wayne
Henare: Mary	Ings: Katrina
Hennessy: Julia	Ireson: Graeme
Henry: Bill	Irvine: Gary
Henry: Bridget	James: Dr. Kathy
Herdman: James	Jeffries: Pamela
Herrman: Prof. Helen	Jensen: Dr. Paul

Johns: Tony	Law: Susan
Johnson: Murray	Lean: Rosemary
Johnston: Kaye	Ledger: Linda
Jones: Lynnette	Lee: Phyllis
Joyce: Prof. Peter	Leggatt: Dr. Margaret
Judson: Dr. Nick	Leigh: Adrianne
Kavanagh: John	Levy: Dr. Lester
Keay: Greg	Liddy: Paul
Keelan: Wi	Lindsay: Vivien
Keen: Tricia	Lipton: Assoc. Prof. George
Kelley: Julie	Little: Ilene
Kelly: Julie	Loan: Dr. Philippa
Kelly: V.	Lomax: Alison
Kempton: Penny	Lyon: Dr. Bill
Kennedy: Collen	MacDonald: Gavin
Kenny: Gerard	MacGregor: Rob
Kerr: Anne	McAuliffe: Peter
Kett: Jamesine	McCarthy: Chas
King: Bob	McCarthy: Eve
King: Cathy	McCullum: Kirsten
King: David	McDaniel: Paula
Kingston: Dr Helen	McDonald: Fay
Kinita: Rangi	McDonald: Kristy
Kirton: John	McFadyen: Beth
Klap: Victor	McFelin: Teresa
Koller: Stephanie	McGeorge: Dr. Peter
Krawitz: Dr. Roy	McGill: Sandra
Kulkarni: Assoc. Prof. Jayashri	McGorry: Assoc. Prof. Pat
Kumar: Ashok	McKay: Darryl
Kydd: Prof. Rob	McKenzie: Georgina
Ladonski: Brent	McKenzie: Dr. Jan
Laing: Julia	McKergow: Dr. Tim
Laracy: Eugenie	McKewen: Shirley
Lardner: Eileen	McLachlan: Moa
Lavery: Mine	McLaren: Rodger

McLeod: Dr. Sandy	Munro: Cheryl
McNeil: Ken	Munro: Chris
McPherson: Sally	Muntz: Tanya
Mackie: Kevin	Murphy: Barbara
Maessens: Lucy	Murphy: Janice
Mailei: Marlene	Mutale: Dr. Theo
Maloney: Judith	Nancekivell: Patricia
Manderson: Doris	Nankervis: Julie
Maniapoto: Winston	Napier: Stephanie
Mansergh: Sue	Natana: Iwa
Marceau: Noel	Neame: Peter
Martenieule: K.	Neill: Lynette
Martin: Heather	Nicholls: Ann
Masters: Dr. Alison	Nisbet-Smith: Louise
Mathewson: Clive (MP)	Noble: Sam
Mathieson: Paul	Noema: Aroha
Matthews: Tracey-Anne	Northey: Stephen
Miles: Dr. Wayne	Noseworthy: Susan
Millar: Bruce	Nowitz: Dr. Andrea
Milne: Duncan	O'Brien-Smith: Chris
Mitchell: Andy	O'Cain: Bev
Mitchell: Isobel	O'Callaghan: Jean
Moke: Karen	O'Hagan: Lynda
Moore: David	O'Hagan: Mary
Moore: Heather	O'Hara: Maureen
Moore: Lisa	O'Sullivan: John
Moore: Mike	Oldbury: Jae
Moore: Mike (MP)	Oliver: Hugh
Morton: Cathie	Olson: Alvin
Moss: Tim	Oranje: Lana
Mothersill: Judy	Ostick: Miles
Mounsey: Karen	Ottley: Heather
Mullen: Dr. Richard	Page: Colin
Mullen: Prof. Paul	Page: Griff
Mulligan: Deirdre	Paget: Joan

Palleson: Terry	Reid: Keith
Panapa: Diana	Reilly: Bo
Parata: U.	Reilly: Marie
Parfitt: Jane	Reynolds: E.
Parker: Dr. David	Ridge: Margaret
Patchett: Dr. Steve	Ritchie: Grant
Patton: Dr. Murray	Roberts: Karaka
Paul: Linda	Roberts: Margaret
Pearson: Karen	Robertson: Dennis
Pennell: Kerryn	Robertson: Diana
Perkins: Patricia	Robertson: Jenny
Perry: Allan	Robinson: Elspeth
Perry: Bob	Robinson: Michael
Peterson: Noel	Roche: Dr. Rob
Pezaro: Dr. Dennis	Roffe: Keith
Phillips: Dave	Romans: Prof. Sarah
Pickering: Brian	Roys: J.
Pilkington: Ila	Rush: Christina
Plank: John	Rushworth: Christopher
Platz: Kathryn	Rushworth: Kathleen
Poutasi: Dr. Karen	Russell: Dr. Annemarie
Preston-Jones: Rhonda	Ruthe: Christopher
Provis: Connie	Rutherford: John
Pulotu-Endemann: Fuimaono Karl	Ryan: Dr. Erihana
Quick: Dr. Don	Ryan: Peter
Rae: Dr. Alma	Sales: Lindsay
Randall: Dr. Patty	Salmond: Dr. George
Rangiheua: June	Salter: Wendy
Ranken: M.	Sanders: Ron
Rankin: Geoff	Sanderson: Ray
Ravlich: Anthony	Saunderson: Bob
Read: June	Savory : John
Recordon: Phil	Savory: Lorraine
Reeves: Vai	Schofield: Dr. Hilary

Scott: Peter	Tahitahi: Kelly
Seifert-Jones: Dr. Gary	Tait: Judy
Sellman: Dr. Doug	Takao: Tahi
Seymour: Trish	Talbot: Bruce
Shea: Annette	Tangitu: Phyllis
Sheely: Cathy	Tate-Manning: L.
Sheenan: Alva	Taumoepeau: Dr. Bridget
Sheenan: Dick	Te Aika-Kopa: Charmaine
Simpson: Dr. Sandy	Temple: Christine
Simpson: Heather	Theunissen: Enrico
Singh: Dr. Satvir	Thomas: Ingrid
Single: Mike	Thomas: Mandy
Singleton: Colleen	Thompson: Bill
Slane: Bruce	Thompson: Gail
Smallwood: Ed	Thompson: Graeme
Smith: Ann	Thompson: Jasmine
Smith: Don	Thornton: Neil
Smith: Garry	Thysen: B.
Snee: Michael	Tobis: A.
Spiers: Elisabeth	Tohovaka: Te Aniwa
St. George: Dr. Ian	Tunney: John
Stacey: Richard	Turei: John
Stanley: Lois	Underwood: Elaine
Stark: Jane	van der Lans: Helma
Stephens: David	van der Sprenkel: Liz
Stevenson: Fay	van der Wel: Dr. Hanne
Stewart: Blair	Varcoe: Graeme
Stewart: Malcolm	Veale: Olwyn
Strang: Clare	Vercoe: Bridget
Stringer: Donald	Voss: Ann Marie
Sturm: Suella	Wade: John
Subritzky: John	Wagstaff: Richard
Sutich: Emma	Wallace: Cindi
Sutton: Pamela	Walmisley: Dr. Gerry
Symonds: Jeff	Walsh: Audrey

Walsh: Dr. Anne	Wilson: Gregory
Walshe: Dr. Jim	Wilson: Harry
Ward: Mike	Wilson: Dr. Janice
Ward: W.	Wilson: Kathryn
Warr: Trevor	Wilson: Marion
Warriner: Rob	Winchester: Ross
Watling: Richard	Winter: Briam
Watson: Chris	Winter: Carole
Watson: Ray	Wirihana: Rae
Watts: Gary	Wisley: Dr. Chris
Weare: Marilyn	Wong: Dr. Sai
Weepu: Te Whe	Wong: Marisha
Welch: Alison	Wood: Margaret
Werry: Prof. John	Wood: Pat
West: Steve	Woodford: Karyn
Whelan: Ken	Woods: Julie
Whittington: Andy	Worfolk: Janet
Wilhelm: Fran	Workman: Kim
Willard: Cyndi	Worthington: Sonja
Williams: Hecta	Wright: Derek
Wilson: Barry	Wylie: Paul
Wilson: Dr. Douglas	Zinzan: Robin
Wilson: Garry	

APPENDIX 3

INTERNATIONAL REPORTS CONSIDERED BY INQUIRY

AUSTRALIA

1. **Health and Community Services. Psychiatric Services Branch.**
   Victoria's Mental Health Services Proposed Amendments to the Mental Health Act 1986. Discussion Paper. 94/0196 February 1995.

2. **Health and Community Services. Psychiatric Services Branch.**
   A Funding Framework for Mental Health Services in Victoria. 94/0019 August 1994.

3. **The Royal Australian and New Zealand College of Psychiatrists.**
   Information Manual.

4. **National Mental Health Report 1994.**
   Second Annual Report : Changes in Australia's Mental Health Services in Year Two of the National Mental Health Strategy.

5. **National Mental Health Report 1994. Overview.**
   Second Annual Report : Changes in Australia's Mental Health Services in Year Two of the National Mental Health Strategy.

6. **Mental Health Workforce Planning Report - Draft**
   April 1996

7. **Summary of Reark Research Report**
   on Community Attitudes to Mental Health. 1995.

8. **Royal Australian College of General Practitioners. Royal Australian and New Zealand College of Psychiatrists.**
   Submission for Funding. Review of the Role of the General Practitioner in Mental Health Services. 1995.

9. **Commonwealth Department of Human Services and Health. Office for the Aged.**
   Scoping Study on Older People and Mental Health. 11 December 1995.

10. **Lawrence, Dr. C., (Minister for Human Services and Health) Lavarch, M. (Attorney-General)**
"Working Together" Mental Health Federal Budget Initiatives 1994-95. Incorporating the Federal Government's response to the Report of the National Inquiry into the Human Rights of People with Mental Illness.

11. **Mental Health Services in Queensland**
Queensland Mental Health Plan.

12. **National Community Advisory Group on Mental Health**
Newsletter. September 1994.

13. **National Community Advisory Group on Mental Health**
Let's Talk About Action. April 1994.

14. **Australian Health Ministers**
National Mental Health Policy. April 1992.

15. **National Mental Health Plan. April 1992.**

16. **Report of the Mental Health Consumers Outcomes Task Force**
Mental Health statement of rights and responsibilities. Adopted by the Australian Health Ministers March 1991.

17. **National Community Advisory Group on Mental Health**
Position Paper. Consumer and Carer Participation in Education and Training. June 1995.

18. **National Community Advisory Group on Mental Health**
Position Paper. Good Practice Guidelines for Consumer and Carer Consultation and Participation in Decision Making. June 1995.

19. **Guidelines for the establishment and operation of State/Territory/Regional Consumer Advisory Groups.**

20. **Victoria's Child and Adolescent Mental Health Services. Psychiatric Services.**
Future Directions for Service Delivery. Draft. January 1995.

21. **Psychiatric Services Division.**
Current Youth Suicide Prevention Activities in Victoria. June 1995.

22. Health and Community Services. Psychiatric Services Division.
Victoria's Mental Health Service. The Framework for Service Delivery.

23. Psychiatric Crisis Assessment and Treatment Services.
Guidelines for Service Provision.

24. Psychiatric Services Division.
Victoria's Mental Health Services: The Framework for Aged Persons' Mental Health Services. Draft only. September 1995.

25. Psychiatric Hospital and Community Service Review.
The Current Status of the Victorian Psychiatric System. June 1993.

26. Queensland Health
Mental Health Services in Queensland 1993. Policy Document FIVE.

27. Tolkein II : Who Should Be Treated?
Comments following the Mental Health Workforce Consultancy. May 18, 1994.

28. Patrick D. McGorry and Bruce S. Singh
Schizophrenia: risk and possibility.

29. Carers' of People with Disabilities: Research and Health Promotion Program
Policy Consultation held on 24 May 1995 St Vincent's Hospital Melbourne. Background Papers.

30. Health and Community Services
Psychiatric Crisis Assessment and Treatment Services. Guidelines for Service Provision. November 1994.

31. Health and Community Services
Victoria's Mental Health Services. Improved Access Through Coordinated Client Care. July 1995.

32. Health and Community Services
Victoria's Mental Health Services: The Framework for Aged Persons' Mental Health Services. DRAFT. September 1995.

33. Health and Community Services
Victoria's Child and Adolescent Mental Health Services. Future Directions for Service Delivery. DRAFT. January 1995.

34. Health and Community Services
Protocol Between Intellectual Disability Services and Psychiatric Services. June 1994.

35. Health and Community Services
Protocol Between Victoria Police and the Victorian Department of Health and Community Services Psychiatric Services Division. September 1995.

36. Health and Community Services
Mobile Support and Treatment Services. Guidelines for Service Provision. September 1995.

37. The Bromham Place Clubhouse
Newsletter. Issue 5 Vol 7 June 1994.

38. Schizophrenia Australia Foundation
Position Paper. "Police Shootings of People with a Mental Illness". November 1995. Attachment to Paper, March 1996.

39. Schizophrenia Australia
Newsletters. Spring 1995 and Autumn 1996.

40. Health and Community Services
Mental Health Services Program Update. 29 February 1996.

41. Victorian Carers' Program.

42. The Royal Australian and New Zealand College of Psychiatrists
Maintenance of Professional Standards Program. Outline. January 1996.

UNITED KINGDOM

1. **The Woodley Team Report**
   Report of the Independent Review Panel to East London and The City Health Authority and Newham Council, following a homicide in July 1994 by a person suffering with a severe mental illness. September 1995.

2. **Office of Population Censuses & Surveys. Social Survey Division.**
   OPCS Surveys of Psychiatric Morbidity in Great Britain. Bulletin No. 1.
   "The prevalence of psychiatric morbidity among adults aged 16-64, living in private households, in Great Britain".

3. **NHS Executive.**
   Health Service Guidelines HSG (94)27. "Guidance on the discharge of mentally disordered people and their continuing care in the community".

4. **NHS Management Executive.**
   Health Service Guidelines HSG (94)5. "Introduction of supervision registers for mentally ill people from 1 April 1994".

5. **Department of Health.**
   HC(90)23/LASSL(90)11. "The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services".

6. **NHS Executive.**
   Draft circular, Supervised discharge. 1995.

7. **NHS Executive.**
   High Security Psychiatric Services: Changes in Funding and Organisation. June 1995.

8. **The Report of the Inquiry into the Care and Treatment of Christopher Clunis.**
   1994.

9. **Department of Health. Home Office.**
   Report of the Department of Health and Home Office Working Group on Psychopathic Disorder. 1994.

10. **Audit Commission.**
    Finding A Place. A Review of Mental Health Services for Adults.

11. **Report of the Inquiry Panel set up by Nottingham Health Authority** to investigate the serious untoward incident at the Tudor Rest Home. November 1993.

12. **Steering Committee of the Confidential Inquiry into Homicides & Suicides by Mentally Ill People.**
"A Preliminary Report On Homicide".

13. **Sheppard, D.**
The Zito Trust. "Learning the Lessons".

14. **Report of the Independent Panel of Inquiry examining the case of Michael Buchanan.**
August 1994.

15. **Findings of the independent review on the management of the case of Erieyune Inweh** during the period July 1991 to 30 October 1992. December 1992.

16. **Independent panel of inquiry into the circumstances surrounding the deaths of Ellen and Alan Boland.** March 1995.

17. **Publication of the Woodley Independent Inquiry Report into the case of Stephen Laudat.** September 1995.

18. **Incident Report. 6 Hammond Road, Horsell, Woking.** 20 January 1994.

19. **NHS Health Advisory Service**
Child and adolescent mental health services - Together we stand. April 1995.

20. **Department for Education**
A handbook on Child and Adolescent Mental Health - The Health of the Nation.

APPENDIX 4

AMENDMENTS TO THE MENTAL HEALTH (COMPULSORY ASSESSMENT & TREATMENT) ACT 1992

INTRODUCTION

This paper outlines the amendments that are considered necessary to enhance the operation of the Mental Health (Compulsory Assessment & Treatment) Act 1992. Each section of this paper comments briefly on the issues to be addressed by way of amendment, and lists the sections to the Act that need to be amended to address such issues.

- Issues that may result in significant or controversial changes to legislation, including:
  Powers of the Police
  Protection and indemnity

- Issues concerning errors or significant issues of interpretation, including:
  Procedural requirements that have resulted in discrepancies in the operation of the Act
  Appointments of officials
  Rights of persons subject to the Act
  Reviews and appeals

- Issues that have arisen as a result of the relationship between the Mental Health Act 1992 and other legislation, including:
  Notification provisions of the Victims of Offences Act

1. ISSUES THAT MAY RESULT IN SIGNIFICANT OR CONTROVERSIAL CHANGES TO LEGISLATION

1.1 *Powers of the Police - Comment*

1.1.1 The 1992 Act enables the Police to use force in certain circumstances (e.g. to enter premises), but does not do so in other instances (such as taking or detaining the person), even when it is probable that force would need to be used. This is particularly unclear in respect of "proposed patients".

1.1.2 Judge Mason's report of the inquiry into the death of Matthew Innes raised a number of issues concerning the lack of clarity in the Act about the ability of the Police to use force when dealing with proposed patients. Judge Mason's findings have resulted in significant problems in the day to day working of the Act, particularly where proposed patients are concerned.

1.1.3 It is recommended that consideration be given to amending the Act to clarify the ability of the Police to use force in certain defined situations, particularly when they are dealing with proposed patients. Amendments will need to be carefully drafted, to ensure that the Police are given appropriate powers and that neither they nor people who may be subject to the Act are placed at risk.

RECOMMENDED AMENDMENTS

The amendments to the Act that have been recommended to address the issues outlined above, are listed below.

- **General comments :** It has been proposed that a new section be included in the Act, to enable the Police to take the person to a medical practitioner for the purposes of a medical certificate, if a medical practitioner cannot attend, and if danger to self or others is considered to be imminent.

- Consideration also needs to be given to any provisions permitting the use of force - whether these be a limited provision, or can be included in section 122.

- **Section 41 : Police assistance:** Section 41(2)(b)(ii): *"Assessment examination"* needs to be defined in terms of the sections to which it refers.

- **Section 112 : Judge may authorise apprehension of patients and proposed patients:** This section does not apply to patients under sections 14 and 15 of the Act, and needs to be amended accordingly.

1.2 *Protection and Indemnity : Comments*

1.2.1 The issue of protection from civil liability concerns protection for health professionals and other officials operating under the Act. Some health professionals consider that the environment in which they are operating may make it more likely that legal action could be taken against them. Judge Mason has also suggested that health professionals operating under the Act be provided with limited protection from civil liability. Others consider that this could reduce accountability and place patients at risk.

1.2.2 The second issue concerns district inspectors who undertake inquiries into issues concerning the rights of patients under the Mental Health Act. The reports of such inquiries may be critical of staff or services, and most district inspectors consider that there is a very real possibility of legal action being taken against them in respect of matters raised in an inquiry.

1.2.3 There is likely to be limited support for any further protection for officials operating under the Act, particularly from consumers of mental health services. The Ministry of Health has undertaken preliminary discussions on this issue with the Department of Justice. That Department has expressed concern about any proposals to provide further protection for officials operating under the Act. This issue requires further consideration before any amendments to the Act could be recommended.

RECOMMENDED AMENDMENTS

The amendments to the Act that have been recommended to address the issues outlined above, are listed below.

Section 122(4) : It has been suggested that this section could be amended to apply to sections 41, 51, 53, 109, 110, 112 - in respect of the use of force. If so, the term "*by force if necessary*" could probably be deleted from those sections.

2 ISSUES CONCERNING ERRORS & INTERPRETATION

2.1 *Appointment of Officials : Comment*

2.1.1 The Act does not enable Directors of Area Mental Health Services to delegate their functions to others. This causes particular problems if a Director of Area Mental Health Services is absent on leave. It has also been noted that there are currently no provisions to remove district inspectors or official visitors from their roles, in certain circumstances.

- **Section 92: Directors of Area Mental Health Services:** Provisions need to be included to enable the DAMHS to delegate or deputise.

- **Section 94: District inspectors and official visitors:** An additional section [similar to section 106(3)] needs to be included in the Act, to enable district inspectors and official visitors to be removed from office in certain circumstances.

- There is also a need to enable deputy district inspectors to be appointed for short periods. It is proposed that the Director of Mental Health should be able to make such appointments.

2.2 *Procedural Requirements*

2.2.1 Section 2 of the Mental Health Act defines the terms that are used in the Act. Some of these terms require amendment to ensure that they are consistent with other legislation. It has also been proposed that some definitions be clarified by way of amendment.

Section 2 : Definitions

- "*Court*" - the definition of Court does not include the Family Court.

- "*Fit to be released from compulsory status*" - It has been suggested that this definition may require amendment to clarify the meaning of "*fit to be released*".

- "*Medical officer*" It has been noted that the role of "*superintendent*" no longer exists under this legislation and it has been suggested that the reference should be changed to "*Director of Area Mental Health Services*".

- *Statutory definition of mental disorder*: This section could be deleted without affecting the Act. It relates to an earlier draft of the Act, when "*mental disorder*" was separately defined for young persons.

- It has been suggested that the term "*proposed patient*" be defined in this section.

- "*Special patient*" This reference requires amendment to correctly refer only to patients detained under section s115(1) of the Criminal Justice Act 1985.

- **Section 9 : Assessment examination to be arranged and conducted:** Section 9(2)(e): The reference to "*patient*" should be changed to "*proposed patient*", as at this point the individual is not yet a "*patient*".

- **Section 11 : Further assessment for 5 days:** Section 11(1): Consideration should be given to the time in which the notice should be given (e.g. "forthwith"). It may also be necessary to include a provision for the rare instances where a notice cannot be given immediately.

- Section 11(1): Consideration should be given to ways in which the meaning of "5 days" can be clarified.

- Section 11(6): The direction to release from compulsory status should be in writing. It may be possible to address this by means of guidelines.

- Also Section 13.

- **Section 12 : Certificate of further assessment:** Section 12(1)(b): Consideration needs to be given to the possibility of including "*fit to be released although still mentally disordered*". This may be covered by an amendment to the definition of "*fit to be released*" in section 2.

- Section 12(5)(c): It has been suggested that the applicant for assessment and the patient's usual medical practitioner do not need to receive a copy of the certificate of further assessment. These individuals often do not have an ongoing relationship with the patient, and do not need to be advised of that person's legal status.

- It is also proposed that official visitors should not receive copies of the certificate of clinical review unless they are acting on behalf of the district inspector.

- Also section 14.

- **Section 18 : Judge to examine patient where compulsory treatment order sought:** Section 18(1): It has been suggested that the word *"examine"* is confusing, as in fact the Judge *"meets with"* the patient.

- Section 18(3)(c): The phrase *"before examining the patient"* is unnecessary and should be deleted, as the actions outlined in s18(3)(a) - (c) are the examination.

- Also section 19

- Also section 78(4)

- **Section 21 : Court may call for report on patient:** Section 21(5): Consideration should be given to referencing this section to 134 to enable payment according to an appropriate range of fees.

- **Section 25 : Restriction of publication of reports of proceedings:** Consideration should be given about the appropriateness of the penalties referred to in this section.

- **Section 29 : Community treatment orders:** Section 29(3): It has been suggested that if the patient is returned to hospital, the order should be suspended for up to (14) days. If an application for an in-patient order proceeds, the section 29 order automatically lapses.

- Consideration also needs to be given to appeal and review mechanisms if a patient is brought back into hospital via this method.

- **Section 31 : Leave for in-patients:** Section does not apply to individuals who are undergoing in-patient assessment. Although the Act does not preclude patients under assessment from having leave, amendment may clarify this matter.

- **Section 32 : Absence without leave:** As above, this section does not refer to patients undergoing in-patient assessment who are absent without leave. Amendment may be required to clarify this issue.

- **Section 34 : Court may extend order:** Section 15(2) enables a Judge hearing an application for a compulsory treatment order to extend the time in which he or she conducts a hearing. Section 34 of the Act does not specifically state that section 15 applies in relation to the extension of a compulsory treatment order, and amendment may clarify this issue.

- **Section 36 : Compulsory treatment order to cease to have effect in certain cases:** Section 36(1): This section needs to be amended to also to patients under assessment.

- **Section 40 : Assistance in taking or returning patient to place of assessment or treatment:** Section 40(1): "*Patient*" should be replaced by "*person*", as this may include "proposed patients".

- **Section 42 : Notice of admission:** Replace "*person in charge*" with "*Director of Area Mental Health Services.*"

- **Section 45 : Application for assessment ..... persons detained in penal institutions:** Section 45(1)(a): Check whether "superintendent" is still the appropriate term.

- **Section 47(3) : Removal of certain special patients back to penal institutions:** Section 47(3): Clarify what is the legal status of the patient during the 7-day period referred to in this section.

- **Section 48 : Further provisions relating to special patients:** Section 48(3)(a): Amend to clarify what happens to patients under assessment. It is proposed that if the sentence expires while undergoing assessment, the patient should revert to the equivalent under the MHA.

- **Section 49 : Transfer of special patients:** Can be addressed by guidelines.

- **Section 57 : No compulsory treatment except as provided in this Part:** Special and restricted patients should be specifically <u>included</u> in this section, and those under section 46 should be <u>excluded.</u>

- **Section 62 : Urgent treatment:** Section 62(a): It has been suggested that provision should be made for urgent treatment of proposed patients where that person presents a serious risk to self or others, and requires transport to a hospital for assessment.

- **Part VII : Special provisions relating to children or young persons: General comments:** Consideration needs to be given to the need for requirements for parents or guardians to be involved in this part of the Act.

It is also recommended that consideration be given to the need for mandatory legal representation for young people.

- **Section 91 : Director and Deputy Director of Mental Health:** Section 91(1): It is recommended that "*Department of Health*" should be amended to "*Ministry of Health*".

- **Section 129 : Registers and records:** The use of "*person in charge*" is unclear. It is recommended that this should be changed to "*Director of Area Mental Health Services or person they nominate.....*".

- **Section 132 : Notice of death:** Amend "*Board*".

- **Section 134 : Fees of medical practitioners:** Section 134(4): Correct references to "*Department of Health*" and "*Board*".

RIGHTS OF PERSONS SUBJECT TO THE ACT

The sections of the Act that define the rights of individuals subject to the Act, currently apply only in respect of persons deemed to be patients. It is proposed that the Act be amended so that rights also apply to proposed patients. The following sections will require amendment.

- Section 5: Cultural identity and personal belief

- Section 6: Interpreters to be provided

- Section 65: Respect for cultural identity, etc..

- Also sections 66, 68, 70, 71 - check applicability of other sections.

- Section 68: Further rights in case of visual or audio recording.

First schedule - Procedural provisions relating to Review Tribunals: Section 8: Restriction of publication of reports of proceedings: Section 8(2)(b): References to "*Department of Health*" and "*Health Service*" need to be amended.

REVIEWS AND APPEALS

NOTE: Amendments currently in the Mental Health (Compulsory Assessment & Treatment) Amendment Bill that relate to the timing and process of Tribunal hearings, are intended to be carried over for amendment.

- **General note :** Consideration needs to be given to the desirability of patients being able to apply for multiple reviews.

- **Section 16 : Review of patient's condition by Judge:** Section 16(1): It has been proposed that "*as soon as practicable*" should be changed to "*within 7 days*". This may, however, cause difficulties in some regions where a Judge is not available.

- **Section 76 : Clinical reviews of persons subject to compulsory treatment orders:** Section 76(2)(a) - "*examine the patient*" Consideration needs to be given to including a provision to cover instances where the responsible clinician is unable to see the patient. It has been proposed that is such cases, the responsible clinician should be required to advise the DAMHS and the district inspector, and arrange to examine the patient within a defined period (say, 7 days).

- Section 76(7)(b) - delete "*medical practitioner*" and "*official visitor*" unless acting for the district inspector. It is also recommended that "*Review Tribunal*" be deleted from the list of those who are required to receive copies of certificates of clinical review. In practice, they do not receive the certificates - these are simply filed by the Ministry.

- Also sections 77, 78.

- **Section 78 : Clinical reviews of restricted patients:** Sections 78(5) & 78(6): Consideration needs to be given to the need for the Minister and the Attorney-General to be involved in changing the status of a restricted patient. It has been suggested that the Court may need to be involved here.

- Also section 81(7).

- **Section 79 : Tribunal reviews of persons subject to compulsory treatment orders:** Section 79(2)(b): This should be deleted if the Tribunal does not automatically receive copies of certificates.

- Section 79(6): It has been suggested this section be amended to include a requirement that the Tribunal should be "*satisfied that there has been no change*".

- **Section 83 : Appeal against Review Tribunal's decision in certain cases:** It is recommended that appeal should be to the High Court, rather than the District Court.

- **Section 107 : Convenor (of Review Tribunal):** This section requires that if the convenor of the Tribunal is not present, another member (although not a deputy) shall be elected as convenor. In practise, this has caused difficulties where the deputy is a lawyer and although that person actually conducts the hearing, he or she cannot act as convenor.

  It is recommended that the Tribunal should be permitted to nominate a deputy convenor. It is also recommended that the convenor should always be a lawyer.

ISSUES THAT HAVE ARISEN AS A RESULT OF THE RELATIONSHIP BETWEEN THE MENTAL HEALTH (COMPULSORY ASSESSMENT & TREATMENT) ACT 1992 AND OTHER LEGISLATION

VICTIMS OF OFFENCES ACT

Offenders who are detained in hospital, may seek to be informed when and if that person leaves the institution. The Victims of Offences Act presently applies only to offenders detained in a penal institution.

It is recommended that the Victims of Offences Act be amended to address the issue outlined above. Such an amendment is supported by the Department of Justice. Amendments will also need to be accompanied by a protocol for mental health services, to be used in advising victims, and further work will be undertaken with Justice officials to refine the protocol.

Further work needs to be undertaken to identify amendments that need to be made to other legislation, to reflect the changes in terminology that have occurred as a result of the Mental Health (Compulsory Assessment & Treatment) Act 1992. This will require ongoing consultation with other key agencies, including the Department of Justice and the Police.

PARTNERSHIP ACT 1908

Section 137(2) : This section refers to a partner "found lunatic by inquisition" or shown to be of "permanently unsound mind". Since neither of these descriptions conform to the current definition of mental disorder, they could be amended to correspond with the definition used in the Mental Health Act 1992.

TRANSPORT (VEHICLE & DRIVER REGISTRATION AND LICENSING) ACT 1986

Section 46 of the Transport Act requires that drivers' license for patients under the Mental Health Act 1969, be suspended. The provisions of section 45 of that Act enable a medical practitioner to recommend that a license be revoked. Section 46 presents significant difficulties for patients subject to community treatment orders, and is unfair in its assumption that any person on a compulsory treatment order is automatically unfit to drive.

It is recommended that section 46 of the Transport Act be repealed.

CORONERS ACT 1988

Section 4 of the Coroners Act refers to patients committed under the Mental Health (Compulsory Assessment & Treatment) Act 1992, and should be amended.

JURIES ACT 1981

The Department of Justice has noted that section 2 and 8(1) of the Juries Act refer to the Mental Health Act 1969. At the time of the passage of the 1992 Act, Justice sought to have the previous definition of mental disorder retained in the Juries Act. This was not resolved and needs further consideration.

APPENDIX 5

HOME-BASED TREATMENT OF FIRST EPISODE PSYCHOSIS

Associate Professor J. Kulkarni

INTRODUCTION

The worldwide implementation of de-institutionalisation has led to the rapid growth of community-based psychiatric treatment. However, the aims of most community treatment teams are still to provide crisis intervention, rehabilitation and maintenance for the chronically disabled, psychotic patient. Many studies [1,2,3,4] have focused on models of community psychiatric care which are predominantly "after-care" models to allow earlier discharge of patients from hospital and prevent readmission. Hoult's work [5,6,7,8] emphasised the clinical feasibility of managing acutely psychotic people in community settings. Stein [9] developed a model of assertive community living programmes for severely disabled, chronically unwell individuals with schizophrenia. Wright and colleagues [10] outlined the large costs involved in the intensive management of patients recently discharged after prolonged periods in hospital.

To date, the acute community treatment of people suffering with their first psychotic episode has not received much attention either in the literature or in the provision of clinical psychiatric services. In view of the high prevalence of secondary morbidity such as depression and post-traumatic stress disorder [11], in hospitalised recent-onset psychosis patients, it seems appropriate to adopt a preventative approach to secondary morbidity by managing the patient in a community setting if possible. Falloon [ ] discussed the home-based management of people identified as suffering with prodromal symptoms of schizophrenia, with a particular emphasis on stress management, but did not routinely extend home-based clinical treatment to individuals experiencing an acute initial episode of psychosis.

This chapter describes a new home-based approach to the integrated management of people suffering from their first florid psychotic episode. The aims of this approach include the effective treatment of the psychotic episode, prevention of secondary morbidity, rapid re-integration into premorbid lifestyle, reduction in relapse rates, improvement in the quality of life and satisfaction with the delivery of the clinical service.

The success of a home-based approach in meeting these aims depends on a number of factors within the individuals, their families and the treating team, which are now discussed in some detail.

WHICH FIRST EPISODE PSYCHOTIC PATIENTS CAN BE MANAGED AT HOME?

A. THE FAMILY

Of paramount importance in managing the acutely psychotic individual at home is an early understanding of the person's family. Without the co-operation of a caring family, the home-based treatment approach is clearly not a viable alternative. Since the family are the constant primary carers in this model, assessment of their needs and capabilities are of equal, if not higher priority than the identified client. To this end, a family rating scale incorporating several key areas is currently being developed to assist in the rapid assessment of the family's ability to embark on home-based treatment. The immediate issues include practical assessments of the family's physical and emotional state with special note being taken of sleep deprivation and signs of physical neglect in family members.

Unlike hospitalised patients whose families are mostly useful informants in the acute phase of illness, in this model of treatment the families' welfare and health are just as important to the treating clinicians as the identified client. Therefore, careful assessment is needed of which family members have "rostered" themselves for "night duty" at home and the length of acute illness. The family's work schedules, availability and resources in terms of extended family/ friends networks are important ingredients in successful home-based treatment. Poor patterns of interaction within the family and pre-existing problems are difficulties that may be exacerbated during this phase. Interestingly, the concept of high family expressed emotion (Ref 18) may be somewhat advantageous during the acute phase of illness in this model. Provided the hostility and critical components are not pronounced, people with over involved families tended to remain engaged in treatment and recovered more quickly compared to people with more distant, disengaged families. Containment of the sick individual by the family is another major determinant in successful home-based treatment. Families may need to be empowered by the treatment team to confiscate car keys or take other temporary actions to allow treatment to commence. Disengaged families often have difficulties with the containment of the individual. Family burden issues may appear in the later phases of prolonged illness, but are related to the individual's rate and type of recovery, again reinforcing the need for rapid, effective treatment of psychotic symptoms.

Initially, the models for crisis intervention is applicable in working with the families of first episode psychosis patients. The implementation and explanation of clear management plans is very important, especially in view of the classical early family reactions of confusion, guilt, denial and emotional numbing. Equally important for the family is the clear message of favourable recovery and outcome from the treating team. Families and people suffering psychosis are usually not familiar with the management of psychiatric illness or with home-based treatment. Therefore the tasks for the treating team are to demystify both processes for the family and sick individual.

B. THE INDIVIDUAL

The severity of illness does not appear to determine successful home-based treatment. The dangerousness of the symptoms expressed rather than the intensity seem to determine whether or not an individual needs hospitalisation. Hallucination prompted suicidal/homicidal thoughts or delusional prompted hostility towards family members may mitigate against home -based treatment. Ready access to firearms or other weapons at home need to be thoroughly investigated and dealt with in the initial assessment of the individual.

Illicit substance abuse is a serious problem in the home-based treatment model, because of the role played by marijuana, amphetamine or opiate use in precipitating or perpetuating psychosis. The client's family need to be able to prevent the individual from having access to illicit drugs during the acute illness phase. Drug rehabilitation issues need to be addressed by the treating team when the individual has recovered from acute psychosis.

The person's role in the family and issues of compliance with treatment need to be assessed to optimise home-based treatment. A shared illness model between patients, their families and the treating clinicians may be useful, but not always necessary for successful home-based treatment. Rather than focussing intensely on understanding the possible reasons for the onset of psychosis, it seems more useful for all parties concerned to agree on the management strategies and their implementation.

C. THE TREATING TEAM

Clinicians involved in home-based treatment need to understand and work within an entirely different framework to hospital or clinic-based practices. The treating team are the "guests" in the patient's home and as such need to respect that the power structures are different. Loss of control over the working environment, lack of access to medical equipment, diminished access to other colleagues and safety issues are some of the new challenges that the treating team need to cope with. This type of work requires a great deal of flexibility from clinicians. Since the clinicians must make many vital decisions about the person and the family's safety and monitor diverse aspects of treatment, it is necessary that clinicians are sufficiently experienced and confident in making independent decisions. All members of the multi-disciplinary team need to be able to function well in both their speciality roles and as a generic community team clinician. Staffing numbers need to be adequate to allow up to three times per day visits if necessary during the hyperacute phase. Our experience suggests that small specialist teams providing home-based treatment suffer from higher rates of "burn-out" related to overwork. Instead, the incorporation of the ideals and goals of home-based treatment for first-episode psychosis into a larger, general community team allows greater flexibility of rostering and a better ability to provide intensive input. Careful rostering is required to overcome the potential problem of the patient and family being seen by too many different team members.

Once a good therapeutic alliance has developed between the acutely psychotic individual, family members and clinicians it is important to maintain continuity of care for at least six months to one year. Again, a larger team with the dual mandates for crisis intervention and continuing care, allow follow up with the same clinicians to take place. Confidentiality issues pose many problems for clinicians working in the home-based treatment model. Since the family is functioning as important primary carers, it is often difficult to maintain strict confidentiality with information received from the client. Also, therapeutic interactions usually take place in the family living areas and it is often difficult to create a private setting. However, if it seems important to establish rapport with the individual then the clinician may conduct interviews in other parts of the home, or in outdoor settings. The clinician needs to be flexible and keep safety issues in mind.

Good communication skills are a very important tool for the clinician because in this model, the client and family often have no other source of psychoeducation or interactions with others in a similar situation. Also, the unfamiliarity of this model to most families and individuals requires good communication from the clinicians to ensure implementation of management strategies. Clear management plans with well-communicated explanations and details of visiting times by clinicians are all necessary to empower the client and family, and thereby optimise the success of home-based treatment. Clinicians need to be pragmatic in early approaches to aspects of returning to school/work, and many other treatment issues. Since the person is living in their own environment, there is often an earlier return to normal activities because of a diminution in the perception of being sick. Most people equate hospitalisation with severe illness and while the individual may be severely unwell, being managed at home prevents the "sick role" from becoming prominent.

The treating team may need to quickly monitor progress at school/work and visits during the recovery period need to be organised around the person's time commitments and confidentiality issues.

Another important task for the treating team is to ensure that all aspects of management are covered. In hospital or clinic settings, there are usually well-established protocols for assessment and treatment which are often followed in a reflex manner by clinicians. In this model where flexibility is an important key, management plans need to be formulated and highlighted for the clinicians, carers and clients. While the task in hospitals has often been to break down the rigid structures and allow individuals more freedom and flexibility; in the home-based treatment model, the clinician's task is to introduce some structure for carers and individuals to optimise a successful outcome.

THE "PACKAGE" APPROACH

In embarking on home-based treatment for the first episode of psychosis, all parties require some structure to the management plan. A way to provide carers and clients with a better idea of what to expect has been the development of a treatment package. This is operating, written timetable which outlines step by step treatment plans and approximate timeliness. In hospital settings, clinicians may have the right to answer carers' questions about length of stay with "wait and see". In the client's home, the alteration of the power structure compels clinicians to deliver more definite answers. A clearer sense of control over the illness for the family and client, is instilled by having a working timetable. There is comfort in having a sense of "closure" to the illness by timetabling recovery and post-acute follow up periods. A written package also assists the treating team in ensuring that steps are not forgotten. All packages are formulated with the client and carers and are individualised. The language used is non-jargonistic and a tangible treatment schedule often offers hope when carers and clients are grappling with the intangible concept of psychosis. Pragmatism and optimism are essential ingredients in successful home-based treatment. An example of a package is given below (Table 1).

TABLE 1

THE PACKAGE

(A) IMMEDIATE/CRISIS PHASE
Duration Average: 2-7 days
Steps:

1. Formulation and delivery of individual package
2. Clear visiting schedule by treatment team
3. Medication (usually sedative) for client
4. Blood tests, X-Rays - to check physical health
5. Assessment of troubling symptoms
6. Discussions with family for purposes of helping family to cope and to gather information about client prior to illness
7. Getting to know client and family
8. Client and family to get to know and trust clinicians.

(B) ACUTE PHASE
Duration Average: 7-10 days
Steps:

1. Medication - choosing the right type and dose of anti-psychotic drug. Treating team to administer medication at first, then family
2. Monitoring the patient's pulse, blood pressure and response to medication.
3. Discussions with family and client about how medications work and what psychosis is.
4. Deal with issues of leave from work, organise certificates.
5. Discuss family tasks.
6. Liaise with client's general practitioner.

(C) RECOVERY PHASE
Duration Average: 14-20 days

1. Discussions about how to prevent relapses and early recognition.
2. Client to take responsibility for medication. Medication times to be worked out again.
3. Number of drugs to be simplified and discussion of when medication can be tailored off - usually about six months from now.
4. Discussion about when to return to work and a visiting schedule to be organised.

(D) FOLLOW UP PHASE
Duration Average: 6-12 months

1. Discuss progress in terms of work and relationships.
2. Watch for relapses - and deal with any.
3. Special training - related to socialising at work.
4. Discussions with family about how they are coping.
5. Tailoring off medication and monitoring outcome.

While an obvious criticism of a package as shown in Table 1, is that it is simplistic and perhaps overly optimistic, it still provides a basis for proceeding with home-based treatment in a manner that makes sense to carers and clients. Along with the package the clinicians undertake many supportive psychotherapeutic strategies to educate the client and family, aiming for a quick recovery.

SPECIFIC ISSUES IN OPTIMISING THE SUCCESS OF HOME-BASED TREATMENT OF FIRST EPISODE PSYCHOSIS

1. MEDICATION MANAGEMENT

In the hyperacute or crisis phase, there is usually an urgent need to safely sedate the patient. This is an especially important step in allowing the anxious and vigilant family to rest and "re-group". Sedating benzodiazepines such as temazepam are very useful in this phase and can be used during the day if necessary, as well as at night. Once physical investigations have been performed and the decision to use an anti-psychotic drug is made, then the correct choice of anti-psychotic drug is very important. In the home-based treatment model, there is a pressing need to prevent any dangerous side-effects since constant clinical monitoring is not available. The treating team needs to routinely carry emergency kits of anticholinergic drugs with intravenous and intramuscular giving sets as well as other emergency drugs and resuscitation equipment. Anti-psychotics with a gentle onset of action are better than drugs with high extrapyramidal side-effect profiles. The newer anti-psychotic drugs such as risperidone are useful because of their lower side-effect profiles. As with all first episode psychotic patients, the drug regime should begin at very low doses and be titrated gradually. However, it is important to provide the client with quick relief from troubling psychotic symptoms as soon as possible. Older drugs such as chlorpromazine can be useful because of its sedating property, but in the home treatment setting it should be prescribed at night, to overcome postural hypotension.

Drug education for the family and client is vital in the home-based treatment model since they have to deal with any resulting problems. Clear guidelines about response time, side-effects and doses need to be given, preferably in writing as well as verbally. Emergency instructions and contact numbers should be given at the first visit. The least possible number of drugs should be used to avoid confusion. It is advisable that on the early phase of treatment, the clinicians on the treating team actually administer the medication and then hand this task over to the family who eventually give the responsibility back to the client. The timing of drug administration can be flexible and should fit in with the client's lifestyle. A sense of closure to drug treatment should be discussed with the client and carers from the beginning. This often alleviates the sense of a "life sentence" on medication, which in turn leads to non-compliance. As with all first episode patients, attention should be paid to the individual's lifestyle and drugs chosen accordingly.

2. PHYSICAL INVESTIGATIONS

In the home-based treatment model, it may be more difficult to obtain access to pathology services in order to perform blood tests for haematological, renal, hepatic, illicit substance and electrolyte measures. However it is important not to overlook the need to perform both physical examinations and investigations, in order to exclude underlying organic disease and to establish baselines for the future. Many private pathology services offer home-based blood /urine testing and should be used if possible. General practitioners are routinely contacted very early in the home treatment of a young psychotic person and can also provide information about their physical health, as well as linking with pathology services. It is possible to organise specialised tests such as CT brain scan or MRI for the client, as an outpatient. The timing and explanations involved in detailing such procedures should be handled carefully, and involve the family as well. Vital signs monitoring by clinicians on the treatment team should be done at every visit initially and then according to the client's needs in terms of changes in drug regimes or alteration in physical state.

3. PSYCHOEDUCATION

Optimism and pragmatism seem to be the keys to successful psychoeducation in the home-based treatment setting. Clear instructions about medication, illness with multimedia presentations to all family members and clients are very important. It is useful for the clinicians to keep in mind that the family and client have no other "peers" to learn from, so all their communications must be clear. Myths about psychosis that are damaging or may lead to non-compliance with treatment need to be identified and refuted. Generally, gently working along with the family and client, rather than enforcing the clinicians' models/perspectives, works more effectively overall.

The illness phase needs to be considered when discussing important issues, and clinicians have to be prepared to repeat information at different times.

4. SOCIAL ISSUES

With the client being treated at home, there is often a more rapid re-integration with little secondary morbidity such as post-traumatic stress disorder or depression which are often related to hospitalisation issues. The rapid re-integration may mean that the client is eager to return to normal activities, and not keen to participate in formal recovery programmes. It may be counter productive to provide introspective programmes to review the course of illness of precipitating factors if the client is keen to deny the psychotic illness and proceed with his/her life. The home-based treatment model lends itself to encouraging the individual to use denial as a recovery style (Ref: McGorry) and the effect of this on longer term outcome measures of relapse are yet to be determined. If clients require specific skills training or have other socialisation needs, then general community resources may be more suitable than specific psychiatric day programmes.

This is in keeping with the general ethos of home-based treatment of downplaying the seriousness and potential chronicity of psychosis, but rather adopting the view that psychosis is a treatable and temporary illness.

5. HOSPITAL SUPPORT FOR CLINICIANS TREATING FIRST EPISODE PSYCHOSIS CLIENTS AT HOME

While attempting to manage first episode clients at home it is important to continually monitor the progress made by the individual and the stress experienced by the carers and client. If the clinicians believe that carers are not able to undertake or continue home-based treatment, then hospitalisation should not be viewed as failure. The community treatment team then has the opportunity to work with the client and family to facilitate a non-traumatic hospitalisation. Voluntary, short-term hospitalisation may be a useful alternative. The community team can provide support and education for the family while the client is in hospital, which may assist in a better outcome.

A well integrated hospital and community service allows easier access to in-patient beds and earlier discharge for intensive community follow up. If staff are familiar with both settings, then continuity of care and follow through of management plans can be implemented.

RESULTS OF A PILOT STUDY ON HOME-BASED TREATMENT OF CLIENTS WITH FIRST EPISODE PSYCHOSIS

A pilot study of eighteen first episode psychosis patients managed at home by the Adult Community Treatment Team (ACTT) of Dandenong Hospital, Victoria was conducted between June 1994 and December 1994. All patients were referred to ACTT during the six month period indicated. Four of the 18 patients were hospitalised. There were seven females with an average age of 29 years $\pm$ and eleven males with an average age of 20 years $\pm$ 2.2. All patients lived with families - the males all lived with their family of origin while three females lived with spouses and children. Diagnoses were made using DSM IV criteria and included schizophrenia, schizoaffective disorder, and bipolar affective disorder-manic phase with psychotic features. Eight patients (7 males, 1 female) used illicit drugs which was further divided into mild, moderate and severe categories depending on quantity and frequency of use. Illicit drugs included marijuana, amphetamines, cocaine and opiates. Alcohol intake was also measured. Psychopathology ratings done at the first visit showed that the mean Brief Psychiatric Rating Scale (BPRS) score was 38 $\pm$ 6.2 points, the mean SAPS score (Scale for Assessment of Positive Symptoms) was 41 $\pm$ 8.3 points and the mean SANS score (Scale for Assessment of Negative Symptoms) was 31 $\pm$ 12.3 points. The maximum daily anti-psychotic drug dose in chlorpromazine equivalents ranged from 50mg to 400mg. A wide range of neuroleptics were used including chlorpromazine, thioridazine, haloperidol, trifluoperazine and risperidone.

Nine patients (7 males, 2 females) did not accept the treating team's model of illness. All carers accepted the illness model presented by the team.

In terms of outcome, 8 patients (4 males, 4 females) had recovered within 26 days of involvement by the ACT team. Recovery was measured by a significant decrease in SAPS scores, subjective reports by the client and carer plus return to previous occupation. Six patients made good recovery using these criteria between 26 and 42 days of ACT team involvement. Quality of life ratings (Ref. 17) made pre and post-treatment for these 14 patients showed a significant mean rise of 43.3 points. Follow up over a ten month period to date has revealed that one patient suffered a relapse - which was treated at home.

In considering the 4 patients (3 males, 1 female) who required hospitalisation several variables were compared with the successfully home-treated group. There were no significant differences in the BPRS, SAPS, SANS scores at first or subsequent visits. No differences were found in the medication doses or type, illicit substance use, economic situation or acceptance of illness modes. A clear difference was found in the subjective rating made by the clinicians at first visit of the family's capacity to cope and provide care. While a formal family assessment tool was not used, clinicians rated families on a scale from 1-10 on the family's state of anxiety, availability, supportiveness and pre-existing problems. Scores closer to ten suggested very capable families compared with scores closer to one suggesting families experiencing great difficulties in coping. When these scores were compared between the groups, there was a significant difference ($p= 0.013$) with the hospitalised group having significantly lower family rating scores. While the sample size is very small and unevenly distributed; this finding concurs with the clinicians' view that a key factor in whether or not home-based treatment is successful depends on the abilities of the carers. Severity of illness, acceptance of illness models, economic circumstances and medication regimes did not seem to influence location of treatment.

This pilot study was conducted at a time when the model of home-based treatment for first episode psychosis was at a very early developmental stage. The study measures are crude and treatment strategies are still in evolution. Fundamentally the ACT team is a general community psychiatric team comprising 17 Multi-disciplinary staff members who have five years experience as a team working in home-based and boarding house settings with usually chronically disabled, psychotic clients. The ACT team provides a 24 hour, seven days per week service. The focus on first episode patients enabled the team to make full use of their already well developed community psychiatry skills and experience.

Dissemination of the goals and strategies for managing first episode patients was by informal and formal education sessions and all members of the ACT team were given the opportunity to manage first episode clients. In this way, the special issues related to the first episode group were highlighted to the whole team, rather than setting up a small, specialist team. A larger study is continuing, with particular attention being paid to a longer term follow up.

CONCLUSION

Home-based treatment of the first episode psychosis patient presents the clinician with several challenges that if met can provide the patient with excellent outcomes. The careful assessment of carers and individuals, ongoing monitoring of their progress and adopting flexible treatment approaches are keys to success in this model. Clinician anxiety is often higher because of the lack of control over the location of treatment, but the resulting decrease in stigma and secondary morbidity for the individual are a rewarding counter balance. The home-based treatment model epitomises a number of goals that all clinicians strive to achieve in the optimal treatment of first episode psychosis. Home-based treatment provides care in a free and familiar environment, empowers the client and carers, emphasises the need for clinicians to work in close collaboration with the individual and family, necessitates careful and minimal medication regimes and offers a rapid return to normal lifestyles.

REFERENCES

1. Braff J, Lefkowitz M. Community Mental Health Treatment: What works for whom? Psychiatry Quarterly 1989; 51:119-134.

2. Anthony W, Buell GJ, Sara S. The efficacy of psychiatric rehabilitation. Psychological Bulletin 1972; 78:447-456.

3. Dharwadkar N. Effectiveness of an assertive outreach community treatment program. Australian and New Zealand Journal of Psychiatry 1994; 28.

4. Bond GR, Miller LD, Krumweid RD. Assertive Case Management in three CMHC'S: A controlled study. Hospital and community psychiatry 1988; 39:411-418.

5. Hoult J, Reynolds I, Charbonneau - Powis M. Psychiatric hospital versus community treatment: The results of a randomised trial. Australian and New Zealand Journal of Psychiatry 1983; 17:160-167.

6. Hoult J. Schizophrenia: A comparative trial of community orientated and hospital orientated psychiatric care. Acta Psychiatrica Scandinavia 1984; 69:359-372.

7. Hoult J. Community orientated compared to psychiatric hospital orientated treatment. Social Science and Medicine 1984; 18:1005-1010.

8. Hoult J. Community care of the acutely mentally ill. British Journal of Psychiatry 1986; 149:137-144.

9. Stein, LI; Test MA. Alternative to mental hospital treatment, I: Conceptual model, treatment program and clinical evaluation. Archives of General Psychiatry 1980; 37:392-397.

10. Wright RG, Hener JR, Shape J. Defining and measuring stabilisation of patients during 4 years of intensive community support. American Journal of Psychiatry 1989; 146:1293-1298.

11. McGorry P.D., Charen A, McCarthy E, Van Riel R, McKenzie D, Singh B.S.: Post-traumatic stress disorder following recent-onset psychosis; an unrecognised post-psychotic syndrome. Journal of Nervous and Mental Disease 1991; 179: 253-258.

12. Falloon IRH. Early intervention for first episodes of schizophrenia: A preliminary exploration. Psychiatry 1992; 55:4-15.

13. Pai S, Roberts EJ. Follow-up of study of schizophrenic patients initially treated with home care. British Journal of Psychiatry 1983; 447-450.

14. McGorry P.D. The concept of recovery and secondary prevention in psychotic disorders. Australian and New Zealand Journal of Psychiatry. 1992; 237:3-17.

15. Overall & Goreham. BPRS (Ref).

16. Andreasen N, SAPS + SANS (Ref).

17. Rosen A, Quality of Life Scale (Ref).

18. Parker G et al - E.E. ref.