CHAPTER 15

SERVICES FOR CHILDREN AND YOUTH, OLDER PEOPLE AND CALD COMMUNITIES

Introduction

15.1 Mental health services are failing some of the most vulnerable groups in society; medical health care will need to be the overhauled and revitalised if community expectations are to be met:

> There are still too many gaps in current programs and services, resulting in some people with mental illness falling out of the health care system. These may include those with co-morbid mental health and alcohol or drug problems, people with mental illness who are inappropriately in the criminal justice system, people in the immigration system, Indigenous Australians, and young people.
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> The indication of increased demand for mental health care, together with the increased expectation of high quality care from consumers and carers, will logically have an impact on how well existing resources and the current workforce can effectively meet the increased demand. Evidence would suggest that these are key areas for future attention, particularly if the pace of reform is to be increased in the future to keep pace with community expectations.[1]

15.2 This part of the report will provide a needs assessment of particular groups—those requiring a more specialised service response—within the broad-spectrum of needs addressed in the body of the report. Some of the groups identified above as 'falling out of the health care system' are discussed; others have been dealt with in detail elsewhere in the report.[2] The groups covered in this chapter comprise children, youth, older people and CALD communities. The service requirements of rural, remote and Indigenous Australians are explored in Chapter 16.

15.3 Obviously, there is much room for duplication in this assessment; most chapters canvass the diverse needs of particular groups to some extent. Discussion of children and youth inevitably highlights the importance of early intervention programs covered in Chapter 7, while the growing prevalence of youth with dual diagnosis, touched upon here, is a focus of Chapter 14. In other areas information of service requirements was comparatively limited. Less was received on older people with

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1 Australian Government, *Submission 476*, Part 10, p. 71.

2 People with co-morbid disorders, otherwise termed dual diagnosis, and those in the criminal justice system are treated in separate chapters. This reflects the growing prevalence of co-morbidity, and the significant influx of people with mental health disorders into the criminal justice system.

mental illness, perhaps supporting the view that older Australians are a 'voiceless' and neglected group. The situation of Australia's Culturally and Linguistically Diverse (CALD) communities is distinctive, and is addressed in terms of established community groups, and of refugees or new arrivals. Some consideration is given to the situation of Temporary Protection Visa (TPV) holders and immigration detainees with mental disorders in the discussion on refugees, reflecting the importance of the matter to submitters.[3]

Children and youth

15.4 It well known that social disadvantage, violence and instability in childhood reduces the chance of an individual enjoying good mental and physical health in later life.[4] Experts have conjectured that improved living standards would reduce the incidence of health problems. Studies have recently shown, however, that despite the general increase in amenity in the lives of people in developed countries compared with 40 years ago, there has been an alarming deterioration in the overall health of children in recent decades. Pre-eminent in that is a dramatic increase in the incidence of mental illness among the young.[5]

15.5 In Australia, between 14 and 18 per cent of children and young people between the ages of 4 and 18 years now experience mental health problems of clinical significance. This equates to in excess of 500 000 individuals nationally.[6] On this basis Professor Fiona Stanley, Australia of the Year 2003 and child health expert, has argued for a more a holistic approach to child health, one that recognises the interaction of social, economic and health policies, to produce a society which can foster and sustain the physical and emotional health of children and young people. Essential to her vision is the promotion of an early intervention approach, away from the 'end of pathway' policy responses currently modelled:

> Modernity's paradox is that in contemporary Australia we just have not been providing enough good early childhood experiences and for some children, our Indigenous children, this has had major negative impacts on their life chances, in spite of us having such a success with our economy…the policy responses on the whole have been at the end of

3 Comprehensive analysis of the circumstances of detainees has been undertaken during the Palmer Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau, and most recently by the Senate Legal and Constitutional References Committee in its report on the administration and operation of the *Migration Act 1958* (March 2006).

4 Women and Mental Health Inc, *Submission 310*, p. 3.

5 See discussion, Professor Fiona Stanley, 'Before the Bough Breaks: Children in Contemporary Australia', Kenneth Myer Lecture 2003, National Library of Australia, www.nla.gov.au/pub/gateways/archive/64/pages/p17a01.html, (accessed 10 March 2006).

6 Findings of the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (Sawyer et al., 2000) and the Western Australian Child Health Survey: Developing Health and Wellbeing in the Nineties, Quoted in Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, p. 10.

> pathways and, whilst that's understandable, they will not deliver the long-term solutions to reduce those problems and neither have researchers actually adequately investigated these problems…we need to respond to this by acknowledging these issues and acknowledging this is happening in today's Australia and we need to start to change our emphasis and activities to make it a better place for our children and young people.7

15.6 This report cannot address the wider issues of social and economic policy which affect the happiness and well being of Australian youth. It can nevertheless acknowledge that the capacity to reduce the incidence and impact of mental health problems in the community[8] is affected by broader social and economic frameworks set up by Australian governments. As discussed in Chapter 7, the lack of support for early intervention is just one, albeit very important, aspect of this. This section will not focus on early intervention services for children as discussed in that chapter, but will look across the spectrum of child and youth need to discuss major service gaps affecting these groups.

15.7 The first and foremost issue is the extent of unmet need. Studies[9] have shown that alarmingly few young people have access to the necessary mental health services:

> Only one in four young people with mental health problems receive help and even among those with most severe mental health problems, only 50 per cent receive professional help. Family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems but even then young people are under-represented in the number of general practice visits as a percentage of the population. Of greater concern, they are also under-represented in visits for mental health issues, even though this issue provides the highest morbidity in this age group.[10]

15.8 Submitters identified multiple deficiencies in national policy as underpinning this low rate of access:

- first, the absence of a national template to drive development of services that are both targeted and better integrated;
- second, insufficient recognition of the diversity of child and adolescent health needs in the structure and provision of services; and
- third, the need for adequate funding to develop the necessary family and community support systems.

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7 Professor Fiona Stanley, 'Before the Bough Breaks: Children in Contemporary Australia', Kenneth Myer Lecture 2003, National Library of Australia, www.nla.gov.au/pub/gateways/archive/64/pages/p17a01.html, (accessed 10 March 2006).

8 National Mental Health Plan 2003–08, p. 6.

9 See National Survey of Mental Health and Wellbeing (NSMHW) 1997, quoted above in AICAFMHA, *Submission 83*, p. 11.

10 Australian Divisions of General Practice (ADGP), *Submission 308*, p. 31.

15.9 These failures articulated into significant service gaps in high areas of need, including those for youth and young adults with emergent mental health problems.

National child and adolescent mental health framework

15.10 The lack of an articulated plan for addressing child and adolescent mental health has been identified as a major policy flaw in an otherwise progressive National Mental Health Plan 2003–2008. AICAFMHA advised:

> A recent study reviewing international policy development on child and adolescent mental health by Shatkin and Belfer (2004) ranked Australia a B (on a scale from A-D) which reflected that Australia had national policies that recognised the unique needs of this population but *did not enumerate a unifying plan of action*. This finding is consistent with previous commentary by AICAFMHA on former drafts of the now current National Mental Health Plan 2003-2008.
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> The minimal recognition of the difference between child/adolescent mental health and adult mental health in the language of the National Mental Health Plans may also be a contributing factor in the National Mental Health Strategy policy areas being inadequately implemented in the infant, child and adolescent mental health fields.[11]

15.11 The West Australian Child and Adolescent Mental Health Services Advisory Committee supports the view that, without such a template for action, child and adolescent services will continue run second in the struggle to fund adult mental health demands:

> CAMHSAC is constantly frustrated with the inability to attend to these issues due to the absence of capacity to marshal resources given the relative position of CAMHS providers within the current organizational structure and the demand for acute clinical services. The current organisational structure is based on mental health districts in which CAMHS service leaders report to the local mental health district Clinical Director who are almost always preoccupied with adult mental health services requirements and imperatives. This leads to a tendency to overlook the needs of children, adolescents and their families and carers and to view them as the "next issue" needing attention. "When the needs of adults are fixed then we will attend to the needs of children" This has been the refrain of senior mental health management for decades.[12]

15.12 Child development studies suggest that models responding to the diverse needs of children and youth across the spectrum of growth, rather than focusing on distinct age based service provision, will be the foundation of improved treatment outcomes for these groups:

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11 AICAFMHA, *Submission 83*, p. 9.

12 Western Australian Child and Adolescent Mental Health Services Advisory Committee, (CAHMSAC), *Submission 24*, p. [2].

> Infants, children and young people are not small adults. They have particular emotional, social and physical needs that should be considered within a developmental framework. Services should be designed specifically for infants, children and young people that work within this framework and address these specific needs.[13]

15.13 The absence of transition frameworks for children moving between service tiers and, in particular, for those moving out of adolescent services into adult streams, creates service gaps for patients with complex needs. The problems of youth aged 14 to 24 with co-occurring disorders, as discussed in the chapter on dual diagnosis, are indicative, and are recognised by government:

> Young people with emerging mental health problems or disorders often have multiple difficulties that make diagnosis difficult and may mean the young people do not clearly fit into specific programs or criteria. The report, *Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems*, published in 2004 by the National Youth Affairs Research Scheme, found that a lack of holistic professional expertise covering both mental health and substance misuse issues was one of the key barriers to services for young people with dual diagnosis.[14]

15.14 Clearly, greater coordination and cooperation within an interagency framework between child and family focused services and other agencies is needed. This is essential to support the early intervention and prevention services discussed in Chapter 7:

> In a well functioning mental health system which truly cares for children, services should be child centred, family focussed, community based, and culturally sensitive with adequate access to a variety of services suited to their needs including clinic, home based, school based services and crisis services, residential centres, and social services which provide attention tailored to their individual needs. In order for this to happen the *health, community and education sectors need to be integrated* for families requiring assistance.[15]

15.15 However, as Professor Margot Prior of the School of Health and Behavioural Sciences, University of Melbourne noted, despite these ideals being well articulated in the National Mental Health Strategy 'current systems are light years away from the ideal', especially when the low access and high rates of need are taken into account.[16]

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13 AICAFMHA, *Submission 83*, pp. 3, 4, 7.

14 Australian Government, *Submission 466*, Attachment 4, p. 2.

15 Submitter's italics, Professor Margot Prior, Professorial Fellow, School of Health and Behavioural Sciences at the University of Melbourne, *Submission 32*, p. 2.

16 Professor Margot Prior, *Submission 32*, p. 2.

Responding to the diversity of child and adolescent health needs

15.16 What is lacking in child and adolescent services is the capacity to provide appropriately tailored services and treatment responses within a care pathway that ensures easy transition between service streams.

15.17 As noted in Chapter 7, there are some concerns about early identification of mental health problems in young people. The NSW Commission for Children and Young People advised that the issue is really about appropriate service access, not the 'labelling' of young people with disorders:

> Discussion should continue to clarify and share definitions of terms like mental health, mental illness, mental disorder and mental health problem. While it is important that agencies are clear about their responsibilities within the service system, we need also to avoid excluding people with manifest problems in behaviour, conduct or mental health from service provision because no agency role statement includes their particular problem.[17]

15.18 The Commission considered that to achieve 'universal non-stigmatising service delivery' for children and families, general health services need to have, or have access to, mental health expertise.[18] However, Professor Prior advised that because of the generic service model currently imposed on service providers, diagnosis and treatment methodologies for child and youth mental health disorders are poorly developed, even among mainstream health specialists:

> Many clinicians working in this field are significantly under trained for the work that is required, lacking specialist graduate qualifications in child and adolescent mental health. The wholesale adoption of the generic model in these services means that treatment is not matched with assessed needs of the client, and when referral is taken up it is likely to be potluck what kind of professional (eg nurse, occupational therapist, psychologist etc) is allotted to the case. Further those professionals who are well trained in the field often do not have adequate opportunity to practise the assessment and therapy skills in which they have been trained and which are needed because of pressures for 'case management'.[19]

15.19 The very serious consequence of this is that evidence-based treatments, even where known, are not often applied:

> Much of the treatment provided in current Child and Adolescent mental health Services is not evidence based. Two salient examples illustrate this point. Numbers of children with anti-social or conduct disorders are seen in psychotherapy over long periods of time. Not only is this absorbing scarce funds but it is known that this mode of treatment is ineffective for children

17 The NSW Commission for Children and Young People, *Submission 399*, p. 3.

18 *Submission 399*, p. 1.

19 Professor Margot Prior, *Submission 32*, p. 2.

> with such difficulties. Children with anxiety disorders often do not receive the treatment for which evidence is strong, ie. Cognitive Behavioural Therapy.[20]

15.20 Screening tools are important for early recognition of the different childhood mental health problems. While sensitivities exist about early screening of children for mental health problems, the case for introducing screening to assist early identification for high risk groups is strong. One such group would be children entering out of home care:

> Young people entering care for the first time usually do not have comprehensive psychiatric or medical assessments despite the fact that this group are a high risk group for both physical and mental disorders. We undertook a pilot project (Stargate Project) providing such assessments for all children entering care over a twelve month period, combined with parent and carer interventions. We reasoned that early intervention might reduce the difficulties and produce better outcome for a highly vulnerable group, preventing further potential trauma from being in care. We found that there was indeed a high prevalence of psychiatric disorder, learning difficulties, and physical and dental problems in this group. Prompt intervention and assessment enabled better planning for the young people and resulted in a more rapid reunification where this was possible but also enabled carers to manage the young people and their problems more effectively, providing support for foster carers, who are unsung heroes looking after some of the most difficult children. Unfortunately the funding for this pilot project was not recurrent.[21]

15.21 Beyondblue argued that screening mechanisms should be more broadly applied by mainstream health services for early identification of emerging disorders in children, and to address the growing incidence of co-morbidity among the young:

> Areas recommended as most likely to produce best outcomes include community screening and treatment for disorders in childhood and well-trained service providers who are adequately versed in the detection, management and referral of people with co-morbid problems. Particular focus is being placed on primary care as a key setting for the identification and treatment of co-morbid alcohol misuse and mental health problems and, while a number of small projects underway are investigating potential models for co-morbid clients, there is little focus on co-morbidity with high prevalence disorders. More focus and investment in this area is required.[22]

15.22 Mainstream and recurrent funding under the national health budget could be an incentive to the states to develop routine health screening mechanisms of identified high risk groups for nascent mental health problems. The Central Australian Aboriginal Congress reported the success, for example, of the new 710 Aboriginal

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20 Professor Margot Prior, *Submission 32*, p. 1.

21 Royal Children's Hospital, Melbourne, *Submission 557*, p. 1.

22 beyondblue, *Submission 363,* p. 8.

Adult Health Check, which it uses to assess emotional and social disorders in Indigenous people aged 15 to 55. This project, however, is not funded as part of mainstream health services.[23]

15.23 Given the lack of agreed methodologies on early intervention and prevention across the spectrum of child and youth mental health disorders, funding for research and developmental consultation mechanisms seems essential. As a case in point, the risks of pharmacological treatment of children and youth with depression and anxiety are not established nor well understood by practitioners, indicating that definitive action must be taken to identify and promulgate key findings on the subject:

> There are some specific issues in regard to the prescribing of antidepressants in regard to young people and children, with little being known about the optimal duration of treatment and the effectiveness of pharmacotherapy in this group. There have been calls for the withdrawal of SSRIs for young children and protocols regarding labelling to highlight potential side effects, including suicidal ideation and attempts. beyondblue has facilitated a national focus group including The Australian Medical Association, The Mental Health Council of Australia, The Royal Australian College of General Practitioners and The Royal Australian and New Zealand College of Psychiatrists and the group are developing a joint statement and highlighting the research in regard to the use of anti-depressant medication in the treatment of depression in children and young people, with a view to ongoing review of this issue.[24]

15.24 The difficulties of achieving appropriate diagnosis for children can place extreme emotional and other demands on their families; then comes the challenge of accessing appropriate services. When the child's disorder involves high support needs, the consequences of not providing early and adequate assistance can be very grave for all concerned. A4 Autism Aspersers Advocacy Australia cited the case of Jason Dawes and his family, heard at Parramatta, on 2 June 2004:

> Jason Dawes was born on 2 Sept 1992. His autism was diagnosed in March 1994 when he was eighteen months old. His parents were advised that Jason was in need of early intervention, but [the local service] advised that they did not have a place for him. He went for years without intervention.
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> Jason's mother was required to educate, feed, toilet, bathe, entertain and love Jason…She constantly lived with the fact that her son had lost his best chance of acquiring later life skills because of the failure of authorities to provide appropriate intervention during his early formative years.
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> Jason's father said autism caused constant stress in the family and pervaded all their relationships, "[His mother] had to fight so hard for help for Jason – early on I couldn't cope at all".

23 The Central Australian Aboriginal Congress, *Submission 486,* p. [8].

24 beyondblue, *Submission 363*, p. 7.

> Judge Ellis said…it is clear that the present system within New South Wales leaves a lot to be desired and was a significant stressor for Jason's mother over an extended period of time.
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> On 24 August 2003…Jason's mother held his hand, placed her hand over his mouth and nose and held him until he ceased struggling. In so doing she took her son's life… [Jason's mother] then went into the bathroom, took a razor and severely lacerated her wrists.[25]

15.25 The submission concluded: 'Jason Dawes had autism, a mental disorder that required treatment that the state did not provide and that he did not get. The fact that authorities failed to provide appropriate intervention for his autism contributed to his parents' mental illnesses and to his death'.[26]

15.26 To address the urgent and diverse unmet needs of children and adolescents with mental health problems, submissions requested comprehensive review of 'service silos' which prevent the development of expertise, and the marshalling of scarce resources to treat the range of disorders across the age spectrum. Beyondblue recommended that a research project of national significance is required to develop best practice approaches for wholesale youth mental health service reform, and research be undertaken to establish and promote:

- an expanded developmental phase to encompass a youth population;
- the epidemiology of mental disorders in young people; and
- young people's access to standard health care systems.[27]

Youth transition—specialised services

15.27 A significant body of evidence to this inquiry concentrated on the particular obstacles to service access for the young people with mental illness, early teen through to age 24 years. This group, as acknowledged by government, has the highest incidence of mental illness of all age cohorts, and the lowest access rate of services:

- mental disorders are most prevalent during adolescence and young adulthood, and account for 55 per cent of the disease burden of those aged 15 to 24 years.
- only 25 per cent of young people aged 13 to 17 with mental health problems used one or more services.[28]

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25 Comments on Judge Ellis' summing up the in the matter of REGINA v DANIELA DAWES, 04/21/1041 NSW District Court, Parramatta, quoted in A4 Autism Aspersers Advocacy Australia, *Submission* 92, p. 4.

26 *Submission 92*, p. 4.

27 beyondblue, *Submission 363*, p. 9.

28 Australian Government, *Submission 476*, Attachment 4, p. 1.

15.28 The 1997 ABS National Survey of Mental Health and Wellbeing found that rates of mental disorder peak at age 18 to 24 years, with more than one in every four young adults having one or more mental disorders. The prevalence rate of anxiety disorders for young people aged 18 to 24 was 11 per cent, 7 per cent for affective disorders, such as depression, and 16 per cent for substance use disorders. Substance use disorders were most common in young males and depressive disorders were most common in young females.[29]

15.29 Happily, the suicide rate for young people continues to decline,[30] although levels among young males, particularly regional or rural males, remain high.[31] Young people overall continue to record substantially higher rates of self harm than those of older adults:

- suicide accounted for 22.5 per cent of all deaths for young people, second only to motor vehicle accidents; and
- 42 per cent of adolescents experiencing very high levels of mental health problems had seriously considered suicide and one in four had made a serious attempt in the last 12 months.[32]

15.30 Reflecting this data, young people's hospitalisation rates for mental disorders have also risen over recent years with about 43 000 hospitalisations for mental health and behavioural disorders recorded between 2000 and 2001 alone. The most common causes for these hospitalisations are depression, schizophrenia, severe stress and eating disorders.[33]

15.31 As widely discussed in this report, the acute care focus of mental health services yields contradictory and very negative service consequences for people with mental illness. On one hand, under deinstitutionalisation, acute care services have been wound back creating a shortage of available beds. On the other, underdevelopment of the necessary community based and crisis management services ensures people with mental illness in desperate situations have no recourse but to go to hospital emergency departments, which are not adequately equipped to deal with them:

> In particular, young people between the ages of 16 years and 18 years have no dedicated emergency response for acute mental disorders and frequently

29 Australian Government, *Submission 476, Attachment 4,* p. 1.

30 The suicide rate recorded by the NMHS in 1997 was 15.2 deaths per 100,000 young people. Suicide rates are now 23 percent below that. See 'Suicide Rate Falls', The *Australian*, 15 March 2006.

31 These are double the rate of the rest of the population. NSW Farmers Association, *Submission 410*, p. 4.

32 *Submission 476, Attachment 4,* p. 1.

33 ADGP, *Submission 308,* p. 31.

> are hospitalised in adult facilities which are not adequately resourced, staffed and structured to meet the needs of this population.[34]

15.32 Submitters maintained that emergency departments are the worst place for young people in acute states of need. The committee received numerous reports from young consumers lamenting their treatment in hospitals, such as shackling and forced injection, sometimes simply because the consumer expressed frustration at being left in the waiting area, or mentioned suicide ideation.[35] Insane australia reported:

> If you talk about suicidal feelings, it is quite likely that you are going to be locked up and then you will have quite invasive treatments imposed on you against your wishes. We find that people are absconding from our mental health services, whether they be voluntary or involuntary, specifically to go and kill themselves. There is quite clear data about that but no-one is asking the question: what is happening in these services that people are escaping to go and kill themselves? To me it is very understandable: if you present to someone seeking help—perhaps your last grasp at staying alive—and you find yourself being assaulted, it is to be expected that you will flee that situation.[36]

15.33 As serious as this is, the main systemic obstacle to better youth service access is the age-based clinical distinctions establishing child and adolescent services, as against adult services, from years 16 to 18.[37] Mr Jurgen Hemmerling, a youth worker from the Albury Wodonga, reports that this unhelpful division militates against children and younger teens accessing out-of-hours emergency care in his region:

> Working in the youth sector has highlighted some serious short comings in the child and adolescent mental health fields. In Victoria, child and adolescent mental health services do not operate an after hours service, so only persons aged 16yrs and above are eligible for the adult mental health system after hours intervention, young people are required to wait til 9am-5pm service delivery. Currently the wait list for service in this region is at least six weeks, hardly satisfactory.[38]

15.34 At the other end of the spectrum, turning 18 can mean losing access to whatever specialised services are available:

> To date the service structure is such that upon turning 18 a young person must utilize the services of an adult service only if they have a defined 'serious mental illness' (meaning in most cases psychosis, especially schizophrenia). Therefore the mental health problems of most young people

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34 CAHMSAC, *Submission 24*, pp. [4].

35 See for example, Ms Jolan Tobias, Platform Team Member, ORYGEN Youth Health, *Committee Hansard*, 7 July 2005, pp.22–23 and Anglicare Tasmania, *Submission 464*, p. 28.

36 insane australia, *Committee Hansard*, 5 July 2006, p. 28.

37 Mr Jurgen Hemmerling, *Submission 366*, p. 1.

38 *Submission 366*, p. 1.

> in the 18-25 age group largely go either undetected or receive no intervention whatsoever.[39]

15.35 In addition, youth with complex disorders must negotiate the gaps between other service 'silos'. As discussed in Chapter 14, dual diagnosis youth for example may 'slip through the cracks'[40]between mental health and alcohol and drugs services:

> Up to 50 per cent of our current client group, who are aged 12-21yrs with serious alcohol and other drug issues, have significant psychiatric pathology, ranging from self harm to depression, anxiety and psychosis. These young people…are poorly serviced by the current mental health system. It is well known, that young people are one of the most difficult of client groups to engage in service delivery, long wait lists, lack of after hours services and the stigma often attached to mental health services are a constant barrier to service access for these young people.[41]

15.36 In addition to the development of transition frameworks and restructuring services to comprehensively address the needs of the young teen to 24 age group, submitters asked for a more holistic approach to support youth mental health needs:

> Basically it is only hard-core psychotic illness that can be looked after in the public system, with access to adjuvant supports such as case managers, linkage to employment and rehabilitation services etc. Yet there are a huge number of needy, but not wealthy people who simply cannot access the services that would help them. A large number of these have mood or personality disorders, and many of them are young. There are significant financial barriers to accessing medical models of mental health care with declining rates of bulk-billing and the rise of a "user-pays" system, and even greater barriers to accessing non-medical models of care which are known to have lasting therapeutic value. General Practitioners (GPs) cannot offer all that is required. Community mental health services are overwhelmed with mostly young people referred for assessment by GPs, who need longer-term talking or behavioural therapies, yet no affordable and available services can be found.[42]

15.37 The focus on symptomatic assessment does not provide young consumers with the emotional or practical support needs to negotiate life with a mental illness:

> When children and young people do present to services, it is often for other matters, such as homelessness or family problems, and the mental health issue may not be immediately apparent. Agencies need to work collaboratively, focus on building trusting and lasting relationships with children and young people and be linked to specialist mental health services.

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39 beyondblue, *Submission 363*, p. 9.

40 Dr Georgina Phillips, *Committee Hansard,* 6 July 2005, p. 16.

41 Mr Jurgen Hemmerling, *Submission 366*, p. 1.

42 Dr Georgina Phillips, *Submission 255*, p. [3].

> The existing mental health service system is complicated and frequently compartmentalised to focus on single issues or acute problems. As a result, responses to vulnerable children and young people are sometimes limited to the treatment of a mental illness, rather than recognising and addressing the full range of problems which the child or young person may face.[43]

15.38 To overcome the stigma and other difficulties faced by young consumers, targeted youth friendly services were suggested. The Youth Mental Health Coalition advised:

> Young people are often reluctant to seek help and are very discerning about when, where and from whom they seek assistance. There is a critical need for youth oriented services. Young people who don't necessarily have a 'serious mental illness', and even those who do, must also deal with the stigma associated with attending a mental health clinic.[44]

15.39 ORYGEN Research Centre advocated the national implementation of a model which combines the best of clinical and life skills assistance:

> Young people with emerging severe mental illnesses should have access to specialist youth mental health services. Young people aged 12-25 should be treated in publicly funded youth mental health services alongside their peers where the therapies, physical environments, group activities, vocational support, staff and work-practices are appropriate to the needs of young people. Access to such specialist youth mental health services should not be a quirk of geographic location—currently access to the only such publicly funded service in Australia is confined to residents of the Western and North Western regions of Melbourne.[45]

15.40 Essential to the model is consumer participation. AICAFMHA recommended that the 'voice of children and young people' be heard in the development of mental health policy, services, interventions and programs which affect them.[46] The report of a young ORYGEN client, cited by the Youth Mental Health Coalition, exemplifies the note of hope that recovery based services of this type can achieve:

> I like to think of myself as an ORYGEN graduate, not a mental health patient, yes I am one of those crazed and deranged people that society is so cautious about. It's funny that, because when I look at what's happening in society today it seems to be on the brink of madness, materialism, consumerism, terrorism, genetics and morals. You must have viewed or at least heard of the saying "the worlds gone mad". Maybe a bunch of people like me in society should get together sometime, us crazy people know our stuff, we could help out.[47]

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43 NSW Commission for Children and Young People, *Submission 399* , p. 2.

44 The Youth Mental Health Coalition*, Submission 285*, p. 9.

45 ORYGEN Research Centre*, Submission* 184, p. 11.

46 AICAFMHA, *Submission 83*, p. 5.

47 *Submission 285*: case study: Jolan's Story, p. 15.

Funding child and youth services adequately

15.41 Many service providers reported the alarming extent of unmet need in their practices. Professor Peter Birleson, Director, Eastern Health CAMHS, Adjunct Professor in Psychology, Deakin University, felt the urgency of the situation personally:

> As I see more children being turned away from my service, and see my staff becoming more stressed trying to meet impossible demands, I am more convinced that we cannot give up. We must communicate about the personal and financial costs of not having enough services, must ally with consumers to make more noise about this problem, and must show we deploy our resources as efficiently and effectively as we can. We can all do this locally, but the College can help us by strengthening its policies, building political partnerships with consumer organizations, actively including the Child Faculty and providing information.[48]

15.42 Professor Birleson considered a reasonable a response by government would be to double the funding allocated to specialist CAMHS from 7.5 per cent to 15 per cent of the specialist mental health budget.[49]

15.43 In similar vein, the AICAFMHA calls on government to 'undertake specific child and adolescent national mental health policy and planning development with defined accountabilities'. It suggested an increase of 15 per cent of mental health funding by 2010 for infant, child and adolescent mental health care, with a further target of 20 per cent of mental health funding by 2015 to facilitate servicing the 30per cent of the population who are in this target age range.[50]

15.44 The announcement of the successful tender of ORYGEN Research Centre, with the Sydney-based Mind and Brain Institute, to run a National Youth Mental Health Foundation is promising for youth mental health reform. The $54 million funding for national service provision will be a good start,[51] but the Government should consider its commitment as a long term one, and act promptly to implement recommendations.

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48 Professor Peter Birleson, Director, Eastern Health CAMHS, Adjunct Professor in Psychology, Deakin University *Submission 429,* Attachment 1, pp. 16–17.

49 *Submission 429*, Attachment 1, p. 17.

50 AICAFMHA *Submission 83,* p. 10.

51 The Hon Christopher Pyne MP, Parliamentary Secretary, Minister for Health and Ageing, National Youth Mental Health Foundation, *Media Release*, CP70/05, 12 December 2005.

Older people with mental illness

15.45 Australia has an ageing population but the provision of mental health services to the aged is underdeveloped compared with other groups in the community.[52] The ratio of mental illness among the aged is lower than in the general population, at around 6 per cent for those aged 65 and over, compared with 18 per cent for general population.[53] Studies have suggested that getting older might reduce anxiety and depression,[54] implying perhaps that there is less unmet need among the elderly. Other factors suggest that older people with mental illness are another particularly vulnerable group neglected by current mental health services frameworks.

15.46 The concurrence of dementia with other mental illness presents special challenges. As the population ages, dementia is increasingly common. As the number of people in dementia rises, so too does the number of those with another mental illness, such as anxiety, depression, or personality disorder. These consumers, particularly the last group, can not be readily managed in mainstream aged care facilities, which lack services to assist them. At the same time specialised community based or acute services remain underdeveloped for this cohort.

15.47 One indicator of this is the very high suicide rate for males over 65: 29 suicides per 100 000. The risk factors for depression and suicide for this age group are influential: death of a spouse, loss of independence, income and status through retirement, increased social isolation and loneliness, reduced capacity or inability to participate in favourite leisure activities and pastimes concomitant to physical illness, and chronic pain associated with injury or disease.[55]

Limited progress under the National Mental Health Strategy

15.48 The National Mental Health Strategy has had limited effect in improving mental health services to older people with mental illness. Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists reported findings that suggest medical service access for those over 64 years is actually in decline:

> The National Mental Health Strategy has had limited effect in improving the mental health care of older Australians in NSW. Although there has been a reduction in patients managed in long term mental health beds there has been no co-ordinated system developed across the State to optimally manage older people with mental health disorders in the community. There is a marked shortage of inpatient resources of all types. There is an even greater, severe, shortage of resources to manage older people with mental

52 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, *passim*.

53 Australian Government, *Submission 476*, Part 10, p. 65.

54 A. F. Jorm, 'Does Anxiety Reduce Anxiety and Depression? A Review of Epidemiological Studies Across the Lifespan', *Psychological Medicine*, vol. 200, no. 30, pp. 11–12.

55 *Submission 476*, Part 10, p. 65.

> illness in the community in all areas of NSW. Some areas have no access to specialist mental health services for older people. As a consequence of this older people with mental illness do not have access to a comprehensive range of mental health interventions. Furthermore older people have less access to private psychiatric services in Australia. An analysis of 1998 Medicare data revealed that per capita the proportion of Medicare expenditure allocated to adults aged less than 65 years was 4.1 times that for adults over 64 years. This was a decline since 1985–1986.[56]

15.49 The main objective articulated in the 2003 Public Health Action Plan for an Ageing Australia is to reduce the future incidence of aged debility, rather than addressing current unmet need of older consumers.[57] The Federal government has funded the ANU's Centre for Mental Health Research to conduct research for this purpose. The Beyond Ageing Project focuses on prevention of depression or cognitive impairment, and improvement of mental health literacy for this cohort. The project will report late in 2006.[58] The Federal Government otherwise reports only one targeted seniors initiative, the Seniors Portal, an internet site providing information about service access. It noes that other broader 'whole of community' 'may address some risk factors'.

15.50 Lack of clarity regarding responsibility for funding between different levels of government, and within each level, is a significant ongoing barrier to improvements in mental health care for older Australians. Similarly, state governments do not appear to be moving at any pace on unmet need for the elderly. The NSW Government's Plan for Mental Health Services released in March 2005 proposes the development of only one aged care mental health unit in the state, in the Illawarra.[59] Dr McKay concluded 'there is a pressing need for clear policy responsibility at a national level for older persons with mental illness'.[60]

Service comparison with other groups

15.51 Submissions remarked that specialist services for older people in all settings are markedly under-resourced, and are significantly less developed than mental health

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56 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, pp. [1–2], quoting Draper and Koschera, 2001.

57 Which aims to 'to progress the health and wellbeing key result area of the Commonwealth, State and Territory Strategy on Healthy Ageing'. See Australian Government, *Submission 476*, Part 10, p. 65.

58 Australian Government, *Submission 476*, Part 10, p. 65.

59 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [2].

60 *Submission 219*, p. [2].

services for the remainder of the population. The lack of research and well trained staff were listed as major obstacles to adequate care for the elderly.[61]

15.52 While some evidence based models for elderly care have been developed, service systems are not well defined to address the coexistence of dementia and mental illness in the elderly. The Australian Government submission advised:

> While dementia is included in the definition of a mental health problem, it is not considered to be a mental illness. The overlap between dementia and mental health remains problematic, with the impact felt most acutely when the person affected, or their carer, needs to interact with the mental health and aged care sectors.[62]

15.53 At hearings, Professor Henry Brodaty, appearing with Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists, explained the stark implications of this:

> We know that dementia is largely looked after by Commonwealth policies and services and mental health problems are looked after by states. If you have both, often you are not looked after by either. We know that rates of mental health problems in people with dementia are huge. Ninety per cent will have some behavioural or psychological symptom at some time during their dementia. Having aggression, depression, delusions or hallucinations is a big risk factor for institutionalisation. We currently spend about $3 billion a year on nursing home costs, and direct costs for dementia are set to rise to $6 billion by about 2011. A large part of that is accounted for by the mental health problems associated with dementia.[63]

15.54 The South Australian Division of General Practice reported the care response in that state:

> Dementia, depression and confusion can be seen by families, carers and the health care system as part of ageing, which leads to acceptance of these problems and not enough attention paid to potential solutions…The Home and Community Care (HACC) system has had difficulty accepting mental health as a source of disability despite figures demonstrating mental health as the largest cause of non-fatal burden of disease. As with all areas, comorbidities with physical illnesses and disabilities impose additional strain on consumers and carers but are not well managed or treated.[64]

15.55 Elderly people with coexisting mental health disorders and substance abuse problems are reported to have extremely poor access to drug and alcohol services. Dr McKay noted that the national drug and alcohol plan has no policy initiatives with

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61 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, pp. [2; 5-6.]

62 Australian Government, *Submission 476*, Part 10, p. 65.

63 Professor Henry Brodaty, *Committee Hansard*, 2 August 2005, p. 72.

64 SA Division of General Practice, *Submission 88*, pp. 7–8.

regards to the elderly, and that a focus on youth co-occurring disorders disregards incidence of dual diagnosis with dementia.[65] The Department of Veteran Affairs has targeted the needs of veterans generally in this area, particularly for alcohol based co morbid conditions, and has increased its focus on aged mental health.[66]

Depression in aged care facilities

15.56 Older Australians in residential aged care facilities are at particular risk of depression, but have poor access to services. In 2004, the Department of Health's Challenge Depression Project reported the results of its national survey of 1758 residents in 168 aged care homes. The project found that 51 per cent of high care and 30 per cent of low care residents are depressed. Assessments of those with severe cognitive impairment able to participate indicated that 38 per cent of high care and 26 per cent of low care residents are depressed. The report concluded that, under normal circumstances, a significant proportion of depressed residents go unnoticed, as staff are poorly informed about and have no framework for systematic assessment of depression in their patients.[67]

15.57 Improved training for nursing home staff is clearly required, as the depression carer support organisation blueVoices observed:

> In reviewing education around the country, we would recommend that a program is funded which offers appropriate education and input into depression and anxiety disorders in older Australians for the many staff who work in these types of facilities. The majority of direct client care in Residential Aged Care is carried out by Grade III Certified Nursing Staff (Assistants in Nursing). These staff often have minimal educational qualifications, and therefore do not have very high levels of knowledge around the areas of depression and anxiety and other mental disorders. This in turn can quite unwittingly contribute to the further deterioration of their clients, instead of assisting older Australians to optimise their level of functionality.[68]

15.58 The New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, observed that the lack of long term acute inpatient care and community care options for people with low prevalence disorders such as bipolar disorder has potential to increase the likelihood that

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65 Dr Roderick George McKay, on behalf of the New South Wales Branch of the Faculty of Psychiatry of Old Age, the Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [5].

66 Australian Government, *Submission 476*, Attachment 26, p. 1.

67 *Depression in Residents of Aged Care Homes, The Final Report of the Challenge Depression Project* (Challenge Depression: Final Report), Report to the Department of Health and Ageing by The Hammond Care Group, March 2004, p. vii.

68 blueVoices, *Submission 259,* p. 9.

residential aged care facilities will have to accommodate more older people with these disorders, to the disadvantage of all concerned.[69]

15.59 Dr Georgina Phillips advised that the current situation for these patients is untenable, as many have no where to go but to hospital emergency departments:

> There is a growing trend for EDs to be used as a form of crisis containment for the mentally unwell aged (psychogeriatric) person. By the time these people end up in an ED, their degree of mental and behavioural disturbance is severe, and chemical and/or physical restraint is necessitated. It is a particularly frustrating phenomenon as often the mental and behavioural issue is not new, but because of inadequate community assessment, management and support, the nursing home/hostel/families/neighbours end up in a crisis situation. The aged are particularly vulnerable to the stresses of ED care and can suffer exacerbations of their mental illness, dementia or delirium simply from prolonged time in such a non-therapeutic environment, as well as a higher risk of physical injury from falls, physical restraints etc.[70]

15.60 To address pressures on care systems and to reduce the level of depression and other mental illness among older people, the NSW Department of Health recommended that more supported accommodation should be made available in the community.[71] Positive results could be also achieved by implementing a national network of suicide prevention workers.[72]

The case for more specialised services

15.61 The capacity building of community support services for older people with mental illness is clearly essential. Support packages such as those developed in Tasmania for assisting people with mental illness in the community, for example, could be extended to offer specialised support to aged consumers and their carers.[73]

15.62 However, experts in the field of geriatric psychiatry also argued that the distinct needs of the aged with mental disorders needs better systemic recognition:

> Mental health problems in old age are different. It is not that older people are just adults grown older. In the same way that child and adolescent psychiatry is qualitatively different from adult mental health, in old age mental health there are qualitatively different conditions, different reactions to medication and different treatment strategies. Old people do not do well in mainstream psychiatric services. The clinicians are not particularly

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69 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [2].

70 Dr Georgina Phillips, *Submission* 255, p. [4].

71 NSW Department of Health, *Submission 470*, pp.38–39.

72 *Submission 470*, p. 23.

73 Tasmanian Government, *Submission 502,* p. 7.

> interested in older people. In psychiatric wards they often get knocked around by younger, violent psychotic patients. There are strong arguments for having dedicated, discrete services for older people, as we do for children and adolescents.[74]

15.63 The development of discrete targeted services of the aged seems inevitable given the very real limitations of the present arrangements to provide both timely and continuous care, particularly for the acute patient:

> Problems arising from lack of expert assessment and definitive care [are] particularly delayed in the aged population, as CAT teams, psychiatric triage and community mental health services limit themselves according to patient age (usually < 60yrs). Psychogeriatric services are ess experienced in acute care and crisis management, and often do not have resources to provide immediate or even 'same-day' assessment. Similarly, psychogeriatric inpatient beds do not have a high patient turnover, and the delay to accessing these in an acute situation often stretches to days.[75]

15.64 The demands that aged people with these disorders put on their carers, often elderly also, needs an urgent and sympathetic service response. At present, older people with mental illness and their carers have little input in the increasingly important consumer and carer movements within mental health, which may explain their relative neglect. Factors such as stigma, very prevalent in rural areas,[76] as well as cognitive impartment, and lack of respite care may reduce the capacity of this cohort for lobbying and involvement and service planning—and all are indicators of their relative powerlessness to change their circumstances.[77] Dr Roderick McKay concluded:

> In summary, despite the increasing concern in the broader community regarding the impact of an ageing population upon our health system, the delivery of services to improve the mental health of older Australians has received very limited resources, and development is hindered by lack of clear responsibility for planning or funding of services. This situation is exacerbated by the reality that older Australians with mental illness and their carers are not as vocal, nor as likely to be in the media, as their younger counterparts. There are known effective systems for improving the mental health of older people, but they require adequate resourcing. We believe that nation has a responsibility to offer equivalent access to mental health care to older Australians as it does to younger Australians. We do not believe this is currently the situation.[78]

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74 Professor Henry Brodaty, Private Capacity, *Committee Hansard*, 2 August 2005, p. 72.

75 Dr Georgina Phillips, *Submission* 255, p. [4].

76 Australian Rotary Health Research Fund, *Submission 68*, p. [2].

77 Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [5].

78 *Submission 219*, p. [6].

15.65 Statistical projections suggest that the need for improved services for older Australians with mental illness and their carers will soon become more urgent. With the number of baby boomers in their eighties likely to quadruple in the next 40 to 50 years, the case for expanded services must inevitably be put on the agenda.[79]

CALD communities and refugees

15.66 Australian society is culturally and linguistically diverse. One in three identify as having a culturally and linguistically diverse background; two and a half million were born in countries where English is not the primary language, and 15 per cent of the population speak a language other than English at home.[80]

15.67 During 2003-04 the Australian Government commenced consultation with multicultural organisations to produce the Framework for Implementation of the National Mental Health Plan 2003-08, which identifies priorities for action on multicultural mental health services. Multicultural Mental Health Australia took part in the process and expressed support for the plan but cautioned that the Framework must be progressed with commitment by the Federal Government according to a comprehensive implementation plan, with agreement by all governments, and must be supported by adequate resources and infrastructure in all jurisdictions.[81]

15.68 Submitters questioned whether this commitment would be forthcoming, given that the pressures on mainstream mental health services around the country are so great. The Forum of Australian Services for Survivors of Torture and Trauma (FASST) noted: 'In most states and territories mental health services are not appropriately resourced to provide continuity of care and culturally sensitive assessment interviews'.[82]

15.69 This section will assess the capacity of and identify the challenges to service providers to people with mental health problems from CALD backgrounds, including that subset of the most vulnerable: refugees and other humanitarian entrants.

CALD established communities

15.70 Information on the level of mental illness and service access in CALD communities is not freely available. This is partly because of underdevelopment of mechanisms of collect and collate information, and partly because available data is not

79 Professor Henry Brodaty, *Committee Hansard*, 2 August 2006, p. 71.

80 21.9 per cent of Australians reporting in the 2001 Census as having been born overseas, and 13.3 per cent born in non-English speaking countries. See Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 1, and Multicultural Mental Health Australia, *Submission 200*, p. 1.

81 Multicultural Mental Health Australia, *Submission 200*, pp.3, 10.

82 Forum of Australian Services for Survivors of Torture and Trauma (FASST), *Submission 397*, p. 4.

published.[83] The Victorian Transcultural Psychiatry Unit provides advice from known studies in a comprehensive coverage of significant CALD service issues, some of which are:

- there is great variation in prevalence of mental disorders across CALD communities, and higher rates of mental disorder in some, including several of the more established resident communities;
- CALD communities have greater difficulties in gaining access to specialist mental health services (both inpatient and community services) compared with the Australian-born;
- they have higher rates of involuntary admissions to inpatient facilities and evidence suggests that they may access services at a late stage when the clinical state is more severe;
- representation in community mental health services is lower than in inpatient facilities and representation in any form of mental health services is particularly low for those with lower English language facility;
- stigma associated with mental illness— both among CALD communities (consumers, carers and families) and health professionals— remains a major problem;
- competence in conducting clinical work across language and cultural barriers remains low among many mental health clinicians and workforce turnover;
- community development and partnerships strategies have been difficult to establish given the structure and funding priorities of mental health services; and
- consumer and carer participation in the development and delivery of mental health programmes continues to lag behind for CALD communities relative to the mainstream.[84]

15.71 These issues are discussed in relation to stigma and access to information, and provision of culturally appropriate services.

Stigma and access to information

15.72 For many non-English speaking communities, mental illness is a taboo subject.[85] Submissions reported that traditional prejudices and fears about mental illness endure among many Australian CALD communities, acting as a powerful

83 Multicultural Mental Health Australia, *Submission 200*, p. 20, and FASST, *Submission 397*, p. 8.

84 Victorian Transcultural Psychiatry Unit, *Submission 216,* pp. 8–10.

85 National Network for Private Psychiatric Sector Consumers and their Carers, *Submission 189*, p. 15.

disincentive to self referral.[86] This is despite the significant psychological stresses experienced in those communities, which can be transgenerational.[87]

15.73 Jesuit Social Services, which runs the Vietnamese Welfare Resource Centre in Melbourne, for example, reported a high prevalence of significant anxiety and depression among people presenting for housing and other assistance.[88] Despite the level of need, program participants generally deny the existence of mental health problems. They may seek advice from family or GPs, but avoid professional help until the need becomes acute:

> …the stigma attached to mental illness within the Vietnamese community is so profound that the mere association with a mental health professional is believed to bring shame and disgrace on the self and the family—for example at one of the information sessions, the mental health worker asked to be introduced as a general health worker for fear being rejected by the group.[89]

15.74 A lack of knowledge about mental illnesses and about the potential to recover or manage disorders through early invention and other services supports the stigma associated with mental illness and supports the reluctance to access care:

> In many CALD communities the concept of recovery is rare or unknown. Mental illness is seen as a lifetime disease from which consumers do not recover. Their families and carers are also permanently affected by the stigma associated with mental illness. These community perceptions, beliefs and judgments about mental illness, based often on lack of information on mental health and wellbeing and the absence of effective promotion can reinforce social isolation and potentially override an individual's positive outlook about their recovery.[90]

15.75 An assessment of Victoria's CALD communities indicated that Hong Kong and Malaysian communities access mental health care at less than one quarter the rate than the Australian born.[91] One submission reported that that residents from the People's Republic of China access mental health services 75 per cent less than do the general population:

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86 Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 9.

87 FASST, *Submission 397A*, p. 15.

88 Social isolation, lack of family support, intergenerational tensions and language difficulties are problems, particularly for the young, the aged and single mothers. Unemployment, low income, migration and acculturation problems, domestic violence, parental problems, gambling or drug addiction are other stressors within the Vietnamese community. The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. [13].

89 *Submission 358*, p. [13].

90 Multicultural Mental Health Australia, *Submission 200*, p. 16.

91 Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 13.

> They don't have basic knowledge of mental disorders and are not aware of existing mainstream mental health service and approaches (such as counselling and psychotherapy) to be able to combat with mental health problems. In P. R China, such services and related ideas on mental health do not exist. Thus, without well-planned and long term mental health awareness promotion, they will not use the services and they will continue suffering silently.[92]

15.76 Submitters urged the need for appropriate culturally based information campaigns to address this problem:

> Whilst there may be some similar attitudes towards mental illness that cross cultural and linguistic groups, education programs are not effective unless there is an understanding of the attitudes and experiences of each community towards mental illness, the availability of treatments and services in other countries that may influence how a particular community views the issues. Education to de-stigmatise mental illness can only be effective when it is developed in collaboration with the community, the "correct" language is used to reach each community and genuine attempts are made to provide culturally and linguistically relevant information and support.[93]

15.77 The Victorian Transcultural Mental Health Centre model was criticised for inefficiencies in this respect:

> Developing one single standardised model or promotion material and then translating them into different languages in a hope of one-meeting-all often miss out the crucial characteristics of the specific community. If considering there are many such mini projects going on at the same time and sum of money being spent, it is even no more cost-effective than a single, holistic, systematic and long term project rooted deeply in the specific culture community.[94]

15.78 Multicultural Mental Health Australia also urged support for CALD carers, who need training to better understand their role. An important aspect of this is the provision of accurately translated information on the rights and responsibilities of mental health consumers and carers. This and other information should be circulated to community leaders and through the ethnic media.[95]

15.79 There has been some recognition of the needs of carers in the area of mental health first aid course development. Professor Anthony Jorm and Ms Betty Kitchener, forerunners in course development advised:

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92 Mr David Han Yan, *Submission 473*, p. [1].

93 Australian Polish Community Services, *Submission 168*, p. 3.

94 *Submission 473,* p. [2].

95 Multicultural Mental Health Australia, *Submission 200*, pp. 14, 17.

> The Mental Health First Aid program has core elements that translate across various cultural groups. However, there is always a need for some cultural modification. In Australia, we have developed the course to suit the mainstream of society, but we recognise this is not suitable for cultural minority groups. Versions of the course are currently being developed for Aboriginal Australians and have recently been developed for a number of groups with non-English speaking backgrounds, including Vietnamese, Croatian and Italian. Instructors have been trained from each of these communities.[96]

Provision of culturally appropriate services

15.80 To overcome the significant cultural resistance to admission of mental health problems by CALD consumers and they families, services to CALD groups must be culturally and linguistically accessible. Overall, mental health service provision to CALD communities was considered to be patchy at best. Multicultural Mental Health Australia contended that, nationwide:

- service availability 'lacks consistency in both range and quality';
- project based funding is undermining development of sustainable programs which can build partnerships with mainstream services, and
- the lack of adequate data collection on the quality of services prevents establishment of performance and accountability benchmarks.[97]

15.81 Short-term project grants to both government and non-government organisations are a much criticised feature of the mental health funding model. CALD support groups maintained that mainstream services, even when funded to progress nationally identified mental health programs, can try to offload their responsibilities onto resource poor CALD communities.[98] The experiences of the Australian Polish Community Services tend to support this view:

> When we approached one agency specifically funded to respond to depression in the community, particularly prevention and early intervention, to determine the availability of information in community languages, we were informed that they don't provide materials in community languages but if we wanted to translate it for them, that's okay. Unfortunately, that's not okay. As an agency we are not funded to undertake translations for other services and agencies, and more importantly, our staff are not accredited translators. The implications of taking this approach displays a lack of professionalism on the part of the other agencies and a lack of understanding about the importance of accurately and appropriately

96 Prof Anthony Jorm and Ms Betty Kitchener, *Submission 47*, p. 5.

97 Multicultural Mental Health Australia, *Submission 200*, pp. 9–10.

98 FASSTT, *Submission 397,* p. 5.

> translated information to ensure the correct message is being passed along.[99]

15.82 Scarce funding can also be hijacked by issues with political significance, to the detriment of real community needs. Mr David Han Yan, a case worker to the Chinese community advised:

> …sudden availability of funding from Casino Benefit Fund in NSW has created a field of Chinese Gambling Counselling. My observation is that underlining the gambling problem, it is the great mental health problems in CALD community. Immigration stress, relationship problems, loneliness and isolation and other mental disorders all find their "legitimate" expressive form in gambling problems. Restricted by funding requirement while I was working in the gambling counselling field, I found difficult to go to tackle real, deep issues.[100]

15.83 The submission from the Victorian Transcultural Psychiatry Unit confirmed that while VicHealth made a large investment CALD mental health in 2001, the funding was for 'demonstration' projects and will not be incorporated in the mental health system.[101] This supports the view that funded CALD mental health projects tend to be 'innovative' and 'one off', rather than integral steps in the capacity buildings of mainstream mental health services to address CALD community needs.[102]

15.84 A lack of language trained practitioners and mental health professionals is a problem for culturally diverse communities, and for the aged in particular. Submitters suggested developing specific training programs in tertiary institutions to support transcultural mental health research, and to develop the capacity of the bilingual workforce. [103] Fostering the knowledge of GPs under the Better Outcomes initiative was another important way that early identification and continuous care could be initiated and maintained:

> Primary care needs to be culturally appropriate and to provide interventions of an enduring nature, where service providers are engaged as part of their everyday practice in cross cultural awareness, understanding stigma and dealing in an informed way with the needs of people from culturally and linguistically diverse backgrounds, their families and communities. All primary health care providers, including general practitioners need cross-cultural competency education, to develop increased capacity in early recognition and intervention, accurate diagnosis, referral and follow-up.[104]

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99 Australian Polish Community Services, *Submission 168*, p. 2.

100 Mr David Han Yan, *Submission 473,* p. [2].

101 Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 9.

102 FASSTT, *Submission 397,* p. 9.

103 *Submission 473,* p. [2].

104 Multicultural Mental Health Australia, *Submission 200*, p. 11.

Refugees

15.85 Australia, like many other countries, has become a recipient in recent years of refugees who have experienced extremes of social and cultural dislocation.[105] As a subset of the CALD community, these 'humanitarian entrants' as termed by the Department of Immigration and Multicultural Affairs (DIMA) have significantly more complex needs. Discussion of these groups in the evidence included reference to 'temporary' entrants—Temporary Protection Visa Holders and Immigration detainees.

15.86 The *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants* (released in May 2003) records that between 1 July and 31 December 2002, the largest groups of entrants were from Sudan (28.5 per cent), Iraq (27.0 per cent), Afghanistan (8.7 per cent) and Ethiopia (4.8 per cent). The report advised:

> Feedback from public consultations and submissions to the review has suggested that this shift towards Middle Eastern and Horn of Africa countries is resulting in a greater proportion of new arrivals with high level of poverty, larger families and lower levels of education and English proficiency. They are facing more complex barriers to settlement.[106]

15.87 The review reports that these people, in most cases, have significant mental and physical health issues related directly to torture or trauma associated with their refugee experience.[107] Studies have found that between 39 per cent and 100 per cent of these people suffer from post traumatic stress disorder (compared to 1 per cent of the general population) while 47 to 72 per cent suffer from depression.[108] FASST provides the following breakdown the mental health effects of refugee experience:

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105 Eastern and Central Africa Communities of Victoria Inc, (EACACOV), *Submission* 394, p. 1.

106 *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, Chapter 8, p. 169; http://www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf (accessed February 2006).

107 The Victorian Foundation for Survivors of Torture found that 80 per cent of refugees assessed in 2003–04 had experienced psychological or physical violence of some kind; a study of refugees who settled in NSW found that 25 per cent had been subjected to severe trauma and torture. FASSTT, *Submission 397*, p. 2.

108 FASSTT, *Submission 397*, p. 1.

Table 15.1 Mental health effects of the refugee experience[109]

Mental health effects	Key issues
• depression • anxiety • grief • guilt • somatic disorders • attachment and relationship difficulties • a loss of a sense of hope, meaning and purpose to life • loss of identity and a diminished sense of belonging • internalised mistrust and post traumatic stress disorder symptoms • cultural adjustment suspicion and intergenerational issues	• mental health effects associated with exposure to traumatic experiences and other antecedents in the course of the refugee experience • may persist long after arrival in a safe country • can be exacerbated by stresses and lack of resources in the period of resettlement.

15.88 Over the last decade Australia has settled over 110 000 people under its Humanitarian program. The Government has recently increased this program to 13 000 places per year.[110] Of these, 6 000 places are allocated to refugees (a 50 per cent increase on previous years), and 7000 places are allocated to the Special Humanitarian Program and onshore protection. About 75 per cent of the offshore places are planned to come from Africa and about 20 per cent from the Middle East and South West Asia.[111] Yet despite the predictable and growing need, submissions reported significant under-resourcing is preventing development of sustainable programs to support these complex cases.

Capacity building of refugee services

15.89 Humanitarian entrants to Australia are processed under DIMA's Integrated Humanitarian Settlement Strategy (IHSS). The IHSS is designed to provide intensive initial settlement support to newly-arrived humanitarian entrants. The aim of the IHSS is to ensure that all of these entrants have access to the information, personal tools, services and basic material requirements they need to rebuild their lives in Australia. The IHSS works with the Early Health Assessment and Intervention (EHAI), Community Support for Refugees and other support services to provide this initial

109 FASST, *Submission 397A*, p. 6.

110 *Submission 397A*, p. 2.

111 *Submission 397A*, p. 4.

assistance.[112] Services are provided to refugees, defined as 'people who have experienced persecution in their countries', and Temporary Protection Visa Holders, who are entitled to limited services, including EHAI and torture and trauma entitlements, during the life of the visa.[113]

15.90 The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) agencies are the principal contractors to the DIMA to provide EHAI services. These services are in part funded through the Department of Health and Ageing's Program of Assistance to Survivors of Torture and Trauma (PASTT). FASSTT reports significant pressure on services as PASST funding levels have been frozen for ten years, with only CPI increases. This is not commensurate with the increased level of need:[114]

> The level of funding forces FASSTT agencies into a reactive rather than proactive position. For example, we recognise the need to develop, in addition to conventional one-to-one interventions, a range of community based interventions in response to the needs of certain client groups (for example African clients). However some FASSTT agencies are struggling to maintain existing services levels, making it difficult to work in a developmental way. Instead, resources that ideally would be spent on training and sector development particularly in regional and rural areas get diverted into acute response— particularly, in some states, with respect to the needs of clients holding Temporary Protection and Bridging visas.[115]

15.91 Other service providers working with recent African arrivals, the projected source of most future refugees, confirmed that the capacity of mainstream and community mental health services to assist this high needs group is extremely limited. Eastern and Central Africa Communities of Victoria (EACACOV) advised:

> It is our experience as African, social and community support workers in the field that when we have clients who display psychotic disorders symptoms/behaviour or suffering from psychological disorders; mental disorder/illness, on a number of times we have contacted many mental health services providers and we have found that there are no strategies for prevention or early intervention.…Mainstream service providers lack awareness about pre and post migration experiences, such as: torture and trauma, vast differences in cultural, religious and gender issues between

112 *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, Chapter 8, pp. 163; 167, www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf, (accessed February 2006).

113 The TPV provides three years' temporary residence in Australia for unauthorised arrivals who are subsequently found to be refugees. See *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, pp. 167–8.

114 FASSTT, *Submission 397*, pp. 1, 3–4.

115 *Submission 397*, p.4.

> countries of origin and Australia and their impact on family relationships and mental well-being.[116]

15.92 FASSTT argued that mainstream services ugently need resources to build the responsiveness necessary to treat this category of patient, whose diagnosis is complicated by post traumatic stress disorders and cultural and communication barriers:

> In all States and Territories there is now a significant proportion of the population who have particular needs as a result of trauma impacts from their refugee or refugee-like experience. All mental health service providers whether in the acute or community sector need to be more aware of the needs of refugee survivors of torture and trauma. For example, practices such as the use of restraints, placing distressed individuals in isolation and forcibly administering medication replicate torture and other experiences that have led to trauma. This greatly increases the level of an individual's distress and potential retraumatisation. Working with such survivors requires specialist skills to recognise their specific needs. Failure to recognise these needs compounds the failures of the mainstream mental health system to deliver coordinated continuity of care.[117]

15.93 Particular concerns were expressed about the lack of early prevention services to refugee children, now the largest entrant group.[118] FASST notes that preventative measures have been found effective in dealing with the trauma and dislocation experienced by these children have experienced,[119] however the emphasis on parental and family assistance means these measures are not systematically employed.[120] A case study shows how, with the service gap in place, identification of even the most plangent needs can be serendipitous:

> A teacher noticed a 15 year old girl in the classroom who was withdrawn and had scarring on her hand which she was trying to hide. The teacher contacted the FASSTT service in her state who arranged through the school to seek permission to speak with her parents. Her parents had in fact been killed and she was living with her relatives who had recently arrived. The young girl was assessed as depressed and suffering severe post traumatic stress disorder symptoms. She had witnessed her mother's face blown off in a sniper attack and suffered burn injuries. She formed a close relationship with the Early Intervention counsellor-advocate, with whom she was able to share her grief. He was able to find a suitable school work-experience placement for her, something she had been dreading and he facilitated a

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116 Eastern and Central Africa Communities of Victoria Inc, (EACACOV), *Submission 394*, p. 2.

117 FASSTT, *Submission 397*, p. 4.

118 The proportion of children and young people in the Humanitarian program has increased from 38 per cent in the year 2000 to 53 per cent in 2004. This increase has been particularly significant in the 0–9 age group. See *Submission 397A*, pp. 8–9.

119 *Submission 397A*, p.11.

120 *Submission 397A*, pp. 10, 15.

> referral to a plastic surgeon. These interventions led to an immediate improvement in active participation at school. Her guardians were offered support which they felt they did not need but they supported the assistance being provided to their niece.[121]

15.94 Concerns were expressed that DIMA's policy of dispersing humanitarian entrants into regional areas will make delivery of approriate servces to children and young people more difficult to achieve.[122] The children of TPV holders are at particular risk, given the limited access this group have to health and other services and the degree of anxiety, and perception of prejudice, they experience as a result of their temporary status.[123] To address this, FASSTT recommmended that the IHSS should build the capacity of the education system in regional and rural areas to provide a supportive environment to refugee students, working closely with new arrivals programs.[124]

15.95 The Department's policy of regional placement, for both humanitarian entrants and TPV holders, is directed by client choice and access to appropriate services. Service capacity exists in number of regional centres.[125] However submissions warned that the present level of need is not being met. Hume City Council reported that a large proportion of new entrants to Hume City require counselling and support services, and should be receiving long-term assistance:

> There is a need to develop specialist mental health services for culturally diverse communities, and for these services to be located in communities, such as Hume City, where new arrivals are settled by DIMIA. The culturally specific mental health services should be developed in partnership between all levels of government, Migrant Resource Centres and other organisations, including the Foundation for Survivors of Torture. Any government assistance for new arrivals to access mental health services needs to recognise the lifetime impacts of trauma and torture, and not be time limited to the initial period of settlement.[126]

15.96 Like other CALD groups, lack of knowledge and understanding about mental illness and of available services, in combination with fear and stigma, supports the

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121 *Submission* 397, p. 9.

122 *Submission 379A*, p. 15.

123 *Submission 379A*, p. 11–12.

124 *Submission 379A*, p. 19.

125 IHSS services are currently available in regional areas such as the Coffs Harbour, Wagga Wagga and Newcastle areas of New South Wales; Geelong in Victoria; Townsville, Cairns, Toowoomba and the Logan, Beenleigh and Gold Coast region in Queensland; and in the Northern Region of Tasmania. Unlinked refugees can be and are sent to these areas. see . Report on the Review of Settlement Services for Migrants and Humanitarian Entrants, May 2003, Chapter 8, p. 177, http://www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf (accessed February 2006).

126 Hume City Council, *Submission 298*, p. 7.

tendency of refugees to avoid assistance until crisis point.[127] EACACOV reported that African refugees in acute states commonly present at emergency departments in the care of police. On release many end up extremely disoriented, homeless, and may be taken to immigration detention centres:

> In January 2005, one of our clients with a mental disorder was locked up in Villa Wood Detention centre Sydney, because he had no identification or travel documents with him, he had not been taking his medication, he was confused and he had lost all his documents, plus his mobile phone. He was released from the detention centre and admitted to Banksia Mental Health Hospital/Psychiatrist Unit when an inmate from Sudan contacted EACACOV's workers on the client's behalf. The staff faxed a copy of his travel document which was on his client file to the case worker/officer.[128]

15.97 A number of proposals were made to address the threat to CALD people with mental illness under the government's detention policy. EACACOV took a holistic view, stressing the importance of the capacity building of community based services to reduce the possibility of such circumstances. These services should provide culturally appropriate assistance and advice, reflecting traditional customs, to address the extreme social dislocation experienced by these people, and to reduce the incidence and severity of mental health problems. It was also suggested that DIMA should advertise any detainment of individuals taken from community, and in particular, utilise the knowledge of CALD community groups and ethno-specific organisations to identify individuals.

15.98 The Mental Health Foundation ACT thought a nationwide missing persons system an imperative as there are many situation in which individuals wander from state to state and cannot be found by loved ones and fall through the cracks in the system or end up in inappropriate situation such as happened to Cornelia Rau.[129]

Mental health of detainees

15.99 In the wake of the Palmer report and the sequential revelation of harms and inefficiency in its detention centres, a number of submissions questioned the wisdom of continuing with the Government's detention policy. Suicide Prevention Australia (SPA) was among the many who saw that the custodial nature of a detention centre is counterintuitive to delivery of appropriate mental health care:

> Mental illness is neglected in immigration detention for a number of reasons. The framework for managing detainees treats them as law-breakers whose behaviour must be deterred. Such a deterrent approach treats suffering and psychological harm to detainees as acceptable 'collateral damage'. Former Minister Philip Ruddock asserted that depression among detainees is not a mental illness, and that self-harm is manipulation (rather

127 EACACOV, *Submission 394*, p. 2.

128 *Submission 394*, p. 2.

129 The Mental Health Foundation ACT, *Submission 112*, p. 6.

> than a reflection of despair). He frequently referred to asylum seeker self-harm 'inappropriate behaviours' and 'moral blackmail', and suggested actions such as lip-sewing stemmed from their cultures and were repugnant to Australians. IDCs [Immigration Detention Centres] are therefore custodial and punitive, rather than being treatment- based. They resemble prisons in that they hold people under maximum security, use solitary confinement, employ prison staff etc, but differ from them in that the inmates are indefinitely detained.[130]

15.100 Submitters called on government to recognise that the policy of detention is conducive to mental illness, referring to conclusive findings:

> In ten asylum-seeker families held for protracted periods in a remote IDC, all adults and children met diagnostic criteria for at least one current psychiatric disorder with disorders identified among 14 adults, and 52 disorders among 20 children. Persistent suicidal ideation was reported by all but one adult, and over half the children; five adults and five children had engaged in self-harm or attempted suicide. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. Exposure to trauma within detention was commonplace. All adults and the majority of children were regularly distressed by sudden and upsetting memories about detention, intrusive images of events that had occurred, and feelings of sadness and hopelessness. The majority of parents felt they were no longer able to care for, support, or control their children.[131]

15.101 Various suggestions were made about how the situation should be addressed. The Mental Health Foundation ACT recommended the government should 'change its 'hardline' attitude to refugees held in detention' which it considered informs 'an uncaring culture' in the IDCs. It suggested that the centres should be located in less isolated locations so that detainees can readily access specialist services when required and that Detention centre staff be given training or refreshment courses on duty of care.[132]

15.102 The Victorian Transcultural Psychiatry maintained that detainees, being at high risk of mental illness, should become an identified group for preventative assistance under the National Mental Health Plan. It recommended in particular that DIMA develop an approach for treatment of detainees with dual diagnosis, and that tensions between detention and other service providers be resolved by developing interagency agreements.[133] The SPA argued that a judicial inquiry into the detention process should be held, referring to sustained international criticism of the human rights affront represented by the policy:

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130 Suicide Prevention Australia, *Submission 425*, pp. 24–25.

131 *Submission 425*, pp. 24–25.

132 Mental Health Foundation ACT, *Submission 112*, p. 6.

133 Victorian Transcultural Psychiatry Unit, *Submission 216*, pp. 6–7.

> Australia remains the only industrialised country in western civilisation that continues to routinely impose mandatory detention on those who seek refugee protection. Those who arrive on our shores without a valid visa, including unaccompanied children, are detained in facilities in remote areas for several months, even years. Such practices have been condemned by the international community as breaching human rights standards with the ill treatment of refugees in Australia being clearly documented by the United Nations Human Rights Commission and the Human Rights and Equal Opportunity Commission (HREOC). Such international instruments demand that each person is afforded the highest attainable standard of physical and mental health available. To date, every independent inquiry into the immigration detention centres of Australia have highlighted the poor mental health of detainees with particular emphasis on the risks to children's wellbeing.[134]

15.103 The Senate Legal and Constitutional References Committee, recently reiterated that view, concluding:

> …the prolonged and indeterminate immigration detention is inherently harmful to psychological well being and its abolition should be a priority.[135]

15.104 The recent court decision awarding compensatory payment to the family of 11 year old Iranian child Shayan Badraie sets a precedent which may prompt the Government to further review its detention policy. During the proceedings, former DIMA (then DIMIA) officials, reversed the official view, and acknowledged the connection between detention and mental illness[136] also confirming the system is not functioning as intended.[137]

15.105 DIMIA facilitated a visit of the Senate Select Committee to Baxter Immigration Detention Facility on Wednesday, 28 September 2005. The Baxter facility is in remote South Australia, and while controlled by DIMIA it is run by a private service provider. The facility is built to house up to 660 detainees,[138] but at the

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134 SAVE, *Submission 483*, p. 2.

135 'Tender for New Client Focused Detention Service Arrangements', *On the Move to Improve DIMA's Progress on Palmer, Fact Sheet:* http://www.immi.gov.au/department/dima_improvements/index.htm, (accessed 1 March 2006).

136 Former head of border control, Philippa Godwin, for example, contradicted the department's previously held position by acknowledging that conditions at Woomera had led to mental illness experienced by Shayan. Dan Box, 'Boy, 11, Wins Payout Over Detention Trauma', The *Australian*, 3 March 2006, p. 3.

137 Mr Alan Clifton, former operations manager, confirmed that Woomera's private detention centre operator, Australian Correctional Management, had not honoured requirements and falsified reports to the government that it was providing education to children and leisure and well being courses to adults as required. Rebecca Gilsenan, 'In Denial over Living Hell', The *Australian*, 7 March 2006, p. 12.

138 DIMA, Immigration detention, Baxter Immigration Detention Facility (BIDF) - Port Augusta (SA), http://www.immi.gov.au/detention/facilities_baxter.htm (accessed March 2006).

time of the visit there were around 125, all adults. The visit included briefings from the DIMIA manager of the facility, and from a representative of service provider Global Solutions Limited (GSL). The Committee toured the facility, and held a round table discussion with some of the detainees.

15.106 In the wake of the problems revealed by the erroneous detention of Cornelia Rau, the Federal Government began implementing changes in immigration detention. The Committee saw some of the first changes already underway during its visit to Baxter, such as modifications to the living environment and the way the movement of detainees within the facility is regulated. GSL stated that their new environmental change program was intended to reflect a community rather than an institutional approach to detention. Procedural changes at Baxter since the Palmer Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau delivered its findings included:

- a 'revamp' of operational procedures;
- mental health screening;
- changes to seclusion times;
- a different approach to mental health services; and
- all GSL officers attended a one day training course run by the mental health team within Baxter.

15.107 A discussion (facilitated by an interpreter) was held with three immigration detainees who volunteered to talk to the committee following a letter from DIMA. The length of stay of the three detainees varied between 4 months and 3 years. There was a sense of isolation and depression amongst the detainees with whom the committee met:

> It is quite obvious we are like a bird in a cage. We would be better happier outside. Of course we would be happier waiting for a visa outside. Here we can only see the sky and the ground - we would be free outside.

15.108 Discussions with medical staff at Baxter indicated that there were difficulties in providing services. Baxter was deliberately established to be remote, and that very remoteness has made it hard to recruit health professionals, challenging to retain them, and adds to the logistic challenges involved in securing effective treatment in cases of serious mental illness. Despite these difficulties, medical staff did say that they were able to communicate successfully with most detainees and overcome barriers to building effective relationships with them.

15.109 Responding to a contemporaneous review of its detention services, DIMA moved quickly to implement a package of reforms. One aspect will be the national implementation of an improved mental health care program being trialled at Baxter Detention Centre, under the auspices of an MOU signed with the South Australian Department of Health. DIMA will also re-tender all detention services, and will award

separate health and psychological services contracts, to be managed by the department.[139]

15.110 These developments answer requests for official acknowledgment of the mental health implications of the Government's detention policy, and show the department's responsiveness in that direction[140]. They do not however address the strongly expressed concerns to this inquiry about the long-term mental health consequences of the detention process, or the damage done to Australia's reputation as friendly nation proud of its cultural diversity.

15.111 The shift to community based accommodation progressed by DIMA for those with identified special needs,[141] and for women and children is a positive development; the Government may wish to review its position on detention in the interests of ensuring unauthorised entrants with mental illness are treated 'humanly, decently and fairly', as intended.[142]

139 'Stronger Focus on Mental Health', and 'Tender for New Client Focussed Detention Service Arrangements' *On the Move to Improve DIMA's Progress on Palmer, Fact Sheet,* www.immi.gov.au/department/dima_improvements/index.htm (accessed 1 March 2006)

140 Suicide Prevention Australia, *Submission 425*, p. 26

141 Australian Government *Submission 476*, Part 10, p. 59.

142 Australian Government *Submission 476*, Part 10, p. 61.