



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

THURSDAY, 19 MAY 2005

CANBERRA

BY AUTHORITY OF THE SENATE

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:
<http://parlinfoweb.aph.gov.au>

SENATE
SELECT COMMITTEE ON MENTAL HEALTH

Members: Senator Allison (*Chair*), Senator Humphries (*Deputy Chair*), Senators Forshaw, Moore, Scullion, Troeth and Webber

Senators in attendance: Senators Allison, Forshaw, Humphries, Moore, Troeth and Webber

Terms of reference for the inquiry:

To inquire into and report on:

The provision of mental health services in Australia, with particular reference to:

- (a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;
- (b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;
- (c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;
- (d) the appropriate role of the private and non-government sectors;
- (e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;
- (f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;
- (g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;
- (h) the role of primary health care in promotion, prevention, early detection and chronic care management;
- (i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;
- (j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;
- (k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;
- (l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;
- (m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;
- (n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;
- (o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and
- (p) the potential for new modes of delivery of mental health care, including e-technology.

WITNESSES

| | |
|--|-----------|
| BOND, Professor Gary, Guest Speaker for Schizophrenia Awareness Week; Visiting International Speaker, Mental Illness Fellowship of Australia..... | 73 |
| BURGESS, Mr Mark Anthony, Chief Executive Officer, Police Federation of Australia | 31 |
| GOONREY, Ms Christine, Project Officer, Mental Health Council of Australia | 2 |
| GRIFFITHS, Dr Kathleen, Senior Fellow and Director, Depression and Anxiety Consumer Research Unit, Centre for Mental Health Research, Australian National University..... | 42 |
| HICKIE, Professor Ian, Board Member and Clinical Adviser, Mental Health Council of Australia..... | 2 |
| KNOWLES, the Hon. Rob, Executive and Board Member, Mental Health Council of Australia | 2 |
| MENDOZA, Mr John, Chief Executive Officer, Mental Health Council of Australia | 2 |
| NOTHLING, Dr Martin, Federal Councillor, Australian Medical Association..... | 58 |
| OZDOWSKI, Dr Sev, OAM, Human Rights Commissioner and Acting Disability Discrimination Commissioner, Human Rights and Equal Opportunity Commission | 2 |
| PRING, Dr Bill, Representative, Australian Medical Association..... | 58 |
| SMITH, Ms Dawn, Deputy Chair, Mental Health Council of Australia..... | 2 |
| WAGHORN, Mr Geoffrey, Research Scientist, Queensland Centre for Mental Health Research and Mental Illness Fellowship of Australia..... | 73 |
| WILDMAN, Mr Neil Thomas, Deputy Chief Executive Officer, Mental Health Council of Australia..... | 2 |
| WILSON, the Hon. Keith, Chair, Mental Health Council of Australia | 2 |

Committee met at 9.10 am

CHAIR (Senator Allison)—I declare open the first hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March 2005 for report on 6 October 2005. I also note that this week is Schizophrenia Awareness Week, which seems an opportune time to begin our public hearings into the important public policy area of mental health.

Witnesses are reminded of the notes they have received relating to parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public but under the Senate's resolutions witnesses have the right to request to be heard in private or in camera. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

[9.11 a.m.]

OZDOWSKI, Dr Sev, OAM, Human Rights Commissioner and Acting Disability Discrimination Commissioner, Human Rights and Equal Opportunity Commission

GOONREY, Ms Christine, Project Officer, Mental Health Council of Australia

HICKIE, Professor Ian, Board Member and Clinical Adviser, Mental Health Council of Australia

KNOWLES, the Hon. Rob, Executive and Board Member, Mental Health Council of Australia

MENDOZA, Mr John, Chief Executive Officer, Mental Health Council of Australia

SMITH, Ms Dawn, Deputy Chair, Mental Health Council of Australia

WILDMAN, Mr Neil Thomas, Deputy Chief Executive Officer, Mental Health Council of Australia

WILSON, the Hon. Keith, Chair, Mental Health Council of Australia

CHAIR—I welcome representatives of the Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission. Do you have any comments to make on the capacity in which you appear?

Mr Knowles—I am also President of the Mental Illness Fellowship of Australia.

CHAIR—You have lodged with the committee a submission which we have numbered 262. Do you wish to make any amendments or alterations to that submission?

Mr Mendoza—There are some minor editorial comments. I am happy to do that in liaison with the secretariat, if that is agreeable. They are not issues of substance or additional points.

CHAIR—Okay. We will now proceed to presentations, after which the committee will go to questions.

Dr Ozdowski—Good morning, Senators. Thank you for the invitation to appear before you. The Human Rights and Equal Opportunity Commission commends the Senate for the decision to establish this inquiry on mental health services in Australia. However, it is a cause for concern in itself that yet another inquiry into this area has been found to be necessary. There are now numerous reports of inquiries dealing with inadequate services and neglect of human rights affecting people with mental illness and their families around Australia. Prominent among those inquiries is the 1993 report of the human rights commission entitled *Report of the national inquiry into the human rights of people with mental illness*. Some people call it the Burdekin inquiry.

This inquiry set up a benchmark linking mental health and human rights issues. It dealt with abuse of traditional civil and political rights and the right to freedom from abuse and discrimination, and it also emphasised the positive right to the highest attainable standard of physical and mental health, which is recognised in article 12 of the International Covenant on Economic, Social and Cultural Rights, to which Australia has been a party since 1975.

Our formal submission will provide much more detail about Australia's human rights obligations in the mental health area, and it will be provided to you very soon. The 1993 human rights commission inquiry conducted hearings around Australia, conducted extensive research and resulted in hundreds of submissions. The inquiry found that people affected by mental illness suffered from widespread systemic discrimination and were consistently denied the rights and services to which they are entitled. Unfortunately, subsequent inquiries since 1993 have continued to find similar problems. Despite the introduction of the National Mental Health Strategy and reforms in policy legislation, 10 years after the human rights commission inquiry we continue to see reports describing a situation of ongoing crisis.

The evaluation of the second national mental health plan published by the Department of Health and Ageing in March 2003 made clear that the central problem is that governments have not sufficiently matched their words with resources. The key conclusions of that report are that, firstly, while community treatment and support services have been strengthened, the community treatment options are often still unavailable or inadequate, with the growth in resources to the non-government sector in particular not having kept pace with the increased role. Secondly, access to mental health care has been improved, but consumers are still frequently unable to access mental health care as and when they need to. Thirdly, follow-up care in the community, particularly after hospitalisation for acute episodes, is often lacking. Very similar conclusions can be found in the *Out of hospital, out of mind* report released by the Mental Health Council of Australia in April 2003, in the lead-up to the third national mental health plan.

In the commission's report of 1993, the aims were, firstly, to provide a forum for people affected by mental illness as patients or families or carers, together with community and professional service providers, and, secondly, to seek to refocus debate in this area to involve matters of human rights. I think that one was achieved. The third aim was to draw public and political attention to this experience as a means of promoting accountability and remedies where the abuse or neglect of human rights was found. With the same aim, the commission decided to join the Mental Health Council of Australia and the Brain and Mind Research Institute in conducting consultations with people in the mental health sector—professionals and people with mental illness and their families. Together with representatives of the Mental Health Council and the Brain and Mind Research Institute, during 2004 the commission participated in a series of community forums to discuss issues in mental health related services around Australia. I must say that these forums were extremely well attended to the extent that when we had a meeting in Melbourne we hired the town hall and it was overflowing. For security reasons we had to close it up and organise another forum.

Everywhere in Australia this is an issue of major public concern. We received numerous written submissions to the inquiry. I can say that, consistently, around Australia we heard over and over again that the issues which were raised by the commission inquiry over 12 years ago largely remain unresolved. To give you a very short summary of what particularly impacted on

me—and the other members of the team will go further into detail—the inquiry found that, clearly, wherever you go, there are not enough resources. Clearly, money is missing.

The most frequently mentioned gap in mental health services is the absence of early intervention and other specialist services for young people. When we are not investing up front we have to pick up the bills much later. We heard many stories of young people who, when they felt they were starting to be unwell, went to a doctor or hospital and were told: ‘We can’t do anything for you. Come back when you are seriously ill.’ Then there were major difficulties in accessing acute care. We were told here in the ACT about a man who needed access to acute care and when he felt an episode was coming he had to smash a number of windows in the centre of Canberra to get attention. We heard from a woman who got herself to hospital because she felt an episode was coming and she was told to go away. She had to walk against the traffic on one of the highways in Melbourne in order to be picked up by the police and taken to hospital. After about two months when she was okay she was released, but she had not been able to get that treatment before. In all states we received reports that children and young people are being admitted to inappropriate adult facilities.

One of the things which particularly impacted on me was the issue of drug use and mental illness. Clearly there is a linkage. We do not know enough about it. This needs to be a priority. At the moment, mental health services are unable to cope at the same time with drugs and mental illness. When you have a dual diagnosis nobody wants to deal with you.

When we looked at community support services we heard very often from people who looked after people with mental illnesses that they have had enough: ‘We have been doing it for 10 years. We have had enough—we cannot cope. We need help in order to be able to be part of a network of services.’ Emergency services everywhere were overburdened. What was interesting was to find that people were saying very positive things about the police, because the police quite often act as a medical service rather than the ambulance. We had a number of stories, as I mentioned at the National Press Club, about how good they were and how they were replacing the medical services that are lacking in this area.

The issue of attitudes is still with us. Clearly, people with mental health issues are being seen as somehow to blame for their own condition. If you have a heart condition you will be looked after or if you have a broken arm you will be looked after and nobody will blame you. But when someone has a mental illness many of us still think that they are sick because of some kind of moral failure on their part. I will finish on that point and ask my colleagues to expand on all the issues that we found.

I will just mention that the human rights commission submission, which will be presented to you in the next few days, consists of two parts. The first part, as I mentioned, deals with the linkage between mental illness and human rights. The second part focuses especially on Indigenous mental health, and I would like to thank you for adding that to your terms of reference. Commissioner Calma, who could not be with us today, asked me to assure you that he will be willing to appear before the committee at your request after his submission is received. Thank you for giving me your attention.

CHAIR—Thank you very much.

Mr Wilson—As Chair of the Mental Health Council of Australia, I would like to join Sev in thanking the Senate for seeing the importance of this issue. We have had, as has been said, a number of parliamentary inquiries. The upper house in New South Wales and the upper house in Western Australia are two upper houses that have conducted inquiries into the state of mental health services in those jurisdictions. Their recommendations have largely been ignored. It is also significant, I think, that this inquiry has come about as a result of the illegal detention of two people who have severe mental illness—two Australian citizens who were denied their citizenship rights by virtue, it would appear, of their mental illness. Therefore, those gross breaches of rights really should be seen not as individual cases but as real indicators of widespread, systemic failure within mental health services all over Australia.

The other point I wish to make is that we still think of the Senate as the states house, and in our rather dysfunctional system of federated health care the most dysfunctional area is the funding and delivery of mental health services. It is therefore a problem that is particularly difficult for anybody to really face up to. That cost shifting and blaming of the states and the Commonwealth for the lack of resources and the poverty of services is a major barrier to making any progress.

The commissioner has already referred to the series of forums that were conducted in every capital city, in major regional centres and in some rural and remote centres in every state last year. I attended most of them with him and others, including Professor Hickie, our former CEO. What you should find when you look at that is a chronicle of recorded voices which would speak directly to you. These voices speak to us directly of the ongoing pain, hopelessness and grief over the loss of life opportunities that are taken for granted by those members of the community, including community leaders, who have never had their family impacted by mental illness. My primary personal commitment to the issue is that my family has been so impacted. I am the carer of an adult son with schizophrenia.

Many of those stories that are recorded were told whilst people were breaking down in tears, because their stories were recalling the experiences of those whose deaths were preventable but for which no-one seemed accountable. In the town of Bunbury in the south-west of Western Australia we had over 100 people at the forum, we had nearly 100 in the regional centre of Geraldton and we had large numbers of people in other regional centres right around Australia. That aspect of the issue, the dearth of services in rural and remote parts of Australia, is one of the huge deficits in the provision of mental health care.

I want to applaud the deep interest and readiness of the Human Rights and Equal Opportunity Commissioner to partner the Mental Health Council in the public forums that were held. That is important because there is no doubt that the direct participation of the commissioner added enormous credibility to the whole tenor of our hearings and the willingness of hundreds of people to lodge written submissions as well. While one of the purposes of the report was to attempt to measure the extent of change over the period of two years since the earlier report entitled *Out of hospital, out of mind*, the direct involvement of the commissioner brought a much sharper focus to bear on the seriously neglected human rights issues implicit in the level of palpable neglect and failure in basic duty of care obligations with respect to basic entitlements to access sustained quality health care, secure and supported accommodation options, rehabilitation and opportunities for real employment for those affected by mental illness.

An additional feature of the report has been the specific focus on the community's response to the current status of mental health reform in each state and territory. Those of us who attended most of these forums were struck, as the commissioner has already indicated, by the similarity of the stories of systemic failure, of neglect and of the lack of any accountability and the protracted neglect, particularly of work force issues within the mental health sector, in terms of the availability of training, recruitment and declining morale all around Australia of those who are still sticking with their tasks of providing mental health care at the hands-on level. In fact, a number of those providers of care at the hands-on level attended our forums and spoke out quite openly in spite of the fact that that was something that as public servants they were aware they should not do. It was, I think, a measure of their frustration.

Unfortunately, we are very wary of a torrent of defensiveness and denial from our political leaders and senior bureaucrats that this community assessment of the state of mental health care and the lack of due access to basic citizenship rights of one in five Australians living with mental illness is somehow flawed. We have heard this before. We are told that our back-up material is not rigorous enough and that our research methods and the need for standardised client satisfaction surveys are lacking. These claims ignore the fact that our governments have not implemented basic and routine assessments of need for services or conducted evaluations before they begin to try and place new services in the community.

Another all too frequent response from governments since the second national mental health plan in 1998 has been in the spirit of the oft quoted mantra that we must expect that progress on mental health reform will be slow. Nothing daunts the sector more than to receive that response when criticism is made of the existing failure and neglect in providing services. Unfortunately, while this slow pace is comfortable for some in that it serves to lower expectations, increasing numbers of chronically ill Australians will find themselves 'not for service'. So we are looking for greater leadership within government and at senior government level that is based on a clear recognition that people have reflected on the forlorn truth of the accounts voiced in this chronicle of lived experiences to accept the reality of this accounting and to act to return to this discriminated fifth of our fellow citizens their rights as Australians.

Prof. Hickie—I would like to speak in more detail about the methodologies that surround the 'not for service' report to give you some idea of what is involved as it has become contentious, particularly with our governments, as to the nature of the report and the representativeness or otherwise of its findings as reflecting on the wider mental health system. As has been discussed by—

Senator FORSHAW—Professor, I do not want to interrupt, but when you say 'governments', are you saying all governments or state governments?

Prof. Hickie—Yes, all governments—

Senator FORSHAW—Including the federal government?

Prof. Hickie—Yes. The federal government and all state governments have been invited. They were provided with draft copies of the report and responded. Each of the formal responses, in turn, has raised issues which go to the representativeness of the findings or a government notion of balance versus our notion of accuracy of a particular situation. This is a key issue for

us. The issue would be simple if under our National Mental Health Strategy since 1993 we had had a system in place in the states and territories and in the Commonwealth jurisdictions of recording the experiences of care in a systematic way. But until 2003 none of the jurisdictions or the Commonwealth has instituted a system where people's experiences of care are systematically recorded. The first time it was attempted was in 2002, in association with the Mental Health Council. Dr Grace Groom, the then CEO, and I were in part commissioned by the Commonwealth to conduct national consultations to report on experiences of care. In association with the consultations we went on to develop a series of surveys to go beyond the consultations to survey mental health organisations with regard to their priorities and the actual implementation of the national strategy.

The findings of 2002 became the 2003 report *Out of hospital, out of mind!* We presented those findings back to the Commonwealth and the states. The community priorities are outlined in a recent *Medical Journal of Australia* article—which I table for the Senate—published by me and my colleagues. We were so distressed by those findings that we expected the Commonwealth and the states to address these community priorities and recommend their implementation in the National Mental Health Plan 2003-08. That, clearly, did not occur. The 2003-08 plan is well worth reading simply for its lack of specificity in terms of what were the priorities of that plan, which we are now operating under, and what the measures of the outcome of that plan would be—whether it had been achieved.

Failure to respond to those issues as they were raised—even though they were commissioned by the National Mental Health Working Group at the time—the intense interest of the Human Rights and Equal Opportunity Commission in citizenship rights and access to basic health care and also the dealings of people who were often not able to express their own view about health care led to us continuing the process of surveys throughout 2003 and 2004. Some of the results are detailed in that publication. Importantly, we conducted another series of national consultations, which has led to the *Not for service* report. The name '*Not for service*' is a direct quote from a person in a country district of Victoria seeking emergency care. To be labelled in our health system as someone who is 'not for service'—as a kind of unit of non-human participation in the health system seeking emergency care—and for that to be an official classification within the Victorian health system amazed us.

What is the system here? Clearly, it is a system of restricted access. Even if you seek emergency services now within many of our settings there is an official bureaucratic classification for not providing a service to that person. We would argue that is fundamentally different from most physical health care systems that we face. Although Victoria is recognised as having the leading mental health care system in the Commonwealth, even within Victoria that is an official classification. Importantly, throughout our submissions—and there are now over 300 written submissions—our national consultations and our surveys, it is the same picture of fundamental lack of access, fundamental neglect and chaotic organisation. It is the chaotic organisation which impacts most on those with chronic and relapsing illnesses on an ongoing basis.

We have stories of people moving to an area health service or within states and receiving no care and no information and now—amazingly—stories of people moving between state and Commonwealth jurisdictions and disappearing from care, becoming disconnected from their families and from anyone else who can explain what might be required or who can actually see

to their welfare. Situations are repeatedly reported to us, usually by family members but sometimes by consumers directly, in very dramatic circumstances of neglect, of suicides, of disastrous outcomes, of major impairments of a person's basic rights to citizenship and to basic health care within our country.

The key issue is that each of the governments has responded by saying that these are isolated cases of inadequate health care in an otherwise very busy system of health care—thousands, or tens of thousands, of occasions of service. Our view is that they are the tip of the iceberg. Not everyone who has a bad experience complains. In fact, many consumers in mental health, as is obvious from some of the cases in the media in recent times, have great difficulty explaining their situation. Unless they have a family member or a carer who can explain what has happened they may not complain at all.

Secondly, there are a series of other inquiries in each of the jurisdictions which Mr Wilson has mentioned recently—the Pezzutti inquiry in New South Wales, the Auditor-General's inquiry in Victoria and the upper house inquiry in Western Australia—with similar stories. When they have gone back to each of the states and said, 'Where is the data? What can you tell us about the progress in mental health care?' the data has largely not been there.

In the final stages of our preparation of *Not for service*, the Victorian Department of Human Services provided us with the only other systematic inquiry that we can find. In that survey, which was conducted in 2003-04, the Victorian department reports that over one-third of consumers and nearly 50 per cent of carers report negative experiences of care in that health care system. There is a notion that we are simply reporting—and you will see the first-hand accounts in the material we have had provided to us; the heart-wrenching stories from families—isolated cases or old cases or that it is an unbalanced representation. The only other systematic inquiry conducted by a service in Victoria in 2003-04 shows one-third of those using the service directly and nearly 50 per cent of their families report negative experiences of care. That is after 12 years of national mental health reform.

The reform process was kicked off at a national level after agreement by all governments. I understand that this week they have all signed up to rewrite another national mental health policy—it is a policy, not an implementation plan—which they hope will influence the plan for 2008-13. This is the process which Keith alluded to—a process of evolution and policies. For us, it is drawings and documents; it is showcased around the world as a national document and proof of progress in Australia. The proof on the ground, we would argue, would be our reports, *Out of hospital, out of mind!* and *Not for service*, and the reports conducted by the independent parliaments in other states. I am sure your inquiry will hear endless accounts of these, plus the very limited data available from the governments which have been responsible for administering these reforms.

We have a deep concern in mental health that there has not been progress. As has been described to me recently by a very senior psychiatrist in New South Wales, we have a 10-year cycle. We had a royal commission in 1961 in New South Wales; we had what is called the Barclay report in the 1970s; we had the Richmond report in the 1980s and we had the Burdekin inquiry in the 1990s. We have had the reports by the Mental Health Council from 2000 onwards. We have 10-year cycles of government commitment for short periods, only to see the citizenship rights of people with mental illness continuously ignored in the community.

The big failure in the last 10 years, however, is that all governments in Australia did agree to invest and progress in the area. We challenge them to produce the data of improved access, improved coverage, improved experiences of care as a consequence of that. The national mental health reports which you will be presented with by government simply report inputs, expenditures and plans. We would argue that we have the only systematic national data about experiences of care and it leads us to conclude, through the direct accounts, the surveys and the written submissions, that there is fundamental neglect of the citizenship rights of people with mental illness.

We could not have dreamed up the Cornelia Rau story or the Vivian Alvarez story. We have argued now for five years about the gross inadequacies of care. It has taken stories like that to demonstrate the fundamental disconnection in information, understanding and appreciation of the difficulty of someone with a mental illness or their family living in the current Australian community and then running into classifications described in *Not for service* when they present for care. I have heard the most extraordinary stories in the last three years of people having to engage in behaviour such as smashing windows, walking down the South Eastern Freeway in Melbourne or assaulting someone in an emergency department in order to get care. They had already gone to an emergency department to get care and had been told that their condition was not severe enough, that they were not yet a threat to somebody else, so they were not entitled to care.

In our reports and our community stakeholder findings the two highest priorities identified by the Australian community are: early intervention—treating the problem earlier, not later—in order to improve not only their own health but the burden on their family and any impact on the wider community; and co-management of the associated drug and alcohol problems that commonly beset those with mental illness whose illness is untreated.

The community is clear cut about its priorities. We do not see priority setting within government plans, we do not see accountability and we do not see a focus on outcomes in those plans. We are obviously aware—and we will go into this later this morning—of the need for more resources but we would argue that accountability and national leadership are the key issues. The current process involving Australian health ministers and an agreement to simply have a policy in place, to have drawings in place, and to have no clear implementation, no clear priorities and no clear outcomes will not change the situation. We are seriously concerned that this will again be just another 10-year cycle of interest followed by neglect. I think it is fair to say that most of the people that we have been involved with welcome the Senate inquiry as a genuine chance for bipartisan national leadership on the issue. A serious agenda needs to emerge in which outcomes and accountability are at the top of the national list.

Mr Mendoza—I want to add to Professor Hickie's comments about methodology. I have come to this project halfway through, following the completion of the data collection, and what I see is that this is the most extensive qualitative study of experiences of care probably anywhere in the world. There were 351 submissions and 22 public forums attended by 1,200 people across the nation, chronicling, as we have heard, cases of neglect and of systemic failure in our mental health services. I have been around the public sector and have been producing public policy for well over 20 years. I would challenge your committee to find another area of public policy where a profound change in strategy is agreed by government and 12 years down the track there

is a dearth of outcome data to show how that strategy has impacted at the community level. I cannot think of one.

A group of directors in a business would not commission a turnaround strategy and accept from its management no outcomes data after 12 months, let alone after 12 years. This is, in my view, a failure of leadership and a failure of bureaucratic management in the implementation of these plans. Our report is an extensive qualitative study and it starkly demonstrates where we have got to over those 12 years. It is imperative that there is leadership at a national level to look at how this plan is rolling out and how we can align resources with the strategy. There is also a need to commit to some basic data which can inform the progress of that strategy and demonstrate over at least a five-year period an improvement in the experiences of care.

The recent cases of detention and the debate that has ensued publicly and in the chambers of this parliament illustrate to me how far we still have to go in terms of community stigma and the understanding of mental illness. There have been statements in the Senate in the last week which demonstrate a complete lack of understanding of mental illness. In the media we have seen ministers, bureaucrats and others saying that these people did not tell the truth and that is why they were deported or kept in detention for so long. These people had a mental illness. That does not seem to have been understood. The public commentary is often comparing what these people did or did not do with normally healthy people, where cognitive function of the individual is normal. That seems to be an entirely unfair and uninformed public discussion.

Mr Knowles—I would like to make my comments on the council's submission, which is the next item.

Ms Smith—I would like to make a comment on the next item as well.

CHAIR—We will come back to questions on that submission after morning tea, but we will use this opportunity to talk about the report. Dr Ozdowski, I want to ask you about the role of the Human Rights and Equal Opportunity Commission in all of this. Former Commissioner Burdekin set up the inquiry more than 10 years ago now. There has been this latest involvement and other reports have also been done. Is it enough for HREOC to just bring forward the information and make recommendations or are there other ways in which you could be empowered to demand that services be provided to people on a human rights basis? Are there other ways in which we can protect people's human rights in mental health services? Should there be a special commissioner for mental health? Can you give us some insights into what the barriers are from a bureaucratic point of view to your organisation making more of a difference?

Dr Ozdowski—The human rights commission has been involved with mental health almost since its establishment. The Burdekin report was certainly a very important milestone. These consultations are also a very important milestone. I was also involved with an investigation into children in immigration detention, on which I delivered a formal report to this parliament one year ago. Basically, when I was conducting the inquiry into children in immigration detention I was exposed to mental health issues in immigration detention. I was exposed to two different forms of it. First, I witnessed the problems that were there, not only with children but also with adults, when I was visiting detention centres. In one of my public statements I even described immigration detention centres as mental hospitals but without the support or resources that hospitals have—it was bad as that when I visited the centres.

The second thing which was of major concern during this particular inquiry was that quite often mental health officials were providing reports to immigration officials about the state of mental health of individual detainees, and basically nothing happened afterwards. In one particular case of a child who was self-harming we found that the mental illness was first diagnosed in 2002 and in 2003 when we were taking evidence there had been some 20 opinions from professionals saying that that particular child could not be treated in detention and that they needed to be released. That child was released only one year later when he and his family won refugee status in Australia.

I started to look at what is available for those people after they get out of detention centres. The vast majority of them were released sooner or later from immigration detention centres. I found that the level of services available for them was very low—there were not enough. Quite often they needed to rely on the support of either civil society or voluntary organisations to start their life again in Australia and to deal with their mental health problems. I met Dr Grace Groome. She told me that she was aware of it and that it is impacting on all of those who do have a mental health problem. After some time we joined forces and decided to conduct that particular consultation. Our purpose was to put the issue back on the political agenda. Because there were so many other reports which documented this in great detail, we decided to talk to the people and allow the media to be present so that everyone knew what was happening. We partly achieved that, and we thank you also for coming on board with your inquiry. Now is the time for action. We need to fix this system because mental illness will not go away. On the contrary, with the ageing population we may have more problems as time goes on.

The commission's powers are very limited. When I am conducting a formal inquiry, as I was conducting one into children in immigration detention, I have a right and a duty to report to the parliament. My report for that inquiry was tabled. When it was tabled, the response was that my report was backward looking and a bit harsh on the department of immigration. It is now one year since then. I think the links that I made between detention and mental illness when the advice of mental health professionals is not followed are very apparent in cases we face today.

The other power I have—and it is a privilege—is that as a statutory officer I can talk to the media and bring issues to public attention. The consultation where I am using the power I have is not a formal inquiry. It will not result in a formal report to the parliament. I am sure it will be available to the members of parliament. But, as I said, our powers are very limited. They are limited to complaints, which are very much private. If they cannot be conciliated in the commission in some areas, like discrimination—sex, age or disability—they can go to the courts. When it comes to civil and political rights, if we find a breach we can report to the parliament, as we do with a number of complaints. We can do a formal inquiry but formal inquiries are very expensive and very time consuming, and our resources are limited, so we do a limited number of them. I am doing one inquiry at the moment, which could be of interest to this committee. That is an inquiry into employment and disability. We found that over the last 10 years people with disabilities have advanced in a range of areas—there is better access and there have been a number of improvements—but there has been no advancement in the area of employment. On the contrary, it looks as though the situation of people with disabilities in employment has worsened. Therefore, we decided to do this inquiry.

The link to this committee is that people with mental illness have the highest rate of unemployment. Somewhere between 70 and 80 per cent of people with mental illness are not

able to work. We are trying to establish how we could assist them, what kinds of barriers need to be removed and whether it is an issue of cost or risk or some other barrier so that we can get more of them into employment. That is the inquiry I am conducting now. Until that is finished, I certainly would not be able to afford any further formal inquiry. Of course we are in the hands of parliament. I would love this parliament to also consider the issue of a bill of rights so the most significant abuses, especially in the area of civil rights, could find a way to our courts.

CHAIR—Just to pursue that a little further, HREOC brings parties together where there is a disability discrimination or a sex discrimination case. Is there not an opportunity within the way HREOC is set up for you to do likewise with a representative body of people who are, for instance, in that category of—I forget the terminology—not being serviced with state health services departments? Is that not a possibility for your organisation?

Dr Ozdowski—It is an issue of individual complaints. If we deal with systemic matters, we have inquiries or consultation. Individual complaints could be handled by HREOC but if they relate to discrimination—for example, in this ability area, and mental health is included there—we will be looking at them. If the process cannot be conciliated then the parties can go to the court and get an outcome from the court.

When it comes to civil rights issues, such as detaining somebody wrongfully, detaining somebody without due cause, our powers are much more limited, because we can attempt conciliation but then the parties cannot take it to the court. If we find that human rights were breached we can and do report to the parliament, but then it is up to the government to take it further. The states have their own systems of dealing with discrimination complaints, and a person may choose also to complain under the state system.

Senator HUMPHRIES—I want to be clear that you are, in general, happy with the direction that the National Mental Health Strategy has mapped out for Australian health services and Australian governments. What you are concerned about is that, within that strategy, targets and goals have not been clearly set, or, if they have been set, they have not been addressed by the provision of data to indicate how far we have gone down the path of meeting those sorts of goals and targets.

Mr Mendoza—We would say that it is not just goals and targets, although they are particularly important, but goals and targets in outcomes areas. We have a lot of measures there that are essentially outputs or near-term results. So numbers—even one that is along the lines that all mental health services will be accredited against the national standards for service—are a near-term result and an indicator of quality. But it is not the experience that people encounter. It is not the end user perspective as such. We think much further work has to be done in terms of defining health outcomes—real measures of progress in this area—as well as much better definition of those near-term results akin to the ones on standards. Further, we would say that there is no linkage with resourcing. These commitments under the National Mental Health Strategy are not matched with real resources.

The meeting that Mr Wilson and I attended in March of the National Mental Health Working Group, which reports to AHMAC—it is the bureaucratic structure for overseeing the deployment of the national strategy—had before it the implementation plan for the 2003-08 strategy. So, halfway into the strategy, we were presented with an implementation plan which lacks any

specificity in terms of outcomes and resources, and it has a number of commitments—pieces of work—that are simply out some way towards 2008 to be completed. All they have done there is to provide activity indicators, not outcome measures. So we think a lot more work has to be done in that area, but also the resourcing to make those things happen has to be put in place.

Prof. Hickie—I think, Senator Humphries, you have raised a terribly important issue, which is that the fundamental direction which underpins the national strategies is also consistent with the human rights agenda. It is about citizenship. It is about residing in the community as other people do with other illnesses, other physical health problems, and then being able to access appropriate care. So the strategy that was developed in 1992 and agreed to in 1993 was consistent with UN developments at that time about the fundamental rights of people with mental illness—the rights to reside in the community, receive care in the community, access ongoing treatment as needed, have citizenship rights and access the other required social and welfare services. The council has always been, and most of the organisations in mental health in Australia are, fundamentally in support of the direction of residing in the community with full citizenship rights. But the most important part of that is the continuing right to access the health care and social welfare services that enable you to live a full life in the community.

Health care has always thrown up challenging issues—in the past, with tuberculosis and, in recent memory, with HIV—about how people with health problems reside in the community. There was a fundamental commitment made in the 1990s to promote a system of community based care so that patients could live in the community with full rights. But there is no disagreement in the mental health community that in order to do that, and for the stigma to break down and for people to understand that these are health problems like any other physical health problems, you have to have the health and welfare services in place for people to live full lives. That is where the issues have got stuck ever since.

As a consequence, there is great concern in the mental health community and amongst families and other people that when people with mental health problems live in the community without adequate health care it is challenging to the community, the stigma may increase and they may live even less fulfilling lives than they were living in the institutional settings in which they previously resided. So you will hear that some families, carers and organisations almost yearn for the past system in which at least there was day-to-day care and housing. And you will see in this inquiry, as in the 2002 inquiry, a lot of things that are striking to us. A number of people say that they were happier residing in the prison system. They were actually receiving care and housing, they were accessing some mental health care and there was some sense that there was some continuity or information about them available. Some of the most significant developments in mental health have been in police services, state based prisons and other systems of custodial care. Even though simply being in those settings undoubtedly has the potential for adverse impacts on a person's mental health, at least there is a sense that they are in a system of care.

Senator HUMPHRIES—Obviously in this country our prisons are, sadly, largely de facto mental institutions for a large number of people. You mentioned that the input we need is \$1.1 billion per year for the next 10 years. How have you arrived at that figure? You say that is the figure that the Commonwealth government needs to meet. Do you think there should be a matching amount from the states or that the states should contribute to that \$1.1 billion?

CHAIR—If I could interrupt for a moment, the Mental Health Council was planning to give us a presentation of their submission after the break. Those questions may be answered in that.

Senator HUMPHRIES—I will ask another question, and I assume this is the right context ask it in, about the problem that practitioners or people in the field have in being able to bring treatment or assistance to a person with mental illness and the problem we see of a distinction between mental illness and mental dysfunction. In many cases a person with problematic behaviour which is deleterious to themselves or people around them might not be diagnosed as mentally ill but clearly has a problem that needs to be addressed through some measure of treatment. That might be treatment which is against their wish. That incapacity to categorise so many people with a problem as being clinically mentally ill leads to, in my experience, a great problem in delivering services to them. Do you have a comment on how Australian governments should deal with that problem?

Mr Wilson—That is a very important question because there is plenty of evidence to show that there are people who, by virtue of those barriers, do not have their citizenship rights in full. That includes those who are labelled, for instance, with the term ‘personality disorder’, because that is a sentence for mental health services to formally neglect them. You are not regarded as having a mental illness if you are designated as having a personality disorder. You are thrown into the too-hard basket and there is nobody else to whom you can be referred. If that is something to do with a drug and alcohol issue then the drug and alcohol services’ response will be: ‘You don’t have a drug and alcohol problem; you have a mental illness. Go back there.’

So they fall into this deep hole, and their problems are not attended to. Often they are the ones who end up on the streets, suiciding or in prisons. You are right that prisons have become the places where a lot of those people are ‘warehoused’, as a former judge in Western Australia recently said. That then raises the issue that has already been referred to—that, with respect to those people whose life condition is a mixture of a mental illness and a drug, alcohol or other substance abuse problem or another personal problem, we need agencies of government to be working together. There is a very good case for arguing that mental health services and drug and alcohol services should be delivered under one agency, because where they are separated there is a constant shifting of responsibility and delivery of service. In other parts of the world that has become common practice—for instance, in the UK it is common practice that mental health and drug and alcohol services are delivered through the same agency.

Prof. Hickie—It is important to say that this is not something dreamt up by lawyers; this was developed in Australia under the first strategy, with the definition of ‘serious mental illness’. It was seen as a need to focus attention on the neglected care of those with schizophrenia and other enduring forms of illness, but in service land it was interpreted as meaning everyone else could be classified as non-serious. In fact, different jurisdictions have different wordings under their state legislation. For example, in New South Wales ‘mental disorder’ and ‘mental illness’ are both covered by its legal mechanisms. The problem is not a legal one; it is actually what the services are interpreting these things to mean. Certainly in our recent consultations you have to have one of the serious mental illnesses—so if you have a personality disorder or a drug and alcohol problem or depression you are excluded, because you are not in that category—plus you have to pose an immediate threat to yourself or somebody else. In reality, we have introduced two more steps away from the community priority of earlier intervention at an earlier stage.

The analogy we use is with cancer. Can you imagine if we said to people with cancer: 'Only come forward when your life is in the last stages. Do not come forward for screening or at an early stage.' We actually have systems in place in Australian states which say that serious mental illness plus an immediate threat are necessary to get a service. It is not what the legislation says in most states. For example, in New South Wales it says that all these things should be considered, because we often do not know if it is the early form of a more serious illness. We are reliant on clinical opinion and reporting. We need a much greater spectrum of care. These categorical distinctions fit our current limited service environment; they do not fit any realistic classification of the nature of mental health problems.

Senator FORSHAW—We look forward to seeing the report when it is released—which is fairly soon, is it?

Mr Mendoza—The expected date is in the third week of July.

Senator FORSHAW—One of the issues you have raised this morning—and we hear it all the time, of course—is this whole question of Commonwealth-state responsibility, relationships and so on. You have indicated, Professor Hickie, that the states have expressed some concerns and criticisms of the *Not for service* report. Do we have a major structural problem here in how the Mental Health Council and the states are functioning in terms of, for instance, the preparation of this report? Were the states involved? What was the nature of their involvement? Why do we end up with such a substantial report being prepared and yet—as I am advised and I have heard from my state—they have some concerns about the methodology? That leads me to another issue, which we can take up later: there is no state representation on the Mental Health Council. I understand that it is an independent body, but is there a fundamental structural problem here in terms of how we move this whole thing forward? You can see where I am leading to. We have two ex state health ministers here. It may be useful to hear your comment.

Mr Wilson—Senator, that is a minor consideration for me. What I would say is, first of all, we do have state representatives on the council. Each jurisdiction, state and territory, nominates a representative from the peak mental health body in their jurisdiction. That nomination comes through the minister concerned and they are not elected; they have an automatic right of membership.

Senator FORSHAW—Are they bureaucrats?

Mr Wilson—No, they are non-government. This is the peak non-government organisation.

Senator FORSHAW—That is what I understand. I am not trying to suggest it should necessarily change. I am trying to understand this. We are supposed to be getting state cooperation under the National Mental Health Strategy.

Mr Wilson—That is certainly true. We make painstaking efforts to talk to state and territory health ministers, to have ongoing relationships with state and territory health ministers. But the nature of our inquiry has to be understood in that it is an attempt by the council and, in this case, the commission to get the community's view. The governments have every resource available to them to put their own view. Our responsibility, as we see it, is to get a real measure of the views of those receiving services—that is, the consumers and their families and the hands-on

providers, who are the nurses, psychiatrists, social workers and others out there in the community and the NGOs, who are also increasingly taking from governments the role of providing those community services. That is our objective.

The governments have got all the muscle they like to do their reviews. We are saying that we are trying to sample the actual views of the people receiving services and to find out whether there is a lack of services available to people in need. That is the basis of this report. And I think that is what a lot of state ministers have not understood. They see it as an attack on them. They see it as something they have to defend rather than accepting that this is the authentic voice of those people in the community who need mental health services and who, in many cases, are not receiving what they need when they need it and for as long as they need it.

Dr Ozdowski—Yes, it is qualitative research but very extensive research. It is easy to attack this kind of research, because there are other methods of research. But it is horses for courses. On this occasion we wanted to listen to the people and it was the most effective way of collecting information. When it comes to state governments, yes, there are challenges to methodology. It is expected. There are not challenges, however, to the fact that the mental health system does not work. There is a general agreement that it does not work. What is interesting is that after we had some meetings, for example, in Western Australia where information came forward that Commonwealth money that was supposed to go into the mental health system was misdirected to physical health, the government suddenly recovered the money and re-established the situation. In some other states, after our consultation, additional money was put into mental health issues. So I think we are having agreement that it does not work, that it requires more resources, more attention. Perhaps there is a bit of a blaming situation. The Commonwealth are saying: ‘We put in major increases over the years. It is a state responsibility.’ States are saying: ‘We do not have enough money. Please, Commonwealth, help us with it a bit.’ So there are these kinds of issues, but I think there is possibly uniform agreement that the system does not work, it needs to be improved.

Prof. Hickie—Senator Forshaw has raised a terribly important issue: our processes would be unnecessary if in the Commonwealth’s and states’ own processes they engaged regularly in these sets of activities.

Senator FORSHAW—That is what I was trying to get to.

Prof. Hickie—That is absolutely the point. We did this in 2002—actually commissioned by the Commonwealth as part of the evaluation of the second strategy. They went to the council as the only body that could independently do such work because they had not set such processes in place. You will see in the national mental health reports, up until the last one in 2004, no substantive work in this area. Each of the jurisdictions now says it is planning. New South Wales says that by 2006 it will have an instrument developed for such a process. Victoria is the only one so far to have developed anything like it and it has only released its findings to us in the context of this report, of a third of consumers and half of carers.

Senator FORSHAW—But why are they all doing it separately? If they are developing an instrument, then I am starting to wonder—

Prof. Hickie—You have just cut to the other critical issue. They say they have a national mental health approach but in fact they each develop their own within their own jurisdictions. Then they say: ‘Queensland is different to Victoria, and Western Australia is different again. We respect our right to develop processes independently.’ But it is the lack of process that forces us, with very limited resources, into ad hoc inquiries. We do not feel that is the way to conduct these processes.

Senator FORSHAW—That may be an appropriate response for a state in a situation where, as you might say, there is no leadership and no recognition that leadership has to be a state and a federal thing collectively, if you like.

Prof. Hickie—There is no agreement about how to report these factors concerning sentinel events, critical events, homicides and suicides in each state. New South Wales has had to establish committee which first reported in 2004. Ten and 12 years after the commencement of a national strategy each state is looking at these critical community processes.

Senator TROETH—That is simply my question. Why is this so? I ask that in the context that you have given us evidence that the policy is there but the implementation and delivery is not. You have mentioned a lack of resourcing, which is a practical reason for it not happening. Why is this so? Is it a failure of will, leaving aside political objectives? Is it simply that mental health is not seen as being in the mainstream of our health delivery services? I know these will be general comments—we can get down to the nitty-gritty in looking at your submission—but I would be interested in your response to that.

Mr Wilson—We note that it is not just a question of more resources. One of the problems with resourcing of mental health in every jurisdiction is that money allocated for mental health services is not quarantined. It is seen as the soft option, when people get into trouble with waiting lists and other politically sensitive areas of health, to put money from mental health services into something else. We started to talk about the need for quarantining, but nobody yet has come up with a watertight means of doing that. That should be done uniformly across Australia but is not done anywhere. That is the sort of problem you face about resourcing. It is just one aspect of the problem. It is symptomatic of the fact that mental health has a low profile in health. Even within health itself it is seen as a lower order of health care. It is not really very scientific. It is not in the same category as cardiology, for instance, or oncology. It just does not measure up. Within the professions it is looked down on as a lesser area of care. So it is stigmatised, and the stigma itself is the reason we have this intractable resistance to progress, I think.

Mr Knowles—I think it is best encapsulated by the fact that the Institute of Health and Welfare have identified mental illness as representing about 30 per cent of the non-fatal burden of disease but, of our total health expenditure, mental illness receives only 6.4 per cent. So there is a clear mismatch between where the resources are going and where the burden of disease is falling. It is that sort of debate. In a former life, when we undertook reforms in the mental health system and mainstreamed mental health services we started a program of funding clinical psychiatric expertise in each major emergency department. It was separate funding; it was quarantined. After a few years, the hospitals and the doctors started arguing: ‘Why do we have to account for that? Why can’t that be rolled in and we’ll maintain it?’ So we did, and within two years in most emergency departments that clinical psychiatric expertise had been replaced,

because in state health systems the public debates are around waiting lists, emergency departments and ambulance bypass. So of course that is where the resources tend to get streamed off.

We have mainstreamed mental health services, so the question is: how do we mainstream mental illness into the health debate so that we get the system allocating resources more clearly to where the burden of disease is falling? Rather than treating mental health systems as an add-on at the end of the health debate, we need to make them much more central in terms of the bigger resource allocation issues.

CHAIR—I will bring this session to a close. Thank you, Dr Ozdowski, for your presentation about your work. We will come back to the Mental Health Council's submission after a break.

Proceedings suspended from 10.27 am to 10.44 am

CHAIR—I call the committee to order and welcome back to the table representatives of the Mental Health Council of Australia. We will proceed to your submission. You have lodged a submission with the committee which we have numbered 262. Are there any alterations or amendments to that submission at this stage?

Mr Wilson—No.

CHAIR—I invite you to make a short opening statement, at the conclusion of which we will move to questions.

Mr Mendoza—Thank you. We welcome the establishment of this committee. I think it comes at an interesting time in terms of the public debate about mental health services in Australia—services which have been brought into sharp public focus through some of the recent cases in detention and continuing concerns in that area. We have provided what we would describe as a comprehensive response. However, there are some key points that we want to pick up on. We would like to use the bulk of our time this morning answering your questions on the submission and other documents that we have provided. There are a series of publications, which I will leave with the secretariat, that have been produced by the council—things like our carer and consumer participation policy, which has recently been released; the *Out of hospital, out of mind!* report, which has been referred to a number of times; and various other resources.

We also provided a draft copy last week of our major report called *Investing in Australia's future: the personal, social and economic benefits of good mental health*. That report in particular we think the committee will be interested in because of the focus at the moment on the welfare to work reform agenda. It highlights where Australia stands internationally in that area—we really do sit at the bottom of the OECD comparisons with the number of people with disability participating in the work force. As Dr Ozdowski said earlier, we are particularly poor in work force participation for people with mental illness. What that report in particular highlights is the need for a movement from a compliance regime to an investment and service regime—that if we are really going to make a dent in that sort of poor performance with OECD comparatives then we do need to see both an investment in service and also systemic connections between the vocational areas, the employment service providers, and the health sector. We do not see much of that happening on a national level. There are, no doubt, local

examples; and some of those have been mentioned in recent publications which we will draw to the committee's attention. There have been some in Sydney in particular where health services have taken a case management approach to consumers, enabling them to participate in work, but we need to see a much more national approach to that issue. That report in particular does highlight that.

There are four reasons why we see the experience of care as we have described in the earlier session and the failure, if you like, of the National Mental Health Strategy over the last 12 years to reach its desired outcomes. Firstly, we see that the burden of mental illness and disability associated with mental illness versus the investment are completely disproportionate. That is not the case when you look at other areas of health, illness and disability. So there is a mismatch there.

Secondly, we see that there is a mismatch between the community based mental health service model and the current system of allocating funding which is largely based around beds and buildings. In the last 12 months, while the council, the Brain and Mind Research Institute and the commission have been out doing the committee consultations, there have been many announcements by state and territory governments about the increase in resource allocations to mental health services. The vast bulk of those, I would have to say, relate to increased investment in acute care facilities—more beds and buildings.

Some of them do point to increases in community housing, such as the HASI program in New South Wales—it is a good case example—and there are serious increases in the number of supportive accommodation places in that state starting to come through from what is, in budget terms, a fairly modest investment. But across the board there is a lack of investment in those early-intervention step-up programs to acute facilities and certainly a lack of investment in the step-down facilities that enable people to leave an acute care facility and then reach their level of optimal participation in life and indeed in employment terms. With some of the cases that have been in the media, you can see from the discussion of what occurred to these people before they ended up in detention centres that there was a revolving door through state mental health services at the acute level and that there was a lack of community based support once they left those facilities.

Thirdly, there is a significant underlying and unmet need for mental health services in the community, and all the investment in recent years that state and territory governments can point to is basically soaked up by that unmet need. Again, I find it rather odd that in this area of health we do not have regular prevalence studies telling us what is happening with mental illness across the Australian community. Is the mental health of the community improving or is it worsening? Again we have to rely on bits and pieces of data to tell us or give us a sense of how that is travelling. That is not the case with smoking. It is not the case with cardiovascular disease. It is not the case even with obesity, an emerging issue, particularly for young people. We know what is happening in those areas and therefore we can direct public policy and programs to intervene and change that epidemiological pathway. In the area of mental illness, we do not have that sort of underlying prevalence data being consistently gathered and analysed and then driving policy.

Fourthly, we have failed to agree on and implement a national framework for accountability. We have spoken a good deal about that this morning. So they are the failures. In particular, our submission draws attention to the ways forward, and we have outlined many recommendations.

In those recommendations we have focused on the federal government more than the state governments, but it is clear that we need collaboration and a cooperative approach to really make the experience of care for all Australians different to how it is today.

CHAIR—Thank you. Are there any other contributions before we go to questions?

Mr Knowles—I would like to add something. One of the points made earlier was about making mental health and mental illness much more central to the debate on mainstreaming health. I think it is worth, though, reflecting on the fact that the first national mental health plan had a profound impact on health services. It did change the way the service system was structured. Clearly, there was some variation around the country, but every state and territory did commit to and did undertake a restructure.

Some of the things that we have heard about already this morning really started as some of the adverts also started. When we first mainstreamed mental health services in this country, there was great concern about trying to keep the resources at the hard end of the system. There was concern that in a mainstreamed service system people with severe persistent mental illnesses would be excluded or would miss out—that it would be easier to treat other illnesses, rather than schizophrenia and bipolar disorders. So there was a strategy put in place to try and ensure that people with those illnesses were not excluded from the system. Unfortunately, it was not followed through with the continued building of the service system to pick up that unmet need, and what started out as being a temporary strategy has, as Professor Hickie said, become so entrenched that we are now excluding other people from the service system because they are not sick enough.

I do not think we should discount the value of that national approach. The Australian government and all state and territory governments agreed to a national health plan. The Commonwealth put up a fairly modest amount of funding but to access it states and territories undertook some quite significant reforms, which was not very easy. The then mental health system was very institutionalised and any institutionalised system means that there are some quite powerful influences that do not like change. I do think we have lost our way in the subsequent ones. We did not build on that gap.

Clearly, our submission highlights the inadequacies of the current resources. Professor Hickie will talk about how we have actually reached that amount, but we ought to see that as a start. If we can get this debate about overall health priorities moving, that itself will deliver additional resources into mental health care. For some of the reasons I have already outlined, I do not think it is going to happen at a state and territory level on its own. It is going to need national leadership. Not only do we have to change the debate within the health system, we have to build much stronger linkages between the operation of the mental health system and those other support systems that we have in place.

I have a particular interest in those with bipolar and schizophrenia, persistent and chronic psychiatric illnesses. Their experience of unemployment is in excess of 80 per cent in this country. They are amongst the poorest members of our society. We know that simply treating mental illness alone is not going to change that. They need access to housing, education and employment services, and the fellowship has brought Professor Gary Bond, who has done some

significant research work on vocational training and people with persistent chronic mental illness, from Indianapolis. He is coming to present to the committee.

His program, which is based on some clearly thought through research, has lifted the employment rate from about 10 to 20 per cent to 50 per cent for people with schizophrenia or bipolar, those persistent illnesses. So it can be done. One of the keys is having the mental health treatment team working with employment placement people, housing, community support and those systems. You have to get those linkages across government policy and in this country it is the national government that is responsible for employment policies and social security. We are never going to lift that unless we get those programs working closely with what are still state based management systems. That is why I would argue that we can only do it with both levels of government working in tandem.

We have demonstrated that it can work through the first mental health program, but that happened because the national government took leadership. They set out to achieve that outcome. We have seen it in other areas. The national government took leadership on national competition policy and very substantially changed the way state and territory governments operated their services. We have seen it more recently in water. There are many concrete examples where the national government showing leadership significantly effects change in the way the service system operates. In this case, I would argue that there is an opportunity for that leadership to demonstrably change the way the service system operates in the lives of those with a mental illness and those who care for them.

There are many good examples of individual initiatives. We need to take those and make them part of the systemic operation of the service system. Our submission would argue that there is an urgent need for national leadership. It needs to be whole-of-government leadership and it needs to be underpinned by some resources and by some reorientation of our current resource allocation. Unless we head down that path, other committees are going to be having these sorts of hearings in a decade's time. The cycle will continue. There has to be that intervention to break the cycle and our submission is built around trying to suggest a way forward.

CHAIR—Senator Humphries, do you want to go back to the question you raised earlier?

Senator HUMPHRIES—I think Professor Hickie might have taken on notice the question of how that figure of \$1.1 billion was reached.

Prof. Hickie—To address the issue of the economics, it is important to say that the council did prepare a very detailed report, *Investing in Australia's future*, prior to the last election, which was tabled for the committee. This is a national issue of economic importance. We have dwelt on the health and personal impacts and been fierce critics of the state health systems, but they are just one part of the system. Using the 2000-01 figures we estimated that mental health costs Australia \$13 billion every year. Only one-quarter of that is in direct treatment costs—what we spend on mental health. Another quarter is in income support and welfare services directly paid by the Commonwealth. The second half is all in the lost productivity of the persons themselves and their families. It is enormously costly to not treat mental health.

I understand the Commonwealth will present figures during this inquiry which update those figures. In fact, they are probably significantly larger at this stage, but you will not find much

significant expansion of the expenditure over that period. Australia is different to other countries in the extent to which we fail to intervene early in severe disorders but provide income and welfare support, which is largely paid for by the Commonwealth. When we work out figures relative to the health burden on what we think should be spent, and what would approach OECD comparisons and move towards OECD best practice, we spend 6.4 per cent of the recurrent health budget. We account for over 15 per cent of death and disability costs, if you include suicide, and 27 per cent of all disability costs per se.

We are quite different to other areas of health spending. Generally in health, if you die quickly of an illness you cannot spend much money on it, so areas like cancer and cardiovascular disease argue that there is an underspend relative to their death and disability costs, but it is largely due to premature death and often at older age levels. What characterise mental health are early ages of onset and then whole adult lives lived with disability, resulting in very large costs. In other areas that are associated with high disability—for example, some of the dementias and musculoskeletal disorders—in neurological and dementia disorders there is approximate equity. They comprise about nine per cent of the health burden and about nine per cent of the expenditure. In musculoskeletal disorders, you spend two or three times the health burden because you can actually do things. You provide services. People are going on living with those disabilities, so you replace their hips, provide their arthritis drugs and allow them to continue to see doctors.

In our report you will see a chart which documents the exceptional nature of mental health. We stop providing services as if our people died early. We behave as if they had left the system—that is, we only provide acute care. We do not behave as if they have lifelong disability, and we pay a price for that. We think it is basically a rights issue. It is the stigma, the history and culture of mental health as a low priority relative to disease burden that has allowed this to be perpetuated over time. We have estimated that to repair that fundamental inequality you would need \$2 billion per year in Australia over the next five years to start to lift that 6.4 per cent up towards 10 per cent of the health budget.

Having said that, the health budget increases rapidly. I am sure senators are aware that we are now up to 9.5 per cent, up from 8.5 per cent over the last decade. There has been much increase. Even the increases we have been arguing for in this report may only make small differences to the actual rate of health care expenditure. Much of the increase in mental health expenditure currently is in the private sector. If you look where money has increased in mental health—and you will hear this presented by the Commonwealth and the states—much of it has been in the private sector, which has low coverage for mental health, and in the growth of day programs in private hospitals.

The Commonwealth has increased its allocation to mental health over the last nine years by 128 per cent, but two-thirds of that is in the national Pharmaceutical Benefits Scheme, where there is an automatic process for applying and receiving funding. It is not in the actual health services that would get maximum benefit from that expenditure. In the models presented in that document, you will see that we have argued for immediate catch-up. We agree with most other health planners, however, that money per se will not deliver better systems. In fact, taking the same roads that we have taken in terms of accountability and response may simply result in the states spending the money in the same way that they have or in the Commonwealth not investing.

To make a real difference economically, we need increased coverage that is getting to people earlier. You may be aware that only 38 per cent of people with a mental health problem actually get any treatment in a 12-month period. For other health disorders, the figure is estimated to be 70 to 80 per cent. So we have low coverage. Coverage relies on getting into primary care services. It relies on decreasing stigma, so people come forward, and it relies on having services to go to. That means general practice in Australia but also other primary care—nursing and schools based services. They are Commonwealth responsibilities. It requires getting in early in life—youth intervention.

Some of the best international models have been developed in Australia, particularly, in Melbourne, Professor Pat McGorry's model of early intervention, but they are not national models. Professor McGorry developed his model in Australia over 20 years ago; it is still not implemented nationally. To reduce the economic cost you need to have coverage, you need to get in early and you need to have targets about return to work so you set targets that are economically and socially relevant. We have not seen any of that influence our National Mental Health Strategy. So we think it is good economics in addition to good social policy and it should be the concern of the national government to ensure that these expenditures reduce the health and welfare costs and improve the lives of the people we work with.

CHAIR—Is it the wish of the committee that this report be tabled? There being no objection, it is so ordered. Senator Humphries, we are running a little behind time and, bearing in mind that we may invite the council to come back at the end of this process, I might suggest that we move to other committee members unless there is something pressing you wish to ask at this stage.

Senator HUMPHRIES—I have just one quick question. You say that \$1.1 million needs to be spent but you would not mind, obviously, if that were divided between the states and the Commonwealth?

Prof. Hickie—No, sorry, let me clarify: currently, 50 per cent of the expenditure on mental health is funded by the Commonwealth and 50 per cent by the states. We are looking for a billion dollars recurrent from each— \$2 billion per year—but using the current funding model, which splits the expenditure fifty-fifty. And we would say that the Commonwealth would actually be the big winners, because they are the ones who, for every dollar they spend, are paying \$2 in actual income and welfare support. They would also probably be the major beneficiaries from the increased taxation associated with people returning to work.

Senator HUMPHRIES—You say it is fifty-fifty but your submission says that the Commonwealth provided 64.9 per cent of total funds dedicated to mental health.

Prof. Hickie—There is where the money starts and where it is expended. So Commonwealth agencies expend 40 per cent, but actually 50 per cent starts in the Commonwealth because it then transfers to the states, under the Australian health care agreement, the provision of the services in mental health in the hospitals. So it is 60-40 at the expenditure end and it is fifty-fifty at the taxation to expenditure end.

Senator MOORE—I have one general question. The mental health plan and also your report talk about the role of consumers and where people who are in the system fit in consultation, in discussion and in having their say. You have given us a significant submission and we are

waiting on the joint submission that is coming later. I am trying to find out exactly what import governments give the significant amount of work that you have done. Given that you are the voice of consumers and authorities, from your point of view what kind of import do governments give the knowledge that you share?

Mr Wilson—If you listen to the governments they say that they are responding positively to that, that they have systems whereby consumers and carers are regularly consulted and whereby they can participate in planning and policy development and so on. There are some signs that that is happening in some places. That even goes to the point, particularly in states like New South Wales, Queensland and Victoria, where consumer consultants are employed within mental health services to advocate and to support clients in those services. But there are other states where that has not happened and where there is a continuing debate about whether that is desirable and affordable. Most consumers and carers that I am in touch with and that the council is in touch with—we have consumer members on our council—would say, yes, they have given token respect to that, but in effect it is only token and it is pretty much a Clayton's style consultation. The impact of that consultation is never seen in practice.

But there are exceptions—and I am very careful to say that. A lot more has happened in Victoria and to some degree in Queensland but the general picture about that is still pretty negative. It has almost become the culture that you talk about consumer participation and they all say, 'Oh yeah, we're doing that,' so you can tick the box. But, in effect, in spite of the standards, the plans and all the noble words, it has not really got a hold. Even in mental health, if you are in a tight situation it is seen as the first area you defund. So it is a bit of a soft option. It is not regarded by the hardheads in government and the bureaucracy as a dinkum way of spending money. It is a bit of a waste of money, in their eyes. I think that is something that is yet to have its day. It is a difficult thing, because it is the only area of health where that issue has been so intensively pursued and where consumers and carers have made such protracted and intensive demands for that to occur. And it is reasonable because, in many cases, people in mental health care are in that care for the rest of their lives. Also, it can impinge on their individual rights, their human rights, simply in terms of the modes of care and the modes of treatment when inappropriately applied. From that point of view, you only have to think of treatments like ECT—people's ability to consent to treatment, and the judicial style of some mental health professionals in treating people. I think all those factors mean it is a key issue, but it has been underplayed and only tokenistically applied.

Senator TROETH—You have mentioned early intervention, and I think we have discussed the fact that many people, through their own inability to deal with the disease, and the system's inability to deal with early signs of mental illness, do not present till a much later stage. If you had the \$2 billion a year what would you be doing to address that issue? I would also like to ask about the role of GPs in early intervention and, much as I hesitate to lay yet another administrative burden onto schools, whether the education system has a role in looking at this issue.

Prof. Hickie—The issue of early intervention is critical. At the moment, in the science of psychiatry and mental health we have very limited primary prevention targets where we are sure we can do something to stop the illness from ever developing. What we have much better evidence for is early intervention—that mild signs of illness go on to moderate and severe forms of illness. And most of these occur before the age of 18—75 per cent of what we see in adults is

mental disorder, and mental illness actually commences before the age of 18. So the early identification in schools, families and in presentation to family doctors is critical at that level. There has been increasing recognition, and some of the world's leading programs in the areas of family training and identification are in Australia. I am sure you will hear about beyondblue's schools initiative and the Commonwealth's excellent programs in schools, MindMatters, which look to advance both better science and better coverage. But that needs to be backed by the health system. There is no point in encouraging young people or their families to come forward if you do not provide interventions that are relevant.

One of the consequences of not providing intervention is that an estimated 50 per cent of the national alcohol and drug problems could have been prevented if the presentation of mental illness prior to the alcohol or drug problems had actually been dealt with. That rolls over as well into other issues such as nicotine use and obesity, where you see a clustering of these adverse health behaviours. So the big issue becomes: how do you back that? Undoubtedly, schools are a major issue. One of the very welcome aspects of the national health plan, particularly with Commonwealth leadership in the second plan, was an emphasis on schools. But it is a very small investment in Australia, and there is much work to be done in developing the best systems.

In the GP area, the Commonwealth's stand-out program, Better Outcomes in Mental Health Care, which was funded in 2001, did not come into operation until 2002. It has just been refunded in the current budget but at a level of \$100 million over four years, which is \$25 million in our current national expenditure of, when last recorded, over \$3 billion. It is a small area still. So the coverage issue is critical. In the GP area, we have good evidence that there has been rapid improvement. Over 5,000 GPs have participated in training, over 4,000 have registered to work with Better Outcomes and about half of them are doing those particular areas, particularly in rural and regional Australia. But they say, 'We can't go much further without specialist support and other services.' The access to psychologists in Australia remains extremely limited. We are extremely unusual, compared with New Zealand, the UK and Europe, in our underutilisation of a major health work force in terms of psychology. So although we have introduced a good structural system, actual access remains extremely limited in the public system, in the states, in the Commonwealth funded access through GP programs. So these are undoubtedly critical areas to improve coverage and promote early intervention.

You have to change community attitudes—and the most important way to do that is to have people who recover. With depression, for example, we estimate that only one in six people in Australia receives effective treatment. Imagine if you were trying to destigmatise epilepsy, and five out of six people did not receive effective treatment so they were having seizures all the time or they were impaired all the time. It is very hard to destigmatise a disorder when you do not promote recovery from that disorder. What you need to get destigmatisation is the belief that people can recover. We see this in breast cancer and other areas where people are effectively treated and they return to work or to their role—people are then likely to come forward. So the goal of community attitudes also depends on effective health services being available, because that will strongly influence people's attitudes to early presentation. There is much work to be done in the science of it. The Commonwealth has been the principal leader in these areas, but until very recent times its investments have been quite small and are still a very small part of the overall structure.

Senator WEBBER—Before I embark on questions I want to put on record my support for the proposal that we get the council back towards the end of our hearings so we can get a wrap-up. There are lots of questions I would like to ask, but hopefully we will see you again so I will get a chance to ask them then. I want to pick up now on the comment Mr Knowles made about the need for national leadership. Obviously, given the involvement of former politicians such as those we have here today and also Mr Kennett and others, there is not a lack of will politically amongst ministers to do things and to exercise that leadership. The problem could be the entrenched views of the bureaucracy within health departments. If we decide to recommend the spending of lots more money but there are these entrenched views then we are not really going to fix the problem, are we? I wonder if somebody could comment on that.

Mr Knowles—I would not just put more money into health departments and think that that is going to solve the problem. I think it is the intersectoral linkages that are critical. In some of these areas it is not that we have to spend more money, it is just that we have to spend our money differently. Many people with a mental illness will have access to six and seven different programs, so there are resources available, but those programs never talked to one another. All of the evidence, particularly for people with a chronic mental illness, is that the treatment team needs to be working with all of the other social supports. When you put someone with a chronic mental illness in public housing, the public housing department does not have mental health workers, so unless there is a linkage there between the housing support worker and the treatment team it is not going to work. People with a chronic mental illness often have to leave the education system. Our education system is geared to people who have ongoing stable mental health, so if someone has a psychotic attack and has to withdraw from school for some period of time, everyone else will have moved on and yet that person is meant to resume. That is not going to work.

We started a program in Melbourne to provide a pathway for people with chronic mental illness back into education. It was geared around the fact that a person will have time out while they manage their mental illness. At the end of 12 months we had 100 per cent success because it was geared to the needs of people with a chronic illness. It had nothing to do with the health department; it was how we got the education department to understand some of those particular needs. If we are talking about one in five people at some stage experiencing a mental illness, mental illness ought to be an issue for every government department, and how do we build those linkages? That is why I am saying that for the Commonwealth to provide the leadership it has to be whole-of-government leadership not just health department leadership.

Mr Wilson—I would like to support that and point again particularly to the fact that any chance of recovery for people—whatever their capacity for recovery is—rests very much on their having adequately supported, stable accommodation, some access to employment and some social network in which to live. The issue of accommodation is still one, as Rob says, where the health and housing departments have poor coordination. That is an area into which the national government could come and give some real leadership. Most of our administrations have no idea about what level of support is adequate for people learning to live with dignity in the community. In fact, I suspect they do not want to know because they will be told it is a lot of money. Therefore, what they provide is inadequate and, in a way, they set people up to fail. The whole question of well-supported accommodation is an issue that I think the federal government could do something about in terms of leadership. Nobody has done enough work to really validate what levels of support in terms of benchmarks are really desirable, so they are all acting

with a fair bit of ignorance about that. Inevitably, the level of support is inadequate and people are often set up to fail.

Prof. Hickie—Senator Webber, you have raised a critical issue. I think we have seen in presentations to the council and in senators and members of this parliament a great deal of bipartisan support for the issues. We have seen health ministers of various varieties commit over the years. There is a fundamental issue with accountability. There are times of political will in these 10-year cycles that we have spoken about. We do not have a national reporting system in Australia that reports back on a national level on a regular basis that provides us with a genuine independent view. We and others have argued for a national commission-like structure, a national reporting structure—such a structure operates in New Zealand and has over the last decade—to report back to the national parliament on progress independently. So we would not have benchmarks in terms of inputs but would have benchmarks in terms of the actual results of expenditure so that these processes would outlive the ministers.

In my brief three years as the CEO of beyondblue, I dealt with 13 different health ministers—on behalf of one national organisation. National organisations use up their time continually reinforcing the minister of the day, and that is just the health minister. In reality, we would argue that, because the AHMAC process of reporting to health ministers does not fundamentally oversee resources and it does not fundamentally work with the other key issues in employment, in education and in other areas of social security, it is doomed to ongoing failure. We think that we need a whole-of-government approach, that this is really a COAG issue in terms of leadership, but perhaps, even more importantly, that without a national annual accountability system we will be having more ad hoc inquiries, probably on a five- to 10-year basis.

Senator FORSHAW—I had a few questions I wanted to put to you, but they may be ones that will be covered when we see the report. If not, I will probably send them through to you on notice and we will hear from you again, no doubt, towards the end of our inquiry. You mentioned the two reports of the New South Wales and the Western Australian upper houses. I think the comment was that they were largely ignored. Would you comment on the value of those reports and whether we can take account of what they have recommended or what they covered.

Mr Wilson—I can answer part of that question, with respect to the Western Australian upper house inquiry. To be fair, it was only a preliminary report, and the committee disappeared when the parliament was prorogued for an election. So what the future of that is, I do not know. We can only hope that those who took the interest to get that inquiry under way may be able to reinvigorate it. The New South Wales situation is probably best addressed by Professor Hickie.

Prof. Hickie—We have a copy of the New South Wales report. They are all available and they can be provided. I think there are those with the Victorian Auditor-General et cetera. I think the issue is ad hoc inquiries in New South Wales have led to a response by the New South Wales government, so now there is a New South Wales set of responses. But, as we are told in the sovereign state of New South Wales, that does not mean they are going to cooperate with the Commonwealth's responses that affect people who reside in New South Wales. So, for example, they are responding on the mental health issues, but they are the lowest users of the general practice incentives that have been set up under the Commonwealth government. They are not a participant in beyondblue, the national depression initiative. So they see the New South Wales perspective for people who live in New South Wales as being the processes controlled by the

New South Wales government, and that is just within health. That is not to take account of the social security, employment and other issues that are actually relevant to the Australians who reside in New South Wales. Each of these inquiries in turn tends to focus on the mechanisms under the control of the particular health department or health minister within those states. As we were alluding to earlier, we think this is characteristic of the approach under the national mental health working strategy—to allow each state and territory to develop its own responses to its own inquiries, to its own processes, without actually agreeing about national outcomes.

Senator FORSHAW—The other area of importance—and there are a number of them that you have mentioned this morning—is the work force, and work force shortages. This is a big area. If you want to expand upon that in more detail or send further comments to us in writing, that would be useful. We are constantly hearing in other committees about shortages of nurses, and of doctors in rural areas and so on, but particularly in mental health care.

Prof. Hickie—There is a crisis in mental health, and it is well recognised. The deputy director-general in New South Wales, Richard Matthews, is recently reported to have said that, even if he had the money, he could not spend it because he no longer has the work force to hire. With the deterioration in systems and the demoralisation within those work forces, we have seen people exit those work forces—nurses are a highly sought-after resource in any health area. The number of services that psychiatrists provide is declining. The Commonwealth has data showing that there has been a seven per cent decline in services provided by psychiatrists since 1996-97 and a 49 per cent increase in the out-of-pocket expenses of seeing a psychiatrist.

When there is short supply, the cost of seeing those professionals increases. The distribution of psychiatrists in Australia is one of the poorest of any of the specialty groups. We have massive shortages on top of GP shortages in particular areas. At the same time, we do not use the psychologist work force in our health system. So we have a work force we do not use and we have major strains on our mental health nursing and medical work forces. But they follow from a deteriorated system of care.

In New South Wales only half the first-year training jobs in psychiatry have been filled in 2005. So not only do we actually have people exiting the work force; we no longer have people entering the specialist work force. It is a competitive area. So we have major work force issues. Again, the Commonwealth has had on its plate a number of reports, going back to the McKay report in 1996, about specialist work forces and the need to take action. We would argue that there have been no substantive actions by the Commonwealth to deal with the specialty medical work force crisis in this area, now compounded by nursing shortages, and only very small attempts to engage one of the biggest work forces available, which is the psychology work force.

Mr Mendoza—The Productivity Commission has an inquiry up and running into health work force issues generally. The council will make a submission to that, and we will be more than happy to table that to this inquiry.

Senator FORSHAW—I would be particularly interested in some comments about work force issues relating to community health teams as well. That is an increasing area of interaction, if you like.

Mr Wilson—It is. It does have to be seen as a federated health issue. As we know, the Commonwealth has a major input into the funding of training and the states have a major output in spending on the work force in services. To provide a parallel example to New South Wales, in Western Australia the state government has announced major new investment in mental health services. At the end of last year it sent a team from the department to the UK to recruit more mental health professionals. When they got there, they found that there were people from New South Wales looking for 2,000 nurses, and people from New Zealand looking for people. This is the short end of the stick, as it were, because this is now a crisis. There are shortages in this work force all over the world. As for recruiting people from the UK, quite often they are people who in turn had been recruited from the developing world who will not easily fit into Western style mental health systems. So all those concerns are raised. Their objective was to recruit 500 new FTEs for their new funding initiatives but, in every program budget they had, the major risk factor in not being able to put those services in place was the failure to recruit. We feel that a lot of those services will not happen because they will not be able to recruit. In fact, they are not only recruiting overseas but also recruiting people from existing services and they are not addressing the issue of what will happen to those services as a result of that. It is a critical issue.

In Western Australia the biggest response to that advertisement was from private psychologists wanting to apply for positions as psychologists in mental health services. Those people do not know what they are asking for, quite frankly, because they will find their terms of employment a little different from the ones they are used to. But there is no doubt that that is a major deficit and that the fees for accessing private psychological counselling are prohibitive for most people with mental illness. Burdekin made a recommendation that psychology services be brought under the Medicare provisions. No government has ever been daring enough to bring that into operation. They obviously think it will be a black hole of expenditure.

This is a crucial issue. The solutions are less forthcoming than the problems. Maybe some of the solutions are to do with a different kind of work force, other than knowing that we will never have enough psychiatrists, nurses or social workers. Maybe we have to be a bit more innovative in looking at the types of work force that could be made available. And of course consumers are saying, 'You have to start thinking about training and employing consumers as part of the work force.' They are going to be a very effective part of the work force because they are basing their care on their lived experience. That is a real objective that they have.

CHAIR—We need to wrap up shortly, but I will finish with one question. Do you have any advice for the committee—and, Professor Hickie, you have mentioned New Zealand—about where we should look to find better practice? Are there any countries where the disease burden matches the expenditure on mental health? One of the submissions today refers to Sweden and the model there for small-scale, community based care. Without going into lengthy detail about it, perhaps you can direct us to where we should look.

Prof. Hickie—There is evidence of different national expenditure patterns, particularly across the OECD countries. The European and Scandinavian countries on the whole have a better investment system. When you look to employment systems, as Mr Knowles has indicated, there are systems that are well worked out in terms of different employment arrangements. There is good OECD comparative data about the advantage of supported employment. The OECD makes a very interesting comment that supported employment programs on the whole do not make much difference except to intellectual disability and mental health, where they do make a big

difference. They have the key characteristic that Mr Knowles alluded to of the coordination over time of health care—since this is a changing disability; it is not a fixed disability—with the employment system.

Within the American system, if you look at some of the managed care systems or the capitated systems in terms of better treatment of people with anxiety and depression in other areas, you will see that where there is one funder holding access to services they tend to buy better services earlier to reduce their long-term costs. They are not national programs, but they are well-worked-out, capitated programs even within the American systems of care. I think the challenge for many countries has been to take their best models to best national programs. That has undoubtedly been a struggle. Probably the best outcomes at the moment are in Europe, in the Scandinavian countries.

CHAIR—Thank you so much. Mr Mendoza, you wanted to say something.

Mr Mendoza—The New Zealand Mental Health Commission is one model for an accountability structure. Also, British Columbia has a Minister for Mental Health who reports separately to the parliament. In the United States, President Bush has a commission reporting directly to him or to the Oval Office on mental health outcomes.

CHAIR—Thank you so much for your submission and for your appearance today. It has been really valuable to us. We do threaten to invite you back again, towards the end of the process.

Mr Wilson—We would not see that as a threat.

Mr Mendoza—It is just the questions on notice that we worry about!

[11.38 am]

BURGESS, Mr Mark Anthony, Chief Executive Officer, Police Federation of Australia

CHAIR—Welcome. Do you have any additional information about the capacity in which you appear?

Mr Burgess—The Police Federation of Australia represents all state, territory and federal police officers and the respective police associations in those jurisdictions.

CHAIR—You have lodged with the committee a submission which we have numbered 254. Do you wish to make any alterations or additions to that document at this stage?

Mr Burgess—Not at this stage.

CHAIR—I now invite you to make a brief statement. The committee will then go to questions.

Mr Burgess—The Police Federation of Australia, on behalf of Australia's police officers, believe that we have a legitimate role to play in this inquiry because, unfortunately, too often police officers in Australia have been either killed or seriously injured as a result of dealings with people with mental illness. In fact, only three weeks ago there was the tragic murder of Senior Constable Tony Clarke in Victoria, which is well recognised as a stark reminder of that to all of us. We argue that inappropriate services and the lack of services in mental health are putting too many mentally ill people in serious confrontations with police. We accept that police will inevitably be in the front line in looking after this issue in many respects because of the 24/7 nature of our service and the fact that we cover all states and territories and even the remote and rural areas of those states and territories. We also accept that there will always be a clear role for law enforcement in emergencies where people with mental illness are posing a risk to themselves or others.

However, there are numerous examples across the country of police officers being inappropriately used by health departments, generally due to lack of staffing in those departments or, unfortunately on some occasions, due to a general disregard for the role of police. Many examples were given to me, whilst I was preparing my submission, of police having transported persons to hospitals only to be told that there are no beds available or, alternatively, having doctors refuse to schedule those persons. Police are then left to deal with them. If there has been no criminal offence committed, what are police to do? Generally, police do not have powers to detain such persons—should they just return them to the wider community?

Whilst we are not suggesting that the deinstitutionalisation policy be reversed, we do believe that a proper and thorough assessment should be made of persons with mental illness before they are released back into the community, as oftentimes they are, with little or no support—as I think previous witnesses have said. There is a lack of adequate access to services for mentally ill people once they are released from many facilities, particularly after hours. Of course, that

becomes another problem for police. Under current arrangements, a significant percentage of high-risk patients are still being let out of those facilities. Unfortunately, many of them are let out straight into the path of police. There is a general lack of security arrangements in hospitals where mentally ill persons are conveyed for assessment, particularly in rural and regional areas. Police complain that, when they transport a person to a hospital for assessment, doctors often leave that person till last to treat, because they feel safe because a police officer is sitting with them. That simply delays police in returning to their normal work duties.

Another significant problem for police that is mentioned in our submission is the transport of mentally ill people. In many areas police are still being used for interhospital transfers; we believe they should not be used unless there is a safety issue attached. The police vehicles that are used are not suitable for that type of transport—they do not have suitable restraints and there are no professional carers to accompany the person being transported by the police. In some states—I can give you the example of Western Australia—police might sometimes have to transport people thousands of kilometres. It is totally unsuitable.

In rural and remote areas there are even more limited resources in the health sector, and police are being used because they are the only service available 24 hours a day, seven days a week. The use of police in these situations deprives the rest of the local community of their policing service. The only other option is, therefore, to call out other police on overtime, which is a significant burden budget-wise on the local police command. Situations often arise where police are required to take a person to a hospital for assessment when they know that actually that person should be transported directly to a mental health facility. In those situations police are again generally required to wait for an assessment to take place. Even if police are allowed to leave—if the doctor says, ‘Yes, it is okay for you to go’—invariably they get called back to then take the patient from the hospital to the mental health facility. That means that normal policing patrols are diverted to dealing with mental health issues when it is in fact not our core business. Unfortunately, police officers are then, when they turn up to a job that has been outstanding for several hours, subsequently confronted with hostile members of the community who wonder what they have been doing in that time. In fact, they have probably been sitting around in a hospital ward somewhere guarding someone that perhaps they should not have had to.

The committee asked earlier if there was anything I wished to add to my submission. There is one issue that I think should be added to our recommendations—perhaps included at recommendation 10. That is, where a mentally ill person cannot be transported in a dedicated mental health ambulance or by some other health service provider and police are required to provide such transport, then it should be undertaken on a cost-recovery basis from the health department. As I said earlier, all too frequently we are finding that, particularly in regional and remote areas, police officers are being called in on overtime to carry out such transfers; that cost burden is placed on the police as opposed to the health system.

In conclusion, we argue that the majority of issues raised today and in our submission require a long-term commitment from all levels of government. I think that is certainly what the witnesses who appeared earlier today were saying. There needs to be funding for more beds in hospitals and mental-health facilities, more staff, better-resourced community support programs et cetera. We believe that doing that will take away many of the burdens currently confronting police officers around Australia and will shift the responsibility to health departments, which should be staffed by well-trained mental health professionals. I am sure, as this is the first day of

hearings, that there will be many other issues raised in respect of the role of police. If there are issues raised that we want to respond to, we will seek an opportunity to respond either in submission form or in person at a subsequent hearing, if that is possible.

CHAIR—Indeed. Mr Burgess, your submission shocked me. I understood that around the country there were crisis assessment teams that were responding to the kinds of situations you describe. It is my subsequent understanding that Victoria is in fact the only state that has taken up that service option. Can you give us some response to the question: are the states all doing this differently and is Victoria now pulling back from that as a way of dealing with the crises you now deal with?

Mr Burgess—I think, with all due respect, that a lot of this is in fact just a cost-shifting exercise onto police. It is far easier to call out a police vehicle that is available 24 hours a day, seven days a week in all parts of Australia. And invariably, as I said, the situation is that when someone in the community sees someone acting irrationally and in a way that is likely to do harm to someone else in the community or harm to themselves, they do not go to find a number for a mental health facility, they actually ring triple 0 and police are the people who respond. The difficulty is that we are finding that police end up in the front line and many of these services that are supposed to be available are not available 24 hours a day—they are certainly not available in regional and remote areas in the numbers that they should be—and invariably police have to pick up the pieces.

CHAIR—Do you ever approach a CAT team and they are unwilling to come, for whatever reason, and what do they say to you?

Mr Burgess—It is a bit hard to answer, because I am trying to talk on behalf of eight jurisdictions as such. All I can say is that the general perception is that the police believe that, by and large, it is under-resourcing that causes the problem. Unfortunately, there are situations where it appears to be just a general view of some in the health system to say, ‘Who cares—we will just pass it on to the police.’ By and large, the perception I get from people I have spoken to since we started putting together this submission is in fact that it is a general lack of resources that causes the problem and invariably police are the only ones left to pick up the pieces.

Senator HUMPHRIES—Obviously the answer to this question varies from state to state, but what level of training do police typically receive to deal with mental illness or mental dysfunction?

Mr Burgess—Again, it does vary from state to state. You people would already be aware that the New South Wales parliament held an inquiry in, I think, 2002. One of the submissions made to that inquiry was from our New South Wales police association, which recommended an upgraded level of training. My understanding is that an inquiry is about to start in South Australia. I am sure that will be an issue that will be raised down there as well. It does vary from jurisdiction to jurisdiction. In our submission we said that we believe that training is inadequate, that it should be improved. Having said that, we are also mindful that the more training police receive the more opportunity there is for some to say, ‘They’re well trained, let them look after it.’ We are very conscious of that as well. Police are not mental health professionals—they should not be considered mental health professionals—but I agree they should have a level of training that allows them to at least try to deal with people in the first instance.

Senator HUMPHRIES—You trained as a policeman?

Mr Burgess—I am a police officer.

Senator HUMPHRIES—In which state?

Mr Burgess—In New South Wales.

Senator HUMPHRIES—I assume you trained some time ago.

Mr Burgess—Yes.

Senator HUMPHRIES—Did you get any instruction on how to deal with mentally ill people at that stage?

Mr Burgess—Very limited. I worked for quite a time at a police station that had a mental health facility located behind its back fence. I could not begin to tell you the number of jobs that I did—very difficult and dangerous jobs—dealing with those people. It would not have mattered what sort of training I had back at the police academy—every job was different, every person I dealt with was different and every circumstance was different. I am not telling you people anything you do not already know. Certainly we would suggest that there needs to be an improvement in the level of training for police in the area of mental health, without trying to push the burden for looking after those people onto police because you give them that extra training.

Senator HUMPHRIES—You mentioned the problem of police taking a person who is obviously in serious trouble to a hospital emergency department or to a doctor, perhaps, and not being able to get them treated because the doctor says that the person is not mentally ill in the sense that they can prescribe some kind of a regime for them or whatever. The police are left with a person who is obviously off the rails, who is not being admitted to the health system and who has not committed a crime, so they cannot be charged and put into a lock-up. Do you feel in that circumstance that there is some benefit in having a kind of protective detention capacity—a bit like the sobering up facilities that exist in some states—where a person can be put into a secure facility with, say, a nurse overseeing them to make sure they are safe until an episode passes? Is there value in that sort of option being available?

Mr Burgess—I think there would be. One of the great difficulties that the police confront in all of this is exactly the situation you have described. The medical staff say, ‘We are not prepared to accept them. No criminal offence has been committed; they are your problem.’ We have had many instances where police have made a decision at that time as to what they might do—whether they might return the person to somewhere or drop them off somewhere et cetera—and subsequently another incident arises and an investigation takes place, which oftentimes takes years and years to finalise, where the fingers of blame are pointed back at the police officers for the actions they have taken. Anything that is going to assist police to find someone who has some sort of professional responsibility for those people is worth investigating.

Senator FORSHAW—Thank you for your submission, Mr Burgess. You have raised some very good points and issues there. You state at page 4 of your submission:

In all jurisdictions police are given wide-ranging power to intervene in the lives of the mentally ill and mentally disordered by virtue of the respective Mental Health Acts.

You have also highlighted—if I can paraphrase this—that around the country there is a lack of consistency, if you like, between the states in terms of the decisions that a police officer may have to make when they are dealing with a mentally ill or disturbed person. Are you able to say that any one of the states has got it right or nearly right? Is there a model of which you could say, ‘If this were applicable across the country then our association and all the members of the various state associations would feel more confident.’

Mr Burgess—I am not in a position to say that, unfortunately. I am not trying to suggest that the respective acts are totally inadequate either. But I think there is an opportunity here. Each of the jurisdictions takes this seriously enough that by and large the person who has carriage for these issues in each jurisdiction is generally a person at assistant commissioner or deputy commissioner level. They take it quite seriously. The ones I have spoken to have indicated that there are certain aspects of their individual acts that might not be replicated in other acts. I think this is an opportunity, perhaps as a result of this inquiry, to have those people sit down and try to develop something that might look like an act that might be applicable, particularly regarding issues concerning police, across all jurisdictions. I am not aware that it has happened, but I would be surprised if this has not been discussed at commissioners conferences or police ministers forums. Like most of the acts that we have across Australia, there is a general lack of consistency.

Senator FORSHAW—Is that applicable generally for policing and is it a problem in the sense that someone might say, ‘If it works in our state then it doesn’t have to be the same as it might be in another jurisdiction’?

Mr Burgess—The whole issue of legislation in respect of law enforcement could be more refined to try to develop a more generic approach to it. Even on issues of DNA testing, which is more recent, we have developed model legislation but when we really got to the crunch various states enacted different legislation, which caused problems. I think that this is an opportunity to perhaps develop, as you said, some model legislation, particularly as it applies to the police. I am not talking about other areas of the Mental Health Act; that is for other professionals to comment on. But, particularly as it relates to police, this is an opportunity to develop some model legislation and try to have that enacted in the best interests of all the states.

Senator FORSHAW—I have heard anecdotally and in some other inquiries—they were not directly into mental health, as this one is, but they dealt with similar issues—that, because of the restrictions imposed under the Privacy Act and the nature of the summary offences legislation, the police service—even though, as you say, they are being called on as the first line of people to get involved to deal with a particular situation—sometimes feel that they are up against a barrier that prevents them from taking some form of action that they would have taken in years gone by. For instance, I refer to taking a person into custody or some form of custody when they presumably have not committed some offence. Are these real concerns of your members? Do they cause problems in how your members respond?

Mr Burgess—There is a whole range of things. We understand that there is work being done, but we do not know for how long it will be done. There are things like a common Criminal Code

et cetera. We are realistic enough to know, as I am sure you are, that we are a federation of states and that states will have different views on different aspects of legislation. We have seen model legislation—the DNA legislation was a perfect example—developed by the Commonwealth but ultimately what was enacted in each state was somewhat different. Therein lie some of the difficulties that we face, particularly when we are dealing with issues where you might cross borders.

Senator FORSHAW—I was going to come to that type of issue. A similar problem was raised in another inquiry by another committee of this parliament some years ago which I was on. It looked at consulate services overseas and the difficulties faced when they may be trying to find a missing Australian who may have a history of mental illness. If that person said, ‘I want my family to know where I am,’ that created certain blockages. You have commented on dealing as a first line of response with individuals who may be suffering a mental illness or disturbance but in a lot of situations you would, I assume, have contact with family members and with people who may not just be exhibiting some signs of a mental disturbance but are engaging in other activities that might have illegality attached to them—for instance, substance abuse, assault, abusive language and all those sorts of things. Could you comment on how those situations affect your members, particularly if they have to deal with a family who are trying to figure out how to handle a member of that family who is having an episode?

Mr Burgess—One of the biggest difficulties of being a police officer full stop is people’s expectations of what your powers really are—for example, their expectation that you can actually do some things when in fact you cannot.

Senator FORSHAW—That is what I was getting to.

Mr Burgess—That often leads to people making complaints against police for inaction when in fact the inaction is the police saying, ‘The law says I can only do that; I cannot go any further.’ That does create some difficulties for police officers. In the area of mental health, that is just one, but there are many others. People expect that the police have powers to move people along at their whim and so on. That just does not apply. So people complain because the police do not take a certain course of action whereas in fact they do not have the power to do that. There are a lot of difficulties in all these things, not the least of which is the mental health area and dealing with the families of people who are affected.

One of the other things we raise is that transport issue. Invariably, if it ends up that the police have to transport the mentally ill, there is that stigma attached to someone being taken almost into custody and placed in the back of a police truck when in fact they are ill; they have not necessarily committed an offence, particularly if it is at a family home or somewhere like that. Those are the difficult things that police and families have to contend with. They often generate complaints about police action but we have no opportunity to do anything else.

Senator FORSHAW—Say a situation arose in a family home and the police were called. If there was obvious evidence that the person was suffering from some mental illness, would a police officer contact a medical practitioner or a medical service at that point? Do they automatically say, ‘Take them to the hospital,’ as distinct from maybe seeing if a GP could go to the family home? Do they just turn up at the hospital emergency door, which has all of its other problems going on at the time?

Mr Burgess—Each situation is different. It would probably be a completely different response if it was two o'clock in the afternoon or two o'clock in the morning, because it would then depend on the availability of people to be called out.

Senator FORSHAW—You talk about this in your submission.

Mr Burgess—Yes. With all due respect, most agencies shut their door at five o'clock of an afternoon and on Fridays they do not reopen again until nine o'clock on Monday. The police are available. There are even more difficulties when you move into regional and rural areas, particularly remote areas. It is hard to say what you would do in each circumstance. There are differences as to what you could do, depending on where you were. If I were in the middle of Sydney or country New South Wales, things would be vastly different depending on whether it was two o'clock in the afternoon or two o'clock in the morning.

Senator TROETH—I would like to go back to the issue of the critical incidents involving police and mentally ill people where, unfortunately, the mentally ill person has possessed a weapon and the police have had to open fire or otherwise take action. I sympathise with the very unfortunate views expressed by members of the public on this sometimes because the police are in an invidious position. They have to take action and, unfortunately, it is often to their detriment, from the public viewpoint. Can you tell me how that is addressed by the various jurisdictions at present? Can you give a snapshot of what happens at the moment? Has that approach changed over time? I think these incidents go back some years. Has there been any modification or change in the police approach over that time?

Mr Burgess—One of the things that have taken place over the last number of years has been adopting an approach to try to look for non-lethal weapons, for example. Some years ago a police officer had a baton and a gun and, depending upon the seriousness of the situation, they used one or the other. All police jurisdictions now have access to pepper spray and capsicum spray. A number are now moving to the use of the Tasers and so on. Those things are all beneficial. Just recently somebody asked me the question: 'How come that incident happened like that and this was the outcome?' Having seen some of those incidents, I can say that every one is different. Obviously the police officer is concerned for their own safety but, in many of these incidents, they are also concerned for the safety of other people around, particularly if they are in a family home. If they have a weapon the situation can become very difficult to manage. I think there is a move to equip police with non-lethal weapons and in the long run that will be very beneficial. Unfortunately, some of these incidents will still arise.

Senator WEBBER—I return briefly to the issue you raised earlier about transportation. I picked up what you said about my home state of Western Australia, which has unique difficulties. I am aware of a couple of instances when the police have been involved in transporting people with a mental illness from a remote part of our community to service provision, which is usually in Perth, because of a lack of willingness of other service providers.

In this case I am thinking about the Royal Flying Doctor Service. When I was up in remote Western Australia and someone had an episode in a hospital and had to be transported, they did not want to take that person, even though the police officer and the nurse on duty said they would accompany them on a plane. That meant that one of the two police officers in that town had to drive to Perth for four days in an inappropriate vehicle for someone who was just ill rather

than having committed a crime. Are you aware of other instances where the police have to do that because of unwillingness of other service providers?

Mr Burgess—I think that is the case. If the person has a tendency for violence or those sorts of things—I am not sure of the situation you talked about—I suppose there would be a reluctance to place a person who was potentially extremely violent into an aeroplane.

Senator WEBBER—We thought we had that covered by having a police officer and a medico there to sedate them, but apparently not, according to the service provider.

Mr Burgess—You can probably understand the pilot's perspective on that as well. I have some information from Western Australia. I have been talking to them particularly about this issue. In a state like Western Australia the vast distances are a real issue. They are saying to me that they are travelling, in some instances, thousands of kilometres, as you say—not hundreds but thousands. It is an enormous task, and it is being done by police in inappropriate vehicles with no mental health professionals there. If something happens on the way, who is there to assist? There is no-one. It is not right for police and it is not right for the patients. Western Australia and Queensland do promote significant problems.

CHAIR—Could I ask you about the two other circumstances where I can imagine the police are involved, which you do not mention in your submission. The first would be to attend the scene of a suicide. Can you confirm that that would be the case. Many suicides are of course related to mental illness. The other area is police involvement in the prosecution of people who have committed crimes or who are suspected of committing crimes. Given the overrepresentation in our criminal justice system of people with mental illnesses, what sort of training is there in that environment for the police to acknowledge, recognise or take account of the mental health state of someone?

Mr Burgess—If you are talking in the first instance about somebody who has committed suicide, if a suicide occurs then police are required to attend. Obviously it is a death and at that stage no-one can say it was suicide. Police attend and investigate. That is clearly the role of police. If you are talking about someone that is threatening suicide—

CHAIR—In all the circumstances around suicide. Firstly, I imagine it has a big impact on your members.

Mr Burgess—Any death does. This is another area of problems for police that we are having debates about in other areas of government—that is, the continued exposure to police officers in those critical incidents of death and mayhem. We are dealing, often, with talking to families of deceased people, be it by motor vehicles, suicides or whatever. It is a real issue for police officers, particularly oftentimes with young people—when police officers have young families themselves it is very difficult to deal with. We have a range of major concerns about the long-term impact of that on officers, the post-traumatic stress aspect of that, particularly for some types of officers. For forensics services type people, for example, it is their job to attend, photograph and investigate those matters. That is pretty much what they do. So you can imagine a long-term exposure to those types of things has a pretty significant impact on them long term. Many of those people end up being forced out of policing through psychological disorders themselves.

With respect to matters at court, about our prosecution, it depends on the circumstances of the matter. When a person has committed an offence and they are taken before the court, if it is a plea of guilty then the arresting police do not normally have to attend. But if it is a plea of not guilty and there is evidence that has to be given then the officers themselves obviously do have to attend. If you are dealing with someone with mental illness or some illness then of course they will not only take a dislike to the police officers who arrested them in the first place; now it is the police officer who is giving evidence against them and is likely to see them incarcerated or undertake some other form of penalty. I am not sure if I have answered your questions.

CHAIR—If, for instance, you or your members find yourselves caught in the difficult situation where a crime has clearly been committed but you can see that the person has a mental illness, does that evidence become admissible? Is that something that is discussed in the courts at that point?

Mr Burgess—Yes. Each set of circumstances is dealt with differently but, by and large, a magistrate would have the power to have a person assessed if there was some concern that the person might have a problem—a mental illness, for example. So it might be that the person might appear in court. A lot of these people have no fixed abode, they are wandering at large, so they might be arrested and perhaps even refused bail overnight to appear in court. If there is any concern by police, the magistrate or whoever, then their defence, the court solicitor, might say that the person should be assessed. There would certainly be the ability for the offences to be dealt with in a different way than through a criminal process if the person were found to be suffering from some mental illness.

CHAIR—My question was about the training that police have in making those assessments. In your submission you speak about the problem with assessments, but it seems to me that your officers would in many cases be required to do some sort of assessment themselves.

Mr Burgess—They do—you are right. One of the earlier questions from Senator Humphries was about the training that police are given. We are not mental health professionals. With all due respect, one of the difficulties is that unfortunately a lot of these people are, more often than not, under the influence of alcohol and other drugs. That complicates the matter all the more. In fact, when you get them to hospitals that sort of thing is almost an ‘out’ sometimes, I suppose, for even professional staff to be able to say: ‘This person is under the influence of drugs or alcohol, so how can we assess their mental state?’ When mental health professionals have that problem, you can imagine the problems that arise for police. It is very difficult to deal with some people like that because you are not really sure whether it is drugs or alcohol or whether these are the symptoms of underlying problems, for want of a better term.

CHAIR—I would like to press this point a bit more. We heard from the previous witness that people go out and deliberately put themselves in a position where they will be given another jail term. They will smash a window, walk in front of traffic or whatever in order to be picked up and put back in prison, because that is where the services will be. I guess that these people plead guilty, so the police do not go on to be part of that process. Is that correct?

Mr Burgess—That is right. There is no doubt that there are people who use that tactic. We often used to say that a lot of the people who had no fixed abode used to do those sorts of things coming into winter so that they would be incarcerated over winter and would not have to live on

the streets. That is something that used to occur. So I am sure that that happens. The other step they take, which we have not talked about as much, is 'suicide by cop'. There is one group who commit an offence because they know we are going to lock them up. There is another group who say, 'I want to end it all, and the way I am going to do that is to have a police officer kill me.' That is another big difficulty for police officers. As I said in the submission, when those sorts of things happen to a police officer, sometimes they never recover. They have to wear it for the rest of their life. Many times they exit from policing because they cannot cope. It is one of those things where you will always think: 'If I had done something different could this have ended differently?' But we are not to know. These are the difficulties that police officers face in these situations.

Senator FORSHAW—What information about an individual is a police officer able to access if they know who that individual is and suspect that there may be a history of mental illness? I am talking about the immediate stage.

Mr Burgess—I cannot give you the answer for every jurisdiction, but when I was working you would have things like warnings coming up. There are a lot of privacy issues now—

Senator FORSHAW—Yes.

Mr Burgess—and therein lies the problem. I think we say in our submission that perhaps some of those databases might be best kept within the health system but accessible in some way, shape or form. No doubt it is like a police officer going to a house knowing that there are weapons registered to those premises; it is certainly going to make them think about the way that they conduct their inquiry from then on. If you were dealing with a person and there was a warning that this person had a propensity for mental illness and for violence towards police, then obviously you are going to be very careful about how you deal with them. That is the reality. So we think that there needs to be some recognition of how that information is recorded, taking into account the privacy provisions but ensuring that a police officer or a mental health professional who turns up actually has that information at hand so that they can conduct themselves in a way that looks after their safety and the safety of the individual they are dealing with.

Senator FORSHAW—Are you saying that your members are not able to access some sort of database? Let me tell you very quickly that members of parliament and senators occasionally get people contacting us, coming to see us or whatever. I had one instance where a person was making threatening calls and, when we contacted the local police station, they knew straightaway that that person had a history, if you like.

Mr Burgess—Because I could not give you an answer for every jurisdiction as to the way it is recorded at the moment, I would be happy to take that on notice and come back to you on the details of how and if that is recorded in each of the jurisdictions. Because you are right: as we say in our submission, that is an important issue not only for police but also, we suggest, for other mental health professionals—that there is some database to assist us in dealing with these situations so that we can take the appropriate course of action when we first arrive at the scene.

CHAIR—Thank you, Mr Burgess. Your perspective has, I think, opened up big questions about the delivery of services, so please pass on our thanks to your association for making the submission and thank you for appearing today.

Mr Burgess—Thank you very much.

Proceedings suspended from 12.16 p.m. to 1.24 p.m.

GRIFFITHS, Dr Kathleen, Senior Fellow and Director, Depression and Anxiety Consumer Research Unit, Centre for Mental Health Research, Australian National University

CHAIR—Welcome. Dr Griffiths, you have lodged a submission with the committee, which we have numbered 186. Do you wish to make any amendments or alterations to that submission?

Dr Griffiths—No.

CHAIR—I invite you to make a brief opening statement, after which we will go to questions.

A PowerPoint presentation was then given—

Dr Griffiths—Thank you very much for inviting the Centre for Mental Health Research to appear before the committee today. Unfortunately, our director could not be here. She is in the United States. She tried to change her travel arrangements but was not able to. So she extends her apologies for not being here.

As the Director of the Depression and Anxiety Consumer Research Unit, it might be worth while my explaining very briefly what the name of that unit means. We set the unit up for people who, in addition to being qualified and experienced academics—some of us at least were already in the centre as academics—had experienced a mental disorder, a depression or an anxiety. So we are both consumers and academics—academic consumer researchers. It is a different perspective.

I would like to give a brief presentation—firstly, to outline the background facts that will inform the terms of reference addressed in our submission; and, secondly, to address briefly each of the terms of reference: e-technology, the role of primary care, prevention, detection, chronic care and mental health research. It is not that I do not know my alphabet, but rather that is the order it makes sense to present them in.

Firstly, some background facts. I am sure that everybody here is highly aware that depression affects one in five people annually. Depression is a major cause of disability. In fact, depression is the leading cause of disability in Australia at the moment. Mental disorders are the leading risk factor in suicide. Mental disorders affect work force participation and cause a huge amount of cost to employers annually through absenteeism and lost work productivity. There are also the significant effects on the mental health of the families—the care givers—who look after people with mental disorders.

One of the really serious problems is that most Australians with a mental disorder do not receive help. Sixty-eight per cent of people with a mental disorder do not receive help. When they do receive help, it is typically not what we would call evidence based help—that is, supported by scientific evidence. So the question is: why not? One of the reasons is that community knowledge of mental disorders is poor. We have done various studies to show that—although our most recent study suggests that it has got better in the last seven years, particularly in those areas with high exposure to beyondblue messages. So it does look as though education in that respect has been affecting community knowledge.

The idea of course is that, if people in the community have knowledge about a disorder, they can seek help earlier because they can recognise it and they know what sorts of treatments are appropriate so that you get a bottom-up feed to the doctors and so on. People can go to the doctor and say, 'I think I am depressed.' That makes a difference. There is evidence that that makes a difference. If you go to a doctor and say that, you are more likely to get an appropriate diagnosis.

Another reason that people do not receive help is lack of access. There is simply not the same sort of access to services and so on in rural and remote areas as there is elsewhere. Many people prefer psychological treatments, such as cognitive behaviour therapy—and I will come back to that a bit later—but they are not widely available and they are costly. Then there is the issue of stigma, which is a really serious problem. Stigma can actually stop people from seeking help. We have recently done some research to show that link quantitatively. The illness itself can prevent people from seeking help as well. If you have social anxiety, it will be difficult for you to roll up and get help. If you have depression and are withdrawing from the world, the same thing applies.

Going back to stigma, we have recently done a nationally representative survey of stigma and it is still a serious problem. There have been no previous national surveys of stigma; this is the first. I have selected one of the items here, which is people's willingness—or unwillingness in this case—to closely work with someone with a mental illness. When you ask that about depression, or a little vignette about somebody who has depression, 21 per cent of people say that they would be unwilling to work closely with somebody with depression. There has been a lot of talk recently—since the budget, for example—about getting people who have mental illnesses back into work. Obviously that is terrific, but I have not heard as much talk about what they are going to face when they get back to work, if they can get a job, because one in five people are not going to be willing to work with them if they have depression. The figure goes up to 34 per cent if they have schizophrenia.

The figures in brackets refer to what people think other people would think, so about 70 per cent of people think that other people would not be willing to work closely with someone with depression. It is hard to know the cause of that discrepancy; it may be that this is an underestimate because there is a social desirability aspect, but I doubt that the figure is this high. There is this implication in there that we should also be educating people—that perhaps their perceptions overestimate the stigma around. Still, it is a very significant problem. I thought you might be interested in what the figures were for voting for a politician with depression. About 30 per cent of people said they would be unwilling to vote for a politician with depression and up to 46 per cent would be unwilling to vote for a politician with schizophrenia.

What can be done about all these barriers and problems that I have just outlined? We would contend that e-technology offers an unprecedented opportunity. There are quite a lot of advantages to internet technology. Firstly, it is anonymous, so it circumvents that problem of stigma. Secondly, it is accessible to rural and remote people. It is available 24 hours a day, seven days a week. Somebody on one of our internet services said, 'When you want to talk, you want to talk.' I think that sums it up. It is effective and cost-effective—there is evidence of that. It can be, at least, engaging, especially for young people. Very importantly, it is empowering and that can enable consumers to help themselves and manage themselves. That is the direction we are going with health in this century. It has the potential to facilitate continuity of care and stepped care.

Is it practical? We know that in 2002, about 60 per cent of people had access to the internet. The ABS does not have more recent figures, but no doubt it has gone up since then. A large percentage of internet users who seek information do seek information on health when they go to the web. Young people are particularly heavy users of the internet. In fact, mental health is often something that people seek when they seek health information on the web. So if you actually look to see what people sought the last time they were on the web looking for health information, what comes out on top is depression. Depression is the most common reason why people seek health information about a health condition. As you can see, it is above cancer and certainly above heart disease. Bipolar disorder and anxiety are others. They are all in the top series of conditions that people seek information about. So it is what people want to do, which is a start to thinking that this is a good thing to be doing.

I would like to briefly go through examples of the value of the internet in mental health by citing work that we have been doing at the Centre for Mental Health Research. There is other work going on; Australia is quite a leader in e-health. Since mental health literacy—people's understanding of mental health—is low, we have developed a consumer web site called BluePages, which is an evidence based information site about depression. It is written at year 8 level so that it is very easily understandable.

We also know that cognitive behaviour therapy, a sort of talk therapy, works for depression, but it is not widely available and it is expensive. You do not get as much CBT in rural areas. So we developed MoodGYM, a CBT program delivered automatically online. These web sites definitely look pretty, but the question is: do they actually help people? We have 18,000 people a month coming to MoodGYM and about 7,000 coming to BluePages. But do they help? We conducted a randomised control trial—the gold standard for looking into whether things work in medical conditions.

We compared BluePages with MoodGYM and a control condition, where people got exactly the same amount of attention but did not get the web sites. We had 525 people from the community in this trial with depressive symptoms. Essentially we took a random sample of people from the community. What we found was very interesting. We found that, yes, these web sites did work for decreasing people's depressive symptoms. This slide shows the level of depression before using the web site and after using it. This group over here is the control group. You would expect a little bit of improvement in anybody with time and there is a little improvement—with no treatment, people do finally, sometimes, get better. We found a dramatic improvement with BluePages and, similarly, a large improvement with MoodGYM. It did have the effect of improving depressive symptoms in the people that used it.

This slide shows the level of people's knowledge—their depression literacy, what they understood. As you might expect, you find no changes with the control group: they did not receive any of the education. But we found a major change with BluePages, the evidence based information. I think 18 is the top mark you can get, so essentially you have a huge improvement in literacy for the BluePages group. So they do work. The other thing we looked at was personal stigma, the sort I just referred to concerning what people thought about certain things to do with depression. We found that, essentially, both MoodGYM and BluePages decreased somewhat the personal stigma in people. It was not necessarily something that we would have anticipated would happen, but it did. So that was a pretty important finding too. There are not too many randomised control trials anywhere in the world looking at those sorts of issues.

We now have some offshoots of MoodGYM and BluePages. We have MoodGYM GP. We are doing a trial in general practice, looking at what happens with MoodGYM and whether or not we get the same results as we did with the community trial. We are looking at MoodGYM in schools and whether it helps year 10 students. We are funded for doing that for the next two years by the Vincent Fairfax Foundation. We are looking at doing a MoodGYM pilot at the moment with the National Australia Bank. We have a partnership with Lifeline. Lifeline counsellors will be doing a randomised control trial. They will be administering either MoodGYM or BluePages, and we are going to compare that with what happens when they do not. We have collaborations around the world. One that has got going is looking at the effect of MoodGYM on traumatic brain injury people with depressive symptoms. We have some collaborations about to start overseas looking at the effect on university students and medical students. One of them is in Norway. They have just got the funding to do that. We will get a translation of MoodGYM into Norwegian. We are doing changes to the interface so that we will be able to develop different MoodGYMs for different languages. Hopefully, that will then extrapolate to culturally and linguistically diverse people within Australia.

At the moment, we have in development, which is funded by beyondblue, something called e-couch. E-couch is the step after MoodGYM. Basically it involves a site tailored very much to the person's individual needs—for example, if they are unemployed, if they are ill and depressed because of that, if they have been divorced or have postnatal depression, they go through a different stream. We give them tools like cognitive behaviour therapy and a whole range of other tools—exercise, relaxation and so on. We are designing this so that it is extendable to other groups and we can add on, for example, pathways for looking at helping people from rural and remote areas.

Another development we have is BlueBoard, which is a self-help online bulletin board for consumers. It provides support, and many people comment on how supportive and understanding the board is. It is very clear from the repeated comments they make that BlueBoard is like a constant supportive workshop. It is available 24 hours a day, and that is important. It is a source of learning and information. People say it has helped them to learn new information. It is very clear when you track through it. It is important for rural and remote Australians, according to the people who use it. It is important, as I mentioned, where mental illness itself is a barrier to access. One person said, 'I found BlueBoard a place of support when I was unable to make contact with the outside world. Our illnesses make it very difficult to keep relationships healthy due to the misunderstanding of mental illness, but that is never an issue here on BlueBoard.'

It is excellent for people with social phobias because it gets them talking to people and they can use the same techniques out in the real world. It is also quite clearly non-stigmatising, and people say it has actually assisted them in their recovery. One person said that it helped him even though his previous psychiatric help was failing. Another person said that she was on unemployment benefits but with the help of non-medication sources such as BlueBoard and AA she now works part-time at \$22 an hour, which considerably reduces the amount she draws on her disability pension, and she pays tax. She feels like these things have made her a valuable taxpayer, not to mention what it has done for her personally. It is complex but you can make these boards safe with the right sort of moderation.

They promote seeking help. A 19-year-old male came on a few days ago and said, ‘I’m certain I have depression but I’m too afraid to see my doctor about it. I have had pretty bad social anxiety all my life and I’m too afraid to make an appointment with my doctor. I’ve talked to my friends and they say there’s nothing wrong with me, and that’s probably what the doctor will say. I know it sounds stupid but how can I work up the courage to see someone about this?’ Then all the people in BlueBoard came on, made suggestions to him and encouraged him to seek help. We are also in the process of developing a support network for mental health workers in rural and remote areas, because they get very isolated. This is a joint initiative with the Centre for Rural and Remote Mental Health in New South Wales. It is a clearing house but also a forum where professionals will be able to share their concerns online. That is in process.

Our next step is looking at online chronic disease management systems, incorporating tracking, stepped care, detection, prevention, support and treatment. It is in the planning stage at the moment, but we are doing this planning in collaboration with CSIRO and we are very serious about it. Our recommendations were that it was important to establish an e-mental health research service and policy centre, and we think that could be built on ANU’s expertise and collaborative links; to support the development of a youth portal and e-based chronic disease management systems; and to develop e-funding models. One of the problems is that, if somebody wants to get a consultation over the Net, there is no funding mechanism for allowing that through, say, Medicare.

The next term of reference that we would like to address is the role of primary care in promotion, prevention, early detection and chronic care management. Our main point here is that obviously general practice is the linchpin, but it is really important to involve a range of agencies and not general practice alone. You can make these interventions which have implications for prevention, early detection, early intervention, management and so on. You make them in the family, workplaces and schools. Lifeline is really important. They get people calling up multiple times, and you even find doctors who refer people to Lifeline for ongoing support. Public health campaigns such as beyondblue are also obviously very important for all of these matters. That is the message we wanted to give about that.

Let us not forget internet resources. You can do a whole of lot of things, like online screening for early detection, and you can encourage referral to formal services. Also, just as you can do risk profile assessments for heart disease you can do them for mental disorder—we are working on it at the moment. For example, statistically, what would happen to your risk of developing depression if you exercised? As I have mentioned, you can also provide interventions and chronic disease management systems.

The final term of reference was around the current state of mental health research—its funding arrangements and so on. According to the Access Economics report that was done recently, mental health research receives three per cent of the health research funding budget but accounts for a much greater number of disability years. The other thing is that mental health does not receive any of the \$45 million from the Commonwealth public health and education research program, or PHERP, funding. There are not any centres of excellence or CRCs in mental health research that are Commonwealth funded apart from the Australian Centre for Posttraumatic Mental Health, which receives DVA funding. There is no private foundation specifically supporting mental health research, but AFFiRM, which we have established, is gaining some profile.

It seems like mental health research is underfunded with respect to overall medical research funding. Another question, though, is that of funding within mental health itself. Are there areas that are particularly neglected within mental health? We were commissioned to do a study on that by the Commonwealth. We analysed Australian mental health publications and grants according to the type of disorder, the type of research, the topic of the research and the setting of the research. We then compared direct health costs, disease burden and prevalence, and stakeholder priorities—all those criteria—with those publication outputs and grants inputs.

The conclusions of the report were that the disorders that were underrepresented with respect to those standards were depression and suicide. The topics that were underrepresented were prevention and promotion, psychological interventions and service evaluation. Most of the research—I think it was 68 per cent—was done in psychiatric specialist settings, whereas consumers and most other stakeholders believe that we should be conducting research within the community and primary care, which is much harder, but that was the opinion. Consumers also placed a high priority on consumer participation in research, though researchers, perhaps predictably, did not. On this diagram of NHMRC funding you can see that health services and preventive medicine does not receive a huge chunk of the funding pie, or did not in 2002.

Regarding the research work force, again, only three per cent of NHMRC research fellows specialise in mental health, so we do not have a big representation there. I can add that none of those three per cent self-identify as both consumers and academics. There is no specific public health training in mental health, and there is no scheme to support lay or academic consumer researchers. We have established what we think is probably the world's first consumer research unit. But CRU does not have ongoing funding, so there is the question of how you sustain that and how you continue to have input by consumers into research. You might ask: 'Why would you want consumers involved in research?' The reason is that what consumers value and think is most relevant is not necessarily what researchers think is most relevant.

This is what a consumer said to me: 'When you're talking to these people in the Senate'—sorry, 'these people'—'do you think you could ask why money isn't going into funding drugs to help us that don't turn us into baby elephants? If they think that doesn't matter, they're wrong—just read some of our threads. Putting on weight drags you down, you get down, they put you on more meds, you get fatter and the vicious cycle never ends. There has to be someone who can help us.' So part of it is listening to these people. Things like the side effects of antidepressants are really important, but if you do a review of the research and try to find out what has been written about that, very little has because it is not regarded as a high priority. It certainly is by consumers, and it probably stops a lot of people using antidepressants that could really help them. That is one reason why you need to have consumers involved.

Our recommendations were that it would be good to establish a national centre for mental health research that would focus on priorities in public mental health, increase the work force in mental health, provide postgraduate training, provide expertise in e-health and policy, and basically promote consumer participation and perspectives in research. It is horrible to sound so self-serving, but we think ANU would serve as a really good base for such a centre. CMHR has an outstanding international reputation. It has extensive links internationally and nationally. It is the only centre in Australia that focuses on public mental health research, and it conducts research on other very important issues such as ageing and welfare reform. It has the leaders in e-mental health research services internationally. It has a strong program in mental health

literacy, stigma and prevention. As I said, it has an innovative consumer research unit. The centre contributes to mental health policy. It has links with the Mental Health Council of Australia and the Department of Health and Ageing, and its proximity to the National Centre for Epidemiology and Population Health is obviously very important. It is at threat. Its funding is due to run out at the end of next year. None of the academics at the centre are funded except on short-term contracts. Basically, there is a problem in ensuring that an organisation that has been going for almost 30 years can continue.

Another recommendation, given that attitudes, knowledge and symptoms can be improved by providing information, is that that should be supported by Commonwealth funding. At the moment the responsibility rests on universities, and it is not necessarily what they see as their priority and it is not necessarily what would get them an NHMRC grant. We also recommend an increase in funding for training in mental health research. Thank you for your forbearance.

CHAIR—Thank you very much, Dr Griffiths. Can I clarify what happens with MoodGYM or BluePages. Is there somebody at the other end in real time?

Dr Griffiths—No.

CHAIR—To put it in a nutshell: you provide information, fact sheets and so forth on the web site, and the rest is people having conversations with one another?

Dr Griffiths—You would normally do cognitive behaviour therapy face to face. You would encourage a person to work through the thoughts they have, challenge them and change them, with the effect of bringing about a change in the person's emotions. Normally you get it from a psychologist or a mental health professional. MoodGYM actually implements that online without another person being involved at all. The person using it does exercises. It is interactive. They think of examples, and the program brings back in the next module what they did before and says, 'You said this before.' It works on the intelligent use of information that is going into a database.

It also works out what a person's profile is. If they have a high need for approval or whatever, they go off onto a certain stream, just as a therapist who determined that somebody had a high need for approval might focus on that and not something else. So basically it is logical and determines which way the person goes through the program. That is a form of therapy that does not actually have a person online, but it needs a lot of support behind it to keep the infrastructure going, as with any technology.

CHAIR—Does anybody come in at any stage and look at the results and the responses?

Dr Griffiths—We can look at the database.

CHAIR—But you do not do that for reasons of getting back to the person about—

Dr Griffiths—No.

CHAIR—There is no interaction with the person who has come on?

Dr Griffiths—They sign on anonymously. Basically, we can do it without knowing who the people are. But that does not mean to say that we have to do it that way, if you know what I mean. We can have a model where we know who the people are, but that it is not how we operate, because, after all, we have 20,000 people and there are issues associated with knowing who 20,000 people are. On the other hand, we have multiple moderators for BlueBoard—in fact, I am one of them. With BlueBoard, we keep out of it, but basically people support each other. If people are going to be posting information onto a web site that is going to be read by other vulnerable people, we have to ensure that there is quality control on that so that they are not saying things that might distress other people. So we have very strong rules and we moderate it. That is why people say it is a very safe environment. You really have to do that, I believe. That is different. We have moderators who go on and say things, but they try not to impose too much so that the community feels that it is their community—and they clearly do.

CHAIR—What bucket of money does your current funding come from that runs out next year?

Dr Griffiths—The NHMRC program grant is our primary source of funding. We have been trying to diversify our funding sources, so, in addition to the NHMRC program grant, we have short-term funding from places like beyondblue to do specific projects. Increasingly, we are trying to diversify that and set up a foundation to try to provide support. But they are for specific projects. The problem is that we need ongoing infrastructure so that academics, for example, can have some sort of tenure to be able to apply for those grants. A national centre would not necessarily want to be funded completely but just enough to have the infrastructure in place in order to have a solid footing to go on. Most people's appointments run out this year or next year. We just need that stability in order to apply for another program grant in the future if we miss out this year, because it is highly competitive. It is not that we are not competitive, but we are competing across the board with all medical conditions.

CHAIR—So you would like to see some siloing of research funds specifically for mental health so that you are not competing with cancer and other services.

Dr Griffiths—I am not necessarily even saying that. All I am saying is that, for example, our centre is acknowledged internationally as being a high quality centre—it recently got a review within the ANU that reinforced that—but it has no guarantee of going forward in terms of funding. What I would like to see is a way that that could be ensured, and I do not mean a free ride or anything like that but just enough infrastructure to have some predictability. It is interesting that we have been able to keep the staff we have. They do not have tenure but they get offers for being professors or whatever elsewhere. I just think it is a difficult situation.

Senator HUMPHRIES—I was interested in what you would say is the empirical track record of research, not just in Australia—I take the point about there not being enough spending on mental health research here—but around the world. There is a perception that mental illness is, unlike many other illnesses, largely incurable, that we can contain or treat symptoms but not actually cure much mental illness.

Dr Griffiths—Did you say 'largely incurable'?

Senator HUMPHRIES—Incurable, yes. There is the perception.

Dr Griffiths—Yes, it is certainly considered a chronic illness.

Senator HUMPHRIES—What is the record of mental health research, say in the last half-century, in addressing and finding, for want of a better word, cures for major mental illnesses?

Dr Griffiths—I would not have used ‘cures’ either, for the reason you just said. I think there is a large degree of recurrence. ‘Management’ may be the word. People manage their illnesses.

Senator HUMPHRIES—Is that the key to the problem? Research does not promise to find a cure. You look for the cure for MS and the cure for diabetes and so forth, but are we saying that there is not a cure for mental illness—there are only treatments and techniques for containing it?

Dr Griffiths—No, I would never say, ‘Give up on the idea of curing,’ for anything. That is just not in my vocabulary, personally. I do not believe that. We are involved in genetic research with John Curtin school. Particularly with advancements of those sorts it may well be that in the future you do get cures, but we do not have them necessarily at the moment.

Senator HUMPHRIES—I suppose what I am saying is that one of the reasons we might not be getting the focus on public funding and private institutional funding is that there is a sense of hopelessness about the exercise, that you can assist people but you cannot actually help them escape. That is just a suggestion.

Dr Griffiths—I will take that one on board. I think there are, on the other hand, chronic illnesses. It is interesting. You say it is not curable, yet people do not seem to think that depression is a chronic illness. When they mention chronic illness, depression often gets left out, and mental disorder often gets left out. I do not think people have the same reluctance—I am not sure—about arthritis or some of the other chronic diseases that do not have that same response or systemic stigma.

Senator HUMPHRIES—You mentioned that only 32 per cent of sufferers from mental illness actually seek treatment.

Dr Griffiths—That was from the national mental health and wellbeing study, which was an ABS run thing.

Senator HUMPHRIES—You go on to say that of those that do seek that treatment, 32 per cent, most do not receive evidence based treatment. What do you mean by that? Do you mean that people are looking for home remedies and informal treatments or self-help type treatments?

Dr Griffiths—No. You could have an evidence based treatment that is self-help or alternative. In fact one of the things BluePages does is not just stick to conventional medical treatments. It reviews alternative treatments and psychological treatments. After all, they are preferred by a lot of consumers. There are some that actually are evidence based. Evidence based means that there is systematically reviewed—not just arbitrarily picked because it seems like it would be nice to cite that—scientific evidence and people have asked what the science says about whether or not this works.

Senator HUMPHRIES—What are some of the non-evidence based treatments that people are accessing within mental health?

Dr Griffiths—I can tell you some of the ones that they access without mental health. Things like alcohol and painkillers are way up the top in terms of what people say they would do to treat depression and what they do do when you then track them.

Senator HUMPHRIES—You are not saying that the 32 per cent who seek treatment are mostly turning to alcohol?

Dr Griffiths—No, I am not. I would have to take that one on notice. I cannot actually tell you, but I can find out.

Senator HUMPHRIES—All right. Lastly, can you just tell us a little bit about AFFiRM. You mentioned AFFiRM as one national fundraising base for mental health.

Dr Griffiths—It is the Australian Foundation for Mental Health Research, which is rebranding as AFFiRM. It is attached to the ANU. It is gaining much more profile. The Press Club dinner is going to sponsor it as its charity this year. We are very pleased about that.

Senator HUMPHRIES—Is that the one that Margaret Reid is the chair of?

Dr Griffiths—Yes, Margaret Reid is the principal director; we are lucky.

CHAIR—The fundraiser is a ball.

Senator FORSHAW—You talked about e-technology and the quality of the information that can be accessed. You are promoting the use of it, which is so widespread today—particularly, as you said, amongst young people. At page 11 in your submission, under the heading ‘The extent to which best practice is disseminated’, you say:

There is very little coordinated effort expended in the provision of best practice guidance to those directly affected by mental health problems, or to the families and carers who support them.

Then you go on to talk about the web and you say:

The Australian Government does not always employ the best quality information on its own sites or those it funds.

What was the basis upon which you made that assessment and who made that assessment? On a more general issue, how can we ultimately ensure that what is appearing on the web is good advice. Presumably, if one went to your site or the site of a recognised medical centre et cetera, one could assume that—

Dr Griffiths—Not necessarily, but I take your point.

Senator FORSHAW—If you wanted to look up something about diabetes and Diabetes Australia came up, most people would think that is a site with reasonably good advice, compared to some other site that their attention is drawn to. I am not phrasing the question well, but this is

an impossible problem to resolve, isn't it? I am interested in getting some idea of how we do that.

Dr Griffiths—I could spend a long time talking about it. It is interesting. Some of the research we are doing at the moment with CSIRO involves developing a search engine that will identify higher quality sites—in this case, depression sites. We are working with them and have produced some really good results with a search engine that is identifying higher quality sites. The idea behind that is that consumers could use such a search engine.

Another thing we have been doing is looking at tools that a non-technical person can use to identify whether something is likely to be a good site. The way we do that is to correlate these indicators with the evidence based information. Those are the things we have been looking at—giving consumers tools that they can use. We have found that the sort of accountability criteria that you just mentioned are not necessarily the best predictors of a high-quality site.

Senator FORSHAW—But, at the end of the day, who do you say determines what is and what is not good advice? We know that there is so much stuff on the web now and I am sure if we typed in 'depression' hundreds of thousands of sites would come up. Is there a lot of bad advice and also dangerous advice on there?

Dr Griffiths—Yes. We published a paper in the *British Medical Journal* showing exactly that—that there is low-quality information out there on depression. In fact, that is why we produced BluePages. When you ask, 'How do you assess whether something is good advice?' we come back to evidence based guidelines and evidence based medicine, which is based on systematic review of the scientific evidence. We use that as a gold standard when we assess science but also as a comparator to find what might indicate to a consumer a good, high-quality site.

Senator FORSHAW—Your comment, 'HealthInsite disseminated health information provided by mental health sites that did not match the quality of those reported above,' is a comment that concerned a lot of people.

Dr Griffiths—I did not actually write that comment, I might say. However, I can stand behind it in the sense that what that is meaning to say is that when you review Australian web sites on depression, which we did, the sites that were the highest in terms of evidence based standards or criteria were not on that HealthInsite site.

Senator FORSHAW—So it was by omission rather than—

Dr Griffiths—I do not recall that at the time, for example, there was anything about cognitive behaviour therapy on Reach Out at the time. Helen Christensen has since become a member of their editorial committee, so I am sure there is now. But that is the first-line treatment for depression—not antidepressants—for adolescents. I am only doing this from memory and it is quite some time ago now and my memory is not brilliant, but as I recall at the time there was information about antidepressants but none about the first-line treatment, and antidepressants were not recommended as a first-line treatment for adolescents at the time. I was the writer of the NHMRC clinical practice guidelines on depression in young people and what young people should receive.

Senator FORSHAW—I am not an expert in this area, but at times I have heard—and I know all of us have heard—people argue against the use of drugs in treating psychiatric disorders because it is dangerous. Other people will argue that the medical professional will say that is dangerous advice, because sometimes the only way you can commence to treat depression includes medication.

Dr Griffiths—Yes, but there is a difference in the metabolism of adolescents and in the evidence based—

Senator FORSHAW—I am not suggesting you are wrong, I am just saying that this is a debate that goes on.

Dr Griffiths—I think there is a general problem in that there has been a confusion amongst people who read the media. I am not saying the problem is that the media is confused; I do not think they are. But in recent times there has been a lot of publicity of problems with antidepressant use in adolescents. That has no implication, necessarily, for adults, because the evidence base is quite different for the two. So you would say that antidepressants are a first-line treatment for depression, for example, in adults, along with perhaps cognitive behaviour therapy for mild to moderate depression, but you would not say that antidepressants were the first thing that adolescents should turn to. If, for example, you think that cognitive behaviour therapy for adolescents should be the priority but that sometimes it might be necessary to use antidepressants—even though there is not strong evidence of their efficacy in that group—there is nothing to stop you from saying, ‘There might be times when ...’

Senator TROETH—I was interested in your description of the interactive conversations on the webpage, particularly by the person who said, ‘I have this problem and what should I do now?’ When you were talking about the level of moderation—

Dr Griffiths—Yes, we don’t go on.

Senator TROETH—There would be a likelihood that other people could put forward quite dangerous suggestions or ones that would not be of any use to that particular person. So when you are saying it is moderated, how does that process work?

Dr Griffiths—The moderator looks at what is posted up there and takes off things that break rules or edits things that break rules. There is nothing to stop you from taking off a section of something if you are worried about it. Generally speaking, what I find fascinating—I was really quite concerned about the sorts of things you were talking about when we established it—is that people come up with the exact solutions that, if I were writing it, I would come up with, but they do it for themselves. They are actually excellent. I am quite amazed. I do not notice these problems that you are talking about as a significant problem.

Senator TROETH—So, if that is up 24/7, there is a moderator on that?

Dr Griffiths—There is not a moderator 24/7, so there can be a delay in what happens. We do not receive any funding to do this. We are doing it at midnight, and stuff like that.

Senator TROETH—I understand that. Obviously, the application is extremely interesting. But I wondered about some of the things that could happen.

Dr Griffiths—I have been staggered. The other thing is that we have rules about things they should not put up and so on. Sometimes because you have that delay we do not get to it quickly enough, and they all get to it, and edit it themselves. I think we should place more faith in consumer empowerment and people's ability to help each other and themselves.

Senator TROETH—Just as a general question, apart from—and I commend you for it—continuing your own existence, what would be, say, the two highest levels of funding, or highest levels of priority, that you would give to increased funding for mental health, nationwide?

Dr Griffiths—In what respect 'priority'?

Senator TROETH—Where do you see the areas of need? Obviously, I am sure we have gathered from your presentation that mental health research is a glaring priority.

Dr Griffiths—Yes.

Senator TROETH—But in practical levels of application, from your experience, where would you see the money as needing to be spent?

Dr Griffiths—I am not sure about the practical levels, but if you go back to the graph, that is what came out of the analysis. It is very hard from me to be totally independent, I guess.

Senator TROETH—I understand that.

Dr Griffiths—Personally, I think that e-technology is the way forward, but I could be a little biased about that! But I really do believe it. To answer your question: I believe in self-help, empowerment, taking the management back to the person—but absolutely supporting them all the way as well; I do not mean leaving them. That certainly is a problem—people get help and then they are just left in the system, with no support whatsoever. I am certainly not talking about that.

Senator MOORE—I was fascinated by the model of a consumer doing the research. Is that a common model in your field?

Dr Griffiths—No. The NHMRC has brought out a document that promotes consumer participation in research and so, lay consumer researchers.

Senator MOORE—Participating in it, as opposed to being the academics doing it?

Dr Griffiths—Not in the academic stream but actually conducting research. Consumers do conduct research. I have done a review to see, and in fact lay consumers do quite a bit. It is quite interesting. However, they do not get any funding, which is a problem. However, the concept of academic consumer research—that term is my term—is a novel concept.

Senator MOORE—Have you done any research on whether that is happening elsewhere?

Dr Griffiths—There are people of prominence who are consumers and researchers, like Kay Redfield Jamison in the States, who I think won some award for being a gold star genius or whatever. There are individuals. But what I think is new is getting together a group of academics who are also consumers who identify with it, and then focusing on consumer perspectives, just making yourself take that perspective. We do not really need to because we already do, and a lot of things that consumers say to us when we collect information certainly resonate with me because it has been my experience as well. Obviously you have to be really careful that you do not overattribute your own perspective to other people, but even just putting that consumer hat on is a really powerful thing.

Senator MOORE—And that is one of the things that you do to promote the centre—you have a stream of consumer research.

Dr Griffiths—Yes; we do the research that is very oriented around what consumers, for example, think the priorities for depression research should be. So, forget about what researchers think; what about the consumers?

Senator MOORE—The people who have it.

Dr Griffiths—We do things of high relevance to consumers, like stigma and so on. Then we have a high priority on disseminating that information. I organised a series of public lectures called ‘Research’—mental health research—‘is Everybody’s Business’. Outreach is really important. It all rolls in together. I have developed a thing called ‘BrolgaNet’ which is a way that consumers and researchers can interact online, and consumers can provide feedback on research protocols but also can make contact with other consumer researchers and other academic researchers—trying to do those networking types of things to bring it altogether.

Senator MOORE—Do you have any specific information on that stream? It was not highlighted in your submission, but it came out in your evidence. Do you have any information you have developed particularly on that idea of consumer research?

Dr Griffiths—I have a paper that I have published. Would that be useful?

Senator MOORE—I would really like that. That would be great. Thank you very much.

Dr Griffiths—Thank you for your interest.

CHAIR—Perhaps you could provide that to the committee.

Dr Griffiths—Okay.

Senator WEBBER—I have one quick question that goes back to e-health and BluePages. I am from Western Australia so I have a particular interest in access for remote and regional people. You talked about there being 20,000 people that access this. Is there an overall profile that demonstrates that it is particularly used by remote and regional or young people?

Dr Griffiths—No.

Senator WEBBER—We all have a theory about it, but do we have any evidence about the take-up?

Dr Griffiths—No. That is actually a really good point. It is something we could build into the front part. There has been more than one version of MoodGYM. At the moment we are running randomised controlled trials online but people can opt out and just go through MoodGYM the way it normally is. We are collecting information a little bit up front. That is actually something we could collect. It would be a good thing.

Senator WEBBER—That would be really useful.

Dr Griffiths—Yes. We had thought about trialling it in a rural and remote area. That is really a good idea. Thank you.

Senator FORSHAW—You could include postcode information.

Senator WEBBER—Yes, just postcode information would be useful. Then it would protect people's identity.

Dr Griffiths—Excellent. Thank you.

CHAIR—I will finish up with a question on the prevention of mental health problems. You have it as a second-order priority. Has there been much work done so far? Underneath that subheading I suppose you would look at particular parts of prevention and what that means. Could you expand a bit for the committee on where the needs are in prevention and where the opportunities might be?

Dr Griffiths—Historically prevention in mental health has really been neglected. There is nobody who would question that we should prevent skin cancer, but there seem to have been blinkers on in terms of mental health, as though it were not something that could be prevented. It is a bit like this 'curable' thing; it is just a mental attitude. In more recent times there has been work to indicate that you can prevent mental health problems. In schools, for example, they have run cognitive behaviour group programs for young people, which have resulted in a decrease in depression.

CHAIR—I suppose if you got rid of bullying in schools that would be a preventive measure, wouldn't it?

Dr Griffiths—Yes, that is right. There are those things. There are other things as well like the Triple P program that operates in Queensland, which looks at conduct disorder very early on with the aim of attempting to change problematic behaviours that occur much later on. That is an early intervention and that is their aim. There certainly are programs in Australia and overseas that have shown that prevention.

At the other end as well there are things like preventive intervention for older people who are bereaved—they are bereaved but not yet depressed. We are conducting studies looking at exercise, folate and mental health literacy as a preventive measure for older people. That is a big study that is being funded by beyondblue and partly by the Commonwealth. The results are not

out yet on that. Certainly there is very promising evidence that you can prevent mental disorders. I just think at this stage there has not been enough research done, because of attitudes.

Senator FORSHAW—What about genetic predisposition? There has been research done on that spasmodically, I understand. Is that an area of interest for your institute?

Dr Griffiths—We have people within our centre, not me, who are involved in it. We have a large risk factor study of about 7½ thousand people who we have been tracking—and aim to track over 20 years—and have tracked over eight years at this point. We have a person at the John Curtin School who is an expert geneticist and we work collaboratively with him on tracking things. It is an interest, although not an area of expertise of mine.

CHAIR—Thank you so much for your presentation. It was very useful.

Dr Griffiths—Thank you very much.

[2.28 pm]

NOTHLING, Dr Martin, Federal Councillor, Australian Medical Association

PRING, Dr Bill, Representative, Australian Medical Association

CHAIR—Welcome. Do you have any additional information about the capacity in which you appear?

Dr Nothling—I am a psychiatrist representing the federal AMA. I will tell you more of my background in a moment. I am being assisted by Dr Bill Pring, who is also representing the federal AMA and has had long experience with the federal AMA and psychiatry in general. He will give you his background in a moment.

CHAIR—You have lodged with the committee a submission, which we have numbered 167. Are there any alterations or additions to that document at this stage?

Dr Nothling—No, not at this stage.

CHAIR—I invite you to make an opening statement, after which we will go to questions.

Dr Nothling—I will make a short opening statement, Madam Chair. I would like to thank the Senate committee for this opportunity to make this presentation here today on behalf of the federal AMA. We believe this is a very important inquiry into mental health in Australia. We have had very serious concerns for quite a period of time, as you will see from the document submitted. In Australia the provision of mental health services receives what we believe is an inappropriately low priority considering the large number of people who are affected by mental disorders. There is a high burden of disease and there is an untoward impact on subgroups within the community, and the potential for the cost-effective achievement of better health outcomes is an important consideration. We believe that ignorance on mental health issues gives rise to stigma and discrimination against patients, and it militates strongly against the provision of an appropriate level of mental health services and resources.

Mental health conditions are chronic and, along with other chronic conditions, the quality of long-term care is compromised by a financing system for medical and hospital services that strongly favours acute, episodic or procedural care over the longer term care that we see for many psychiatric patients. It is really long-term care that we are looking at. We believe that there is much that Australian governments can do to address Australia's underachievement in the care of patients with mental health conditions and with comorbid mental and physical illnesses, because they are so often linked, as you will see in our document.

We believe that a lot can be done to ensure better outcomes in the future regarding the rising incidence and prevalence of mental disorders in the Australian community. We believe that any failure to invest in mental health services will harm the Australian people and economy—and Australia's human capital is our greatest asset. The Australian people will place a high value on

care that generates strong, positive patient outcomes in terms of disability-free years of life. The question is not whether we can afford to do it but, rather, whether we can afford not to do it.

I will now make the important points as we see them. We believe that urgent government action is needed in the following areas. Firstly, in determining federal and state-territory government health spending priorities, it is essential that mental health services receive a higher priority than is currently the case. We believe that no new money is not a viable option. If we are going to achieve better outcomes, we will have to see new money coming in for funding and we will have to ensure that those new funds are properly spent.

Secondly, current and prospective work force shortages must be addressed concurrently with funding issues. The current mental health work force is not able to provide all Australians with an acceptable level of care, reflecting both the overall work force shortage and the dysfunction in the health delivery systems. The growing incidence and prevalence of mental health conditions sounds a warning for the future. The resolution of work force shortages requires careful attention to both the resources for training and the incentives for participation in the work force. We believe that funding without a work force would be foolish and a work force without funding would also be foolish. In other words, funding and work force go hand in hand. If we do not plan for them combined, the end result will not really achieve very much. Thirdly, urgent action is needed to address access and equity issues for three groups in particular. They are the people living in rural and remote areas of Australia, the Aboriginal and Torres Strait Islander peoples, and children and adolescents. Those are all areas in which we believe there are considerable difficulties.

If you were to ask me to say in one minute what we really needed to do, I would say that the really top priorities are the work force issues. There is an impending work force problem. In psychiatry we have one now. We believe this could deteriorate further unless appropriate steps are taken. If you were to also ask me what could be done as to hospitals and the delivery of mental health care, I would say that there are major problems in emergency rooms all over Australia and major problems with acute care facilities for patients. We have a shortage of acute care beds for people who are very severely disturbed. We need more step-down beds in psychiatric facilities to enable patients who are acutely disturbed to be reintegrated slowly back into the community. Then we need better funding—as you will see in our submission—of community mental services. That has been a neglected and underfinanced area as things have evolved over the last 20 years. We were promised that as long-term hospitals were closed appropriate facilities would be developed in the community to treat people with mental illness. I am sorry to say that they have not eventuated to the level that we believe they should be at.

Dr Pring—I will add that we were also going to be represented today by Dr Chong Sien Yong, but he is sick and is unable to attend.

CHAIR—I will start by asking you about the Commonwealth program for GPs to be trained in mental health.

Dr Nothling—Better Outcomes in Mental Health Care.

CHAIR—Yes. It was suggested earlier today that very little research has been done into the effectiveness of that program, not to mention others, and that we have very little by way of

scientifically or evidence based systems for people with mental illness. Do you have a view about that program? Can you suggest to the committee why it is that such a small percentage of doctors have taken it up? I think it is still only around 15 per cent. What is your view about the part of that program which allows GPs to refer patients to psychologists?

Dr Nothling—I will ask Dr Pring to address that question, because he has had some involvement in the development of that program.

Dr Pring—There are probably three different parts to your question. With regard to the program itself, we have certainly had input in our submission from our GP colleagues in the AMA. Our GP colleagues say that general practitioners are very interested in the program and quite a number of them have done the training course. They sometimes find the bureaucratic systems in place somewhat burdensome. That is probably one of the reasons that the full take-up of the three-step process has not occurred, but the training side of it has been very popular. They are also saying that one of their problems arises when they have taken people through that process and the process fails to deliver a satisfactory result for the patient, at which point the program sort of comes to an end—it has not been linked to other strategies that might link it with private psychiatrists and with public sector mental health services. I think that was something that was left out at the beginning of forming up that program. In taking that program forward, if those other linkages could be introduced then GPs would not be left with a program for patients that can tend to stop dead and leave them with a problem, in the sense that people have gotten so far but are not able to move further with it. That is probably, in a short form, an answer to some of those things.

You mentioned something about evidence based care in mental health. I think that is a separate issue. It is an interesting issue, because much of medical care has not been through randomised control trials. It is interesting, as we are all becoming aware, that the evidence base does have certain limitations because the funding authorities that authorise funds for the accumulation of research evidence tend to put money into areas that are of particular interest to government or to drug companies and therefore one can find that the evidence base is strong in some areas and not so strong in other areas.

Certainly as doctors working in the mental health sphere we very much value the evidence that is available that we can use in our practices, but often the evidence for exactly what one should do with very unusual and complex syndromes is not there. That is because most research in mental health is done on selected patient groups and if there is complexity in a person's symptoms that person is removed from the research and not included. Many of the people a psychiatrist sees have highly complex syndromes and the evidence is not available for the exact treatment that might be best in those circumstances. We rely on our science and our clinical knowledge to produce a tailored solution for the particular person in those circumstances.

The third part of your question was about access to psychological services. It is certainly limited under the Better Outcomes for Mental Health Care program to essentially, in most instances, a CBT type of approach for a limited number of sessions. The AMA feels that that is an appropriate sort of linkage for that particular program in primary care. But the AMA would certainly be interested to be involved in discussions with government and with the representative organisations of psychologists and nurses et cetera on how those other professions in mental health could be integrated with existing specialist mental health treatment, especially in the

community with private psychiatrists. There are some options and opportunities there that we could progress, given time and goodwill.

CHAIR—So the AMA would not be opposed to there being a Medicare item number for psychological services for certain conditions? The Mental Health Council effectively recommended that this morning.

Dr Pring—We would not in principle be absolutely against it. What we would like to see is some sort of medico-legal supervision of such cases in that sort of circumstance, because that would be safer and more secure for patients.

CHAIR—Is that on the basis that a GP has more training in mental health treatment than a psychologist?

Dr Pring—In certain areas it may be true that the GP has more capacity with the disorders that have a biological component to them—or an imputed biological component for some of the serious disorders. The GP, through their experience, may have a greater ability to recognise those conditions. It is very important that adequate assessments are done.

This is an important issue. There are probably two major concerns that we as an association might have—and we are not saying that these rule out the possibility of talking about how we could make positive steps happen. Just looking firstly at psychology, I believe there are about 40,000 psychologists in Australia, and it would be great if they could be integrated more into mental health care, but there are only approximately 1,000 clinical psychologists. As psychiatrists in the specialist mental health sector, we are very happy to work with psychologists who have had sufficient experience with the serious conditions—often that means that they have worked in the public mental health sector for some time—because then we have a mutual understanding of the conditions we are dealing with.

Over the last 24 years I have been in private practice predominantly but I have also worked throughout that time in general hospital psychiatry—psychosomatics, if you like. I have worked in both general hospitals and their emergency departments over those 24 years. What comes in the doors of emergency departments provides a very good window on the community and on mental health services. In every year I have worked there have been a least three or four cases that I have picked up of people who have been seen by someone supposedly working in mental health—not always but sometimes a psychologist—who has just not recognised that those people have very serious mental illnesses, and then those people have come in with overdoses or after suicide attempts of some kind. It is crucial that there is an adequate assessment at an early stage. If people were then judged as being able to benefit greatly from psychological management by a psychologist or a mental health nurse, it would be excellent if that was available to them under Medicare.

CHAIR—The evidence coming to us is that people mostly miss out on both.

Senator HUMPHRIES—Following up on that last point: are you saying that if the system can engineer more opportunities for experience by clinical psychologists in, say, hospital settings then it will give them the background experience to be able to bear more of the load in the system of these mental health services?

Dr Nothling—The psychologists who work in those settings and work closely with psychiatrists gain a lot of knowledge in that area. It is like with anything else—once you gain that knowledge you become much safer, in the sense that you realise your own capabilities and the extent of your abilities. Psychologists have a lot to offer that we cannot offer, and vice versa. But we believe it is very important to keep it in a medical model because, as Dr Pring said, many patients present to people providing ‘mental health type services’ and they are unrecognised. I saw a case very recently that ended up very tragically. A psychiatrist really only got involved right at the end. If that case had been properly treated and diagnosed psychiatrically right at the word go, there would have been, I am sure, a much better outcome. It is like with anything else—if you thought you were having a heart attack you would want to go to someone very specialised in an emergency room who can diagnose straightaway whether you are having one or not. In psychiatry we believe that when people are acutely disturbed it is very important to have a psychiatrist there to make the diagnosis and know what is happening, and then psychologists can work in very well. I have worked over many years with psychologists and I really respect what they do. We have a very close working relationship. They know what they can do and they know what I can offer.

Dr Pring—I certainly think there would be benefit in further training in the serious disorders for people who are saying that they are working in mental health—of all descriptions, I suppose. But if you are talking about Medicare, as Senator Allison said before, we are saying that, in terms of Medicare funding arrangements, it would be wisest to make sure that people are adequately assessed before they go on to other treatments.

Senator HUMPHRIES—One of the problems that has been put to me about the psychiatric professions dealing with mental illness is that psychiatrists are prepared to treat people diagnosed as mentally ill, because they are diagnosable and treatable, but they are less willing to treat people who are mentally dysfunctional. That distinction is quite important. There are many people in the system who, for example, front the emergency departments of our public hospitals and are determined not to have a mental illnesses as such but who are clearly unwell in some way, and they are sent away. It has been suggested to me that that makes up the majority of people who experience some kind of ‘mental disorder’—as you put it, Dr Nothling. What is your reaction to that? Is there a reluctance on the part of psychiatrists to acknowledge that some of the unwellness of people in our system is not technically diagnosed as mental illness and therefore cannot be treated and will not be dealt with by some of the people you represent?

Dr Nothling—I have some difficulty with you saying these people are unwell. If someone is ‘unwell’ that more or less implies that they have a disorder. Perhaps what you are saying is that these people are stressed or feeling unhappy with something that is happening in their lives. Psychiatrists are really trained overall to treat the broad spectrum of people presenting with what we call mental disorders or mental problems. I would not really see it that psychiatrists could not provide that sort of service, but of course there are manpower problems, as you are well aware. At public hospitals there can be major problems getting people in to see a psychiatrist in outpatients, for instance, because there are work force problems. I think what you are saying is reflecting that very serious problem.

Dr Pring—I think there are a number of layers to that question. First of all, there are the very severe conditions that we believe probably have a biochemical basis—conditions such as schizophrenia and bipolar disorder, where we believe there is probably a biochemical

disturbance in the brain. But there are a number of conditions that are perhaps less severe in people's estimation that can nevertheless cause a great deal of disturbance and a lot of downtime, loss of work hours et cetera—conditions such as anxiety and depression. Some of those conditions may have biological components as well. So there is a spectrum—I think this is what you are getting at—of psychological difficulties in the community. Certainly we believe that psychiatrists are well based to be able to assess and diagnose across that whole spectrum.

When it comes to providing treatment, there is a bit of a dichotomy in that in the public sector under the early national mental health plans there was an emphasis on what was called serious mental illness. That has limited the sorts of services that are available from the public sector largely. And a lack of funding has not allowed the public sector to move out into a broader spectrum of treatment. In private psychiatry, which after all treats twice as many Australians as are treated in the public sector, there is more grappling with the moderate disorders and then appropriate referral—where people have sufficient money—to psychologists or mental health nurses for assistance with treatment as well, with the less severe conditions. So probably in terms of services provided there is that unfortunate dichotomy out there.

Senator HUMPHRIES—If that were the case, though, how do you explain the large number of people who are mentally ill ending up in prison? I was led to believe that was because these people are not always necessarily diagnosable as mentally ill but they clearly have a problem, which goes beyond being stressed, as you put it. Yet they end up in prison. How does that occur if psychiatry has the means to be able to diagnose them adequately and presumably prescribe treatment regimes?

Dr Nothling—When the treatment system is dysfunctional, you have difficulties accommodating all of the patients who are presenting, and that is what is happening. Because of inadequate facilities in these acute psychiatric admission centres in large hospitals and in emergency rooms, a lot of these people who may well have a medical problem or quite a severe psychiatric problem are being shunted off, or they are not even being taken to those particular places. They are being charged with particular offences and are ending up in prisons. A colleague on mine in the United States said that the largest psychiatric hospital in Washington is the local jail. That sort of scenario is fairly common, I think.

We are very concerned that that is what will happen. When you move a lot of people with mental disorders away from the treatment facilities that they should be treated at, because there just are not enough facilities, many of them tend to drift into committing petty crimes. They have drug problems. They get picked up by the police and they may well end up in the prison system. We have seen examples of that recently, of course, in Australia.

Senator HUMPHRIES—Are you saying that we fix that with adequate work force numbers and with better facilities? Then we would not end up with people in prisons who are mentally ill.

Dr Nothling—I think it would be a very convincing argument that if we had adequate facilities and we had an adequate work force then that problem should diminish.

Dr Pring—We also need more mental health services in prisons to try to treat and rehabilitate people and have follow-up so they are not so likely to reoffend. In your question, too, there is probably the unspoken problem of stigma and the fact that people often will not want to see a

psychiatrist because they see themselves as labelled with mental illness. Our GP colleagues and the AMA tell us that. It is a common problem for them to be able to refer on to us someone who might be quite sick. In that case we often try to provide advice to the general practitioner about the best treatment of that patient, even if we have not been able to see them.

Senator MOORE—Dr Nothling, your submission mentions, and you mentioned in your evidence a couple of times, the work force issues. Just for the record, would you like to expand on exactly what the issues are around adequate work force staffing in Australia at the moment, in particular why the submission says that psychiatrists' jobs have been left unfilled across Australian hospitals—why is that happening and what should be done about it?

Dr Nothling—That is a very good question.

Senator MOORE—I read it, so I led with it.

Dr Nothling—We have been thinking very carefully about this one for quite some time. If I could just take you back—and I will not take long—to explain the history of this. We believe there is a shortage of medical practitioners in Australia. Probably 10 to 20 years ago there was a run back in the number of medical school places. There was a belief that Medicare costs would be less if there were less doctors, so there was a move in that direction. We are paying the price now, when there is a shortage of doctors.

Why are the doctors not going into psychiatry? It is clear that they are not going into psychiatric training. I have talked to a lot of doctors through federal AMA and in my other activities teaching psychiatrists and other young doctors and they all tell me the same thing—it is a very common story. They go into these emergency rooms and they see how dysfunctional they are. If you have a patient who is psychotic, what do you do? It is extremely difficult. You spend a lot of time on telephones trying to find a bed somewhere. You cannot get them in. The treatment they need is in-patient facilities. They are not available. The emergency rooms get clogged up. The young doctors see all that and they start thinking, 'Would you want to be in this area?' That is a big problem. Many doctors who have said to me: 'Look, I wanted to be a psychiatrist,' said that once they started to see how the system was not working decided they would go elsewhere.

There are other issues. For a psychiatrist who is practising, say, in private, it can be extremely difficult to get an acutely psychotic patient admitted into a public health facility. I can tell you from my experience recently that you can spend an hour and a half on the phone only to find that you cannot get a bed anywhere. The psychiatrist is not reimbursed for all that time, and there is a considerable amount of time spent doing that. The underfunding in the area spills over to reimbursements. You have probably seen recently that psychiatrists have the lowest average income of any medical group, including general practitioners, who are reasonably higher paid than psychiatrists. It could be that there are a lot of psychiatrists just working part time. A lot of females go into psychiatry and would possibly not be working full time. So there are those difficulties that we have there. All in all, it adds up to a system which is not working and is not an attractive one for doctors to go into it.

Another really important issue that the committee should think about is that psychiatrists are really providing services to people with chronic disorders. If you are looking at private

psychiatry, which treats about two-thirds of the psychiatric patients in Australia, there is complexity in the community now—as has already been alluded to here—in that patients may have a lot of other problems. They may have medical problems, they may have substance abuse problem, they may be presenting with bipolar but they are also heavily drinking. So a lot of integration of services is required by the treating doctor or, in this case, the treating psychiatrist. And the treating psychiatrist is not reimbursed for a lot of cognitive time which could be spent on communications with other facilities to get adequate treatment for their patient. It is totally different to the procedural specialties where you are relatively highly reimbursed for doing a more or less quick procedure and you do not get this long-term follow-up, a lot of conferences and that sort of thing. Doctors are just weighing it all up. We really need to look at the overall functioning of this whole area, taking into account all of those factors. Dr Pring may have some other ideas.

Senator MOORE—A couple of us are also on the inquiry into services and treatment options for persons with cancer that the Senate Community Affairs References Committee is looking at at the moment. One of the things that we are looking at in that inquiry is the concept of integrated care and, in the treatment of cancer, having a combination of medical practices working together with the patient. From some of the comments you just made about people with psychiatric conditions, Dr Nothling, it seems that same model of integrated care, which would have a number of people who are working together with the patient and then looking at a way to have that best reimbursed in the system, is one of the suggestions you are making. Is that right? Am I hearing that right?

Dr Nothling—Yes, you heard me correctly. I did not go into that in detail but an integrated system is what is required, because many of the patients that we see with psychiatric disorders have comorbid conditions. In other words, they have other serious medical conditions. If you are going to manage the patient properly this requires communication with the other specialists, the treating general practitioner or maybe the other people who are allied professionals involved in the care of the patient. That involves conferences and a lot of cognitive effort on behalf of a team. But that will lead to a better outcome for that particular patient. We believe that is an important direction that we should be heading in.

Dr Pring—I think most psychiatrists that are trained these days are trained in a team management environment, so it would be very good if we could have greater team management environments in the community, available to private sector practitioners as well. There is an interesting thing about Australia and psychiatrists in particular that not many people understand, and that is that we have a rather specific system in Australia because we have the universal coverage with Medicare but for psychiatrists' patients to get the full remuneration rebate they have to be referred by a general practitioner. In America, where there is a strong private sector, that is not the case and so people just roll along and get the specialist care they want. The interesting thing in Australia is that, because we have had GP referral for 30 years or more and it has been written into the universal system, private psychiatrists are very aware of primary care mental health—much more so than psychiatrists around the rest of the world. That also means that private psychiatrists are much more in touch with psychosomatics too. I know that you will get complaints that GPs are not able to contact private psychiatrists and work with them adequately, but you will also be able to speak to GPs that say they have had excellent working relationships with some private psychiatrists over very complex patients. So there is already a

fair degree of team work out there in the community and there is a fair bit of knowledge about comorbidity, which we should really capitalise on, I think.

Senator TROETH—We have had several points made already about the National Mental Health Strategy. I understand that you have some concerns as well, particularly about the implementation of it. At a general level, would you give us your views on that? For instance, we have had comments saying that it is not the policy itself; it is implementation and delivery of it. Would you agree with that or have any other comments to make on that?

Dr Nothling—I will let Dr Pring comment first.

Dr Pring—It is very hard for any plan or strategy to work well if it is underfunded, for a start. We strongly believe that there has been underfunding in mental health for quite a long time. I think that with de-institutionalisation there was an underestimation of the amount of funds that would be necessary to provide equivalent services in the community to hospital based services, given that there are very significant economies of scale in hospital based services in terms of hospitality services, food and all of those sorts of services. So there is that.

I think the other major mistake that was made early in the plans was the whole concept of ‘serious mental illness’, which then skewed the plan for 10 years or so and really has not been officially acknowledged, I think, at any great level. It needs to be acknowledged. The public sector services should ideally be providing a very broad spectrum of specialist services, which would link in well to the primary care area as well.

Senator TROETH—So which groups do you believe are not being catered for?

Dr Pring—People with what are seen as less severe disorders still are, in most jurisdictions around Australia, not being adequately looked after in the public sector. That includes people with anxiety disorders, milder forms of depression and some of the psychosomatic conditions, somatisation disorder et cetera.

Dr Nothling—Some of the people suffering from anxiety disorders can be just as disabled as someone suffering from what we call a serious mental disorder, because they cannot function at a work, perhaps as a result of a panic disorder or a generalised anxiety disorder—and yet they were not seen under the mental health plan as having a serious psychiatric disorder. You will see in our report that we say what we have to look at—and this follows the question Senator Humphries question asked us—is a treatment that will cover all of these people, because many of them are really quite severely disabled and yet they do not come under the umbrella.

Senator TROETH—No, they do not qualify. You have also mentioned that the current management systems within public mental health facilities are creating a barrier to attracting doctors and nurses to training positions in those facilities. Could you give some further explanation of that?

Dr Nothling—That is similar to the question Senator Moore put to me.

Senator TROETH—Yes.

Dr Nothling—I could talk for a long time about it, but—

Senator TROETH—But what you said to Senator Moore covers it, in your view?

Dr Nothling—In essence, yes.

Senator TROETH—Okay.

Dr Nothling—Dr Pring may have something to add.

Dr Pring—Yes. I will just add briefly that it bears on a number of the things we have been saying. When I talk to my public sector colleagues, they tell me they are often put in invidious situations where they are medicolegally responsible for the patients under their care but they are told by their management that there is to be a budget cut and that they just have to wear it. There is something wrong with the system when the clinicians responsible cannot get through that the budget cannot be cut any further. So we are not absolutely sure, I guess—we do not have the golden way of cutting through that problem. It probably is a problem that affects a number of other areas besides mental health. It may affect education and so forth.

Senator TROETH—So the suitable level of care cannot be provided because there is simply not enough money to do it, according to the way in which the management does it. Is that what you say?

Dr Pring—There is a split from the clinical level to the management, and there seems to be a lack of true responsibility at the management level for the clinical results.

Dr Nothling—Senator, I might have missed what you were actually getting at. I think you asked about the management.

Senator TROETH—Yes.

Dr Nothling—We believe that an important step will be to introduce psychiatrists and medical practitioners into the levels of managing particular teams and psychiatric facilities, then to have other managers who are answerable to them and who are not necessarily medically qualified. In many centres it has gone the other way and we have managers who are not medically qualified. They do not understand the issues and they are cutting funding in certain areas where it is inappropriate to do so. That is really frustrating for medical practitioners and psychiatrists working in those areas who know that it should be done a certain way and they cannot get through to the managers. So shifts in management, if that is what you are getting at, would be very important along those lines.

Senator TROETH—That tallies with what we were told earlier. I would also like to ask your view on the current funding arrangements between the federal government and the state governments. I know this is an eternal political football, no matter who is in government at either level. For instance, we were told earlier this morning that the provision of funding is fifty-fifty but the actual management of it is something like 40 per cent by the Commonwealth government and 60 per cent by the state governments because of the way in which services are delivered. Do you have a view on those funding arrangements?

Dr Nothling—When we see two funders being involved and the difficulties with the delivery of service that we have outlined, clearly there is dysfunction there. We are told by a lot of doctors who work in the system that, in many cases, funds which are allocated for mental health services do not actually get through to mental health services.

Senator TROETH—That is right, yes.

Dr Nothling—They get sidelined into some other medical service. We believe that is a major management problem which should be addressed. Whether that is due to this interaction between the state and the federal systems I think needs further investigation, but clearly something does go wrong there in terms of accountability. We really believe that there should be some system set up to enhance accountability so we know that the funds allocated do go to that area.

Senator TROETH—As was explained to us, the money is not quarantined, so, if the aforesaid managers who we were just discussing see a bucket of money that is not necessarily earmarked for mental health and can be used for something else, perhaps it will be. Thank you, that is very helpful.

Senator FORSHAW—You talked about the shortage in the work force, particularly of psychiatrists. You also mentioned during your comments a couple of personal situations you have dealt with in your own practices. I want to ask you this: if a GP wants to refer a person to a psychiatrist and believes that person has a serious situation—I will describe it as that—and it is a first-time referral, how soon would they be able to get that person to see the psychiatrist? I think the general experience of a lot of people in the community is that, unless you are going to be sent off to the hospital for an emergency or whatever, you may wait weeks to get to see a specialist. What is the position with psychiatrists? As you just said, a GP might decide to give people with anxiety disorders some initial medication, but how quickly can they get to see a professional?

Dr Nothling—It depends. There will be variation depending on the local area, of course, but in many cases there can be delays of weeks or months before someone can be seen because psychiatrists are literally so busy. It is common talk at any psychiatry meeting you go to where you talk to colleagues—everyone is booked out. How can you keep seeing patients? You cannot. There is a quality of delivery of services issue. You just cannot keep adding on patients and working on into the night. It does not happen. So the answer is that it is a work force issue and there are shortages. If it is really acute and the person has to go to hospital or absolutely has to be seen, I think you would find that a psychiatrist would somehow do it; but, if it is not that acute, there are waiting lists. I think that reflects the work force issues. That is the importance of general practitioners working, as Dr Pring was saying, in teams with psychiatrists, because that can often be very helpful. They can tide a patient over until the psychiatrist can actually see them.

Senator FORSHAW—I expected that that is what your answer would be, but trying to tide the patient over, as it were, for that length of time with this situation or this type of illness or complaint is extremely serious, isn't it? If a person has, say, an arthritic condition—and I do not want to belittle that—it may be that they can cope with that until they get to see the specialist a month or two months down the track or whatever it is, but that is not the case with a severe anxiety disorder or depression. I understand the problem and I know you are telling us the

problem, but surely the profession has a view about how you deal with it now, given that you are not going to get a lot of additional psychiatrists in a hurry setting up private practice.

Dr Pring—We have said that we are interested to look at ways of better integration with other services and with general practitioners et cetera in the community. I will just give you a little personal glimpse of this. Basically, we cannot win. I am now used to, after 15 years, having private psychiatry criticised for not having sufficient access.

Senator FORSHAW—My comment is not a criticism.

Dr Pring—No. I do not mind if it is. It is reasonable to have a criticism. We have not been able to respond to it—that is my pain about it, essentially. I will just give you a little glimpse. The care that a person gets will depend a lot on the quality of the general practitioner at that point. There is a lot resting on our general practitioner colleagues. I am just in the process of moving my rooms, not terribly far away from where I have been, just a short distance away. In the process of that I now know who my core referring GPs are because my secretary and I have gone through and I have sent out specific letters to the GPs that I give same day service to. There are 60 of them, in fact, in my local area. I know I can trust those people because I have a long-term good relationship with them. If they tell me the person can wait a week, they can wait a week—or they will ring me up again if they cannot. There are 60 GPs that refer to me that have that type of service. There are probably another 300 or 400 GPs that will get notices from me. Unless I can develop a good relationship of mutual trust with them, their patients will be waiting three or four months to get in to see me. If people have adult ADD, which is a subspecialty practice of mine, they may be waiting even longer. If I took every patient with that condition that came along, I would not see any other type of condition.

Senator FORSHAW—We have heard in other inquiries of GPs and other specialists basically closing off their books to new patients. Does that happen in psychiatry?

Dr Pring—I suppose that is one way of trying to cope. This is my way of trying to cope.

Senator FORSHAW—As an association are you aware of that?

Dr Nothling—Some doctors who have in been practice for a long time have built up so many patients who have a chronic disorder coming back to them that they will periodically close their books for a period of some months. They just cannot take any more referrals and they do not like to say, 'I can see them in six months.' They feel it is fairer to say, 'Look, I can't realistically do this.' They might suggest a younger colleague or someone who is starting in practice. This is being addressed with a new item number that is coming in at the moment, too. The department is introducing a liaison one with general practitioners to provide a consultation service. I think it is to be introduced this May. That will hopefully take some of the pressure off because the psychiatrist would see the case, then the person would go back to the general practitioner with a plan of how to treat them, and if things do not work out they have to come back.

Senator FORSHAW—We heard earlier today from the national Mental Health Council. They are about to release a report called *Not for service*. Are you able to tell me if the AMA made a formal submission or had a formal involvement in the preparation of that report? You might want to take that on notice.

Dr Pring—Sorry, I did not quite hear that.

Senator FORSHAW—The national Mental Health Council appeared today and told us that they are about to release a report which is to be called *Not for service*. It is an assessment of mental health services, particularly looking at, amongst other things, the National Mental Health Strategy.

CHAIR—The phrase comes from a group of patients who will not receive any mental health services, for whatever reason.

Senator FORSHAW—I just wanted to know if the AMA, particularly your section representing the psychiatric profession, made a formal submission to the preparation of that report. The people working on the report included, of course, specialists in mental health. You are not aware of that?

Dr Nothling—No. We were not invited to participate, so I do not know.

Senator FORSHAW—To be fair, it did include a lot of community forums, the seeking of input and so on. I just wondered if you had been involved in the development of that report.

Dr Nothling—We have not had any involvement, no.

Senator WEBBER—I will try and be as brief as I can. I will touch on two issues. First, I want to return to the work force issues. Whilst I accept a lot of the evidence we have heard from the Mental Health Council and others about the shortage of mental health professionals, not just psychiatrists, it seems to me that another issue is the impact of drug and alcohol use and the increased incidence of psychotic episodes. I am thinking more particularly of modern-day designer drugs and the impact they have on people having psychotic episodes. Isn't it the case that there is not just a shortage in resources but an increase in demand for services in society?

Dr Nothling—Yes. We believe that the increased substance abuse in our society—whether it is alcohol or these other illegal drugs—is certainly leading to an increase in the presentation of mental disorders, because many people who use those substances present with symptoms and behaviours which can mimic all sorts of other psychiatric disorders like paranoid schizophrenia, paranoid psychosis or even bipolar disorder. As a psychiatrist, until you have worked out whether it is the drug which is causing it or a combination of both, it is quite a difficult exercise. During my years in psychiatry I have become much more aware of this increase in the use of these substances. It complicates the situation. I do forensic assessments as well, and I can assure the committee that illegal drugs are playing quite a role in the presentation of people who have mental disorders which are causing disabilities in terms of their work or their other functioning.

Dr Pring—In our submission we have certainly advocated a greater integration between mental health services and drug and alcohol services. We think that is very important. In terms of drugs to watch, I think the killer-diller is actually the ordinary drug—marijuana. I think it is going under the radar because it is now almost an ordinary drug in society even though it is illegal in most jurisdictions. It is like cigarettes and alcohol: it is important because it is so big. It is used so much that it is producing a lot of morbidity in the population.

Senator WEBBER—I could pursue that issue for a while, but I am sure I will have another opportunity. The other issue I want to touch on is the provision of services in detention centres. Whilst I do not want to embark on an argument about whether detention is an appropriate thing to do to people seeking asylum or refuge in our country, it has certainly been put to me that these are fairly traumatised people and, therefore, they have a need to access more highly specialised mental health services than the rest of us in the community. Therefore the choice in placement in detention centres has a severe impact on their rights in terms of accessing top-line mental health assistance. I obviously have Baxter in mind as an example.

Dr Nothling—The federal AMA believes very strongly that many of the refugees held in those detention centres have been traumatised previously, so they are at high risk of mental disorder in the same way that anyone else is at risk of mental disorder if they are held in a centre like that. It is really an imprisonment situation. We believe that those people should have the same rights as all other Australians citizens in terms of the standard and quality of medical care, including psychiatric care, available to them. We have a very strong view on that and we have put that view a number of times. We are constantly given information which is very disturbing about the lack of care for people in those facilities.

Siting those facilities well away from centres of medical excellence or medical availability is compounding this problem again. The facilities need to be made available so that those people can be adequately diagnosed. We constantly hear in the psychiatry world that people in those centres who are disturbed are not being diagnosed properly, and we are all well aware of a recent famous case. That should not occur in a society like Australia's, where we do have the resources. This is a small group of people; the costs would not be very great at all to provide those services. We have a very strong view that they should get the same standard of care as all other Australians.

CHAIR—I am not sure whether it is 50 per cent, but it must be close to that, of the submissions to this inquiry are from distressed families, usually about a son or daughter who has attempted suicide and with complaints that the families are not included in discussions about regimes. Do you have a view about whether our privacy laws ought to be changed in regard to this? Do you see any movement in terms of the medical profession dealing more with families or is this not an issue for you?

Dr Nothling—I had experience in child and family psychiatry in 1974 in Canada at McMaster University. It is very important to involve the families of adolescents and children. There are problems with the privacy laws in this country that doctors have to be aware of when they are treating younger people. There are ways around that. One of them is to get the permission of the adolescent to have their family come in and for doctors to see them all together, but there are difficulties of course if a doctor should then try to communicate with the family if the adolescent says they do not want that to happen. We believe that is an area that needs further investigation. I think we need to be clear about what we do there.

Dr Pring—I have a particular interest in privacy in relation to mental health. I am on the federal Privacy Commissioner's advisory committee. It is a difficult issue and one that we are very interested in. Through our own colleges of psychiatrists and also through the AMA I have discussed with my GP colleagues the importance of health workers, including doctors, being familiar with dealing with family groups. That is one of the key things that Dr Nothling and I

had in our early training, but not everyone in the health area has had that training. I think that is a useful area of training so that people become familiar with interacting with family groups. Interacting with families is different than interacting on a one-to-one basis. We are already initiating things in that area.

One interesting area that touches on government is that, for psychiatrists, rebates are available under Medicare for seeing family members on I think two occasions a year. The rebates are extremely small, so in my own practice I usually do not bother charging for family members. But, if you really wanted to encourage it from a government perspective, it would be possible to look at those item numbers and combine that with a proper training program, perhaps not just in psychiatry but in other areas, to foster greater involvement of families and carers.

When it comes down to exact privacy, the practitioner will still have to make difficult decisions on a case-by-case basis. Interestingly, I was at a meeting about privacy and a number of consumer members were present. One spoke up and said that, if they had known that the practitioner was going to communicate with their family at one particular time they would have definitely suicided, in their opinion, and the fact that they knew that the practitioner would not communicate with their family allowed them to get through that time to a point where they had much better mental health. So you can find cases on either side of the question. It is very complex. I think the privacy laws are not too bad in Australia under the present regime, but dealing with that difficult situation is the hard bit, really.

CHAIR—Thank you for your presentation today and for making the submission. It is very valuable to us.

[3.38 p.m.]

BOND, Professor Gary, Guest Speaker for Schizophrenia Awareness Week; Visiting International Speaker, Mental Illness Fellowship of Australia

WAGHORN, Mr Geoffrey, Research Scientist, Queensland Centre for Mental Health Research and Mental Illness Fellowship of Australia

CHAIR—Welcome. I understand, Professor Bond, that you are in Australia on a Schizophrenia Awareness Week trip. We are very grateful to the Mental Illness Fellowship for facilitating your visit to Australia and for the timing being such that you can appear before us today. I understand you have a presentation for the committee. I would ask you to proceed with that now. At the end of that, we will ask you questions.

A PowerPoint presentation was then given—

Prof. Bond—Thank you. I am pleased and honoured to be here today. What I would like to talk to you about is the potential for people with severe mental illness to work in mainstream employment, which is an area of research that I have pursued for the last 25 years. I could not have given this presentation when I started out 25 years ago because most professionals believed that people with schizophrenia, manic depressive disorder and other psychotic disorders could not work. In fact, we did not have good programs that were effective in helping people achieve those goals. But recently in the United States and elsewhere we have developed a new approach, called supported employment, which is the terminology used in Australia but which has a different meaning here.

The supported employment approach I am going to describe aims at mainstream employment, and I have a pretty simple message which has three parts. Firstly, people with severe and persistent mental illness want to work; secondly, they have the capacity to work; and, thirdly, in order to achieve this goal, they need the help of the particular types of services that I am going to describe. I have given this talk several times in the last couple of days, so in the interests of time I will skim through some of this and zero in on some of the issues that I think are important for you.

The first part has to do with the importance of employment for people with severe mental illness. Why do we focus on employment? Secondly, in talking about the evidence for this approach of supported employment, I am going to describe why I call it an evidence based practice. The term ‘evidence based practice’ has gained increasing currency in the US with regard to the whole field of medicine but more recently in mental health. Evidence based practice simply means practices that have sufficient research evidence to conclude that they are effective for getting the kinds of outcomes you are looking for. Then I am going to spend a little bit of time talking about how this particular model works and, finally, what the conditions are under which it works. More particularly of interest to people in Australia is what is the chance that it could be imported from the US and work with the same results that we have achieved?

Let me begin by saying that in thinking about mental health and rehabilitation services for people with psychiatric disabilities we are increasingly, in the United States and elsewhere, trying to think about programs that are aimed at the personal goals clients would like to achieve and not focusing solely on helping them maintain in the community. In the past—in the present really, as well—many mental health programs have been aimed at stabilisation and ensuring that clients take their medication and not be a nuisance in society. The broader vision of mental health services is to look at what are their personal goals and aspirations. It turns out that most people with psychiatric disabilities have the same goals, wishes and dreams for their lives that all of us have. If you asked a person with a mental illness, ‘What would you like for your life?’ they would say, ‘I want a nice place to live, I want to have a girlfriend, I want to have a job’—a job is very high in their priorities—‘and I just want to have a decent life.’

It turns out that helping people to achieve these basic goals is a win-win situation. These are the goals that family members have for their loved ones and, in terms of society, that we want for our fellow citizens who have a mental illness—that is, they are well-integrated in the community, they are contributing members to the society and they are productive members of society and so on. On several accounts, a recovery vision makes a lot of sense in terms of designing services, especially if we can show that these services can be delivered in a cost-effective fashion. One of the points that I am going to be making is that the supported employment approach we have identified can be provided with an overall saving to the mental health community by reducing the amount of certain kinds of services which are not evidence based. I will be explaining that in a minute.

This slide showing the typical day in the life of somebody with a psychiatric disability is from a study that looked at a group of clients who kept a diary of what they did during the day. I should mention that people with mental illness are more likely to sleep longer than healthy people. The key bar that I want to focus on in the slide is the amount of time spent in what is labelled in the study as ‘passive leisure’—in other words, sitting without contact with other people, smoking, drinking, often watching television and leading pretty empty lives. Many clients are saying: ‘I’m lonely. I’m desperate. I don’t have much meaning in my life.’ Employment is one of the things that can change that picture.

When I talk about employment I refer to mainstream employment. In the United States we call that ‘competitive employment’. I do not know whether you use that term. It simply means a regular job that anybody can apply for, that pays at least the minimum wage. It is not a job that has been created. It is not a temporary job. It is a job where regular people work—that is, people without disabilities are there in the workplace.

The benefits for consumers include the fact that having a job is a typical adult role in our society. Often the first thing you ask a person when you meet them is: ‘What do you do?’ To say, ‘I don’t do anything; I go to day treatment,’ is a very different thing from saying, ‘I work at JC Penney.’ A psychologist has written about the hierarchy of needs—the things that a person needs in order to have a satisfying, meaningful life. At the bottom of the list is the need for safety. You need to feel that you are not going to be under attack. There is a need for food and shelter. You need a decent place to live and you need enough to eat. You need a place where you feel that you belong. You need to be part of a community in order to lead a full life. However, another very critical ingredient is the need to be productive.

Research shows that there are numerous benefits for people with mental illness who engage in competitive employment. There is not only increased earnings but also a very fundamental shift in a person's self-identity—their sense of self. Again, the arguments here are not very complicated. It makes a lot of sense that working changes the way that people think about themselves. Interestingly, working also has been shown to decrease the psychiatric symptoms associated with schizophrenia and manic depressive disorder. There are a lot of benefits from competitive employment and, aside from the commonsense reasons that should occur to all of us, they are part of the reason that we should be pursuing employment programs.

A lot of professionals are hesitant to encourage their clients to go into competitive employment because they worry that work will be too stressful. Family members often feel the same way: 'Gee, we just got Johnny out of the hospital. Let's not rock the boat. Let's just keep things as they are. Maybe somewhere down the line Johnny will be ready for work.'

As it turns out, it is true that work has its stresses, but, as a friend of mine says, if you think work is stressful, try unemployment for a while! Unemployment has a lot of very well known negative consequences for people without mental illness: increased depression, despair, drinking, suicide attempts. One of the major effects on mental illness is not the illness itself but one's situation and the long-term effects of not meeting the goal of being productive. Those are a few reasons, and we could go on to talk about the benefits of employment. I have been focusing on the standpoint of the consumer, but I think you could make similar arguments from the standpoint of society.

What is the reality? I mentioned earlier that work is a goal that many consumers have. In fact, over two-thirds of many surveys show that they would like to work. This is a surprise, because a lot of the professionals assume that the clients do not want to work. The reason they assume that is they have never asked them. But the surveys come out pretty loud and clear that this is one of the central dreams for people with psychiatric disabilities. In a moment Geoff is going to talk about the Australian scene. In the US many surveys have looked at the average employment rate for this group. The rate is somewhere around 10 per cent—or less in some surveys—so there is a big gap. The question is: can we close this gap? Can we help people who want to work to find jobs, or is this just a pipedream? Part of the problem in the US and elsewhere is the fact that we do not have services oriented towards helping people get jobs. One set of studies has found that fewer than five per cent of people with psychiatric disabilities have access to the quality programs that I am going to be talking about.

The answer, based on recent research is that, yes, there is an approach that works, and that model is called supported employment. I am going to present evidence that supports the claim that it is an evidence based practice. I am going to describe the approach in a little bit more detail in a second, but the big picture is that it is a very straightforward approach and one that you might use if you had a loved one who had a mental illness and they were out of work and wanted to work. You would probably already know what they are good at, what they would like to do and what they have done in the past that has been successful. You would start there in terms of looking for a job and then you would help them to locate that job. You would go through your personal network; that is the best way to find a job in most cases. Once they have landed the job, you would make darned sure that they had you as a resource to help them figure out those bumps along the road—those misunderstandings and other things that lead people to lose their jobs. It turns out that many times the reasons for job termination are small misunderstandings which we

can solve. So the idea behind supported employment is that we can help people to maintain work once they get it. I am going to leave it at that brief description and come back to the critical ingredients that have been identified as part of this model. I will now go to the evidence.

The evidence from supported employment comes from two lines of research. I have been studying programs for people with psychiatric disabilities for 25 years. I have looked at housing, case management, illness management, family psychoeducation and many other areas, and the evidence in this area, even though it is a fairly recently developed approach, is as strong and consistent as any evidence I have seen. The evidence here meets the highest standard for scientific evidence.

The evidence for supported employment comes from two sources: one consists of a series of studies that looked at converting day treatment to supported employment and the second consists of 12 randomised controlled trials. The day treatment studies involve the conversion of an approach used in the United States—and I believe you have similar types of programs in Australia—that we call day treatment. Day treatment is an approach that was originally developed to help people who were leaving hospital to avoid staying there longer and to provide a bridge back into the community. Day treatment is a structured daily routine where people come to a centre. They attend group training in how to cook and how to wash their clothes, they have recreational activities and they are often served a meal there. Often there will be artsy kinds of things that they can do. It becomes a place where people go and occupy their time.

As a short-term intervention and as a bridge back into the community, there is evidence that day treatment has its place. Unfortunately, in the United States day treatment has become an institution in its own right. People will stay literally for years in day treatment. They have had the same skills training five times, so they recycle through their cooking class five times. They get assigned to classes they do not necessarily want, because they have to fill up their dance card. So day treatment—to be unkind—has become a babysitting service in the United States. The bottom line is that there is no evidence that this is a good idea. I have scoured the literature; there is simply no research to support day treatment as a long-term solution for people with psychiatric disabilities. There is no improvement in symptoms. There is no justification for it. There is a very simple reason why we have day treatment programs in the US: that is, Medicaid pays for it and it is a very lucrative way to support mental health centres.

The logic here is: if you have an ineffective treatment, why not eliminate it and replace it with an effective treatment? That is what has happened in these six studies. All six studies were demonstration projects that required some courageous mental-health centre directors to undertake them. It has taken a lot of grief to make these changes. If you came in tomorrow and the sign on your door said, 'You've been reassigned to the motor pool; you're no longer a senator'—or, if I came home after this trip to Australia and they said, 'Sorry, Gary, you're no longer a professor; we've decided that you're going to be a secretary,' I might be a little shaken up by that. That is not how they did these conversions, these day programs, but the point is that people had a routine, the professionals liked what they were doing and had a lot of pride in what they were doing, and these conversions required breaking eggs in order to make omelettes.

I should mention that some of the staff who were opposed to this have become our greatest advocates when they have seen the changes that occur with these conversions. One of the things that happened with the day-treatment conversion studies was that, by instituting this change,

there was a large increase in the number of people working in mainstream employment. Interestingly enough, the folks that benefited the most from this conversion were the clients who were the most conscientious about coming to day treatment every day. So, if I learn of somebody who regularly attends day treatment, day after day, month after month, I am very likely to consider that person to be a treatment failure, not a success. If you look at the treatment plans in most mental health centres, even though a client might attend day treatment five days a week as a treatment goal, it is actually a failure because somebody else is forgoing an opportunity to realise their dream.

The clinicians always feel that the elimination of the day program is going to cause lots of relapses and treatment drop-outs and lots of problems, such as suicide attempts, yet in the six studies we found no evidence of any increase in any of these areas. In one study there was actually a reduction in hospital use after the conversion. Interviews with the various people who are involved in this have uniformly indicated that these conversions were positive changes. They changed the gestalt of the mental health centres. They started thinking about their clients as people who had potential. They were not just patients to give medicines to and talk about their problems with. They started thinking about what they could do. The one thing that consumers mentioned was that some of them missed going to the day program and hanging out with their friends. I should mention that one of the sad things about being a mental health patient is that over time you increasingly start identifying as your only friends other people with mental illness and your therapist. We should be going about the business of community integration, helping people to move out into the community and make connections with others without disabilities. That is also what has happened in these conversion projects. Many people who had been attending the day programs are now going to community centres, libraries, restaurants, parks and sporting events in the community. They are less likely to be hanging out at the mental health centre.

As for the final bullet point, this is a complicated matter. Economists never give us simple answers to these questions. There is some evidence—and the logic of it would seem to suggest this—that if you eliminate day programs, with their big facilities, their rent, their heating and electricity costs, and if in fact you have fewer staff required to do supported employment compared to day treatment, you can do this as a cost saving. So one of the messages here is that supported employment can be used to substitute for ineffective services. If we can find ways to realign, in terms of evidence based practices, the service systems and the different programs that the federal and state governments fund, we can get better results for the same or less money. That would be the argument that I would propose.

This graph shows the aggregated data across these six conversions. For those clients that were in the conversion sites the employment rate went from 13 per cent to almost triple that. I mentioned earlier that about two-thirds of people say they want to work. Some people did not want to work and they got out into the community more but in the denominator there are some people who did not at that time want to work. Anyway there was a dramatic increase, and for the sites that did not convert you can see that the employment rate did not climb. So you can put this one in the bank: day treatment programs do not increase employment rates.

The second line of evidence consists of randomised controlled trials, which are the gold standard in science. In medicine, if you want to test a new medication, you will compare it to an established medication and you will have random assignment of clients: clients will be randomly

assigned through a flip of a coin to either the new medication or an existing medication and then you will follow it up and look at the symptoms after a period of time and see if there is a difference. The same logic applies here. In supported employment there have been a series of 12 studies that have compared supported employment to a variety of different vocational programs—in some cases vocational programs that were believed to be the very best in their community. Eight of these studies have been done using all of the principles that I listed earlier and will be talking a little bit more about. Four of the studies were in the earlier stages before we had firmly identified this model, which was first identified in the late 1980s. This graph shows the employment rate, study by study, for supported employment and the comparison groups. The black line shows the employment rate for supported employment. Almost all of the later studies in particular had a success rate of 60 per cent, so 60 per cent of clients were achieving competitive employment after involvement in the supported employment program. You will recall that I mentioned earlier that 10 per cent is the baseline, as a rule of thumb, for what people achieve without any assistance.

You can see that the comparison was lower in every single case in the control group, and these were done in a variety of settings—in large cities like New York City, Chicago, Baltimore, Maryland and Washington DC and in very rural areas like New Hampshire, South Carolina and parts of Indiana. So the model has been very robust in replicating different types of communities. The summary from these data is that 12 out of 12 had significantly better employment outcomes in terms of earnings, job tenure, time of first job, the number of people working full time and employment rate. Aggregating across those studies the rate was about 59 per cent, and the rate for the comparison groups, which were regarded at the time as the best the community had to offer, was one-third of that rate, and that is a large difference. So those are the data that say that we should consider this an evidence based practice. As in other areas of medicine, if I have hypertension and go to the doctor, I want the very best treatment for it. I do not go to the doctor and say, ‘What funding programs do you have available?’ and ‘What government programs do you have available?’ I do not ask the doctor, ‘Where did you go to school; which school of thought do you have on hypertension; do you believe in the psychodynamic theory of hypertension?’ We ask: what does the science say? That is exactly the question we should be asking for people with psychiatric disabilities. We should not be asking: what governmental program can we tweak to serve our clients? We should be starting with the answer. The answer is: how do we get the results we want? We should be asking the question: how much does it cost? I agree with that. Let me throw out that figure, because you might be interested in that. Our data show that, on average, it costs \$2,500 per year per client to serve people in a supported employment program. So, from my standpoint, that is a bargain compared with day treatment programs, which are considerably higher.

I want to talk a little now about the ingredients of this model. It has been a very well defined model, and each of these ingredients has evidence to specifically support the theory that this is a good idea. The first principle says that there is only one criterion for being accepted into this program. This is a very provocative idea: that there should not be preconditions to be enrolled in this program—except that you have a psychiatric disability and you say that you want to work. That is the only requirement. You do not need to get a permission slip from your case manager, and you do not have to say that you are taking your medication. If you have a drinking problem, that does not exclude you. In fact, interestingly enough, people who are dually disordered with mental illness and substance use do just as well as people without a dual disorder. You do not have to show that you have passed some test to show that you have some abilities, and you do

not have to show that you are work ready. All these things that I have mentioned are things that have been used in the United States as barriers and conditions before people can enrol in one of these programs. The reason we have this in principle is not that we are bleeding heart liberals but that the evidence says this is the way to go. A list of some other things that have been used to exclude people includes that they are too young, that they are too old, that they lack motivation et cetera. The evidence says that we are unable to find any subgroup that would benefit more from another type of program. In every single case, every time we look at an age group, a diagnosis, a work history or ethnicity, we have not found a single subgroup that did better in sheltered workshops, job clubs, clubhouses or in any of the dozens of other vocational approaches that have been developed. In every case, if you have a mental illness you are better off going into a supported employment program. Therefore, I conclude we should not have exclusion criteria unless we have a reason for doing so.

The second principle, to integrate supported employment with mental health treatment, is also very important. It has been shown in eight or nine studies to be an absolutely critical ingredient. I know this for a fact, because we did a study in Indiana where we found this very thing. Supported employment works best when you have good clinical care—with a psychiatrist involved, with a case manager who is involved in illness management involved, with housing personnel involved and with the group of professionals who are helping individuals achieve community integration working together, meeting on a daily basis and talking. Ideally, the employment staff should be employed by the same agency that employs the clinical treatment team, and they should meet and talk to each other on a regular basis.

What happens when you have this integrated approach—and I should mention that integration is important in other areas, such as in the treatment of dual disorders of mental illness and substance abuse—is that you have better communication between the different players in the care of the clients. You have more engagement, you have a lower drop-out rate and the clinicians start seeing their clients not only as people who have a lot of problems that they are trying to correct but also as people with potential. The clinicians can then get involved in the helping in the vocational planning and vice versa—the employment specialists can give information to clinicians about symptoms and other things that the clinicians should be primarily concerned with.

The third principle says that the focus should be on mainstream employment, without providing intermediate services such as day treatment or sheltered employment. In the 1950s, the idea was to develop these protected employment programs where people would do piecework, get paid a subminimum wage and get used to the idea of working so that once they had been in a sheltered workshop they would be able to graduate and move on to mainstream employment. Sheltered workshops are like the Hotel California—you can check in but you cannot check out. There is one statistic that I heard from a woman who knows the data in the United Kingdom. She said that, if you go into a sheltered workshop in the United Kingdom, you have a better chance of leaving there in a coffin than going into competitive employment; you are more likely to die and have that as your exit strategy than you are to go into competitive employment.

By analogy, this seems to be the case for other types of programs that are designed as stepping stones to going into competitive employment—they do not work. Intuitively, it makes a lot of sense. Twenty-five years ago I believed you needed to have that preparation, but in fact that is not what the data show. In addition, if you ask clients what they liked, the vast majority of them,

whether they are working currently in sheltered employment or in supported employment, say they would prefer mainstream employment. So, if we focus on what their goals are, we should keep our eye on the ball and move in that direction.

The next principle is closely related to the last, and it says that, for an employment program to be successful, it should be efficient in mobilising the resources to help the client soon after they enrol in the program. Too often we have a bunch of bureaucratic hoops that clients have to go through. Sometimes we require them to go through some kind of skills training first before they can be eligible for the employment program, and what happens so often is that the courage that it took a client to step up and say, 'I'd like to try employment,' gets dissipated. They get sidetracked on something that was not the reason they came in in the first place, and they do not have the success that a rapid job search approach has.

The rule of thumb is that, within one month of your coming into a supported employment program, you should have made at least one contact with an employer about a job. Nine studies have looked at this and eight of them have found higher employment rates when you have this rapid job search approach.

The next principle is very simple. It says that you look for jobs that match a client's preference. The story I tell around this principle is from my time in the army. On my first tour of duty the sergeant said to me, 'Private Bond, I would like you to paint this office.' So I picked up the paint brush and started painting. Two days later he stormed in and yelled at me, 'Private Bond, in my 20 years in the army you are hands-down the worst painter I've ever met.' Of course I could have told him that if he had just asked me. We do that all the time with clients. This was true when I started out in this area 25 years ago. We told clients: 'Take this job. I know you do not want to work as a janitor but it will be good for you. Trust us. You're lucky to get any job whatsoever.' That is the wrong way to go about it. It makes a lot of commonsense—and lot of these principles fall back on our common experience—that, if clients are helped to find jobs that fit with their dreams and aspirations and with their capabilities, they are going to do a lot better than if they are stuck in something that they do not want to do. That is exactly what the research shows.

Most of the time clients have a good idea of what they want to do. One of the myths is that you cannot ask clients what they want to do because they all want to be rocket scientists or airline pilots or something else that is totally unrealistic. In point of fact, most clients have a pretty good handle on what they can do. It turns out that you can work with even those who have grandiose aspirations and that you will get to a better place than if you start off by saying: 'We have a fast food job here. It's a nice low-stress job. We'll get you started tomorrow.' First of all, they are not low-stress jobs—but that is another story. Clients who are helped to get jobs that fit what they would like to do work twice as long as those who are shunted into jobs that happen to be readily available.

The sixth principle has to do with long-term support. Again, this is commonsense. We are talking about illnesses that are episodic. People need to have a lifeline. They need help with the problems that arise at work. The research shows very clearly that when clients continue to receive this support they have better outcomes than when you have government programs that say: 'After six months, sorry, that's all the funding we will give you. We've got to move on to the next client. See you later. Thank you very much.'

The *Findings from long-term outcomes from supported employment* study, which looked at outcomes three years after a client's involvement in supported employment, found that, of those who continued to receive support, 70 per cent were still working compared to a third that number who were no longer connected to the mental health centre.

Another study—and it is a very hopeful study—is the *Long-term SE follow-up study*. I have just talked to a leading researcher by the name of Bob Drake who says that this study has been replicated but not yet published. This study said, 'Let's look at people 10 years after they start in supported employment. In this study, 86 per cent of the clients were still connected to a mental health centre 10 years after enrolment in supported employment. During the 10-year period, 90 per cent of those clients had worked.

Interestingly, almost half of them were working on the day of the 10-year follow-up interview. That is a phenomenal difference when you look back at the rate of 10 per cent or at those day treatment studies where they did not convert over when they went from 12 per cent to 13 per cent. A third of the clients had worked for at least five years. If these kinds of findings hold up, they will be a real message of hope. If I could take a pill for my cholesterol that had these kinds of outcomes 10 years later—that is, if my cholesterol level was still as low 10 years later as it is now—by golly, I would continue taking that medication.

The seventh principle has to do with looking at the benefits counselling and what happens if I work—am I going to lose my disability payments? In the United States, of course, it is social security. You have an advantage here in Australia in that you do not have Medicaid that is in jeopardy if you go back to work. But that is a big worry. Forty per cent of clients say that is their No. 1 worry and the greatest fear about going back to work. Or they ask: 'If I get to work and go off benefits, can I get back on?' So what we have found is that it is critically important that you have a benefits counsellor who knows all these intricate rules. I know that in Australia you do not have the complicated rules that we have in the US—

CHAIR—We do!

Prof. Bond—It takes a rocket scientist to figure it out in the US. So in order to be able to explain it to a client—'If you earn \$10 more a week this is what is going to happen'—adding a benefits counsellor is an absolutely critical ingredient. We have one study in which Vermont deployed highly trained counsellors throughout the state. They showed that they were able to increase the clients' incomes through employment—and, consequently, they were paying more taxes too because they earned more money—as a result of this benefits counselling.

That was a whirlwind tour through this model here. Let me just say a couple of words before I turn it over to Geoff. Often when I give this talk I have people come up afterwards and say: 'Boy, that was very inspirational. Too bad that you're not talking about my clients. My clients are sicker than the ones you are talking about.' That is in the US. Sometimes I go from Indiana over to Illinois and they say: 'Boy, it must be nice for you guys in Indiana that you can do that. But it would never work in my community.' So what I want to say here is that it is model that is very flexible. It has worked in many different countries. It has been successfully implemented in the United Kingdom. We have two very good programs in Canada: one in Vancouver that has been written up and another one in Montreal. There are other programs being developed throughout Canada. Hong Kong has a number of very nice programs under way. I have been to

the Netherlands—they are starting a program there. In Japan they have just translated some of this material and they are starting down this path. So we believe that it is something that can be transported to different countries.

Does this model work in large and small communities? Sometimes models are a good idea but if they take a large team they are impractical in very rural areas. The answer is that this model has been evaluated in very rural communities as well as in large cities. It seems to be very flexible, and that seems to be one of the major advantages. So it works in different communities. It has been studied among African-Americans, Latinos, the Chinese and a number of ethnicities.

Can it work in our agency? In the United States it has predominantly been developed in mental health centres but it can also be developed in the rehabilitation sector if there is close integration with mental health agencies. I could describe a project that was done in Canada that illustrates this. But I will stop here and simply reiterate that we need to orient our mental health services towards win-win goals, of which employment seems to be a pretty obvious one. It is a simple one. It is something that people can relate to. It has a lot of social validity. It has enormous value to clients and, I believe, to our society. We have a model that has very solid data in support of it.

Mr Waghorn—This presentation relates to a discussion document that was submitted to the inquiry and it was written by Dr Chris Lloyd and me.

A PowerPoint presentation was then given—

Mr Waghorn—I have been studying this field now for eight years through both my doctorate in rehabilitation for people with schizophrenia and through my work at the Queensland Centre for Mental Health Research. In Australia we have a particular challenge. We have an award-winning level of sectorisation and fragmentation of services. Professor Bond was quite stunned by the extent of that fragmentation. We have five types of services available across four sectors—and unevenly distributed at that. We have huge amounts of money going into acute treatment and continuing health care. My boss, Professor Whiteford, has demonstrated that that has increased by about 65 per cent over the last 10 years. The employment rates for Australians have not increased in that time.

Vocational rehabilitation and disability employment is available as a Commonwealth funded system in open employment services. Disability employment services are called ‘supported employment’ here. There is room for a bit of confusion in terminology, because what we officially call ‘supported employment’ here is actually a sheltered workshop model. What Professor Bond is talking about is what we refer to typically as ‘open employment’. We also have psychiatric rehabilitation in some states and not others. It is extinct in Queensland but we do have some in Victoria. Various in the states we have quite a lot of disability support in terms of lifestyle support and support for independent living. That is also available through the PSP—the personal support program—a Commonwealth funded program. We have educational and vocational training in the state and private sectors. We have a world-leading level of income support and fringe benefits through our Commonwealth system.

However, when we map it a little further we get the array of services shown in the box chart on the next slide. The columns represent sectors: the private sector, the non-government sector,

the state sector and the federal sector. The services shown in colour down the left hand side are the ones I am particularly interested in; however, they are also nested in with psychiatric rehabilitation, home and community care, disability support and advocacy services, which are much less frequently available. Income support and fringe benefits are more evenly distributed. However, you can imagine how difficult it would be to access all of those different services if you were a mental health consumer or a family, because each of those services has its own access requirements, its own set of rules and its own definitions of what psychiatric disability is. It is what I call the ‘unholy mix’. It is an unholy mix of things which are more or less inaccessible because they are so fragmented.

A notable thing is that not one of those services is funded to provide any sort of coordination with any other service. Whenever I talk to anybody represented by one of the cells on this chart they are almost noncognisant of the others—they always talk as though they are the only service in existence. As a researcher it is extremely frustrating trying to draw their attention to this mix, because if they are a federal government service, like CRS Australia, they are not particularly interested in what is provided by the state government by way of psychiatric rehabilitation. They are not particularly interested in or knowledgeable about Home and Community Care. It is incredibly frustrating. One of the things that Professor Bond’s research is showing is that doing something really simple like combining mental health treatment and care with vocational rehabilitation can take a lot of that complexity out straight away. Sure, it may be a challenge in terms of how we combine the funding and quality systems to monitor that type of approach, but if someone had the power to do it at the stroke of a pen it would be an immediate improvement.

Senator TROETH—What is the benefit available listed on the chart above ‘fringe benefits’? It is not easy to read.

Mr Waghorn—Income support.

Senator TROETH—Thank you.

Mr Waghorn—That is the most consistently available service, and a very good one. I must point out that I worked for Social Security for 17 years and I did some of that benefits counselling that Professor Bond was talking about. I found that we were able to make an enormous difference to people’s motivation to engage in employment once they understood how their pension would or would not be affected, so that was really important.

This slide shows a few things we can say about that system. Professor Whiteford helped to draft the National Mental Health Plan and he acknowledges openly that recovery for people with mental illness cannot be achieved in the health sector alone. There is only a certain amount that the health sector can do for people with mental illness. It can provide treatment and health care, but it cannot restore their lost lives. Their lives are lost because mental illness disrupts their education and it disrupts their transition from school to work. The most severe mental disorders occur in the second and third decades of life, at that critical time when people are forming career pathways and trying to complete their high school. So the other sectors have to play a role in taking up the assistance.

Access is the major difficulty reported, and access difficulties are increased by the multiplicity of services. Services are not evenly distributed. I imagine that in some areas we have a surplus of

services. Certainly, in Victoria, you can have up to six case managers looking after a person. This has happened in my experience. You can be trying to place someone in employment, and a lifestyle support service will contact you and they have a case manager that is looking after the person. A psychiatric rehabilitation service will contact you. A Job Network provider will contact you. A CRS person will contact you and tell you they are looking after the person. Their psychiatrist may ring you and their mental health case manager will ring you. You can actually be dealing with an awful lot of people—and that is before you have even got to their family. There can be a huge amount of waste and an overlap. And often each one of those services will not have responsibility for employment. They think of psychiatric rehabilitation as some kind of recovery model. But when you ask them more about their recovery model, you find it does not include employment. It does not include employment because they never ask the people whether they want a job, because they are not funded to do employment; therefore, they never ask about that. That is the kind of conundrum I come across all the time.

The other issues are important too. In the non-health sectors, people with mental illness frequently encounter unfair discrimination. It is usually because there is a low level of mental health literacy. Sometimes illness behaviours are interpreted as bad behaviour and people are treated unfairly because of that. Also, in the health sectors, I frequently encounter psychiatrists, psychologists and allied health professionals who think that people with mental illness cannot work. They think that because they have never seen anybody succeed in psychiatric vocational rehabilitation, and that is because they deal with treatment; they do not see anybody for the purpose of psychiatric rehabilitation. Jacob Cohen once described it as the clinician's illusion. If you only see chronically relapsing patients because you work in the public mental health sector and you do not deal with employment, you begin to think that all patients are chronically relapsing. And you can get the opposite illusion in a very effective employment service that might have screening criteria. If it has screening criteria and only the people who are most well come along, you begin to think that only well people can get a job. So we can be fostering these two opposing illusions.

As community mental health services are not funded to provide psychiatric vocational rehabilitation, they have no skills in that. Whereas they might be accumulating skills in community mental health care, they have no skills in or understanding of what is needed in the workplace. Quite often, if they ever do train support workers for disability support or lifestyle support, those support workers do not understand the type of support that is needed for supported employment because there is a different goal operating. The aim is to get the person to come up to the employer's requirements. So there are expectations of normal behaviour: good social skills, being well dressed and well groomed—appropriate behaviours in the workplace. In much of the disability and lifestyle support that I see, the support workers start to dress like their clients. They start to wear jeans, they start to get sloppy and they start to go around and visit for coffee. They stay having coffee for two hours. They seem to act as if there is nothing else to do every day. That is exactly the wrong kind of support to provide for someone that wants to get a job. So that is another issue that we are up against.

We now move to some figures that we have accumulated over the last few years. These figures come from two important surveys in Australia. This is where I can be proud of what happens in Australia. In the United States it is very difficult for them to do a national survey—the sampling difficulties would be horrendous—whereas in Australia we have the Australian Bureau of Statistics, which does a wonderful job of conducting the five-yearly surveys of disability, ageing

and carers. This slide is from the 1998 survey. The information in the schizophrenia row down the bottom of the slide is from the low-prevalence sort of survey that was conducted through the ABS of people with psychotic disorders. That was a random sample of 980 people from a screening of 3,800 people in contact with mental health services. So that is a very representative number. These other lines are from a sample of 40,000 in the ABS survey. The top ratio is healthy Australians. We removed everybody that had a long-term health condition or disability, and we found that 19.9 per cent of healthy Australians were not in the labour force in 1998, 6.3 per cent were looking for work and 73.8 per cent were employed either part time or full time. This proportion of employment decreases through anxiety disorders, bipolar affected disorders and psychotic disorders and reaches the lowest in schizophrenia, at 16.3 per cent.

To me, the question is: what does this mean? As a researcher, this means to me that our existing network of services, vocational and other, do not penetrate to people with mental illnesses. In this population survey people were also asked, 'Did you get help from a job placement agency?' Nobody with a psychotic disorder said they did, and only 2.4 per cent of people with anxiety disorders said they did. This to me indicates that there is a large proportion of people here not in the labour force—discouraged job seekers, you could call them—that are not being reached by our existing services network. That concerns me a lot.

The other figures you might be more familiar with. These are the figures that come from the department's concern that 25 per cent of people receiving a disability support pension—roughly 200,000 people—of working age have psychiatric disabilities. Thirty per cent of clients of open employment services in 2002 had psychiatric disabilities. But only 12.2 per cent of those had employment outcomes, whereas 55 per cent of people with intellectual disabilities had employment outcomes. So I ask myself: why is that? It is quite natural, really, when you think about the origin of the disability employment service concept. It arose from the model designed for people with intellectual disabilities. Of course it works better for that group. The disability category with the lowest durable work outcomes in 2002 was also people with psychiatric disabilities. The message here is that the current service designs are not working well for people with mental illness in Australia.

This next slide shows data from the survey of disability, ageing and carers. This is the whole-of-life picture, the picture by age group, even though it is a cross-sectional survey. We have 15- to 24-year-olds in this corner of the graph that I am pointing to, and 55- to 64-year-olds in this corner. The black line on the graph represents healthy people with no health condition or disability. You can see here the rapid exodus from the labour market at age 55. You can see how the addition of anxiety or depression—and there is nobody with a more severe disorder than that in this group—leads to an even more rapid exodus and also downward displacement, where you have the maximum displacement among those with severe to profound employment restrictions. Anxiety is on this line and depression is on this line.

It is a bit of a complicated graph. But it shows that both the type of disorder—anxiety and depression—and the level of employment restrictions are important. It varies over the age group. The interesting thing about this graph, too, is that at this point here 60 per cent of healthy persons aged 15 to 24 are in employment. But what I do not show is that there are another 30 per cent that are in school. So that would bring that up to about 90 per cent in vocational activity, whereas for people with anxiety disorders only three per cent are in school. So we could add another three per cent to some of these, and that would give us an even bigger gap.

Even though the focus of what Professor Bond has been saying has been on severe mental illness, I am showing here that a relatively light level of mental illness can lead to a huge displacement from the labour market. This indicates to me that our existing services are not even doing well for light mental illness, let alone severe mental illness. I cannot be exactly sure of the causes of all this but that is not a very good picture. I think that is the baseline from which we need to improve.

We also looked at the reasons people are not in the labour force. We found that 50 per cent of people with anxiety disorders said health reasons were the main reason they were not in the labour force. Amongst healthy people, it is only 1.9 per cent, as you would expect. People with anxiety are not actually seeking early retirement as much as we would expect. It is only 11 per cent, compared to 15 per cent of healthy people. Some are caring for children and other adults, but it is a lower percentage than in the healthy group. I mentioned the figure for formal study before. Thirty per cent of healthy people are studying compared to three per cent of people with anxiety disorders. Interestingly, concern for preserving welfare payments was not a major factor in the survey. I am not sure what exactly that means but it could mean that, compared to these other reasons, concern for welfare payments was not anywhere near as important.

CHAIR—I need to go at a quarter to five exactly but other members are able to stay a little longer, possibly until 10 to five or five o'clock. I am not sure what your time constraints are. Professor Bond, I know you have another presentation to give. Are you able to go on a little beyond the timetable?

Prof. Bond—Yes.

CHAIR—So you will not mind if I disappear and hand over to Senator Humphries to chair.

Mr Waghorn—Thank you. So that was revealing for us. Then we looked at the kinds of employment restrictions that people reported. Amongst the anxiety group, 23 per cent said they felt a need for ongoing support even if they were to get a job. Amongst people with psychosis, it was 61 per cent. That is important because many of the services in Australia do not provide ongoing support. Our biggest provider of vocational rehabilitation is CRS Australia. They provide support for over 30 days. So that to me indicates a shortfall in the service design.

Some people said that they were restricted in changing jobs. That is important too because we do not fund any services in Australia to help people change jobs. We only fund services to get people into an entry-level job as soon as possible. But, to have a career, people with mental disorders, like the rest of us, need to move sideways sometimes to go forward. Changing jobs is an important, unmet need. Some people with mental disorders need special arrangements or equipment, which is often overlooked. Only a small percentage in each group reported no employment restrictions. To me that is important because that means that services like the Job Network, where mental health literacy may be low and the understanding of people with more severe employment restrictions may be lacking, may be unsuitable services for the vast majority of people with mental disorders. This is what I use to explain to people a little more about employment restrictions.

This also gets at the concept of work-readiness too. None of us are work-ready for any type of job. We can only be considered work-ready with respect to a specific job. One of the

philosophical issues I have constantly is that I hear some ministers talk about work-readiness: 'If only we could assess work-readiness better, we would be able to stream people into the right programs.' But I think work-readiness is a myth or it is a concept used to deny people access to services. I am not ready to be a professor. I am almost ready to be a senior researcher. I think I could manage some of that quite well.

I have to ask about Snoopy in the cartoon on the slide, though. Is Snoopy just unmotivated or is he welfare independent?

CHAIR—He has language problems.

Mr Waghorn—I am sorry this next slide is so busy. By column, I have open employment services or sheltered employment, CRS Australia, Job Network, group based programs like clubhouses and social firms, and the community mental health sector. On the left side, I have added the seven principles that Professor Bond has been talking about. I have tried to map whether I think those principles exist in Australia or not. This could be seen as an attempt to benchmark what we are currently doing. Is eligibility based on consumer choice? In open employment services, partly. They choose to apply to that particular service, but that service has a right of refusal. CRS Australia? Partly. CRS has a right under section 22 of the Disability Services Act 1986 to say, 'No, we don't think so; we can't see substantial gain happening.' Each caseworker can say no to anybody. If the person is a bit scruffy or smelly or smells of alcohol, they would say no immediately. They might even say no to anybody who has more than a very light level of employment restriction. If they are being driven by a business model, that kind of structure would probably reinforce that approach. Whether they were able to admit it or not, it could easily happen.

The Job Network? Partly. There is a lot of choice about which provider people go to, but they have to admit Centrelink requirements first, so it is not all consumer choice. Clubhouses and social firms that are designed particularly for people with more severe mental illness tend to have much more of an open-door policy. They tend to take many more people, if they have the places. Community mental health? Definitely not, even if they have a very severe anxiety disorder like post-traumatic stress disorder or obsessive compulsive disorder. They have strict eligibility requirements. Sometimes they are restricted to people with psychosis. The entry requirements can be quite strict. Integration of employment with mental health treatment? Partly. It depends on how well they consult with their local mental health providers. CRS Australia are a bit different because they have a multidisciplinary team of allied health professionals. Job Network? It could be added but generally not. Group based employment? They generally see themselves as self-sufficient; they do not try to liaise with psychiatrists or treating professionals. I will leave that with you to look at if you need to, but it shows that in no one column are we doing more than half of the things that Professor Bond has indicated. To improve, we need to do all of the things in at least one column.

This is the last busy slide I will be showing you. These are the forward-thinking ones—things that we think could lead to innovation and improvement beyond the evidence based principles that have been identified already. Intensive on-site support is sometimes required when you need the job support worker to learn the job to find the best way to teach it. Multidisciplinary teams can add things as long as they do not use that intervention to slow up the process. In treatment, the rehabilitation alliance is a very powerful thing. Sometimes the non-specific aspects of that

can be better than the actual formal treatment. I have written about planned strategies to manage disclosure and counter stigma in another paper that I submitted a while ago. That is not generally done in Australian services because there has not been much work done on this topic, but there are ways of planning disclosure so that it does not lead to unfair discrimination. There are ways of planning strategies to counter stigma in the workplace, because the antidiscrimination legislation is not sufficient; it is too easy for employers to evade their responsibilities. There are too many other reasons they can use to fire someone or downgrade their duties. What we find is that, if the employment specialist can learn some planned strategies to manage disclosure and counter stigma throughout the placement and educate the workplace, that can lead to improvements in the wider community.

Next, there is the use of families to support employment goals and provide natural support. That is something we think could help in the future and we would like to see that kind of thing investigated. These are just a few things we would like the research to pick up in the future. These are a couple of things we think can be drawn from this work so far. The first one is about the nonparticipation in the labour force and the possible nonpenetration of existing services by the people who might benefit from those services.

Coexistent with that is a frustration I have as a researcher trying to gain access to quality data. All of the systems that provide these services have data collection, but gaining access is another issue. I have been negotiating with the Department of Family and Community Services for three years for access to the case based funding trial data but I still have not succeeded. CRS Australia tell me regularly that they have data but they have not offered me any agreements to share it. I can sometimes get data through the Australian Institute of Health and Welfare when they publish reports on open employment services but by far my best source of data is from the Australian Bureau of Statistics. Unfortunately, they do not collect much in the way of vocational service variables. Although their mental health and disability variables are very good and their labour market variables are good, their data on the actual services a person has received are very poor. So I could use a better set of variables to follow in the future.

As a broader issue, that means that there is no point in spending more money on these services until we can evaluate them and inform the development of them over time. Even if we were to change to a fantastic new evidence based model we would still need to know how badly we were doing now in order to gauge the improvement and in order to justify a broader shift to an evidence based practice. It is not the data collection that is the problem—data collection is happening everywhere—but data integration, accuracy and validity are the real issue. Maybe agencies like the Australian Bureau of Statistics can help with that because they are very good at that.

The other thing that is missing in Australia is supported education. We do not fund anybody to do that even though we recognise that education is a strong predictor of employment outcomes. The data that Professor Bond presented showed that there were no predictors of outcomes in his research because they were high intervention studies. With those energetic interventions almost all the other demographic variables and predictor variables can be overcome. But in my research through the population surveys, I found that education is a very strong predictor of outcome among people with mental illness.

For young people in particular the issue is not just getting them an entry level job, it is about getting them access to the skills and training they will need to have a career. I think that goes for older workers too. They need career opportunities, not just jobs. You cannot have career opportunities unless you have skills and education. People with mental illness are not intellectually disabled; they can study. The research that we have done indicates that the study support systems in our universities and colleges are not adequate for people with mental illness.

Even though we have disability support systems they are usually geared towards people with physical disabilities, and the disability officers usually have low mental health literacy. So they are not usually very good identifying the accommodations that might be needed for people with severe mental illness. So these things, too, need a little bit of work. Accredited training in psychiatric vocational rehabilitation and mental health literacy is needed across the sector. Just as the training in dementia has been identified as a need in the aged care sector so training in vocational rehabilitation is needed in the health sector. Pooling knowledge and mental health expertise with vocational expertise is one of the key things we could do quickly in Australia.

In summary, increasing resources may not help at present unless we can get a shift towards more evidence based practices. Without coordinated data collection and demonstration projects to inform service development we may not be able to convince people that change is beneficial. So those are a couple of suggestions for the way forward. I would just like to acknowledge Professor Harvey Whiteford, Dr David Chant, the University of Queensland and in particular the Mental Illness Fellowship of Australia, including the board members, staff and the 15,000 members and member organisations who assisted in the preparation of the report.

ACTING CHAIR (Senator Humphries)—Thank you very much, Mr Waghorn and Professor Bond, for those presentations. There was a lot of useful information in those slides. Would we be able to get a hard copy of those slides for the committee's perusal?

Prof. Bond—I have the presentation on the laptop. Will that work?

ACTING CHAIR—Yes, if you give it to us in that form we can download it and distribute it to the members of the committee. Thank you for that. There are a lot of issues that you have raised in those presentations, but we do not actually have time to deal with them at the moment. My colleagues may well have questions about the issues you have presented on, and we may deal with those by way of correspondence with you. We may have the secretary get in touch with you with some questions and it would be great if you could provide us with some answers on those issues.

Prof. Bond—Sure; I would be glad to do that.

ACTING CHAIR—In light of the shortness of time, we might draw this hearing to a close. Thank you very much for your time here today. Professor Bond, I hope your time in Australia is successful. I also want to thank all the other people who have given evidence today before the committee. As there is no other business, I declare the committee adjourned.

Committee adjourned at 4.55 p.m.