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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

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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, Scullion 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.

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Committee met at 9.02 am**PHILLIPS, Dr Georgina Ann, Private capacity**

CHAIR (Senator Allison)—This is the fourth 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. Witnesses are reminded of the notes that 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 an in camera session. It is important that witnesses give the committee notice if they intend to give evidence in camera.

Welcome, Dr Phillips. Thank you for coming. You have lodged with the committee a submission which we have numbered 255. Do you wish to make any amendments or additions to that submission at this stage?

Dr Phillips—No.

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

Dr Phillips—Firstly, I would like to thank the committee for inviting me to give evidence at this public hearing. My evidence is based on my personal experience and observations as a doctor working within the public hospital system for over 10 years, having graduated in medicine in 1993 from the University of Melbourne. I have been based for the last eight years in inner urban public hospital emergency departments as I have completed my specialisation in emergency medicine. I currently work as a full-time staff specialist in emergency medicine in an inner urban public hospital.

The particular mental health experience enabling me to give evidence today derives from my clinical involvement in the assessment and management of the acutely unwell psychiatric patient in the ED as well as a six-month placement as a psychiatry registrar in a community mental health clinic in 2002. My evidence focuses on issues relating to the acute care and after-hours crisis services for people with mental illness, including the practice of detention and seclusion. I will also make a brief comment on community care and discuss issues pertaining to two special-needs groups: the aged and those with the dual diagnosis of drug and alcohol abuse.

Demand for acute psychiatric services in an emergency department context is increasing as the complexity and acuity of mental illness in the community grows. Emergency departments are accessible and provide a safe and secure environment, with highly trained staff immediately available and multiple therapeutic resources at hand. Alternative sources of acute containment and assessment such as the police and CAT—the crisis assessment and treatment teams—are increasingly using the ED as their preferred site of care. This is appropriate and desirable, yet it is made difficult by a lack of both personnel and material resources in emergency departments.

For acutely mentally unwell patients, violations of privacy and dignity are carried out daily in emergency departments. Threatening behaviour and violent incidents and the management of

these have implications for the wellbeing of the patients themselves, for other patients and carers in the ED as well as for staff who suffer a high incidence of burnout. These issues are magnified by time delays to definitive care, where acutely mentally unwell patients may wait hours in the ED for a formal psychiatric assessment and often over 24 hours for an in-patient bed. Time delays affect the mental state of the unwell patient and often necessitate the application of restraint in either a chemical—drugs—or physical—shackles—form. This form of containment can be appropriate in the short term; however, prolonged restraint has risks and is unpleasant, inhumane and possibly unethical from a human rights perspective.

The pressure on in-patient beds—bed access—sets up a cycle of crisis management where unstable patients are discharged early, without adequately resourced community supports. They deteriorate and require more urgent care, then turn up to an emergency department—thus the cycle continues. Novel approaches by some emergency departments to provide better care have included dedicated rooms for acute psychiatric assessment and containment. More creativity is needed. As we have seen the evolution of trauma centres in Australian emergency departments, so we can hope for a similar level of enthusiasm and support for state-of-the art expertise in the emergency care of the acute psychiatric patient.

Public mental health in the community is focused on crisis management, with services limited to those with mostly psychotic illness. This is a resource issue, yet it results in restricted access for a large number of needy people with mood and personality disorders. Financial barriers exist to accessing medical models of care with the rise of the user-pays system. Without significant financial resources, it is virtually impossible to access non-medical models of psychiatric care which are known to have lasting therapeutic value.

Lastly, a brief comment on two special needs groups. Recent years have seen an increase in the use of the ED as a form of crisis containment for the mentally unwell aged—the psychogeriatric person—often as a result of inadequate community assessment, management and support. The ED is a particularly non-therapeutic environment for the aged with both mental and physical risks. Psychogeriatric services are ill-equipped to provide acute care in this setting and delays for definitive care can stretch to days, which is clearly unacceptable.

Patients with both substance abuse and mental illness issues are particularly vulnerable to social and medical risks, including accidental or deliberate self-harm. They are heavy users of the emergency department and are extremely stressful for ED staff to manage, not only because of acute behavioural disturbance but also because of frequent re-presentations and a lack of willingness or capacity of either mental health or drug and alcohol services to own the patient and direct their care. These patients are too complex for the limitations of our current system, yet they are at real risk of harm.

In summary, the emergency department is the necessary and appropriate site for the assessment, containment and management of the acutely unwell, mentally ill patient. Resource allocation in the future must acknowledge this to ensure that the care provided is safe, humane and therapeutic.

CHAIR—Thank you, Dr Phillips. I will start by asking you about how it is historically that emergency departments have not developed adequate services and an adequate environment for

people with mental illness. It cannot be that it is just over the last two or three years that emergency departments have found a great number of people attending them for that purpose.

Dr Phillips—Emergency medicine as a specialty is fairly new to begin with. There has certainly been a rise over recent times, over the last five years or so, in the attendance of acutely psychiatrically ill patients. Many emergency departments were designed before then or around that time, and there is a debate going on about how much this is our business and how much it should be the business of mental health services. Whilst issues such as trauma are obviously emergency services and are also glamorous—there are a lot of resources for that—our thinking about how we might better look after psychiatrically unwell patients has lagged. Maybe it is an image issue, but also there has been a real increase in the utilisation of the ED as a place for containment and acute assessment.

CHAIR—I for one was under the impression that CAT teams were being used extensively here in Victoria, where I think the concept began, and in other states. We were surprised to learn that in Canberra the Police Federation, as they explained, were essentially now the first port of call. They even sat with patients in emergency departments for some hours on end and sometimes had to take them back and leave them on the streets because there was no service for them. Is that your experience here in Victoria?

Dr Phillips—Increasingly, police and CAT teams prefer to use the emergency department as a site for assessment and containment. It is much safer and there are more options for urgent containment. It is a more appropriate site than, say, a police lockup for someone who has an acute psychiatric problem. There is a safety issue when assessing people in the community, and there are fears about loss of control or what might happen if something goes wrong. I think that is behind the preference for bringing people into the ED to perform the containment and the assessment.

CHAIR—Can you explain how, if at all, you work with the CAT teams?

Dr Phillips—We work extensively with the CAT teams. Most hospitals in Victoria—and I dare say probably in other states—would have a 24-hour psychiatric triage worker in the emergency department. They are usually members of CAT teams who rotate through the ED, and they are liaising constantly with the community teams. Often we have people come into the ED who require a CAT team assessment. It may take hours for the CAT team to come in and assess the person in the emergency department. There is an extensive liaison with CAT teams, which may refer patients into the emergency department for a medical assessment, and the assessing clinicians in the ED will often be the follow-up source for patients who did get discharged from the ED.

Senator HUMPHRIES—Looking at your description of what should change in an ED to more humanely deal with people in a psychotic state, it sounds to me as if the most important thing would be to create stand-alone facilities or separated facilities where there could be a sensitive handling of people with that kind of condition. Is that the nub of what you are saying? What would cause the great expense that you have referred to, in upgrading the facilities to accommodate that new approach?

Dr Phillips—I would caution against a stand-alone facility. I think most emergency people would like to—

Senator HUMPHRIES—I probably used the wrong word; I meant a separated facility.

Dr Phillips—Yes. I think the care of the psychiatrically ill patient should still be part of the broad practice of emergency medicine. What I am referring to is a section of the emergency department that may be secure; it may be locked. It might have lounges or couches rather than people shackled on trolleys or in cubicles. There may be a place to make a cup of tea or coffee. Also there may be a more acute site for the urgent attention of people who, with severe disturbance, may need more medical involvement.

There is certainly an overlap between people with acute behavioural disturbance that may be in the end from a medical cause rather than from a purely psychiatric cause, so you certainly need to have the two systems working in collaboration. There is certainly room for a lot more geographical resources, but also personnel resources. Because it is quite often very stressful and high intensity looking after these kinds of patients, it requires quite a high level of training and support. So that would mean medical staff, nursing staff, security staff, orderlies et cetera—all those people who are involved in the care of patients in most emergency departments—all need training, support, back-up and all those sorts of things.

Senator HUMPHRIES—So it would be a secure area but it would not have the air of a seclusion cell or something like that.

Dr Phillips—You may need something like that, but there are many people who need to be kept in an emergency department to prevent absconding but who do not need to be shackled or sedated, so you certainly could have a space for those kinds of patients that is much more comfortable and humane. It could also be for the elderly who are waiting. They sometimes wait for days for a psychogeriatric bed in a cubicle on a trolley—it is just a recipe for disaster.

Senator HUMPHRIES—We have heard evidence about the deleterious effects of seclusion on some mentally ill people. Obviously that is a matter that ED staff would be well aware of and they would make a judgment about the type of treatment of a particular individual. We received some evidence yesterday about the nature of mental illness and the question of whether or not it was necessary for some people to be treated against their consent or without their consent. The argument was put by groups like *insane australia* that there should never be a pretext for involuntary treatment. What is your response to that view?

Dr Phillips—I think in an emergency context it is virtually impossible to make that judgment of whether a person is competent to decide management for themselves. They often come in acutely distressed, often with acute behavioural changes and they may have drug or alcohol issues as well. They are often brought in by family members, police or other members of the community for assessment. In that highly charged environment it is just about impossible to say, 'This person is safe for discharge and they are competent to say that they can leave.' So we often have to err on the side of caution and we will contain somebody against their will for the purposes of thorough assessment.

Senator HUMPHRIES—And that is necessary, in your view?

Dr Phillips—Yes, I think it is necessary.

Senator HUMPHRIES—Lastly, this situation with the pressure on EDs and the inappropriateness of treatment and so on is obviously an issue that spills out to and affects other operations and other procedures going on in the ED. Has there been any public pressure or public raising of this issue in the media? Has it spilled over into unfortunate headlines about what goes on in EDs? If so, has it led to reaction from the state government to deal with the problem in some way?

Dr Phillips—It has certainly been a topical issue in the Victorian media just recently—the number of psychiatric patients that come to EDs per year. Of course every now and then there are stories that enter the media about the inhumane and distressing treatment that somebody received or a patient's relative or another patient witnessed in the emergency department. It is certainly a very hot and controversial topic. Many emergency departments are exploring this issue of how we can respond more appropriately, but it comes down to willpower and resources.

Senator HUMPHRIES—Cynically you might say that it is not until the issue becomes a very squeaky wheel that there will be some oil applied to it.

Dr Phillips—Yes, of course.

Senator HUMPHRIES—Do you think that is going to happen? Do you think there is enough public awareness of this problem to see some action in terms of spending more money to get those sorts of facilities within EDs?

Dr Phillips—I think mental health suffers adversely in many ways from the historical stigma of being unattractive and often distressing. There is always the tension between people's human rights and liberties and the necessity to keep people in locked or ward environments. Also there is the tension between treating people with mental illness as non-medical or separating their treatment away from the rest of the medical approach. I certainly think that it is part of the broad church of medicine. It is certainly a large part of our workload in the emergency department; we embrace it and try to do the best that we can. I do not think it should be separated from the practice of medicine or emergency medicine. Those tensions mean that there is always debate about the appropriate way forward. You need champions to move things forward and maybe there are not many champions for mental health.

Senator FORSHAW—Does the hospital that you work at have a psych ward?

Dr Phillips—Yes.

Senator FORSHAW—Am I correct in taking from what you have said that there are shortages in terms of the number of beds or facilities in that area generally? Could the sort of setup that you are suggesting be attached to the psych ward?

Dr Phillips—There is a shortage of in-patient psych beds in the whole state. It is certainly not unique to my hospital. It is the case in most emergency departments that people wait sometimes days for in-patient beds in emergency departments.

Senator FORSHAW—That is quite disturbing.

Dr Phillips—On Monday morning when I turned up for work there were four people waiting for an in-patient psychiatric bed who had been there from the weekend. It is common. The solution is not simply to open more beds because of course they will be filled instantly. The danger—and this is part of the debate about what is the most appropriate way forward—is that if we set up something, a large geographical space that is comfortable and appropriate, and start therapeutic treatment then that de facto becomes another ward.

Senator FORSHAW—Presumably many of these people who are presenting are in need of at least some period, even if it may be a short period, of hospitalisation.

Dr Phillips—That is right.

Senator FORSHAW—We can call it all sorts of things—respite.

Dr Phillips—It is very complex and it takes a whole system approach. I can only speak from my small area in the emergency department from what I witness on a daily basis of what goes on. Setting up a space in an emergency department would have to be done with fairly careful agreements with not just our health network but other psychiatric health networks, so we do not end up—

Senator FORSHAW—Hospitals have one A&E or emergency department generally. It would cost money but is there something inherently wrong with the idea that a psych ward actually has its own, if possible, emergency department service so that people presenting in the normal ward—

Dr Phillips—Certainly, many psych—

Senator FORSHAW—I am not trying to stigmatise it, but you know what I mean, if it is a problem for the A&E.

Dr Phillips—Psychiatric wards often will take quite disturbed patients directly to their ward from the community depending on their capacity.

Senator FORSHAW—That would be for assessment.

Dr Phillips—This is how the system is ideally supposed to work. CAT teams will assess somebody in the community who needs urgent in-patient care and they will go directly to the psychiatric ward. The ward has capacity for looking after people with severe disturbance. They have seclusion sections and so forth but the problem is that there is often no capacity there and so they end up in the emergency department.

Senator FORSHAW—Everybody agreed that deinstitutionalisation was a good idea at the time and we all know the problems that that generated because of lack of services in the community. But part of the whole thing was to locate psych wards within the general hospital system.

Dr Phillips—Yes.

Senator FORSHAW—That, I would have thought, carries with it the notion that they could have their own, if you like, ED section. That is what used to happen in the old days. People would often be taken straight to the psychiatric hospital rather than going through the general public hospital system.

Dr Phillips—Yes. I think mental health belongs with the rest of medicine. Part of our emergency business is the acute care of the psychiatrically unwell patient. As I say, it is not a neat categorisation. There is often overlap between psychiatric illness and medical illness. Psychiatric patients often get consultation with various other specialty units within the hospital. I think that one emergency department is an appropriate way to go, but, as we have a trauma room—a resuscitation room for trauma cases—why can't we have more appropriate resources allocated to acute psychiatrically unwell people?

Senator MOORE—Is that view that it is appropriate for psychiatrically unwell people to be part of the emergency service area shared by other people?

Dr Phillips—I think that is—

Senator MOORE—That is the standard view?

Dr Phillips—Yes.

Senator MOORE—It is inevitable, if you are going to be sick, that you are going to go there. But we have had evidence in other places regarding a recommendation that people with psychiatric training, either doctors or specialist nurses, should be available in every emergency department or outpatient area. We were told that is not standard across the country. What is the situation in Victoria?

Dr Phillips—From my experience in urban hospitals, almost all of them have 24-hour psychiatric triage workers.

Senator MOORE—What about in regional Victoria?

Dr Phillips—That is different. The country hospitals that I have worked in have more problems accessing psychiatric assessment in an emergency department.

Senator MOORE—You said earlier that some of the issues are resources and willpower. Is that the same kind of situation there?

Dr Phillips—Yes.

Senator MOORE—In terms of the amount of thought and effort you have put into your submission, it is obviously something you have worked on and worked in for a long time. Who else do you talk to about this stuff?

Dr Phillips—My colleagues are of like mind. The team in the hospital that I work in is very supportive.

Senator MOORE—What about the various departments in the health and mental health areas?

Dr Phillips—I think there is a debate going on that I personally have not entered, although I may. I am aware that these issues are being discussed at a higher level.

Senator SCULLION—Thank you, Dr Phillips—it is fantastic to get real coalface appraisal of some of the issues that we have been talking about. I have some questions that you could perhaps take on notice. I would like to have a bit of an understanding of the demographic. What percentage of those presenting with some sort of mental illness go through the triage process? One would expect them to have a longer stay. In emergency, after there is some sort of immediate triage, you are straight out of the door, basically. There may be some treatment and you are straight out the door. It may be because the principal issue at presentation is a medical issue. What percentage would actually need the things that we started to get to—that is, seclusion or intermediate stays? As I said, perhaps you can take that on notice, although if you cannot give me that information I will understand. Maybe the secretariat can find it. Also, what percentage of those presenting with a mental illness would also require medical attention? In other words, what percentage would obviously need to be in A&E irrespective of any distress?

Whilst you say and I accept that A&E is probably the best place for people to present because of all of the issues we have talked about, clearly A&E, as I do not have to tell you, can be a pretty stressful place in any event. I have spent some time in those places myself and I recall that some of the most stressful incidents for other patients who are waiting involve people who are presenting with some mental disorder or mental illness. So when you are talking about the level of amenity, where that needs to be in a geographical and spatial sense is obviously really important. The level of amenity we have in most A&Es is such that they are packed already. It is not as if we are going to mysteriously and suddenly find another room. In hospitals we are not finding any more room. Your comments should have a serious impact on how we think about the future in terms of building new hospitals, but it is not going to be dealt with in the space of a lunch time, which is probably what this committee is thinking about.

If we are not able to have the level of amenity that you are suggesting directly within A&E, do you think for example that your hospital would have the capacity to find something somewhere away, spatially, from A&E, and not necessarily within the mental health unit in the hospital? I am referring to an intermediate triage process where they can be directly and immediately triaged, where the principle is that people need to be held outside of A&E but within an area that provides the amenity that you are discussing. Do you think the hospital would be able to find somewhere outside of A&E?

Dr Phillips—I think our hospital has the capacity to extend the emergency department. Emergency departments have extended to incorporate trauma centres. There was the willpower and the capacity to do that.

Senator SCULLION—To basically physically build it on?

Dr Phillips—Yes. I think it is a matter of being a bit creative and having the willpower to do it. I can think of space that can be utilised.

Senator SCULLION—Regarding the personnel where you work—the people who are in the front line of triage in the hospital—do patients enjoy the services of someone such as yourself? Is there a 24-hour psychiatric registrar? Where I come from, the Northern Territory, that is unheard of. What is the capacity of the registered nurses that come to you pretty much new or fresh out of university—wherever they come from—to cope with presentations of people with mental illness, as against their capacity to deal with the traditional medical issues? Because they are the sorts of people we are getting in places like the Northern Territory. When they are fresh they do not have the capacity of people such as you in that experiential sense. How well trained do you think they are to step straight into triage in A&E in respect of mental health?

Dr Phillips—Staff new to emergency departments in general find it stressful. I personally have observed the extreme stress and shock of new staff when they are confronted with an acutely psychiatrically unwell patient that is in the process of being contained or restrained in some way. That is not just junior nurses. Often doctors who have worked in lots of other environments and then come to a hospital such as ours—an inner-urban hospital that has a high number of psychiatric presentations—find it very confronting and are inexperienced in dealing with the situation.

Senator SCULLION—We have heard some comments about some human rights issues, which you have touched on. A comment from one of the submitters was that she felt it was pretty awful that people appeared to get used to those circumstances fairly quickly. She reflected on people that she had worked with in general nursing who she then saw in a psych environment and asked, ‘How can you possibly do this to people?’ She said that, because it was the sort of circumstance that people got used to it, the critical issue was raised of the very fine balance between reasonable restraint and the breaching of someone’s dignity or human rights. How do you think we can make it easier for people to draw a very clear line and standards which are not crossed?

Dr Phillips—You have highlighted a very pertinent issue. It is an extremely fine line between respecting someone’s human rights and dignity and responsibilities not only for the care of that patient who is in an acute state but also for everybody else in the emergency department and staff—who do suffer assaults and leave their jobs because of it. I guess better training and knowledge is the first thing. If you have better knowledge, training and experience then you are able to deal with it and incorporate it much better.

Senator SCULLION—So do you think we should start talking about that issue in training right up front?

Dr Phillips—Absolutely, yes. It is very hard to have clear guidelines saying: ‘This is a time when you should shackle someone and this is a time when you shouldn’t.’

Senator SCULLION—I understand. It is very difficult.

Dr Phillips—It is pretty hard to draw up guidelines about that, but I think education and training would have to be the most essential first part of it.

Senator WEBBER—I have one brief question, because Senator Scullion was pursuing one of the issues I was going to ask you about. I notice you picked this up in your submission, but some of the evidence we have had has also been about the fragmentation of mental health services on one hand and drug and alcohol services on the other. It has been put to us that we need to bring them together but that there is resistance to that within health departments, bureaucracies and what have you. What is your view on that?

Dr Phillips—I fundamentally agree that these are the people who slip through the cracks between the neat categories that we have. It is quite easy for someone to say, ‘That’s not psych,’ ‘That’s not medical’ or ‘That’s not drug and alcohol,’ and usually the people with those combined problems are the people who do not fit in. I think philosophically there are differences in approach. The psychiatric illnesses are seen as medical and the drug and alcohol problems are seen more as lifestyle issues. But I certainly think there needs to be more integration and an embracing of the two, because it is certainly an increasing phenomenon and it is mostly young, very vulnerable, chaotic people who suffer from those problems.

CHAIR—I would like to ask you about community care centres. You have had some experience in that area. You said that ‘GPs cannot offer all that is required’ and so they are referring people to community health centres—fortunately Victoria is blessed with a number of those—and you said that people need longer term talking or behavioural therapies. What typically happens in a community health centre? Are they not able to do that with those who present? Are people told they have to go off and pay for a psychologist, and do they? Can they?

Dr Phillips—The centre that I worked in, a community mental health centre, was attached to the health network and so referred people to the in-patient psychiatric ward of the hospital. Its main business was looking after people with long-term psychotic illnesses. Often GPs referred for a psychiatric assessment or some kind of CAT assessment and the person would be considered to be not sick enough to entail case management from the community mental health clinic, which brings with it all the adjuvants: support for finding work and all those kinds of lifestyle supports that people need. So if you are not sick enough to require that then the community mental health clinic really has no resources or capacity to provide ongoing support. Then there is the job of finding somebody who can do that for the person, and there are not many psychiatrists who will bulk-bill or see people without additional charge, and certainly other therapists—psychologists, behavioural therapists or other kinds—are very difficult to access.

CHAIR—There are nonetheless some community health centres that have those services and provide them free of charge, are there not?

Dr Phillips—There are.

CHAIR—They are just not adequate?

Dr Phillips—Yes, there are just not enough of them. My experience was that we were constantly swamped with referrals for young people who had long-term issues that needed long-term therapies and we really struggled to appropriately refer them to something that was not going to be quite financially difficult for that person.

CHAIR—And it would be fair to say that that failure to deal with those long-term problems would see them in your emergency department now?

Dr Phillips—Possibly, yes.

CHAIR—Can I go back to the question of transporting people with mental illnesses and police involvement. Is there an alternative to this method of apprehending people and bringing them to hospital? Obviously, ambulances are not the appropriate place because there is too much equipment and so on that needs to be secure, but should we be looking at something that is between an ambulance and the police that is specifically designed for and suited to people with mental illnesses? Do you know whether there is such a system operating anywhere?

Dr Phillips—I am not aware of any system that operates like that but it certainly would be appropriate in some instances.

CHAIR—What would be the requirements for that sort of service?

Dr Phillips—It would have to be a contained space which protected the drivers or the transporters and ideally had one or two people in the space able to talk to and calm or restrain the person. It is often the case that there is a physical threat or even a threat to use arms in some situations, and I think the police have to be involved in those situations.

CHAIR—Could you have someone with police training and extra training in mental health services?

Dr Phillips—Yes, certainly. It is often the case that someone is brought by the police and there is a lot of tension and anxiety over a physical threat or violence or maybe even arms. When the people get delivered to the emergency department, the threat and the anxiety dissipate quite quickly just with a different approach. I think there is certainly a role for people who understand a lot more about mental illness and have that other ability too to be involved at a much earlier stage.

CHAIR—I do not want to be seen to be criticising the police, because we have had lots of evidence that young police in particular are much more empathetic to people with mental illness and do a very good job. Clearly it is not the favourite part of their work. Can I ask you a question about geriatric patients. We have not spent a lot of time on the aged. Are these people coming to you from residential aged care?

Dr Phillips—Yes, at times.

CHAIR—Are these people with dementia or are they people with other kinds of mental illness? Why is it necessary for them to be transferred to a general hospital?

Dr Phillips—The aged patients come from all environments, including nursing homes and aged care hostels. Their underlying diagnosis is often a combination of dementia and mental illness. The things that have prompted their referral to the emergency department are usually escalating behavioural issues—violence towards staff in the hostel or the nursing home or yelling and screaming and other generally disruptive behaviour that has become unmanageable.

As I allude to in my submission, often these problems are predictable. There may have been an escalating problem. It has been evolving but there is limited support to try to nip it in the bud before it becomes an absolute crisis.

CHAIR—Would you expand on ‘limited support’ to nip it in the bud? Does that mean that people are not trained in nursing homes and hostels to manage these situations?

Dr Phillips—Nursing homes and hostels are not really set up to manage people with a combination of behavioural or psychiatric illness and dementia. They do not have the staff or the resources to look after those people.

CHAIR—Even those with dementia wards or dementia sections?

Dr Phillips—In this state there are very few hostels specifically designed for those kinds of problems in the aged, so people wait for a very long time for an appropriate placement and in the meantime are in a general hostel or nursing home which does not have the capacity to look after them.

CHAIR—Does this mean that they are going to be more likely to be sedated in those environments?

Dr Phillips—Yes.

Senator FORSHAW—So do they end up fronting the emergency department?

Dr Phillips—Yes.

Senator FORSHAW—That suggests to me that there is a real lack of any sort of system or service whereby a GP or somebody could go to the nursing home to do that.

Dr Phillips—It is not about GPs or other people not trying to address the issue. Those people are often involved. It is a matter of it being three o’clock in the morning when the person is screaming or punching or hitting or whatever, and that is the last straw.

Senator FORSHAW—I understand that scenario.

Dr Phillips—There are aged care CAT teams, but they are simply not set up for this level of acute crisis management.

Senator SCULLION—Do you think that the changes in the level of amenity that we have been discussing could be discussed with hospitals? These could help towards ameliorating the issue. You could have, say, an extra place when you are building a residential care home. It might not be for acute care but it might be for an emergency such as we have discussed so a GP can see someone and talk to them in isolation given, as you would be aware, that nursing homes are little communities.

Dr Phillips—Do you mean separate from or attached to a nursing home or hostel?

Senator SCULLION—Would you think it would be useful if something like that were built?

Dr Phillips—Yes, if it were adequately staffed.

CHAIR—Thank you very much for your presentation. It has been very interesting and useful to us. Thank you for your submission as well.

[9.45 am]

CROTON, Mr Gary James, Clinical Nurse Consultant, Eastern Hume Dual Diagnosis Service, Northeast Health Wangaratta

ROLFE, Dr Timothy John, Consultant Psychiatrist, Eastern Dual Diagnosis Service, Victoria and Clinical Director/Consultant Psychiatrist, Southern Dual Diagnosis Service, Victoria

CHAIR—Welcome. You have given the committee a submission which we have numbered 374. Are there any amendments or additions you want to make to that document at this stage?

Mr Croton—There are no amendments or additions.

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

Mr Croton—Although I said there were no additions to the submission, is it okay to tender some things as exhibits for the committee?

CHAIR—Is it the wish of the committee that they be tabled? There being no objection, it is so ordered.

Mr Croton—There is a resource folder about co-occurring mental health and substance use disorders with an expanded audio overview. One of the recommendations contained in the submission was to generate clinician focus manuals around co-occurring disorders and just arrived yesterday is the latest version from the US, from the central SAMHSA, so I would like to table that.

I will provide a brief overview of the submission. The first part of the submission looks at the situation now in Australia around co-occurring mental health and substance use disorders. It argues that there needs to be a refocusing of priorities around co-occurring mental health disorders and it cites four main areas of demand for that. The first is the prevalence of co-occurring disorders; there is the recognition that in treated populations—mental health, substance use or even primary care—co-occurring disorders are the expectation not the exception. The numbers are often greater than 50 per cent in any of those treatment settings. It cites the costs, harms and undesirable outcomes strongly associated with co-occurring disorders. Because each of the disorders affects the other in their genesis, severity and relapse circumstances there are a lot of consequent costs, harms and undesirable outcomes. There is a great deal of research—particularly North American research—which clearly identifies those costs and harms.

The next area is consumer care and societal demand. The latest and strongest evidence we have in Australia of that is in the submissions to this committee, where co-occurring disorders feature very strongly. There is substantial potential for more effective responses by mental health and drug treatment agencies and in primary care situations.

The submission moves on to examining potential barriers to improving the system's response and then examines international developments, particularly in the USA and the UK, around co-occurring disorders. The background to that is that two years ago I was fortunate to be given a travelling fellowship to examine what was happening in the UK and the USA around co-occurring disorders. The PDF of the report of that fellowship is contained in the CD. The report examines significant Australian initiatives over the last few years at the federal and state level and refers to the Australian Division of General Practice Managing the Mix project. On the next page it moves on to propose some ideas about possible ways forward. It identifies concrete goals for each of the mental health, substance treatment and primary care treatment systems around what an improved response to co-occurring disorders would look like. It discusses approaches to systems change and argues that a strategically planned, collaborative and robust implementation with top-down and bottom-up strategies towards well-defined and locally grounded goals is one way forward, and is warranted by the demand and the concerns around co-occurring disorders. It concludes with nine recommendations about possible improvements.

CHAIR—Dr Rolfe, did you wish to add anything.

Dr Rolfe—No, not at this point in time. I am happy to contribute by answering questions.

CHAIR—I will start with a terminology question. Is 'co-occurring' the new term for 'dual diagnosis'? Can you explain why?

Mr Croton—There has been a lot of argument about the various terms. Comorbidity has had a lot of currency in Australia but there have been concerns from consumers and carers that it has pathological overtones so they are not that happy with the term. Co-occurring disorders is the latest term to come from the United States. They seem to have settled on that. There are pejorative overtones to dual diagnosis in some sectors now.

CHAIR—So you would recommend the committee use that term?

Dr Rolfe—That is my preferred term.

CHAIR—It is an interesting statistic that you have given us about the prevalence of co-occurring disorders. Is this worse now than it was some time ago and, if so, why?

Mr Croton—There is a greater recognition of the prevalence of co-occurring disorders. Going back on the time line to when we had large institutions, there was no recognition of co-occurring disorders. De-institutionalisation occurred around the world to various degrees. The initial focus was on the seriously mentally ill type co-occurring disorders—the people who were presenting with multiple severe problems. More recently there has been a focus on the high-prevalence type co-occurring disorders. There has been recognition that a large percentage of people with high-prevalence mental health disorders, like anxiety and depression, also have a substance use disorder for various reasons. The opposite is also true: having a substance use disorder puts you at greater risk of having a high-prevalence mental health disorder.

CHAIR—Have we untangled that dilemma of which comes first, the mental illness disorder or the substance abuse?

Mr Croton—The chicken or the egg. I think the wisdom at the moment is that there is a huge range of possible relationships between the disorders depending upon the individual. One disorder may be primary, one disorder may be secondary. The principle that is really emerging strongly now is that, in terms of treatment, you often will not be able to tease out what was the primary disorder and what was the secondary disorder. It will come down to clinician judgment. The principle that is emerging is that you treat what you see, whatever the treatment setting. If there is a mental health disorder and a substance use disorder, you provide evidence based treatments for both disorders.

CHAIR—One of the submissions to this inquiry suggests that, if interventions in mental illness were timely, 60 per cent of substance abuse problems would be prevented. Would you agree with that assessment?

Mr Croton—I am not familiar with that statistic but it would not surprise me. Prevention has not been my area of expertise.

Dr Rolfe—Nor am I familiar with the evidence behind that statement. I am not sure where it came from.

CHAIR—It was a paper in the *Australian Medical Journal* that was provided to us as part of our briefing. I think Dr Groom and Professor McGorry, from ORYGEN, and others were the authors. And it is an estimate, of course. I just wondered whether you had a view.

Dr Rolfe—I think the context of that is important. You can be dealing with a group of young people and seeing high rates of comorbidity or co-occurring disorders and it would appear to you as a clinician, as a person in that environment, that there were many opportunities for prevention—and I certainly think that is true. However, there are many people with co-occurring disorders who do not present early, who present later. There are many people who do not present in such a straightforward way. They may present with, for example, developmental or intellectual disabilities or some other level of complexity added to their mental illness, such as acquired brain injury through substance misuse or as a consequence of substance misuse. So I think the statement makes sense from a particular perspective but I think it misses out on the more severe end and the longer term end, if you like, looking backwards. I doubt whether 60 per cent of comorbidity could be prevented or whether morbidity could be prevented.

CHAIR—It is obvious that a substance abuse problem, an addiction, is a huge barrier to delivering a treatment that might work for those who do not have that problem. Do you think that there is an expectation that those people with mental illness do not have an addiction, that there is substance abuse going on but that it is somehow less difficult to overcome than it is for others? Do you get a sense there is a prejudice against people with—

Dr Rolfe—I would not put it perhaps as strongly as prejudice. I think in some circumstances it is as strong as a prejudice. I think that what we see largely is, on the one hand, ignorance and, on the other, work force pressures such that demand for acuity outstrips the capacity to be able to deal with complexity. There are work force issues there as well such that people do not actually have the skills to be able to treat the co-occurring disorder. So they are less likely to pursue that for fear of being put in a place where they feel helpless and unable to respond. So some of it, I would agree, is prejudice but some of it is a systems problem.

Senator HUMPHRIES—I looked at the model that you have suggested for where we should get to, what kind of ideal model should work in Australia to deal with this dual diagnosis problem. It is very comprehensive. If we could get to that stage I am certain that we would be much better off. My question goes to how we actually get there. You suggest with primary care, for example, that there needs to be an uplift of the skills of GPs to be able to identify dual diagnosis and ideally have in-house mental health referral options available and things like that. We have already heard some evidence about doctors being quite heavily loaded with all of these additional specialist areas through continuing medical education and so forth. How realistic is it that we would expect doctors to acquire the level of understanding of the issues inherent in this model to allow this model to work across the board, particularly in rural and remote areas of Australia?

Mr Croton—I guess on my wish list, if you were a GP working in general practice, the principle would be that you pick out one of the disorders and you automatically screen for the other disorders—as simple as that. It is a trigger to screen for the other disorder and the numbers on prevalence would support that as a reasonable intervention. Then when you move to assessment and actual treatment of the disorders, there are a lot of tensions in general practice, whether general practice is able to do so. Hence that gives rise to the in-house referral options. I guess with the primary care initiatives that are occurring federally and at the state level in Victoria, we have seen some advances on that in recent times. In my own area up in the north-east of Victoria, every general practice has a visiting mental health clinician able to provide up to six sessions of treatment for high-prevalence mental health disorders. All the workers have had training on the recognition and treatment of co-occurring substance use disorders and try to provide integrated treatment of the two disorders. And that is a promising model.

Senator HUMPHRIES—Victoria is probably better serviced with those sorts of supports for GPs than most other parts of Australia—and that is more a comment than a question. Can I ask you about evidence of links or interaction between cannabis and schizophrenia? That is an area I have heard a lot about and I am not sure what the latest understanding is about those things. Is there evidence of a particular problem and what is the nature of that connection?

Dr Rolfe—I probably cannot give you a very quick and comprehensive answer to that. I can say that there would currently appear to be a subgroup of people who are prone to schizophrenia who have a particular vulnerability to the impacts of cannabis use particularly at a young age while their brains and their neurochemistry are still settling down. On the other hand, there are a large number of young people who use cannabis who do not develop schizophrenia but who develop other disorders—in fact, probably develop other disorders more commonly such as depression and anxiety disorders. So we really need to be looking at the issue of cannabis and mental illness in a public health view, and people such as Wayne Hall, for example, have articulated this very well. Again, if you are in the position of seeing young people who present with severe mental illness and psychotic disorders, you will see a lot of cannabis use. Certainly cannabis use in that population is upwards of 60 to 70 per cent. That does not always mean that the cannabis use caused it but in many cases it will exacerbate the psychotic symptoms. There is increasing evidence that if you treat the mental illness and the cannabis use at the same time those young people will achieve a very good outcome.

Senator HUMPHRIES—Is cannabis more associated with the onset of those sorts of mental illnesses than other forms of illicit drugs?

Dr Rolfe—The problem there is whether there is sufficient evidence really. Cannabis is so widely used that there is enough of a sample, if you like, to be able to draw conclusions about cannabis use. We certainly know that other substance use, such as amphetamine use or hallucinogen use, is much more likely to precipitate psychotic symptoms even in people who are not vulnerable to psychosis, but the population rates of those kinds of substance use is smaller. Where we are seeing some evidence is in the growth areas of substance use in young people, which are stimulants such as amphetamines and substances such as ecstasy.

There are really two issues there. One is amphetamine induced psychotic disorders, which are usually short-lived and present very spectacularly in emergency departments. You may have heard about that kind of problem. The second is the association with, say, ecstasy use and similar drugs with depressive disorders in young people. So there is quite a complex web of interactions and I think it would be fair to say that the co-occurring disorders are changing in complexity and in their nature as the years pass and different drug use patterns emerge in young people.

Senator HUMPHRIES—You have said that doctors should regularly check for the evidence of one of those problems if the other problem presents itself in the patient. Is there a problem in patients not accepting that one is a problem and the other is? A person may present with a mental illness problem but not accept that a bit of cannabis on the side is really a problem. Are there resources that you can provide to families in the way of web sites or pamphlets or something of that kind which give people information about that to help change that expectation or awareness?

Dr Rolfe—I think that there are many ways of addressing elements of your question. The first is that I think that a lot of people would not necessarily present to their GP with either of these disorders—whether they be depression or substance use—but may present somewhere else, for example with family and friends, school counsellors or other community agencies. It is a whole-of-system approach. Secondly, to answer more specifically if we can do something for families and carers: I think we can. In conjunction with the Mental Illness Fellowship of Victoria, we conducted a specific program for carers of people with dual diagnosis that I believe is still going. That showed very positive impacts for carers. They were provided with education and a capacity to learn about the respective services, how to access services and the nature of the interaction between mental illness and substance use. There is a lot of fertile ground for intervention with families and carers.

Mr Croton—And in terms of treatment approaches, there is a drug and alcohol approach to treatment and motivational interviewing which is quite effective. It frames up people who are being ambivalent about their drug use or ambivalent about their mental health—rather than being in denial about either—and it exploits that ambivalence. Most drug treatment workers are very familiar with that treatment approach, but not many mental health workers are. That is an issue where we can improve: increasing the knowledge of mental health workers of those treatment approaches for co-occurring substance use disorders.

Senator HUMPHRIES—Lastly, you say that one of the things that the mental health system needs to do is to ensure that co-occurring substance use disorder diagnoses are routinely recorded with mental health diagnoses. Do you mean within the setting of a treating GP or of a mental health service? What happens at the moment? Surely if a patient has those problems, those diagnoses are recorded together anyway, aren't they?

Mr Croton—Not routinely, no. An experienced clinician will record multiple diagnoses, but a lot of Western medicine is predicated around focusing on one disorder rather than multiple disorders. So it tends not to be the case.

Dr Rolfe—It harks back to the point I made previously that if you identify something then the onus is on you to do something about it, so there is a systems pressure, if you like, to underreport, even if you do have the skills to detect. There is a detection error and then there is a reporting error in the recording.

Senator MOORE—Senator Humphries asked you about your trial—I do not know where; I do not know Victoria well—which you were describing in the little box, the IPMHS—

Mr Croton—In north-east Victoria.

Senator MOORE—And you said that all the GPs in that area, and other people in that area, have had some specialist training and are working collaboratively at the moment. Is that right?

Mr Croton—They have had some amount of specialist training, but I would not say that all the GPs in the area have. They all have visiting mental health workers, so they are able to provide the treatment pathway.

Senator MOORE—How big an area is it? And what kind of population are we talking about?

Mr Croton—It is not a large area. I think it is a catchment of about 200,000 people. But it is a large geographic area extending from Corryong and Wodonga up in the north-east, right down to the northern boundaries of Melbourne.

Senator MOORE—Do you mean Victorian ‘large’?

Mr Croton—Yes.

Senator MOORE—Not a Queensland or Western Australian ‘large’. The way it is described in your submission seems to be that it is not everywhere in Victoria, that the kind of services that are offered there are fairly specialised. Is that right?

Mr Croton—That model is unique in that it has managed to blend Commonwealth and state funding. The BOiMH and MAHS moneys have been integrated with the state Primary Mental Health Initiative, and that has allowed the initiative to have a lot more impact and get a routine mental health worker presence in all the general practices.

Senator MOORE—And how long has it been operating in such a way?

Mr Croton—About two years. It has been evaluated.

Senator MOORE—Was it evaluated positively?

Mr Croton—Absolutely. I guess they have tapped into an unlimited demand. That is the only problem now. They are having to close their books in some surgeries because the referral rates are so high. There are very positive evaluations. I would be happy to forward the evaluations.

Senator MOORE—I would very much like to see that. That seems to be a model that people have got together and worked on and it is working, but now we are hearing that there are limitations in its process.

Mr Croton—One of the unintended by-products of the model is that referrals to the area mental health services—which look after the seriously mentally ill—dropped substantially. We are looking at deploying the resources from the seriously mentally ill focused area mental health services to the primary mental health.

Senator MOORE—So that is another unintended outcome?

Mr Croton—Absolutely.

Senator MOORE—In your submission, you are both introduced as the dual diagnosis service. That is an area that I am not familiar with. A similar title is not used in Queensland—if in fact there is a similar service. Is that somehow already identifying that there is this need? If so, could you tell me whether it is giving some hope, whether it is standard across Victoria and whether it is somewhere towards the CCISC—which I am not even going to try to say in full—model that you are recommending?

Mr Croton—The Victorian dual diagnosis initiative is a state-wide initiative with joint mental health and drug treatment money. It has been running for four years and it has recently been evaluated. I think there are about 35 workers across the state. So it is a fairly thin resource. It has largely adopted a capacity building approach for drug treatment and mental health services to improve their response to co-occurring disorders. It does have some direct service component. I guess my own prejudice is that I see dangers in going down that road too far and creating a third treatment system. I think the Victorian initiative is really good in that a large part of it is around building the capacity of mental health and the capacity of drug treatment to recognise and treat the co-occurring disorders.

Senator MOORE—Dr Rolfe, could we have your perspective?

Dr Rolfe—I would like to make a point from my experience as a member of the National Comorbidity Taskforce. When I was participating in that process it was clear that the various states were at different places in their service development and their thinking about how to handle the issue of co-occurring disorders. Western Australia had a fairly advanced model and has recently changed its model. Some states are quite well advanced in the integration of mental health and substance use. A great proportion of psychiatrists work in drug and alcohol services in both South Australia and New South Wales, whereas that is not the case in other states. I think the difference in the way that the state services have evolved in separation and collaboration has a lot to do with the nature of the state itself and the size and the complexity of organising services.

It is important to note that drug treatment as a service is a relatively new entity. It emerged as a breakaway of mental health services in the 1960s and 1970s as part of a push towards adopting a public health and prevention model and went down that pathway. It accumulated a lot of evidence around early intervention and prevention, drink driving and those kinds of things, but now finds itself without the top end, if you like, of services, such as in-patient beds and a high level of clinical training and expertise for the people who do not respond to early interventions. Similarly, it is interesting that mental health is turning itself around and now looking backwards from its point of dealing with institutional or severe problems and looking backwards at the public health model and the possibilities for prevention and early intervention. So they have kind of split apart and are now coming together from different perspectives. But it is fair to say that there is no uniformity at all across Australia in terms of response to comorbidity.

Senator MOORE—You can take this question on notice. I know you like diagrams. From your perspective, what is the difference between what is happening with the dual diagnosis model in which you are both working and your preferred model—the one that you are recommending? There must be some things that are similar but there must be some things that are not. In the background paper that you have given us, you refer to your preferred model. I would like to know what is happening now, at least from your perspective, in the dual diagnosis model—which, I am sure, we will hear about from the Victorian government—and how that differs from what you would like to see.

Mr Croton—There are a few elements that I would like to see: its robustness of implementation.

Senator MOORE—What does that mean? Is that resources and monitoring?

Mr Croton—It is rolling out a heap of targeted strategies. It is developing a whole lot of targeted strategies in recognition that the problem is huge—the barriers to moving the system to more effective treatment are huge. To address those barriers, to move the system, we need a lot of well-targeted strategies with agreement from all the stakeholders so everybody is behind it. I think the Victorian dual diagnosis initiative is fantastic and it has made big steps over recent years. One of the next steps I would like to see is the judicious use of policy. In the United Kingdom, Louis Appleby, the head of mental health for the whole of the UK, in 2002 made a statement that co-occurring substance use disorders are core business for the mental health agencies. That one statement and policy really served to concentrate the focus of health planners, agencies and clinicians in addressing their response to co-occurring disorders. It was a low-cost thing with a huge impact.

Senator WEBBER—First of all, congratulations on your submission. The increasing incidence of co-occurring disorders is something that I have been focusing on during this inquiry. Before I return to that, Dr Rolfe, I am from Western Australia. You alluded before to the WA model and the changes that have been made. Can you expand your views?

Dr Rolfe—I do not have intimate knowledge. I have experience working with the National Comorbidity Taskforce and there are probably no more than a dozen psychiatrists or even doctors who are working actively in the public field in dual diagnosis.

Senator MOORE—Across the whole country?

Dr Rolfe—In a high profile sense, yes. There are not many. In Victoria there might be perhaps half-a-dozen or so. You are certainly looking at small numbers of people. As a by-product of that, personal relationships get built up through contacts at committees and various other forums reviewing grants and all those sorts of things. There are only so many committees that you can be on before you bump into people. I have had involvement with Steve Allsop, for example, from Western Australia and had discussions with him. I hesitate to comment on someone else's system but it is interesting that Western Australia, from the outside—from my perspective—devoted a large amount of resources and expertise to putting an integrated response together and now seems to have moved away from that. I would really like to know from a national and Victorian perspective why that happened so that we can learn from that. One of the things that happens is that people in different states are doing different things and we are not learning from one another. There is no capacity to be able to share experiences and to be able to learn other than at the very informal level. There is no single centre or body of people that holds this knowledge. That is a real difficulty, I think.

Senator WEBBER—It is an issue that we can pursue when the committee gets to Western Australia but I think that change has got something to do with people at the top of the system rather than any change underneath, and it is a change for the worse in my view. I will pursue that with my friends in the Western Australian government.

As I said, congratulations on your work with the co-occurring disorders. It has been a concern of mine that we have these islands of treatment rather than a whole-of-patient or whole-of-consumer treatment, so it is good to see those things coming together. I want to go back to the conversation you were having with Senator Humphries about the use of illicit drugs and the whole chicken-and-egg situation with that. Certainly, from a Western Australian perspective—and drug use is different in every state depending on availability, manufacturing and whatever—there does seem to be a growing use of amphetamines and speed and those kinds of drugs, and that does seem to be then causing a lot of long-term mental health problems with young people in particular. Some of that is the price—it is cheaper—and drugs that they are using. From the ones that I know, they also use cannabis and what have you. How do we go about segregating the mental health impacts of each and every one of those illicit drugs?

Dr Rolfe—Perhaps I could make a general comment about the cause and effect thinking that is happening. A lot of the research evidence would show that there are common risk factors for both substance use disorder and mental health disorder, and they might be at the genetic level, at the early childhood level, at the learning level. For example, the pathway that you might take could be one where, because of your learning disorder, you gravitate towards a group of peers that is a substance-using group of peers and so, therefore, you are exposed and your risks magnify and then you become further marginalised. I guess what I am trying to explain is that it is a complex and dynamic process as to which basket you might end up in. Our services need to be flexible and responsive to that process. We need to be looking at where there are common factors and, if they have evidence based treatments, we need to put those treatments in place, obviously.

But we also need to be dealing with the issue as it presents to us, wherever it presents, and whether the same individual with the same risk factors and the same problems could equally present in both factors—and frequently does. In Victoria, for example, they might present in mental health, they might present in physical health in emergency departments and they might

present in drug and alcohol services. One of the issues is that the individual might choose to keep that information about their contact with each of those services limited to that agency alone, so there is no way of those agencies knowing that the other services are involved. Clearly, there are issues of privacy and information sharing and all those kinds of problems there. But there are also issues of work force development and interagency collaboration in order to be able to respond more effectively to those individuals.

Senator HUMPHRIES—I have a question to ask on behalf of Senator Scullion. He wanted me to ask you about both the public and the medical professional perception of psychiatrists. Are they seen as effective operators within the mental health system, or do they suffer some perceptual problem that might limit their capacity to influence change positively?

Dr Rolfe—This is not my area of expertise, but there clearly are experts who have made representations to the committee. People like Tony Jorm, for example, who specialise in and who have looked extensively at help-seeking behaviour and people's perceptions of various forms of help and its efficacy. There was a paper this week in the *Medical Journal of Australia* that looks at young people and their expectations of help and help-seeking behaviour. In general, it is fair to say that the public's perception of psychiatrists as a first port of call is an infrequent one. They will more frequently go to other agencies. Young people, in particular, would choose to go to family, friends, school counsellors or perhaps even the drug treatment agency or other agencies rather than think of a psychiatrist first-up.

I am not sure that we have the system capacity for psychiatry to respond even if people did do that or whether we would want a system that gives people direct access to an expert resource. I think it is a matter of having a whole-system approach where people can access the level of expertise that is required according to their needs. It is a matter of filtering people and building links between the various service elements so that people can get the highly specialised care that they might need—from a psychiatrist, for example—quickly and expediently through a process of good communication through the network of agencies.

Senator HUMPHRIES—We heard that about 95 per cent of the private psychiatrists in New South Wales are to be found in the CBD of Sydney. Is there a similar concentration of private psychiatrists in Melbourne?

Dr Rolfe—Yes. And it would be fair to say that in Victoria there are very few psychiatrists who will see patients with a comorbid disorder, with a dual diagnosis, in the private sector. Because psychiatrists employed in the dual diagnosis initiative are part of the teams that very rarely consult directly, there is a very limited availability of expert treatment for dual diagnosis in the private sector. People ask me, 'Who should I refer to?' I have, perhaps, one or two names of people in Victoria that I can mention to them.

CHAIR—That is very alarming, Dr Rolfe.

Dr Rolfe—Yes, but I think there are initiatives, for example, at the college level within the section of addiction psychiatry, to improve the knowledge and confidence of psychiatrists in treating and managing drug and alcohol problems. Similarly, the newly formed chapter of addiction medicine of the Royal Australasian College of Physicians is aiming to increase the profile of the specialty of drug treatment within medical specialty as a whole. The college of

physicians and the section of addiction psychiatry are working closely together to try to improve the situation. When drug and alcohol services split off in the 1970s, there was a large amount of de-medicalisation of that sector.

CHAIR—Which was not necessarily a bad thing.

Dr Rolfe—I absolutely agree. I think there are many positive benefits from taking the public health approach. I think it is now about finding a balance where the expertise is available at the right time.

CHAIR—I think you said that you were a member of the National Comorbidity Taskforce—the federal initiative on comorbidity. Your submission says that it has not met in some time. Did the federal government drop the ball on this? What is going on?

Dr Rolfe—No. As far as I am aware the National Comorbidity Taskforce as a committee ceased to function about 12 months ago. Its functions were absorbed into the intergovernmental task force on drugs—I cannot remember its exact name—with the formation of a panel of experts available to that committee. The specialist comorbidity task force ceased to function at least 12 months ago.

CHAIR—And you are not critical of that fact?

Dr Rolfe—I think there were lots of benefits to having interstate communication. I think it did not go nearly far enough. Clearly, yes, I am critical of it. I think there needs to be a nationwide approach to coordination of strategy and information sharing. I think the Western Australian example is a good one. It goes right down to sharing the research, for example. With the allocation of research funding we find in Victoria, there might be four or five different sources of research funding all going to different people for comorbidity research, or co-occurring disorders, in a very uncoordinated, haphazard fashion. I am critical of that, too. Perhaps I do not understand the way the Commonwealth government works very well, but my belief is that it should have leadership and a whole-of-Australia view. It would be in a good place to coordinate such efforts of collaboration. It should encourage collaboration between the states or encourage collaboration through the distribution of research moneys and the sharing of information about the effectiveness of services so that people are not in the position of reinventing the wheel over and over.

CHAIR—That sounds like a good recommendation for us to consider.

Senator WEBBER—Earlier you were discussing the skilling of the work force to deal with these co-occurring disorders, and particularly skilling up primary care providers. In Western Australia, with a large Indigenous population, that is even more important because they feel a lot more comfortable approaching primary care providers than those that are more hospital based. Have you given any thought to any specific training or methods of addressing the needs of Indigenous people with co-occurring disorders?

Mr Croton—Have you heard of Tracy Westerman from Western Australia?

Senator WEBBER—Yes.

Mr Croton—She would be the best informant that I can think of on that. She has developed a tool on how to do a mental health assessment with an Indigenous person. She has given some consideration to co-occurring disorders, but in Victoria it has not been a high priority for us.

Dr Rolfe—It has been very difficult for us to respond to the Indigenous community in Victoria. In some of the rural regions there are dual diagnosis clinicians who have attempted to provide services to local Indigenous communities. I think it is fair to say that we have not really been able to make any significant progress—not to my knowledge.

Mr Croton—There are lots of issues about engagement.

Senator WEBBER—Absolutely.

CHAIR—Can you expand on those? What are the difficulties?

Dr Rolfe—I am speaking second-hand because I am reporting to you what the clinicians are reporting to me in their attempts to engage Indigenous communities. For example, there is a fairly large Indigenous community in the Gippsland region, which is the rural region that is attached to the Southern Dual Diagnosis Service. It is south-east of Gary's catchment area. The clinician in that area made many attempts to engage the Indigenous health services and provide consultation to them. One of the things that occurred was that the clinician said to the Indigenous health service: 'Let's deal with these two problems.' The Indigenous health service said back to them: 'Look, this isn't about two problems for us; this is about six or seven problems, and our resources are already all in one basket, trying to struggle with delivering integrated services.'

When an Indigenous person approaches their service, they do not come with a label saying, 'I'm drug and alcohol,' or 'I'm mental health.' They just come with a help-seeking label. The nature of the interaction is that they want to go to one person and get all of their needs met with that one person. Again, I stress that I am not an expert in this field, but I think that the nature of service delivery for complex and overlapping disorders in the Indigenous population is very difficult. I recommend that you consult some experts about it. It is fair to say that we have had a great deal of difficulty. Our model is not encompassing enough. It is seen as being too specific, too narrow, for that group.

Mr Croton—I have had some discussions with Roy West from Queensland and he has said much the same thing: it is not even touching the sides.

CHAIR—But is the more general approach effective?

Dr Rolfe—In an ideal world we would be advocating that the general approach is the gold standard, but we are very far away from local control of all of the health services and their provision. We have multiple layers of bureaucracy and organisation of health services that have divided and compartmentalised our services to a point where we now have problems communicating between the various elements of them. So I would say that the gold standard is further towards that integrated care model.

CHAIR—But only if there is good training and extensive knowledge about this particular area, which there probably is not. Is that what you are suggesting?

Dr Rolfe—Yes.

CHAIR—Thank you very much for your presentation.

Senator MOORE—Before you go, it is just too much of a temptation—you were on the National Co-morbidity Taskforce?

Dr Rolfe—I was, yes.

Senator MOORE—And you said that to the best of your knowledge that does not exist anymore but has been caught up into something else. How were you told about that? As a member of that task force that was operating with a certain process, how were you advised about the change?

Dr Rolfe—I was informed by letter and then some time later invited to become a member of the panel of experts that would be available to the intergovernmental task force.

Senator MOORE—So that was purely by letter. There was no discussion?

Dr Rolfe—No. It came at a time when Professor Raphael was the cochair with Keith Evans of the National Co-morbidity Taskforce. That was when Professor Raphael stood down and handed over the mental health leadership, if you like, of that task force to Dr Ruth Vine, so the task force fell into a little bit of limbo. At that time, the task force sought funding to continue and to fund a secretariat through a submission to the Commonwealth. As I understand it, that funding did not eventuate, so the functions of the National Co-morbidity Taskforce were absorbed into existing structures.

Senator MOORE—This whole process is operated by so many people, so I am just fascinated by how we actually keep the knowledge and the impetus going, and the changeover in titles and secretariats is of particular interest to me. I have not had a chance to ask someone specifically about that before, so thank you.

Dr Rolfe—I believe that is what has happened.

CHAIR—Many thanks again.

Proceedings suspended from 10.37 am to 10.47 am

EPSTEIN, Ms Merinda Jane, Policy Officer, Mental Health Legal Centre Inc.

SALTMARSH, Mr Keir Justin, Chairperson, Committee of Management, Mental Health Legal Centre Inc.

TOPP, Ms Vivienne Margaret, Lawyer and Policy Worker, Mental Health Legal Centre Inc.

CHAIR—I welcome our next witnesses. We have received your submission, which we have numbered 314. Do you wish to make any amendments or additions to that document?

Ms Topp—No.

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

Ms Topp—As outlined in our submission, the Mental Health Legal Centre has been in place for 18 years. Over that period we have probably acted directly for about 20,000 clients in Victoria and we estimate we have taken over one million phone calls in relation to issues for people with mental illness in Victoria. We are one of two mental health legal centres in Australia—one in Western Australia and one in Victoria—and specialise in legal advice, policy and law reform, advocacy and promotion of the rights of people with mental illness. Our submission was based on our case experience as well as on focus groups that we often conduct in relation to policy issues.

The two major concerns of the Mental Health Legal Centre would be the shortage of advocacy services available to people with mental illness and the lack of rigour applied in dealing with people's complaints. People have a lot of issues in their lives where they suffer discrimination, particularly within the mental health system. There are no independent mechanisms which properly redress these issues for people. Our advocacy work is primarily to do with appearances before the Mental Health Review Board. The Mental Health Act is the legislative regime that we have the most familiarity with, but we have only 1.7 lawyers for the whole of Victoria. Only about 10 per cent of people who appear before the Mental Health Review Board are represented.

We—along with Legal Aid—provide a service to people which they must pay for through obtaining legal aid services. Institutionally, we find that it is impossible for people to access their rights. For people appearing before the Mental Health Review Board it is a breach of human rights paralleled only by perhaps the criminal justice system where people are incarcerated and there has to be a bail application. If we look at that parallel, no-one appears before a court without an advocate in a bail application, but there are people in Victoria appearing without advocates before the Mental Health Review Board.

Ms Epstein—I have a couple of things to talk about that I have been specifically involved in. The first is about living wills, or advance directives. In the late 1990s, a major evaluation took place in Victoria which looked at consumers and their experiences of acute psychiatric hospital practice. Almost to the person, consumers said that they did not want to talk about the community services, even though everyone else seemed to want to talk about the community

services. They wanted to talk about what happens to them when they go into acute services. They argued that whatever happens to them there is going to colour how they experience anything that they experience in the community—it was a really strong evidence-backed thing.

That led us to think about how we can make acute setting services less harmful and less of a problem. How can we do that practically, because there is no point just criticising? One of the things that came to our attention was living wills or advance directives, which are a way that people who have episodic illness, who might find themselves locked up against their will, can anticipate what is going to happen and have on their record—written by themselves—some directions about what is really important. This might include treatment; for example: ‘I do not want ECT unless’ or, ‘I have been tried on Mellaril and I have really bad side effects from it. Please don’t put me on Mellaril, but I have had this other drug before and that has been okay.’ So it is a way in which people can stay empowered over their life. We now know that empowerment is one of the major reasons for recovery.

We did that, but when we talked to consumers they said, ‘We don’t want to talk only about treatment.’ They wanted to talk about things like this: one woman was taken by the police from her flat. They left two children under 10 in the flat. This woman became very upset. They saw that as part of her psychotic illness so they just kept medicating her more and more. It turned into a crescendo in the acute setting. This woman said to us that she wanted to have an advance directive that said: ‘If I get taken away by the police, this is my sister’s number. Please ring her. She needs to come straightaway and look after the kids.’ That does not seem to be too difficult a request. If it is all written down beforehand, it is very empowering for people to have.

We are now working with a law firm which is providing pro bono work for us to work up living wills, or advance directives, to the point where we can explore whether they will be able to hold legally. We are very excited about that.

The second thing that I have been interested in is ‘women only’ wards, because consumers are saying to us that acute units are dangerous places. To be put in with other very disturbed people in an acute unit is terrifying, but it is even more terrifying for a woman to be stuck in a seclusion unit with five very disturbed men. We have heard of situation after situation where that has happened. When you add to that equation someone who has suffered childhood sexual abuse or someone who has been violated as an adult, you are creating a very unsafe place. We do not understand why there are not at least one women’s only ward, and we have been advocating for some more work to be done around that. I think it is probably because mixed wards enable the greatest flexibility. If there is a demand for beds, you can make them mixed wards because you are not holding beds for women. But I do not think that is a good enough reason for not having them. They are the two things that we are doing that I think are really important.

Mr Saltmarsh—It is interesting to note that the first contact that Cornelia Rau had was with the police, and this is often the case with those who are suffering a mental illness. There is no other health issue that is so bound by legislation. For a consumer or a person suffering from a mental illness, the way in which the police handle the initial contact is often inappropriate. We have had many instances of that in Victoria, via police shootings, where training has not been adequate in terms of handling that particular situation. I recall very vividly working out that the only way to stop the Victoria Police from coming into my premises was to set up a political party. I knew that if you set up a political party—

Senator MOORE—It always works!

Mr Saltmarsh—That is right. I was able to provide my house as the secretariat and therefore knew that the only people who could enter the premises were the Federal Police. I became embroiled in a grave cat and mouse chase, which involved a lot of other federal agencies becoming part of the whole episode as such. We have had the experience in Victoria—

CHAIR—Can you explain what you mean by all of that? There was a mentally disturbed person whom you were providing a secure environment for?

Mr Saltmarsh—No, I was the person who was mentally ill at the time.

CHAIR—And the police were after you?

Mr Saltmarsh—Absolutely!

Senator FORSHAW—You might find some other political parties coming after you in preference to Hillsong!

Mr Saltmarsh—That is right! Anyone who joined the party instantly became endorsed as a candidate. So you can appreciate the strength of that type of situation. But what was interesting was that I did engage and I was pursued very carefully and observed very carefully by other government agencies, as would be the case in that situation. What is their defined role in that case? Instead of being confronted with eight police officers pointing guns at me at one particular point, why couldn't they have just contacted my family or done something along those lines? It is interesting that a whole lot of agencies become embroiled in health services but are not expert in delivering health service. This is the case in Victoria, particularly with the Victoria Police. We had an instance where 16 armed police officers arrived at a young man's home and other instances where people have been sprayed with capsicum and hosed down and handcuffed before admission. So it boils down to a lack of training of police officers to handle a health issue and to identify that as such.

Ms Topp—Just to sum up, we are just concerned that there was no specific term of reference in the inquiry around adequacy of advocacy services to people with mental illness and other disenfranchised people and we hope that the committee will address advocacy as an important issue. It is essential in its aims towards empowerment, equality and justice for people with psychiatric disabilities and it is a person's right, we believe from our service, to have an advocate to act on instructions and not in an assumed best interest model—and I know that Keir did say to contact family. But we are really strong in that our service does not provide a service to carers. We act for people with disabilities themselves. Their voices are the most important. So often an overview of the person is without even an interview with the person. It is all hearsay evidence, which in a court of law would not stand.

CHAIR—To respond to that last point, Ms Topp, there was no intention on the part of the committee to exclude advocacy as an issue. The listed terms of reference were not exclusive and I think we have had appearances from advocacy groups probably at least as much as any other group so far. Certainly advocacy has been well represented in the submissions.

Ms Topp—That is good.

CHAIR—Ms Topp, you referred to human rights. At the present time the Victorian state government is consulting on a bill of rights for Victoria—

Ms Topp—A charter.

CHAIR—Charter of rights or whatever it is called, and the ACT has one. The ACT is currently looking at reviewing its legislation to see whether it also requires adjustment. Are you part of the process in Victoria and what are you saying to the Victorian state government should be included in that bill or charter of rights?

Ms Topp—We are involved with it. We have looked a little bit at the ACT model. We have concerns, as do most people in Victoria I think, that the model is fairly toothless in terms of its approach. There are no determinative powers, no penalties and no real force behind the ACT model, which we would like to see in Victoria. The process is just rolling out at the moment but I think that from the perspective of people with psychiatric disabilities we would like to see access to housing, to health care and to a whole range of different sorts of day-to-day services that would support people in the community entrenched in a bill of rights.

CHAIR—Do you think that is likely?

Ms Topp—We publish a few things which I have brought and I will leave for you. If you think of the right to complaints mechanisms, the right to services and the right to decent housing, yes, indeed, I think they should be in.

CHAIR—You are struggling to find it. Maybe we will leave that until a little later or you can send it to us after the event.

Ms Topp—I will find it while Keir makes some remarks.

Mr Saltmarsh—The point is that the rights that are enshrined are often unable to be delivered so that the person in psychiatric care has their rights denied on a whole lot of levels and in a whole range of ways. It really comes down to the lack of choices provided to those in care. That is not to say that they are unable to make those choices at any given time but that those choices are denied at all times.

CHAIR—I understand. Ms Epstein, with respect to the living wills approach or advance directives, it is good to hear you are in a process which might see some results from that. How practical is it though? You describe an incident where police arrive at the door and there is someone who presumably is having a psychotic episode. Does that person produce it and say, 'Here, this is my advance directive. You have to read that before you do anything else'? Do we expect the police to have done that before they arrive? How does such a document come to be respected and understood and known?

Ms Topp—Can we just start a little further back than that? Really what is happening in Victoria particularly at the moment is that we are doing a lot of crisis management and it is a lot to do with people in emergency departments in hospitals being apprehended by police. When

people become unwell they recognise they are unwell and often they are trying desperately to get into hospital or they are trying to seek support services. They do not have a case manager and they do not have a support service network. We do not want people to have to give 18 police an advance directive. We need to step back before then, and that is perhaps part of the process.

Ms Epstein—Yes, that is right. What we envisage happening is having some sort of template with a number of different advance directives—one page, short, easy to read. Consumers then choose which ones are relevant to them. For example, the one around children will not be relevant to someone who does not have children so they just do not do that one. Then they would work through the advance directive with their case manager, if they have one, so that the service knows what this consumer wishes to happen if they become unwell and then a copy of it gets into their file.

Ms Topp—It is part of a communication process too. In essence, it will be about people sitting with their practitioners and saying, ‘I don’t like this, I do like this, I don’t want you to speak to my mother. I do want you to speak to my sister.’ It is those sorts of things. Presumably when people become unwell—maybe not immediately but, hopefully, pretty quickly—they get on to the primary carer. They might get on to the case manager or they might get on to the doctor. I hear what you are saying about the immediacy of being able to respect the document but it is a process and it elevates the person’s voice very loudly in the process.

CHAIR—I suppose as much as anything it is about awareness raising too, isn’t it? It is about this person having the right to tell you what it is they do or do not want to see happen to them.

Ms Epstein—Absolutely. From a consumer perspective it is about keeping them as empowered as possible, because losing total control over your life is not very good for you.

Ms Topp—It also signals that that person is not just a person with a mental illness but they are also a mother, a pet owner, a person who pays bills and has to keep a house and has to keep a garden, so it actually signals all those things as well.

Senator HUMPHRIES—I have difficulty reconciling two viewpoints that have been put to the committee. On the one hand there is the need for treatment or restraint on occasions, which is delivered without the consent of a mentally ill person, and on the other hand the empowerment of consumers and their capacity to influence and, indeed, to agree to what is happening to them. Can I be clear, first of all, as to whether you would argue, as some have argued before the committee, that treatment or restraint should not be delivered to a mentally ill person without the consent of the person concerned?

Mr Saltmarsh—Yes, that is a very pertinent point. There are times when restraint is the choice of others and not of that person who is unwell at that time. Choices should be given, as was the case back in the late nineties when that crisis support unit was implemented in Victoria whereby police were accompanied by a mental health specialist and a formulative negotiation process was able to take place. That process does not seem to be available to those who are unwell. It also needs to be understood that being unwell is only for a very short period of time. During that period of time what you require most is support and assistance, not force and not lack of choice in terms of what you feel is best for yourself.

Ms Topp—We need to be a bit more sophisticated about our understanding of how to engage people with treatment without forcing them into treatment. Within the framework though, we are respectful of the Mental Health Act. The Mental Health Act is in place to protect people from harm against themselves and others. There are times when we believe that the Mental Health Act should be brought into full force to protect people from harming themselves or others. We appreciate that.

From the perspective of the centre, we believe that under the act people must have access to proper appeal and review mechanisms, that the act should be used properly and that people ought to be able to appeal very quickly. In Victoria, you cannot appeal before eight weeks. It is different in others states but it is eight weeks in Victoria. If you are taken into hospital, you might be discharged after five days so there will be no accountability mechanism in terms of whether the act is properly enforced to force future treatment.

Senator HUMPHRIES—Are you saying that although the act allows treatment without consent you believe that it should be possible, with properly resourced people—case workers, police and others—to deliver treatment only with the consent of the person who is being treated?

Ms Topp—No. We are saying that there are times when the act needs to be put into play. There are times and occasions when people are unwell and when they fulfil the elements under the act that they need to have a substitute decision-making process, which is an involuntary detention order.

Senator HUMPHRIES—I assume that the situation would be greatly alleviated if there was a higher degree of training and capacity to recognise symptoms and so forth with case workers and with other people such as police, particularly, ambulance officers and so forth. Of course, GPs also need certain skills in recognising symptoms. We have heard about the need to recognise dual diagnoses situations and so forth. All of that requires a large amount of upskilling of a very large number of workers who have a variety of reasons to come into contact with mentally ill people. Realistically, how are we going to achieve that? Obviously a lot of money would do it but there are so many opportunities for interaction between public servants, for example, of all descriptions and mentally ill people. It might be in a Centrelink office. It might be in all sorts of settings. How do you realistically provide people with a capacity to meet those situations sensitively enough to be able to avoid a situation where a person is involuntarily restrained or treated?

Ms Topp—I think that we need to listen to people themselves. People often say to us that you cannot even get into hospital now if you are feeling suicidal. You actually have to claim to be homicidal for them to take you seriously. People recognise their symptoms. They know. It is about engagement. It is about keeping people well and not allowing the service system to withdraw when people are asking for services. We are not here to say we need an injection of services. We just need to listen to what people are saying more often than not and to provide the support in many different ways. Clients of ours are more than happy to see their general practitioner. People do not necessarily want and in fact often do not want to go through the area mental health systems. They are very labelling. They are very stigmatising. I think there are other ways, such as the advance directives.

Mr Saltmarsh—It is more a reactive system as opposed to a proactive system that you see in other areas within the health sector that promote healthy living. It is geared towards reacting as opposed to proactively involving a consumer in leading a much healthier lifestyle.

Ms Topp—If you think about mental health systems, the proper model is for people to control their own health, as it is with diabetes or anything else. Any good practitioner is working towards that person having control of their own life, recognising symptoms and looking at risks. So that is really where we need to put a lot of education and assistance.

Senator HUMPHRIES—I suspect that a lot of people—a lot of doctors, emergency department workers and others—would relate countless cases of people who present in hospitals, GP clinics and so forth and say, ‘I believe that I need to be treated; I am really stressed out,’ or ‘I’m going through a bad patch; I want a bed in a hospital or some sort of facility.’ There would be a huge number of such demands. For all other kinds of conditions or illness there is a gatekeeping role for hospitals and facility operators, but you are almost suggesting that that role should be transferred to the consumer in the case of a mentally ill person, aren’t you?

Ms Topp—As it is with people who have diabetes or heart conditions, this is an illness—

Senator HUMPHRIES—No. With respect, a person with diabetes cannot say, ‘I think I’m going through a stage where I need to be in a hospital bed, not at home.’

Ms Topp—No, but a person with diabetes can say to the doctor, ‘I’m not going to take insulin,’ and the doctor cannot do anything to enforce it, even though the person might die. So we have a different standard in terms of people with mental health issues, as opposed to other general health issues.

Senator HUMPHRIES—Yes, but the person who refuses to take their insulin might then develop symptoms that require hospitalisation and, when they do, the system would make a decision to admit them. The system would not make that decision at the point where the person says, ‘I don’t want to take the insulin.’ They would not ordinarily be put in a bed at that point, would they? To say that mentally ill people should be able to access a system almost on demand, which I think is what you are suggesting should be the case, on the basis that they self-diagnose that they need to be in some sort of care sounds fine in theory but in practice would not work, surely.

Ms Epstein—The whole issue around that is a really important one. I think that you are right, to be honest; we are not going to have an ideal system where everyone who wants a service can get it. That is unrealistic. What we need is a much more sophisticated way of gatekeeping. At the moment, we have gatekeeping that induces illness. We in the consumer movement have a lot of secret consumer knowledge, and a lot of that is around how you can get in to hospital. This thing around homicide and suicide is one of them. People know exactly the questions that will be asked around suicide: do you have a plan; do you have the means? So people have rehearsed what their results are going to be. It is not because they are being manipulative. It is not because of any of those horrible words that service providers can put on us. It is because we are trying to stay empowered in relation to our lives. I think that one of the important things for gatekeepers is to learn from consumer educators. We need to teach the gatekeepers some of the ways that they can gatekeep in ways that are not so distressing. For example, if you are gatekept out and what

you have is obviously serious but it does not look like it is a mental illness—it is not a psychotic illness—don't say to people: 'That's not serious.' You say to people: 'We can't provide a service in the public service; let's have a look at where the private practitioners are. Can we help you find a service?' People are being hurt by the rhetoric as much as they are being hurt by the practices. We have to be a lot more sensitive around the ways that gatekeeping is done, because it is often done brutally and I think that is unhelpful.

Mr Saltmarsh—What it sometimes boils down to is that there is only one choice in that particular situation and that is a pharmacological response. That is the only choice. If you have gone through that particular experience and it is a personally horrifying experience, you would rather not go through that experience again. What it boils down to is the lack of holistic, complementary and alternative therapies that one must seek outside of the system, on their own, to alleviate and make disappear the need to have to present again at any public hospital, GP or psychiatrist. So what it boils down to is one choice available—a pharmacological response. If that is not your choice and you still present, you are forced, therefore, to have that administered to you. You will find a lot of consumers who have turned their backs on the health network, who have sought refuge within the holistic approach and within alternative therapies and sought solace in those areas.

CHAIR—I interrupt to ask you to spell out why that is such a horrific and violent approach, so the committee understands.

Mr Saltmarsh—It often boils down to a lifelong diagnosis that there does not seem to be any hope and there is no ability for a patient or someone suffering from a mental illness ever to be engendered with a sense of personal responsibility and a sense of hope, a light at the end of the tunnel. It is very distressing because you are caught in a drug-taking trap. Often there is polydrug use to begin with, so you are being treated for substance abuse in itself and you become enmeshed in a drug-taking culture.

Ms Topp—And even the newer and atypical medications have debilitating side effects for people, quite apart from the psychological implications of being forced treatment. It is disturbing to see, just as one example, how much weight people gain with particular medications, as well as other impairments that stem from medication—tremor, difficulty in concentrating, loss of libido. There are a lot of nasty side effects of medication. A lot of people in the public sector do not have access to newer, different and more sophisticated medications.

Ms Epstein—Acute units have now become nothing more than holding bays for drug pumping. It is a really big problem. They are no longer doing therapeutic things; they are just getting people stabilised to send them back out into services in the community. I think there is an enormous capacity for harm from the sorts of things I spoke about yesterday, including assaults by other patients. They are so common, and I think one of the things our clients are saying is that they need routine postadmission counselling, but it does not happen.

Ms Topp—There are other treatments like ECT, which are controversial and vary across states. In Victoria there is no accountability mechanism for the administration of ECT. In other states, the equivalents to the Mental Health Review Board can review the use of ECT, but in Victoria we cannot do that, so it can be forced. ECT is a very traumatic experience and also a treatment that many people oppose.

Ms Epstein—My sister had over 200 ECT treatments before she eventually killed herself. She did not have a lot of memory left.

Mr Saltmarsh—You would be aware of the current statistics on suicide. Suicide is a real choice and often the only choice, as opposed to having the opportunity of pursuing other health regimes.

Senator FORSHAW—Do you provide advice to families of consumers? Let me give you two instances. Some years ago I was on an inquiry which looked at Australia's consular services overseas. It was pointed out to us that they deal with many cases of Australians who are overseas, they become unwell, they are picked up—in a hospital or some other facility—and difficulties arise when they say, 'I don't want you to contact my family or let my family know back in Australia.' That situation can arise here with people who travel interstate.

Another instance was a mother who contacted me. She said her son was schizophrenic. He was over 16. He was living on his own. He point blank refused to apply in his own name for disability support payments or disability allowance. He would not sign the papers and this was known to his local Centrelink office. The mother was terribly concerned about her son's welfare. She knew that he was not in very good circumstances financially and housing-wise, but she could not break through this privacy and third-party barrier. I could not break through it either, even after writing to the minister, because this young person had to apply himself.

So those sorts of instances do arise. The question then is: in situations where you have the consumer—the patient—wanting to assert their rights, and the family members saying, 'This is the situation, and there is a history of it,' and they want the person hospitalised but that person does not want to do it, how do you cope with that? I appreciate that there are strong arguments for the rights of the consumer, but very often families have to grapple with the situation. How do they get treatment for a loved one? And how do their rights get looked after?

Ms Topp—We are lucky, because we only take instructions from people themselves.

Senator FORSHAW—That has answered the question.

Ms Topp—So we are in a terrific position, and we will not take instructions from families. We refer people on. Often carers do ring. Sometimes we get permission from the client to speak to a carer. Often young people particularly, say 16 or 17, will say, 'Look, I'm in trouble with the law; dad was with me; can you speak to my dad?' We would get a written consent and speak to the father about that particular issue.

Senator FORSHAW—They may say the opposite too: 'I don't want to have any contact with my family.'

Ms Topp—Absolutely. I used to be a Children's Court lawyer, and we applied the same principle. We speak to the child; that is the principle. There are other systems that are available for carers, and we have got no shortage of them. The shortage is actually with people who act on instructions.

Senator FORSHAW—I am not so sure that families do know that. They may be in a desperate situation. They may have a husband or wife or child who is going off the air, and they have got to cope with that immediate situation and get something done about it.

Ms Topp—But it is the same issue. Some of those are clinical decisions. They are the same clinical decisions that might arise if, for example, you have diabetes—the doctor might ring your wife if she is concerned that you are not taking your medication. The clinician has to make a decision in relation to his relationship with you, exactly the same as they do with people with a mental illness. There are reasons that 45-year-old people who experience mental illness do not want particular members of their family to know things that are private. And it is the same in any doctor-patient relationship. The clinicians are challenged in those situations, but they are challenged and they manage it with general health issues.

Senator FORSHAW—Can I be devil's advocate for a moment, and pick up Senator Humphries's point. And this is not in all cases—please do not misunderstand me. I am not so sure it is the same, in this sense: the person who has diabetes understands that they have diabetes; they know it, if they have been diagnosed. The person who may be suffering some sort of psychotic episode, or is manic, and is displaying all those classic symptoms is not necessarily fully aware of what is happening to them if they are delusional or if they are hallucinating. So they are not necessarily capable, if I can put it that way, of making the choice that a person who may be diabetic is. That is the sort of situation that often does arise, I think. I am talking here just about family situations: the mother who has got—not an uncontrollable child, that may be another issue—a person who is having a psychotic episode. The question is: what right do they have to ensure that that person gets treatment?

Ms Epstein—The trouble with this is that it flows very close to discrimination, because an adult, a 45-year-old, with a mental illness is often treated like a child. The centre is very aware that we do not want to do that. I want to give an example of something that happened to me. It illustrates the point that sometimes the division between carers and consumers is a false division; it actually is camouflaging bad communication practice of services. I was in hospital, and the service spoke to my ex-husband about my sexuality—they had said nothing to me—and said that they all thought I was a lesbian. What relevance this has to my mental illness, goodness knows—but they were talking to my ex-husband about it. It is that sort of story that we hear too often and that makes us really want to be there for consumers. I agree: carers do sometimes need support, but not from us.

Ms Topp—We do hear from carers and we refer them on. We provide them with access to service reports or self-advocacy support services for carers.

Senator FORSHAW—We are not trying to set up some sort of debate here, but you hear about situations like one that happened in the area where I live, where the high-school captain, an excellent student, committed suicide three days after doing the HSC. The parents, whom I know, said, 'God, if we only knew that our son had been suffering from a depressive illness.' It turned out that there had been some symptoms, if you like. There had been some evidence, but they were—

Ms Topp—It comes back to good clinical practice. It is not hard to explore with clients who they would like to know about what and to say, 'To ensure that you get good treatment, we need

to know who is around you, who you want to know about what and what you want to do if this happens or that happens.’ Do risk assessments or risk analysis. It is good practice.

Ms Epstein—Many consumers would say: ‘I do have support people. These are the people in my life.’ It might not always be family carers. I think that is the thing; it might actually be somebody else. Services need to be open enough to realise that. The other thing that I was going to say quickly—and this brings up an old issue—is that I think the divisions between consumers and carers actually exist. I do not think that by sweeping them under the carpet and pretending they are not there, as has been happening in Australia over the past 10 years, is going to solve the problems in the end, because their interests are sometimes different and we have to recognise that.

Mr Saltmarsh—What it boils down to is denial, basically: denial that you are in a situation where you are showing signs of an illness at that temporary point in time, the inability to admit that that is the case, your experience of the type of treatment, or the overall stigma that has been engendered for many, many years, if not centuries—the public stigma and the family stigma. It is very difficult to arrive at a point where you can decide, at that particular point, that you may be unwell. It is a very difficult issue and it is a very personal issue, but it is also one that can be easily overcome given the type of communication that can be provided by family, friends and others.

Senator MOORE—I just have one question, to do with the amount of knowledge in the community about your services and the interest of the legal fraternity in what you do. I am wanting to know whether legal students come and do placements with you and, with your very, very limited resources—and I know that is an overwhelming part of your submission—what ability you have to do work with the community and various legal fraternities to raise awareness of this critical area of legal activity.

Ms Topp—We are very dependent on that, in fact. A large component of our time is spent doing community education. We do things like develop the *Advocates’ Guide to Hearings before the Mental Health Review Board*. We had a small amount of funding from the Department of Human Services to do a rural project, in which we were trying to engage local solicitors to appear for people. They do get a grant of aid in Victoria, so they can do that. We developed a guide for practitioners, which we distribute throughout Victoria. At the moment in Victoria there is a pro bono scheme that is endorsed by the Attorney-General. We assist some of the big private firms to act as advocates in Mental Health Review Board hearings. That is highly successful, but we cannot resource the people who want to do it.

It is really interesting. Merinda referred earlier to one of the big law firms who are assisting us with advance directives. After one meeting with them, they had 12 young lawyers who wanted to do the research. People would eat this stuff. In big law firms, young people who have been through uni want to do some work in this area. They are really keen to. It is quite controversial. It is basic human rights stuff. We do have a lot of people who want to do it. We have four or five volunteers a week. We get law students to do little bits of research for us. Having students is very resource intensive, though, as you can imagine.

With regard to the legal fraternity, we are a specialist community legal centre. There are more than 40 community legal centres in Victoria, and we network with them. We work with other

specialist centres and with the Federation of Community Legal Centres in terms of some of the policy. Merinda or I will look at it and we will put in some bits that are specific to our client group. We have to do that, because we just cannot respond to everything. We have a couple of projects that we do that are proactive, but a lot of our work is reactive, such as changes to the Children and Young People Act. I do heaps of work in the criminal justice jurisdiction and, apart from doing two or three days in court, a lot of that is just follow-up. We try to do a bit of both so that we can validate our policy by our experience. That is what we continue to do.

Senator MOORE—It is important to get that on the record.

Ms Topp—Yes.

Ms Epstein—I think there should be a mental health legal centre in every state. I cannot imagine what consumers in other states do. They got me out of hospital before I started working for them.

CHAIR—We will ask as we travel around the states.

Ms Topp—I will table our annual report and our pamphlets with you. We do two publications. We are about to get Legal Aid funding for a patient rights book. Under the legislation, everybody has to get a copy of their rights. The Department of Human Services produce their own document, but people like ours because it is written to them. We also develop a publication for people who are in the criminal justice system, about how to navigate the criminal justice system.

CHAIR—Is it the wish of the committee that those documents be tabled? There being no objection, it is so ordered.

Ms Epstein—I want to add one last thing for Senator Forshaw, after we talked about gratitude. I found a good article written by an American consumer about gratitude after forced treatment. I table that as well.

CHAIR—There being no objection, it is so ordered.

Ms Topp—I also table an article that was in today's *Australian* about doctors in New South Wales saying that the only way that they can get people into care is by making it involuntary.

CHAIR—Thank you very much.

[11.38 am]

BURT, Mr Michael John Gavin, Chief Executive Officer, Victorian Institute of Forensic Mental Health

MULLEN, Professor Paul Edward, Clinical Director, Victorian Institute of Forensic Mental Health

CHAIR—Welcome. Do you have any comments to make about the capacity in which you appear?

Prof. Mullen—I am Professor of Forensic Psychiatry at Monash University. The Victorian Institute of Forensic Mental Health provides mental health services to mentally abnormal offenders through the state of Victoria.

CHAIR—You have given the committee a submission, which we have numbered 306. Do you wish to make any amendments or additions to that document at this stage?

Mr Burt—No, we do not.

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

Mr Burt—I begin by thanking you very much for inviting us to appear today and I also thank you and your colleagues in the Senate for including a reference in this inquiry to forensic mental health. So often, both in Australia and in overseas jurisdictions, the forensic mental health area gets left out of any inquiries into mental health services, so thank you for including it. I intend to briefly set the scene and the context for our submission and introduce our organisation and its place within Victorian public mental health service system.

Contemporary forensic mental health services primarily provide specialist mental health assessment and treatment for mentally ill persons in the criminal justice system. There are a number of subgroups, but to make it clear it is best to describe them in two ways. Firstly, persons referred from courts for assessment and/or treatment, including those adjudicated as unfit to plead to a criminal charge or not guilty on grounds of mental impairment, and, secondly, mentally ill persons in prison. The third group that we as an agency have a responsibility for are mentally ill persons who are not necessarily from the criminal justice system but are from the general mental health system, who have severe and enduring illnesses, and who potentially pose a serious risk of committing offences.

Across Australia and overseas these particular patient groups have a history of neglect and poor or non-existent service provision. Nationally, Victoria has led the way since the early 1990s—with bipartisan political support, I might add—in developing specialist services to meet the needs of this population and the community. The Victorian Institute of Forensic Mental Health is a statutory authority created in 1997 to provide a dedicated platform for provision and development of specialist forensic mental health services. Its mandate includes assessment, as Professor Mullen said, care and treatment of mentally disordered offenders, professional

education and training, and research. Forensicare, although a stand-alone government authority, is in fact an integral component of Victoria's state network of public mental health services. This submission is made in the context of 10 years of major improvements in the area of mental health in Victoria, but it is made to highlight the critical shortfalls in service levels in the face of high and unrelenting demand for services. Importantly, it also identifies key service gaps and currently lost opportunities to target services to high-risk groups—high risk in terms of illness relapse and criminal behaviour, including violence.

CHAIR—It is the Thomas Embling Hospital which is the Victorian forensic hospital. That is located away from our prisons here?

Mr Burt—We provide a statewide service, of which our secure in-patient facility is the Thomas Embling Hospital, and it is located on the border of the inner city in Fairfield. Relatively speaking it is very close to the city. The main prison from where we receive mentally ill prisoners is the Melbourne Assessment Prison, which is in Spencer Street in Melbourne. I should emphasise that we have a service system with a community forensic service, with a forensic service dedicated to courts and magistrates courts and with provision of services inside the prison system. So we have a considerable critical mass, particularly compared to other jurisdictions in Australia. That work has occurred, as I said, over the last decade or so.

CHAIR—Thomas Embling has 100 beds, and they are full at all times?

Mr Burt—Yes, indeed.

CHAIR—What would typically be the waiting list, if you could describe it that way, for accommodation at Thomas Embling?

Prof. Mullen—It is very variable. What happens in practice is that we always have people in the Melbourne Assessment Prison who are waiting admission to Thomas Embling. The number of people at any given time who would be suitable for admission if and when a bed becomes available varies from five to 10. So you have a constant pressure on beds but also a constant throughput. I do not think the waiting list would go down if we had more beds. What would happen is that we would shift our admission criteria and admit a rather wider spectrum of the seriously mentally ill. So what actually happens is what often happens in any acute medical service: the number of available beds determines the level at which you set your admission, rather than some notion that you would eventually find enough beds for the service. I do not think that is a practicality.

CHAIR—Can you describe what happens in prisons where there are people who have been assessed as being suitable to be housed at Thomas Embling but who must stay in the prison for whatever period of time? Can you respond in particular about the Deer Park prison and the situation for women there?

Prof. Mullen—In the men's prison the situation is significantly better than in Deer Park. In the men's prison we have a psychiatric unit which, although it is not ideal in that it is within a prison, has mental health staff, psychiatrists, psychologists and mental health nurses. It has at least some potential to provide a therapeutic and holding system for people with mental illness.

In fact, a number of people will not come to stay at Thomas Embling, but will be managed there and then returned to the main prison.

In Deer Park that situation does not obtain. We do not have a psychiatric unit in Deer Park where we can treat people within a mental health context, even one which is limited because it is in a prison. If people are not transferred across they are managed within the general prison system with very limited input from mental health professionals. Sadly, a number of them finish up in the block which is designed primarily as a control system and not as a mental health care system.

CHAIR—If I can put it a bit more bluntly: does that mean that women in that prison may be confined to a space and pretty much have no services in the case of a psychotic episode? Are they stripped? Can you describe the space in which they are held? What is the maximum length of time of stay that would apply, if any? What is the situation for those people?

Prof. Mullen—Currently the situation is that there are no adequate facilities for the care and management of mentally disordered women within Deer Park. If they cannot be transferred across then they have to be managed as best as can be provided within that inadequate set-up. It is my understanding that there is a plan to open a unit there for mentally disordered women but we have not had any part of the design of that, so I am afraid I cannot really comment on what is going to happen there. How awful the system is I think is something you would have to ask someone who has more direct care responsibility within the women's prison. Our role in that prison is largely to run a clinic and to transfer women when they become available. We do not provide the care and treatment of women within that prison.

CHAIR—That is a curious distinction in your responsibilities. How do you account for that?

Prof. Mullen—The privatisation of the prison system and the fragmentation of the provision of health services throughout the prisons of Victoria.

CHAIR—I see. So it is the responsibility of the contractor, although it is not in their contract. Is that correct?

Mr Burt—The women's prison is now operated by the state. It was in fact commissioned by a private operator but taken over by the state, my memory is, about four years ago. An organisation called Corrections Victoria, which is part of the Department of Justice, is directly responsible for the management of the women's prison. I can confirm, as Professor Mullen has said, that it is our understanding that the government has the intention of addressing the issue of the lack of a dedicated and appropriate program of psychiatric services within the prison, but we have not been consulted on this matter.

CHAIR—How extraordinary. I could continue to ask questions all day but I had better hand over to my colleagues.

Senator HUMPHRIES—You say in your submission that there is a high percentage of prisoners with a mental illness but you do not say what that percentage is. What is it?

Prof. Mullen—It varies according to the criteria you use, as you would expect. In most services around Australia you would expect that somewhere around six to eight per cent of prisoners to have a psychotic illness. You are looking at mainly schizophrenia, very severe depressions and mania. If you then include within that the broader notions of depressive illness—anxiety disorders and obsessional illness—you then start to push the levels up to well above 10 per cent. If you include substance abuse, then of course you push it up to extraordinarily high levels. For the figure in relation to personality disorder, again that depends exactly on how severe it is before you start counting it. If we just focus on the core business for public mental health services, which is psychosis, even just on that very restrictive notion of mental disorder, we are going to be looking at five to 10 per cent of the prison population having psychotic disorders. Perhaps it would be helpful to give the figure for the general population. In the general population, you would have somewhere between 0.7 and one per cent with that disorder. So in the prison population you are looking at something 10 times higher than you would expect by chance.

Senator HUMPHRIES—In Victoria there is some extent of streaming these people into the services provided by your institute. Would you say that in an ideal world there should be further streaming—in fact, a complete separation of these people from the prison system?

Prof. Mullen—Certainly in an ideal world one would like to see a lot more of the patients with schizophrenia treated outside the prison system. Very few jurisdictions around the world manage that. One of the few is probably Scotland. It has a very large number of forensic and general mental health beds, and it has a tradition of removing people identified with schizophrenia from prison and not returning them. But, to my knowledge, that is the only jurisdiction where this occurs. I think we should go a lot further down the route in Australia—and not just in Victoria but throughout Australia—of providing appropriate hospital services for offenders with schizophrenia. This is not just for the sake of the patients—although this is obviously the most important thing—but also for the sake of the community. It is the failure to manage the problems that arise from their mental illness which is so often important in driving reoffending when these people return to the community.

Senator HUMPHRIES—I notice that in your summary of the objectives of forensic care you do not mention rehabilitation.

Prof. Mullen—That is an omission.

Senator HUMPHRIES—From what you have said elsewhere, I assumed that that was the case, but I thought I would check with you.

Prof. Mullen—If we were to use one word to try to define what we would like to be doing, it is ‘rehabilitation’.

Senator HUMPHRIES—I am glad to hear you say that. In your submission you said:

The Mental Impairment and Unfitness to be Tried Act 1997 is a huge improvement on the earlier system of detaining people indefinitely at the ‘Governor’s Pleasure’ ...

Could you tell us how the act works and what it actually means?

Prof. Mullen—Yes. The change is that, under the old governor's pleasure provisions, when someone was found to be unfit to plead or, as it used to be called 'insane', they were then detained until a decision was taken essentially by politicians. The minister would have to recommend it, and it was a cabinet level decision, with all the problems that inevitably followed that. What happens now is that discharge is dependent on the court which imposes the order. So, if it is the Supreme Court, it goes back to the Supreme Court. It hears the evidence and makes the decision. In practice, this has meant that there is a lot more flexibility, particularly around moving patients from in-patient settings to community settings. There is a lot more willingness to try people who are seen, from a medical point of view, to be safe and fit to return to the community. The courts, by and large, will sanction that. It has taken out of the whole system a lot of drivers that were very conservative for the fear of any risk. Courts are much more used to taking acceptable risks in this area than I think politicians are who, to be fair, are suddenly in this position for a very short while. As they are often anxious, they do not want to expose themselves unnecessarily or the community to any risk whatsoever.

Senator HUMPHRIES—Does this lead to people being released who used to be at the governor's pleasure earlier in the process of their imprisonment?

Prof. Mullen—Much earlier in the process. It has also led, which I think is a gathering trend, to much more appropriate use of the provisions. What used to happen is that the criminal bar knew perfectly well that a finding of insanity and putting someone on governor's pleasure was tantamount to a life sentence. They avoided it unless they absolutely had no choice. What has happened with the new approach is that the criminal bar are becoming increasingly willing to advise their clients to go down the mental impairment route if that is an appropriate route for them. I think it is gradually moving some of the most severely mentally ill people who have committed very serious crimes out of the prison system and into a secure hospital, which is to be welcomed.

The difficulty for us is that each time we take someone it decreases the number of beds available to serve those who are psychotic in the prison. You might say: 'You've got one less psychotic person in the prison because they have come to your hospital. Isn't that the same thing?' It is not quite because typically our mental impairment patients will stay for years, with three or four years being quite a common length of time, whereas our psychotic prisoners stay typically six to 10 weeks. So it means that each time we take someone on a mental impairment sentence it excludes that bed for a very large number of patients who are in the prison. But, by and large, I think that the mental impairment act is working well. It is gathering momentum. It is being used more and more appropriately. I had some very real reservations about it when it was introduced and I think that practice has shown that most of those reservations were not justified.

Senator HUMPHRIES—I have lots of other questions but we are running out of time, so I will not ask them. It was an excellent submission. Thank you very much.

Senator FORSHAW—On page 12 of your submission, you refer to limited counselling services provided by police and the Office of Public Prosecutions. In the last sentence of the first full paragraph on that page you say:

For carers to receive the optimal level of support required in forensic mental health however, a more assertive carer advocate model needs to be developed and implemented—a development that can only occur with additional funding.

Putting aside the funding issue for one moment, could you explain what you envisage with that sort of a model?

Mr Burt—In forensic practice there has been a history, until very recently, where it was seen to be an absolute anathema to have a carer advocate in a forensic hospital or with a forensic population. It was seen to be a total anathema. What we have begun to do in recent times is to start to reflect the approach taken in general mental health services in terms of having carer advocates and consumer representatives. What we are saying here is that, given the forensic population and the complexities of operating between departments and between systems, a rather more proactive approach is required to that which is generally the standard in general mental health services due to system complexity and responsibilities. A very mentally ill prisoner can one day be the responsibility of the Minister for Corrections and the next day the responsibility of the Minister for Health, so you have patients moving from one service system to another. That is the general answer to your question. There is a high level of complexity and it requires a more proactive approach.

Prof. Mullen—One of the things that has been a remarkable success—to me, at least—has been the development of consumer representatives within the hospital and within the community service. Again, when this started seven or eight years ago I was somewhat sceptical about whether this could work, given the nature of our system and the nature of our patient population. In fact, it has been an extraordinary success. Every unit has its own consumer rep. We employ consumer representatives who have been patients in the hospital and are now in the community. They make a very important contribution to the running of the hospital and to the whole way in which we manage treatment.

What we would like to do is to see a much greater involvement not just of consumers but also of carers. It is a real problem, because many of our longer term patients have killed, and they have usually killed a relative. So you have this appalling situation where relatives are struggling to come to terms with both the loss of the person who has been killed and the loss of the person who did the killing. The person who did the killing has not only to come to terms with what they have done but also to somehow cope with an imposed alienation from all of the supports they once had.

That kind of complexity is totally different from the carer or consumer problem within the general mental health service. It is something we have been putting a lot of thought and a lot of effort into and I think we are beginning to get some sort of progress. Part of it is that you have to recognise and help the carers come to terms with the offending as well as the offender. It is a very difficult but very important system because, if these men and women are going to survive as effective human beings in the community when they return, they desperately need any support and any family networks that they can get. We think re-establishing and maintaining those and helping the carers through the complexities of it is an important part of what we do.

Senator WEBBER—I want to turn to the issue of Indigenous people. I am from Western Australia. The 2002 Corrections Victoria survey is alarming enough. If this is what happens here I can only imagine what it would be like in my home state. In your submission, having highlighted the fact that most of the Indigenous prison population do not realise they have a mental illness, if they do have one, you highlight the need to do more effective screening and assessment. Have you given any thought to how that can take place?

Prof. Mullen—I suppose it is obvious that we have a disproportionate number of Aboriginals in prison, that there is a very heavy burden of physical and mental health problems in that population and that some of these problems are recognised and many of them are not. It is very concerning to us that, despite the number of Aboriginal prisoners in the prison system, the number who are coming into any kind of treatment in our service is considerably less than you would expect. So we have a real paradox. We know there is more pathology there yet we are seeing fewer of them.

There are a number of systemic issues around that but I think there are also issues of training. One of the tragedies for mental health services and general health services around Australia is still the rarity of Aboriginal health workers, particularly at the senior levels. We do not have Aboriginal psychiatrists—at least we do not have any Aboriginal psychiatrists in Victoria and I do not know of any anywhere—and we do not have Aboriginal clinical psychologists in our service. So we have to rely on groups who are very often not professionally trained to make the contacts and make the recommendations, and that is essentially not working. It is a very big issue—not just in the prisons but broadly—how one provides decent mental health care to the Aboriginal minority within Australia. Part of it is training but, much more importantly for the long term, another part is beginning to develop professionals with Aboriginal backgrounds. That is a totally unsatisfactory answer, I know.

Senator WEBBER—It seems amazing to me that we are still in the situation we are in, given all the work done over the deaths in custody report. These statistics are just shocking. We do not seem to be fixing the problem. It is well defined but it is not fixed.

Prof. Mullen—Mental illness is only one of the contributors to death in custody. One of the important drivers for death in custody is how you treat vulnerable and frightened people within a prison system. That is much more to do with an enlightened correctional service than it is to do with mental health professionals. I think there has been progress. I would like to see a lot more progress, but there has been progress in the way in which correctional services manage vulnerable minorities, particularly Aboriginal minorities. From that point of view there is an improvement but we have not made the same kind of impact on, if you like, the hard-core, serious mental illness in that population.

Senator WEBBER—If we were able to better assess them we may be able to remove them from the criminal justice system.

Prof. Mullen—I think that is right.

Senator WEBBER—That may then help with the levels of imprisonment.

Prof. Mullen—We are still not dealing with some of the problems of the severe substance abuse which characterises so many of these young men and women who come to us at 17 or 18, having histories of a decade of gross and grotesque abuse, particularly solvent abuse. Many of them have significant brain damage, much of which is reversible but only if you can stop the continuing substance abuse and all of the problems that go with that. Our service does not make any substantial contribution to that because we are just not seeing it.

Mr Burt—I will add one point to that: if one looks at this issue from a national perspective, and I think it is really important to that, one sees an absolute gulf in what we know about the mental health of Indigenous Australians whether they are in prison or not. We have really only touched the surface in our Victorian study and they similarly touched the surface in a New South Wales study. In Western Australia, the Northern Territory and South Australia the work is not being done. There is a considerable challenge facing us nationally to come to understand the problem better. It is certainly a challenge to design a more sensitive screening instrument but we do not know enough about what the issues are. We do not understand enough yet to be able to do that. From an epidemiological point of view there needs to be significantly more work done in this area. At the moment I am not aware of any being done.

Prof. Mullen—A little.

Mr Burt—Perhaps I am being unfair. I would like to make two points if I can before we finish.

CHAIR—We have a couple more questions but make your points now.

Mr Burt—Given that they are relatively contentious I am happy to make them now or at the end.

CHAIR—Go right ahead. We might want to question you on them.

Mr Burt—I am happy to be questioned on them. I would like to make reference to the term Professor Mullen used earlier and that was the ‘fragmented’ service system in prison health and mental health care, which he correctly linked to the policy of prison privatisation which occurred in this state in the early 1990s. That fragmentation still exists now, more than 10 years after that policy was put into effect. To be fair to the policy makers, at the time of prison privatisation the primary objective was to close the terrible Pentridge Prison and to get some new prison beds in Victoria, and they succeeded in doing that. What they failed to do, of course, is to take into account the fact that prisoners require health services. To be fair, prison health was simply not on the radar when the larger policy decision was made.

What has happened now is that the arrangements that were set up then are now very difficult to unravel and we have multiple providers of both health and mental health services in the Victorian prison system. As a result of that we have a service system which is far from seamless and far from adequate both in its funding and in the provision of even reasonable clinical pathways just for the half optimum treatment of people with a serious mental illness.

One of the difficulties of the multiple-provider arrangements is that agencies such as the Victorian Institute of Forensic Mental Health are necessarily treated as providers amongst other providers. The tensions associated with the purchaser-provider split, which I am sure you are all more familiar with than I am, adversely affect the dynamics of the service system and inhibit proper service development from occurring.

CHAIR—Do they also inhibit your capacity to provide policy advice?

Mr Burt—Yes, they do.

Prof. Mullen—We actually provide more policy advice in every other state of Australia than we do in Victoria.

Mr Burt—We provide extensive policy advice in all jurisdictions in Australia, and we have done so in the UK, the US and other countries as well, but we provide very little in Victoria. The second contentious issue, which I think is a national issue, is that one of the most important barriers to improving both mental health service systems and general health service systems for people in Victoria—and, in fact, for people in all states of Australia—is that people who go to prison in Australia become ineligible for Medicare. That arrangement is extraordinarily inequitable, if one looks at the very strong epidemiological data we have on people in prisons in Australia in terms of both their general health and their mental health. It seems extraordinary that, given a relatively small, captive population, the provision of appropriate services to that population is inhibited by a policy which makes them ineligible for Medicare. Clearly, I am saying that there is no provision for dollars to follow the need, and that is one of the most important barriers to the provision of adequate services for this group across the whole country. This is not a criticism of Victoria; it is an issue across the whole country. I wanted to raise that issue.

CHAIR—Does that mean prisoners become the football when federal and state governments argue about this issue?

Mr Burt—I do not know that there has been a debate between the federal government and the state government on the issue of prisoner health. I cannot say I am aware of that, but certainly responding in an appropriate way to the level of demonstrable need in these populations is inhibited by the fact that there is a structural funding barrier.

Prof. Mullen—It produces the most extraordinary situations. You can have a prisoner who is physically or mentally ill in a relatively isolated prison somewhere around Australia, which may very well have a base hospital nearby, but you cannot access the doctors and the skills in that hospital or the practitioners who live nearby and might be prepared to provide care. This is because the state will have funded a health service which may be hundreds of kilometres away, so it will transport the prisoners to that service rather than use the facilities right next door.

CHAIR—So when you say Medicare you are not just talking about the GPs and psychiatrists who would be available?

Prof. Mullen—I am talking about the whole system.

CHAIR—So you mean public health services per se?

Mr Burt—It is public health services, but primarily it is about the subsidisation under Medicare of health care by GPs and specialist medical services. That is what would make the difference.

Senator SCULLION—I want to examine a little further the issue of Indigenous incarceration. I take the points that you have made, and it is great to see that some evidentiary work has been done on that. It is my personal view that our first Australians have particular challenges in terms of communication, but in these circumstances I do not believe they are vastly

different from other Australians of non-English-speaking background. It is a matter of communication and drilling those issues in. I know of many nurses and GPs in the north of Australia, and particularly in the Northern Territory, who have absolutely no drama at all in communicating with and effectively providing these sorts of services to Indigenous people.

Is it really about a cultural indoctrination of those people with those existing skills rather than waiting for Indigenous people, by some dint of good management, to somehow come up with a whole bunch of psychiatrists, which I frankly think is just pie in the sky. The way forward in this matter, I would have thought, is to provide a cultural training and a better understanding of the people who are currently clinicians in this area. I would have thought that there is an opportunity now that you have identified this very great need that, in the initial triage upon entering any forensic institutions we have, you would be able to train those people who are providing that first triage. We know that that demographic is moving through without the right sort of diagnosis being applied and I think today you have identified that that is not happening because of some sort of communication or cultural skill rather than any of the clinical skills. Do you think there is some capacity to move forward in that direction given what we know?

Prof. Mullen—I am sure you are right, Senator. There can be no other short-term solution to it. Having worked previously in New Zealand for many years I would not be quite so pie in the sky. Fifty years ago New Zealand made the decision that it would make very positive decisions in terms of discrimination at university level and at school level to ensure that there were Maori doctors and Maori lawyers, and they have been extremely successful in that. One of the things that is disappointing is that perhaps we are not doing as much of that as we could do. I agree with you entirely that education and sensitivity and using the skills that are there is important. It is more difficult, however, in the prison system than it would be outside the prison system. Those who come to prison are not selected randomly from society. They are selected, by and large, from the most disadvantaged, the most inarticulate and often the most disabled groups in the population. So you always have a problem with communication with many of the people who come into prison and it gets much, much, worse, as you say, with ethnic minorities, cultural minorities and Aboriginal Australians.

Senator SCULLION—One other issue has been a common theme that we have been hearing here. It has been asserted—perhaps not in these words—that there appears to be a possibility of institutionalised breaches of human rights in dealing with those people who are suffering from mental illness. In the particular spheres that you are in, do you think that is a possibility? If so, what are you doing to try to repair that?

Prof. Mullen—There is always a problem with providing mental health care within the context of a prison. The culture of prisons inevitably is a culture of observation and control. The culture of therapy for mental disorder is a culture—or should be—of communication and enablement of people to begin to stretch their capacities and begin to move. You see it very clearly when you come across suicide risk. The response of a prison to suicide risk is to restrict the possibilities of suicide. At the grossest end, you put people in a plastic bubble, take all their clothes away and watch them. That does prevent suicide but it also, in my view, produces enormous destruction to the psychological and human aspects of that individual, and it is not the way to go. So whenever you are trying to provide mental health care to severely distressed and disabled people within a prison, you are running up against a clash of cultures, the result of which can lead to abuse. The only solution is not to try to treat severely mentally ill people and

acutely suicidal people in prison. They should not be there. But that does mean a radical rethinking of priorities. Also, it is not just that we do not have the beds and the resources. Sometimes the beds and the resources are there but they are not available to our patients.

We had recently a man who was imprisoned—it goes with the process—whose offence was not paying for a coffee and a sandwich at one of these casual coffee stalls. He was severely psychotic. He did not need to be in a secure hospital. He could have been managed in any hospital, any psychiatric unit, anywhere in Australia. But the combination of the unwillingness of a correctional service to release someone who was a prisoner and the unwillingness of mental health services to contemplate admitting someone who was an offender combined to mean that the only place for this man was a high security hospital, which is where he came, where we treated him. But it is absurd.

It is absurd in terms of the restrictions that were placed on that man. It is absurd in terms of the cost. These are very expensive high-security beds, and he did not need that. He just needed a hospital. In the end we got him back to the Magistrates Court and the case was dismissed. But these kinds of absurdities are around rigidities in the way in which correctional services function and rigidities in the way mental health services function in terms of accepting people from prison. In other jurisdictions, people in prison who need mental health care who do not present any risk to the community do not go to secure hospitals; they go to general mental health services, which is where they should be.

CHAIR—The third group of prisoners you refer to, who are in prison because they pose a risk to the community by virtue of their mental state, are effectively involuntary patients. Is that correct?

Mr Burt—I think I created that confusion. The third group of people are those who are currently in the care of general mental health services, invariably as involuntary patients, and through challenges associated with their illness, threatening behaviour or perceived threat of significant harm they are frequently referred to our in-patient service because of our staffing levels and the expertise we have with people who are overtly threatening and violent. They become a very small but very important subgroup of people that we manage. However, they are not from prison; they are civil patients.

CHAIR—Do they have the same rights as prisoners?

Prof. Mullen—They have all the rights of patients.

Mr Burt—They have all the rights of patients under the Mental Health Act. Whether they are in our in-patient secure hospital, Thomas Embling, or whether they are in a psychiatric unit at the Royal Melbourne Hospital, the Mental Health Act applies to their care.

Prof. Mullen—This is not in response to your direct question, but it is something that I can say. One of the solutions that is sometimes put forward for the treatment of severely mentally ill people in prison is to allow the compulsory treatment of prisoners with mental illness. In Victoria you cannot compulsorily treat someone in prison—which is not true of all Australian states—so you cannot force medication on them. I think there are very good reasons for this. I think it would be a disaster if we began to try and produce short-term solutions to the shortage of

mental health beds by treating prisoners compulsorily. It would do a number of things. You are already coerced and controlled in a prison. If you add to that the capacity to compel medication—to literally hold people down and inject them—I think you have a gross and grotesque infringement of human rights. You also run into the problem which historically we ran into, when that was possible, and that is using medications not for treatment but for control and for punishment. I think there are many short-term solutions which may appeal, but one that I hope will be resisted is compulsory treatment of patients within prisons, which would be a disaster.

CHAIR—We have run out of time, but there is one area we have not explored at all and that is the extent to which confinement in prison or in detention of some sort gives rise to exacerbating mental health stats or even to mental illness. If you have a moment to do this, perhaps you could refer the committee to some work—perhaps your own work or that of others—that would enlighten us on this situation and how you ameliorate it.

Prof. Mullen—Certainly.

CHAIR—Many thanks for your submission and for coming today. It has been very useful.

Prof. Mullen—Thank you very much for your attention. I will leave our annual report with the secretariat.

[12.24 pm]

BURROWS, Professor Graham Dene, AO, KCSJ, Chairman, Mental Health Foundation of Australia

McQUEENIE, Ms Megan Ann, Executive Director, Mental Health Foundation of Australia

CHAIR—Welcome. You have lodged with the committee a submission, which we have numbered 434. Do you want to make any amendments or additions to that document at this stage?

Prof. Burrows—No.

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

Prof. Burrows—Thank you very much. In preparing our submission, we looked at your terms of reference and decided that we would like to comment on all of them, but we decided that we could not do that in the time available and instead would concentrate on the role of non-government organisations and illness prevention and health promotion. We then gave you one of our projects, which is called Embrace the Future Young Australians Mental Health and Wellbeing.

I thought I might just put that in context because in my real-life job, I run the Austin Health Mental Health Clinical Service Unit. I have been in psychiatry in this state since 1967. I would like to say that mental health in this state has dramatically improved since 1967 but it has a long way to go, as does the whole of the country. In 1970, I ran a hospital at Ararat, which is north-west of here. We had 850 patients and at times I was the only doctor—on a good day we had two doctors—plus outpatient services and so on. We ran the forensic psychiatry ward. If I put that in context—and I was interested to hear my colleagues talking to you before—we have made big advances in Australia, so let us be positive to start with.

At the Austin I run an in-patient service, community service and outpatient services, and I have 500 staff. So I have been involved in public psychiatry for a long time. In 1970 I joined a mental health group, which was then called the Victorian Council for Mental Hygiene. I have been in the non-government organisation since and we have changed the name over the years. We have actually been the Mental Health Foundation of Australia for approximately the last 25 years. But it did start in Victoria in 1930, if you like. I thought it was important to say in context, as a psychiatrist who is involved in the day-to-day management of patients and in research and in teaching, that that is what took me into non-government organisations. I recognised that if we were really going to change mental health in this community—because in 1970 I could not find one brochure on mental health—we had to involve consumers, carers and the general public.

The message that I would probably give to the Senate inquiry is: until we involve and educate the general public, we will continue to have problems. I am sure that senators have already been told many times by many groups that we need more resources—that is, more money—more training, better workplace relationships and better facilities. I know you will hear that time and

time again because it is true. But, being pragmatic, I would also say that you politicians, who are pragmatic in a way, will respond to the community's requests, needs and demands and so on. If we look at what is happening in mental health at the moment, it has come about because of one or two isolated cases which are the tip of the iceberg of many other problems that occur in mental health services. I do not want to lecture you, but I spend a lot of time doing that. I thought I would ask Megan, the Executive Director of the Mental Health Foundation of Australia, to make some comments and then we will answer questions.

Ms McQueenie—I want to give you a bit of an overview of the foundation itself. Under the leadership of Graham Burrows since the early eighties, the foundation has been responsible for writing the initial consultation document around the country. We did a national consultation in 1984, which eventually brought about the national mental health policy. So the initial reform grew through the genesis of the foundation way back in those days. We were also instrumental in doing background documents for the preparation of a human rights inquiry and obviously then participating in that human rights inquiry. So we were focused on getting awareness of the need for a national policy and involvement of federal government in those days. We pushed that area and we were, I believe, successful in that we did get reform in the early nineties. That brought with it a plethora of organisations involved in mental health and mental illness services. Obviously those services are not at the level they should be now. We are still having the same sorts of responses we had from people in those days. But there are organisations working specifically in that area.

In the meantime, we focused on depression. We felt that we needed awareness of depression in the early nineties when people were talking about people experiencing depression being 'the worried well'. We were extremely concerned that that was a view held in high places. We knew that a significant population of Australia were experiencing depression but were not necessarily receiving treatment for that. So we established the national depression awareness campaign, and out of that eventually grew beyondblue, as people know it today, which is a different and new organisation. We are also involved in the National Suicide Prevention Strategy, and that linked into that area as well.

Another area that we were particularly focused on was the Towards a Gentler Society campaign. We felt in the early eighties that we needed to start addressing the issues of violence both within families and within workplaces as well as the road trauma issues that were happening at the time. We established a program called Towards a Gentler Society and then sought funds to promote that. We did not get the funds we needed to run the campaigns that we wanted to as public media campaigns, but we managed to work through a whole range of areas, including the Transport Accident Commission's 'If you drink and drive, you're a bloody idiot' campaign, which grew out of that eventually. We worked on the areas of domestic violence and, specifically, stress within the workplace. Now the National Occupational Health and Safety Commission have taken up that issue and we are working with the ACTU also in developing those areas. So those have come out of the genesis of this organisation.

We were also particularly keen to get health promotion up on the public agenda as well as prevention, and we started the National Mental Health Week in 1985. That was difficult, but it is now something that everybody knows about and is running itself quite happily throughout the country, obviously with the support of the Mental Health Council. We were also the organisation that established all of the support groups for mental illness throughout the country. That was in

the very early days. All of those groups have now become organisations in their own right and are basically providing support to people with a variety of mental illnesses and also to carers, through ARAFEMI and the carers councils and those sorts of groups. They originally grew out of the research that we did.

We have now moved on to a stage where we really believe that, whilst the services are certainly not being provided to the level they need to be as yet, at least they are there in embryo and are developing further, obviously. We feel that it is important now to focus on the broader community. We have worked in the last few years with a group called Partnerships in Health Promotion, which is quite specifically there to bring together a range of health and social impact agencies to jointly work on the seamless provision of service across our joint areas of interest. So we are now working with groups like the St Vincent de Paul Society, the National Stroke Foundation, the Australian Red Cross, the Alzheimer's Association, the Smith Family and others, specifically to work on issues that interest us all.

We have started with depression, stress and anxiety, through those agencies training their paid and volunteer staff in recognising their constituency and supporting them across the country to access services for stress, anxiety and depression based issues. Part of that was also being aware that we needed to address the nexus between depression and dementia. We want to ensure that mental health services are being provided adequately for the ageing community, for a variety of reasons—including my own ageing—but certainly because we are aware of the extent of ageing within the community and its increase in coming years.

We also want to work in the area of prevention, particularly with young people. An area that is not being adequately addressed yet is that group between the ages of eight and 13. We certainly would like to go back to kindergarten years, but we will start at that level to ensure that kids are trained in developing self-esteem, self-confidence and resilience in those years of transition between primary school and secondary school so that they learn ways of dealing with issues as they come up rather than allowing them to fester—which leads to problems later on and kids not having the experience and the knowledge to deal with those things or to know who to talk to about them and where to get support. That is where this prevention program is coming from. Embrace the Future has grown out of a steering committee—one of our subcommittees—and a committee of young people from across the country basically advising us on how we might go about developing the program. We are looking to work it into schools. Perhaps Professor Burrows can talk a bit more about that.

Prof. Burrows—You have read the submission; I suppose that is fairly straightforward. To emphasise what Megan says: we call it stress, anxiety and depression because we know that if people are stressed long enough they go on to develop anxiety disorders and later go on to become depressed. The biggest problem we have in 2005 and beyond is a stressed community, so we think we have got to do something—which is prevention.

Megan mentioned the aged. I am not certain whether you have had submissions on the aged, but we did start the Alzheimer's Association Victoria. I am president of that as well. I am concerned that the aged population is going to be a tidal wave for us in that we in Australia are not really prepared as a community to look after them, basically. To put that into context: today, if you are 70, you have got a three per cent chance of being demented; at 75, you have got a seven per cent chance; at 80, you have got a 15 per cent chance; at 85, you have got a 50 per cent

chance of being demented. Dementia goes up like that. Children born today—and I have three grandchildren—will live to be 100, and if at 85 they have a 50 per cent chance of being demented then we have a real problem.

CHAIR—Perhaps by then it will be 95 years before you have a 50 per cent chance.

Prof. Burrows—I do not think so.

CHAIR—We can live in hope.

Prof. Burrows—I think that is good, but I do not believe that. But that is another issue.

Senator SCULLION—It is a very interesting proposal. I like the way you made some very specific recommendations about how we need to move, particularly in the demographic of the young. I think that is excellent. I was interested in the connectivity of organisations like yours. You have spoken about beyondblue and some of the things they do. Does your web site, embracethefuture.org, have a link to depressionNet?

Prof. Burrows—No, but it will have. At the moment, of course, the dilemma is that, like all non-government organisations, they run on the smell of an oily rag, if I may say so. They very much depend on fundraising events; we spend a lot of time in that area. We will be linking all of the groups that are involved in it. At the moment, our links are more to the partnerships and health promotion that Megan talked about. How that came about—and we started that in 1990—is that too often mental health people spend all their time talking to mental health people. We were very keen to talk to other organisations, other groups. When we went around and asked them what is the biggest issue that they have to deal with, they said stress. It was the stress on their workers; it was not just the stress of the people they are concerned with.

But you are quite right. At the moment, we are looking for a person with expertise and who is really skilled in IT technology and in developing those sorts of linkages. And we will be linking to depressionNet; we have had discussions with depressionNet in the past and also the pharmaceutical industries and every group you can actually manage. You see, until the Australian community in total takes up the responsibility of mental health, we will still be having the problems that you are hearing about around the table and will hear about as you go around the country in the next six months.

Ms McQueenie—We also do not necessarily believe that depressionNet would provide the best service to the age group who are using [embracethefuture](http://embracethefuture.org). We could refer them to beyondblue. They could also get information from the ReachOut! web site and other web sites. That web site provides kids with information about going to get health services for themselves. We would see that as being more appropriate.

Senator SCULLION—The reason my question was in two parts was, firstly, to understand the connectivity between those people who are delivering a greater awareness and, secondly, because of the age group. I was particularly enamoured of the chat sites. People are very familiar with those sorts of processes when they are young, and the chat site on depressionNet was something that I thought you might want to—

Prof. Burrows—We would agree with you completely.

Senator SCULLION—Indeed. I have just a couple of quick questions on the national database. First of all, why do you think it is that for such an essential issue we lack connectivity between existing databases to make the system effective; and why haven't we had one so far? The second question, if you can address it in a similar way, is to do with living wills, which we have heard about today. In living wills people may flag certain situations and say, 'When I am not fully cognisant and unable to make decisions, I want people to take these circumstances into account.' Do you think that information can be attached to a national database? How are you going to deal with the associated privacy issues? We have heard all along that there is a need for a balance between privacy and making lots of other agencies aware; how are you going to deal with that tension?

Prof. Burrows—'With difficulty' is the short answer. But it is not unsolvable. We do have encryption in our system. We actually have the defence system of the American defence force so that we can communicate with colleagues and so forth, so it is possible. We have of course spent a lot of money over the years on things such as bequests, wills and so on as a way of funding non-government organisations. This country runs on volunteerism in many ways and it would crash if the non-government organisations did not do their work; I am sure you realise that. We do not have all the answers at the moment but what we are saying is that we are trying to get across the concept of doing things to prevent the illness. We have spent too much time in mental health treating the severe end of it or the early diagnostic. Although we will not fill up your time with it now, we believe that there is a lot of science to show that you can actually do things early on to prevent people getting illnesses—not all of them, but a lot of them.

Senator MOORE—There is a long history in your organisation. I want to ask about the role of the media, because the campaigns you have focused on in your submission seem to have a very strong media component in terms of getting to the groups that you are targeting. In terms of the work that you have done and hope to do in the future, has there been a response from the mainstream media in Australia whereby, instead of having to use your hard-won funds, they are prepared to come across and help out with community funding?

Prof. Burrows—Yes, we have the full commitment of the press. We have the Murdoch press, in particular, behind us. Here in Melbourne, the Herald and Weekly Times board and their people are completely behind it. My problem is not getting into the media; it is keeping out of the media. I would get three requests a day to do a media article.

Senator MOORE—It is a problem for you in terms of your workload?

Prof. Burrows—Yes, but also because you cannot be too high profile. Some people like to be there all the time and comment on everything, and others need to share it. That was the reason we spread it with the Partnerships in Health Promotion program. But the media often, as you know, want the bad stories, not the good stories, and we want to get some of the good stories out there.

Ms McQueenie—As part of the campaign we are collaborating, as we do, with a range of agencies. Currently, we are collaborating with the Australian Children's Television Foundation—

Senator MOORE—That was what I was getting to.

Ms McQueenie—and we are moving in that direction, definitely, working with them on television programs that they are putting together so that the programs provide a positive mental health message as well as an awareness of illness. We are also working with them on a program called Cahoots, which is a program put into state schools throughout Victoria and, I think, currently in the ACT as well. They have certainly sold it internationally. This program is giving children the opportunity to see creative programs as part of their web based services. They can interrelate with other schools so that they are speaking to other children. I think there was one group in central Victoria speaking with an Aboriginal school in Darwin. They are working on joint processes to put stories out with positive mental health messages, and our intent is to work in that area. So we are getting into schools at that level, but we certainly will be using mainstream media as well—and we have been doing so for many years. I should say that the other thing we managed to do prior to the national policy being put in place was to have a unit on mental health included in the undergraduate training for journalism. So those sorts of things happened as a result of working with those groups, and we continue to work with those same groups.

Prof. Burrows—We have not been successful all the time. We tried to establish a parliamentary committee in Canberra many years ago, with a chair from one of the major parties. It only ran for a number of months. I am being serious. That one failed, but we did form the Friends of Alzheimer's group and that is going quite well, as you probably know. However, we have used prominent people all the time, whether it is Prince Charles, Lady Di, Her Royal Highness Princess Mary or whoever, because we really do believe that until you get everyone talking about it you have got problems.

Senator HUMPHRIES—Just briefly, can you give an idea of how, with a program like the one you are talking about, you inoculate children with strategies for positive mental health practice? Give me some examples of that.

Ms McQueenie—The program is being developed currently by psychologists to include ways that children can learn to speak to one another, to family or to a significant other so that they feel safe and comfortable. We will continue to develop our antiracism and bullying programs that we ran in schools in the very early 1990s, I think, and use those same techniques there—having kids made aware of how to speak to one another, how to deal with the issues of being perpetrators and also victims of bullying, and how to move out of that process. There is a whole series of techniques and curricular programs that we will use within schools.

Prof. Burrows—As you know, it is really what some people would call cognitive behavioural type techniques, therapy and so on. Our groups are made up of psychiatrists, educators, psychologists and so on. There are ways in which you can create a positive approach to life, rather than a negative approach to life. Even in hard times you can create positive approaches, and that is the sort of educational program that we want to do. We want to work with the education department themselves.

You might be surprised to hear that it was not many years ago that you could get through an educational curriculum and not see the words 'psychology', 'emotion' or 'mental health' in any of it. We went through 300 schools here in Victoria looking at what was basically mental health

education, but it was done under the title of ‘bullying’. When we first went into them, the schools did not really want us to come in and tell them what to do. Then, after a while, they asked us if we would please come in and tell them what to do. It was the way the message was sold, rather than the actual message.

Ms McQueenie—Part of the program also is ensuring that teachers learn mental health literacy so that they know the language to use. Very often just a couple of words in one class are going to remove the self-esteem of a child. What we want to do is ensure that, right throughout a school community, there is awareness of how to promote positive mental health.

Prof. Burrows—Senator Scullion, if I might add, spoke about a national database. When we went and saw Dr Neal Blewett, who was then the Minister for Health, we went with two aims. One was to establish a national mental health policy. I would have to say that the first and second were quite good; the third one has fallen over and needs picking up, if I might be critical. We also would say that we wanted a national database. We have not got a national database and that is why you will hear different figures around your review. Some people will say we spend 6.5 per cent of the gross domestic product on mental health and 27 per cent is the problem. Others will say seven per cent; some will say 10 per cent. You will get different facts and figures because there are different ways of collecting it. That is the whole problem, and we do not really have an ability to say accurately what is going on. I do believe we need a national database.

Senator FORSHAW—Following up on that discussion about teachers, is there anything within the core teacher training, which teachers receive before they are first starting out in teaching, that picks up on any of these issues?

Prof. Burrows—No is the short answer. That is a great gap. We have done it in individual things, and we are in fact running another program now called SAD.

Senator FORSHAW—For stress, anxiety and depression?

Prof. Burrows—Yes. And it involves educating people on causes, symptoms, signs, cures and so forth.

Senator FORSHAW—Do you think there should be something in there as a sort of basic set of skills?

Prof. Burrows—I do, because they are dealing with young people all the way through. I feel sorry for teachers because they are supposed to be experts on everything. That is one of the dilemmas, so I think the structure of how you actually do it has to be adequately funded. I know we could solve a lot of our problems in Australia if you gave us another billion dollars per annum or something—those sorts of figures are thrown around—and it is not silly. There is a need for more resources. There is not doubt about that, but I think there is a need for planning a bit more in the early stages, and that is what we are really talking about in our approach here today.

Senator FORSHAW—Thank you.

Senator WEBBER—I want to follow up on the discussion you were having with Senator Humphries. I was wondering whether there is anything specific in the work you are doing with young people that targets Indigenous young people. I am from Western Australia. We have children as young as eight committing suicide in the Kimberley.

Prof. Burrows—Yes, you do.

Ms McQueenie—I am not sure if you were here when we were talking about the Children's Television Foundation.

Senator WEBBER—Yes, I was.

Ms McQueenie—Part of the program there is quite specifically so that we can work with Indigenous young people without specifically identifying Indigenous young people. We will be working with the communities in Darwin that we are already working with on the Cahoots program. We intended to move in that direction. Having said that, the funds are not available. We are totally dependent on corporate support. We currently have no government funding. We are hoping that this program might attract some funds at some stage.

Prof. Burrows—I lobbied four ministers before we started up the Mental Health Council of Australia. But they get peanuts, with all due respect. They are trying to coordinate 36 separate organisations—it might even be more now—and they are running on the smell of an oily rag. That is the issue. If you look at what we are trying to do in mental health, in the end we have to get significantly more commitment.

Ms McQueenie—I would like to come back to SYN FM. SYN FM uses the FM radio network. It works throughout Australia and has specific radio programs throughout Central Australia. I am not sure about how far it goes into Western Australia or what it is providing, but those radio programs are developed for young people by young people. There are Indigenous programs being developed with SYN FM and we have been working with them for some time. SYN FM has just recently appointed a mental health project officer with a view to providing programs to youth throughout Australia, but it will be working specifically with Indigenous youth in Central Australia.

CHAIR—I am just having a quick look at your program now, Professor Burrows—the latest one on prevention—and I cannot see anything in it about parenting. A lot of the submissions that come to us talk about mental illness arising from abuse that occurred in childhood. If you look at the statistics on women in the prison system particularly, you will see that overwhelmingly they are there and they have a mental illness because—one can assume—they have been abused in childhood. Does your research tell you that?

Prof. Burrows—Yes, it does.

CHAIR—How do you overcome this really difficult area? It is not just abuse, it is also neglect, I think it is fair to say.

Prof. Burrows—It is too.

CHAIR—How do we tackle that?

Prof. Burrows—Again, you are going to have to have resources and people doing it. I am also on the Victorian Community Council Against Violence. I could spend hours talking about violence in the community and what we might do about it, but in the end I would have to say, ‘Education, education, education—right from the beginning.’ You might think it is strange for a professor of psychiatry to say that but I really do believe it. In our program we have spent a lot of time looking at what we might do with parenting and how we can do things earlier on.

We now know that if you look at violence, for example, you will find that violent people came from violent beginnings. Generation after generation promulgates that approach. If children are brought up in a harmonious environment where there is a lot of love, caring, commitment and individualisation, the chances of those children becoming violent is minimised. We are trying to say, ‘Let’s start at the beginning.’ Why did we pick on ages eight to 13 in the group that we have given you? We have started a program that will cover ages zero to 24, but we have to focus on a particular area to start with. Part of that involved the parenting of those people. But that group should have been started before eight years of age. The reason we picked on that age group at this stage—and we will go to the other groups later—is that this is the group in the transitional stage and they often get missed completely. Also, it is a very formative stage. If you want to get some results, do it at a very formative stage where you can evaluate and manage it, because everything that we do, we try to evaluate and turn into publication material and so on later.

CHAIR—Have you had a chance to look at the National Safe Schools Framework, a federal initiative which really means encouraging the states to do something about it? There is not much money from the federal government. Have you been consulted on this initiative? Have you given advice?

Prof. Burrows—Yes, we have looked at that and we have given advice, directly and indirectly. But you just touched on a very big issue. If I might say, a criticism of Australia is the state-federal relationships. We get this all the time: ‘No, that’s a federal issue’ or ‘That’s a state issue.’ I do not know the resolution to that—you know that very clearly—but that occurs in mental health probably more than in many other areas. It is a play-off, one against the other, so we have to put our feet in all camps. We are non-political. We believe that mental health is above politics and that it is important for the community. We believe that the way we look after our mentally ill is the biggest reflection on what our community is like. If you cannot look after your disabled, you have really got a problem.

CHAIR—My experience in travelling around schools in Victoria is that, when they run antibullying programs of whatever shape or form, they scratch the money from a gift from Rotary or whatever it is. There is no funding stream for this work, and the fact that funding is so tenuous and you have to put a great deal of effort into getting it is a major barrier to doing something serious. I have not come across a single school that would not like to entirely eliminate this problem, but that is usually one of the barriers.

Prof. Burrows—You are quite right. But I think it comes back to what Senator Forshaw said before: that we have to start with education people thinking about mental health right at the beginning. We are collaborating with our education people both at departmental levels and at individual levels.

CHAIR—There is a school I would like to mention: Quarry Hill Primary School, near Bendigo, which you may or may not know about. Their program was begun by the domestic violence unit—it is not called that; I forget the name of it—in Bendigo, which said they wanted to break that cycle of violence, and I think they have done that very successfully in that area. Are you aware of that sort of work, and would you encourage those antiviolence units around the country to link with our schools and do that kind of work?

Prof. Burrows—Yes, I would. Yesterday the state Attorney-General here launched a program which is on violence units in the magistrates courts of the state. They will be looking at that. That was launched in Heidelberg yesterday. What we are trying to do is to get people to work collaboratively, because one of the biggest problems that you have is that if you are in one department you know what is going on in your own department but you do not know what is going on next door, across the border or in another department. One of the things that we really have to achieve is integration, and one of our biggest problems is that we do not have enough integration in that area in Australia, not just Victoria.

Ms McQueenie—That is one of the things we have been doing for a long time, particularly through the Mental Health Foundation's Victorian branch. Prior to Mental Health Week it ran a creative writing program in schools for upper primary, lower secondary and upper secondary. One of the things that has come out of that, time and time again, is that the country schools are usually much more aware of health promotion issues and specifically the need for self-esteem and resilience training in kids. They take those things very seriously, so I am not surprised that Quarry Hill, in particular, would be doing something like that.

One of the other things that Graham has just referred to is this notion of networking. We found, particularly in the options program we ran on racism and bullying, that there were some areas where agencies had no notion of what another agency might be doing locally. So one of the things we have done wherever we can is to collaborate with and bring together agencies within an area. It may be a school, it may be the police or it may be the domestic violence organisation in that area or even some sporting group. We bring them together to talk to one another about how they might support the children or the community in that area to work together rather than do things in isolation. They are very often providing resources to overlapping communities but they are not necessarily talking to one another, so that is one of the things we have been really focused on.

Prof. Burrows—One of the problems is that when people say the words 'mental health'—and I do not know what it means to you as individuals—they often think of ill health. What we are on about is not only ill health but health. We believe that, just as you can do things for physical health—and we can show the evidence—you can also do things for mental health, and that is what it is about. For too long people have thought of 'mental' as meaning that you are nuts, you are crazy or you have a major disorder, when in fact we all have mental health and how we use it is important in what is going to happen in the community.

CHAIR—Many thanks. I am sorry we have kept you later than expected. Your evidence was very informative and we value it.

Prof. Burrows—We wish you all the very best.

Ms McQueenie—Can I also submit some of our documents—some of our books and brochures?

CHAIR—Is it the wish of the committee that these be tabled? There being no objection, it is so ordered.

Proceedings suspended from 1.01 pm to 1.38 pm

HAPPELL, Dr Brenda, Director, Centre for Psychiatric Nursing Research and Practice

JACKSON, Mr Brian, Executive Member and Senior Nurse Adviser, Centre for Psychiatric Nursing Research and Practice

ROPER, Ms Cath, Consumer Academic, Centre for Psychiatric Nursing Research and Practice

SGRO, Ms Silvana, Policy Analyst, Centre for Psychiatric Nursing Research and Practice

CHAIR—I welcome the next witnesses. We have your submission, which we have numbered 217. Do you wish to make any amendments or additions to that document?

Dr Happell—No.

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

Dr Happell—The Centre for Psychiatric Nursing Research and Practice is the only organisation of its kind for psychiatric nursing in Australia and the only organisation to employ a mental health consumer academic. One of the statements we would like to make is that psychiatric nursing makes an important contribution to mental health services and is the largest professional group. Psychiatric nurses are educated to play a central role in influencing consumer outcomes from a perspective which represents nurses as more than merely assistants to psychiatrists. There are a number of challenges facing psychiatric nursing, which include recruitment, retention, disproportionate under-representation of funding for nursing research, and significant changes to nursing practice. We believe that additional funding is required to strengthen the psychiatric nursing work force.

For example, despite widespread changes to mental health service delivery as a result of shorter lengths of stay, increased acuity and a high level of community care, in-patient services are still operating largely under a philosophy of care that was more relevant to the previous institutional approach. Research moneys are needed to enable a thorough investigation of current practices and the development of a model to provide care and treatment which is more responsive to the needs of consumers and carers within our contemporary model of care delivery.

The CPNRP affirms the position of local mental health consumer bodies in aspiring to achieve a model of in-patient care which is more therapeutic in its focus, which operates in genuine partnership with consumers and which includes exploration of alternative models of care and treatment to those currently offered. Psychiatric nurses are instrumental in initiating and progressing changes and are key influences in the provision of effective multidisciplinary care. I will pass over to Brian Jackson.

Mr Jackson—Senators, I might just add more specifically to some issues that have been mentioned. Regarding succession planning, for a large mental health service like us—North Western Mental Health—at the moment our succession plan for the psychiatric nursing work

force is not fully developed. I will be more specific. We currently have an ageing work force. Our nurses are, on average, 44 years old. We also have 20 per cent of our work force over the age of 55, so they are due to retire. Out of a nursing work force that is approximately 750 head, we currently have a graduate program that is introducing 15 graduate nurses a year. We also have an intake of around 15 postgraduates a year, so our total recruitment into our succession plan is currently 30 new places every year, and we are the largest in Victoria.

We therefore have to go to recruitment and retention, and we go to overseas nurses because we get experienced, qualified, specialist nurses. This often is trying to address the greatest demand, which is our acute in-patient units, where we have our most inexperienced nurses looking after our most unwell clients. We also have an issue—it has been mentioned already—where we do not have a model of care that identifies contemporary acute models. We equally do not have models of care for community care. There are very established and developed community teams and there are psychosocial interventions for the development of a skills set.

Ms Roper—This is from the consumer academic perspective. The position taken by the CPNRP and by the numerous consumer educators with whom I work is that consumer perspective is a unique discipline in its own right. It has its own theoretical bases drawn from other areas such as social and cultural theory, and it has alliances with writings and pioneers from other social movements like feminism, social justice and civil rights. Consumer perspective is non-combative in its practice. Through providing learning opportunities for mental health practitioners, we seek to unite energies in making current service systems less custodial and more in tune with what consumers' expressed needs and concerns are. Our unique perspective means that we can help students and practitioners in mental health to hold on to the reasons why they have chosen this difficult and rewarding work and to continue to have faith in taking up opportunities to work with us and to make improvements.

Research conducted under the auspices of the National Mental Health Strategy in 1997—it was by Frank Small and Associates, and there is a chapter that I would like to table from that—found that it was the attitudes of mental health professionals themselves that consumers found more debilitating than symptoms of illness. This is one reason why consumer perspective in the education and training of all mental health practitioners is an imperative. It is six years since the report was written. In that time we are aware of only one consumer academic position having been created. I believe in education and training, and I believe in its power to transform people and the cultures within which we work. Why is it that we are still voiceless in research and voiceless in academia—almost?

Despite over 10 years of policy about the importance of consumers providing learning opportunities for mental health practitioners as teachers, educators and facilitators, no attention has been given to creating the infrastructure necessary to achieve this. The lack of genuine opportunities and the lack of a commitment of proper resources for consumers mean that it is impossible to participate effectively in the planning, implementation and evaluation of service delivery at either an individual or systemic level, to deliver peer support and consumer operated services or to provide education and training of the mental health work force and in tertiary training.

The time has come for governments to be held accountable for their appalling track record on funding consumer perspective activity. In academia, the only way forward is to mandate

substantial consumer roles in academia across disciplines and across the nation. There needs to be a mechanism to bring the five disciplines together with consumer educators to address the gaps in the training standards of the different disciplines regarding consumer perspective. Requirements to work with groups of consumers in setting assessments and informing curricula through teaching must be backed with solid funding arrangements with consumer groups.

A concrete example of how consumer perspective might have been used is a current piece of work that the Commonwealth is undertaking, which is to review the implementation of the national practice standards across all of the five mental health disciplines. Let us say that there was a national centre for mental health consumer perspective studies, with representing sister organisations in each state. We would now be in a position to contract with the Commonwealth to assess the implementation of those standards which relate to us in particular. These three would be: how are practitioners doing with involving us in service reform; how are they doing with our right to be involved in treatment; and how are they doing with other rights as specified in mental health legislation?

In addition, we could be contracted to hear what consumer groups have to say from a solution-focused vantage point about what is needed. The fact that we have no such place, no formal association of any kind, as do other professional groups, that we are mostly working under 20 hours per week and are not backfilled and that we have disabilities to contend with while trying to make governments aware of the straits we are in just trying to fulfil the basic obligations of our working roles is not only unjust; it is profoundly discriminatory.

A word on research: this is the last bastion. Consumers have not been able to influence research agenda. In many instances we are still understood to be the subjects of research, rather than leading research that we have identified as being important. We cannot easily gain access to research funds or be published in refereed journals, so our interests remain on the fringe. A recommendation is that a consumer perspective curricula research and training centre be established in each state and territory to develop, deliver and evaluate consumer perspective curricula; support consumer educators and consumer researchers with their training needs; tender competitively; assist and evaluate such projects as peer support programs and consumer operated services; and promote consumer perspective projects.

I am wearing many hats—as are a lot of other people—as an activist and an educator. You may recall that yesterday I gave evidence around force. I have been reflecting on that and I would like to add a couple of sentences. I understand how controversial it is to sit before you with a resolute moral and philosophical position that says force should not be used as part of the art of healing. I understand that many of the issues brought before you will concern the difficulty of accessing services and the problems associated with discharging people when they are not ready to leave, in either their own or their kin's estimation. But access and discharge do not speak about what we, as a community, should expect for our loved ones when they need help.

We also need to have alternatives to this medical response to our experiences, but we do not have any. For example, there is evidence that peer support works in promoting recovery. Interestingly, the World Health Organisation has repeatedly found that outcomes for the treatment of schizophrenia are better in so-called developing countries—where treatment might consist of the local shaman and the person's family and community—than they are in Western

countries using a medical approach to the appearance of psychosis. I would like to table an article by Mary O'Hagan on that subject.

CHAIR—Is it the wish of the committee that those documents be tabled? There being no objection, it is so ordered.

I will start with the fairly alarming work force statistics you have just given us, Mr Jackson. Do you have an explanation as to why it is that only 30 psychiatric nurses are being trained every year? Presumably not all of those will go into the system, for a range of reasons, but at least twice that number will be exiting over the next 10 years.

Mr Jackson—Maybe I could do a comparison. I will try to describe our service. We have 420 mental health beds, we have 16 community teams and we have 30 graduates and postgraduates combined. Let us take a general hospital such as the Royal Melbourne, which has 330 beds. They recruit 100 graduates and at least 75 postgraduates every year. My explanation is as follows. Today, if I wish to be a psychiatric nurse and I am 18 years old, I go to a careers fair and say, 'How do I become a psychiatric nurse?' They reply, 'You must become a general nurse first.' So I enter general nursing and I have exposure to medicine, surgery, critical care and intensive care—you name it—and I still have to try to hold on to my desire to be a psychiatric nurse. Unfortunately, by the time nurses get to the end of year 3 the leadership around them is in general nursing, their career promotion is in general nursing and really very few hang on to the desire and ambition to be psychiatric nurses. So it is because they have to do general nursing first; then, if they wish to go and do mental health, they can do a graduate year in mental health. In the three years of general training, at the most they get six weeks experience in mental health, and that is usually a four-week placement and a two-week block.

CHAIR—So you propose that there be a specific psychiatric nursing course—that from day one that is what it is about?

Mr Jackson—No, I am saying that the way that it is promoted and the way that mental health clinical leaders have access to undergraduates in promoting a career in mental health are not enough. I am not advocating for a direct psychiatric nursing course but I do believe that mental health should have an opportunity to be far more integrated into a general nursing curriculum.

CHAIR—Can you expand on what that means? Does it mean more undergraduate subject matter in mental health?

Mr Jackson—Yes, more undergraduate subject matter, more mental health lectures, more mental health in the curriculum and greater opportunities to integrate psychiatric nursing into general nursing. General nurses can benefit from having a suite of skills that are based on interpersonal skills—being able to engage people and build relationships with people who are distressed, for example. I believe the Nursing Board of Victoria is reviewing the mental health content of undergraduate courses at the moment but I am not sure where that will go.

CHAIR—Who determines that there will be 15 places made available and not some other number, and how?

Mr Jackson—You mean 15 places for graduates?

CHAIR—You gave us two figures, with 15 being trained a year.

Mr Jackson—Fifteen graduates and fifteen postgraduates.

CHAIR—I see. Who determines those figures?

Mr Jackson—We would take more if we could get more. We would probably take 40 graduates but we do not have enough undergraduates wanting to commence a career in psychiatric nursing.

CHAIR—So the shortage is due to nurses not wishing to specialise in psychiatric nursing—is that correct?

Mr Jackson—Correct. So we do not have a clear succession plan from the day that they start undergraduate nursing through wanting to come to psychiatric nursing because they already know how to be a psychiatric nurse and the great benefits there are from being one.

CHAIR—Are there funding restrictions?

Dr Happell—I would like to comment on that. I believe there are funding restrictions as well. I know certainly that, in the case of North Western Mental Health, they are actually funded for only eight graduates, but they take 15. They would take more if they could because they recognise that as being an important priority. Each area of mental health services is funded for two graduate places. A number of them take more than that, using their own funds. If there were additional funding—and there is a much higher level of funding for graduates in the general health care system—there would be more opportunity to develop stronger programs that are more attractive to new graduates and more opportunity for that to become better known within the education system so that students come through and have exposure to mental health. They would become much more aware of a strong graduate program in mental health. There would also be more opportunities for them to have rotations, as part of a general health graduate nurse program within mental health, so that they, again, would have more opportunity to see it as a viable career choice. What Brian said is absolutely correct. There is a real difficulty in attracting graduates into mental health nursing, but funding is certainly a significant part of that difficulty.

CHAIR—What opportunity is there for specialisation in undergraduate courses—in other words, can you choose a suite of units or undergraduate specialisations, if you like, that take you in a particular direction?

Dr Happell—Currently there is very little opportunity for specialisation.

CHAIR—Would you recommend that there should be?

Dr Happell—I would think that that is an opportunity well worth exploring, yes.

Senator HUMPHRIES—I would like some clarification on the chart on page 10 of your submission. First of all, what is an affective disorder exactly?

Dr Happell—It is a disorder of moods, such as depression or bipolar affective disorder.

Senator HUMPHRIES—I assume that, according to the chart, affective disorders make up about three-quarters of the mental illnesses that are encountered in a given 12-month period. What is the other slice—the 5.8 per cent—of the pie? Is that for ‘others’?

Dr Happell—The chart is missing something. The affective disorders slice is actually 5.8 per cent.

Senator HUMPHRIES—Okay. What is the big chunk? Is it possible that that big chunk—the three-quarter slice—of the pie is for healthy people?

Dr Happell—Yes, it is. To be honest, I will need to check that.

Senator HUMPHRIES—You can take that on notice and come back to me. As I understand it, of any disease in Australia at the moment, depression carries the largest incidence of disease burden. It would be helpful to clarify that.

Ms Sgro—It may well be that, in the translation from a table to a chart, something has fallen off.

Senator HUMPHRIES—Yes, it does happen. Another stat which I take a little issue with is where you referred to the growth in Commonwealth expenditure on mental health and you pointed out that, although there has been a 73 per cent increase per capita in Commonwealth spending on mental health, the bulk of that is made up of the increase in pharmaceutical costs. As I understand it, that is not just an increase in the cost of pharmaceuticals; it is an increase in the range of pharmaceuticals that have been made available for mental illness. Pharmaceuticals are a very important part of the treatment regime at the present time. Is that the case?

Ms Sgro—Yes, that is the case.

Senator HUMPHRIES—Ms Roper, you said that there was evidence that peer support assists the recovery of people with mental illness. Can you summarise how that evidence suggests that? In what form has that peer support been taken and how has it been measured?

Ms Roper—I do not have the data with me on that, and the data that I do have has been gained from looking at web sites particularly in America, where these services have been operating longer. In terms of the evaluation of those, it is only just now that we are starting to see some public information about how exactly that is working. I could furnish you with that.

Senator HUMPHRIES—If you could, it would be helpful. The only other thing I was going to test you on concerns a mental health commission. In your submission you suggest that a mental health commission could do a number of things. It could monitor the state of all matters pertaining to mental health nationally. It occurs to me that there have been quite regular reviews of mental health around Australia—usually state based reviews, obviously—for a number of years now, which have made assessments of the state of mental health. None of them have been terribly encouraging reviews, but they have done that process of reviewing. Another thing you suggest is that the commission could perform the role of a consumer and carer advocacy body. I assume that there are largely voluntary bodies which, to some extent, provide that role already in Australia—bodies like the ones who have already come before us in these hearings. Is there a

case for another national reporting and monitoring body, given that this is a process which has already gone on or is going on in other forms all over the country?

Ms Sgro—I think part of the problem has been the sheer number of reports. In particular, I read the transcript from the Canberra hearing where you had the Mental Health Council and people such as Professor Ian Hickie, and they went through the raft of reports and the recommendation reviews—both at state and national level—that have been done. In respect of that, I agreed with what they seemed to conclude, which was: ‘Let’s not just keep doing reviews, reports, surveys and so forth; let’s do something concrete and make it very specific and long term, with forward planning and resources—all of those things.’ I would certainly agree with what they put in their statements.

In respect of advocacy and representation and all of those roles, there has been quite a trend at both state and national level to start looking at the role of ombudsman advocacy tribunals and all of those sorts of things, and I certainly think that this is a step in that direction. Also, when it comes to representation of consumers, I do not think that they are adequately represented in the advocacy role and they are often advocating for themselves, which is a very difficult thing to do. Advocacy is perhaps thought of as being easier than it actually is. Being an advocate is a very hard thing to do, and to have the skills and resources necessary to advocate is very hard and it takes a lot of courage. I think as well that to have a place such as a commission to represent consumers, who have a myriad of issues relating to the way in which they are treated and represented, would give a strong indication that governments at all levels are interested in their perspective and in their voice. As I said at the start, we have had a myriad of reports, and we have mental health plans that say really important things around consumer representation and advocacy and so forth but which perhaps fall down on the resourcing side. If there were such a commission, it could play that role on an ongoing basis. You would then save the cost of having to establish commissions, undertake reviews and do reports all the time, and you would have it there for a very long term. In a policy sense, I think it is important.

Ms Roper—Yesterday, in speaking with Pat from insane australia, we were drawing a distinction between a Senate standing committee, which would hear the testimony of people’s experiences, and a mental health commission, which—for me and insane australia and other people whom I have spoken to—would represent more of an ombudsman-like capacity. I will give you an example. In Victoria you can complain to the Chief Psychiatrist, you can complain to the Health Services Commission, you can complain to community visitors and you can complain to VMIAC—Victorian Mental Illness Awareness Council. You have quite a few avenues of complaint, but those things are not necessarily brought together, so you never have an overarching picture of what is going on. Each individual organisation takes on those complaints or the issues that are revealed which might need attention. There is no body that is responsible then for taking those issues on board and doing something about them, and they do not necessarily put all those reports together.

Senator HUMPHRIES—I am not sure the commission would do anything about it either, frankly, if their role was advocacy and so on. But that is just opinion.

Ms Roper—The way I envisage this kind of structure is that it would have multiple capacities. There at least is nothing there currently, and there are several things that are not being addressed.

Senator HUMPHRIES—Incidentally, I did not get a chance to say yesterday that, as to the recommendation that was made about there being a standing committee on community affairs in the Senate, there is actually such a committee. In fact, Senator Moore is the chairman of it these days. So it does actually exist.

Ms Roper—We need to know about it.

Senator MOORE—It is not a standing committee specifically on mental health, which is I think your recommendation, but it could look at those things.

Ms Roper—That is good to know, thank you.

Senator FORSHAW—In this paragraph on consumer operated services, you are saying that we are lagging behind New Zealand, the UK, Europe and the United States. In particular you say that it is not surprising to find there are almost no such services in the whole of the country, and therefore almost no current evaluative data. Is it simply just a matter of funding those resources that do exist? There are some. Can you point to what exists in some of those other countries that we could look at and say, 'That is where we should be; that is how we should be doing it,' both in terms of funding and also structurally? I was surprised by your comment that there are almost no such services in the whole of the country. I understood that there were. There may not be as many. They may not be national. They may be scattered. Could you expand on that and tell us what is happening in those other countries that we could emulate?

Ms Roper—Looking at our closest neighbour, New Zealand, would be very salutary for us. As I was saying yesterday, in a comparatively short time since the production of their Mason report, they have taken some really strong steps to include consumers right through so that consumers appear in all of their policies and consumers are involved in taking charge of and managing government contracts. I am not clear how their funding arrangements work, but they are not the same as they are here, and that may have something to do with their ability to be successful in this. They also have trusts in ways that we do not that are quite small in their operation; consumers are managing those trusts and also, again, in their health districts are able to contract and run projects and so on.

Senator FORSHAW—When we met with representatives of the National Mental Health Commission in New Zealand who were in Australia a week or two ago, the picture I got was that they had a lot of localised bodies, groups, in the regions—and we have to remember that New Zealand is different, much smaller, and that things are a lot closer. The national commission drew all that together and took over, if you like, direction and had a more hands-on role than previously. There were still tensions with the department of health or whatever the relevant government department was. They also pointed out to us that the National Mental Health Commission has a defined life and they are not sure whether it is going to continue to exist. There are concerns about it dissipating. We heard all that. But what about the UK, the US or Europe? It might be a bit more logical for us to compare ourselves with a bigger country with a bigger population.

Ms Roper—Certainly the US have a really strong history of consumer operated services, and they have just released an online document looking at putting together a directory of all the consumer operated services. I tabled that yesterday, just to give a clue.

Senator FORSHAW—Do they have a national overview or a national integration of that? The states in the US, in many areas of public policy and delivery of services, jealously guard their states' rights even more than we do.

Ms Roper—The national consumer clearing house is starting to put them all together online so that people can work their way around them.

Senator FORSHAW—If there is more information on that issue, I would certainly like to receive it from you. We have heard from so many people that we need a national approach to this issue.

Ms Roper—Absolutely.

Senator FORSHAW—We are hearing that all the time. We know that it is something that can easily be said. I am not being disrespectful here, but if we were to recommend that—which does not seem to be too difficult to me—the questions then are: how do you bring it about and what does it mean in terms of structure, funding and relationships?

Ms Roper—I think one tangible thing we are asking for at the moment that would be a beginning is this national centre for consumer perspective studies, because that could start to draw together all those things and then be the seeding area for lots of other stuff as well. I think that would be a relatively small, achievable and practical thing to do. Without that we cannot fulfil the very policy that we are supposed to be attending to. The policies are great—everyone loves our policies; they have been around for over 10 years and they look really good—but really it has been impossible to fulfil the depth of those policies because there has not been the infrastructure. There is enough out there in the UK, the US and New Zealand already to give us some ideas, but I would be really pushing for this national centre as well.

Senator FORSHAW—If you could take that on notice and if somebody could give us some specific material—publications, articles—that would be good.

Senator SCULLION—There is an issue that has been a common theme, which I have already asked some submitters about. Mr Jackson, you reflected on the woes of recruiting the most important resource, which is of course psychiatric nurses, to the profession. Over the last couple of days I have listened with great concern to submissions from people who are in a very good position to make some judgments. It is their view that the profession of psychiatric nursing may be seen in a very poor light in the future and that there may be institutionalised breaches of human rights, not as a result of mischief or any deliberation but by the nature of the work that they do.

Ms Roper is one of the people who put forward that issue, not quite in those terms but effectively. You are responsible for the Centre for Psychiatric Nursing Research and Practice. Clearly, it is an essential aspect to deal with this perception—and, potentially, practice—to come back in line with basic human rights. If we do not do that, there is obviously going to be an even further crisis. Who wants to put their hand up to work in an area that is seen as a breach of human rights, if it is going to be even worse? I would have thought this would have been a major objective of your organisation. If you accept that as the premise that I am putting, would you

share with us some plans that you have to ameliorate not only that perception but some of the practices in psychiatric nursing?

Mr Jackson—I would like to respond from the point of view of being part of a clinical service. Victoria has had a big advantage in that we closed our large institutions 10 years ago. I think we have been at the forefront of developing community teams and providing community services. As an example, our crisis assessment and treatment teams are at the frontier of providing crisis assessment models that New Zealand and that UK have followed. We have research programs that look to first providing early intervention to emergent psychosis work, with first-episode psychosis work from ORYGEN.

We have developed mental health services into primary care. We have recognised that mental health services do not provide for everybody. We provide for the severely mentally ill and not to the high-prevalence disorders of depression and anxiety. I disagree with the view that we are in breach of human rights and that we provide institutional care. I believe, on the contrary, that we have gone the other way, to provide a community model. We look to uphold basic human rights; however, there is an issue with supply and demand. We do not have the supply to meet the demand. We have seen the emerging gridlock of the mental health system, whereby we have long waits in emergency departments for people who should be in psychiatric beds. I believe that is where the basic human rights breaches occur in the contemporary climate, when we are not able to provide the supply to meet the increasing demand on our services.

Dr Happell—Can I also respond to that. I agree with what Brian has said but, from the perspective of the CPNRP, we have recognised that there is a negative image of psychiatric nursing within the nursing community and that this influences undergraduate students as they do their nursing program. We have been instrumental in producing some more positive attitudes through a very successful preceptorship program that we have been running. The aim of that is to encourage registered nurses who have contact with students to be more proactive in helping them feel less anxious in that environment and to produce a more conducive environment for them to learn in. As an added benefit, it makes some students start to think, ‘This is an area of nursing that I never would have thought of before, but I might actually like to work here after graduation.’ It is a small contribution but, I think, a significant one in producing much more positive attitudes to psychiatric nursing.

Senator SCULLION—Perhaps I could not draw an analogy but show where some work has been done in another sphere. I know there are people on the committee who will disagree with this, but I think that the series of standards that were developed for detaining people in detention centres was a set of standards where, basically, we had the human rights and a whole range of what we thought the wider community would expect, and we tried to write them down. In your circumstances and in those circumstances it is a balance of rights. You sometimes have to take existing rights away from people to protect the other people’s rights. We understand that. So they developed a transparent set of standards that was available to everybody on the internet. That allows people to say, ‘Look, there is the standard that we have set,’ and psychiatric nurses have undertaken to meet the standard. There is a standard there and it is like a benchmark of some form. I know nothing about this area, but I know that in general nursing these sorts of standards often apply. Do you know if there is some sort of particular standard that is like that in psychiatric nursing?

Dr Happell—The College of Mental Health Nurses has standards, but whether they specifically deal with what you are talking about, I am not sure. I think it is a relatively small scale, but I think that having a consumer academic teaching postgraduate students certainly helps to raise some of those issues, and often there is that direct contradiction that Cath talks to students about. You come into this profession, presumably, because you want to help people and you may be placed in a position where you are forced to do harm to them. Without giving a magic solution to that issue, she certainly encourages them to make that something that is always in the forefront of their minds.

Senator SCULLION—It is useful to be able to claim Cath, though. There are not a lot of them around.

Dr Happell—No, there are not. I guess that is a situation where we would advocate that there should be more.

Senator SCULLION—I wonder if on notice you would be able to give me some indication of where I could find those standards.

Dr Happell—Yes, certainly.

Senator SCULLION—Thank you.

Senator MOORE—I just want to get on record a little bit more about what the centre does in developing best practice in policy. We have heard a lot about the various things the Victorians have done in developing policy and practice in the various areas of mental health. I think the funding to your group is one thing that is not replicated in some of the other states. Whilst the focus seems to be quite clearly on the development of best practice in nursing, I am interested in whether you have a role in other ways in terms of the general discussion around issues of mental health in the state, the various reviews and the development of skills in other areas such as in medicine, the police, emergency services and all those areas. What role does your organisation play in any of those?

Ms Sgro—Perhaps I could answer that. I have been working for the centre for about three years now. I am a policy analyst. I do not have a nursing or psychiatric nursing background; I have a diverse background. The role was specifically created to do a number of things at once, which I think was lacking. One of the premises that I start from and that I have learnt over the last three years is that nurses are not good advocates for themselves. That has to do with the historical hierarchy of medicine. They are not as good as they need to be at articulating what they know.

Part of my role has been to take some of the great research that has gone on and actually put it into a framework that is perhaps more absorbable, if I can use that expression, by policy makers to ensure that what we do is communicated better, not just within the nursing academy and the mental health nursing framework and community but beyond that—so establishing links with other funding bodies who may not be thinking about psych nursing as a research area and to start doing that. It has been quite a challenge because, firstly, as I said, nurses are not good advocates for themselves, and, secondly, nursing attracts such a small amount of research, whether it be from the Australian Research Council or any other body. So it has been quite difficult.

I think the CPNRP is a unique organisation, not just because it is the only one that funds psych nursing research but because, as has already been mentioned, we have a consumer in there and we also have someone specifically on policy. It is a part-time position but it certainly does that. It builds relationships with both state and federal governments. I spend a lot of my time researching where submissions might be placed and where we might be able to have a psych nursing voice. For example, the Productivity Commission is doing some research at the moment into health work force needs over the next 10 years and we are putting a submission into that. In the past that certainly would not have occurred. It is really interesting to me that people attending academic psychiatric nursing conferences are quite interested in learning how to write submissions, how to write letters to the editor and how to have a voice. I think that that is emerging. The centre is certainly at the forefront of doing that. It is the only position of its kind that I know of within an academic environment.

Senator MOORE—I am unaware of them in other states. We had joint evidence in Canberra on Monday from various nursing organisations: the ANF, the rural nurses and one other that I cannot remember. Does your group have links with those various bodies? Do they use your knowledge that you have acquired?

Ms Sgro—Yes. We have really opened communications. For example, a number of us are members of the Australian and New Zealand College of Mental Health Nurses.

Senator MOORE—That was the third one.

Ms Sgro—Brenda and a couple of other nursing staff are involved. Kerrie Hancox is the president of the Victorian branch. She is one of our lecturers. We are a small organisation but we are very well represented in terms of where we are connected and where we sit.

Senator MOORE—Ms Roper, I wanted to ask particularly about your role because you have come before the committee in many hats and because of the peculiar nature, in the most positive sense of the word, of this particular organisation. Are you used by a range of organisations because of your very special role as consumer academic? Do organisations ask to share your skills and to see how your role operates?

Ms Roper—I can answer that question on a lot of levels. We have had interest from South Hampton where they set up a similar—not the same but similar—academic position in the UK. They came out and saw what we were doing. I get calls from consumer colleagues around projects that they might be involved in. I am in a mechanism with consumer educators and nursing educators that is a vehicle to do that sort of work. Rosemary Charleston from the CPNRP and I last year were asked to come and do a session in Canberra in response to an ACHS survey looking at consumer satisfaction or consumer focus services. That was something that the two of us were able to do together. It was a really nice piece of work. There are an awful lot of calls. I am only half time. This role could go in so many different directions—and needs to—and there does need to be peers. New Zealand has also picked this up and are interested. They have created a similar position. I have also conducted workshops in mental health services. I have done a few things around consumer participation with child and adolescent services. We are just beginning to do work on rights charters and so on. There are many different areas.

CHAIR—Thank you. Unfortunately, we are out of time. Thank you for your submission and for coming here today.

[2.27 pm]

INCERTI, Mrs Kate, Housing Information and Support Officer, City of Port Phillip

MAHONY, Ms Nicole Helen, Director, City Communities, Hume City Council

SHEARER, Ms Denise Maureen, Manager, Social Development, Hume City Council

CHAIR—Welcome. We have your submissions, which we have numbered 326 for the City of Port Phillip and 298 for Hume City Council. Do you wish to make any amendments or additions to those submissions at this stage?

Mrs Incerti—No.

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

Mrs Incerti—We have a summary. Our overall approach to this area is that we feel local government in general and the City of Port Phillip in particular is well placed to take a leadership role in ensuring that policies are inclusive and facilitate community strengthening initiatives. We feel that the social model of health and active citizenship is a good model to work from. The community development approach and active citizenship promotes increased inclusion and participation in a range of activities, recreation and access to services for people with mental illnesses and that leads to better outcomes for them as well as for the local communities. Communities are better informed and supported in adjusting to people with mental health needs living amongst them.

From our local government perspective there is inadequate funding of all levels of support and treatment within the mental health system and it appears predominantly limited to this grossly underfunded medical model. We feel the mental illness can impact on many aspects of life not just the medical ones or ones encapsulated within the medical model—housing, financial security, community life, behaviour in public places, food security, neighbour relationships, family life—and attention must be given to joining up the mental health system with all those other areas and groups. That is the gist of the approach that we have given in our submission.

Ms Mahony—Thank you for the opportunity for Hume City Council to make a submission and presentation today. We most want to highlight the special issues confronting suburban growth areas of metropolitan cities that abut rural areas. They are the areas we have referred to as ‘interface areas’, otherwise known as fringe areas. They represent the Campbelltowns of Sydney, the Woodridges of Brisbane and the Craigieburns and Caseys of Melbourne. They are the so-called ‘low-cost mortgage belt’ that represents a significant proportion of the Australian population, particularly young families, and we believe there are special issues for rapidly developing communities and the support systems that are needed.

I just want to talk about the role of local government in the health and wellbeing of the community as local government is the level of government closest to the community. Interface

communities have increased vulnerability due to the pressure of high mortgages, low disposable income, newly formed families in very newly formed communities with poor public transport in what is a service-poor area. There is effectively a lack of a mental health platform because the key planks of a mental health platform are not in place—from prevention, early intervention and support services. The examples I will give you are Craigieburn and Roxburgh Park areas on the northern fringe of metropolitan Melbourne.

The ratio of GPs to the population is one to 2,025 for the resident population and there is no female GP. Our submission talks about the general ratio which should be one to 1,100. For the whole of Hume City we only have 25 practitioners with mental health qualifications. In the Craigieburn area the workload has increased for GPs by 64 per cent between 1998 and 2003. We only have four practitioners with qualifications to enable them to deal with mental health issues in the Craigieburn and Roxburgh Park area for a population of 35,000 people.

We do not have any psychiatrist services. The limited psychological service is public health based and is largely focused on social work and counselling. There are about 3.5 EFTs. There is no comprehensive family support service. Unlike the more settled areas of the city where you have existing Anglicare, the Brotherhood of St Laurence and McKillop Family Services, the Craigieburn and Roxburgh Park area has outreach services from organisations located further in the city. You lose a very important development of social capital when you do not have agencies—key family support agencies and accommodation support agencies—located in an area.

The state government has said that there is no new growth funding for community health so there is no money even for growth areas. The focus is on ambulatory care. For us the focus on prevention is around the social and environmental determinants of health which community health is best placed to engage with in conjunction with agencies like local government. Craigieburn is due to get a super clinic which is ambulatory care. It will have a primary mental health service with five EFTs proposed. However, we are finding it incredibly difficult to attract and retain health professionals in areas such as Craigieburn and Roxburgh Park. The hospital at Epping currently has significant problems recruiting and attracting staff generally. There will be no after-hours service, no emergency service and no additional GPs associated with the super clinic. So you have got a very poorly serviced area and on top of that you have got an increasingly vulnerable community not being able to access support services.

Senator MOORE—How many Centrelink offices are there in Craigieburn ?

Ms Shearer—There are none. Broadmeadows is the nearest one.

Ms Mahony—We have talked about a variety of recommendations in our report, including ensuring that there is a platform of family support and community health services. We would strongly support psychology services being part of a Medicare safety net, given that we have no psychiatry services in Craigieburn and we have very limited public health services. We would like incentives for health professionals to practise in the interface areas and additional incentives for GPs to provide mental health services, because it is clear that the enhanced primary care item is not sufficient to attract GPs to practise.

Local government does have a key role to play in the health and wellbeing of its community. Issues like active citizenship, developing a sense of belonging, community cohesion and community safety are fundamentals; but, in the absence of an effective service system, they are not going to have the effectiveness that they need to have for a community's wellbeing.

CHAIR—Thank you. To clarify some figures, you said that only 25 out of all of your GPs have any mental health qualifications. How many GPs are there altogether? I cannot figure it out.

Ms Mahony—We have—

Ms Shearer—The figures come from the north-west division of GPs; we are covered by two division areas, and the data and planning for a local government is quite complex and problematic to actually ascertain how many GPs you have in your area. It is our understanding from the northern division, which covers what we call the eastern part of the municipality, that that is where there are the 25 GPs who are trained in mental health services.

Ms Mahony—But I am not sure about the total number of GPs—we could get back to you on that.

CHAIR—Okay. It would just be useful to know what percentage of your GPs have the training—the raw figure of 25 is not all that informative if we do not know what the total is. It would also be useful to know which have level 1 and which have level 2 training. And do you find that they are able to refer people to psychologists under the better mental health outcomes program?

Ms Mahony—Given the extremely poor access to public transport, and that we only have four practising psychology services in the area, it is very difficult to refer. Their experience is that there are incredible service blockages, and it is only when problems escalate that they can get better traction with services, prevention, support, and early intervention; particularly in newly formed communities it is very difficult to access those services.

CHAIR—Mrs Incerti, perhaps you could describe for the committee, firstly, the differences between the City of Port Phillip—and I am one of your constituents—and the City of Hume; and, secondly, how the social model of care that you propose works in practice.

Mrs Incerti—Port Phillip has traditionally been an area of diversity, particularly housing diversity; and I guess that it is a chicken-and-egg situation. There was traditionally a whole range of different boarding houses, rooming houses and private rental accommodation that was financially accessible to people on a limited income. So partly, I guess, it has drawn people from a whole range of backgrounds, including a lot of lone households. The density of population is very high: one of the highest densities in the country. So a lot of statewide services, such as Hanover and the Salvation Army, have also situated there, and that has drawn more people to those services. So it is a bit hard to know what has led to what. But I guess, from a local government point of view, it has also been one that has been more comfortable with difference and with diversity, compared to other local governments.

What we are looking at is an inner city area that has undergone tremendous demographic change in the last 10 years as the property market has moved. Rental affordability is now less than one per cent, so on any given day there might be only one or two properties in the private rental market that are affordable for someone on a low income. They would still probably be spending 40 per cent of their income on their rent, so it is questionable what is affordable and what is not. But, traditionally, people have called Port Phillip home and so they are still drawn there, whether or not they can afford to live there. The population is around 82,000, we are right near the city and a lot of people have migrated to the city and inner city from other areas. So it is a very transient, mobile area. That presents slightly different challenges to those in an outer or regional area, because public transport is very accessible, which is another reason why people have been drawn to this area.

The social model of health is what I was referring to in my opening comments: health is much broader than just a physical or psychiatric diagnosis. It affects the way someone feels about themselves and their community. It affects their access to services, their ability to work, their ability to seek education outcomes and their ability to maintain their housing. It is really the World Health Organisation approach of seeing health and wellbeing as having a much broader holistic definition within this very turbulent, diverse, eccentric and at times chaotic inner city area.

Senator FORSHAW—Listening to your comments and looking at your submissions, I am trying to envisage how local government across the country would pick up on this, particularly in the smaller local government areas. I am from New South Wales, from Sydney, and one of the things that is happening in New South Wales is the amalgamation of councils to give them greater critical mass. As a general question, are you suggesting that local government should become more of a provider of services, or should it have more of a coordination role for services that might be there or should be established, whether it is through the non-government sector or through state governments et cetera? Because what we are seeing increasingly in local government is some of the traditional services—and this has been going on for a number of years—being outsourced. In some areas, like child care and accommodation for the aged, the role of local government has been overtaken by the private sector. Sorry, it is a bit of a rambling question. As for the point you made about local government being closest to the community, we all know that. Can you comment on what I have just put to you?

Ms Mahony—What I would suggest is that the role of local government is to partner, plan, advocate and, in limited areas, strengthen their role in service provision. But what I am saying in terms of mental health is that health, wellbeing and community safety is the core business of local government. Seeing that you come from Sydney, projects like the belonging project, which Marrickville Council has run very successfully with highly vulnerable communities, actively decrease the sense of social isolation and look at participation and people's rights. That is a foundation for good mental health.

We are saying that local government's role in active citizenship and participation is a foundation on which the other clinical and nonclinical services should be based. However, local government also has a role and responsibility around service planning because direct service providers are so busy providing direct services that, if local government does not align local needs and issues with the service system, you will get duplication and gaps and no-one else will do planning that is as comprehensive. You may not be aware of this, but local governments in

Victoria have a unique role in direct service provision. On the whole, we provide maternal and child health and all home and community care services—something that other states do not do. I would not be suggesting that local governments in Victoria need to expand our direct service provision. We are already huge service providers.

Senator FORSHAW—Yes, and I appreciate that there are substantial differences across areas. Because the area I come from does not have a high ethnic community concentration, such as in Marrickville, it does not have that type of program, but it has a lot of children's services because of the age demographic. I suppose this all raises the big issue of funding. In my state at the moment, some local councils are looking for 20 and 30 per cent increases in their rates to cope with the services they are providing. If you had a big lift in this sort of activity, it could well require a lot more funds.

Mrs Incerti—But some of it is about working more efficiently. We have developed a protocol in terms of responding to issues around behaviour in public places and particularly camping on council land, as it is called, but that covers a whole range of definitions. A lot of those people who are basically homeless or actively out and about in public places have some kind of mental health issue. We already have a great proportion of the local law officers, the parks and gardens people and the traffic people, who, in doing their core business, are being presented with requests to ameliorate or attend to these issues. It is not necessarily always about having extra money but about having partnerships with local police and having strategies in place that are not just a zero tolerance or total enforcement approach but that actually lead and help equip police and local laws to have a better link-up with community outreach services.

We have been operating our homelessness protocol coordination over the last five years. It has not required extra money, apart from my position, which is council funded. Not all councils have it, but I think it has saved money and led to greater efficiencies because we do not constantly have residents up in arms and traders associations and all sorts of people getting very worked up about an issue. We have been able to get the homeless outreach team from the local clinic linked to a person quickly at times and have been able to link that person up with treatment. This has given residents and traders a greater sense of calm and a greater sense that a person has a health issue rather than just being bad and scary.

Senator FORSHAW—Finally, on the accommodation issue, is there any direct involvement by the local government with, say, the communities you represent or others in partnering with organisations? I see that in other areas such as aged care, where the council might do the development but does it in conjunction with Anglicare or some other provider.

Mrs Incerti—Port Phillip is the largest local government community housing developer and provider in the country.

Senator FORSHAW—But I am thinking here particularly about providing accommodation for people who may need it after coming out of psychiatric hospital.

Mrs Incerti—A number of those accommodation options are single units and some are rooming houses. In the rooming house accommodation we develop, probably well over 50 per cent of the people there would have mental health issues. It is not specific psych disability accommodation. It is low-cost permanent accommodation.

Senator FORSHAW—I may be wrong, but this was almost the single biggest concern not long after the Richmond report and deinstitutionalisation in New South Wales, where lots of people ended up in these run-down, privately owned hostels and boarding houses, and that was totally inappropriate.

Senator MOORE—How many Centrelink offices are there in Port Phillip?

Mrs Incerti—There are two. One is in South Melbourne—it was going to be closed, until we had a big community rally—and the other is in Windsor. I do direct casework and I notice that more individuals who apply for disability support, for example, have to be directed to the main office in Windsor, so I am not sure how long we will have two offices. We did have three.

Senator MOORE—I ask that question because that is my background. For the kinds of things you have talked about, community networks used to be set up in which the then Department of Social Security was a key player locally. Is that still occurring in your area?

Mrs Incerti—It is not my experience that they are as involved. With a couple of our projects, a Centrelink representative comes along, but they do not attend many of the other networks.

Senator MOORE—What about in the Broadmeadows area?

Ms Shearer—It is a similar comment. When they are able to be, they are very helpful. But they are not in the networks in the way that they were in the networks when it was the Department of Social Security.

Senator MOORE—That seems to be my experience as well. In terms of your location—and this shows my ignorance of Victoria—how close is the City of Hume to the area of east Hume?

Ms Shearer—In terms of size, the Hume municipality is 504 square kilometres. It stretches from the Hume Highway in the east to the Calder Freeway in west. The southern boundary is the ring road and the northern boundary is a little north of Kalkallo and across around the creeks. It is about a 20-minute to 25-minute drive from Sunbury, which is rural township located in the west, to what we call Eastern Hume. It takes about 25 minutes to drive from the bottom of the built-up population area near the ring road to Craigieburn.

Senator MOORE—Perhaps you would like to look at the submission we received from people who were from the east Hume mental health area, who demonstrated some innovative approaches to mental health issues they have taken in their area, which seems to be more rural than what you were describing with the challenges in the outer suburbs.

Ms Mahony—Yes, it is confusing, and that is why we say it is Hume City. There is a Hume rural area in central Victoria and then there is a Hume City Council.

Senator MOORE—Is there a sharing of knowledge?

Ms Mahony—No, just a name.

CHAIR—They are a long way away from each other.

Senator MOORE—Is the kind of specialised support for mental illness—which identifies the issues of dual diagnosis—operating in your area?

Ms Shearer—The area mental health teams work with clients with dual diagnosis, but all of our mental health teams are based in the Broadmeadows area and only outreach to Sunbury or up to Craigieburn. As a consequence, there is a visiting service there but, because it is not part of the community fabric, people are not likely to engage with it or use it. For example, in places such as Sunbury, which is a community of about 30,000 people, it places enormous pressure on the one local community health service to be all things to all people and to patch together its service. It does a remarkable job but it is not necessarily funded to do that remarkable job.

Senator SCULLION—As we read through the submissions there is a clear, common thread of pressure points in the process. One of those points is clearly emergency departments. Whether it is a spatial issue or a human resource issue, it still seems to be that that is the place. I am delighted to see in a very practical way that you seem to have not only recognised that but attempted to address it through the connectED program. Could you talk about the program generally, and about how successful it has been. Particularly I would like you to draw some comparisons between your virtual acute support team and the CAT teams. What are the principal differences and what sort of skill suite does the worker have who works in the ED but who can come and go from the emergency department? How successful is it and how have you measured those sorts of things?

Mrs Incerti—That is interesting because I was just talking to their team this morning. They seem to be a particularly experienced group of workers. I would say most of them are mid-30s upwards and they have been psychiatric nurses, community health nurses with extra psych training. They tend to all have been from that background, so they have considerable years of experience.

Senator SCULLION—About how many are there on the team?

Mrs Incerti—There are nine on our connectED team.

Senator SCULLION—Are there particular skill sets within the team?

Mrs Incerti—Yes, they do have slightly different expertise. I understand, for instance, one is situated at the Prahran Mission, one is at the Windana Society, so also has drug and alcohol expertise and one is at the Sacred Heart Mission and has some housing outreach expertise. So, if they get a referral from Southern Health, the Alfred and associated clinics, they can see where the person geographically is gravitating to as well as perhaps some other factors that might point to a particular worker picking that person up. My understanding from the Hospital Admission Risk Program, which includes the Better Care for Older People Program and connectED, is that presentations to ED and preventable admissions have been reduced by 40 per cent over six months. So the case management being able to straddle the acute and community sector and being able to access both databases and information really quickly has enabled that worker to gain greater effectiveness in outcomes for people.

The worker in the emergency department is situated within emergency but is able to leave emergency when one of the cases they are attached to comes in. They go out with them in an

outreach capacity which may include driving them around, going shopping or going out for a coffee. Usually you cannot get a hospital worker that can take time out just to be with a person. It is very important to be able to engage and make trusting relationships with someone who otherwise has perhaps led a fairly frenetic, unattached lifestyle. It is ongoing, so it is not just three or six months; it is about more immediate availability and accessibility to workers. At times we have had a nine-month wait for case management through arbias, which assists people with alcohol related ABI. There are two workers in arbias and one has a nine-month waiting period. To refer someone when there is a nine-month waiting list is not worth doing.

Senator SCULLION—Are the people who access the connectED process basically people who present at the emergency department or are they part of a specific case load and, when anyone in that case load presents, then the connectED process comes into effect?

Mrs Incerti—My understanding is that it is a bit of both. If they are an initial patient it would be flagged on the system when they have presented three times within a certain time frame and then they would get referred to be picked up as a connectED client. Then my understanding is that if they come in in the future, they are already flagged. But my understanding of the whole of HARP, the hospital management strategy program both for older persons and connectED clients, is that once you have had so many admissions or so many presentations to ED you will come up in the system and it will be automatically reviewed whether you would meet the criteria.

Senator SCULLION—So, basically, once you reach a certain number of presentations to ED, there is a possibility of moving into using the connectED system. You are saying it will be reviewed; what do you mean?

Mrs Incerti—I guess it is if you have complex needs, rather than just being physically unwell and needing to come to ED. If you present to ED, you will still be flagged in the system but you may not necessarily meet the criteria. You may have good physical reasons to come and be admitted. So it will flag everybody who has come in that many times within that time frame. They would look at the criteria, complex needs and other issues.

Senator SCULLION—I want to talk about the opportunities provided by this program. Your submission shows clearly that there have been some benefits with flexible funding, and that is one of the principles of it. Can you tell me roughly how that works with those different funding bodies and how the flexibility of funding individuals rather than programs is different from conventional types of funding.

Mrs Incerti—Are you talking about the flexible funds that the connectED program has at its disposal?

Senator SCULLION—Indeed. This is just about the connectED program.

Mrs Incerti—That is funded through the hospital management strategy, so it would be through the Victorian state government. As a direct care worker, I know that sometimes you just need to buy someone a new bed, a new mattress or some new clothes, or use some support to get them new teeth—

Senator SCULLION—So it is discretionary.

Mrs Incerti—It is very practical and very much about enabling a connection with someone that can make a huge difference in their life. That is a way that that person realises that you are fair about what you are doing, that you are really listening when they say, ‘I need this,’ and you actually get it for them. So my understanding is that it is not huge amounts of money but it is money that can have quite an impact on and make quite a difference to someone’s overall health—things like getting them to the dentist or getting transport for them to get to Centrelink. It is that practical, flexible care funding that we as direct care workers and connectED are often really struggling with for the most complex people. You would not believe how hard it is to get beds and fridges sometimes. You get people the housing and you have to spend ages getting items for it. There is an awful lot we take for granted, and it impacts most on vulnerable, marginalised people like this.

Senator WEBBER—Speaking of vulnerable, marginalised people, I note in the submission from the Hume City Council that you refer to your poverty inquiry—first of all, congratulations on that initiative and in fact on your entire submission—and make particular reference, which captured my attention, to the fact that many people cannot afford to purchase heating and food, let alone computers. A lot of the evidence we are getting is that there are staff shortages and all sorts of other shortages in terms of being able to deliver services, and therefore we are going to rely on telehealth and the internet, and people can browse the web. But your study backs up my gut feeling, I guess, that there are a whole bunch of people who are never going to be able to do even that. In your poverty inquiry, did you notice much of a correlation between suffering from mental illness and poverty?

Ms Shearer—The poverty inquiry and our submission refer to a condition that is unique across Hume. Because of the low socioeconomic status of some parts of our community, we have very low levels of computer use at home. In our poverty inquiry we talked to a range of people who are socially excluded—we talked to women, we talked to older people—and we also talked to people who are engaged within the intellectual disability support program. Through that, we heard a range of stories. Many of the stories we heard were about people who would not be recognised as having a diagnosable psychiatric condition, but their capacity to live what others regard as a normal life has been severely impacted by their life experiences and they would be in that borderline category that does not actually justify any of the treatment thresholds. That is the case for so many of the people that we talk to.

Senator WEBBER—One of your recommendations is about community capacity building. Can you expand a bit on that and the initiatives that you think can be taken to reverse that?

Ms Shearer—We and the Port Phillip people have talked about the need to address active citizenship and social inclusion. As a local government, we can do a range of things. It is everything from us supporting our sporting clubs, running festivals and events to funding. We fund about 125 community organisations \$300,000 annually to support those community activities. That is the breadth, if you like, of building social capacity.

Another important strategy within Hume City Council is our global learning village. We have a ‘learning together’ strategy. The membership of that group involves over 300 different organisations, including us, the university, TAFEs, neighbourhood houses and community organisations. Together they address one of the determinants of poverty, which is education levels. It is about promoting lifelong learning and assisting our community to value and aspire to

greater learning and educational attainments. That is the raft, if you like. We put our actions behind our words. We do have a social justice charter. We do have a bill of rights. We report annually on that range of activities that we undertake which we think strengthen our community.

Senator WEBBER—Congratulations.

CHAIR—I do not think we have had a submission from the MAV or the VLGA, but to what extent is their cooperation between governments and through those peak bodies on these issues?

Ms Mahony—The MAV have a very active role, particularly in representing local government to the state and Commonwealth governments, largely the state government. They have a number of standing committees on aged and disability services and children's services, and they do look at undertaking both advocacy and planning work. One of the things referred to in our submission is a study of the needs and issues for interface councils around family support services. That work was undertaken with the help of RMIT and the MAV. They are very active but, in the community services field, there is only one person who has the role of covering the breadth of what local government needs to advocate, plan and provide in community services.

CHAIR—I imagine it would be quite good to be able to share ideas on what works and what does not. We heard evidence yesterday of Horsham Rural City Council running a program for teaching hairdressers about mental illness and how they might converse with people who could be troubled.

Ms Shearer—That is a great idea. I will add to Nicole's words. The VLGA run a Community and Social Planners Network, which is a tremendous resource. They support us on anything from looking at issues of problem gambling through to an issue like this and community safety. It is a really good place to go to learn and pinch ideas from your colleagues.

CHAIR—Thank you very much for your submissions and for appearing today.

Proceedings suspended from 3.08 pm to 3.28 pm

FREIDIN, Dr Julian, President, Royal Australian and New Zealand College of Psychiatrists

LAMMERSMA, Dr Johanna, Honorary Secretary, Royal Australian and New Zealand College of Psychiatrists

LOVELOCK, Mr Harry, Director of Policy, Royal Australian and New Zealand College of Psychiatrists

CHAIR—Welcome. The committee have your submission, which we have numbered 323. Do you wish to make any alterations or additions to that document at this stage?

Dr Freidin—No.

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

Dr Freidin—I thank the senators very much for their interest in this area and for inviting us to speak on our submission. To introduce ourselves a little further, Dr Lammersma works in private practice in Adelaide and will address those aspects of our submission. I work in public sector community psychiatry in Melbourne, in a program for homeless people. Our submission outlines where we believe the system can be improved and provides potential strategies for consideration. In our view, the three critical issues are funding, service integration and the mental health work force. Mental health services are significantly underfunded and disintegrated, and there are inadequate strategies to meet work force needs in terms of numbers and skills. As we note in our submission, mental illness is unlike most other illnesses, in that for a proportion of patients it is chronic, disabling and affects all aspects of life. Although mental illness is common, it is widely misunderstood, and people with mental illness often face stigma and discrimination.

I would like to make some general comments about the experiences of Australians with mental illness to explain where we are coming from. Mental illness can cause changes in a person's feelings, thoughts and behaviours. They experience emotional changes such as being depressed, anxious, scared or suspicious, and their ability to feel emotion and to react to others' emotions is impaired. Thoughts can become odd, eccentric, confused, sped up or slowed down. Behaviours can change in many ways. People with a mental illness may become overly suspicious, withdrawn or impulsive. Their ability to think, to plan and to understand what is happening around them can deteriorate. Their capacity to form relationships to gain support and to access complex services can be impaired. We would say that the complexity of the mental health system inhibits their access to appropriate care.

Mental illness, similarly, has an impact on family and other carers, who also struggle with accessing appropriate support in an extremely complex system. Compare the situation of someone who has a severe mental illness to someone who is developing a physical illness such as heart disease. With a physical illness there is usually a process of care that is well understood by the patient, by their family and by the community. The patient is not blamed or stigmatised. They are assisted in accessing care and they are not seen as unfairly using up resources or

blocking access to others who are in need. Integration of service delivery is seen in general health where, unlike mental health, the transition from the private to the public sector, from primary care to specialist care and across geographic boundaries all happen without severe difficulties. Illness of the mind, illness of the brain, is stigmatised and the individual is seen as less of a person. They become known by their illness. Unlike a person suffering heart disease, they are a 'mental case', a 'schizophrenic'. Claims that emergency departments are blocked by people suffering from mental illness similarly imply that they are less worthy of care.

Isolating people with mental illness into separate hospitals we do not believe is the solution, unless these hospitals are highly resourced, expert services where all needs are met. The risk is that there will be a return to the days of hiding mentally ill Australians from sight, and a return to isolated and underresourced institutional care. When we emptied the institutions there was no matching increase in community services. Increasing the number of hospital beds is not the sole answer either. We need to have an adequate number of outpatient and community services across the public and private sectors and these need to be integrated with all other forms of support. We say that most mental illness is treatable, as demonstrated by the increasing body of evidence. The inability of people with mental illness to get appropriate help is one of the main barriers to the provision of treatment. The treatments are available—it is just that the service system does not deliver them.

In terms of funding I am sure you have heard the figures many times already: mental disorders account for 27 per cent of all disability costs but attract only seven per cent of health funding. We have consulted with the Mental Health Council and we support their economic analysis that indicates that a \$1 billion increase in annual funding is needed to have a significant impact on the problem. We believe there needs to be service integration. Many people have complex needs and have been let down by the lack of integration. Integration is needed not just within the mental health sector but across all sectors of government that deliver care, and of course across non-government organisations too. Work force shortages and difficulties in recruitment are a major problem. There is clearly a difference between the need and the size of the work force, particularly outside the major cities. Issues of distribution of work force and work practices add to this.

A key finding of our recent internal survey of psychiatrists shows that the population of psychiatrists is ageing, more so in rural areas, and there is a high rate of imminent retirement. Recruitment into specialist training in psychiatry is down, influenced by the marginalisation of the specialty and by the stigma associated with mental illness and working with mental illness. Increasing demands on the public sector make the work more complex and add to the negative perception of the specialty amongst potential trainees. Work conditions and limited opportunities for broad training are other factors acting against the choice of psychiatry as a career.

Overseas trained psychiatrists help enormously with our work force problems, but there is a worldwide shortage of psychiatrists and attracting psychiatrists from overseas is not the solution. When we are thinking of the work force, it is important to state that we see the problem across all disciplines, not just with psychiatrists, and mental health nursing in particular is a major problem for service delivery in Australia. Again, issues of stigma, lack of understanding across the sector, negative attitudes to mental health nursing amongst other nursing specialties, a lack of focus on mental health nursing within their basic education, increased workload and the pressure of service delivery all add to the problem in nursing as well.

In advocating for the rights and needs of Australians with mental illnesses—men and women, adolescents, children—the RANZCP believe there must be a much more equitable distribution of the national health budget. We believe it is a matter of equity. The percentage of the health budget should more closely match the percentage of disability costs. As a community, we can sit back and speculate on why there is this difference but, more importantly, we can start to act to correct it. As a minimum, we need a proper system of care that is funded appropriately, is integrated across a simple service delivery system and is attractive to highly skilled staff. We acknowledge that there is no easy fix to Australia's mental health problems. However, Australia will take a giant step forward if all levels of government give absolute priority to achieving the best attainable quality of psychiatric care and mental health. Thank you.

CHAIR—Mr Lovelock or Dr Lammersma, do you wish to add to that statement?

Dr Lammersma—No.

Mr Lovelock—No, thank you.

CHAIR—Psychiatrists have come in for a bit of criticism one way or the other in this inquiry. I wonder if I can try a few on you.

Dr Freidin—Certainly.

CHAIR—The fact is that more than 90 per cent of psychiatrists choose to practise in city areas. Can you perhaps give the committee some examples of the factors that encourage this with psychiatrists? Why is it that they are less willing to work in country areas?

Dr Freidin—The issue of where people choose to work is of course an issue across all medical specialties.

CHAIR—But it is worse, is it not, with psychiatrists than with any other specialist group?

Dr Freidin—It is a very significant problem. We are certainly not saying otherwise. We are familiar with some areas where outside the cities there are virtually no psychiatrists, and where there are they are often not locally trained psychiatrists, so the psychiatric work force is highly dependent on overseas trained doctors and specialists. On the issue of the disincentives for psychiatrists to work in particular areas, we believe there are inadequate numbers of psychiatrists in total. Market forces allow psychiatrists to choose to work where they wish to work.

There are many social reasons as well as clinical reasons why someone would in general choose to work in a city rather than in a rural area. One wants to be close to one's colleagues to share information and for continuing education programs. One wants to work where one's family has access to education and one's partner has access to employment commensurate with their skills and so on. So we see that it is more that there are too few psychiatrists and that people are choosing where they want to work that significantly adds to this problem. We do have psychiatrists working in the rural areas, but as I mentioned in our work force figures our own fellows are telling us that the psychiatrists in the rural areas are older and they are thinking more about retiring from isolated, distant practices.

CHAIR—We will perhaps come to the issue of work force shortages in a moment. Can you advise the committee on what kinds of measures could be undertaken by government to encourage psychiatrists to go to country areas? Do you have any suggestions to make about how we might entice people beyond the bounds of the city?

Dr Freidin—Certainly, and there are in fact existing rural specialist support schemes to try and assist psychiatrists. Some of the issues include remuneration encouraging people to work in rural areas, systems of providing clinical and educational support through systems such as telepsychiatry and tele-education—

CHAIR—And where would you say we are with telepsychiatry or telewhatever? Have we tapped into that 10 per cent of what might be possible with known technology, or is it less than that? Where are we in terms of effort?

Dr Freidin—We are really near the start. Although it is said that Australia is one of the leaders in this, we are very close to the starting blocks. We know what can be done, but there are complexities in setting up high bandwidth systems so that pictures can be sent distances and people can talk. It is still in its very early days. There are no proper funding models to support this. If you want to set up a conference with several people in different parts of the country speaking to each other on a video link, it is very expensive. That is the sort of area where government support, to encourage people not just to move into rural practice but to be supported in a rural practice, would be very beneficial.

Dr Lammersma—I think the other difficulty with telepsychiatry is that, if you ask consumers and their families about it, it is seen very much as second-best to a real face-to-face interview. One needs to realise that, in treating and assessing someone with a mental illness, the face-to-face component and the interaction are very important. It is quite difficult to do that across a video link in telepsychiatry. That is one of the things that I think limit it. That is probably why a lot of psychiatrists also feel limited by it and do not always feel particularly comfortable doing it. I think that is an issue. Speaking as a private psychiatrist who for a number of years went to the country, one option, although it is not an ideal option, that is meeting some of the needs of country areas is the fly-in service. I think there is an opportunity to increase that by removing some of the barriers that stop people doing that.

CHAIR—What are those barriers?

Dr Lammersma—Barriers such as having a place to go, having a local community that is willing to work with you and issues to do with remuneration. One has to remember that, being in private practice, when I went to the country I still had to pay all my costs associated with running my practice in the city as well as paying the costs associated with practising in the country. So there are some of those practical issues. However, I have to say that, on the whole, working with country GPs was a real pleasure. I think that they in particular often have a great interest in working with people with mental illness. Working on increasing those links with GPs is another very important area that can improve the care of people in country areas. At the end of the day, as with many other specialist areas, it will be the GP who will be central in providing the care.

CHAIR—What do you think of the training for GPs—six hours for level 1 and 20 hours for level 2?

Dr Lammersma—That is something I have been involved in with the college. I have been involved with the Better Outcomes in Mental Health initiative. Although, on the one hand, it sounds very limited, on the other hand it is a big step forward from what was done before—at least some training now occurs. What has been found is that those people who become interested in providing mental health services in primary care will often then go and do further work anyway, and there are now more supports available for GPs to do that. Many people who are genuinely interested in working in this area will do much more than the six hours or the 20 hours that are required—not all GPs, because not all GPs are interested in mental health care.

CHAIR—In fact, only 15 per cent have done it so far.

Dr Lammersma—That is right, but I guess it is about beginning to have more of them do that kind of work.

CHAIR—It is also said that the colleges of any specialisation are partly responsible for some of the shortages of specialists. Is that the case with your college? Are there any barriers that you have created to taking on this specialisation? As part of the answer to the question, can you comment on women? Dr Lammersma, it is good to see you here as a psychiatrist, but I have to say we have not seen a lot of female psychiatrists.

Dr Freidin—It is good to have Dr Lammersma here, because the percentage of females in our new trainee intake is now about 50 per cent in all the colleges.

Dr Lammersma—And in psychiatry, over 30 per cent of qualified psychiatrists are female.

Dr Freidin—So it is one of the highest for all the colleges. Dealing with other relevant issues, may I say that we are also very supportive of part-time training and breaks in training while people have families and so on. But the original question was: to what extent was the college part of a barrier to training? Our view is that we are not, and our data for that is that we have a consistent problem now filling our training places. We identify as well as we can places within the public hospitals essentially where people can train in psychiatry. We advertise those positions; we interview people to enter training. We do set some standards. We believe that not everyone who declares they want to be a psychiatrist is appropriate to train, but the vast majority of people expressing interest do enter our program. And still, in most states, about one-third to half of the positions available are simply not filled. We do not believe we are preventing people entering. It is not like there is only one training post in Victoria; there are 35 new training posts in Victoria, but only 20 get filled. There is a shortage of doctors coming into those posts.

CHAIR—Do you have some suggestions to make about how recruitment might be improved? We talked with the nurses earlier, who made some suggestions on nursing. They mentioned the fact that nurses have to do general nursing before they specialise, and that the opportunities to specialise in mental health are not there until after they graduate. Is this the case as well with the medical profession?

Dr Freidin—We are trying to set up a program to encourage young doctors to consider psychiatry and to enter the training program. Because we are a binational college, we have also been talking to the New Zealand government. The New Zealand government have been prepared to fund us to develop a resource kit, which we launched at our congress in May in Sydney. That was a month ago, but that is for New Zealand use. We would very much like to—in fact, we are talking to the department to see whether they would support the development and funding of an education package including a DVD, online materials and so on—get down into medical students and doctors when they first graduate to promote psychiatry as a career.

We also think there are parts of the problem that we cannot address to make it more attractive as a career. We cannot address the remuneration issue. We cannot address the difficulty of training in the public sector at the moment, which we see, as I said before, as a highly stressful and under-resourced sector. Young doctors look at what is happening in our emergency departments and in our acute care wards and think: ‘I’m not sure I want to do that, as a trainee, for another five years. I’d rather go off and do something else.’

Senator HUMPHRIES—As you have heard, there has been quite a lot of criticism of psychiatrists, and I want to explore some of those issues with you. There has been quite an attack on—I suppose the ‘medical model’ is not the right term; the ‘psychiatric model’ might be a fairer way of describing it—the psychiatric model that emphasises decisions being made, particularly for severely mentally ill people, by clinicians without the involvement of the consumers of those services, as they are termed. It even goes so far as to suggest the closure of freestanding mental hospitals or mental institutions and emphasising community based responses or, at best, services provided in connection with general hospital services. Going through those in turn, can I have your reaction to some of these things? What about the question of whether there should be a greater role for consumers in the framing of services and even the delivery of a personal service, if I can put it in those terms, to a person who is mentally ill? Do you feel that the system at the present time is too disempowering for individual consumers, for mentally ill people? Do you accept that there is scope for some transfer of that, forming a treatment plan more for the person who is receiving that treatment?

Dr Freidin—Very much so. The college is quite supportive of there being as much involvement of the consumer and carers as possible. Perhaps it is of less relevance today, but with our own internal structures we actively seek advice and we have consumer and carer members of our committees and so on. In the clinical setting, the more information you can get about someone’s social circumstances and social network and the involvement of their carers and their families and their own views, quite simply the better able you are to plan with them what needs to be done and then to implement a plan that will be successful and acceptable to them. So, from the college’s point of view, that is very important.

We are also aware, though, that practically, in stressed, underresourced services, when people do start having to act fast to make decisions more quickly than ideally they should—for a host of reasons—one of the things that slips by the wayside is the time that should be taken to consult in detail with family and with the patient before deciding on an ongoing management plan. It is a little easier in private practice because one is a bit more able to control the pace of things. My comments are more about the public setting.

Dr Lammersma—One of the advantages of working in the private sector is that it is much easier to work very much in a partnership with not only the consumer but also their family and their carers. That is one of my great passions. I am also passionately involved with community education and awareness. I believe very much that that is part of empowering people to make some of those decisions. Certainly, I think this is where, in private practice, it is much easier to give people the opportunity to have a say in managing their own condition. That is possible in the private sector because there is more time and there is more ability to work with family as well, as I said. Having worked in the public system in the past, I think that is much more difficult to do in the public system because of time constraints and so many other pressures that are upon you.

Senator HUMPHRIES—Why is this happening now, though? We are told that there is a huge gulf between what is happening at the moment and what should be happening. We are told that there are horrendous practices going on in psychiatry, particularly in psychiatric facilities where people are held in a secure sense. We are having information compiled for us about what are termed to be abuses in that context. We are told that this would be largely avoided if there were a much greater empowerment of consumers, as they are termed. If there is such a large gulf, and given the acknowledgment of that need by you, why has that gap not been closed already?

Dr Freidin—The gap has not been closed already because time, effort and resources are needed to close it. There are some things we can do from our point of view as the college. For example, in our recently revised training program we have introduced modules so that every year trainees have to have some involvement with consumers, carers and non-government organisations to try to broaden education. But the reality is that if one ends up in a high-pressure, stressed service system where there is not time to do things properly, unfortunately, ideal goals are not met. We want to work collaboratively with the consumer and carer movement, particularly through the Mental Health Council of Australia, to try to lobby for the changes that will close that gap, but we do not take responsibility as a college for there being that problem. We are part of a complex system and will accept our part of it.

Senator HUMPHRIES—You, as representatives of the college, might like to go back and look at some of the submissions that have been made by groups like the Mental Health Legal Centre and possibly pass some comments on those. As I said, they made some fairly compelling cases for a major paradigm shift. It is argued, by some anyway, that nobody should be treated involuntarily—that the episodes of mental illness are often very short, that it should be possible for most people to frame some kind of treatment regime before they are actually in that episode of mental illness or psychosis and that it should be possible to deal with that without involuntary restraint or treatment. What is your response to that?

Dr Freidin—The reason people end up in a situation of involuntary treatment is usually that their illness has progressed to a point of severity. If we had a service system where, instead of 40 per cent of people with mental health problems getting some form of intervention, 80 per cent or 100 per cent were then certainly people would be treated earlier, they would be less disabled, there would be less likelihood of them needing involuntary treatment and so on. I am in agreement with that, although not 100 per cent. I would still see that, given the nature of some psychotic illness, occasionally it is still necessary for the person's own safety and wellbeing and the safety and wellbeing of the rest of the community that there is involuntary treatment. But it

would certainly be decreased a great deal by adequate early intervention programs and long-term community treatment programs, both of which are severely underresourced at the moment.

Senator HUMPHRIES—Should we close freestanding mental institutions?

Dr Freidin—We should progressively move to integrate mental health into general health. There are enormous advantages in having the majority of psychiatric services in general hospitals as part of the culture of general hospitals with regard to constant review and quality improvement and in the accessibility of general health care to patients with mental illness as well. There is probably going to be a need for small specialist services for people with particular disorders where all they need is psychiatric intensive care, but I would see that as being a very small part of the much larger integrated system.

Senator FORSHAW—The last question that Senator Humphries asked you was something I wanted to take up—that is, the state of affairs with the availability of acute care services in the public sector and the private sector. It seems from what we are told that there is a critical shortage of acute care beds and maybe facilities in the public sector. Representatives from private hospitals told us the other day that they are in a position to help out in that regard but of course there are issues regarding health insurance coverage and so on. That impacts on a lot of people who because of the very nature of the illness may not have private health insurance. I would like you to comment, with the profession's knowledge, on what is the state of play there.

I also wanted to take up this issue of stand-alone facilities, deinstitutionalisation and the location of psychiatric wards or services within general public hospitals. I understand the proposition that it should be integrated into the general health care sector. I also understand what led to deinstitutionalisation some years ago. But I have often wondered whether or not something was lost in that process. Not all psychiatric hospitals were terrible institutions where people were chained or locked up. In some cases, there may have been specific units or particular wards within a hospital where, because of the nature of the illnesses of people in those highly restrained areas, that may have been the case. I know people who spent time in Rozelle or Callan Park, which Rozelle was initially known as, or Gladesville would say that they were quite good rehabilitative places for them to stay.

I have visited some facilities in public hospitals which to me, as a layperson with a longstanding interest in this issue, seem to be stuck in the middle of a large public hospital and do not appear to be the sort of environment which maybe did exist in some of the stand-alone facilities and which I think do exist in some of the more specialist private hospital arrangements. That was a long comment regarding questions about the general nature, if you like, and supply of acute care facilities.

Dr Freidin—There has been, as we all know, an enormous call for more acute beds: 'There should be more acute beds and that will solve the problem.' I was talking before with Senator Humphries about how illness is a progression and that it is when it reaches a severe level that people end up being involuntarily treated. In the same way, the need for acute beds is a fair way down that spectrum. We have consulted a lot in our fellowship, and of course there is divided opinion, but our view is that putting in more acute beds to try to tackle the end of the problem rather than the start of the problem is not the best way to go. It is an expensive system and it is

not what the patients, the community and their carers want. Patients do not want to go to hospital unless they absolutely have to.

We believe we have this problem because with deinstitutionalisation, as I am sure many others have said, the resources were not put into developing the community services to assist people before they become so unwell that they need hospitalisation. We are now at the point of course where all there is left in some sectors is hospital and so that is where the problem is seen. The demand for hospital beds is a consequence—it is not the cause. Lack of beds is not the cause of the problem. Where the beds should sit is the other part of your comment and question.

Senator FORSHAW—It is about the quality of acute care too, I suppose.

Dr Freidin—It was not all bad in institutions and all good in general hospitals—of course not. I was part of the shift, in Victoria, from the 600-bed institution of Larundel as it broke up into eight small units. Some have gone very well and some less so. The risk with recreating institutions is that people are once more out of sight and out of mind. The risk is that if you—

Senator FORSHAW—I am not suggesting that at all.

Dr Freidin—No. But that is why we are being cautious about the ‘rebuilding institutions’ argument. For some people, and particularly those with rehabilitation needs, somewhere to be for three to six months to get intensive assistance would be very beneficial. One of the major service gaps at the moment is the long-term rehabilitation facilities. That is not about getting access to a psychiatrist for six months; it is about getting assistance with cooking, cleaning and living, and getting occupational therapy, social work assistance and family counselling. That does not exist any more, or if it does it is very rare that anyone can gain access.

And picking up a unit and putting it in the parking lot of the general hospital does not work either—that is not integration. Integration is when it comes under the one hospital board, when the medical staff and nursing staff rotate through and when the mental health unit becomes part of the general hospital unit and is not the place down the end of the corridor. There are not many places that have actually integrated in that sense. There are many more that have co-located, which is the word that is being used to describe what you were reflecting on.

Senator FORSHAW—Thank you.

Senator MOORE—We have had some questions about people who identify as Aboriginal or Islander in your profession. Do you know whether or not you have any Aboriginal and Islander people who are psychiatrists in Australia?

Dr Freidin—Yes, we do. Dr Lammersma might know the exact numbers.

Dr Lammersma—No, I do not.

Senator MOORE—We had a specific question about it and none of us knew the answer. Can we find that out from you?

Dr Freidin—Yes—it will be very simple for us to look up our fellowship list. There are Maori psychiatrists as well.

Senator MOORE—It was actually in that context: that the Maori experience had been much more positive, that there had been direct encouragement and that we had not done as well in Australia. That is where it came from.

Dr Freidin—We can generate a list for you.

Senator MOORE—That would be good. One of our terms of reference, on which we have received many submissions, is to do with co-occurring disorders. We heard evidence today from one of your Victorian comrades that very few psychiatrists practice specifically in that area. Do you agree that there are few people who specialise in that form of psychiatry?

Dr Freidin—By co-occurring disorders you are referring to drug and alcohol—

Senator MOORE—Dual diagnosis.

Dr Freidin—There is drug abuse. Dual diagnosis, which is the term we use, is the interaction of drugs and alcohol with dual disabilities—with intellectual disability, which is an even larger problem.

CHAIR—There is a new term coming, Dr Freidin.

Dr Freidin—A new term?

Senator MOORE—A co-occurring disorder. That was why I particularly wrote it down. It is actually the dual diagnosis.

Dr Freidin—Yes. It is an enormous problem. Historically, drug and alcohol did fit in under the psychiatric sector. The mental health sector was split off, and we think that was a very bad thing. There are psychiatrists who are specially trained in both. We do have an interest group, a section of people within our college, who do both and we are trying to promote and develop that. Certainly, there are people who work in the public sector with the homeless program for people around St Kilda. Ninety per cent of the people I deal with tell me that they are on substances and the other ten per cent, I suspect, probably are too. So we have to deal with this; it is just a day-to-day reality of public sector psychiatry. In the private sector alcohol and minor tranquillisers are much more the problem. Intellectual disability is even more distant from us, and we think that that is a mistake. The UK model has intellectual disability falling under mental health and so there is much more integration. We strongly support moving in that direction.

Senator MOORE—And your submission recommends moving together.

Dr Freidin—Yes.

Senator SCULLION—I noticed one of your last comments where you were talking about getting a bit fair dinkum about integration. That would obviously mean staff cycling through, so I thought for a moment that the difference between co-location and integration was clearly

having the capacity to run something there. There is no point translocating the challenges you have from wherever you are in terms of qualified staff and those sorts of issues, so I am assuming that that was your point. That would mean that everybody on a hospital staff—general nurses, the ENAs, GPs—would need to gain a higher level of understanding of identification, triage and the treatment of those people who were debilitated through some sort of mental illness. How do you think the wider medical community would view that? That may be the only way forward—I recognise the difficulties you have with recruitment—but how do you think they would recognise that? Do you think that would be widely embraced given that there has been only a 15 per cent uptake thus far?

Dr Freidin—I am not suggesting that for integration everyone has to do the same work. Rather, there would be some greater sharing so that, for example, in medicine doctors in the first year or two would rotate through a medical unit and a surgical unit and so on. Or maybe everyone needs to spend three months in psychiatry as well. We do not expect that everyone in medicine or nursing is interested in mental health, in the same way that I am not interested all that much in orthopaedics. But I want to know that there are enough people who are. So if there are 15 per cent of GPs, that actually translates to quite a few thousand people and that is 15 per cent more who have done the training and are getting involved than there were. It needs to go back a step beyond GPs to medical schools to integrate mental health as core business for all doctors. But, as with the other specialties, people then choose how far they go down a particular path. Yes, there will be resistance—there is always resistance to deal with mental health issues—but, with education and support, destigmatisation programs work. They work for doctors just as much as they work for the general public.

Senator SCULLION—I just needed to clarify whether you were looking for a system with the whole staff cycling through the system or whether it was, as you have now pointed out, where everybody takes some time with perhaps geriatrics, obstetrics or psychiatry. I understand that now. I have a couple of questions, the second you can take on notice. The chair spoke to you about the issues in rural Australia, but generally I would like some comments about recruitment. You can say more money is needed and you could do all that. But a lot of submissions that I have seen, and even the sorts of things that you have spoken to me about today, indicate that it is not only about money. Governments are the least wise about your particular profession. How do we encourage people to make psychiatry more sexy and more acceptable? You are effectively responsible for that from an industry perspective. What advice can you give us?

Dr Freidin—No, it is not about money. Otherwise, there would not be the 2,500 of us that there are already. People do psychiatry because they are interested in the field, but they are usually interested in the broad field, not the very narrow part of it. We think that changing the experience of the doctors who are thinking, ‘Will I go into psychiatry or something else?’ is the critical point. If you expose them to something that is frightening, intellectually difficult, has issues to struggle over or if they have to deal with a lot of conflict, they will think about what else they might want to do. On the other hand, if they have a positive experience of seeing, in psychiatry training, what psychiatrists do—they meet with the community; they talk with patients, carers and families; they have time to stop and think and work through complex issues with people; they see that people are grateful for what they are doing rather than angry or resentful; they find that, instead of just being in the hospital, they have access through Medicare funding or some other model to go into private practice and do some of their learning there; and they see that what they have trained for is actually a very broad, enriching life rather than a very

narrow life of dealing with in-patient psychiatry—then we believe it will be much more attractive. In fact, when we talk to medical students, some of whom are still interested in psychiatry, they say that is why they are interested and that is what they want to do. As they get closer to starting training and they see how narrow it is, they think, ‘Gosh, I could do all those things if I were a GP or a physician who just happened to be a bit interested in psychiatry.’ So it is about broadening the experience.

Dr Lammersma—There are psychiatrists who enjoy their work—I love my work; I think it is a great job and I go to work every day with pleasure—and I think it probably behoves those of us who enjoy the work to be more upfront about it and be out there and say that to people. This is where the New Zealand DVD recruitment package, which goes to medical students and young doctors, I think, is really good. They have captured on DVD a number of prominent psychiatrists in New Zealand, and you can see their enthusiasm shine through on the DVD. You can see that they love what they are doing, and that is the message that is being portrayed. But, if we keep on portraying all of this as a terrible situation, that it is terribly complex and very negative—I would say to all of you: ‘I wish you could come and spend a day in my practice and see what I do and see the difference the treatment has made to people’s lives.’ It is not at all dim and dark, miserable and horrible. People are flourishing and are doing all sorts of wonderful things with their lives. They live very meaningful lives and contribute a great deal to their communities and their families and friends. I think that sometimes in situations like this we can get so bogged down in all the negatives that we forget there is another side to all of this.

Senator SCULLION—Thank you for that; that is a very practical answer. You gave the figure of \$1 billion in recurrent funding. Could you tell us, on notice, how, notionally, you might break that up? Obviously you have come to the sum of \$1 billion, so you have worked out roughly where you would break that up. If you could supply that, on notice, to the committee I would appreciate it. Again, in a notional sense, in terms of the inequity in the national health budget, perhaps you could suggest areas that we could take the money from to give to mental health. Obviously at some time we will be happy to consider those things, not in terms of the \$1 billion but the percentages. You might want to look at the other aspects of our budget to find out where we might take and transfer that from.

Senator WEBBER—I have two issues I would like to raise with you. The first is about treatment of Indigenous people. I will say before we start that I am from Western Australia, so that issue is of particular interest to me. I will preface this by saying that we should bear in mind the discussion we have already had about the availability of psychiatric services; they do not exist outside Perth, particularly in the north-west. In your submission you say:

Services should include improved support for hospital based consultation-liaison psychiatric services to Aboriginal and Torres Strait Islander peoples ...

There are lots of hospitals and lots of Indigenous people outside Perth, so how do we achieve that if we do not have psychiatrists?

Dr Freidin—How do we achieve that in Perth?

Senator WEBBER—No, outside Perth. That is largely where the Indigenous population with mental health illnesses is. That is where there are hospitals, but there are no psychiatric services. So how do we achieve what your submission says we should have?

Dr Freidin—The issue of the delivery of services outside the cities is the same as the rural issues. Some of the models that have been tried—which are very expensive—such as the fly-in, fly-out model, where you convince someone to leave their base and go somewhere for a day or two, can deliver some service, but not very much. And then someone has to be there to implement the recommendations they have made. It is not terribly helpful for a doctor to turn up once every month or two if no-one is able to monitor the patient in between that time. That is one model. Telepsychiatry is another model. It has its problems but it is better than nothing at all. We are talking with the department about reviewing the telepsychiatry item numbers to make it more workable, because it is not terribly workable at the moment.

Can we recruit psychiatrists who want to work well outside the capital cities? It is a real problem. We do not have an easy fix, an easy solution, for that. As I said before, there is so much work to be done by psychiatrists and they are choosing to work where they want to work at the moment.

Dr Lammersma—I think too that this is where the Aboriginal mental health workers come to the fore. I know more about the Northern Territory model and the Darwin model. I know that Darwin mental health services have quite a large number of Aboriginal mental health workers who work both within Darwin as well as in the local communities. That is a particularly good model that works very well. There are a number of psychiatrists who have a real interest in Indigenous mental health and that is certainly one of their strong recommendations—to use the Aboriginal mental health workers and train them and upskill them and have them working with them.

Dr Freidin—An early draft of our submission had many more pages from our Aboriginal affairs committee which, for various reasons, were culled. If you would like to see the original half-dozen pages—

Senator WEBBER—I certainly would.

Mr Lovelock—I think Dr Rob Parker has submitted a separate submission around Indigenous issues to the Senate select committee. That is there as well. He has also developed an Indigenous curriculum that we are looking to put online in the next 12 months.

Senator MOORE—Where is he located?

Mr Lovelock—The Northern Territory.

Dr Lammersma—Darwin.

Senator WEBBER—One of the other issues that has been raised with us, although not quite so recently, about career progression not just for psychiatrists but for other mental health professionals is that, in order for them to progress their career, the emphasis tends to be based on non-clinical things—administration, teaching, research, what have you. There is a question as to

whether that is actually a barrier to attracting and retaining people or whether that is an incentive and we should deliberately move people away from service delivery. Have you got any comments on that?

Dr Freidin—That is an interesting one.

Dr Lammersma—It is why I am working in private practice and have not remained in the public system, because my interest was that of a clinician rather than an administrator. So I think it is an issue and it probably is a reason why a number of people move into private practice, because there they can be a 100 per cent clinician. However, I should let Julian speak, given that he is actually in the public system. He is probably part administrator and part clinician.

Dr Freidin—I suppose there is some perception that, if one stays in the public sector, the career path leads towards administration and if you choose not to do that and remain in clinical work, which I have done outside my college activity, one remains somewhere around the midpoint of the hierarchy. But that is a personal choice. I do not see that as really affecting recruitment into the profession in any significant way. Some people are happy being clinicians; other people want to be administrators.

Senator WEBBER—That is interesting. Thank you.

CHAIR—Thank you very much. I hope you do not think, as you probably do, that we have focused not on your submission but rather on other people's submissions. It is what happens, once you get into the hearing process. But there are actually a couple of things in your submission which I will not ask you questions about because we have run out of time. I would love to talk for a long time about the necessity for mother and baby units. It is good to see that you have made that recommendation and I think we will explore this in other areas. There is something that is not in your submission, and I ask you whether you have done any work on this—that is, the lack of clinical trials done on children and medication. As I understand it, pharmaceutical clinical trials are by and large based on adults, and there was a report recently that drew attention to this problem. To what extent is that a problem for you and has anybody in your college or anyone to your knowledge in the profession done work on this issue that you might draw to our attention? I do not ask you to answer that now, but if there is a chance of getting back to the committee on that, we would value it.

Dr Freidin—Yes.

CHAIR—Thank you very much for your submission, for coming today and for presenting to us.

[4.21 pm]

JACKSON, Professor Henry James, Private capacity

RUDD, Mr Raymond Peter, Private capacity

CHAIR—Thank you for appearing before us and good afternoon. Do you have any comment to make on the capacity in which you appear today?

Prof. Jackson—I am here in a private capacity but I am also a head of school and an ex-convenor of our clinical training program. I am here, in a sense, to advocate for my profession.

Mr Rudd—I am a clinical psychologist working in public mental health services in Victoria. I am here in a private capacity.

CHAIR—You have provided us with a submission, which we have numbered 401. Do you wish to make any changes or additions to that document?

Prof. Jackson—No.

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

Prof. Jackson—I will start off for a couple of minutes and then ask Mr Rudd to take over. I have been around the system for a long time and I should point out that I do not wish to engage in psychiatrist bashing.

CHAIR—Why not? We all have this afternoon!

Prof. Jackson—I have great respect for a number of colleagues, notably people like Professor Hickie, Pat McGorry—who I understand is presenting tomorrow; I worked with him for a long time in the early psychosis domain—and Fiona Judd. I respect them for their knowledge and for their inclusiveness, which is something that I think has been lacking elsewhere.

Why we are here, in a sense, is that we believe that in this country—as opposed to the United Kingdom, Canada and the United States—clinical psychology has a very low presence in the work force, for a variety of historical reasons but perhaps also poor leadership in the past and so forth. Also, one could argue that historically there has been antagonism from the medical discipline and, more recently, I believe, an internecine rivalry between nursing and other members of so-called ‘allied health’, a term I object to. We accept that there is a need for a multidisciplinary work force, so I do not want us to be seen to be just pushing our own case, although it may appear that way. It is clear that we need a multi-skilled work force—the emphasis being on ‘skilled’. However, I believe at the moment—and I am talking specifically from a Victorian perspective here, one I am familiar with from having worked in the system for a long time—that there has been recruitment at the four-year undergraduate degree level in a variety of disciplines. My strong view is that people who come out of that system are not adequately prepared for mental health work.

My strong belief is that one needs training in diagnostics and assessment, psychopathology, therapy instruction and also in the research tradition which underpins clinical trials and how we understand psychopathology. I am very concerned that at the moment we do not have that. If training occurs, it tends to be minimal and patchy at the undergraduate level in a variety of these disciplines. I also include here psychology at the undergraduate level. I know, because I am the head of school at the University of Melbourne. One has to remember, for example, that psychology is a preparation for different career tracks. As you may know, clinical psychology, along with neuropsychology, is a postgraduate discipline. That is true in the United States, in the UK and in Canada. Until recently, medicine has been an undergraduate discipline, although there seem to be moves towards looking at the MD model, which is the case in the United States, where people do four-year degrees and then do an MD degree—in a sense, a coursework degree rather than a research degree—after that. Could I table something, if people are interested? They may or may not be.

CHAIR—What is the document?

Prof. Jackson—It is a document that sets out our courses. I am not trying to sell it to anyone. I am trying to set out the components that make up our training, so people may gain some understanding of the nature of the coursework.

CHAIR—Is there any objection to the document being tabled? There being no objection, it is so ordered.

Prof. Jackson—Our training has traditionally been at a masters level but, in the last few years, to make it more equivalent to the United Kingdom, it has been done at a three-year doctoral level—one-third didactic coursework, one-third research and one-third placement. We also have another degree, which we are having some graduates coming out of, which is essentially a four- to five-year degree and is a combined masters/PhD degree. We have the very best students coming out of that. People who have that latter degree are much more equivalent to people training under the United States PhD model.

It is hugely competitive to get into clinical psychology. We had 176 applications last year for eight places. What is very interesting is that these programs cost us money big time. Essentially, people are reliant either on HECS or, if they do the PhD model, on getting a scholarship after doing the first year of a masters program and then doing the PhD after that, with a third masters course work in each of the other three years. We have had no fall in applications. There are six such programs in Victoria, as I understand it—I may be out by one, but not by much more than that.

The problem is that these people go into the work force and they are employed as case managers—generic workers. Very few of them are employed as specialist clinical psychologists. They are often seen to be extras, if you like. When there are financial downturns or problems with finances—as there were recently, in one of the parts of the system here—they are often considered to be non-essential. Frankly, I find that ludicrous. Whilst one would not argue against the fact that psychiatrists are well trained in a variety of areas, especially pharmacology, which we are not—we receive some training in pharmacology, but more from an understanding point of view, as we obviously cannot deliver it in this country, unlike in the United States, where some clinical psychologists do—the fact of the matter is that our skills are not used

appropriately. We are few in number in the work force, as Ray will talk about in a moment. We have the training. In fact, some of us have devised some of the treatments that we are using. I refer, for example, to CBT for psychosis, which is one of the best understood treatments for people who have chronic resistant symptoms—in other words, symptoms that have not responded to medication. It is an evidence based treatment that is underutilised. There is a problem there.

We are only talking here at the moment—and I have heard much of the conversation so far—about the severe end of the spectrum. We are not talking here about people in the community or community settings, community mental health clinics and so forth—who may in fact present with depression, alcohol problems, anxiety disorders, social phobia and panic disorders, for example—who in my view are not receiving adequate attention.

I mentioned earlier Better Outcomes in Mental Health. I was the beyondblue member of the allied health committee. You may wish to ask me questions about how that committee worked. I have fairly strong views about that. To answer the question about the six hours and the 20 hours: my belief is that it is, to put it subtly, suboptimal. That would be my word for that.

We have a situation which the APS, the Australian Psychological Society, is trying to address, which is the discrepancy in standards between registration boards—all states have them—and the college of the Australian Psychological Society. I will give you an example. For clinical psychology, the Australian Psychological Society insists on people having at least a two-year master's degree in clinical psychology plus two years of supervision. I believe if it is a doctoral degree then they will have one year's supervision. The registration board right now in Victoria—and they do differ slightly around the country—insists on a four-year undergraduate degree, which in my belief is not preparatory for practice with people, and then two years of on-the-job one-to-one supervision, typically but not always with a private practitioner.

My belief is that managements and governments—this sounds slightly paranoid, but I believe it is a true statement—have exploited the discrepancy in standards between the registration board and the APS requirements. This is something that the APS is keen to fix at the moment by bringing the registration boards together with the APS. The problem is that the registration boards are directly responsible to the state government, and managers, in my belief—and certainly I am aware of a couple of instances—have brought pressure on the registration boards to maintain existing standards, obviously because that would separate psychology out from the rest of allied health and would presumably have monetary implications as well.

CHAIR—Professor Jackson, could I just interrupt you. You are talking about two different registration boards. One is the Psychological Society. What is the other one?

Prof. Jackson—There are two separate bodies. There are the registration boards which all states have for legally mandating whether you can practise as a psychologist. They report to state governments. And then there is the APS, which is a professional college which insists that for membership and to call yourself a clinical psychologist you have to have a two-year master's degree or better and two years of supervision. In short, I am arguing strongly for greater recognition of specialist clinical psychologists in the work force. I believe they are a major component of the work force, and should be, and they are largely left out of the system in this country.

Mr Rudd—I would like to elaborate on some of the points raised in the written submission because I believe they are important. Henry has already talked about the problems with resourcing, the use of specialist skills and so on. The fact of the matter is that the College of Clinical Psychologists in Australia currently has around 1,200 members, which is relatively small compared to international numbers. That comes out to somewhere around six per 100,000. In the UK it would be at least double that. I do not have figures readily available for the Canada and the USA because they are not on their web sites, but those countries are bound to have at least that number, if not more.

I will not go into Henry's comment on employment policies except to say that in the public sector it does result in very limited career prospects and that the case management model, which came in with mainstreaming, although it has obvious advantages for many clients in the way that it should work, had the unfortunate spin-off of leaving the professionals a bit out on a limb, because it went immediately to budget programming and had a managerial emphasis rather than a clinical emphasis in the first instance.

The third limiting factor professionally, as well as the relative small numbers, is that clinical psychologists belong to a larger umbrella body called the Australian Psychological Society, which has to advocate on behalf of all psychologists. We do not have sufficient numbers to have our own independent voice, and that is very restricting. I will give you a practical example. Only for the sake of accuracy regarding work force make-up, which is pertinent in this venue, we need to point out that the APS submissions, Nos 50 and 479, state that 'at least 10,000 are well qualified'—psychologists, that is—'to treat mental health disorders.'

That, I am afraid, is an inaccurate statement because it does not define 'well qualified'. For clinical psychologists and international best practice, 'well qualified' means a minimum of a postgraduate qualification in clinical psychology. As noted, there are only approximately 1,200 members, plus a few more who are eligible but not currently members of the College of Clinical Psychologists within the APS. The APS submission's oversight is that it has no specified benchmark as to adequate training. This example is brought to the committee's attention to reinforce the need for national specific benchmarks as to adequate, evidence based practice skills.

Benchmarks for practice and training need to apply to not just clinical psychologists but all staff, from those who provide the most basic mental health services to those who provide the most complex mental health services. We need to adopt nationally a level of skills model—that is in page 10 of our submission—which clearly specifies levels of skill and problems able to be addressed at that level, as well as providing a system of accreditation for such skill levels. A key current example is the treatment CBT, which Henry has mentioned. This is recognised as an approved treatment in the better outcomes program. The term has unfortunately become overused and misused, and there are currently no national standards of training and practice for CBT. As part of my membership of the Victorian section of the clinical college, I have, together with colleagues, put together a first draft for the national executive on just that matter. The lack of available standards means a lack of clarity for clients as to what their expectations should be about treatment that is non-pharmacological.

A lack of available standards also means that the providers have difficulties managing the issue of accountability. The issue of accountability is much more acute now because rebates for

psychological input are provided by the federal government under the better outcomes scheme. That has currently been re-funded for a second cycle, as you would be aware. My understanding is that there is wide variability in the way that the program is administered and decision making is devolved to the GP division level. An acknowledged lack of mental health expertise already exists amongst GPs, and we have heard about that. The decision making model of better outcomes needs revisiting.

For clinical psychologists, who are very commonly involved in this program, there needs to be more independence in decision making, and the amount of access to clinical psychology is also currently far too little. It is instructive to note that the European Union last year approved a common benchmark for professional practice in psychology across the board, not just in relation to clinical specialties. Within the more specific area of mental health services, having only one national player, I am sure we can achieve national benchmarking in a timely fashion.

The issue of access is also very important. There will be improved access generally as numbers are increased through more training places, but more ready access also means affordability for those seeking services from private clinical practitioners. Currently, access to clinical psychological services is relatively costly. The standard fee is now \$181 an hour in private practice, although most people know that for most individuals it is not possible to pay that amount and so charge about \$100 or \$120. Unfortunately, the current rebate available from private health funds is only for small amounts and only if you have top cover.

Just as in public mental health services, we need increased numbers and better job prospects in private practice, and clients require rebates. Clinical psychologists, as we have been informed by Professor Jackson, have specialised training that is time intensive and in their workplace frequently carry a high level of responsibility for challenging clients where risk may need to be carefully managed. Together with psychiatrists, clinical psychologists are the most highly qualified in the mental health direct services work force.

We strongly suggest the provision of Medicare rebates to accredited, experienced clinical psychologists, with high benchmark criteria for accreditation. They would be something in the order of, first, a minimum of five years work experience in direct mental health service delivery, including complex and high-risk cases; second, demonstrated knowledge of related services, for example, in-patient, emergency police and supports; third, a nil record of professional disciplinary action; and, fourth, approval by a recognised senior clinical psychologist. I refer to the Vines article in the *Medical Journal of Australia* last year which showed clearly that clinical psychology services were of significant benefit to people with mental health problems presenting at GP practices.

The last issue I wish to deal with, the second issue, is a big picture issue—the important challenge of enhancing prevention. This is particularly important given current projections of increasing mental health needs in adults as well as children. A comprehensive approach to prevention by mental health services will address it fully. Without that, the potential burden of mental health problems on the individual and on society in both service cost and lost productivity remains much higher.

Some serious mental illnesses such as schizophrenia and bipolar disorder are currently unpreventable because they have a very large genetic base. Others are not. Personality problems

and the more severe personality disorders make up much of the mental health workload. Personality problems are very difficult to alter in adulthood, but personality problems are largely the result of negative experiences in childhood. Negative experiences in childhood can and must be addressed through prevention, but mental health needs are usually interwoven with other problems, be they physical or life opportunities. Thus, a comprehensive prevention focused program and standards are needed. A key aim would be better overall integration of services—currently a problem, as referred to by the previous speaker—across all of federal, state, local and NGO levels.

The next step after implementing an early child program, up to the age of 18, is to develop a similar program for across the life span. We know that mental health needs differ with different age groups, and clinical specialties already exist in older age psychiatry as well as in child and adolescent services. In that respect, I would like to table documents to do with the federal ALP's own draft position papers on the early child and young persons program and standards and the accompanying documentation and letter I have with me which I previously sent to Simon Crean.

CHAIR—Is it the wish of the committee that the documents be tabled? There being no objection, it is so ordered.

Senator HUMPHRIES—What is the relevance of the Labor Party's draft policy to this committee's work?

Mr Rudd—The relevance is very acute. The relevance is that without an integrated program across the board, including mental health services for children and adolescents integrated with their physical needs and other needs, we are not going to see any significant impact on the prevention of mental health problems in our life—and, as I have mentioned, quite a large array of disorders outside the serious mental illnesses are preventable.

Senator HUMPHRIES—But, again, what does that have to do with the Labor Party's policy?

Mr Rudd—The Labor Party policy position was just such a proposal—that there needed to be an early child and young persons program which would cover all developmental domains, including mental health.

Senator WEBBER—It is a very good policy.

Mr Rudd—I commend the documents to you, because they were a very good summary of the whole area.

Senator HUMPHRIES—Perhaps it is the hour of the day, but I am not quite clear about what you are saying needs to be changed about the present system of accreditation and integration of clinical psychologists into our system that would allow them to pick up what is obviously a crying need for more clinicians in the field to help address the huge load of mental illness in the community. What specifically do you think should change to allow clinical psychologists to share that load?

Prof. Jackson—Funding for postgraduate programs is a problem at the federal level. In other words, if you think about a discipline where you have to have one-to-one supervision, you are

immediately looking at something that is more costly than large classes such as you have in undergraduate programs where you could have literally hundreds of people attending lectures. So you immediately have an added cost. Essentially, from a university point of view we are getting insufficient moneys per person, per student, to offer more places. In reality, we are probably getting about two-thirds of the money we need to cover our activity costings—if you want to think of it in that way.

Senator HUMPHRIES—More money for training is one thing. What is the next thing?

Prof. Jackson—More money for staff to do training as well so that we could actually increase—

Senator HUMPHRIES—This is for existing psychologists?

Prof. Jackson—Yes, because we have lots of applications from suitably qualified people—we do not have the same problem as psychiatry—and we just do not have the slots, if you like. That is one issue.

Senator HUMPHRIES—If you are a trained psychologist, how do you get to work in a field where there is need but where you are not working at the moment?

Mr Rudd—The better outcomes model is quite a reasonable model, if it were to proceed, but it needs a lot of adjustment to it, as I said in my opening statement. The issue of affordability for clients is the third factor that needs to be addressed. That is a very acute factor because most people cannot afford to access private clinical psychological services due to the inherently large cost.

Senator HUMPHRIES—So is Medicare accreditation the solution to that?

Mr Rudd—Medicare accreditation is a very necessary advance if there is going to be any impact, especially for the high-prevalence disorders, which are the non-psychotic disorders including anxiety, depression and personality disorders. As I pointed out in my opening statement, much of that is preventable with a very good long-term, integrated, comprehensive early-childhood program.

Prof. Jackson—I have two points. My experience with the better outcomes program is from attending three meetings as the beyondblue representative. They seemed to become very much concerned about the number of sessions that GPs would be required to undergo to train. GPs would be the gatekeepers for the system, despite the fact they would have less training in therapy, psychopathology and assessment skills—for example, mental-state examinations. My view is that, essentially, in the end the committee self-destructed—I do not know if that is the right terminology. In my view, at the point where the meeting was curtailed, it had disintegrated to such an extent that the outcome was that any practitioner could deliver the treatments that the GP divisions felt comfortable with. For example, in the area of obsessive compulsive disorder, it is very clear there are two major treatments. One of them is pharmacology, a serotonin specific medication. The other is exposure to response prevention treatments for people who hand wash and check and so forth. There was debate around whether they were really evidence based treatments—and I know that literature very well.

My point is that I believe there was some perversion of what evidence based practice meant and, secondly, that the GPs were very keen to have control to determine who the practitioner would be—and that may or may not be someone who, in my view and in the view of some of my other colleagues who were on that committee, were appropriately trained people. We were arguing that the better outcomes program should be expanded but should be re-examined. As for Medicare, obviously, there has always been a concern amongst politicians about a blow-out in the budget. I understand that very well. Frankly, I would not be in favour of giving masses of non-medically trained people access to it. But, of the other hand, I do think, as Ray has pointed out, there is probably some room for a pilot project or at least a limited access to begin with.

CHAIR—In practice, have GPs gone to the 1,200 clinical psychologists or have they gone to counsellors with 10-minute training somewhere?

Mr Rudd—There is wide variability in the way that it is implemented. I do not have the figures, as there are a lot of different divisions, but my understanding is that, in many divisions, there is a preference for clinical psychologist providers. That will obviously depend on the educative input that is available for the decision maker—in this instance we are talking about the GP and the GP division—so it is quite variable.

CHAIR—We will ask that question of the divisions.

Senator FORSHAW—I was going to invite you to comment on the issue that you raised in your opening remarks where you said, if we ask you the question, you will comment on it, but that was about allied health care. Have you just covered that?

Prof. Jackson—Yes, there were three committees that they set up. I think one was concerned about the length of training that GPs would need, although that issue seeped into the committee I was on. I think the people who were psychologists on that committee—there were other representatives of the APS; some of them you may have heard from or will be hearing from—were dissatisfied with the procedure. I think some of them thought, ‘This is better than nothing,’ which is not my particular view. Some would have thought that it was better to get some crumbs than none.

Senator FORSHAW—Another theme that has come through from consumer groups and consumer representatives—and a couple of them were rather critical in their written submissions and in their comments as well—is that groups like beyondblue do not really represent consumers. They have said that they are the public profile end of it—research and so on—and that they are not picking up the consumer voice. From your involvement with beyondblue, is this a fair criticism or is it more representative of a frustration coming through from people have been sufferers and who are now endeavouring to use their experience to contribute to the whole debate?

Prof. Jackson—The latter could be true; I am not sure. I should point out that Professor Hickie appointed me to the allied health committee as a beyondblue representative only. I had no other position at beyondblue, so it was only for those particular meetings that I represented beyondblue. I think that was a decision he might regret! I cannot comment on it.

Mr Rudd—I understand the point about consumer frustration—

Senator FORSHAW—Professor Jackson, you are doing everything except using the term ‘empire building’. I do not know whether that is what you are intending, but I am getting that sense.

Mr Rudd—Because mental health is such a complex area, there are some clients and ex-clients who become very vociferous about the treatment that they have received or not received. They get a lot of media attention because they are sensational, which is good for media sales, obviously. There is a way in which that can become too much of a focus. That frustration is clear in many of the complaints that you must have heard about.

Senator FORSHAW—Yes.

Mr Rudd—I am not intimately familiar enough with beyondblue to know whether that is a fair comment or not, so I cannot directly answer your question about it. But certainly some aspects of programs become distorted through that sensationalist part of the whole scenario. It does happen sometimes.

Senator FORSHAW—I do not want to open up a big debate about this, but they have also used high-profile public figures who have come forward and said that they or their family members have had illness themselves. If nothing else, part of what they have been trying to do is to promote understanding and education, to remove the stigma. I do not know whether or not that is at the top end of the consumer aspect.

Senator WEBBER—I have three issues that I want to touch on. I first want to go back to the six hours and 20 hours issue. When we heard evidence from the Divisions of General Practice we discussed the training that GPs have. We were told how many had taken up the six hours option and that not many had taken up the 20 hours. We were told that these are very busy people and that therefore six hours is a big chunk of time for them to have to do this training in. But no-one could tell me how much training they get in mental health and dealing with mental illness, when they go through medical school, to then add the six hours to. Apparently, when you add the six hours to their degree it makes them competent. Do you know how much training they get? Do they get any, apart from this ‘big chunk of time’ of six hours?

Mr Rudd—By analogy, the issue of our umbrella body saying that there are 10,000 well-qualified psychologists in Australia in mental health practice flies in the face of all commonsense. That was part of the problem with the previous Medicare submissions from the APS: they were not specific to clinical psychology at all and therefore failed—and should have failed, in my view. The other issue is a difficult one. Perhaps Henry can clarify some of it for you. At the moment I am lost for words.

Prof. Jackson—The University of Melbourne essentially have a new curriculum. They do a term—I am not sure how many weeks it is—in psychiatry. That typically occurs in semester 10, which is in year 5. They could do that in a variety of different places. It is usually in a psychiatric facility. That might change over time with increasing pressure on places, because we know there are new medical schools starting up which have caused consternation for a number of people. But that would be it. They would receive that and some lectures from people like me, which are very sporadic.

Senator WEBBER—So one term and six hours and off they go.

Prof. Jackson—You have to look at when the gap is too.

Senator WEBBER—Absolutely.

Prof. Jackson—I have been involved in preparing a manual for their rotation in psychiatry in semester 10. There is no competency assessment for that. That is a concern I would have. We are not talking about one-to-one supervision or videotaped or audio taped supervision and so on, which is what we are used to. That might vary according to medical schools around the country; I want to be careful here.

Senator WEBBER—We will be going around the country, so I am sure I will get the opportunity to pursue this issue elsewhere.

Mr Rudd—There has been some research done that I have just remembered now. GPs by their own admission said that they felt grossly unprepared.

Senator WEBBER—I guess it is better than nothing. The other issue that we have been exploring and that I explored with the psychiatrists earlier is the provision of services outside the metropolitan area. I live in Perth, but you cannot find a psychiatrist outside Perth. However, you can find psychologists in places like Port Hedland and so on. How is it that we can get psychologists to go out there but we cannot get psychiatrists to do so? Is it because you are a much more benevolent, sharing, caring bunch of people?

Mr Rudd—To pay Western Australia a compliment in the first instance, they of course had the first course in clinical psychology in Australia, back in 1970 or thereabouts. So there is a tradition of clinical psychology that is very strong in Western Australia. What motivates people to move from the city there where other providers will not do so so readily, as we heard previously, is a number of factors. Many of those mentioned by the good doctor apply. But it is not a simple matter. There is a difference, of course, as I have pointed out, between clinical psychologists with a postgrad specialty and any old psychologist, and that has come out in bold relief with the Cornelia Rau case, as I am sure you know. At least one or two of the so-called psychologists at Baxter were not even registered. So it is a complex issue. Henry might like to say something about the rural issue.

Prof. Jackson—It has been an issue in Victoria too. At Bendigo Health Care we have a person who worked in Wagga Wagga and who is totally committed to working in the country. On graduating from the doctoral program, they took up a position here. My belief is that we should be offering scholarships to people from those areas to actually put them through the programs and set up a career structure for them. That is what I believe we need to do, if we want retention. I do not believe in the bus in, fly in model; I think that is unsustainable.

Senator WEBBER—Certainly that is the kind of model that Western Australia is looking at in nursing. Specific scholarships are offered to people from regional areas to come to Perth and study nursing. They tend to want to go back to the community that they come from and have an attachment to. Perhaps that is something that is worth pursuing.

Mr Rudd—The question of incentives is important here. This was brought up previously. I think that we could perhaps even revisit the notion of tied scholarships, where you have to commit to two or three years of service in that particular area of need after you graduate.

CHAIR—What about geographically designated provider numbers?

Mr Rudd—They are worth considering.

Senator SCULLION—I do not expect you have had the opportunity to read all, or even some, of the submissions. Perhaps I could just paraphrase some of the issues that have come before us and why I would support the fact that GPs are seeking, very clearly, an upskilling in some areas. The issue is not only about GPs and psychiatrists; it is about the entire environment. It is about the front line having a definite lack of skills to cope, and that is everyone from the drug and alcohol counsellors to the nurses in the emergency departments, the GPs in the emergency departments and the GPs in general practice. Even the time, in terms of a referral to a psychiatrist—if one exists and if they are in that sort of area—is time during which a GP, for example, might have to deal with this person. What do you do? There is somebody who is in fairly elevated circumstances. He is in the rooms. You could hardly just put him out on the street. There is a duty of care about ‘how much knowledge do I have?’ So we are at a pretty critical point here.

My concern with some of the things you have been saying—and I am sure you will be able to put my mind at rest—is that your submission deals with concerns that the regulation of a particular aspect of a very important profession is being devalued, and I recognise that. You have also expressed concerns that this top-up training is suboptimal, which is a pretty diplomatic way to put it. Clearly, your views on that may be strong. But can you see that there is a real need to provide skills to people who are being asked to make decisions? We have had submissions from people saying: ‘You can see a psychiatrist, no drama at all. You present on Saturday. As long as you do not want to see them before 10 am on Monday, that will be fine.’ So there is a fair bit of time when the rest of the world needs these skills. Given that that is the situation right here, right now, and you have said that you have concerns about the top-up and those sorts of things, how do we then go about providing within a time frame an upskilling for GPs that allows them to really operate in this environment, which is often not of their own making, and that gives them a suite of skills so that they can at least meet the duty of care obligations that a GP would have under those circumstances? It is not six hours; it is not 20 hours. What is it and where do they get it?

Prof. Jackson—That is a very good question, because the prevalence of mental disorders in a 12-month period, as you know, is something like 17 or 20 per cent, depending on which survey you look at. So the need is enormous. If even half of those people actually require treatment—because we know half do not present for treatment; maybe some of them are not aware of services or even that they have a problem—that is enormous. Obviously, it would be bizarre for us to argue that they should all be seeing us or a psychiatrist. You are quite right; I agree. I think the issue here, my criticism of beyondblue, is in the sense that GPs were asked to decide what the level was, and I believe that there should be much more of a task force approach from a federal level to determine what the mental health needs are for all professions.

You can see, at the end of our submission, it is only one model but it is a multi-level model where everyone is expected to have these kinds of skills, whatever discipline they are in, and you work your way up from that. So, for the practitioner who is a GP working in a remote community, we might expect them to have these kinds of skills and so on, and then we might expect another level of people, as we have pointed out in the model, who might do formal study, for example, and undertake a diploma or degree type course. I agree absolutely with your point, because it is ridiculous to believe that you can only have specialists like psychiatrists—or indeed, as we are advocating, clinical psychologists—trying to address all these needs. But I do think the way this worked was that GPs were deciding what was needed and then becoming the gatekeepers for people like us. It was kind of around the wrong way.

Senator SCULLION—I actually understood that aspect.

Mr Rudd—I can respond with a concrete example: there has been a lot of talk in Victoria recently, and particularly in Melbourne, about setting up separate areas in emergency rooms to deal with the more difficult cases. Obviously they are disruptive, in terms of acute onset psychosis or some other acute problem. Obviously there is a staffing issue there, too. That is a very pertinent current example. We need to have staff who have a dedicated role there but also a level of skill that is recognised through the kind of accreditation scheme that I proposed previously.

Senator SCULLION—I was very interested in your comment, Professor Jackson, that there was a competency based assessment at the end—even if it were time based—before somebody would be accredited to that level of care. I agree with that. Who do you think would be best suited? There will be a need for competency based assessment in a number of places. I hope that the 15 per cent will increase and I hope, for example, that some of these needs will be assessed in Darwin—heaven forbid.

But, obviously, the difficulty we potentially have now is that it is an even smaller group of those people who have the capacity under an ACTRAC sort of process to actually do that assessment. So would a competency based assessment be able to be done through some tele-exam or teleassessment? You would be able to observe those circumstances. I wondered if that were possible, because it seems that, if that is not able to be provided for, that would be a major impediment to this process.

Prof. Jackson—You are getting at the issue of remoteness here, for example.

Senator SCULLION—Indeed.

Mr Rudd—I think many of the mental health difficulties are nested within the state-federal differences, and without a national approach to standards, benchmarking, competencies and so on we will not get very far with that kind of remote location question you are asking. In fact, we already have a body. It is called the National Mental Health Strategy. I think that that needs augmenting so that it can address some of these issues about accreditation and levels of skill as well as provide a centre of excellence for monitoring what goes on in the field. I am not aware of any overseeing body that does that on a federal basis, hence we lack integration on the ground not just at a state or local level, which we all know about—and I thought the ALP proposal was terrific from that point of view—but at a national level. So we are all at sea when it comes to

trying to answer and grapple with those questions you raised. However, I think a national approach could well be nested within the Mental Health Strategy.

Prof. Jackson—To pick up on this point, I can see internecine rivalries breaking out here about which discipline or whoever is going to be in charge of deciding who is and is not competent. From my point of view, it would need to be outside of any specific discipline. I do not know how that would occur, but it seems to me that that is what is needed for people to have confidence in the fact that this given practitioner who is in a remote location can assess appropriately.

Senator SCULLION—That is right, and if he cannot we can have access to someone who we know meets a certain standard, because that is the standard. In the CBT environment it is actually about the quality of an individual who makes that assessment rather than something else.

Prof. Jackson—That is correct.

Mr Rudd—The current model of CAT teams you would be aware of does address these emergency situations. In Victoria, the teams are relatively okay in terms of their function, but there is also a wide variability there in relation to how a client who is presenting with exactly the same kind of problem—a state of severe agitation or whatever—is managed and whether they are gatekept in the appropriate fashion. You can see that there is slippage there, but with some standardisation of competencies you would be able to greatly assist that process. That is my understanding.

CHAIR—This question comes out of Mr Rudd's comments. Six months or so ago, the government announced \$360 million worth of early childhood development programs which would be available as grant moneys to charity groups. Were you consulted about the distribution and the way in which those funds would be spent with regard to mental health?

Mr Rudd—Who do you mean when you say 'were we consulted'?

CHAIR—Prof. Jackson was consulted about better mental health outcomes. The question came from your comments, Mr Rudd, but it was addressed to Prof. Jackson.

Prof. Jackson—One of my problems, having been in this field for a while, is that we do not have a place at the high table in Canberra in the same way as the AMA have, for example.

CHAIR—I do not even know that the AMA was consulted on this one.

Prof. Jackson—But that is my general point.

CHAIR—If I can put words into your mouths, would you recommend that the committee recommend an evaluation of better mental health outcomes?

Prof. Jackson—Yes.

Mr Rudd—Definitely.

CHAIR—Thank you very much for appearing today.

Committee adjourned at 5.09 pm