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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH
Wednesday, 27 July 2005

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

Senators in attendance: Senators Allison, Forshaw, Humphries, Moore 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 9.07 am

WILLOW, Ms Winsome, President, Mental Health Community Coalition; and Manager, Inanna Inc.

CHAIR (Senator Allison)—I call the committee to order and declare open this hearing. This is the sixth 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 they have received relating to parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private, or in an in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

I welcome the representative from the Mental Health Community Coalition of the ACT Consumer and Carer Caucus. You have lodged a submission with the committee, which we have numbered 214. Do you wish to make any amendments or additions to that submission?

Ms Willow—No.

CHAIR—I invite you to make a brief opening statement, at the conclusion of which members may wish to ask questions of you.

Ms Willow—Thank you for the opportunity to be here. I am here in my capacity as President of the Mental Health Community Coalition. We are a newly formed organisation in the ACT bringing together carers, consumers and service providers in the community. The other capacity by which I am informed on these matters is that I am also manager of a crisis service in the ACT which provides accommodation and outreach workshops for women and their children. We were set up over 20 years ago, and I have been associated with them since then. We joined what was known as the women's refuge movement, but we started up really to take women who did not fit into the refuge movement because of their mental health and drug and alcohol problems and chaotic behaviour.

I would like to start by acknowledging, firstly, the Ngunnawal people and their land. In doing so I note that Indigenous people have some of the worst mental health outcomes, which are not necessarily seen in that light. I had a recent experience with a family involved in a neighbourhood dispute. Inanna, where I work, manages the tenancy for their house. Someone in their family had died and all the other family members came from interstate. They could not afford to stay in hotels so they were all at that house. They could not afford to bury the family member so they spent 10 days getting the money together to have the funeral. At the heart of all these things there is a lot of distress. When something happens in these families, a lot of people with a lot of mental health issues come together and there are lots of drugs and alcohol. So what would go down as a neighbourhood dispute is really about very low mental health outcomes for Indigenous people.

I acknowledge people living with mental illness and the courage and skill with which they live their lives. I also acknowledge carers and families, the impacts on families, the workers in the mental health system and the things that have been done. In my more than 20 years I have noticed that some things have changed. I know that there are lot of people with a lot of strong convictions and energy for the issues we are dealing with.

There are a few issues to talk about. Even though more money has gone into the system, if you talk to people with mental health issues you find that they do not feel cared for in their illness. While more money might have gone into the clinical management, most of the care of people with mental health issues is done in the community by their friends and families and by community organisations. Most people live their lives in the community. Of course we need clinical services, but in my view there is a lack of resources in the community to assist people to live their lives.

We talked in our submission about discharge planning from hospital. For instance, the ACT has put in a discharge officer, who basically makes a plan on a piece of paper and sends the person home with it. That person could have gone to hospital in a very chaotic state, the house could be trashed and there could be rotten food in the fridge. They go home and there is no-one there. People who have mental health issues often live very isolated lives. There is no-one to buy their milk, and they probably do not drive home in a car. So a piece of paper does not make them feel very cared for, nor is it very manageable for them. In my view, much more needs to be put into caring for people and the day-to-day issues that would assist them—things that most of us would take for granted such as having friends, family, food, driving a car or having other resources.

A lot of people with mental health issues have worn out their families and carers, and so they do not have the same kinds of resources in that way. Often they might have come from families where there are other issues and the families are not particularly well resourced to deal with those issues. When I am talking about mental health issues, my view is that it is the result of people's response to life. Along with that, people with mental health issues often respond to their distress by using drugs and alcohol, so a great deal of those things exist together. Those people have children, and their children are brought up in families where the parent has a diminished capacity to parent them, so they grow up with the same kinds of issues.

Just on the use of the term 'dual diagnosis', that is a statement about the way we organise our health system. We call it dual diagnosis because we separate our drug and alcohol response from our mental health response, so then we have got this term. These people are called dual diagnosis, but to me they are people responding to distress in their life. They do not call themselves dual diagnosis people; they struggle to manage their lives in whatever way they can. They become dual because they have got to go to two different services to get treatment. While it is something that we are beginning to think about, we are a long way from doing it in a very good way.

The other thing is that we did have this move to have people live their lives in the community with the view that that would be a more dignified and respectful response to people with mental health, but we have not put the resources into the community. In the ACT we need some kind of service that has a step-down, step-up facility that is 24-hour funded. My service provides some respite beds; they are provided at a cost of \$12,500 a year. They certainly could not be funded 24

hours a day, seven days a week for that. That is a very low cost to manage people. The reason why we have those respite beds is for people coming home from hospital or if they are feeling unwell, but the amount of service that can be delivered for that money is very limited.

Senator FORSHAW—Is that \$12,500 per bed?

Ms Willow—Per bed per year, yes. And, if you look at what a hospital bed costs, you see that it is more reasonable to fund the community. My service has money from the ACT mental health service and also the homelessness money. The homelessness money per bed is about \$36,000 a year and the mental health money for the mental health beds—we have an equal number of mental health beds and homeless beds—is about \$12,500 a year. Those services are co-located. We also run about eight crisis houses for women and children. Some of them are shared houses; some of the families, depending on their size, might get a house to themselves. The reason why we can run the quality of service that we do for our mental health clients is because we have SAP money.

CHAIR—Can you expand on that point and tell the committee how this works? How are people referred to you? You say you have got eight crisis houses. How many beds is that?

Ms Willow—It is 25 beds.

CHAIR—And they are for people with mental illness who have come out of their patient care. Is that correct?

Ms Willow—No, they are for a variety of reasons. For example, the homeless beds would be for people who are homeless. There really is no distinction between the people in our service from one lot of funding to the other, I have to tell you. It is just that we get our money from different places. We take the women who do not fit into the DV refuges. They have got lives of trauma; they have become homeless through their trauma. Often it is child sexual abuse or it could be domestic violence somewhere in their life, and that has been exacerbated by all sorts of experiences and they are not able to manage by themselves with kids. So we get referrals from all sorts of places: other crisis services, the mental health crisis team, the hospital—a range of places. Our service generally takes the women who would be presenting with less self-managing behaviour than other people.

CHAIR—You have 25 beds. Do you service the whole of Canberra, or are there other service providers that—

Ms Willow—They do not do what we do. There are other refuges that take women escaping DV but who do not take the broader range. We talked about this in our submission. There are no responses in the ACT to women who are classified as borderline personality. ‘Borderline personality’ is a collective term given to women whose behaviour is difficult to manage. They are seen as having personality disorders, but they are also very time consuming and difficult to manage and, at any time, quite a few of our clients would have that diagnosis.

They do not fit well with other people because their behaviour can be quite disruptive. They are not accepted into the mental health system because they are seen as having a personality disorder. Occasionally some of them might get a second diagnosis, so they might qualify for that

sort of support. Often they end up in the criminal justice system because there is nowhere for them to go. If we cannot manage them in our place, we have had people say, 'I'm just going to have to go out and do something because I've got nowhere to go; at least I can get in to BRC.' They are homeless and there is no service that can take them. They cannot go to the PSU. We cannot always manage them, because we are only there from nine to five, so they end up in the criminal justice system. They will deliberately do things in order to go into the criminal justice system, so that someone will be forced to house them.

CHAIR—Do people with a personality disorder present to a hospital or a GP looking for help, or do they not?

Ms Willow—They will present to a hospital. The mental health system is so stretched that it has had to find categories of people that it can assist. The crisis service will only see people who could harm themselves or others—but they do not see people who could harm themselves or others. Last Friday I was with a woman whose daughter had been assaulting her all day. Eventually the daughter was taken and put in the youth detention centre, but she had tried to get the crisis service to assist. It was not the first time it had occurred. The daughter does have something wrong with her—whatever we want to call it—but in the end the only response was by the police. The crisis service did not come and assist. The situation got worse during the day, and she was taken to a youth detention centre. But she was clearly unwell. They say what their criteria are, but there are no beds, there is nothing. That has all become narrowed down; we can blame them for it and say they are not doing their job, but I do not think they have the resources to do their job.

CHAIR—They are not seriously suggesting that someone with a personality disorder ought to just get over it?

Ms Willow—They do. In fact, I can tell you a story about something that happened a couple of weeks ago. I was on call; there was a call to me from the mental health team to say: 'One of your women who has a borderline personality is behaving badly. The police have been called and I hope they take her away and lock her up.' I said, 'She's not well; she does behave badly.' The comment was, 'I hope they take her away and lock her up.' They do not know what to do, and I guess that when people are stretched and stressed, that is what happens—they do not know what to do. We do not know what to do, either. Sometimes, if we cannot manage the person and we ask for their assistance, they will come and say, 'This person appears to be escalating, so we're not staying; we're leaving.' In what other crisis situation could you attend and say, 'When we arrived you weren't crying and now you are; I think we'll go'?

I know there is a particular view about how you handle people who are classified as borderline personality. Borderline personality has emerged in more recent years as a category. It does not have to be taken up by the mental health system because they are not mentally ill; they have a personality disorder. But there is no-one to manage them. In Melbourne there is Spectrum, which is a service that we consult with regularly and ask: 'How can we manage this person?' If you have private health cover, you can go to a program in Sydney, a hospital based program, for three to six months. But if you do not have private health cover, there is no cure; there is no rehab. But these people definitely need support. They are very problematic and troublesome in our community. There is a fine distinction between them and someone with a mental illness.

CHAIR—The committee has heard a lot about the need for a step-down facility—something which is between in-patient care and even support out in the community. What do you think is an ideal model for that? Is it good to have people with personality disorders mixing with people who have just come out of acute care and others? I do not know how many are in each of your houses. Is it four? Is that a good model, or should people mostly live supported but by themselves?

Ms Willow—One of the things about having a number of houses is that we have the capacity to mix and match and see who will go with whom, but I think as a model you do need to have a service that is not too large. There is a view that people should try to live their lives more closely with the normal routines of life around them, such as having the garbage truck coming or getting up in the morning and having breakfast, but they would need to not be all together in a big institutional type place.

Some of our houses are co-located. There are four houses co-located where the office is. That is quite a good model, because people can have privacy but they are not that far away from support. The support is in a slightly separate place, so they live their lives in their own rhythms of life, and if we can co-locate a couple of people they can be quite supportive of each other, depending on the mix. But there are some mixes that just do not go together, and people who are becoming unwell and who need a bit of peace and quiet would not go well with people who are quite chaotic—in fact, nobody goes very well with people who are quite chaotic, unfortunately. Sometimes you can mix the kinds of chaos together.

Senator HUMPHRIES—Can you tell us a little bit about the Mental Health Community Coalition? Is it made up of individuals or NGOs?

Ms Willow—It is quite a unique organisation, because it has a caucus of carers and consumers that meet. They have their own meetings and then that caucus has representatives that sit on the management of the organisation. As to the management of the organisation, you can have individual membership and community organisations also have membership on the committee. It is the ACT's peak body, which we did not have before in the ACT. We did not have any kind of system where the issues that are common to everyone can be represented by a body and lobbied for collectively. One of the aims of the caucus is to keep the voice of the consumers and their carers central to the organisation, so the service providers that belong to the coalition are also working to keep that voice central. If we listen to that voice, that voice talks about wanting care for their unwellness and those kinds of things. It has not even been a year; I think we just got our money last August in the ACT.

Senator HUMPHRIES—From the ACT government?

Ms Willow—Yes, from the ACT government. We have got \$100,000 from ACT Mental Health to run the coalition. We lobby and we try to have a voice on the Mental Health Council of Australia, whereas before the ACT was not represented in any way on the council.

Senator HUMPHRIES—You mentioned in your submission:

Cross-border recognition of orders, transfers and admissions despite formal agreement and legislative base remain problematic.

Can you explain what you mean by that?

Ms Willow—I did not actually write the submission, so I probably will not be very good at explaining this.

Senator HUMPHRIES—I assume it refers to a situation in which a person has some sort of order made by a court or the Mental Health Tribunal and lives, say, in Queanbeyan.

Ms Willow—Also, the ACT does not have some services. It does not have a forensic mental health service, so it is problematic for people. If they need a forensic mental health service, what happens is they are transferred to Sydney, so they are transferred away from all the people who can support them. And if they are not transferred then they are left here in the criminal justice system, which does not respond very well or sympathetically to people with mental health issues, because their focus is on the criminal justice system. They do not provide the same kind of care. As I said, I am not very good at answering that question. We do have protocols, but they do not work very well.

Senator HUMPHRIES—You might have to take that question on notice and see if someone else could give us more information about that kind of problem. You also say in respect of the forensic mental health services:

- Some prisoners having been apparently ‘black listed’ by mental health services including the forensic service ...

Can you give us any more information about that?

Ms Willow—I can tell you about a particular case where a woman was charged with endangering life. The life she was going to endanger was her own because she was going to set herself on fire. So she was put in the BRC on the charge of endangering life.

Senator HUMPHRIES—That is the Belconnen Remand Centre?

Ms Willow—Yes. She remained there for over two weeks. She certainly deteriorated in that time. But that was the response to her. Subsequently, the charges were dropped because she was found to have a mental health issue. ‘Endangering life’ suggests someone else’s life, but it was her own life. That was their only way to contain her. Because they would not contain her in the psych unit, they charged her with a crime and put her in the remand centre. She remained in isolation and eventually got to the point where she was not wearing her clothes and was lying around in her own shit. We watched her deteriorate. She should never have been there. It is not okay. It was all because the system could charge her with something. We did get a solicitor to try to get her out, but it took quite some time. Eventually the charges were dropped and she recovered but not due to any assistance from the mental health services.

We are not a very big organisation. We are only a fairly small community organisation. You will have heard from many other people that often the community organisations intervene in some of things that the mental health services do. I know you have to weigh the protection of people against their care, but I think there needs to be much more time and effort put into care and having conversations with people. The other thing is that people live with these conditions all the time. They often know what will help them, if someone asks them. But we are living with a system where the clinical view takes precedence, particularly over someone with a mental

health issue. The attitude is: what do they know about themselves? But they know a lot about themselves. They are often subjected to other people's expert view of them, whereas more time should be put into asking them, 'What will help you here and what can we do?' More time should be put into understanding them and giving them more responsibility for their life.

Most people with mental health issues are not at the extreme end, where they need to be locked up. Most people live their lives across a spectrum and can be consulted with and do have good ideas about what will help them, if you ask them. You need to take the time to make their knowledge central in the treatment plan, rather than imposing things on them—which can be seen as the answer, but most consumers think that those answers are only someone's best guess. It is fine that someone is helping, but there is no proof that it is going to work. If there was more of a conversation and more consulting with them about what they think, it would help.

Senator HUMPHRIES—Do you think a time-out facility would help a person like that woman you are referring to, where an episode of mental illness could be dealt with but not on a custodial basis?

Ms Willow—Absolutely, and that is where the 24-hour care comes in. The woman I mentioned became more and more unwell, but there was no response to her. When that happens the behaviour escalates and eventually something happens where they cannot be ignored. It would be better if she could choose to manage her own illness by saying, 'I feel really unsafe in my home now; I need to be somewhere where there are people around me to remind me of and assist me with the things that help my life.' One of the things that is happening more and more is that we make advance agreements. We would have worked out with her what kinds of things we can talk to her about and what kinds of things she thinks are helpful. We would document all that. So when she rings us up we will go through all those things with her and say: 'What have you done? What have you tried? Where are you up to?' If we could do more of that, it would help. It could even be a case of going to her house and going through all the steps of cooking a meal, such as going to the supermarket and buying the food, going to the video shop and getting a video and then cooking dinner with her and watching the video.

We run a group on a Thursday at my organisation, and for many of those people that would be the only a meal in the week that they would eat with other people. I know that going once a week to someone's home to cook dinner with them and watch a video does not sound like much, but it is such a preventative thing because it links them back to people and to what is normal—this is what you do if you have friends. Some of these people do not have any friends because they do not have the skills to manage friendship, but they long for something that we all take for granted.

With that person we tried to organise a support package but in the end we decided to go once a week to go shopping, cook the dinner and so on—very simple things. It really assisted that person to maintain a relationship with us where she trusted our views. When she did ring up we would say, 'Can you try this; can you try that?' That person is now recovering, despite a lot of other people saying: 'You're wasting your time; nothing will help this person, because she has a personality disorder.' But that is not true. Those normal things help people get back into a normal swing of life that in unwellness you can move further away from. You can get outside of it, and you cannot get back in because you do not have the same things as other people, like a

job. That is what I think care is: it is not just waiting for someone to get sick but providing people with the same opportunities that most of us could have in our lives.

This includes children. We would take those people out with their children and be with them so there is not so much stress on their parenting; so they can enjoy their children and have a nice time with them. They have opportunity rather than everything being too much and full of anxiety. Having to organise anything with children can make anyone anxious, but if you have an anxiety disorder it is a total disaster. So it is good to get someone to do those things.

I do not know that it always has to be paid work. Supporting other people to do things like that—and there are volunteers who do this—is about having community. Speaking about community, it is one of the things that we try in our organisation to have: it gives people opportunities to be other than their problem. We organise a range of things, for example doing art, going on the social outings, going to the movies with people, having barbecues with their kids and having family outings, so we become that person's community of belonging. And belonging is a really important part of feeling mentally well. You have to belong somewhere.

Most people understand and realise that with mental illness you become very socially isolated and that that in itself creates more and more problems. You often see people being blamed for attention seeking, whereas really they are just trying to belong somewhere. And if they can only belong by having a problem, then a problem they will have. However, if they can belong in a different way a lot of people are more than happy to take up that invitation. I do not think a lot of the things that need to happen are rocket science; I think they are more commonsense. We need to value those everyday living things as important and to resource those things as well as the other end of the stick. Most of the money for mental health goes to the hospital systems and the clinical systems. The amount of money that goes to community health is minuscule in comparison, and I think there needs to be a shift.

Senator FORSHAW—The couple of questions that I was going to ask have already been covered. Particularly, you were going to get some information on cross-border issues. Further to the issue that it is often the police who are the first to be called in—and we have had evidence of this before—it strikes me that whenever a person displays other forms of illness, heart attack or whatever, usually the first group you call is an ambulance, or a doctor, or both. Could you comment on the role, the level of service and the involvement of ambulance services in responding to these situations? I am thinking here more of a situation in a family home rather than somebody who might be 'behaving badly' out in the street and so on.

Secondly, there are programs in place to provide incentives to GPs to be more involved in this area. We know there is a very low rate of bulk-billing in the ACT and that some GPs have closed their books. Do you have some comments on those parts of your submission and on areas where we may be able to improve services?

Ms Willow—Yes. Sometimes the police are called because people are not managing and just want someone to come. In fact, I have to speak quite highly of the ACT police. Even though I know that some things have gone wrong from time to time, we have witnessed them showing much more compassion to some of the people than the mental health crisis team have.

Senator FORSHAW—That has been noted in some of the comments in your report.

Ms Willow—The police have not used the heavy arm unless they have really needed to. They have really tried to deal with that. Sometimes you can think that calling the police seems a bit extreme but in fact we have witnessed them displaying quite good skills with people—it depends, but they often have.

Senator FORSHAW—If the police are going to end up taking these people either to the local hospital—and we have heard a lot of evidence that they take them to the emergency department—

Ms Willow—I suppose the issue is: why can't the ambulance take them?

Senator FORSHAW—Yes.

Ms Willow—I suppose it is because there is a view that people behaving badly could do anything at any time—and the truth is they could. We do not know how to predict that. So there is a bit of a dilemma in doing that, as often we cannot predict what a person will do next. They might have done something quite dangerous to themselves or others. They might need to be restrained. For some people calling the ambulance would be fine, but they are the people we would have been able to take in the car anyway. For people who are refusing to go, sometimes—

CHAIR—What about a cross between a divvy van and an ambulance—something secure that is not a divvy van?

Ms Willow—Yes. Watching someone get locked in the back of one of those vans does feel really awful. That feels horrendous.

Senator FORSHAW—One of the problems of the police getting involved, and I am not saying they should not be, is that that triggers a whole lot of other things, including that the person's details are recorded on a police file, whether they are charged or not.

Ms Willow—There are only two responses and neither of them are very satisfactory. I guess the point you are making is that we could make another alternative which would be much more sensitive to these people's needs.

Senator FORSHAW—In the old days, if a person were acting violently or out of control or the carers or family were desperate, they might call the police, who would take the person to a police lock-up or, if the police had the power, to a psych hospital—rather than to an emergency department, as they do now, where they might not be able to get them in. That is one of the impacts of deinstitutionalisation. What about GPs? It seems, from other inquiries that most of us have been involved in, that there is a problem of accessing GP services that is sort of quite out of proportion, if you like, in the ACT.

Ms Willow—GPs are so time constrained anyway. Because of the money that is involved I do not know whether many of our clients would see GPs. There are a few practices in the ACT which are very sensitive to people with mental health issues. We get a few in there and then they say, 'Please don't send us any more,' because of the length of time they require. So their health outcomes are generally much worse than for other people. I do not know whether they go to the doctor very often.

Senator FORSHAW—But that is the catch-22.

Ms Willow—Yes.

Senator FORSHAW—You point to the fact that other illnesses can then go untreated. We know that going off medication is often what triggers a relapse or another episode. I have one other issue. On page 5 of your submission you talk about early discharge and you state:

It was reported that people are frequently discharged too early from inpatient units ...

Is that driven by a lack of beds and the pressure on acute care or inpatient services, or is it part of the system of getting people discharged and back out into the community as quickly as possible? It could be both, I suppose.

Ms Willow—I think it is both. There is real pressure on beds; there are known staff shortages and so on.

Senator FORSHAW—There are staff shortages but are bed shortages due to—

Ms Willow—They are due to that. PSU is an awful place to be. There is nothing to do and it is not a very healing environment. Much comment came from consumers—this paper was done through consultation with people living with mental health issues—and their view is that they did not feel well enough to go home. But I guess the medical view is ‘not much is happening for you here’. You are there to provide some kind of treatment but, other than medication, there is not a lot of treatment happening. The view of your treating psychiatrist or the medical profession is that you might do better by going home. And that would probably be all right if you could go home to something other than nothing. If you could go home and continue care, that would probably be all right.

Senator FORSHAW—I am not saying that we should go back to the old system—please do not get me wrong—but people who were in inpatient care in specific psychiatric hospitals in the past often would go home for a weekend and then come back as part of the treatment process.

Ms Willow—Yes.

Senator FORSHAW—It seems that that is not freely available, from what I have observed.

Ms Willow—No; you are there or you are there, and there are miles between and there is not much preparation for it.

Senator FORSHAW—Because often it is now part of a general public hospital set-up.

Ms Willow—Yes. For most people that does not work well.

Senator FORSHAW—Which comes back to your half-way step down.

Ms Willow—Yes. If there were a real step down, you would still have some kind of care and some kind of assistance to get back into the rhythm of your normal life and take care of some of the problems that probably drove you there in the first place.

Senator WEBBER—I want to return to an issue you mentioned earlier: the children of those who suffer from mental illness. Could you take me through what kind of support services your organisation provides for them and what in an ideal world you think we should do to look after those children.

Ms Willow—Most of the women that our organisation looks after have children in care, so they would have them only overnight or twice a week. We facilitate all those kinds of movements of children about the place to try to promote and maintain their relationships, particularly in periods of unwellness. That was never something that we set out to do but it has become what we do. That has its own struggles because they might come only one night a week but if they have three kids and they come one night a week we still have to have four beds for them.

Many women with kids have mental health issues and often drug and alcohol issues as well. They are very vulnerable to all sorts of unhelpful relationships, particularly those involving violence. Those kids are probably going to grow up in pretty bad environments. They do not do well at advocating for themselves or following through plans. They do not have a thought process that goes, ‘This relationship isn’t good for me; I’ll get support from here and go to this group and get over it.’ They are very chaotic in the living of their lives anyway. Unless they are lucky enough to get someone to walk all those steps with them, they do not recover. They just launch from one mad thing to the next. Even if that one gets too much and it all falls apart, they are bound to pick up again in the same place. They become like that and earn a bit of a reputation of someone who does not help themselves, or whatever. These people cannot manage those things by themselves. They do not make appointments and turn up like everyone else. They wake up and say, ‘I’ve missed the bus and I’ve missed that appointment.’ For someone trying to help them, there is no point in making a plan for them. You have to give them a support worker to walk the steps of the plan with them.

Also, a lot of the kids who are with these women go completely undetected for many years of their lives, in terms of what is going on in their lives and the kinds of lives they are living. If they are really young babies they are more likely to get a response from child protection services, but the older they get the more likely they are not to have child protection services involved because they are not at their high end of need. They become quite adapted to living in these environments and managing their mothers with mental illness. They become the adults and the parents in the house.

We have heard amazing stories of what kids will do to make sure that everything looks okay because they see child protection services as a big stick. The mum will say, ‘If you tell them what is going on, you’ll be taken away.’ The services that support them need to weigh up both the care of the children who do things to support their families as well as whether they need to be removed. Some children should not be there; they are in danger. The services should not blame a parent and say, ‘You’ve had six months of care and that’s all you’re getting because we have limited resources.’ This person is going to live with this illness all their life. If they have children, what are you going to do? Removing children from families is not a good result for the

children for a variety of reasons. It would be better to bite the bullet and say, 'For this family we're going to have to have some kind of ongoing plan that is not about removing the children.' It is about accepting that, for some children, other people need to be involved in their lives in an ongoing way. And they should not have to fear that they are going to be removed and have to hide what is going on because that hides a whole range of other problems.

Senator MOORE—I have some data type questions. In your evidence you said that you have 25 beds in the service that you offer. Is that right?

Ms Willow—Yes. We also run 12 houses for families. I forgot to tell you about that; it is new.

Senator MOORE—I am interested in the 'unmet need', which is the trendy term used all the time in these areas. If you are providing 25 beds plus your family houses, how many people do you have to turn away?

Ms Willow—We also have four workers doing outreach work—that is, working with people in the community and in a range of other community activities. Constantly, we would never have fewer than 15 to 20 people waiting to come into our service in terms of accommodation. The ACT has hit a bit of a bad time around crisis accommodation and homelessness. We would always have up to 20 people on our books waiting for outreach. They are only the people who are prepared to think, 'I want to go on a waiting list.' They are the people we try to get involved in some of the groups and programs and that we have some kind of contact with or make a phone call to. There would always be more people on the waiting list than we are seeing. At any one time we have up to about 120 to 150 clients in our service. We have 16 workers; only two workers are full time. So there is a lot of unmet need in the ACT.

Senator MOORE—Is that women and families?

Ms Willow—That is women and families. I guess there is unmet need everywhere. For some people there is a crisis in their lives and they are going to get better, pick up their lives and move on. For a lot of our women, that is not going to happen—they are going to have good and bad times. Once they have made a relationship with you, they keep coming back to see you. People can drop into our place. It is not as though we have a worker who deals with people who drop in; we just do what we can. They maintain their relationships. We try to intervene earlier in the problem rather than having it get worse, but that does not always happen.

Senator MOORE—In that case study you mentioned earlier about the mother and daughter, how old was the daughter?

Ms Willow—Which one was that?

Senator MOORE—The woman who was being bashed by her daughter.

Ms Willow—The daughter was 17.

Senator MOORE—I have a lot more questions, but we do not have time. Thank you.

CHAIR—Thank you very much, Ms Willow. That was a good insight into the sort of work that people like you do.

[9.57 am]

MAHAR, Mr Keith, President, Mental Illness Education Australian Capital Territory

STEEPER, Mrs Elizabeth, Committee Member and Project Officer, Mental Illness Education Australian Capital Territory

WYLDE-BROWNE, Ms Margy, Executive Officer, Mental Illness Education Australian Capital Territory

CHAIR—I welcome representatives from Mental Illness Education ACT. You have lodged with the committee a submission which we have numbered 354. Do you wish to make any amendments or additions to that document at this stage?

Ms Wylde-Browne—No.

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

Ms Wylde-Browne—Our organisation, which we call MIEACT, is a community mental health promotion organisation that has been operating in the ACT since about 1994. We are concerned with reducing stigma around mental illness, increasing mental health literacy in the community and encouraging people to seek help early if they are experiencing mental health problems. Many of the programs that we run are aimed at youth. We have a youth mental health web site, for example, and we have a play about body image and self-esteem. We also have a special project at the moment where we are getting young people to create alternative media messages around mental health issues.

We also conduct a huge number of sessions with community organisations—they are really mental health education sessions—such as the university, TAFE, the local library and maybe the police. We have also developed a very specialised delivery for people from different cultural backgrounds. Over the last 18 months we have been working very closely with the Tongan, Chinese and Finnish communities in the ACT. Our core business is what we spoke about in the submission that we put in: our school education program. Currently, we service two-thirds of the high schools and colleges in the ACT. Our mission is really to see every student in year 10 if we can.

Our community and school programs are delivered by mental health consumers and carers. They deliver factual information, but they also deliver their personal stories. It is the telling of these personal stories that has a profound effect on young people in the school setting. We have 22 mental health consumers who carry out this work at the moment, and seven carers. We have had a lot of anecdotal evidence that students get a lot of benefit—positive outcomes—from our sessions. We have provided a copy of the international journal article for you to peruse. Our work is also carried out in other states throughout Australia. There is a very strong program in New South Wales and Queensland. They reach many students and the general public. There are smaller programs in Western Australia and Victoria.

Libby has been involved with our program for many years. She is a carer and she currently sits on the mental health tribunal. She has been a very strong advocate over the last 20 years for mental health in the ACT. Keith is a mental health consumer. He is one of our presenters who go to the schools and the community groups. He is also a consumer adviser and policy officer for the Mental Health Council of Australia and he is the chair of the bipolar disorder reference group for beyondblue. I will hand over to Keith for a moment.

Mr Mahar—The personal stories of the lived experience of mental illness by our courageous and trained volunteers are the key to the effectiveness of the program. Following is a brief summary of my personal story and how MIEACT has impacted on my recovery and rehabilitation. I lost round 1 in the contest against mental illness in a humiliating fashion. In 1994 I suffered delusions of grandeur and resigned from my corporate broadcasting career in Canada to try to change the world. To start, I independently campaigned to reform the federal broadcast regulator, a body that regulates about \$40 billion a year in revenues.

Before finding out that I was suffering from the symptoms of a severe mental illness, I made some progress, to the point where one Catholic publication described me as ‘hero of the nineties’ and illustrated me in a Superman costume. I am not religious, but I felt that I had found my purpose. Less than a year later I discovered that I had bipolar disorder when I suffered a life-threatening depression that made me cry like a frightened child. I cannot accurately describe the agony. The mortality rate for the illness is extremely high. Approximately one in six people die from suicide. My classmates in high school selected me as the outstanding male graduate in 1980, but surviving that first depression is what I consider my truly outstanding accomplishment.

Despite my doctors prohibiting me from resuming my political activism due to stress being a trigger to episodes of mental illness, I soon returned to my campaign, and I suffered a psychotic episode and gave away \$3,000 to homeless people before walking naked in downtown Toronto. This is not my normal behaviour. I thought that God wanted me to prove that all I needed to change the world was the truth. Upon careful consideration, I presently advocate that clothes and the truth are a more effective one-two combination in our society for promoting social change.

Of the tears that I have shed in my 42 years, the only ones that still hurt are not my own but those of the people closest to me since my diagnosis. Mental illness plays dirty, and its pain is needlessly magnified in society by discrimination, ignorance and stigma. Volunteering at MIEACT after immigrating to Australia on my 38th birthday on 12 October 2001 has been a major turning point in my life. Ironically, I left Canada partly to try to hide my mental illness. However, it did not feel natural doing so and it further eroded my already depleted self-respect. I felt caged to a degree that was not sustainable in the long term.

Educating people about mental illness, especially youth, has been extremely rewarding to me. Giving young people knowledge in relation to how to best protect themselves and others against mental illness is extremely satisfying. I know that I am making a difference, and the response from students fills me with optimism, both in terms of mental health and in terms of the future in general. I wish that I had been informed at their age about mental illness by our presenters.

When I immigrated to Australia I was more broken than fixed. That is no longer my status and I no longer exist in a cage. Words cannot express my gratitude to the people who have helped to

secure my release from that position. I plan to spend my life trying to assist others in my community to get out of that same cage, one that is reinforced by discrimination, ignorance and stigma. I thought that I had lost my honour forever in Canada. In reality, all I did was lose my clothes in Toronto. I am not prepared to surrender my honour without a fight. Educating people about mental illness permits me to fight my old opponent in the public interest and on neutral ground. I invite any questions.

CHAIR—Mr Mahar, you obviously use humour in the way you talk with young people about your own circumstances—this works well?

Mr Mahar—It does. I had to find a balance. We could go into classrooms and just tell students about the absolutely worst things that can happen to us in the course of our life, but I think we would traumatise the people in the classroom. The best way to do it is by having a balance to show how serious it is. Sometimes I tell students how much money it will cost in terms of lost walkmans, gameboys or whatever. It is a way of showing loss. It is really important for me to have a balance and to be able to connect. I thoroughly enjoy the rapport that I am able to build up with students in the short term.

CHAIR—Is the advice you give about prevention something more than ‘here are the first warning signs that something is wrong; if I had known, I might have been able to do something sooner’? Is that how most of it is or is there more?

Mr Mahar—There is a curriculum. Personal stories are essential, but we have a curriculum around that. Personal stories reinforce and tie in. I have been a high school student. If somebody just goes in and reads the information without telling the personal stories, it is easily forgotten, but when you put it in the context of a personal story it challenges people and they remember it. Whether it is like a vignette, a small movie or whatever, they remember those things and hopefully that will let them use that information in the future. We leave them with information which we ask them to keep. Obviously we do not expect people to get mentally ill that moment; it is just something that they have to keep for their friends and families and anyone else.

Ms Wylde-Browne—We give all the students a list of places in the ACT they can go to for help.

CHAIR—Do you test them before and after in terms of stigma and knowledge about mental illness?

Ms Wylde-Browne—We did that, as outlined in the article, over that period of time. Last term and this term that same professor has been conducting research at our sessions. She administers a questionnaire a week before we come, a short one on the day and two or three weeks later. But we do not have the resources to do that on an ongoing basis, and the schools would not really want us to. After the sessions different presenters ask different things. Sometimes they will just ask a little snippet: what did you get out of the session today? The students might say something on that. They write on it and we get all those forms back. We also ask the teachers to evaluate every session, so we get that faxed back to the office.

Mr Mahar—Some of the most gratifying experiences are those that are instantaneous. It is not in every class that someone will disclose that they or one of their family members has an

issue, but it does happen on a frequent basis. We go in in twos, and that is for quality control to give students a diversity of different experiences. We try to balance the different mental illnesses and the roles of maybe carer and consumer. One woman was talking about her son having schizophrenia, and a girl who was probably 16 or 17 came up and gave her a big hug right after class, because she had just come back from psychosis. What happens is that, firstly, we are helping people for the future—if there is an issue in the future—and, secondly, if they are going through a problem right now, it is very helpful to normalise it and to have people come in and talk about these things. In my family, my father had bipolar disorder and it was not diagnosed; because of the stigma he never sought help. If we give information to kids they can then go home and understand their family members, their siblings who might be having a mental illness. It is really important in that regard.

Senator MOORE—I am really interested in the program you follow up in Queensland; I was unaware that it was working so well up there. I think I understand the evaluation document—they always seem to be written in Korean. Basically it looks as though there are positive aspects. You said that you are looking at that third point—the one where it said it had a limited impact on the self-help aspects. What kinds of things are you doing as an organisation when you have had the research and it has come out well on two aspects but it has raised a question about the third one? What are you doing with the program to look at that area?

Ms Wylde-Browne—We have looked at our delivery, and we have rejigged things to bring that issue up a bit earlier, asking the students to identify things. One practical example we use in the classroom with school students is a hand exercise. We ask them to just draw on a bit of paper or to share with each other where they can get help. We have tried to include little exercises like that. We have brought all the presenters back in again and retrained them on that aspect.

We go to the schools, and it is up to the school to determine the time we have. In some schools we might have 50 minutes; if we are lucky, in some schools we might have an hour and a half or two hours. On average, it would be an hour or an hour and 15 minutes. So it is not a lot of time to go through the causes of a mental illness. We really only cover the two illnesses that the presenters share and how it affects the family and all those sorts of things—it is not a lot of time.

Mr Mahar—One issue about measuring help-seeking behaviour is that, if a student has not gone through a problem while they are being evaluated, it is really hard to judge whether this has accurately helped their help-seeking, because they have not gone to seek help as they have not had a problem. It is one of the more difficult issues to measure.

Ms Wylde-Browne—We did develop the Reality Check web site. We developed it after that evaluation. That has been something that is on the list of things that we give them afterwards, so they can go to that site and check where they can get help.

Senator MOORE—This is a chance to get you into the conversation, Mrs Steeper. You go and talk as a carer.

Mrs Steeper—Yes, I do.

Senator MOORE—Can you give us some information from your point of view about the impact it has.

Mrs Steeper—The children are interested in hearing from a semi-outsider's view what the illness looked like and felt like. They are encouraged when I tell them my daughter recovered. Quite a few of them come up later and say that their mum has an illness, or a brother or a sister does. In fact, I got so concerned about it that we got funding at one stage to set up a little support group for children with a relative with a mental illness. I thought the kids would come for a few weeks, because they are very busy young people, but they were still coming two years later. They just like that supported feeling. I think it was just the tip of the iceberg, though. We were not getting to a lot of children who needed that help.

Mr Mahar—The other thing is that I think a lot of the carers have lost children and what is important for them is that they are coming to schools and giving something back and hopefully helping to make sure that does not happen to anyone else. I think they experience growth by doing that.

Mrs Steeper—Indeed. I lost my husband to mental illness. This is a way of making things change a little bit. I was very angry when my daughter was diagnosed, I must tell you. This was way back—wasn't it, Gary?—when ACT services were very poor. I could not get information about mental illness. I did not know where to turn. I did not even know whether it was drugs or an illness. It was just a nightmare. I swore that, if I could help it, this would never happen to another parent. The suffering was so much worse than it needed to be. So I am still pretty energised by that. For parents and children—anyone who comes into contact with mental illness—understanding and knowledge drive out the fear, ignorance and stigma. They are the best weapons you have. I thought I was going to be a one-woman mission, but I am very glad now that I have MIEACT.

Mr Mahar—I also think that services like MIEACT help to take some pressure off the health sector. You end up becoming normalised because you meet other people with mental illness. You hear their stories and you realise how resilient, intelligent and brave these people are. You build up friendships. If my mood is fluctuating a bit, I can phone up someone who has already gone through the same thing and say, 'This is what I am feeling like.' It is actually an informal support network. Then we often do not have to go any further; it is very helpful.

Senator HUMPHRIES—I was very pleased to see, reading the article that you have extracted for us, how broad the MIEACT program has become in the ACT. It was really quite pleasing to see what progress has been made with this. Some of the evidence that we have received suggests that preventive programs—whole-of-population type programs—can be quite effective in picking up people with an illness and helping them to an early diagnosis and early treatment but that in terms of actually making people more resilient against mental illness, if you like, a preventive strategy is not really effective. But I see that in your study there was evidence that, although there was only a moderate or weak impact on changing help-seeking intentions, there was a moderate impact on reducing stigma. Can you tell us more about that? Is reducing stigma really an important part of reducing the incidence of mental illness in the community or is it really just about making the path of a mentally ill person less treacherous and personally damaging than it is at the moment?

Mrs Steeper—I would say that it is an important part of helping people to get treatment early and more effectively. I do know of a number of people who just did not want to go to hospital because they did not want to be labelled with the mentally ill. One of them suicided quite soon

after. The illness got so out of control that they committed suicide. In fact I know quite a lot of people who have committed suicide. That is the sad part of this work. Understanding and a lack of stigma help the path of a person. I would say our society has come a long way in the 20 years that I have been busy with this issue. I know that newspapers present it more wholesomely and kindly. People that you run into are surprisingly understanding now. There are many ways of reducing stigma; ours is just one. One of the things I say about our program is that it makes mental illness discussable, so groups of people will talk about it amongst themselves; it is no longer a secret. That normalises it as just another illness—a pretty terrible one, but just another illness—that has got help.

I do a lot of work now with adult groups like the police. I am working with ACTION buses and the ambulance service—groups who have a lot to do with mentally ill people. It is just astonishing to see the difference. People are a little bit tense at the beginning of the session. At the end of two or three hours they are talking about it, bringing up examples in their lives, talking to each other about family members. It really opens up the whole discussion, and that can only be healthy. That is a group of people I think we are sending out into the community who will be really helpful.

Mr Mahar—From my perspective, stigmas are one of the worse elements of mental illness because they should be able to be avoided. The chemical imbalance, the suffering that people go through, is one thing that has to be addressed. But stigmas are unnecessary. I call it ‘stigma assisted suicide’ when you have someone struggling to survive: they are on the verge, they are almost drowning in their pain and agony. All they need is that last straw and that is it. That is what stigma does. It closes doors, it closes minds and it distorts things beyond what they should be.

Ms Wylde-Browne—I have been doing this work since about 1993 or 1994, and the major stigma campaigns that the Commonwealth government brought out then, which I am sure you will remember, have had an effect. It is much easier for us to get into a school. When we tried to get into a school back in 1994 it was very hard for us. It is very easy now; the schools will approach us. Stigma is alive and well, even with our program. If I went through the list of presenters that we have, which would probably be at least 22 mental health consumers, I think Keith would be the only person in his workplace, because his job is really to do with being a consumer. As for everybody else, many of them work in government departments. One of them works in Immigration. None of them have told their workplaces—I can tell you that now. So there is huge stigma out there. This work is ongoing. I think the amount of money that has probably been allocated nationally for organisations, programs like ours, is disappointing. I suggest that there is probably a huge amount of stigma still out there, even within policy makers, because sufficient funds are not put into programs like ours.

Mr Mahar—I would look at the DEWR fund—I think it is a \$50 million fund over five years—which is a consumer or an employer demand fund, for getting the disability service provision back on track. To put it into perspective—we are trying to change people’s minds, discrimination and everything else—the last election cost the parties about \$40 million to run. We are asking to change attitudes. Most of these are just subsidies. We need major promotional dollars to be able to ensure that people that are being encouraged to get off these welfare services have a place to go.

Ms Wylde-Browne—It needs to be a separate stream of funding, because we are constantly having to compete against clinical funding. That is obviously really important, but our work is at one end.

Senator HUMPHRIES—Mr Mahar, when you emigrated from Canada were there any problems with your mental illness in that respect?

Mr Mahar—No. I was deeply concerned about that, but I had started a relationship in Toronto with a woman who was born in Canberra and had lived in Toronto for a while. Even with that, there was a lot to go through anyway with the medical records. I was panicking that it would have an impact but it did not. I deeply appreciate the Australian government for doing that because it has been a new start.

Senator FORSHAW—We have received evidence on something that has been debated publicly for some years now, and that is the relationship between cannabis or drug use and the onset of depression or schizophrenia. Does your program focus on those issues with young people at school?

Mr Mahar—We see that we have a social obligation to let young people know that more and more research suggests that there is a link between drugs and these illnesses. We walk a fine line in that if we go in there preaching too strongly on drugs then we lose credibility for what we are bringing. It is something that we do; we incorporate it and it is in the literature. But half our program is not talking about drugs. It is really saying that there are links. Some of our presenters are carers whose children became ill through drug psychosis and the story is very clear of how their lives degenerated. So we do walk that line between giving them the information and giving it to them on a basis where they are not going to ultimately reject everything that we are talking about, but take it on board.

Mrs Steeper—I say to the children, ‘I advise all my kids, the ones with and the ones without the illness, to avoid cannabis because they possibly have more of a tendency to be affected by it than the average person.’ That is one thing that they can control. They can keep away from cannabis.

Senator FORSHAW—You have just said there are programs that are run in schools. I am from New South Wales and I think there is a program there—it might be called ‘life education’ or something like that—which does pick up on those issues, as well as healthy living and diet and things like that. We probably should have them running a few programs down here for people like me—the diet part of it, that is. What relationship and interaction do you have with the other sorts of programs that are being run in schools, picking up on health and so on?

Mrs Steeper—MindMatters, I think, would be the main one. How it is taken up by different schools is a bit patchy, though, so you cannot rely on it giving a particular piece of information or a particular curriculum. But most schools do have this MindMatters program which is Commonwealth funded. That covers things like bullying, mental health, a lot of aspects of resilience, and so forth.

Senator FORSHAW—It seems to me that there are a lot of things happening, or potential for things to be happening, and we have to focus on how we get that much better integrated and on involving the teaching profession in it as well.

Ms Wylde-Browne—The MindMatters program is Australia-wide, and we are on the reference group for that in the ACT and have been since 1998. But Mrs Steeper is right—each school takes up parts of that program in a different way and, to be honest, most teachers do not want to deliver the mental illness component of that. They will ring us and ask, ‘Can you come and do the whole eight lesson plans?’ We have not got sufficient funding to do eight lesson plans, but they do not want to do it. Often, we will complement that program. That is one strategy that the Commonwealth has put in place.

CHAIR—Do they say why they do not want to do it?

Ms Wylde-Browne—It is because it is a bit too difficult for them. They feel uncomfortable about it, really. Also, all those teachers are stressed. They are so busy that we are the icing on the cake when we come and do our session. It would be more comprehensive if they took that MindMatters kit and did the eight lesson plans and we were just one part of that. Often they are just overwhelmed by the work they have to do.

Mrs Steeper—You cannot rely on MindMatters getting to every school.

Mr Mahar—Also, I probably see close to 2,000 students. The teacher will say beforehand: ‘These are difficult students. Be careful.’ As soon as we go in, they may get a little loud, but as soon as we start talking about personal stories there is a hush. I have never had any problem. The only problem I have had was with one teacher who I think had a mental illness issue in the family. To come back to your drug issue, we talk about mental illness and how there is no known cause for predispositions. But then we ask, ‘What can you change?’ Those are the triggers. We emphasise: ‘Okay, you can’t do much. You’re going through puberty. You can’t do anything about that and you can’t do anything about your family history of mental illness, but you can do something about drug and alcohol abuse and stress in the classroom.’ What we try to tell them is that if they are stressed out, they might do better at exams if they just learn how to reduce their stress et cetera. It may not be a mental illness perspective, but we give them all the different attitudes about it and information on how to change that. That is one of the things we emphasise.

Mrs Steeper—When we talk to police, we go into a lot more depth about drugs. I talk about the even nastier ones like amphetamines because the police do run into people who are affected by amphetamines and the police have to make very quick judgments about how dangerous their task might be. So the police are, of course, much more interested, and the way we teach them is different to the way we teach in the schools.

Senator WEBBER—That answers one of my questions; I was going to ask you whether you discuss the use of amphetamines as well. First off, congratulations on the program. It sounds fantastic. I am from Western Australia. You say there is a small program like yours there, but I must admit I have not come across it yet.

Ms Wylde-Browne—That is with ARAFMI in Western Australia: the Association of Relatives and Friends of the Mentally Ill.

Senator WEBBER—Yes, I met some people from there when I was doing a previous job. It just seems to me that the sooner we can engage young people and create that acceptance and understanding, the closer we are going to come to combating and controlling illnesses and getting some tolerance in our society. It is a great start. Mrs Steeper, you said you have been talking to people for about 20 years.

Mrs Steeper—Yes.

Senator WEBBER—Have you noticed whether there has been any change in young people's perceptions over those 20 years or whether we are still dealing with the same stigma or whatever? It seems to me that they are a bit more open when talking amongst themselves these days about how they feel.

Mrs Steeper—I think so.

Senator WEBBER—But that is just my perception from my dealings with young people.

Mrs Steeper—I believe you are right, because they now see it quite sensitively portrayed on television, and that is effective. They read more about it in newspapers—if kids do read newspapers. It is becoming more discussable, as I said. I would still say that our work is in front of us when we walk into a classroom. The basic knowledge is not there. The stories are important in a way that just knowledge cannot be, because they meet people who are nice, funny, admirable and competent, and they think, 'That is a mental illness,' and immediately it is not so scary.

Mr Mahar—Our quality control is that we do go in with two people at one time. Also, since we have consumers whose moods fluctuate a bit, we make sure that you do not go into a classroom if you are not feeling well, because then you are not doing the job. That is part of the project as well: to make sure that that is working out.

I would say that stigma is an international problem, but it is tracking better. I was looking up the hospital where my grandfather died in the psychiatric ward. When it was first built, the farmers in the area boycotted it because they thought that mentally ill people were going to make their animals sick. I think stigma is definitely tracking properly but it still has a long way to go. My grandfather did not make any of the animals sick.

Mrs Steeper—It makes me sick sometimes.

Senator WEBBER—I am pleased to hear that, Mr Mahar. Can you tell us a bit more about what the response to the web site has been like, how many people use it and whether you get any feedback from young people about it? Is it national?

Ms Wylde-Browne—We looked at putting up the web site a number of years ago because two of our presenters were really concerned that we would never reach all the young people in the ACT. So we looked at six youth mental health web sites. I do not know whether you have looked at them—sites like Headroom, and others that I cannot remember the names of at the moment. We got three groups of young people: from Campbell High; from DCAP, at Dickson College; and from the Civic Youth Centre. We ran about six sessions with each group of students. We

looked very thoroughly at those web sites, at what they liked about the web sites and at what they wanted on the web site we were going to create.

The young people did not want all that glitzy stuff. If you look at those web sites, you can see that they have spent—I think the federal government would have spent millions of dollars on those web sites. Our young people in the ACT did not want that. They wanted very basic information. They wanted to know the hours that places are open, so there is information about where to go for help. They wanted to know whether they need their parents' consent, whether things would cost them, whether they need their Medicare card—they wanted very practical things.

Initially we also put on the web site stories from people like Keith and Libby. Profiled there is a wonderful story that I encourage you to read. It is about a young lady who became bipolar when she was 18. There is also a story from her mother and her insights and a diary extract from her sister. There are three different ways of looking at her story.

The way that the information is written is very youth friendly. We launched the web site a number of years ago, but we have recently updated the information, particularly in relation to eating disorders. That is a huge problem, and something that we have recognised in the ACT. As I said earlier, we have a number of projects around that issue. There is also more information on drugs and alcohol. Updating the web site is hard work. We have had some feedback from young people and we have had some feedback from interstate people who have really appreciated the information on the site. In the next six months we will run some focus groups with the person who did this evaluation, and we will be looking at the web site as well.

CHAIR—Thank you very much for your submission and for coming today. It was very useful to us. We are glad you are doing the work that you are.

Mrs Steeper—Before we go, may I make one suggestion?

CHAIR—Certainly.

Mrs Steeper—It is that any funding for such work needs to be sustained. It is easy enough to get project funding, but to set up an organisation like ours needs a lot of expertise. Margy is a brilliant manager of a very difficult to run organisation. Years of experience have gone into making it as good as it is.

Senator MOORE—Where exactly does your funding come from? On the first page of your submission you talk about funding.

Ms Wylde-Browne—Our initial funding was through the Australian Youth Foundation, when Brian Burdekin was part of that. That was seed funding of \$7,000.

Senator MOORE—That was at the very start.

Ms Wylde-Browne—Yes, which was in 1993-94. We then got money through an organisation called Healthpact, which you have the equivalent of in all the states. Basically that is health promotion money, and Gary would be able to tell you about that.

Senator MOORE—And that is state funding?

Ms Wylde-Browne—They gave us some state funding, but that was only a small amount of money. They do not provide ongoing funding, but they provided funding for five years. We could not get any Commonwealth money because all the Commonwealth money that came in through the National Mental Health Strategy did not come to community groups, even though it was earmarked for these kinds of projects. We were only able to access that in about 1999 or 2000. We now have ongoing funding through that, and we now have some recurrent funding through ACT Health.

Senator MOORE—So you have federal funding through one level and you are still getting ACT funding for your particular branch?

Ms Wylde-Browne—We get about \$40,000 in National Mental Health Strategy money and the rest is recurrent through ACT Health.

Mrs Steeper—And we get money for projects.

Ms Wylde-Browne—We get project money through Healthpact to get the web site up and going and for those other projects.

Senator MOORE—It is the same situation for your sister bodies in the other states. They would be getting the core federal money and, depending on the state, they would get some money out of each of their states.

Ms Wylde-Browne—That is right but it is very difficult to get money out of some states.

Senator MOORE—You could say it is very difficult to get money out of all of the states but some are having a tougher time than others.

Mrs Steeper—Yes. But the ACT government really see the importance of this and they give us as much as they can. They are very good about making it a bit sustainable. I just make that point because it has made a difference to us.

Proceedings suspended from 10.35 am to 10.51 am

GREEN, Ms Deborah, President, Australian Healthcare Association

JOHNSTON, Mr Brian, Associate Member, Australian Healthcare Association; and Chief Executive Officer, Australian Council on Healthcare Standards

POWER, Ms Prue, Executive Director, Australian Healthcare Association

CHAIR—Welcome. You have lodged with the committee a submission, which we have numbered 169. Do you want to make any amendments to that document or add to it?

Mr Johnston—I would like to add a document. I got involved in this process a little late but the information that we have is somewhat unique and may well be of interest to the committee. I table the additional document.

CHAIR—Is it the wish of the committee that the document be accepted as evidence? There being no objection, it is so ordered. I now invite you to make an opening statement, after which we will go to questions.

Ms Green—Thank you. I would like to talk a little about my history. I started work 30 years ago at the old Callan Park Hospital in Sydney and spent 10 years working in mental health back in the days when there were several thousand patients in those hospitals. In the last several years I have been a CEO of a large area health service that had four acute psychiatric units. I have seen over three decades what has happened. That shows my age and context.

As President of AHA, I will speak to the submission. AHA has been a high-level policy advocate for public health in Australia for around 50 years and we remain committed to universal access for effective health care interventions for people across the country. We focused on some of the things that we felt were not adequately implemented following the national health plan—but we obviously commend a national approach being taken to mental health—and they were: emergency and transitional care work force, which is now really a very acute issue in the public sector; enhanced treatment options, including shared care; rehabilitation; the involvement of consumers, which is done very well but needs to be enhanced; carers; and the targeted groups. When you look at that list, you see that it seems like most of it.

We believe that funding over the decade has remained relatively stable at somewhere under seven per cent of the total expenditure. This is against a background of really compelling data about rising rates of incidents and of levels of disability in mental health in this country. We heard earlier a little bit about the impact of drugs and, certainly, in mental health units in the inner city and along the coast you see a very stark description of that. Since the late eighties we have also seen, I believe, an increase in fragmentation—increasingly uncoordinated care—and a necessary focus, due to the limited and finite funds, on the most acute patients. Those that are most seriously mentally ill are the ones that will get access to a bed. That is where a lot of the effort has to go.

Within that sort of background, which I am sure you have heard all about during your deliberations, we have seven key principles that are around accountability, incentives, planning,

consumer partnerships and better investment—that is on page 7 of our report. We support a national approach—a national agreement—on the levels and mix of services. We do believe this is the way to go. AHA has a fundamental view that we support a national funding model for health care generally, and we believe that applies specifically to mental health. We have a view about how that funding could be invested—that is on page 9. If you look back to the late eighties, you will see the funds that were taken out of the big hospitals that should have been invested into other models of care but were not. As a consequence, we are seeing some of the challenges we see today. We support a national funding model with local service delivery, including a national approach to work force. We believe that there need to be better partnerships between public and private, particularly around work force, and also better partnerships with the non-government sector, which has the capacity to deliver more services than it currently does. We support better care planning, better shared care planning, better support for families, better research and contemporary national standards.

Mr Johnston—The national standards for mental health services were developed by a working group established by AHMAC in 1996. To some extent it is regrettable that those standards, whilst they still exist and are still applied, have not been updated since that time. The intention of the standards was for them to provide a framework for good government—good management—within the mental health arena and to provide a focus on certain priority areas.

I have explained before I am wearing somewhat of a dual hat, but the position of the Australian Council on Healthcare Standards is very complementary to the case that is being put forward by AHA, with which I am associated. The Australian Council on Healthcare Standards does the majority of assessments for organisations that receive public funding around Australia. Undergoing an assessment against the national standards for mental health services is a requirement for organisations which receive federal government funding under the National Mental Health Strategy. Whilst the standards were developed in 1996, they were slow to be taken up by mental health services. So, at this point in time, we have completed a total of 82 surveys, which are the subject of the report which I have tabled today. However, there are another 26 which are in the process of being finalised. In addition, there are three organisations who have just undergone a survey for a second time. The point that I wish to make is that this is fairly new ground.

There are four key findings that I would like to bring to the committee's attention. They are summarised probably to best effect on page 6 of the document which was tabled. The four areas where most improvement has been identified as being required relate to planning and delivery of care, the assessment system identifying consumers and patient needs, the processes for discharge and transfer, and the community having information on and access to appropriate services. I do not want to take the committee's time and read the rest of my organisation's submission, because the detail is there. We would be more than happy to provide further information if required.

The point I would like to make is that, despite the fact that this program has been around since 1996—but in reality it has only come into effect in around 2001; that is when we started seriously doing surveys—no-one has ever asked us for this sort of information that we provided to the committee today. We generate the reports and provide them to the organisation, but the opportunities for higher learning or for shared learning across the system have, quite frankly, been largely ignored. This sort of information, and maybe even information drilled down to a greater depth, we believe has value at a policy development and review level, so that is an

opportunity which has also been lost. It also has value in terms of general knowledge that is available to the broader community around the performance of mental health services.

As I mentioned briefly before, the standards review is in fact overdue. By our assessment, 10 years is way too long. We think that there are some aspects of our findings so far which should be brought into account in reviewing the standards. I should mention that the review of those standards has been foreshadowed but nothing has happened so far, and it has been foreshadowed in the past and nothing has happened so far. So I think the standards are in fact outdated. But there are some opportunities to give renewed and possibly expanded emphasis to what is important, particularly around standards of the assessment of patients, and maybe to take into account potential to establish some aspirational standards—in other words, where compliance is not required but organisations should be able to demonstrate that they are moving to a higher level of activity than they are at the moment. I am happy to respond to any questions.

Ms Power—There are two additional things that I would like to draw the committee's attention to. The first is on pages 7 and 8 of our submission, in relation to deinstitutionalisation. I am sure the committee has heard plenty about this in the hearings. The deinstitutionalisation when it was first considered as a concept had strong social underpinning, but I do not believe it has really worked, because it could not be implemented in an environment of cost cutting, which is what happened. What we have is the fragmentation and exclusion of services for people with mental disorders. There just was not enough money put into the community sector to really take care of these people. That has been shown in the increased number of people with mental illness in prisons and so on.

The second major thing I would like to draw the committee's attention to, on pages 9 and 10 of our submission, is continuity of care. It is extremely important, as you would know, but it becomes very difficult when we are trying to link programs that have different funders. This is particularly difficult between Commonwealth and state programs. Patients fall between the gaps at the boundaries there. We have mentioned that in the submission and would be happy to talk about it more. Until there is some more commonsense around funding between Commonwealth and state programs, we will continue to see patients suffering.

Senator HUMPHRIES—The recommendations you make about a national system of funding are interesting. There are some strengths in those arguments, I have to concede. Whether the earth will move enough to make that happen is another matter, I suppose. In the meantime, in an environment where there is a division between state and territory governments on the one hand and the federal government on the other about the resourcing of mental health, do you have an opinion about where the greatest urgency of need is to be found in terms of additional funding? You have listed a whole series of areas, for example, in your submission, where additional funding should be looked at. Can you prioritise within that list what are, say, the three most important specific funding initiatives that we could recommend as a committee that would address the sorts of problems that are referred to in the Council on Healthcare Standards's list of priorities, for example?

Ms Green—I will kick off by talking a little bit about shared care arrangements. We have talked a little bit about fragmentation: somebody is discharged from hospital and they are not followed up. I will give the example of the United States, where one of the health funds over there has a performance indicator that anybody who is discharged from a mental health facility

will be followed up by a general practitioner within 28 days. I believe we do not have that kind of standard, so we cannot really be assured that somebody is being followed up adequately.

One of the things that we have become aware of in the ACT is some work that is going on into the integration of general practice and community health including community based mental health services. I think that is one of the areas that we are going to have to seriously start looking at, because the bulk of somebody's care is actually provided in the community while there is a very small number of people that are in hospital for years. So we really need to have community health and general practice starting to integrate now. I do not think that means you have to have a single funding source but it does mean you have to reorganise your work force better. The second issue around that is really discharge planning. We need greatly enhanced discharge planning. Within that context is monitoring of medication. One of the reasons that people come back to hospital is they do not maintain their drug use, often for sound reasons because of the side effects et cetera. As to discharge planning, I think we are more focused on trying to create beds because of the next acutely disturbed person coming in rather than on planning the next chapter in a person's life.

The third issue that I think we need to very much focus on is adequate support for families and carers. There are people out there doing it very tough; they have been for years and years. I do not feel that we have really addressed that one. So those are three that I would pick. My colleagues may say differently but that is how I feel.

Mr Johnston—Of the information that is contained in our report, the first three items of most numerous recommendations certainly support the shared care argument that has been advanced by AHA. Putting on my other hat, I say ACHS would strongly support AHA's representations in that regard and would see it as an area of priority.

Senator HUMPHRIES—Those areas seem to be mainly state and territory government type funding responsibilities at the moment. I assume you would like to see a model worked out which would presumably receive financial support from the Commonwealth in the present funding model.

Ms Green—Yes, but I think we are also saying that we would like some standards set nationally. If you look at the variation in terms of investment made by the states, and I use that as an example because I did have a look at this recently for my organisation, you see—this is as to the last time I looked—Western Australia is the best funded per capita of the states and New South Wales is the worst. That will change and jump year to year, I suspect—and I do not know if you are aware of that—but the last time I looked that was the case. It seems to me that in terms of those investments we need to start setting some standards such as, in terms of Medicare, what our priorities are. We have talked about something under seven per cent. Is that good enough? Those standards would be for the nature of services to be delivered, the shared care arrangements that we are talking about and getting some results, some measurable performance indicators, out of those. All of those sorts of things need to start happening.

Senator HUMPHRIES—You make this recommendation on page 4 of your submission:

Nurture and further develop shared care resources in primary mental health care including offering incentives to encourage psychiatrists to consult to primary care practitioners.

Would you elaborate on that recommendation?

Ms Power—Yes, certainly. We would be talking about financial incentives there. They could come through direct funding to community health centres, which would complement the sorts of things that my colleagues have just been saying, or, presumably, through the MBS. We have not really talked about that internally in the organisation but I suspect that direct funding to community health centres would be supported by people in our organisation.

Ms Green—What we are doing there is trying to look for ways to bring some of the private psychiatrist work force back so it is at least engaged a bit more in the public sector, where the most disturbed people come. There are still quite a few barriers in work force terms, so we are looking to get that happening better to support a shared care model.

Ms Power—Yes. If the funding went directly to a centre then it is much more likely that people would be able to get access to that than they could to a private psychiatrist through the MBS. There is probably one other priority area too, which would also compliment what we have already said, and that is in the first dot point on the bottom of page 3, which says:

... additional funding ... to ensure ... expert 24-hour specialist services in emergency departments—

because a lot of problems occur in emergency departments, which are usually busy and not funded to cater for people who are in mental crisis. They are much more organised around physical and other emergencies. If there were proper funding of emergency departments, then that would complement an approach to managing the care of those particular people back into the community, which we have already discussed.

Ms Green—In New South Wales, they are just about to fund some psychiatric emergency units, which will be co-located with emergency departments. They will be four- to six-bed units. They are modelled on an American one—I think there is one in Queensland already operating—so that when you present you can be triaged into the appropriate specialist care, as you might be with cardiac, for example. That is a model that is starting to sort out those needs much earlier than they are being sorted out now.

Senator FORSHAW—I want to compliment you on your submission. A lot of the questions I would have asked you, you have actually covered with your comments and also with your recommendations. You have covered quite a number of important areas. You discuss the issue of funding and Commonwealth-state relationships. In recommendation 3 on page 7, you recommend:

... serious discussion among Health Ministers to consider reforming Australia's system of health financing including the option of the Commonwealth taking over full funding responsibility for the public system.

That is a huge debate. Is that referring to the public hospital system?

Ms Power—Not entirely; it would include the public hospital system, but we do mean the whole of the public system. That is the ideal; there would be options.

Senator FORSHAW—What I was going to follow up with, given that it is probably unlikely to occur at the moment as it depends upon views of the governments of the day, was the idea of the federal government taking over funding and control of mental health in acute care as well as other aspects. We know, for instance, that GPs are essentially funded by the federal government through Medicare and acute care for mental illness is looked after by the states. But there seems to be a case to be argued that it might be appropriate for that to be hived off. They could still be co-located in public hospitals but funded in the same way as the federal government has responsibility for funding of aged care with nursing homes. I am not saying the two are comparable, but a large part of the service that is delivered by the psychiatric acute care system is recovery time to stabilise patients and so on. It is not necessarily intensive, intrusive surgery or whatever.

Ms Green—We had a good, broad debate with the health minister, Tony Abbott, about this issue last November at our meeting. I think he enjoyed the discussion, but I certainly would agree with you that I do not think we are heading down a path of federal funding. But he did talk about wanting to chip away at a range of issues. I would agree with you that this one is probably worth looking at. One of the reasons why is there is a real feeling in this sector of a lack of confidence that their money is protected within the general health bucket. Under this sort of model you would clearly draw it out, similar to aged care; you clearly separately identify it. That would support our view about having national standards and then setting some models of care. I doubt that would be supported by state health ministers or the state departments, though.

Senator FORSHAW—I do not have a fixed view on this but I have long had a concern that through the process of deinstitutionalisation we did throw the baby out with the bathwater somewhat in that we have taken away from what used to be the nature of psychiatric hospitals—the good ones—which was to provide the right environment and atmosphere for people to stabilise and be able to go back home or back into the community. Many of those units are located now in public hospitals. On the one hand that is good because we are trying to remove the stigma of mental illness being different from all other illnesses, but on the other hand a lot of the units I have visited seem to be stuck in the middle of a big public hospital and the type of treatment being provided is totally different from what is provided to people who are in an acute care hospital. That is just an observation.

Ms Power—If you are looking at federal-state relations and funding, obviously there would be two ways to go to make sure that you do not have programs that overlap and impinge on each other. That would be by either by all-Commonwealth funding or by devolving it to the states. We do not particularly advocate devolving it to the states, because that would then fragment health across Australia as such.

I referred the committee to a submission that we put to the House of Representatives Standing Committee on Health and Ageing inquiry into health funding, chaired by Mr Somlyay, because in that we talk about other models that might be in between those two extremes. One model could be that, say, the Commonwealth would manage all the funding for a type, such as aged care, or for a program, such as pharmaceuticals, which at the moment is a bit mixed when patients are in hospitals compared to when they are out. Or, say, the Commonwealth might manage all of ambulatory care, as against in-patient care.

All of these end up having some grey areas. For instance, with mental health, when a person is in a public hospital it is difficult under mainstreaming to isolate the funding for that particular patient. Perhaps it would be easier if there were stand-alone institutions, but that is probably turning the clock back too much.

Senator FORSHAW—That exists in the private health system, in private hospitals, where a large part of the funding does ultimately come through the federal government, through private health insurance subsidies or whatever.

Ms Power—Yes, certainly. Does that answer the question?

Senator FORSHAW—Yes, thank you. And you have directed us to that submission.

Senator MOORE—Your submission touches on many things. In a previous inquiry into cancer we talked a lot about multidisciplinary teams. They were one of the key themes of that inquiry, and you refer to them in your submission. I would like to you to comment on how you would see them operating in the area of mental health care and who would be involved in those teams. You are very positive about a multidisciplinary team approach in your submission, but the bulk of it has only a couple of paragraphs on it. I would like to get some more evidence on that approach for the record of this inquiry.

Ms Green—We probably all know that much of the care of mentally ill persons is delivered by general practice. I think I made the comment earlier that I would like to see a lot more integration between general practice and community health, and we are starting to see some examples of that.

In terms of multidisciplinary teams, psychiatry, particularly in the public sector, is so difficult. When there is a death in a facility and it becomes very public it is very difficult for a young registrar. It is not such an attractive profession for them to go into and not all of them stay and complete their studies. So we are looking at a pretty challenging area. It has to be complemented by mental health nursing, psychologists, social workers and the full range, because you cannot always get access to a psychiatrist.

One of the things that make mental health special, in my view, is the very strong involvement of carers and of consumers. We were at a safety and quality conference in Adelaide two weeks ago where there were 800 people present and 500 of them were consumers. They were not just in mental health, but we have seen in mental health more than anywhere how much consumers can contribute to that. So I would certainly add them into that group. So there is the full range of people.

Then there is the issue about rehab when we have perhaps got somebody out and have got them stable. There is a much better focus than we used to have on rehabilitation and getting people back into meaningful activity. That can involve a range of allied health professionals. Again, I would include the non-government sector as possible. So, yes, I would fully support that, because a person's needs are often so complex and challenging. You need the expertise of many to help.

Ms Power—People in the work force also need to support of their colleagues in an environment where they are giving care, particularly when we have work force shortages, so that they can perhaps substitute for other carers at certain times of work force shortage. I think that health professionals need to be educated differently to be able to work in a multiskilled environment better than they do now. There needs to be an emphasis on undergraduate and continuing education to ensure that health professionals can work together. Possibly there could be many more core units in undergraduate education so that health professionals understand the work that their colleagues do, particularly in the medical profession working with others.

Senator MOORE—I was going to follow up on the better outcomes process, which you refer to. We have had in evidence about the better outcomes process—the upskilling of GPs with the hours of intensive research on these areas that lift them up. You mention it in your submission. I am interested in your standards hat—and there is a whole other thing there—about whether there has been any consideration of the impact and credibility of the training aspects of the Better Outcomes in Mental Health Care initiative for GPs—I think it is six hours to get stage 1. Has that been touched on?

Senator WEBBER—They can do 20 hours training and they are a fully fledged counsellor, apparently, whereas other health professionals seem to do six years.

Senator MOORE—It is a joint question.

Mr Johnston—Sadly, no, because the standards are 10 years old. I am sorry, but it is not good enough. That is from our perspective. We do not do it with our other mainstream standards. The scene changes progressively. Health is a constantly evolving environment. These standards should have been revised well before now. The very issue that you have drawn attention to is the sort of thing that needs to be not just absolutely included but considered. If this has been an important investment by government and there has been a significant take-up by general practice in this area, how would we best reflect that in the standards assessment process? What weight would we put on it in terms of developing national standards? There are ebbs and flows in those sorts of dialogues. But what is lacking is the debate. The debate leading to the next edition of the standards has not taken place.

Senator WEBBER—You were having a discussion before with Senator Forshaw about specialist care rather than care taking place in the general health community. I was wondering, therefore, how we assure that the care we give reaches the standards you have referred to in remote and regional parts of my home state in Western Australia, where there is no specialist care above Geraldton? How we do that and how, in particular, do we make sure that the care that we offer our Indigenous population matches the standard?

Ms Green—Certainly in our proposal we have talked about telemedicine. It probably started in mental health before any other speciality; it probably first commenced in relation to mental health. I think there is some good evidence that it can support remote and rural communities—certainly that has been our experience in New South Wales—to close those distances.

Senator WEBBER—I am not convinced that telehealth actually addresses that. I am not convinced that it is culturally appropriate for Indigenous people.

Ms Green—Last year, at our conference in the Northern Territory, we saw a presentation where mental health professionals and Aboriginal health workers went in partnership out to communities. It was one of the most innovative presentations I have seen. I was not aware it was being done anywhere else in the country. As an example of what you are saying, it seemed to really impress where people were not being disadvantaged. The example they gave was that Aboriginal communities could see by the way someone had painted himself that he was psychotic, but nobody else would have picked that up.

Senator MOORE—Can we get the details of that submission?

Ms Green—We could try to track that down for you. We might be able to get the paper from a year ago for you.

Senator MOORE—Then we can see whether that stimulates more stuff.

Ms Green—It just came into my mind when you were talking, Senators. I think those sorts of models are culturally sensitive. They are getting access to professional care but it is actually combining both.

Mr Johnston—Whilst I know it is a cliché, standards need to be realistic. You can have standards which are aspirational and people have to demonstrate that they are working towards that point, but rural Western Australia is a classic example. It is something that we confront and hopefully deal with reasonably effectively all the time. We are working very closely with country health services for Western Australia at this very moment. You have to write standards which are meaningful to people in the location where they are working. They have to be capable of being interpreted in a way that is useful to that person—not just so that they understand it but because it actually helps them do their job and does not just provide some sort of bureaucratic hurdle which they have to climb over and which they cannot see the purpose of.

CHAIR—Mr Johnston and Ms Green, I will pose this question to both of you. We hear a lot about the big mental health dollars going into the acute end of the care spectrum yet people have provided us with evidence that the acute care sector treatment, for want of a better word, consists of people being given medication in a possibly secure environment but that most of the reluctance that people experience in being discharged is because they feel they have not had any treatment. Do you agree, Mr Johnston, that our standards of care in our acute centres are failing? Ms Green, you have had experience in institutional care. Were there other therapeutics, such as psychosocial programs and assistance, given to people who were acutely ill, or do they just sit around all day and wait for the next bunch of pills to be handed to them?

Ms Green—I think it is probably true to say that the system is under enormous pressure and that on many occasions you will actually have more patients than you will have beds. The reason you can do that is because they are out on leave for a couple of days. I think the number of acutely mentally ill persons against the number of beds is always going to be challenging. We are often confronted with how we can actually make sure that somebody who needs a bed gets a bed because they may be a danger to themselves or to others. I think I said that it is in that environment where there is a focus on who can we get out of hospital. I think there is a bit of a tendency to do that. From the point of view of the person who has the mental illness—looking at it through their eyes—it must feel a bit like that too.

Going back to Senator Moore's comments, we do have a really good range of multidisciplinary professionals within those units. There are social workers, there are psychologists, there are a range of people who are available. By and large, people have a pretty good assessment. But the problem, of course, is that their length of stay may be five or six days: we get their medications stabilised, we get them a program and we get them out. So it is intense; it is short-lived. It may or may not be supported adequately in the community—probably with a lot of the investment going into the acute in-patient experience, perhaps not.

CHAIR—So where does this variation arise? You say there are some services where there may be a social worker, a psychologist and whoever else to work with people, but a lot of the evidence that we are receiving is that there are none of those.

Ms Green—I am sure that is true as well. I can only speak about the ones that I am aware of.

CHAIR—Mr Johnston, is that the sort of thing that standards should determine? When you arrive in an accident and emergency department in a poor state, is there something more than being sedated and attached to a trolley until you get to a space where there is medication?

Mr Johnston—In the view of ACHS: yes, without a doubt. The standards should go further in certain instances than what they might in others. Part of the value of looking at performance is that you can see where the areas of emphasis may have been in the past—but, more importantly, where they need to be in the future. If this issue that you have referred to is seen to be a priority, then let us make it a priority in the next edition of the standards. It may not be a priority in the subsequent edition but it might be something for emphasis now because the performance is not where it should be.

Our experience is that, by and large, the mental health services that exist in acute hospitals do attempt to provide a balanced, dare I say, episode—or experience—of care for the patient. But the time frames are very short. Some organisations will make decisions about allocations of resources in different ways, and that is probably part of the Commonwealth-state funding dilemma, broadly looked at. So yes, there are issues that are identified from time to time but, by and large, what we see is not so much the wellbeing of the person while they are in hospital as the process lacking in certain respects, particularly around the continuity of their care.

CHAIR—If I can stick with that acute end of the spectrum for a minute more, some of the most powerful evidence the committee received was from the Orygen Youth Health service in Melbourne. That has a research institute and the University of Melbourne backing it, so best practice and effective treatment is obviously at the forefront. I think it is fair to say that we were bowled over by the stark contrast described by those young people who appeared before the committee with their treatment in the public sector. Whether they were adult services through mainstream hospitals or accident and emergency, they described a service that worked for them and which allowed much more recovery than they could foresee in what they described as a violent approach to their illness. Can you comment on that? To what extent are services in this country based on best practice and on good information about what is effective? Sorry, that is a big question.

Ms Green—It is a big question.

Mr Johnston—It is a good question.

Ms Green—In relation to medication we can probably say that the answer is generally, yes, there is good evidence basis for medication. As to how effective it is, I cannot answer that question. In relation to other programs I think we can go back to our point about research. We believe there is serious underfunding of research into mental health and what works—not necessarily curing conditions so much as effective interventions and identifying what actually works for people and what does not. I am not familiar enough with the detail of that to give you a good answer, except to say that there needs to be a lot more focus on good research into what works in terms of interventions for people. If you compare what goes into mental health with a number of the other conditions that focus the mind in terms of research—and there are many—then mental health is a very poor cousin.

Mr Johnston—Can I add a dimension which I think you have touched on but maybe not put the popular brand on—that is, consumer involvement. It seems to me, without being familiar with the Orygen scheme in Melbourne—but I am certainly going to make myself familiar with them—that they have designed a system that meets their needs, and they are the users. That is a really powerful weapon. I am not sure how extensively it has been taken up.

CHAIR—At Orygen it has been absolutely taken up.

Mr Johnston—Yes, but I mean elsewhere. It is the real face of the power of consumer participation.

CHAIR—That is sadly all we have got time for so thank you very much for an excellent submission and one that will be very useful to the committee. Thanks for appearing.

[11.35 am]

GORDON, Ms Amanda, President, Australian Psychological Society

LITTLEFIELD, Professor Lyndel Kay, Executive Director, Australian Psychological Society

STOKES, Mr David Lewis, Manager, Professional Issues, Australian Psychological Society

CHAIR—Welcome. You have lodged with the committee a submission which we have numbered 50. You must have got in really early; thank you for that. Do you want to make any amendments or additions to that document at this stage?

Prof. Littlefield—We actually lodged two submissions and the more important one is 50A, which is a much more comprehensive submission. I checked with Ian yesterday that that was the one we were talking to. We do not have any additional information. I was hopeful that there would be a PowerPoint available but there was not. I wanted to speak to that. I had it printed out just in case. Does everyone have a copy of that?

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

Prof. Littlefield—I am going to skip through this. We all know about the mental health burden in Australia, and the Australian Psychological Society is deeply concerned about it. We all know about the high prevalence of mental health disorders, the impact on consumers and carers, and the cost to the community. I am sure you all know that the demand for services far exceeds supply at this point in time.

With regard to the mental health work force, general practitioners are often the first point of contact. There are a number of them—22,000. Psychiatrists number very few—only about 2,500—and psychologists are really an untapped work force. We have 22,000 in Australia and 10,000 of those specialise in mental health. I note that our society has a large number as members—14,600.

It is a pity that there is a huge work force of psychologists available—spanning metro and regional areas in about a 70-30 split—and we are underutilised because we are not accessible due to funding issues. Psychologists are highly trained—it takes six years of training to become a psychologist—and our practice is evidence based. In contrast to a few of the previous comments, we do know the literature. There is a lot of literature about evidence based practice. We have been commissioned by the government to write a total review of it, which we have just completed. That is available if you want it. There are proven effective treatments for many mental health disorders, and psychological treatment is cost efficient—six to 12 sessions quite often cures a lot of mental health disorders.

In relation to the public sector, we are very concerned about the underfunding of in-patient and community care and we argue for effective services and treatment, first of all for the low

prevalence disorders in in-patient care. We are very concerned about what goes on there. We do not believe that effective treatment is going on. You can see that from the revolving door. People leave after a short space of time, only to be readmitted not so long after. That is a great concern. We are also concerned about the high prevalence disorders. We believe most of them can be treated in the community but if they are very serious it is quite hard to get into in-patient units. If you have a crisis and you are anxious or depressed, unless you are suicidal it is very hard to get in.

We believe the public sector service should be based on evidence-based practice. There should be built-in relapse prevention. We need to integrate the care across the sectors from hospital to community services. And one of the big issues is work force retention. It is not a very pleasant place to work, it is hard to get career structures, and good people leave.

In primary care—I want to focus a little on this—as I have said, GPs are the first point of contact. They have enormously high workloads, so they need support. Mental health is one area that they are not particularly well trained in, so it is an obvious area for support. They can identify mental problems, assess risk and undertake some minimal interventions but that is about it, by and large, so they do need support from psychiatrists and psychologists and they do need to be able to refer their patients to accessible psychological treatment.

I want to speak a little about the Better Outcomes in Mental Health Care. I have been involved in it in a very big way right from the beginning and I believe it is a good model. GPs, psychiatrists and psychologists all work in partnership. The GPs can be trained to level 1, which is only six hours training, but after that they can pick up mental health problems in people presenting with psychosomatic type problems. Then they can refer to allied health for what is called focused psychological strategies. It is a bit limited because it is only for six sessions but they are evidence based, effective strategies. Even so, the demand for psychological services under this initiative far exceeds the funding cap. Better Outcomes in Mental Health Care has been evaluated, and access to psychologists has been seen by all parties as the most valued part of the service. GPs, consumers, carers and other people concerned all report that it is the most valued part.

GPs can be trained to level 2. As was mentioned in the previous discussion you had, 20 hours of training is ridiculous. Psychologists need six years of training to deliver psychological services. I think we have to be concerned about quality assurance issues. It is dangerous if you are not aware of what the problems are. You can treat anxiety by certain things that are not suitable to particular patients and make them worse. So it is a real worry. These GPs with 20 hours of training have access to what is called the focused psychological strategy Medicare item. It is just crazy that psychologists who have this high level of training cannot access that particular item. It would solve the most enormous number of problems if GPs could refer to psychologists who could get access to that item. That is one of the strongest points or recommendations that we would like to make in our whole submission.

What is happening is that there is a new chronic disease set of items where money has been transferred from Better Outcomes into this chronic disease item, which is extraordinarily concerning. It means that it is not contained for mental health. Chronic disease covers a whole range of diseases, from diabetes et cetera. Mental health is included but the money that has been transferred out of the Better Outcomes bucket into it is not quarantined for mental health. So it

might be totally dispersed. What is worse is that it is now a two-tiered process. The first tier, the general practitioners alone, can write a management plan, which they will opt to do, rather than write a multidisciplinary care plan, because it is just so much easier. They complained to the red tape task force that they did not want to write multidisciplinary plans—too hard; too much work. The big problem is that the allied health items are not linked to the general practice management plan, so they cannot refer to psychologists or other allied health. So we have actually gone backwards. In the last year, with this transfer of funding, access to psychologists et cetera has gone backwards.

GP management plans have to be directly linked to the allied health psychologists items. Interestingly, the Royal Australian College of General Practitioners and the Australian Divisions of General Practice all support it. They told Tony Abbott in their discussions and he said no, because it was too much money or something—he was worried about it. We argue that it can be contained, because we have always argued that only psychologists who are properly qualified and accredited should get access to this anyway. So you can contain it by setting the standards for appropriately qualified allied health to access this money.

The other thing that I think is really important is that we need in Australia to build a system of primary care, which is general practitioners in true partnerships with allied health. There could be all sorts of models of primary care teams developed. For instance, psychologists could be employed by the divisions of primary care or by general practices. They would obviously have local referral networks to community health and others. So it would be a proper system set up where all these parties that play a really meaningful part in treating mental health are linked.

I am arguing to convert the Divisions of General Practice to divisions of primary care with allied health on the governance body and the governance steering committee. The reason for my putting that up is that the Australian Divisions of General Practice absolutely support that. That has happened in the last few months. They have decided to develop a policy where they will convert to the divisions of primary care and they will have allied health on their governance bodies. They are actually going to propose, when they release this policy later in the year, that there be a parallel body, a government body—do you know the GPRG; the General Practice Reference Group?—that is the divisions of general health with allied health. So it is a real movement, a real change, that is being forecast.

After asking for lots of things, the Australian Psychological Society would actually like to support all this. We are most concerned with the mental health situation in Australia. We are right on top of the evidence based practice information. As I said, we have just done a total review of it. We are happy to give it to you. We provide training and ongoing professional development and, in that, evidence based practice to ensure quality in service delivery. We are happy to accredit psychologists for eligibility to access Medicare. We believe that only the ones who are properly trained should get access. We are already supporting psychologists in rural and remote areas through networking and getting professional development out there. I believe we did so in Geraldton recently. There is a group of psychologists in Geraldton.

Senator WEBBER—There are even psychologists in Port Hedland. That is a very good thing.

Prof. Littlefield—We are also going to form a branch, apparently, which is good.

Senator WEBBER—But no psychiatrists.

Prof. Littlefield—We are also prepared to assist with—and we have started this, actually; this is not a new thing—setting up and coordinating a system between universities and ADGP to train our clinical health psychology interns in general practice. That means putting them into general practice so that they learn how to work in primary care. If they do it in their last year of internship, they often go on to stay in that sector. That has been started. We as a society are very happy to facilitate it. We would also be happy to encourage psychologists to work in the public sector if it were somewhat improved to do with career structures. We do now mobilise psychologists to take part in government initiatives like Better Outcomes in Mental Health Care. We actually promote them.

So the outcome we see of all of this is better mental health for Australians, particularly the Australia-wide system of integrating mental health professionals into primary care. We do believe that we have an untapped work force out there of thousands. It is not small. We need them to be accessible. We believe that if that happened there would be much greater consumer access to the appropriate mental health workers. We offer quality assurance. The outcome, we trust, will be better treatment for Australians with mental health problems.

CHAIR—Thank you, Professor Littlefield. Do either of your colleagues wish to speak?

Ms Gordon—We are happy to take questions.

CHAIR—Thanks very much for a useful presentation. It is good news about the Divisions of General Practice taking you on board. That is excellent. This is obviously only a first step. It would appear to us that GPs still have a long way to go in understanding the shortcomings of their training, by all accounts. We were told by the AMA that, despite having only six hours training, GPs were very experienced in counselling people on a day-to-day basis and that they were best able to provide this service because very often there was a physical aspect to mental illness. Do you agree with that?

Prof. Littlefield—Yes. I think it is good for GPs to be absolutely integral to the treatment because people often present to them with a physical illness which has a mental health issue underpinning it. So, as long as GPs are trained to pick that up and ask the right questions to uncover what is underlying the psychosomatic physical disorder, I think the six-hour, level 1 training should be integrated into their undergraduate training. All GPs should have six hours of training to be able to do that. The big question is the 20 hours. You cannot learn to do this sort of evidence based treatment in 20 hours; it is a great worry.

CHAIR—We will ask when we get to New South Wales, but one of the submissions indicates that there is a program from, I think, the New South Wales psychiatric institute, which has a program for training GPs. Have you been able to look at that program, and how do you assess it? Is it more than 20 hours, and what does it do?

Prof. Littlefield—I do not know the specific program, but I sit on the Royal Australian College of General Practitioners GP mental health standards collaboration that accredits the 20-hour programs. So I know every one that has been accredited. I cannot recall an individual one. Basically, most of them do not have any more than 20 hours. The greatest worry is in this second

triennium of them—they actually do not even have to have 20 hours face-to-face. They have cut down the requirement in this triennium to 16 hours, with four hours—

CHAIR—The rest is homework, is it?

Prof. Littlefield—Yes. And the 16 hours are to fit into a weekend.

CHAIR—I see.

Mr Stokes—All the principles of adult learning are abandoned in the same way too. You cannot cram effective learning into 16 hours in one weekend.

CHAIR—Indeed. In terms of psychologists and their capacity to deal with what is presented by way of mental illness, what sort of training do your clinical psychologists in mental health have in what is variously called co-morbidity or dual diagnosis—in other words, usually, a drug and alcohol problem as well as a mental illness or a difficult to diagnose mental illness?

Prof. Littlefield—Clinical psychologists have to have at least a master's degree and another year at least to be a member of a clinical psychology college. Most now are doing doctorates. They have training not only in treating the mental health disorders that we know regularly but also in treating drug and alcohol problems. It is an accredited part of the course. The Australian Psychological Society accredit all courses in all universities across Australia. We set the standards; it is written into the courses to be accredited that you must deal with drug and alcohol problems as well as mental health disorders.

CHAIR—That might be one of the criteria you would use for accrediting somebody under Medicare for a rebate.

Prof. Littlefield—Absolutely. We know that any graduate that comes out of one of those courses has to have it or the course would not have been accredited.

CHAIR—I understand.

Senator MOORE—There is a lot here. I just want to concentrate on two things. I know, Professor Littlefield, that you have been involved in the whole Better Outcomes process. We are hearing a lot about that. When the decision was made to move funding out of that area into the very important area of chronic disease, were the people involved consulted? Did you have a chance, when that decision was made, to put forward the significant concerns that you have raised about that decision?

Prof. Littlefield—You are asking a very political question, and I am going to get myself into trouble over the answer. I am on the implementation advisory group and I have been on all of the major groups.

Senator MOORE—Your name is there all the time, Professor.

Prof. Littlefield—We were not consulted; in fact it happened without our knowledge. After it happened, and we had seen that the money had disappeared out of Better Outcomes, questions were asked. Last Friday there was more or less a crisis meeting to quiz—

Senator MOORE—I did not know about that meeting. So, it was quite recently that it took place?

Prof. Littlefield—It was last Friday. It was to quiz why it had happened and why we did not know about it as the major advisory group. The explanation was that doctors' SIP payments were not used by a huge amount of money—a huge amount—so they decided that if they were not going to be used they would shift them into another bucket. So they are still under Medicare but now under chronic disease. What is so ridiculous about that is that certain doctors hit their ceiling and were not given any more. This is under the same bucket. They could have just had more. Then there are the allied health pilot projects, in which every bit of money was expended and people were screaming for more. For instance, we are rung up by doctors after three weeks—it is funded on an annual basis—saying: 'I have used all my money for 52 weeks. Can you help me? I can't refer another patient for the next 49 weeks.' It is just wrong.

Senator MOORE—The question was not meant to be overtly political. I have been asking other people about changes in policy. People are involved in the process, and it has been a long-term decision to involve people who are active and knowledgeable in various consultative and advisory groups at all levels of medicine. When changes are made, how are people advised? I have asked that question of a number of people across this committee. We are getting different answers. Given that you were not consulted before it happened, how were you advised that it had happened? Was there a formal letter?

Prof. Littlefield—I will get into deeper water. I went to the budget lockup and discovered that there was money missing—or it was less than what we expected for the base funding of Better Outcomes. We expected \$120 million plus an increment. Instead of the \$120 million there was \$102 million.

Senator MOORE—There was a bit missing.

Prof. Littlefield—After, we asked where it went. It took something like three months to be told where it went.

Senator MOORE—One of the things we are trying to find out is whether people involved in the processes were formally advised by a letter stating: 'Dear so-and-so, this decision has been made and these are the reasons. If you want more information please consult so-and-so.' You did not get a so-and-so letter?

Prof. Littlefield—I feel that a committee that is run as the advisory committee right through should not have even just been told. I would have thought that around the budget estimates time we would have been consulted and that they would have said what the situation was and we would have had some input into what should happen.

Senator MOORE—Is it fair to say that your organisation is continuing to ask these questions?

Prof. Littlefield—It is not just mine. It is all of the general practices—everyone on Better Outcomes. In fact it was led by the general practitioners.

Senator MOORE—A few of us are involved in the Senate estimates process in this field and the issue of Better Outcomes continues to be raised. Moving on, I asked questions about multidiscipline teams before. You have referred to it. Can we get on the record your professional view of the value of the multidisciplinary approach to this particular form of health care?

Mr Stokes—I think it is a crucial element in this, not just from a clinical treatment point of view where best practice is involved but also in the enhancement of continuity of care, which we know is a terribly important aspect of mental health treatment. Many of the problems that are reported are because of discontinuity of care. The multidisciplinary team is another arm to ensure that that continuity of care happens. We are 100 per cent behind the notion of multidisciplinary care at all levels and in all settings, not just in the public setting or in the private setting but across all settings.

Ms Gordon—In acute care we know that one of the reasons for the revolving door is that people are not compliant with medication. When they are just medicated and not given strategies, motivational training and help in taking their medication they are inevitably going to fail. Psychiatrists and doctors are not trained in helping people deal with that element anyway. If psychologists were involved in that sort of work when medication was first prescribed people would be much more likely to maintain their medication regime in an ongoing way.

Senator WEBBER—I want to return briefly to Better Outcomes. I am pleased to hear that you are confident about how well it is going, because I have to say that when the Australian Divisions of General Practice appeared before us I was fairly unconvinced. We heard about the six hours of training and we were told that, really, it was unrealistic to expect much more, because that is a big chunk of time to expect a GP to give for training so that they will know how to deal with people who suffer from mental health conditions. So I think we have probably still got a bit of work to go with them. On a personal level, I am dealing with someone at the moment who is suffering from depression and has been to see a GP who has done the six hours of training, and all that has happened is that he has been put on drugs. He goes to the GP regularly and the dosage is increased, but months later I have not noticed any improvement in his circumstances. There is obviously something more that we need to do, particularly as GPs are the main source of treatment for people.

Prof. Littlefield—The six hours of training does not allow them to do the treatment. They have to have done the 20 hours.

Senator WEBBER—Six hours is a big chunk of time; it is going to be hard to get them to do 20 hours.

Prof. Littlefield—But the six hours of training allows them to refer patients, so there needs to be more education about referral and what psychologists and others can do to help. The drug issue is a real worry, because drugs do not cure mental illnesses; all they do is reduce the symptoms. So if you deaden the symptoms and come off the drugs, by and large, they will recur unless you have learned, while on the drugs, how to manage your mental health problem: learned coping skills, how to manage stress and how to deal with your problematic thought

patterns. Medication on its own is no solution. We are not against medication. We believe that for serious disorders sometimes you need medication to get people to lift their mood so they can work in a psychotherapeutic way. But that is only for the serious disorders. GPs or others just putting people on drugs is a real worry, if that is all they are doing.

Ms Gordon—And it is not working, according to the evidence. The evidence is that medication on its own is unlikely to be effective.

Senator WEBBER—But that is the majority of treatment? That is the treatment that the majority of sufferers get.

Prof. Littlefield—We do have to encourage them to refer. That is the problem.

Senator WEBBER—That is obviously something we have to do a bit more work on, particularly in Perth.

Prof. Littlefield—The success I was referring to is the success of allied health. Some GPs say: 'I am only joining up to be able to refer. That is the only reason I am joining this program.' Consumers say it is the best part of the program. That is why I was referring to the success. The other problem is that only about 18 per cent of GPs in Australia are level 1 trained, so it is pot luck whom you go to and whether you can get into the system. It would be far better if that training were in undergraduate study so they could automatically get into the system.

Senator WEBBER—Particularly when you look at the disease burden that is mental health. What does this FPS Medicare item stand for?

Prof. Littlefield—Focused psychological strategies.

Senator WEBBER—And the people who can access that are GPs?

Prof. Littlefield—I will explain this, because this is our major point. If we get anything across, it should be this point. The bases of effective strategies are mainly what are called cognitive behavioural therapies. In the 20 hours of training, the GPs learn bits of them. They are called focused psychological strategies. There is a Medicare item that they can access to deliver them.

Senator WEBBER—Can you access that?

Prof. Littlefield—No.

Senator WEBBER—So, we have a Medicare item that refers to psychological services that psychologists cannot access?

Prof. Littlefield—Yes, but GPs can.

Senator WEBBER—And we have a committee that deals with red tape. This has to be the biggest piece of red tape that I have ever heard of.

Prof. Littlefield—It is almost shocking—

Senator WEBBER—Absolutely.

Prof. Littlefield—because the Medicare system is promoting access to this item to people who are not really well qualified and cutting off access by the most qualified. It is almost against the Trade Practices Act, in some way, too. Is it not a restrictive trade practice?

Senator WEBBER—Yes, it is restraint of trade.

Ms Gordon—One of the reasons that GPs do not refer to psychologists is that their patients cannot afford it, because we do not have access to Medicare but they do. That goes to that whole aspect of our having access to the focused psychological strategies items so that we can treat the patients, but effectively and efficiently and probably in fewer sessions than the GPs could possibly do.

Senator WEBBER—It is absolutely staggering that you can have something like that. It is news to me.

CHAIR—We probably need to move on, Senator Webber. Do you have another question?

Senator WEBBER—I do have another question. I was going to say that you can find psychologists north of Perth—this is my bugbear—and that it would make sense that you are usually going to be the only specialist service that people in remote and regional areas can access. I wanted to return to one of the general questions I have asked other people. At the moment we have silos of treatment for people: we have mental health, we have drug and alcohol treatment and we have all these other things. Some people have suggested to us that we need to bring drug and alcohol treatment back in and integrate it. I was wondering what your views are.

Prof. Littlefield—Absolutely, because you get people that have both. It is very common. When you diagnose mental health disorders such as anxiety and depression, let alone psychoses, between 70 and 80 per cent of people have co-morbidity—it is as high as that. A lot of the co-morbidity is with drugs and alcohol. So if they go to a mental health service, they are told, ‘We won’t treat you because you have a drug and alcohol problem.’ If they go to drug and alcohol, they are told, ‘We won’t treat you because you have a mental health problem.’ Because of the high level of co-morbidity the two must come together. People in most need are falling through the cracks.

Senator FORSHAW—This might be something that you can take on notice and provide to us if possible. I did not notice it in your submission—it may be there. I am interested in getting a picture of the number of patients/consumers that psychologists, particularly those you describe as specialising in mental health, are seeing in a year and any break-up of that number. Also, what are the main complaints, if I can use that term, that you are dealing with? Is it anxiety related, is it depression?

Ms Gordon—Depression is the highest.

Senator FORSHAW—Could you provide data in table form to the committee?

Prof. Littlefield—We can provide pretty exact data if you could give us time to do it.

Senator FORSHAW—That would be good.

Prof. Littlefield—The high-prevalence disorders are depression and anxiety, and there are various forms of them. There are several anxieties—eating disorders, obsessive-compulsive disorder. There are the psychoses—bipolar disorder. They are all very common, probably more or less in the order I have said. The high-prevalence disorders of anxiety and depression far outnumber all of the others. Hence our concern to provide services in primary care where they first go. Picking up these things early, you can save so many problems. In early intervention you can even pick up kids in schools that are going to have and develop anxiety, depression et cetera. It would be ideal to have programs in schools.

Senator FORSHAW—There are obviously a lot of other things that are being dealt with by psychologists that you would not include in mental health, given the figures you have provided. What are they—behavioural problems in young children?

Ms Gordon—Sports psychologists, educational and developmental psychologists, organisational psychologists.

Senator FORSHAW—It would be good to get a picture of that.

Prof. Littlefield—We could give you a breakdown.

Senator FORSHAW—There is another issue you might like to comment on. We hear a lot about CBT. What about hypnotherapy? Is that widely used by psychologists?

Prof. Littlefield—There are people who are trained in hypnotherapy that are not necessarily psychologists. Some psychologists—

Senator FORSHAW—I am talking about hypnotherapy by psychologists.

Prof. Littlefield—It is not widely used. There is some limited evidence of its effectiveness in conjunction with the other therapies. There is not much evidence—

Senator FORSHAW—Such as using hypnotherapy with some form of relaxation therapy?

Prof. Littlefield—Yes. As an adjunctive therapy to the other therapies, there is some evidence of effectiveness, but not on its own.

Senator FORSHAW—If you could give us that data, that would be excellent.

CHAIR—We have well and truly run out of time, so we will need to leave it at that. Thank you very much for your submission and for appearing before us today.

Prof. Littlefield—Thank you.

[12.11 pm]

GERRAND, Ms Valerie, Former Convenor and Current Member, Mental Health Special Interest Group, Public Health Association of Australia

HUMPHRIES, Ms Susan Margaret, Interim Convenor, Mental Health Special Interest Group, Public Health Association of Australia

LAUT, Ms Pieta-Rae, Executive Director, Public Health Association of Australia

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

Ms Gerrand—I am the major author of the submission that you as a committee have received. I have also recently completed a PhD in public policy—which hopefully will be of value—looking at the Victorian mental health reforms from 1993 to 1998 under the first national mental health plan. My background experience includes working as a social worker in mental hospitals back in the late sixties, so I know what those institutions were like. I then went on to manage and work in community mental health services. I worked at the state level from 1993 to 2000, covering the reform period, and I also had two stints with the Commonwealth mental health branch, developing the national mental health strategy and co-writing the second national mental health plan. That is the background that I bring to this committee.

Ms Humphries—I have a background as a research assistant in health services evaluation in a range of areas from paediatrics to hospice and palliative care and aged care. I come to this area with a personal interest too. Like Senator Webber, most of us have somebody we are close to experiencing problems, and we then experience the problems with the system.

CHAIR—The committee has your submission, which we have numbered 212. Are there any amendments or additions to that document at this stage?

Ms Laut—There are no amendments.

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

Ms Gerrand—Rather than just working through the submission as such, I would like to—and I will lead this and the others will chip in—pull out particular points from it, because I know your time is limited and I know also that you have had a huge number of submissions. We have read those and also looked at some of the transcripts. First off, as a public health association, our overall interest is that Australians with mental ill health can receive the right treatment at the right time, irrespective of age, where they live and their level of disposable income. Our concern is that that is not happening at the moment, as you would also be well aware.

The other aspect of the public health focus is that we do look at the population as a whole. We try and take a broad, multifactorial approach to both understanding and treating mental ill health.

We are also concerned that the promotion of mental health and wellbeing is a second and major goal of national initiatives, and also at the state level.

What I want to do now is go through and pull out the positives that have been happening in mental health, talk about the problems and then talk about some solutions. Then, obviously, I will welcome your questions. I will go through this quite quickly because I know time is limited. On the good news side—I think it is important to stress this, particularly as I have had a longitudinal view of mental health over a number of years; these things need to be said—community antistigma campaigns are actually working; they are having an effect. More people are coming forward for assistance with mental health problems and the more serious disorders. We need to be noting that. The problem is that the system has not been brought in to bear and is not ready to match the number of people who are coming forward. However, I will work through a number of points.

On the positive side, we know that the more evidence based treatments actually do work—the drugs with fewer side effects; psychological treatments, as you have just heard; and recovery programs. There are also innovative services that are working. You have heard from Orygen, which is a public mental health service in Victoria. It started with EPPIC, the Early Psychosis Prevention and Intervention Centre, and has now renamed itself, but it does a lot of very good early intervention work with young people with psychotic disorders. Its approach is now being replicated across different parts of Australia and also in other parts of the world, particularly in the UK, which I think is a very positive thing to note.

I would also note some of the other innovations—the step-up, step-down services that have been started in Victoria. There are a few of them at this point. They are an alternative to inpatient admission but they also provide a transition for people after discharge. A person can stay in this supported accommodation for up to four weeks—disability support staff are on site 24 hours a day—and they have clinical input from the local CAT, crisis assessment and treatment, service. These services are particularly good in country areas. It has been said that the Shepparton service, for example, which is one of the new ones, is working extremely well. For instance, people who might be in more remote farm locations can get that assistance in the town. Rooming-in has been used successfully in rural New South Wales and makes use of district general hospitals. The other innovation I would note, again from Victoria, is the notion of a youth precinct where you can have co-located drug and alcohol services, mental health services and GPs. In Geelong, the Clockwork program is a very good example of that.

The Commonwealth can make and has made a difference with the National Mental Health Strategy and has given real impetus and direction for mental health reform across Australia. We do know how to transform what are still residual institution based services into community care and how the Commonwealth can help with that. Referring obviously to my PhD research, in Victoria the Commonwealth funds that were provided for start-up and transition were absolutely critical for Victoria to transform its service system. As you probably know, Victoria closed all its psychiatric institutions and replaced them with the bed based services needed across the state and also the community based services. To give one very simple example, the former Royal Park Psychiatric Hospital, which is now the site for the Commonwealth Games village, was closed and replaced with 13 bed based facilities—that is quite separate from the community based outreach services that were also put in place. The notion that deinstitutionalisation meant closing institutions and throwing people out into the streets is quite wrong. These were replacement

services for the institutions, and they are far better and much more humane in what they can provide than an institution.

Going on to the negatives—you have heard a lot about them, so I will not repeat them all—there are gaps in the antistigma campaigns, and that is a real problem. Mental health professionals are seen by consumers as being the group that is the most stigmatising in their attitudes, and there is a lot of work that needs to be done to change that. Diagnostic labels are real barriers to treatment for a lot of consumers. Just to add a comment on the issue of co-morbidity, which you have already heard about briefly, there can be some real difficulties with stigmatisation if you bring together, in a physical sense, drug and alcohol services and mental health services. If someone has a problem with drugs and alcohol that does not mean that they have a mental disorder and vice versa. Rather than bringing the two services together and blending them, I would suggest other ways in which the issue of co-morbidity could be dealt with—for instance, around the training of staff and in co-locating with youth precincts.

The other negative, which you have heard about already, is that getting access to treatment largely depends on where you live and how much money you have. There is an overreliance on drug treatment, so the access to the full range of what we know are the evidence based interventions is limited. The current publicly funded mental health work force is used ineffectively and inefficiently. Private psychiatrists, who are largely funded by the taxpayer, are congregated mainly in affluent suburbs in the big cities. They have long waiting lists and are unavailable after hours, at weekends and on public holidays, and they are rarely in rural and remote locations, outer metropolitan areas or the more deprived outer suburbs.

You have heard that clinical psychologists in private practice are not reimbursed under Medicare, and they are really only available to those who can afford the cost, which can range from \$120 to \$180 per session. Many GPs are underresourced and undertrained in recognising, diagnosing and treating mental health problems and are overreliant on drugs for treatment. University programs in GP psychiatry—and I am most familiar with the one run by Monash University; although, as I understand it, the New South Wales Institute of Psychiatry is running them as well—are costly, so if GPs want to do them they have to fork out quite a chunk of money. For instance, I know someone who is a sole practitioner GP and completing that course cost her about \$18,000, which was really expensive and a chunk of money for her to fork out. GPs are also quite poorly supported by psychiatrists as the specialist consultants, and I think we need to make note of that.

You have already heard about what to us is the really retrograde step of cutting funding to the Better Outcomes in Mental Health Care program by \$18 million over the next four years. The other group I have mentioned are mental health nurses, who we would argue are inadequately trained in treating people in the community, either because they were originally institutionally trained or their training was institutionally based or because they are insufficiently prepared through the generalist nursing courses.

The next group I want to refer to is probably the one that we want to stress; that is, the invisible work force of families and friends, who have little information, education or support in helping a person with mental health problems or disorders—who usually does live with them. Clinicians are poorly trained in how to include families in treatment planning or preparing for hospital discharge. Private psychiatrists often use confidentiality as a way to keep families at

bay, even though the patient may be living with the family. I draw your attention here to standard No. 6 of the English National Service Framework, which is on responding to carers and under which staff have to talk to carers and family members to work out their needs and prepare a plan to respond to that. That is something that we can table.

The other point I will make before moving to solutions is to note that in most states that still run separate psychiatric institutions most of the state mental health budget is taken up by the institutions. For example, in South Australia I think the one institution left there, Glenside, absorbs something like 45 per cent of the mental health budget, and the effects of what can be provided in other ways is extremely limited.

The other issue is that people with psych disabilities have very poor access to key programs and resources such as stable low-cost housing—which can have a huge impact on their mental health—HACC services, day rehab and vocational programs. Non-government services that run those programs are very unevenly distributed across Australia. In some states and territories they are well developed and in others they are not. The innovative services that work are not universally available, even in major cities around Australia. You will recall the example I gave you of the step-up, step-down services in Victoria. There are still only two or three of them in operation in Victoria, with another two being planned, as I understand it; yet in Victoria there are 21 area services. So the difference between what is in place, what is planned and what is actually needed is large.

Moving quickly to solutions, we would argue strongly about the role of the Commonwealth and the real need to revitalise and strengthen the role of the Commonwealth in providing national leadership, setting national directions in consultation with states and territories and setting specific targets to be achieved.

The other strong role for the Commonwealth is in providing the transitional start-up funding for states and territories to expand particular services. I do not mean one-off projects that go nowhere but rather doing what they did for Victoria, which was allowing Victoria to start up its community based services. You could then downsize institutions and free up that money to reinvest in the new community based services.

You have heard a lot about better use of the work force already. We argue for incentives for private psychiatrists to provide sessions in geographical areas that are not covered presently and for higher rebates for initial assessments, so there would be more accessibility and more focus on that. They could be required to have a proportion of patients bulk-billed as part of getting a provider number.

The problem of clinical psychologists in private practice not being registered for Medicare rebates is a major one. There are some suggestions there. There could be an income test for those getting access to rebated sessions with clinical psychologists. There could be a cap on the number of registered providers; on where they were located, because the issue of services in rural and remote locations is critical; and on the number of sessions per patient, although I would put a proviso that it not be limited to just six, which is a drop in the bucket.

There is a real need to boost the number of mental health nurses to cope with the fact that mental health nursing is not popular and there are lots of competing specialities. One suggestion,

for instance, is that the Commonwealth could be providing HECS-free postgrad training places in mental health nursing. Also, the rural health scholarships could have a proportion ring-fenced and allocated to mental health nursing. The possibilities with GPs is for the Commonwealth to fund GPs to undertake the specialist training in GP psychiatry.

The next area is the family and friends of people with mental health problems or disorders and their need for information, training and support, which needs immediate and urgent attention. The family support organisations that are in place across Australia and in most states and territories are excellent but they are underresourced. A proportion of the Commonwealth State Disability Agreement funds could be targeted at this area.

The other issue is that all mental health professionals need specialised training to work with families. We had the example in Victoria this year of Dr Grainne Fadden, a clinical psychologist from the Midlands in the UK, who has been running a seven-year program called the Meriden program training staff to work with families, coming to talk to the April 2005 carers conference. The Commonwealth could be setting national objectives and targets for states and territories to meet that as a requirement.

We have some interesting material that we would be quite keen to table. It shows, for instance, the impact of including family intervention. The evidence there is from a number of studies that show the difference between when there is family intervention as opposed to a control, and the effect on relapse rates. The reduction of relapse rates is absolutely dramatic when staff actually have the training in working with families.

Another area to mention briefly is that there is obviously a need for staff to have exposure to evidence based interventions. The Commonwealth can play a role in funding the provision, circulation and dissemination of that sort of material, let alone in support of the training. The Commonwealth can obviously also have a significant role, as I mentioned already, in providing start-up funding for particular services.

Lastly, I would argue that a proportion of the Commonwealth State Disability Agreement, CSDA, funding be ring-fenced, quarantined or targeted at those services for people with psychiatric disabilities. This is not happening at the moment; they are underrepresented in the range of services that are actually provided. One suggestion is that the proportion of funding actually match the percentage of people on disability support due to psychiatric disability. We may then see some turnaround in the provision of services there.

CHAIR—Thank you very much. I would like to start on the family, friends and carers question. We have heard in a number of submissions from carers that a great barrier put up to them is privacy. Practitioners say, ‘The Privacy Act will not allow us to tell you anything about your 19-year-old son or daughter,’ and that is the end of it. The work done in the UK is very encouraging, but you say that work is being done here. In fact, we heard it again from Orygen that including families and carers in the process is working. Is this question of the Privacy Act a furphy? If it is not, how was that overcome in cases where it has been a problem?

Ms Gerrand—Putting it simply—I am not a lawyer, so I cannot answer that as a lawyer might—there do seem to be two separate issues: one is private practitioners and the other is practitioners in the public mental health service system. There are various ways around privacy

and confidentiality provisions. One of the interesting things with Grainne Fadden, when she was out here, was that she went through particular ways in which there could be circumvention or circumnavigation, if you like, of the confidentiality concerns that consumers have as well as practitioners. It can range across having joint sessions so that boundaries to the provision of information are outlined and agreed to as part of a negotiated session with the consumer and family carers there with the practitioner.

Ms Humphries—It would be useful to read what the UK Royal College of Psychiatrists said on this in 2004:

‘Even when the patient continues to withhold consent, carers are given sufficient knowledge to enable them to provide effective care. The provision of general information about mental illness, emotional and practical support for carers does not breach confidentiality’.

The UK Department of Health’s guidance says:

But issues around ‘confidentiality’ should not be used as a reason for not listening to carers, nor for not discussing fully with service users the need for carers to receive information so that they can continue to support them. Carers should be given sufficient information, in a way they can readily understand, to help them provide care effectively.

Senator FORSHAW—You made a statement there about the argument put that deinstitutionalisation has led to a lack of acute care facilities or beds—I assume that is what you were talking about. You went on to say that, in Victoria, they did replace what was lost or they did provide beds and facilities. You were talking specifically about Victoria, but what about nationally and in other states? I have heard from lots of people and we have had evidence to say that the money that should have gone into community care programs, that should have gone into more modern and better facilities and more appropriate environments for people who need hospitalisation, was not provided and we are now suffering a severe shortage in both areas.

Ms Gerrand—My initial response was to try and get across the message that deinstitutionalisation does not mean throwing people out into the streets. I think that is the popular image of what happened across Australia and across the world—you could argue it happened in other places. It has happened differently in different parts of Australia. I am talking about Victoria because there is the most evidence there about that. But I also need to note that, under the National Mental Health Strategy, money saved from closing institutions or reducing them was supposed to be hypothecated. It was supposed to be ring-fenced, quarantined and reinvested. That was supposed to be one of the conditions that the states and territories signed up to.

Senator FORSHAW—It seems that Victoria has done a better job of that than other states.

Ms Gerrand—Yes, and what I am saying is that Victoria did it because it got this big chunk of money at the beginning from the Commonwealth, firstly, to build new buildings before closing institutions. The \$52 million went a long way in building a lot of new buildings, I can tell you. That was added to by the state as they then started to close institutions and sell off the land. Secondly, there was the Commonwealth transition funding, which meant that they could start up community based services that would reduce the number of admissions and the number of readmissions. So, again, it changed the way in which the institutional beds were used.

But the other thing to note about Victoria which I think is really important is the range of types of beds. They did not just put acute units into general hospitals; they also built a whole lot of what are called 'community care units' or 'continuing care units', which are right across all the 21 mental health areas. They range up to 20 beds. They are in the community, they are extended care and they have 24-hour clinical staffing. These are for the people who used to be in the open extended care wards in the institutions. That has not happened in other parts of Australia. I know Queensland Health came down to Victoria to see what was happening, and they certainly have done a lot of that and set up a lot of those units. But it has not been consistently done in all other parts of Australia.

The other advantage in Victoria was that back in 1993 a proportion of the new CSDA—Commonwealth State Disability Agreement—funding was allocated to psychiatric disability. That allowed the state to develop over five years a very strong supported housing program. So it is the range of different types of beds in Victoria that is quite striking when you look across the different states and territories.

Senator FORSHAW—Essentially, would you be supportive of recommending that that model be picked up by other states?

Ms Gerrand—Absolutely. It is the range of different bed based services. There is one last thing, which I have not yet mentioned, that is incredibly important—that is, the development of what are called 'psychogeriatric nursing homes'. These are nursing homes for older people with a mental illness or who might have behavioural problems associated with dementia. In years past, they were in those long-term wards in institutions, and in some states they are still there.

Senator MOORE—Your submission talks about the role of the consumer in the process and mentions only that it has been successful. We have had evidence from people who say that it has been tokenistic and that the role of the consumer has not been particularly well used by various governments. That evidence came particularly from Victoria, and I know you have done your study in Victoria. For the record, how do you see that intrinsic element of the role of the consumer operating in the development of policy on mental health?

Ms Gerrand—That is a difficult question to answer. Probably the simplest way of putting it is to say that we have all learnt along the way—consumers, policymakers and clinicians—and there is a long way to go. Someone commented, as part of my research when I was asking about the closing of psychiatric institutions, that consumers were not involved in the process of planning. That is something we would find unthinkable now, which shows how far we have gone in that sense. In 1991 the Commonwealth put out, as you are probably aware, the national statement of rights and responsibilities of consumers and carers. Most people have not even seen it. So there is a real need to refresh that commitment and put it up there as an absolute priority.

In Victoria we have been fortunate in having a state-wide consumer body—who I think you are going to hear from this afternoon—called VMIAC, the Victorian Mental Illness Awareness Council. That has had great strengths. It has been able to sponsor a lot of consumer oriented research and provide a big network to support consumer groups in Victoria. There is also the whole issue of consumer participation in services, where there have been consumer consultant positions funded for each service. Whilst at one level that has been tokenistic, it has been a real beginning.

The other thing is having consumer satisfaction surveys. That might seem tokenistic, but there is no doubt they have had a huge impact on services, because services knew that they were going to be rated by consumers on their performance. They also knew that they were going to be rated by family carers.

Another development which I think is really important to have alongside consumers is having carer consultants as part of services, as well as consumer consultants. Their interests can be different or they can be shared, but both need to be represented.

Senator WEBBER—At the beginning of your evidence you referred to the need to get the right treatment at the right time, and Senator Forshaw talked about the move away from institutionalised care to more community based care. One of the concerns I have with our discussions about specialist institutions is that it is a very capital city approach to treating people. I come from Western Australia, and there you will only get institutionalised care in Perth. Therefore, to give people that specialist care, you remove them from their families and carers. Do you have any views on what kind of support we need to give those families and carers to help them make sure the person they are caring for accesses the right treatment at the right time in regional and remote Australia, particularly Western Australia?

Ms Gerrand—There is obviously not going to be one answer or solution. It really is about taking account of where the innovations have been tried and where they are working. I mentioned rooming-in because it is one that is not well known, yet it seemed to be incredibly effective. So my question is: why didn't more people know about it and why hasn't that been tried out more? It does mean that people can actually stay in their own community and their families and friends are obviously very much part of that and can readily be part of their treatment. So there is a question mark about why it has not been tried elsewhere. It does still mean that there is specialist advice and intervention required, and the question is: how do you provide that? You may not have a psychiatrist, other than on the end of a video conference link-up or the end of a phone line. So that is something that is not easily answered.

However, you may well be able to have a clinical psychologist who is accessible, so that you are saying you are going to use your work force in different sorts of ways. Similarly, if you can, for instance, provide GPs who have training in GP psychiatry—and I mean the full training, not just the six or 20 hours that we were heard about earlier—they would be able to provide a higher level of service and treatment than has been available before. What I am saying is that there is no simple answer to that, but there are a number of different solutions that need to be looked and maybe packaged together.

Senator WEBBER—Does your organisation have a view about the better outcomes model and the six hours and the 20 hours?

Ms Gerrand—Our concern would be that there has been a rolling back of the funding. The loss of the \$18 million, when all reports seem to be that this is the beginning of a much more effective way of treating people at a primary care level, seems to be really retrograde.

Ms Laut—I think this is one of those things where rules get laid down, there is a cut-off point on an individual GP and you get a ludicrous result. Some GPs will use their allocation very early—within weeks, if not months. It is insane to have such tight rules that you cannot see that

you need to move the cap around rather than say, 'That money will not get spent,' and shift it sideways into another field. There needs to be intelligent reasoning behind some of these caps rather than just having them as one cap fits all. That is a significant problem.

I would like to touch on one other area that we did not touch on earlier but that I am sure you have had other submissions on, which is the problem that sits with law enforcement, a mental health care provision and people in custody. I think that this is a very significant area in which we do far too little for people who are taken into custody as a result of actions brought on by mental illness. They are substantially untreated while incarcerated and they go back out into the community untreated.

We have a very significant concern about the difference between actions undertaken through a desire to gain money, notoriety or whatever and actions undertaken by people who are much less capable, if not incapable, of sorting out their actions in public and who need care and help but are being forced by the lack of provision to be treated as though they are of the same criminal ilk as those working against society quite deliberately.

CHAIR—In fact, we have a submission that we are dealing with this afternoon on that subject. It argues that these are the people who are the most vulnerable in the prison system and more broadly. Thank you very much, Witnesses, for today's presentation and your submission. They have been really useful.

Proceedings suspended from 12.45 pm to 1.39 pm

OLSEN, Mr John Lloyd, Mental Health Consumer Advocate, Greater Southern Area Health Service

SKELTON, Mr John James, Convenor, Sapphire Coast Group, Association of Relatives and Friends of the Mentally Ill

CHAIR—Welcome. Is there anything you would like to add to the capacity in which you appear today?

Mr Olsen—I am appearing today as a consumer.

Mr Skelton—I am appearing on behalf of carers on the far south coast.

CHAIR—You have lodged with the committee a submission, which we have numbered 5. Do you want to make any changes to that document or any additions to it at this stage?

Mr Skelton—No, I do not think so.

CHAIR—I invite you to make a brief opening statement before we go to questions. I should point out that we are missing two members, but we expect them to be coming in shortly, so do not be surprised if someone walks in.

Mr Skelton—Thank you very much for the opportunity to speak to our submission. It is quite important for you to know where we are coming from in both of our cases. In my case, my wife and I have been caring for a daughter with a form of schizophrenia that is chronic, it is unrelenting and it does not respond to the current forms of antipsychotic medication. We have been caring for her for the last 25 years, so we have a depth of experience—my wife does as she is the primary carer—as carers. However, prior to that I had a career in mental health and mental illness. For 25 years I was a clinical and occupational psychologist, including being in charge of psychological services and research for the Australian Army in New South Wales. I was also with the New Zealand forces for two years on exchange duty where I was in charge of their personnel research and psychological services. So as well as being a carer, I have had professional experience.

During my period as a carer, I have kept myself sane by being involved in carer support services for the mentally ill at both state and national levels. I was the president of the Queensland ARAFMI and the president of the national ARAFMI council and their representative on the Mental Health Council of Australia. But I have only been in the far south coast of New South Wales for the last 2½ years, so my depth of knowledge of the services there is not nearly so great as John's; he has been resident there for a long period.

I would like to leave most of the detail we are presenting and commenting on our submission to him, but I would like to make some general comments as I am able to compare what I have observed on the far south coast with what exists elsewhere, particularly in Queensland. I had a fairly intimate knowledge of services throughout Queensland in my position—I was also secretary of the umbrella organisation for non-government organisations in Queensland—as well

as Australia wide through the Mental Health Council of Australia. I feel that services on the far south coast of New South Wales have all the virtues and all the shortcomings of most of the services throughout Australia—only more so. My experience so far of the far south coast of New South Wales is that it is the end of the line as far as state services are concerned. It is almost a forgotten corner of the state where the services are, in fact, minimal in most respects in the area of mental health.

We suffer from shortages of funding. No psychiatrist is resident in the area; we have a visiting psychiatrist from Canberra for a couple of days a month, I think. It is a very basic service. It is therefore very difficult to relate it to my other experiences. Generally speaking, it is far and away below the services that I experienced in Brisbane and in other areas of Queensland, particularly. Had my wife and I not had a wealth of experience as carers, our daughter would have suffered greatly by that dearth of services. I will leave the rest to John, and he might ask me to comment about various aspects of my experience.

Mr Olsen—I am one of the lucky ones. John's daughter is a person whom I have never met. But from what he tells me, and from what I understand, her schizophrenia is resistant to treatment, meaning the medications. When I take medication, the period from being to sick to becoming well and being discharged from hospital may take as little as one or two weeks. Then I am ready and quite happy to go. Within the next few months I get back to more or less 100 per cent of my previous functioning. I am very lucky in that the medications work very well for me; they suit me. I have not been as well in my life as I am now that I am taking Risperdal. I do not mean that as an advertisement for the drug itself, but it means that I am the lucky type of person with the genotype that the treatment works for. That is how I can be a consumer advocate and maintain a three-day-a-week job. I also do voluntary work on a community housing board. That is not the case for probably 80 per cent, at least, of people with schizophrenia. If you ask the opinion of their treating psychiatrists, people are generally not expected to get to my level of functioning, and that is a cause for concern. I would like to point to the question of whether drug treatment alone is going to be the answer for most people with schizophrenia or psychosis. I will leave that as an open question.

Broadly, as I see the service from my point of view as a consumer advocate—and bear in mind that I am employed by the Greater Southern Area Health Service, so I am not an entirely independent person; there is a bit of a tendency to defend the service for the situation they are in with funding and so forth—I do have a role to be critical of the service, and I see two main areas to be critical of. Firstly, funding is inadequate. There are not enough hospital beds, as we mentioned in our submission. Because of the lack of beds, there is always pressure to discharge people while they are still unwell into the community, and carers and the community at large have to cope with people who are not really quite well enough, I think, to function independently in the community without support. It happens a lot. People eventually get better if they are lucky. However, there are those who, without the supports and the necessary time available to be put in by mental health workers, end up on the wrong side of the law, in bad company and getting into trouble. That has happened to me in the past. In 1989 I went off medication. It was not malicious but I guess it was just out of a lack of understanding of the real need for it. I ended up in jail after a bad episode in which I assaulted several people. It was in jail that I learnt that for me medication is a lifeline to wellness and that, being as lucky as I am, it works. So I need to keep taking it. I have learnt in that way but a lot of people are not as fortunate as me. I had a good education and a good, loving background with my family—I have a lot of good things to fall

back on. But a lot of people in the community do not have those things to fall back on, and sometimes medication does not work as well as it might and the supports are not there.

On top of that, there is my second point. I have said that funding is an issue. The second point is the expertise of staff in mental health. There are a lot of good workers, I must admit. By and large, when you ask consumers and carers how their treatment has gone, which I do as part of quality assurance efforts in the southern area, they say, 'We respect our mental health workers greatly.' Generally that is the case. However, there are people who are too hard to handle. There is a class of people who you can more or less name in any area dealt with by any team in Australia who would be the problem people. Dealing with those people, you can more or less predict that they will at least get into trouble with the law, if not go to jail. There is more that you can do than is being done to keep them taking medication and at least at a reasonable standard of mental health. That involves involving carers. That involves supporting people, giving them hope and so forth. The crucial thing is involving carers, because quite often they are the people who can be the most help when people choose not to take their medication, for example, or to deny that they have an illness.

I notice a big problem with getting mental health workers to realise how useful carers can be and to involve them effectively as a normal part of their practice. The previous submission, before lunch, was talking about this. Even though it is well known that the best practice in mental health is from the very outset to involve carers and families in an inclusive way and you have to get around problems of confidentiality by basically ignoring it at first and saying, 'Everybody needs to be involved in the treatment who wants to be involved,' that is not done enough by workers.

There are all sorts of ways that you can help people to stay well. I must admit I am talking about seriously mentally ill people now, not so much about those with anxiety and depression. I am talking about people with psychosis and severe depression who would benefit from relapse prevention plans, which once again involve carers. These can be a very good way of keeping people well insofar as they involve people being able to notify at the earliest stages of somebody going off the track. That is not being used by most mental health workers even though it is mandated in New South Wales as part of good practice. Relapse prevention plans could be very useful, and at the most I would say that five per cent of people in the state who need a relapse prevention plan actually have one. By that I mean a documented plan. The intake system of the local service where you live would need to have a copy. When a carer rings up and says, 'My son'—or daughter, for example—'has a faraway look in their eye,' quite often the response is, 'There's nothing we can do because this is not serious enough and it does not meet our intake standards.' But the situation is such that, if you do not act then when there are just the earliest signs happening, you miss the chance to prevent a lot of drama, trauma and trouble for families as well as for consumers.

Relapse prevention plans are something that I am always extolling the virtues of. I have had one; it has worked for me. In 1998 it kept me out of trouble. It kept me working in the community, doing the work I was doing, without having to go to hospital even though there was a problem with my medication. So I know from first-hand experience how well it can work and I just wish there was a way of making mental health workers more generally understand just how useful and necessary they are. That is in the line of expertise. I am talking about relapse prevention plans as one example of best practice which is often not being followed.

Expertise is a whole area that needs to be addressed. I do not really know exactly what the solutions are. You would imagine that training is part of the solution but part of it is also the culture of the mental health service. I cannot really say anything more than that. If you have problems with the culture, if you have problems with morale, if you have problems with commitment to the job that is supposed to be done then you will not get the best practice happening. It just does not happen. Relapse prevention plans are one example of it.

The other area I mentioned was funding in general. Without enough hospital beds—and that is just the very basic area where funding is needed—you are going to have a lot of problems in the community because people cannot be held beyond the numbers that they are allowed to be in the acute unit. So there is a problem there. I will stop there and leave it at that.

Mr Skelton—I might comment on the issue of culture and its relationship to the limitations of the present treatment model for psychoses. I think there is a vital link between those two things. The present drugs for treating psychosis are very blunt instruments. They have very severe limitations. As John said, only about 15 to 20 per cent of people reach a level where they can live independently. For mental health workers that must inevitably be frustrating and limiting and over time must create a culture of feeling a failure. That shows through. I have been observing it for the last 25 years. You can see it very plainly. The culture is there, underlying it. That is fundamentally because of the basic limitations of the present medication model, which consists of treatments that were devised in the 1950s. With a molecule being tweaked here and there, there have been a few changes and a few improvements which have reduced the often severe side effects of these medications, but they still are not getting more than 15 to 20 per cent of people, at best, sufficiently well enough to function effectively in the community.

People are dependent on the support of their families. One of the problems with so many people with psychosis is that they have no insight into the illness. One of the effects of that is that they often reject their family. Our daughter regarded us as the cause of her illness for a long time. She has accepted it now and continues to live with us. Had we not been able to give her a haven and strong support and care throughout that period, she would have been on the streets or in a grotty boarding house. She would be on drugs, in jail or most probably dead. It is as severe as that.

I do not want to expand on treatment issues because I have had an invitation to appear on behalf of another organisation that has made a submission—the Bio-Balance Health Association—which has brought to Australia a form of treatment. My daughter has been on this treatment. It is complementary to the conventional antipsychotic medications. She has only been on it for the last three months and in the last three weeks she has started to respond. She is starting to become a normal person again. After 25 years that is something to be remarked on. It has given us new hope. I will have the opportunity to present on that matter later, so I will not expand on that now. I would like to make the point at this stage that the severe limitations in the present medication program model are a very basic cause of everything you are looking into now—in relation to psychosis certainly.

CHAIR—Thinks, Mr Skelton. Mr Olsen, I want to ask you about the services you were provided with in prison. We have had a number of submissions that have suggested that people are so desperate for services that they commit some crime which lands them in prison for that very reason.

Mr Olsen—I tried to do that myself when I was without food, accommodation, money and support. I simply refused to pay for a cup of coffee thinking I would be arrested, but it did not happen. I have been in that situation. In my sickness—this was at a time when I was not taking medication—I have sought refuge in a prison as at least a shelter over my head and a guaranteed meal.

CHAIR—Can we ask what prison that was?

Mr Olsen—I was in Perth at the time. I did not actually go to prison but I was in Perth expecting to go who knows where. It is a long story. I was actually absconding from my duty to report to the police in New South Wales. I just got into a situation where I was very sick. I took my last money, got on a plane to Perth and then was stuck in Perth with no money, no social security, no nothing and ended up, naively, thinking that by refusing to pay for a cup of coffee I would go to prison. That is what I ended up doing to try to get some sort of shelter. I had been around the shelters in Perth and had been refused entry because there was no space or whatever and was facing another night in a park on a bench. That was my option.

CHAIR—What were the mental health services you received in prison?

Mr Olsen—This was back in 1990 or 1991. It took them a long time to realise I had schizophrenia. When they did, I was put on medication. I think I lasted two weeks on medication and then came out. The first time I was due to get a top-up injection, I said, ‘What happens if I refuse to take it?’ The nurse said, ‘That’s your prerogative. No worries. Off you go.’ This was, like I said, over 10 or 15 years ago. I do not know if things have changed since then.

I also found somebody in a Perth prison—a man with a white coat who I could not really believe could possibly be a nurse but who seemed to be a nurse; at least, he had a white coat—who said to me: ‘This medication is bad for you and you do not have to take it’. This was a separate incident. He recommended that I just not take the medication because he thought the side effects would be too bad and he had never seen any usefulness in the medication, and probably the best thing was for him to turn a blind eye and for me to walk off. So that is twice I have been allowed to neglect my responsibility to take medication, or at least have not been assisted in taking responsibility that way. It just led to further exacerbation of the illness and a continuing of dysfunctionality. That is hopefully changing now. There must hopefully be more education of prison officers about mental illness. I know that the attitude was very slack. That was at Long Bay jail. The one where the guy in the white coat said, ‘Don’t take the medication’ was in Perth.

My last port of call was a prison in Parramatta after I left Perth and was taken back to Sydney. This is where it is about luck, because I happened to get a psychiatrist who was very good and who realised first off that I had schizophrenia. She actually went so far, probably contrary to ethics, as to say, ‘We won’t allow you to stay on protection unless you take your medication voluntarily’. So protecting my life was why I was on protection. She said, ‘I won’t allow you stay on protection unless you take the medication’, which is probably bad ethically in some senses but for me it was the best thing that happened. That was January 1992 and since then I have never gone off medication. It was the beginning of my reawakening and relearning how to live, basically. So I am thankful to the psychiatrist for going that far to indirectly threaten my life

to get me to agree to take medication voluntary and thereby to start a process of recovery that continues today.

There have been good patches and there have been bad patches. The Long Bay prison hospital, where I did spend some time, does have good facilities. But, as I said, once I got out, the first time I went for a top-up I was able to say, 'I don't want it', and that was okay. So there were definite problems there back in 1990.

CHAIR—I would like to make the observation that groups such as yours, who are consumers and carers combined and even service providers in some instances, present us with a perspective quite different from that of consumer organisations alone. In Victoria we heard from a consumer legal centre and a consumer representative centre. Both were fairly clear about whom they represented and it certainly was not carers and families. Can you explain to the committee how your organisation works and why you think it is important—presuming you do—that the two come together?

Mr Olsen—It is so important in general. I know from research that at least 50 per cent of consumers live with carers; they live with their family or other carers. As a consumer advocate, that means that at least half my constituency would be needing their carers. I know that if you have a serious mental illness you need your family. You may hate your family when you are ill and you may think that they are the cause of all your problems—as John said about his daughter and as has been true of me when I have been ill—however, there is a family's overriding duty of care that does not have to be legally enforced; it is just there. It is the most useful thing for consumers to have. Families are doing it out of their own heart and out of their need to do the right thing. I cannot be compassionate and not include carers in the work I do, otherwise it does not make sense. Consumers are members of a community, and the first line of that community is our carers and our family; it is the part closest to our lives.

I know there is a lot of suspicion in the consumer movement about carers and their motives. I am really against that divisiveness. I am so much in favour of carers being on our side and our being on their side. We can certainly have differences and there will be lots of tensions over things and behaviours that people have exhibited but overall there must be a long-term community orientated goal of unity. That is what guides me. I would not think of doing anything without a carer if there were a carer issue involved. For example, I would not think of coming here today without John or a carer to represent their side of the story, as it is just so important. Even if you took the selfish view of what is best for consumers, you would involve carers. What is best for everybody must involve carers.

Mr Skelton—How it works in our area is that the consumers have their own organisation and the consumers have their own group but we meet in a forum. There is a tremendous amount of common ground but consumers have their own separate, specific interests and concerns and carers have their own specific interests and concerns. We are able to discuss those things in our own separate groups and to work together with them and we meet periodically as a forum and then we are able to share the common ground. That works extremely well—that is my experience.

Frankly, it is the first time I have had this experience because up in Queensland—and indeed nationally—my experience has been of a purely carer organisation. Carers' primary concerns are

the consumers. They are not putting themselves first. They do not put themselves first—that is my experience. There are families who have people with a mental illness and who put themselves first, but the first concern of people who take on the role of carer is the ill person and other people who are ill. So there is a tremendous amount of common ground but there are also separate interests, and I think that has to be recognised.

Senator MOORE—Mr Skelton, I can remember your work with lobby groups in Queensland. One of the things that we found in a previous inquiry concerned the situation of carers who were caring very strongly for a family member but were themselves becoming ill or getting older and were concerned about what was going to happen to their family member. I am aware that your organisation has done a lot of work in this area. For the committee's benefit, would you like to make a comment on that?

Mr Skelton—I would love to make a comment on that. As a matter of fact, that has been one of the areas of my activities in Queensland. It does not apply only to people who are mentally ill but to all carers of people with any long-term disability: 'What is going to happen when we die?' I am 80 years of age. We moved down to the far south coast of New South Wales and built a house next door to our son. We recognised the problem; he recognised the problem. He said, 'If you are prepared to move down to where we are, we'll build a house next door.' He subdivided the land and he will care for his sister once we are no longer able to. However, while in Queensland I recognised this problem. I was starting to get more and more worried about it and so was my wife. I started looking on the internet for possible solutions that have been found elsewhere to this problem. The United States and Canada have each developed a slightly different program. The program in the United States is called the Planned Lifetime Assistance Network—PLAN. The program in Canada is also called PLAN, but it is the Planned Lifetime Advocacy Network. The difference in name reflects their slightly different approaches. The United States were first and Canada took up the baton and shaped it slightly differently.

I decided: 'We have a problem and the best thing we can do is try and build a similar sort of organisation in Queensland.' New South Wales was involved, but that is a longer story. New South Wales ARAFMI was involved, but they decided not to go on with it. I was president of ARAFMI Queensland before I moved down to New South Wales two and a half years ago, and I have kept in close contact. The Queensland government, I understand, is about to provide seed funding for an organisation which has been developed along similar lines to the Canadian and United States programs but is shaped to suit the needs of the Australian situation. There is a whole field of endeavour there that looks as though it is just about to start to get legs. Once it does get started, I feel sure that other states will take it up over time. It is a very, very important issue, because that is the greatest worry of carers who get to around the age that I am, and younger carers too. A lot of the people who are involved in it in Queensland are younger carers of people with other disabilities, in fact. That is something that is emerging now, and it is a very important development.

Senator MOORE—And we should follow up with the Queensland mob to see what they are doing.

Mr Skelton—Yes. I will let the secretary know the contacts so that you follow up on that, because it is a very important development.

Senator MOORE—That would be very useful, Mr Skelton. Thank you.

Senator HUMPHRIES—You use a couple of acronyms in your submission. What does NEAMI stand for?

Mr Olsen—That is the North-East Alliance for the Mentally Ill, based in the north-east of Melbourne.

Mr Skelton—It is a non-government organisation which provides support services for people in their homes. I understand it also sets up supported accommodation. That is a very important aspect. In our area there is virtually nothing in the way of supported accommodation. For people who do not have family support or in the case of families who cannot have the mentally ill person living with them, that is an absolutely essential form of support and it is completely lacking in the far south coast of New South Wales.

Senator HUMPHRIES—Is ARAFMI the same kind of organisation?

Mr Skelton—ARAFMI is the Association of Relative and Friends of the Mentally Ill. Once again I will refer back to Queensland and what we did there. My wife had not had a holiday from caring for our daughter for 15 years, and I became rather perturbed at this. I was President of ARAFMI, so we developed a program to provide respite care for families and people with mental illnesses. We got funding from the Queensland government and we set up a service for the south side of Brisbane, and another service for the north side of Brisbane: a five-bedroom house in the community where people with a mental illness could come on a daily basis or they could come and stay overnight or a couple of nights, they could come and stay up to two or three weeks, so that the family could have respite. If they stayed for two or three weeks, the carers could go away and actually have a real holiday. That is something that is rare for carers. It is working extremely well. There are two services in Brisbane which are working extremely well and are providing excellent support for both the ill person and their carers. I can provide the secretary with contact details.

Senator HUMPHRIES—We are going to Brisbane next week, so we can have a chance to catch up with them there. You also mentioned the lack of acute care psychiatric hospital beds in the southern area and you say that the only resource in the region is the Chisholm Ross Centre at Goulburn. Would beds at the Canberra Hospital be available to you?

Mr Olsen—They do become available, but not in significant numbers—and there are always cross-border issues and so forth. But they do become available occasionally and are used.

Mr Skelton—But they are generally not accessible. Goulburn is six hours travel away. There is no direct service. You can go to Canberra by bus and catch a train to Goulburn if you want to go and visit the mentally ill person who is in hospital. If the family wants to go and visit, it takes six hours to travel there. Care for people with mental illnesses is supposed to be community based, and the most important part of the community is their family, surely. It infringes the concept of community care to have the only hospitalisation for people with mental illnesses six hours away.

Senator HUMPHRIES—Mr Olsen, what were the cross-border issues that you just referred to?

Mr Olsen—Just how we are not in the ACT, for example, from the point of view of the hospital. They cater for a certain population, so there are a certain number of beds available for your population. If there happens to be a vacancy then people are admitted, but if they are full—which I think these days is usually the case—then you do not get a bed. In practical terms, the vast majority of people go to an acute unit go to CRC if they live in the southern area.

Senator HUMPHRIES—In Goulburn?

Mr Olsen—Yes.

Mr Skelton—There are only 15 beds available at Goulburn. Even on the basis that the New South Wales health department works on, the population of that area means that there should be 45 beds for that area. It is for the whole south-east corner of New South Wales. It is utterly absurd.

Senator WEBBER—Following up on that issue: you say in your submission that there should be 45 beds in the region. In arriving at that figure, I take it that they are 45 beds that would have a fairly high—

Mr Olsen—That is the formula that the New South Wales government uses. It could be a national formula; it is a stated formula that the strategic plan of the old southern area stated. The formula comes up with the population that we cover. That hospital would need 45 beds under the formula that the government itself uses.

Senator WEBBER—But that would be 45 beds at a fairly high utilisation rate?

Mr Olsen—That would be 45 beds to cover adequately for the 280,000-odd people.

Senator WEBBER—And you have 15?

Mr Olsen—It is hard because there are actually 20 beds there. However, there is Wingecarribee Shire, which is between Goulburn and Bowral. It is right next door to Goulburn so it is not in the area health service but everybody goes there. They have five beds for those people so there are 15 beds for the rest of the people. That means that the whole South Coast has five beds available to it. For Bega Valley and Eurobodalla Shires—that is the lower half of the South Coast—we have five beds that we can use at any time.

Senator WEBBER—And what would your population be?

Mr Olsen—It is a bit over 70,000.

Mr Skelton—The result is that most of the time people are discharged from hospital when they are still not stabilised.

Senator WEBBER—That is the point I was coming to. If you have a need for 45 beds, where do the people go?

Mr Olsen—They go home. They go home, to jail, back to the streets, or whatever they happen to fall into.

Mr Skelton—The police take them up—six hours travel. I know a case where the person was taken up by the police on Friday. They were discharged on Monday and had to find their own way home. They returned home about a week later, I think, and that was probably purely accidental.

Senator WEBBER—When they were not well and did not have resources anyway. You also mentioned before, I think, Mr Olsen, the lack of psychiatric services.

Mr Olsen—Do you mean the lack of psychiatrists?

Senator WEBBER—Yes. That is obviously a nationwide problem. I am from Western Australia and we feel it particularly acutely outside Perth. You cannot find a psychiatrist outside Perth. What about the other health professions that specialise in mental health? Apart from the acute care beds that you have, are there other services provided in your region?

Mr Olsen—Yes, we have mental health workers and mental health teams—one for each local government area that we come from. There is a team—of, I think, 14 members if you include those for children and adolescents as well as adults—of professionals who range from social workers, occupational therapists and psychologists to mental health nurses. They all do a very good job. In fact, the better members of the mental health teams are likely to be advising GPs what medication is necessary because GPs are not usually so across the whole area. There are some very good workers but there are also some not so good workers, and that is a problem because mental health consumers and carers suffer from less than adequate practice.

If the question is about whether there are enough people in the teams to service the number of people in the community who need their services, I think it is a moot point. Maybe if everybody was a committed and skilful mental health worker you could do it on the case management loads that are mandated now—that is, about 20 per case manager. However, the fact that everybody is not doing their jobs as well as they could means that there are not enough people to do the job. There are other shortfalls. For example, if you wanted somebody to be followed up every second week for their injection—maybe they typically run off when it is about time for their injection—you might try to dedicate somebody to spend a whole day chasing them around town. There are places they can hide—they can go bush and there are all sorts of areas where people who are at the problematic end of mental health can abscond to, to avoid their injections. If they do not abscond, those people can make it very hard for anybody to pin them down long enough and give them an injection. If you wanted people to be on top of those people and get their lives back in order you would have to involve carers and community. And you would probably have to change the situations that they are living in—their accommodation and their ‘colleagues’, for want of a better word. There is more work there than you can possibly do, with the current number of case managers.

Quite often you wash your hands of people who present problems like that and say, 'See you in jail.' Health workers end up more or less knowing that people are going to get into trouble. Those people are sold down the river because they do not have the time to chase them up and turn their lives around so that they develop an attitude where they might take a bit more responsibility for themselves. In those cases you might need to put in work related to the role of medication in staying well, and so forth.

I do not want to paint too bleak a picture. It is obviously not everybody with psychosis who is like that, but these are the people that you read about who are filling up the jails. They are the dribs and drabs from all over New South Wales who are the absconders, the ones who do not want to face the fact that they need an injection to keep at least moderately well. These are the people who are falling through the net.

Mr Skelton—I might just make the point that it is not just people who do not want to; it is also people who do not have the insight to know that they need the medication. That is probably the most important factor. If they are in a severe psychotic state, they do not know that they need treatment. My daughter still, after 25 years, does not have any insight into her illness. It is only because we have made it a condition of her living with us that she take her medication that she takes it. She still tries to avoid taking it. My wife puts it in water and watches it go down. That is the only way we can be sure that she takes it and that she keeps well enough to stay with us.

Senator WEBBER—Finally, Mr Olsen, you mentioned relapse prevention programs. I was wondering if you give the committee a bit more information on how effective you think they are. Is that something peculiar to New South Wales?

Mr Olsen—I do not know how widespread it is.

Senator WEBBER—Do you think it should be widespread and available to everyone?

Mr Olsen—Yes, I do. I think relapse prevention plans should be a mandated part of all mental health work. It is on the MHOAT form in New South Wales—the feedback form the clinicians have to fill in. It asks, 'Do you have a relapse prevention plan?' The problem with that is that you are asking people who may not necessarily be the most honest of workers about whether they have a relapse prevention plan in place. If you ask them on a form where the obvious answer is yes, they are going to say yes, aren't they? However, if you then turn around and ask the consumers and/or carers—the people related to the case that you are talking about—whether there is a documented relapse prevention plan, and if it is working, they will say, 'No.' There is no document and there is no plan; there is a loose verbal agreement that, if the person gets sick, you can ring the 1800 number and get back in contact with the mental health service.

You need something that is more elaborate than that where the early warning signs are delineated and where you involve the person as the consumer. Hopefully, you are trying to get their agreement as to what the early warning signs are. It takes a long time to even get the person across the concept that they might have early warning signs, and what they are for them when they get ill. Get their agreement but, more particularly, get the carer's agreement on what the early warning signs are. This is what we notice: if you get the consumer carer and the mental health service to agree what the early warning signs are with the objective that, as soon as those signs start to appear—the carers do not have to go back to the paper to see if they are there; they

know as soon as they look at the person that something is happening—they have more or less a contract with the mental health service that something will be done now that the first signs are appearing, rather than two weeks later when the person has taken off and got into trouble.

For a long time, and still, mental health services are likely to say when a carer rings up, as I said before, that they cannot help the carer at the moment because the person is not sick enough, or they say that this person is not wanting help from the mental health team and, until they commit a crime, they cannot do anything. Relapse prevention plans are about ignoring that whole approach and saying, 'Let's get in at the first signs; let's put some pressure on.' You do have to put pressure on. When the plan worked for me, they had to sit around and threaten me with a schedule that I would go up to Goulburn. It was either that or I increase my medication voluntarily. Faced with that situation, and being on the border of being unwell and losing my insight, I was able to say, 'All right. It will be easier for me if I stay around, keep working and increase my medication.' You need to put a bit of pressure on people but you cannot do that unless the carers, who are the first ones to notice, get in early and tell the mental health team. Then we can have a meeting, we put a bit of pressure on and we sort the problem out. It might not just be medication; it might be more than that. But, whatever the problem is, at least early intervention will make it easier to fix the problem before it gets so bad that the person is way out there.

Mr Skelton—I might add that over 25 years no mental health worker has ever spoken to either me or my wife about a relapse prevention plan, and I do not know of any other carer that I have struck to whom any mental health worker has spoken about a relapse prevention plan. So that is a reflection of the fact that it is observed in the breach!

CHAIR—Indeed. We will have questions about that as we go around, Mr Skelton.

Mr Olsen—I will just mention that Debra Rickwood at the ANU has put out quite a comprehensive paper on relapse prevention. It is very early days yet. Debra Rickwood is the author. She is an academic at the ANU—or at least she was. In that paper, she is dealing with relapse prevention at the early phases. I actually think we could go further than she has in the paper, but it seems to be more at the stage of establishing whether or not it is a good idea. I am sold on the idea. It has worked for me; I know it can be a good thing.

Senator FORSHAW—I apologise; I missed the start of your evidence, Mr Olsen and Mr Skelton. One issue that I do not think has been covered is situations—particularly, say, with carers and family members—where they run up against blockages or impediments with the bureaucracy in trying to locate their relative if they have gone missing and they know that they are having an episode. I am interested in any experiences or comments that you might have about situations where carers and family members have to deal with impediments or privacy issues in the system which prevent them from taking some action or being able to find out details about their loved one or even locating them. This has been brought to my attention in other inquiries: the person, who is overseas or interstate or somewhere, does not want their family to contact them, but they are seriously ill. One such issue was raised with me, where the mother was trying to get assistance from Centrelink for her son to get a disability payment, because he would not apply himself, but he did not want to do that. He had a paranoia about signing forms. You come across these cases, I assume. Do you have any ideas about how we can break through those issues?

Mr Skelton—It is very difficult because it involves legal issues, in fact. I think the situation does vary from state to state, because each state has a different mental health act. The situation is rather easier in Queensland, to my knowledge, than it is in New South Wales. In terms of the actions on the part of the professional and support staff in relation to this issue, the privacy issue, the difficulty is that they tend to stick to the legal framework of their particular state—for very good reasons, I suppose. So, when it comes down to it, it is a legal issue. The only way that that legal base can be overcome is to change the act to enable carers to have a say, to have access to information that they need. It is a very difficult and very thorny problem.

Senator FORSHAW—Part of the problem is that they may have to go to court to do it.

Mr Olsen—Yes, which I think is part of the problem. It becomes a legal problem and that in itself is the problem. When you actually treat somebody from the outset as if you want to involve their family, as if their family matters as much as them and as if it is completely natural that everybody would want to know how they are going and that their family or their carers are interested in the consumer's welfare—when the whole attitude from the outset is one of inclusiveness, you have more chance of re-including people when the person gets sick later on. When it is a legal issue, of course it is a minefield.

As a worker for the Greater Southern Area Health Service, I sign a confidentiality agreement. I am already a bit paranoid; it made me more paranoid to read it! You cannot say anything to anybody about anything without breaking confidentiality rules. I have been caught out at different times for telling people's mothers, for example, what was happening in their accommodation at the time. I have been told that I had done wrong thing. However, when I did the training about involving families, it appears that I actually did the right thing; legally, I did the wrong thing. If you go by the confidentiality agreement that health services get workers to sign—obviously inspired by the general health situation, where people have a right to privacy about their health condition—it starts to get ridiculous. When their accommodation and the lease that they are undertaking are at risk of falling over, you end up saying to their housing worker, 'We can't talk to you about your housing client, because of their confidentiality rights.' We can't talk to the carers, because of confidentiality. We can't talk to bloody anybody because of confidentiality. It is a problem that does probably need a legal remedy, but as long as you are thinking in legal terms you will not be helping consumers and carers to solve problems.

Mr Skelton—It works well when the professionals work on the assumption that the family, if they are willing and able to be involved, are a necessary part of the treatment program—that they are an essential part of the whole scene. Of course, even then, because the ill person might be paranoid and feel that their family are the cause of the problem, you can still have a very thorny situation. We have just assumed that we are part of it. We have talked to the professionals on the basis that we assume that, and most of them have responded, with certain reasonable reservations. Both my wife and I have been used to negotiating this sort of thing. My wife was a nursing sister so she has the appropriate background. We are fortunate in that regard, but most or a great many families strike tremendous difficulties in this area.

Mr Olsen—I know that the problem at the Chisholm Ross Centre, for example, is that if it is a known fact to the nurses that the consumer has said, 'I don't want anything to do with my family,' then when that person's carer rings up and asks for even general information—even

general information about how the person is travelling on the day—quite often it is not given. I do not think that is right. I think general information should be generally available to families.

CHAIR—Thank you very much for your presentation and submission, and for coming all the way to Canberra to give evidence today. We very much appreciate that.

[2.38 pm]

LEAHY, Mr Denis, Alternate National Councillor (NSW), Pharmacy Guild of Australia

MAY, Ms Khin Win, Policy Officer, National Secretariat, Pharmacy Guild of Australia

SIMMONS, Mr Paul, National Councillor (SA), Pharmacy Guild of Australia

CHAIR—I welcome representatives of the Pharmacy Guild of Australia. You have lodged with the committee a submission, which we have numbered 295. Are there any amendments or additions that you want to make to that document?

Ms May—No.

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

Mr Leahy—On behalf of the Pharmacy Guild, we would like to thank you for allowing us the opportunity to address this inquiry into mental health services. As you are obviously aware, the community pharmacy is well represented across Australia in both rural settings and city settings. We form an infrastructure that has the ability to deliver health services in a wide variety of areas. Community pharmacies have been working with government on a number of funded projects, including medication reviews and consumer information, and a variety of other products and services that are available through the community services—particularly in relation to the Pharmaceutical Benefits Scheme.

Residential medication reviews for people in residential care have been available since 1985 and, in more recent times, home medication reviews, a collaborative service between GPs and pharmacists that provide additional reviews and safeguards for people living at home, have been introduced. As of 30 June 2005, some 77,855 home medication reviews have been completed since its inception in October 2001. This program has been seen as a very successful program and obviously the integration with mental health, as a step to providing services for mentally ill people, means this service has great potential to work for them. In 2002 the initiative of the Commonwealth and the Pharmacy Guild saw the development of a consumer information program for medications, and that is giving more accurate information to people when they have prescriptions prescribed. It is also seen to be of great benefit for people understanding, and their carers understanding, the medication that people have.

We believe that pharmacy has a unique position in being able to promote mental health issues and actually make some contribution to improving the outcome for people who may be involved in handling mental health. In recent times health promotion through community pharmacies has been a common sight. We give an example of the introduction of the organ donor register through community pharmacies and our work with the Commonwealth on this. In New South Wales we had a very successful mental health awareness campaign where people were able to self-evaluate their need for further help, and the community pharmacies were involved in that.

Dissemination of information to communities, in a way that uses an already existing infrastructure, is very important for us to maintain our face with people.

In rural pharmacy we represent a face that is quite often the first port of call because of the scarcity of other services in certain areas. I believe that has the potential to be developed, in the case of people dealing with mental illness, to get the pharmacies more closely involved. We note that the vast majority of people with mental health issues are living in the community; a few people are in residential care, but most of the people are, in some way, in care in the community. We believe that the community pharmacies have a role in normalising those circumstances and developing and working with GPs to have the best outcome for the patient, for the community and obviously for the carers and the families who are looking after those people. We believe the pharmacists also, under different programs, are in a good position to explain pharmacology and the effect of these medications upon the patient who is taking them and, obviously, to allay any fears that this medication would, in some way, harm their outcome or make their condition worse. That becomes a pivotal role in gaining the confidence of both the carer and the patient.

In broad terms, activities that we would foresee ourselves involved in would obviously look at explaining the drug therapy to people as they are getting their medication, to reinforce what the doctor has already provided for them, to have the infrastructure available to deliver information to carers and to patients. We also hope to follow up with medication management for those people who are in the community and making sure the optimum conditions for their treatment are maintained; to identify potential side-effects that may, in some way, make the medication less acceptable to people, but obviously weighed against the end benefit that they have; and to make sure that, in some way, the carers and other people supporting them are provided with adequate services and management along the way.

We believe that the development of care plans with general practitioners involving community pharmacies has the enormous benefit of tying up a number of these areas that are of concern to us at the moment. We would also like to look at the policy of post-discharge care for patients who are leaving institutions where they have received help for their mental illness, and we look forward to having both case conferencing and developing care plans as one of the pivotal roles that community pharmacies, GPs and other workers would provide in maintaining these people in communities in as well a state as possible.

I would like to address some of those areas where we believe we can actually provide more help to the community at a later stage during this presentation. Perhaps I could now defer to both Paul and Khin to explain where the community pharmacies at this stage interact and where we see people being at. Then perhaps we can discuss and put forward some solutions we believe are worthy of consideration to see if the situation can be improved. Thank you.

CHAIR—If you are both going to speak, can I ask you to be as brief as possible so that we have time for questions.

Mr Simmons—I will just give a brief outline. I am community pharmacist who spent my first 20 professional years in the country and moved to the city seven years ago. When I bought my pharmacy in the city I got a contract to look after a mental health outpatients service. In 1998, that outpatients service ran a clinic. All patients went to that clinic and the clinic, through the state government, paid for their medication. We packed their medication if they wanted to, the

clinic delivered it or the patients came in—whatever suited the patient, we did. The clinic nurses and social workers went out and gave injections when they needed to. People were either community patients or ones called CTOs—community treatment patients with a court order that insisted they be medicated, similar to the gentleman who was sitting here.

For some reason, in 2001 there was a change. It became cost driven and not outcome driven. The patients who were not on community treatment orders were shipped off to GPs and no longer saw their psychiatrists. The case workers only then intervened if the patient asked. If you are mentally ill, you do not necessarily want to ask to be helped, because you do not know you are unwell. In the period of four years two patients I knew have died from complications from their medication. That was in the city. In the town where I have my country store we had three suicides related to the withdrawal of mental health services. When you are talking about a town of 3,500 people, three suicides is fairly significant in a short period of time. After those suicides, the mental health organisation took more control.

I was quite upset about this, so I was introduced to Khin, and I put in a submission, which you have received part of. I come from a community pharmacy background where I feel that the mental health population have been let down mainly for cost reasons rather than for health reasons.

CHAIR—Who made the decision in 2001? Was it the state government or the federal government?

Mr Simmons—It was the state department of health. They wanted to reduce their costs. They had the philosophical thought that people who are out of institutions should have some control of their outcomes, but the way it was done they were abandoned. Before coming here today I rang a few people who still are in the industry. I spoke to a doctor who runs a community outpatient setting and he said that they have been abandoned. If the doctor cannot handle the traditional doctor-patient relationship, they refer them to a specialist and the specialist then gets back to them and tells them the best treatment. He said that that's okay, but now it takes three months.

People get discharged from hospitals and sent out to their GP. There is a shortage of GPs in rural areas and in Gawler there is a three-week wait and because they are non bulk-billing doctors there is a \$10 charge. Unfortunately, mentally ill patients would much rather spend their money on cigarettes than on their health. It is part of the condition; they cannot help it.

We have one example of a pharmacy that I know. Their region has not been deregulated. She looks after 100 patients per month and packs all the medication, at a state government cost of \$3,000. That is what she bills the state government. Most of those medications are subsidised by the PBS. That is \$3,000 for 100 patients. If just one patient spends a week in hospital you have lost all that saving.

CHAIR—That is the cost that goes to the pharmacists for doing the packaging up, not for the costs of the pharmaceuticals.

Mr Simmons—The cost of the pharmaceuticals is borne by the federal government under the Pharmaceutical Benefits Scheme.

Ms May—I have some of the blister Webster packaging to show to the committee. We can leave it with you if you would like to have a look at it.

CHAIR—Thank you.

Mr Simmons—Denis will talk about the solutions which we propose. Then you can ask us some questions.

CHAIR—Are the solutions in your submission, Mr Leahy?

Mr Leahy—One of them is not.

CHAIR—Tell us about the one that is not. You can assume we have read your submission.

Mr Leahy—What is available to the GPs is an extended care plan that would list the people who would be providing help to any patient that has this care plan. Where we believe this has some benefit is where the community pharmacy is identified as one of the participants in the care plan and the GP or specialist say that this mentally ill patient would receive considerable benefit from having unit dosing, from collecting the medication from the pharmacy or from some other way of taking their medication on a regular basis and having it listed up. We believe that that should be an identifiable way of linking into the care plan. A subsidy could be offered to the patient to come and get those Webster packs packed up each week. If the care plan is done on discharge we know the patient is leaving an institution to go to a GP or psychiatrist for ongoing care so we have a way of following them up. If they sign the care plan in the community it could well have all the elements of the care plan, like sharing information. If you were a carer you could be part of a care plan. If the person in treatment agrees that the carer shares information so would the pharmacy, the caseworker and a number of other people. You would get over the problem, maybe legally, of having a number of people seeking certain legal ways of obtaining information.

The third way is that if people who have Webster packs made up for them collect them at the pharmacies you can see what they look like each week or so when they come in, and you can see that they have picked their pack up. You can probably arrange for payment to be made through Centrelink so that these people do not have to worry about money. They could then be free to have their medication, unfearful of being denied it because they do not have any money. The other important thing is that when they do fall off the rails you have a very quick system of reference back to the GP to manage these people. The care plan gave you the outcome, people who are responsible and a mechanism when things did not work. I believe care plans should involve unit dosing and a referral system within them. That warrants serious consideration.

CHAIR—Thank you. I thought your submission was very interesting. The suggestions you make to the committee are very good ones. I have a couple of questions. You say pharmacists might be able to provide early detection of depression. What sort of training do pharmacists do that would equip them for this? Are you suggesting there should be training for pharmacists in this area?

Mr Leahy—We have done a couple of things. We worked with the Australian Divisions of General Practice on *Unravelling D&A*, which happens to be a drug and alcohol CD. In it I

insisted that a whole section be put in on mental illness. What we developed was a resource kit, so the pharmacist who came across the patient could log on, pick up all the information they wanted that was relevant to the particular disease state they were looking at and give patient information or in some way work with them.

When we did the project with the Mental Health Association in New South Wales, offering people the screening test: 'Are you depressed? Do you get the score 10 out of 10? If so, you should go and see a health specialist,' we provided a training kit with it, so the pharmacist had specific training for that. We believe there are a number of avenues that could be followed. As soon as you make a CD it goes out of date. We believe that we should work with the Commonwealth and the Divisions of General Practice in the AMA towards having a set of standard interventions, which could be available through our web site and theirs, that would allow health professionals to look at the most up-to-date information and resources that are available to them.

The other thing we have in New South Wales is a professional help line that both pharmacists and doctors can use for people who have pharmacotherapy problems. That number is available 24 hours a day, so if I have an issue with somebody on pharmacotherapies, I can ring up and go on call divert to the specialist who is on that day. They will tell me what is the best practice for me to follow, either as a pharmacist or as a GP, to manage that patient. That is a scheme that should be put in place nationally for mentally ill people. It is only a call divert; our technology is so good. It is a great resource to have, because there is nothing worse than managing something that you do not clearly know what the outcome is likely to be or what the best practice is. I believe there is certain potential in developing this in the area of mental health as well.

CHAIR—Are all of your pharmacists similarly interested in this field? The reason I ask is there are some pharmacists, for instance, who do needle exchange and you would imagine they would come into contact with people with mental illness, perhaps at a higher level than some other pharmacists.

Mr Leahy—I think you would have to consider it mainstream. There are a number of people who are now seeking treatment for depression. You would see a substantial number of prescriptions and events going through every day that would relate to that area of mental illness.

CHAIR—So you would be confident that all pharmacists would be interested in this service?

Mr Leahy—They certainly would. It would be core business to what they provide in the way of service. The number of children taking attention deficit syndrome medication is very widespread, and you see more and more people using the newer range of antipsychotic drugs for depression. You see it constantly, every day. In some cases, where I am in the inner city of Sydney, you see the homeless and all the other sort of people who are dumped into boarding houses come around. They are the people who the most difficult to manage of the people we see. It goes from the very top to the very bottom. Everybody sees it.

Ms May—We run some training programs on mental health issues and some pharmacies take them up as continuing education: people who want to seek further information can do that.

Senator HUMPHRIES—The model you have proposed is a very interesting one. I assume this is being progressed with the federal government in a more formal sense as well.

Mr Leahy—The care plan has always been around. The question is whether or not the extract element of what I call an ‘active care plan’ has had funding sought and has unit packaging and involvement. That is the part that I believe that you would need to see. I have no doubt that this unit packaging and making people get the dose actually makes things work, because I see people all the time that I do for it for do very well.

Senator HUMPHRIES—Are you pursuing this idea with the federal Department of Health and Ageing?

Mr Leahy—We are, as far as the unit packaging goes, but the care plan is something that has always been in the domain of general practice. We have never received any financial remuneration for being involved in the care plan. That would have to involve a working submission between the Division of General Practice, the AMA and the guild saying that with this whole care plan, instead of having a number of people who are going to participate and do (a), (b) and (c), we need to activate a particular level of it that has a particular delivery service put into it. I do not believe we have come across to do that, but I think in this area of mental health it is the most glaringly obvious thing to use—unit dosing within the context of a care plan.

Mr Simmons—In a community setting, once you have a person who is on unit dose packaging, as Denis said, they do much better and you can monitor how they are going. If they are not taking all of their tablets, you ask them why, and if they say, ‘I have been in hospital for three days,’ then you understand. If they say, ‘I just forgot,’ then you could perhaps go and talk to their doctor or carer and it progresses their treatment.

Senator HUMPHRIES—That last issue is one that I want to ask about. Let us say that a person on this package admits to not taking their medicine or you can see that they are not taking their medication. What are the barriers to you going back to the doctor and saying that the patient is not taking their medication if the patient themselves does not give that permission?

Mr Simmons—Under the duty of care, I think we are expected to contact the doctor. Depending on the patient, some would say, ‘Do you mind if I ring the doctor?’ With patients who believe they do not need to take medication—a number of people say, ‘I think I’ll stop now; I feel so much better’—you just need to ring the doctor. Pharmacists see their customers, or their patients, once a week or once a fortnight and they get quite a relationship with them. I see some of my patients more than I see some of my brothers, so I have a fairly good idea of what they will accept and what they will not accept. At the end of the day, if a person commits suicide, I am sure the pharmacy board would say, ‘Why didn’t you ring the doctor?’ I would accept that as a valid judgment.

Senator HUMPHRIES—So any privacy issues can be finessed through a bit of persuasion, personal relationships and things like that?

Mr Simmons—I think the Privacy Act takes exception if there is danger to the patient. The Privacy Act is a bit silent on that.

Senator HUMPHRIES—I was intrigued by the graph you have in the submission, the beginning of which looks at the number and location of pharmacies across Australia. I am curious about hospitals that administer pharmaceutical products directly to the community. They are community pharmacies within hospitals, aren't they?

Mr Simmons—Some public hospitals are able to dispense pharmaceutical benefits inside the hospital—I think that is what that refers to.

Senator HUMPHRIES—You said public hospitals, didn't you?

Mr Simmons—Yes.

Mr Leahy—They would be higher priced drugs, usually.

Mr Simmons—The pharmacy has an approval number to dispense pharmaceutical benefits, which are then subsidised by the PBS. It is federally funded.

Senator HUMPHRIES—I was curious because there are three hospitals for the ACT but there are only two public hospitals here. Does it operate in some private, non-government hospitals as well?

Ms May—I would not think so; it is probably public. This comes under the Department of Health and Ageing; it is HIC data.

Senator HUMPHRIES—I will follow up with them.

Senator WEBBER—First of all, I will declare that I am from Western Australia. One of the areas in your submission that I was interested in is the prescription to school children who have ADHD. In Western Australia I think we have the highest rate of medication, so it is something that really concerns me. I was wondering whether you could expand further about the things we could perhaps do to more effectively monitor and control that. Apart from the high prescription rate for very young, primary school aged children—and it concerns me that they start life on such strong drugs—the other issue we have in Western Australia is that these drugs are prescribed for high school children who then sell them to their mates. I was wondering whether you could comment a bit further on that.

Mr Simmons—With amphetamine type drugs, it depends on the philosophy of the psychiatrist in the area. Different psychiatrists have different philosophies on it. They have different levels of judging a person as an attention deficit candidate. From my experience, I know that a lot of high school students tend to try to get their prescriptions a lot faster than they should. Most pharmacists usually deny it. Sometimes the students have a valid reason, but I suspect they are selling to their friends. But if nothing has been proven you cannot really say that. You tend then to go back to the prescribing doctor and alert the doctor to that, because it can be quite serious.

Mr Leahy—In my pharmacy I provide a separate container for use at school, which the parents are then handed to give to the school for administration. That is what we prefer to happen. The original bottle stays at home. We try to seriously restrict it so that the volume that

goes to school is for one dose only for one day—and that is it. It is a duty of care in that we provide extra labelling and extra bottles for those people.

Senator WEBBER—Would that be a fairly common practice for most pharmacists?

Mr Leahy—I think most pharmacists would do that. It is also very good working with the people who come in because they appreciate the fact that you are giving them something that is highly addictive or highly profitable to people wanting to take it, so they know more care is required with it than an ordinary paracetamol, or something like that.

Senator WEBBER—Like Senator Humphries, I am quite taken with the dispensation model that you talked about—the care model. I think that is really worth pursuing. Apart from that, the other issue that you raise in your submission that caught my attention is the role that pharmacists can play in the early detection of postnatal depression. It seems to me that you are probably ideally suited in that women with young children spend an awful lot of time in the pharmacy, probably more time there than any other shop, and you develop that relationship. I know because there is a chemist in the shopping centre where my office is. It would seem there is a significant role there. I was wondering if there was something we could do to expand that.

Mr Leahy—Perhaps on discharge the mother leaving hospital should be acquainted with what is going to happen in the next week and the next month and she should be told that, if she has any questions, the support services available are A, B and C. You get the immunisation book and chart to go home with; why shouldn't you get a book to look after yourself? The simple process should be: one chart for mum and one chart for bub. Then you have a way of guiding yourself through the first three months. It is the worst time of your life when you cannot sleep all night. It gives the mothers a feeling that, although it may or may not happen, there are people out there who have documented it because it has happened. You get specialists who write in that area and you look for the supporting mechanisms that go with it. You give them commonsense things like how to sleep, how to manage the baby and how to manage other things. They are just commonsense things. You do not give medication until you work out that commonsense has not worked.

Senator MOORE—I have been working my way through the privacy cum freedom-of-choice issues raised by your submission. I have not got there yet, so I may have to come back at a later time when I have worked through this. I want to ask about two things. The first is the Mental Health Promotion Day. The example in your submission related to 2002. Is that now a regular occurrence or was it a one-off?

Mr Leahy—It was a one-off payment through a non-government agency whose specific funds were to run that project. I do not believe that giving people information without any other physical tool to go with it is all that useful. The advantage with this was that you got a self-evaluation tool that went with it and you could score how you felt. I think the figures are probably underscoring what actually happened. People had a way of saying, 'These are what health professionals tell me. If I keep on scoring these feelings that I have, I need to seek help.' I think that tool or instrument is pivotal to any campaigns you run on mental health. It is pivotal that you have a tool for evaluation and referral as part of them.

Senator MOORE—Was the involvement of your members in that voluntary?

Mr Leahy—It was voluntary and had a very high take-up. Most of the pharmacies took it up.

Senator MOORE—The other point is on the multidiscipline teams. Increasingly, the medical focus has been on getting the different streams of medical practitioners together. We heard evidence this morning, from the group representing psychologists, of a proposed move to change the Divisions of General Practice to the Divisions of Primary Care involving a range of professions. Is that the kind of thing that has been discussed with pharmacists? It seems the thrust of your paper is how you integrate the various people involved in care to the best advantage of the client. Have you been involved in discussions around that kind of change?

Ms May—Apparently there have been discussions, but we have not been directly involved in them.

Senator MOORE—It does not involve the Pharmacy Guild?

Ms May—We have heard of some suggestions about Divisions of General Practice being renamed as the Division of Primary Health Care or whatever, but we are not directly involved.

Senator MOORE—Does that involve the pharmacy stream as part of that care?

Ms May—At the moment, no, but we have facilitators.

Mr Leahy—We do have facilitators within the Divisions Of General Practice to try to link pharmacists and doctors. There are a number of projects—home medication reviews is one, or it could be mental health. It is a bit flexible in what happens. If you look at the elements they were talking about, one was care plans, which are about who is involved and what you do. The other one was case conferencing, which at the moment has a financial reward for the GP for doing it but for nobody else. Just the fact that it exists is not good enough. You should say, ‘If you case conference, what will your outcome be? Who will do what? What will you follow it up with?’ That is a worthy outcome from a case conference. In three months the review process will be part of the next case conference. You may have had to have a care plan in there, and you may actually have to give some written input as to what you did as part of your care plan that influenced the next case conference. So there is an ability to look at extended care items that are already there, provided by the Commonwealth, and to put other people actively in there and to work out what the level of remuneration should be for the time they use to provide it.

You have a good opportunity to specifically look at some disease states in there. People with mental illnesses will not have only one thing wrong with them. Quite often they will have high blood pressure and diabetes as well because they have a history of other sorts of lifestyles that do not make them very healthy. So if you can put your care plan in with their dietary control, smoking cessation and a few other things, you are starting look at reducing health costs overall. If you can say, ‘We’ll make it easier for you to pay for it by managing your affairs or by giving you a subsidy on your medicine that is directly attributable to this extra care that you have agreed to,’ in the end the taxpayer has to be better off.

Senator MOORE—Mr Simmons, you gave an example earlier of your home state, where one area was doing care in one way and another area was doing something different.

Mr Simmons—Yes, that is correct.

Senator MOORE—So that is actually happening: the same group of people but in different parts of the state are having care provided in different ways?

Mr Simmons—That is correct. Yesterday I rang the pharmacist who is involved and confirmed it. She was saying that the pressure was to change it, but the region was resisting because they felt they were doing the better job. As I said before, it is cost driven not result driven.

Senator MOORE—Thank you, I wanted to make that quite clear.

Senator FORSHAW—In your answers to earlier questions you covered pretty much the issues I wish to raise, particularly those related to those two paragraphs at the top of page 5. A large part of what you are doing and trying to promote is pharmacists providing information and developing that relationship with the patient. In the area of people being treated for mental illnesses and depression how much response do you get from people coming back and volunteering information such as, ‘This medication is giving me these side effects’? Or is it a more proactive thing and pharmacists elicit the feedback? It is one thing to give out the information or to point them in the right direction; it is another thing to use your own personal observation of a person.

Mr Simmons—Most pharmacists would love to give out information, because they have a lot and they have trained very well. They do not always get an opportunity to give it out, so when they do get the opportunity they try to. I have found that those who are well controlled with their medication will talk about it more. Those who are not well controlled or who have been medicated for a long time do not seem to care. There is no average person.

Senator FORSHAW—I am thinking particularly about side effects. If a person has been prescribed for the first time with an antidepressant and they come back for a repeat, would you expect members of the guild to be saying, ‘Have you had any of these side effects’? Sometimes when you look at the information that comes with medications it is indecipherable, and it covers every known side effect anyway.

Mr Leahy—Normally, when the person comes back for their repeat, you would ask them how well they went in the first month or the second month. If they were on antihypertensives you would be saying, ‘Have you had your blood pressure rechecked after your change of medication?’ It is usually at that change, when people are moving from one medication to another or having the dose increased, that you are more likely to want to follow up six months down the track.

Senator FORSHAW—I suppose what I am asking is whether the guild is trying to encourage its members to do that.

Mr Leahy—We believe that the introduction of these information leaflets at first dispensing is the starting point, and we would always promote the importance of the patient’s history. Whenever you do a script, you should get the patient’s history up in front of you. You look at it

to say, ‘That’s a reasonable thing, given the history the person has,’ and if it is not reasonable you would intervene. So you do have the opportunity to do that.

Senator FORSHAW—Because side effects is one of the big issues that relate to any of these psychotic drugs.

Mr Leahy—We would always be aware of that, and other herbal medication they might take becomes a big issue now.

Senator FORSHAW—Yes, good point. Thank you.

CHAIR—Thank you very much for appearing today and thanks for your submissions and ideas. I am sure you will find that those appear in our report at some stage. Is it the wish of the committee that the guild’s CDs be accepted as evidence? There being no objection, it is so ordered.

[3.17 pm]

BUSH, Mr William, Member, Families and Friends for Drug Law Reform (Australian Capital Territory) Inc.

McCONNELL, Mr Brian Peter, President, Families and Friends for Drug Law Reform (Australian Capital Territory) Inc.

CHAIR—Welcome. Thank you for coming. You have lodged with the committee a submission which we have numbered 319. Do you wish to make any alterations or additions to that document at this stage?

Mr McConnell—None that we have noticed at this stage.

CHAIR—We will forgive you for typing errors. I now invite you to make a short opening statement, after which we will go to questions.

Mr McConnell—Our submission covers links between drug policy and mental illness and disorders. You have already received some evidence on that very extensive link. I understand Professor McGorry of Orygen in Victoria told you that drugs and alcohol is the worst problem we have and that Dr Lubin, also of Orygen, told you that we know of a substantial proportion of young people who have problems with drugs and alcohol at a very early age and will develop more entrenched morbidity and both substance use and mental health problems. On the links between drug policy and the pressures on the mental health system, we believe some of those pressures are because of the separation of the drug and alcohol field and the mental health field. This is inefficient and not in the best interest of the patients. There are also links between drug policy and the overrepresentation of people with mental illnesses in custody in the criminal justice system.

There is in fact a large overlap between people using illicit drugs and those with a mental illness. The link between drug dependence and mental illness or disorders is not necessarily confined to the pharmacological effects of the drug concerned. The committee should not, therefore, rest content with a recommendation that illicit drugs, because they have deleterious effects, should be made less available. It is not enough to point to the obvious correlation between illicit drug use and mental illness or disorders to observe that there would be fewer mental illness or disorders if there were less such use. Ignoring the impact of existing responses to illicit drugs and urging intensification of those responses will only intensify the mental health problems that so many families are going through. That is going to do nothing to reduce the uptake of drugs by young children—which, for example, is a point of particular concern regarding schizophrenia. As Dr Rolfe has told you, 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. Only by thoroughly integrating drug and mental health policy will it be possible to focus on the reduction of availability of cannabis for those young kids of 12 or so. Existing drug policy has failed to do this. Because it does not have a public health focus, it has increased other risk factors for mental illness.

The committee should recognise that the response in Australia to illicit drugs contributes to the worsening crisis in mental health, far beyond the adverse effects of drugs themselves. We ask the committee to consider three main aspects. We ask the committee, firstly, to reject the current view that insists first and foremost that people should overcome their addiction before other problems in their lives are addressed; and, secondly, to acknowledge that existing drug policies contribute to the worsening plight of those who suffer from mental illness. Great improvements would be possible if national mental health and drug strategies were integrated, rather than passing off the problem to one or another set of those service providers. Thirdly, we ask the committee to base its recommendations on the best available evidence.

We see that there are three main obstacles to securing improvement. Firstly, there is a moral belief that overcoming addiction must take precedence over all other issues. Addiction is a chronic relapsing disorder and as a general rule cannot be cured, but it can be managed, not unlike a person's heart condition or another's diabetes. Secondly, there is a view that existing policies, whatever their negative effect, have worked to make illicit drugs less available. In fact, existing policies promote the distribution of illicit drugs among vulnerable populations. The third obstacle is a failure to be guided by the best available evidence in formulating measures to give effect to policies. Families and Friends for Drug Law Reform appreciates also that there may be political obstacles in taking the approach it urges, but if real improvements are to be made this committee needs to be innovative. Nevertheless, the evidence is there, and it remains for the committee to draw the connections.

CHAIR—I will begin by asking you about some personal stories from your members. Typically, what do families know about mental illness when it is co-morbid, as one descriptor puts it?

Mr McConnell—I think probably the best anecdotal examples that we can give are the stories of people who try to get treatment for one or the other of their problems. If they have a co-morbid condition, they may well go to the mental health area and ask for treatment. They are told: 'Well, you've got a drug problem, so you'll have to have that fixed up before we can deal with you.' A similar situation occurs when they go to the drug and alcohol people. They are told that they have a mental health problem. So in essence they fall between the cracks. We had a conference some years ago where a number of personal stories were told. The conference proceedings, which we have on our web site, tell many of those stories, and many are of people with co-morbid conditions. It is quite a serious problem, and in many cases it seems quite intractable.

CHAIR—It has been suggested to us that this is partly a cultural problem that clinicians and services generally have, but that it is also a convenient excuse for not dealing with people when you have enormous pressures on you to cope with big case loads. Do you have a view about that?

Mr McConnell—Yes, I would think that is a fair assumption. It has to do with the structures of the organisations as well. They are set up essentially as two separate structures, in silos, with their own area of responsibility to look after. They do not wish to be involved in other areas. We see a similar sort of thing when the person's family is looking for help and the clinician or the counsellor says, 'I'm only dealing with the patient; I'm not dealing with the family.' That is a

similar sort of situation, where they try and limit the scope of what they are looking at. It may well be pressure of work; I suspect you may be right in that.

CHAIR—Do you think the moral belief you attribute to government practices with regard to drugs also applies to GPs and others providing mental health services?

Mr Bush—It is more than a moral belief. The attitude is one that is provided for by law. Medical personnel cannot be complicit in the provision of an addictive substance to someone, or even the nodding of the continued use of an addictive substance by someone. The choice is taken out of their hands. It is also the case with many parents that we have heard about. The choice is: do you kick your kid out if they are using illicit drugs or do you permit them to use them at home? Do you actually procure drugs to hand out to them? Some parents do do that, but they are breaking the law. It is a question of what the highest priority is in the life of that person. If there is a mental health problem and a whole series of behavioural disorders that go with that, and if—as you have heard so much evidence on—there is a problem of addiction to an illicit drug, which do you tackle first? The law tells you that you are a law-breaker if you do not make the choice of tackling drugs first. This applies to parents and it applies to caregivers.

CHAIR—And it applies to GPs? Is that what you are suggesting?

Mr Bush—Yes.

CHAIR—These are state laws?

Mr Bush—These are the laws of the land—of states. There is legislation before the Senate's Legal and Constitutional Affairs Committee that would extend Commonwealth drug law, down to the level of possession, across the whole Commonwealth. If that is passed, there will be concurrent state, territory and federal law.

Senator HUMPHRIES—In your submission you give us some information about the incidence of mental illness among those who are experiencing substance addictions. As we do not have any accurate figures, do you have an impression, from the people who are members of or within the orbit of your organisation, of the incidence of mental illness among those who have an addiction within their family? Would you say that more than 50 per cent of those people who experience a problem with addiction are also mentally ill? Would there be some other figure or is it not possible to estimate that?

Mr Bush—It is anecdotal; you hear stories.

Mr McConnell—We do not have any substantive evidence. We do not really survey our members to that extent. It is a fact and it is present, but as to the extent it is present we do not know.

Mr Bush—All the data is that it is the depressive personality anxiety disorders and compulsive disorders—it is that bundle of disorders that predispose many people to take up illicit drugs. The psychotic situation linked to schizophrenia is a relatively small proportion of that. You have evidence that the stimulants that have been increasingly available since the time of the heroin drought are mimicking the same psychotic effects as those of schizophrenia.

Senator HUMPHRIES—I assume you would argue that bringing drug addiction in from the cold in terms of the legal status of that phenomenon would make it easier to collect accurate information about the correlation between mental illness and drug addiction and to get a more accurate picture of what exactly is going on.

Mr McConnell—Certainly if it were treated as a health issue then it would come under the umbrella of the health area. Harking back to your previous question, I note that Bill, I and a number of other members are also on a voluntary telephone line, a parents' support line, so that parents who are concerned about drug use in their families can ring and talk to someone about it. There seems to be quite a proportion of those calls that have co-morbid conditions. It also seems that many of the people with mental illness are self-medicating. It seems that the illicit drugs that they are using probably give them in some way better relief—I am not sure how—than the medication they may well be on that is prescribed by a doctor.

Senator HUMPHRIES—As a society we have gone a long way down the path towards harm minimisation in recent years and a great deal of the problems in the overlap of these two areas have been to some degree dealt with by that process. Is it not possible to go further down that path in treating addiction primarily as a health issue, rather than as a criminal issue, without necessarily getting to the point of decriminalising the use of those drugs by, for example, diverting people out of the criminal justice system when it is recognised that a crime that they committed has been predicated at least partly on a mental illness?

Mr McConnell—A point to start with: Australia has a policy of prohibition. Under that policy of prohibition is harm minimisation, so it is not one or the other. So it is prohibition, and harm minimisation ameliorates many of the harms that are caused by the prohibition laws.

Certainly if we treated addiction as a health issue then we would be far better off than we are now. The diversion programs do divert people away from jails but still quite a large proportion of the people in jail have both mental illness and drug addiction problems. We know that drugs are available in jails. If we cannot stop drugs from getting into jails, one of the most secure environments that we have in this country, then, using our current methods, we have very little confidence that drugs can be stopped from coming into the country. We need to look to innovative solutions to deal with that.

For example, we need to look at some changes to, say, cannabis laws between South Australia and Western Australia. A very good study that was commissioned by the federal Department of Health and Ageing showed the difference between the two laws. Western Australia had very tough cannabis laws while South Australia had a simple cannabis offence notice, the same as the ACT had. SA calls it something different. The study showed that by doing that, possession of the drug was still illegal but it did not attract a criminal sanction. The outcome of the study showed that there was really no difference in the use of the drug in either of those two states, given that the laws were substantially different. So it would seem that if we moved down that part of the path then the use of the drugs might not be any different. If we went to the process of regulating the drugs in some way or other, what it might do is undercut the black market and reduce the profit margin that goes to encouraging more and more dealers and traffickers in drugs into the country. Bill has an interesting chart here. It is a graph about drugs, but not in Australia. I have a copy for the committee. At about this point of the graph, before it starts to go upwards, it shows some leakage of drugs.

CHAIR—Could I ask you to indicate where it is from?

Mr Bush—It is from a recent British report by the United Kingdom Strategy Unit Drugs Project entitled *Phase 1 report: understanding the issues*, dated 13 June 2003.

Mr McConnell—The middle of the chart says:

1950s: system of prescribing heroin to a small number of addicts in UK begins to break down as a few doctors allow heroin to 'leak' ...

By 'leak' it means that they are leaking onto the black market and are being sold on the black market. You can see that the far right-hand side of the chart says:

Late 1960s: restrictions on prescribing coincide with increase in black-market availability: drug industry begins to enlarge ...

So two things came together: there was a restriction on the use of prescription heroin in the UK and people who might have otherwise got it on prescription went to the black market, and the black market boomed from there.

Senator MOORE—Your organisation has been formed locally by concerned people but you say that there is national interest and involvement in it. How do people find out about you?

Mr McConnell—We have regular meetings. We advertise the meetings. They are usually held locally, here in the ACT. We have a web site that identifies our organisation, and a number of inquiries come from that. We have a newsletter, which we provide complimentary to every member of every parliament in Australia. We sometimes write press releases and get some press attention. We also have an annual memorial service for people who have lost their lives to illicit drugs. That is not so much directly related to our aim but is to provide some comfort to those people who have lost loved ones and need to feel that they are not alone in this particular phase of their lives.

Senator MOORE—Your submission is very detailed and brings out lots of research. The question I kept asking all the way through relates to the current methodology in Australia, which is following the American 'Just Say No' stuff. How do you respond to that? It seems to be so different to your argument. In the current environment, what do you say to the people who are saying that the only response to the issue of drug usage, its impact on families and resulting mental health issues is to 'just say no'?

Mr McConnell—I think we would start from the point of saying that 'just say no' is an option, and it may be the first option. But if you stop at that point you have to ask the question: what happens when the person does not say no? What other options do you have? We say you must have other options beyond that point. If a person does not say no then you have to try to keep the person alive and as healthy as possible during that drug using experience.

Senator MOORE—Do you have examples from families where that has worked?

Mr Bush—We have members whose children are still alive.

Senator MOORE—That means it has worked. It means that these families have identified that their methodology is to follow the kinds of arguments that you have raised in your paper. Is that right?

Mr Bush—I can think of one member whose adult son has had a bad heroin problem for many years. He is the sole parent looking after his child. He is on methadone but he gets topped up occasionally with street heroin. He is doing a course and is a model parent. But the fact of someone being alive is the key to it.

Senator MOORE—And the family being united in that process.

Mr Bush—This is where it is a wedge. We are talking of a mindset issue. Our submission talks about heroin prescription and things like that. Heroin prescription and things like that are not going to happen in this country, unfortunately, I imagine, for quite some time. But we can change a mindset immediately. The mindset that comes in is stopping families who have children with mental health issues from dealing with those mental health issues because they also have a drug problem. Their mindset is that they have to stop that drug problem—they have to turf them out or do whatever it is. Study after study shows that those very things are stress factors for mental illness themselves.

Senator MOORE—For the whole family.

Mr Bush—For the whole family and for the aggravation of the mental illness of the person concerned. It is a mindset issue. It is coming through in this whole study in relation to grandparenting; there is a lot of work being done on that. Often you will find one grandparent completely at loggerheads with another grandparent in relation to custody or any access of a grandchild to a still-using parent. When this is mixed up with a mental health condition, as it very often is, it tears families apart. I suggest that it is the biggest factor that keeps the mental health professional group apart from the drug and alcohol professional group. It is a wedge mindset that drives through society and is in a large measure responsible for why there are so many people in prison.

Senator WEBBER—The silo approach between mental health and drug and alcohol treatment is something that has concerned me for a while. I have raised it with a number of witnesses who have appeared before this committee. It seems to me so far that carers, consumers and mental health professionals who are involved in service delivery and what have you all agree that we need to look at bringing it all back together and treating the individual as a whole. The only people who have given me a justification for keeping them apart are health bureaucrats. They are the only people who have said, ‘We’ve got to keep the silos.’ Perhaps it is the bureaucratic turf war rather than the community mindset that we need to address in terms of trying to treat people as a whole and in that way actually keep them alive and safe.

I was interested that you picked up on the changes that we have made in Western Australia to the cannabis law. That was actually something that was recommended and pursued by our now deputy police commissioner. Obviously law enforcement is on the side of trying to minimise the interaction that these people have with the justice system.

Going back to mental health issues, I want to have a chat about methamphetamine. Certainly in WA, in Perth, ice is probably one of the most accessible drugs at the moment, particularly in terms of cost. It is also having a dramatic impact on our mental health facilities, involving a number of young people—although a couple of the people I know who use it are not that young; they are about my age, which is not young at all anymore, unfortunately. We have a large mental health institution at Greylands. It is full to overflowing at times with people who have had to come in with psychosis caused by use of amphetamines, which is then placing a whole lot of other pressure on our system in dealing with people with long-term mental health issues who we then probably have to discharge for a while as we deal with these acute problems. How are we going to deal with this in the long term? It is a drug that is not going away; it is a drug that is manufactured in Australia.

Mr Bush—As I said, it is a drug that only started to come in from about 1998—that was when it was first discovered. It was earlier in Western Australia than it was throughout the rest of the country. It is a real problem. The professionals, as far as I know, are largely at a loss to know quite what to do about these ‘yah bahs’, ‘ice’ and things like this that are particularly potent. They are just so available. The most recent household survey shows, for example, while cannabis is tending down or flat, these drugs are going up.

Senator WEBBER—They are accessible; they are cheap.

Mr Bush—They are accessible. This is something where we need to have a policy that is going to make these drugs effectively less available and not at the same time add to the risk factors of mental illness by casting young people into prison, as would this legislation that I just mentioned. A standard pattern is for a young person to buy the E pills—mostly ecstasy, for in fact at least half these drugs are not MDMA—for their friends and sell them. They are going to be liable to something like 20 years imprisonment and about \$440,000 fine under this legislation. How the heck are we helping by doing that?

The report of the House of Representatives Committee on Family and Community Affairs that came out in 2003 is 400 pages. I think three and a half pages are confined to the methamphetamines. We really have to get real on it and look at it. We are not doing it. One of the other things that came out of the heroin drought is that most of the seriously dysfunctional drug users are polydrug users. They would use any drug available. Their drug of choice was heroin. When that ceased to be available, thanks to a marketing decision by criminals, they switched very quickly to the injection of these other drugs.

Senator WEBBER—Of speed.

Mr Bush—There was in existence a pyramid marketing system that allowed these new drugs to penetrate into an entirely new market of youth who were not injecting drug users. The drug-using workers, the police and families with domestic violence are under enormous stress because of the violence that is very quickly associated with heavy use of these drugs. It is a problem.

Mr McConnell—I will cover a couple of points in there. With regard to the silos and whether it is bureaucracies, I think you would have to ask who has things to gain by leaving things as they are. I suspect that the patients/clients of the services are not those that are on top of the list; I suspect that it is the people that have a vested interest in maintaining the silos, as you say. The

other thing that became obvious when the heroin drought came about was that one would have expected that a lot of people who were on heroin would have sought treatment. It did happen to a small extent, but not to a very great extent and not to the extent that one would have thought. We saw that people shifted onto other drugs. As Bill says, they were polydrug users who could not get the drug of their choice so they opted for another drug. We found here in the ACT that the service providers—those who are dealing with people with drug and alcohol problems—pretty much had services down pat for heroin treatment but they had almost nothing there for excessive methamphetamine use, which is really—

Senator WEBBER—Which creates a whole new set of needs.

Mr McConnell—I would suspect—although I do not have any evidence to say so—that moderate use of any of the drugs is probably not problematic, but it seems to me that excessive use is when the problems and psychoses start to occur. We did not have any treatment services to plan for that new fashionable drug that came in. I suspect that our services are still the same way now. Whereas we might be just starting to get a handle on treatment for methamphetamine use, we have no treatment services for the next fashionable drug that will come in and we have no insights into what we might do until something happens, and then we are scrambling to catch up.

Senator WEBBER—They are only just starting to fund those treatment services in Western Australia for amphetamines.

CHAIR—Isn't it the case that the culture of polydrug use is problematic in terms of treatment? You might find a treatment for methamphetamines but, if there are alcohol and a whole range of other things being used, it is not likely the users will seek treatment, is it?

Mr McConnell—It depends on whether they are enjoying their drug use, to put it bluntly. If they are happy in their drug use and they do not see any problems, why would they go to treatment? If the treatment services that are being provided are not attractive, are punitive and stigmatise them, again, they are not likely to go to treatment.

CHAIR—We will finish on that point. Thank you very much for making your submission to us in person.

Mr Bush—In the light of the questions you were asking the previous witnesses about case plans and things like that, are you aware of the so-called Milwaukee Wraparound program? It is a successful program for youth with mental health needs that was developed, I think, in Canada but has been applied in a number of places in the United States. We have covered that and a number of other aspects of mental health, down to a level of specificity we did not think you were going to go to, in a submission that we made to the ACT Assembly. Are you interested in references to that?

CHAIR—I am sure the committee would benefit from that. Perhaps you could forward the submission to us; that would be useful.

Mr Bush—We can make it available to you.

Evidence was then taken in camera—

Committee adjourned at 4.59 pm