



COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

## SENATE

SELECT COMMITTEE ON MENTAL HEALTH

**Reference: Mental Health**

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SYDNEY

BY AUTHORITY OF THE SENATE



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**SENATE**  
**SELECT COMMITTEE ON MENTAL HEALTH**

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

**Senators in attendance:** Senators Allison, Forshaw, Troeth and Webber

**Terms of reference for the inquiry:**

To inquire into and report on the provision of mental health services in Australia, with particular reference to:

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

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**Committee met at 9.01 am**

**CHAIR (Senator Allison)**—This is the seventh 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 by 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.

[9.03 am]

**ALSHAMS, Mr Maqsood, Spokesperson, Specialist Assignment Volunteers Enterprise Australia Inc.**

**CHAIR**—Welcome. You have lodged with the committee a submission which we have numbered 483. Do you wish to make any amendments or additions to that submission?

**Mr Alshams**—No; so far, so good. I have looked at the submission again this morning; it is fine.

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

**Mr Alshams**—The submission we made to the committee followed the terms of reference of the committee's inquiry into mental health. Although it is not very closely aligned to the specific terms of reference I will try to focus my oral evidence on the submission and my experience and background as an immigration detainee for 16 months. I will also try to focus on how detainees are being treated in the immigration detention facilities within Australia and my practical experience of facing 16 months of incarceration, a significant period of that time being in solitary confinement. I will focus on that. I am happy to answer any questions on anything the committee would like to clarify.

**CHAIR**—Is that all you wish to say as an opening statement?

**Mr Alshams**—I have a concern that I would like to raise with the committee. Some names might come out—those of the Department of Immigration and Multicultural and Indigenous Affairs officials as well as ACM officials. Would I be allowed to make them public or do I have to ask to give evidence in camera? That is my concern at the moment.

**CHAIR**—You can delete references retrospectively. The committee will provide you with the *Hansard* record of today's hearing. But you can also indicate before you wish to say something in particular that you wish that part of your evidence to be provided in camera.

**Mr Alshams**—The particular concern I have at the moment, in my experience from appearing before a number of Senate committees and other inquiries, is that every time I have seen the Department of Immigration and Multicultural and Indigenous Affairs send their representatives nobody can identify who they are. Ultimately the people who give evidence at these kinds of inquiries are being unjustly treated. It is well evident, and everybody knows that it is happening, so I have to be careful, I think.

**CHAIR**—It is also the case, Mr Alshams, that witnesses to Senate inquiries are afforded parliamentary privilege, which means that it is an offence for someone to take action as a result of evidence given to a committee. The extent to which that reassures you, I do not know, but I can say to you that Senate committees have in the past followed up issues that have resulted out of intimidation of witnesses or subsequent actions against them.



**Mr Alshams**—I appreciate your assurance, Chair, but I will try to provide evidence in which, as far as possible, I do not mention names and other things. If there is any problem, I will approach the Senate committee again. We can proceed.

**CHAIR**—So you have finished your opening statement? That is all you wish to say?

**Mr Alshams**—Yes.

**CHAIR**—Perhaps you could give the committee some insights into your personal experience with mental health services while you were in detention. In what way did you regard them as inadequate?

**Mr Alshams**—I am not a mental health professional—I am not a psychologist, nor am I a psychiatrist—and I had never faced mental health issues before in my life, apart from the day-to-day troubles, turmoil and other things I faced as a political activist back in my country. My troubles include coming to Australia and ending up in a detention centre. When I first entered an immigration detention centre I asked for mental health support. The regulations in the department of immigration and the detention centres are usually that people cannot just ask for something—they have to go through the process of submitting a yellow request form. I filled the form out and gave it to the ACM, and ACM passed it on to the department of immigration.

Three or four days later somebody appeared before me and introduced himself as the clinical psychologist employed in the detention centre. I explained to him the issues I was going through. He listened to everything and did not make any comment—not a single word. A few days later he came back to me and listened to me again. He listened to me a few times. Afterwards, the suggestion he proffered was: ‘Maqsood, have you got another place to go to? This is a bad place. You won’t get protection here, so try to go somewhere else.’ I felt devastated and upset with the issue. I was seeking protection from a signatory of the 1951 Geneva convention, a country that is known to be a humanitarian country. I was asking for mental health support from a qualified mental health professional, and he asked me to go. Instead of getting a remedy for my mental health issues, I felt devastated, mentally tortured and really upset with the fact. I found there was no option, no opportunity and no mechanism through which I could raise these concerns with anybody.

During 16 months I found that the position of the clinical psychologists and counsellors in the immigration detention centre was severely compromised. Private contractors have to make some sort of deal with the department of immigration to encourage detainees to leave the country. They are bound to implement the compliance regulation that people have to leave. In other words, the clinical psychologists and mental health professionals in the detention centre are being asked specifically by the compliance branch of the department of immigration to somehow convince detainees to leave this country. That will help them to justify the fact that they are doing the right job.

I have had numerous articulate conversations with them. My previous profession was as an investigative journalist, so I have been able to find out a lot of things about how the clinical psychologists are being used in the detention centre. I have not seen any clinical psychologist continue for more than three, four or five months at the facility I was detained in. Ethically,

morally and in principle they cannot continue their work there. They do not have the professional freedom.

Since my release from the detention centre I have been involved with the asylum seekers rights advocacy. I have seen many of the mental health professionals—those who have been working in the detention centre—ultimately leave their jobs and join with me to voice their concern about the government's mistreatment of asylum seekers, particularly the department of immigration's mistreatment of people seeking asylum in Australia. I can name hundreds of people here. Many of them have called me personally to express their concern: 'I had to do this job to pay my bills, but this is not a good place.' They tell me there is a serious level of corruption, mistreatment and all these things going on within the detention centre. This is a deep-rooted problem and it cannot be solved.

**CHAIR**—You talk about the correlation between the length of stay in detention facilities and the onset or exacerbation of mental illness. Is the uncertainty of the length of stay also a factor? In my visits to detention centres that is what is often said: 'If I only knew it was 10 years, I would at least know what I was working towards.' In your experience does that matter?

**Mr Alshams**—Of course. That is a very important factor: when people stay longer in a detention centre the main problem is uncertainty—no-one knows when their imprisonment or sentence will end. If I am a killer and I am sentenced to two years in prison, I know that in two years I will be free. But immigration detainees do not know how long they will be detained in the facility or when they will be released. Importantly, many of the people I met in the immigration detention centre have been transferred to state prison systems. They have spent a few days or a few months in prison and returned to the detention centre. I have talked to people like that and they often said that treatment in state prisons is 100 times better than in immigration detention centres. The inevitable conclusion I have drawn is that it is probably because those in prison are Australian citizens while those in immigration detention are not Australian citizens, and noncitizens are not treated as human beings.

**CHAIR**—What are the differences? Were you able to discern them?

**Mr Alshams**—Let us take the food. The food is 100 times better in the prisons. Although the department of immigration claims that the staff culturally prepare food and all this kind of thing, this is not true. It is absolutely false. One day I showed the centre manager that the halal certificate they had been displaying expired three years before. They said, 'We have to get a new one.' I said: 'That is not the solution to the problem. This certificate expired three years ago and you are still showing it. Do you think that no-one can read English here?'

With regard to accommodation, the Villawood immigration centre was built with the capacity to keep only 75 detainees. I have experienced 125, 130 or more people living there. There was a story on the ABC's *Lateline* program as well as the *7.30 Report* or *Four Corners* about the fact that there is not a single place to step somewhere. When a facility that is built for 75 people accommodates 150 people, what could it be? There is no proper sanitation. The previous minister for immigration, Mr Philip Ruddock, clearly agreed that the facilities were purpose built. Yes, they were purpose built. The purpose is to discourage people from seeking asylum in Australia—not to come here. The message is 'even if you end up in a detention centre, do not stay here; get out of this place'. That is the purpose.

The medical treatment really surprises me. In a First World country like Australia, medical treatment should not be like it is there, whether it is for a noncitizen or anyone else. I have no fear to say that even criminals, drug dealers or the worst people in the world who are in the prisons are treated 100 times better than the people in immigration detention centres. I will give you a simple example. A fellow countryman used to live in the next dorm. He was complaining about heart pain. Every time he complained, he had to come to me, because I could write English, to fill out a yellow request form. The form goes to ACM and ACM sends it to DIMIA. It goes through so many register books. Ultimately it goes to what is called the medical team. The nurse comes with two proudly Australian Panadol capsules or tablets, saying, 'Take these; they will ease your pain.' That is how people are being treated. I raised concern about these things. They said, 'We have an in-house medical professional but you have to go through this procedure, fill out the yellow request form and all these things.'

Mental health professionals are a mouthpiece of the complaints branch to convey the message to the people that they are not welcome here and they should get out of this country. The way people are being treated within the detention centre is significant enough to give someone mental health issues, even though that person has never had mental health issues before in their life. I must say that this has to be stopped. Ultimately, 85 or 90 per cent of people from immigration detention centres are granted residency and come out of the detention centres. They become part of the community. The prolonged indefinite incarceration and the ill-treatment, mistreatment and intentional mistreatment from the department of immigration is injecting mental health issues into these people—those who are potential citizens and residents of this country.

**Senator FORSHAW**—The pages are not numbered but there is a statement in your written submission on the second-last page just before the eight recommendations, if I can call them that. It says:

To date, the Australian Government has done little to address the mental health crisis of detainees occurring within the walls of its detention centres.

Have you found that paragraph?

**Mr Alshams**—Yes; please go on.

**Senator FORSHAW**—I am particularly interested in the last sentence. You say:

The adverse media attention resulting from serious deficiencies in policy issues in detention centres left unaddressed revealing the illegal deportation of scores of Australian citizens suffering mental illness.

We have had recently the tragic circumstance of Ms Alvarez Solon being deported and it later being discovered that she is an Australian citizen, but you say 'scores of Australian citizens'. Can you expand on that? You are putting a serious proposition—firstly, that Australian citizens are being deported and, secondly, that they are suffering mental illness.

**Mr Alshams**—Thank you for the question. It is an inevitable fact that one in five people in Australia suffer mental illness and require immediate clinical intervention. Out of the 10 or 15 people in this room, two suffer serious mental illness and need immediate clinical intervention.

**CHAIR**—I am sorry to interrupt you, Mr Alshams, but Channel 2 and Channel 10 are coming to take some footage of today's hearing; are you okay with that?

**Mr Alshams**—Yes, that is fine. Out of the 10 people in this room, at least two people suffer serious mental illness and need immediate clinical intervention. We have only just discovered the case of Vivian Solon and of Cornelia Rau and these two cases build a bridge to address the issue.

**Senator FORSHAW**—Please excuse me and I am sorry, but Cornelia Rau was not deported. I am concerned that you have said that scores of Australian citizens have been deported illegally. We know there is a substantial figure in terms of the prevalence of mental illness in the Australian community and it is much higher in prisons and in detention centres; obviously I accept that.

**Mr Alshams**—Let me just clear this up. What I mean is that the policy is a bit arbitrary. We do not have clear access. We have the right to bring into public scrutiny the number of people being deported, but I do not think the Senate committee has had the opportunity to check all the records of the department of immigration to find out how many people have been deported from Australia since 1958 through to today and how many people have been detained illegally. Many people who have been detained and subsequently released have probably left this country; nobody knows. My main concern is about the policy of the department of immigration in that no-one has the right to check its documents and records properly and, therefore, we can never discover how many people have been deported.

**Senator FORSHAW**—It seems to me that there are two issues here. The first is whether large numbers of Australian citizens are being deported illegally. The second relates to the fact that there may well be people who have been deported after being denied refugee status or asylum and having their application for a visa or residency or whatever refused. Certainly there would be a concern as to the mental health state of those people, but whether or not they are being deported illegally is the real question I was getting at.

It seems to me that people who are put into detention centres when they first arrive may be suffering already from symptoms of some form of mental illness or mental stress due to the circumstances where they were previously, whether that was a refugee camp or a war-torn country or whatever. You would understand what I am getting at.

**Mr Alshams**—That is right.

**Senator FORSHAW**—Do you have any comment to make about the number of people coming to Australia and being put into detention centres who are suffering or showing signs of mental illness when they are first placed in those centres? In your submission you say—and there are studies and much commentary about it—that long-term detention here can create or bring on mental illness. However, I think we should be concerned also about whether people with a serious mental illness or who demonstrate signs of having one at the very outset are being placed in detention centres and whether some alternative process should be available from the very start.

**Mr Alshams**—For people who have left their country for some reason—such as for political reasons, as I did—there are issues that could lead to bigger mental health problems. When I left my country, I experienced fear and uncertainty in that I was going to an unknown destination and accepting an unknown life. Having those kinds of uncertainties, I had minor mental health issues, but prolonged and indefinite detention further exposed and increased my mental health problems.

**Senator FORSHAW**—Exacerbated them.

**Mr Alshams**—That is right.

**Senator FORSHAW**—When you were first placed in detention, and perhaps you could also speak generally, in terms of the health checks that were done, were you—

**Mr Alshams**—No, there is no mental health assessment system.

**Senator FORSHAW**—Do you think there should be some?

**Mr Alshams**—I think it is really important to have mental health assessment for everything. I do not know whether Australia has already introduced a mental health assessment system in its criminal justice system, but in Sweden, as far as I know, every criminal undergoes a mental health assessment. From what I have heard in news stories and so on, the man who killed Swedish Prime Minister Olof Palme has not been charged because of his state of mental health. But in Australia we are very good at locking up those who show any sort of mental health inconsistency or issue and throwing away the key.

**Senator FORSHAW**—Magistrates and judges here have the power to order a psychiatric assessment at the committal stage or at any point in a trial, but generally that would be either if they were showing some sign of mental impairment, distress or illness or if the nature of the alleged crime suggested that there were some—

**Mr Alshams**—That would be a discretionary matter for the judge.

**Senator FORSHAW**—But you say that no assessment of a person's mental state is made at the outset of their stay in a detention centre.

**Mr Alshams**—The second part of your question referred to whether there should be any recommendation for psychological assessment. I think it is really important to assess the psychological health of every immigration detainee. In the process they go through there are harsh stages, from their interview with the department of immigration to, subsequently, their interview with the refugee tribunal. Even if a person is telling the truth, with the way he expresses himself at that time the authorities do not believe him. With a psychiatric assessment, there would probably be a better outcome with the applications—such as whether this person is really telling the truth and whether he is really facing fear. Those kinds of things would be more clearly exposed.

**Senator WEBBER**—I want to continue briefly looking at the treatment received by people in detention centres. It seems to me that, if we want to provide adequate rather than good mental

health treatment, there may also be a problem in the placement of our detention centres. I come from the state of Western Australia and it is impossible to access good mental health facilities outside Perth; there are no psychiatrists outside Perth. I do not know how you would expect, therefore, to get psychiatric help in a place like Baxter, for instance—

**Senator FORSHAW**—Or Port Hedland.

**Senator WEBBER**—or, indeed, Port Hedland. Are you aware whether treatment is worse in detention centres that are further away, like Baxter, rather than in Villawood or Maribyrnong?

**Mr Alshams**—I understand what you are saying, but my point is that the psychiatrists and psychologists in the detention centres are not free to exercise their profession. Their professional freedom is being jeopardised because the department of immigration wants them to work that way. Private contractors, ACM and now the GSL, are obliged to listen to the department of immigration about the way it wants them to rule. As a matter of fact, there is no democracy in the department of immigration; it is an autocratic regime. I have had a number of conversations with senior DIMIA officials about this matter in providing evidence to the Senate Legal and Constitutional Committee and various other committees and they consider that there is no democracy in the department. The mental health professionals who work in the immigration detention centres need to have the freedom to exercise their profession. There should be some sort of mechanism. I can see a number of what are called psychiatric assessment reports being presented to the department of immigration; it then says that they are unacceptable and chucks them in the bin.

When the children in immigration detention report and various other reports came out, Minister Ruddock just chucked them in the bin—unacceptable, unbelievable. The country's human rights commissioner assessed all these things and took evidence from hundreds of witnesses, and the department of immigration rejected the report. It is unacceptable. If the department of immigration wants to be a psychiatrist, I do not know what to do with it. I have no comment about it.

With the media now exposing their work, my conclusion is that people without any professional efficiency are taking First World prices and giving Third World services or even worse. From what we are seeing in the media, I think the immigration system of many Third World countries is much better than Australia's immigration system at the moment. If you are advocating for prolonged detention of people in detention centres so that psychiatrists will be able to look at them, I do not think that is the case.

**Senator WEBBER**—I think you misunderstand me. I am not saying that at all. I am saying that it is even harder when these people are more physically isolated. In many ways, perhaps there is not as much scrutiny and the people who are involved in the delivery of service are not of such a high standard because these facilities are so physically isolated. That is just another barrier for the people who are detained there. The best psychiatrist services in Australia are provided in the Sydney CBD.

**Mr Alshams**—I have had contact in that context and it would be hard. Only a few months ago I was in Western Australia organising a forum at that state's parliament house. I have looked into the life of several asylum seekers who have been released into the community. They were

tormented, mentally tortured and devastated people who are now out of the detention centres. They are taking good care of their mental health. The Uniting Church in Western Australia—

**Senator WEBBER**—They do an excellent job.

**Mr Alshams**—and other people in Western Australia have provided them with some sort of mental health support through their connections and contacts and the people are recovering and doing excellently. It is impossible to address someone's mental health issues while they are being kept in such a heartless prison.

**Senator WEBBER**—Another concern I have with the treatment of refugees is that DIMIA used to fund a specialist counselling service called ASAS, which people could access, which DIMIA has now defunded. That means that people can no longer access that specialist service anymore. I am sure that DIMIA has funded someone else now; but, as no-one in my office has heard of them, we cannot refer people to them. As you seem to have recent knowledge of things that are happening in Western Australia, could you comment on any of the after-detention care that former detainees get?

**Mr Alshams**—I would not get a tiger or a crocodile to babysit my baby; I would try to find somebody else. Perhaps you know that I organise a conference every year called 'Human rights and mental health'. Last year, when I organised that conference, I spoke to one of the service providers. I asked them, 'Who funds you to run this service?' and they said, 'The department of immigration.' The lady then laughed and said, 'Look at how funny it is. They're the ones who torment the people and inject them with mental health issues and then they give us money to look after them; it's good employment.' I said, 'Well, that's fine.'

I do not know that there is any remedy within the department of immigration to look after these things. I spoke previously about the compliance branch of the department of immigration. According to my visa regulations, I am obliged to go to the Parramatta compliance branch once every month. Let me tell you how I feel when I go there. I was in a detention centre for 16 months, out of which I spent 12 months in solitary confinement. Since my release from that detention centre, I have seen senior DIMIA officials in front of Senate estimate committees and other committees clearly denying that there is solitary confinement in detention centres. That is an absolute lie. When I see people lying, I feel really bad.

When I go to the compliance branch of the department of immigration, the only thing I have to do is sign a piece of paper. Can you imagine how long it takes me to sign that piece of paper? To sign that paper, I have to wait for 2½ hours or more in the department of immigration's office in Parramatta. I would ask the Senate committee to go one day to the Parramatta compliance branch and look at how they treat people. It is not good to give someone in the community the sense that, 'You are not a part of this society; you are not a part of the community. You are a bloody illegal immigrant; get out of my country.' That is enough to inject someone with mental health issues. The committee is investigating mental health, which correlates with many other issues. It is a vital factor with immigration. I think the department of immigration needs to come under public scrutiny; it is time to find out what is happening with these things and how it is tormenting people. People have committed no crime; all they have done is ask the Australian people to provide them with a home, a sanctuary.

**Senator TROETH**—I have no questions.

**Senator WEBBER**—I have one further brief issue. You have mentioned that, while you were in the detention centre, you spent 12 months in solitary confinement.

**Mr Alshams**—Yes.

**Senator WEBBER**—I know that these sorts of questions can be a little intrusive, but could you tell me whether they gave you reasons for putting you in solitary confinement? How did you end up in there?

**Mr Alshams**—When I was in Villawood Detention Centre in 1999, they had two stages, stage 1 and stage 2. When I lodged my protection visa application, they transferred me to stage 2, which was a bigger facility. I had been in contact with a number of detainees. The way that people were treated and those sorts of things really outraged me and I organised a one-day hunger strike in the detention centre. DIMIA officers came to the centre and we presented them with a letter stating our concerns. They said, ‘We will talk about these things. We will fix these problems and we will send this letter to the minister’—those kinds of things. Two or three days later I was transferred to stage 1, where they gave me a cell to live in by myself. I spent most of my time there. I appeared before the Senate Legal and Constitutional Affairs Committee about my being in an immigration detention centre, and I understand that I was unjustly treated and under clear scrutiny and observation by DIMIA because I had appeared before that committee. This kind of treatment is hard to prove because a detainee has no resources and has access to nothing, but DIMIA and ACM have access to everything and can control and manipulate every fact.

**CHAIR**—I will ask you a little more about that solitary confinement. For how many hours of the day were you by yourself?

**Mr Alshams**—They put me in a cell and for the first few days I was by myself. Then the detention area became overcrowded and they assigned another detainee to share my room.

**CHAIR**—Were you able to mix at all with the general population at the centre?

**Mr Alshams**—After 6 o’clock in the morning I could talk to and mix with those who were in the dorm. Some incidents occurred during that time. One day the shadow immigration minister Con Sciacca MP came to the detention centre. I was in my room and suddenly the operations manager of the detention centre came and locked my room from the outside. He knew that I was articulate and would approach Con Sciacca and tell him about the bad things at the detention centre. These kinds of cunning and nasty things happened a number of times.

**CHAIR**—So you were free to come and go, except when your door was locked?

**Mr Alshams**—Yes, that is right.

**CHAIR**—I understand. Thank you very much for your submission and for appearing before us today. The committee very much appreciates it.



**Mr Alshams**—Thank you. I would like to present something to the committee. As mental health and human rights is highly correlated, I am organising a conference at federal Parliament House in Canberra. Because it is a rare opportunity for us to have public representatives come and listen to us, we are going to Parliament House to make them listen. I have some flyers here that I want to give to the committee.

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

**Mr Alshams**—Also I would like you to look at this book to see that the thing we are talking about, the unjust treatment of asylum seekers and refugees, is nothing new. I think the people who created the Migration Act 1958 had serious psychological problems. Please look at this book when you have time. I want to officially present this book to the committee.

**CHAIR**—Thank you very much.

[9.41 am]

**BROWN, Mr Alan, Board Member and Chair, Rural Affairs Committee, New South Wales Farmers Association**

**CASEY, Ms Brianna, Senior Policy Manager, Rural Affairs, New South Wales Farmers Association**

**CHAIR**—Welcome. You have lodged with the committee a submission, which we have numbered 410. Do you wish to make any amendments or additions to that document?

**Mr Brown**—No. We would like to read to you a short statement and then answer some questions on the submission.

**CHAIR**—That is what we will proceed to now.

**Mr Brown**—Firstly, the New South Wales Farmers Association is an apolitical, voluntary industry body representative of the whole farming community. We penetrate intensive industries as well as broadacre and livestock. The association presently has around 11,000 members across the state. Much of the association's knowledge of, and concern for, mental health conditions and services in rural and remote New South Wales has arisen due to the current severe and ongoing drought. The emotional stress from such adverse circumstances is impacting not only on farmers but also on their families and communities, and even on drought support services themselves. You may be aware that we conducted a rally in Parkes in May, where over 2,000 farmers turned up. I will talk about that in a bit more detail later.

Even in times of non-drought, the stress levels of farmers are rising due to the changing nature of farming—its globalisation and restructuring and the ageing of the farming population. There is also an ongoing technological revolution, which has meant that farmers are able to operate on a much larger scale than before. The problem is that acquiring larger scale usually means that you acquire larger debt. You would be well aware of the debt levels in the farming population at the moment, and they are rising. The drought has compounded that effect, leading to what we think is a worrying level.

The number of deaths by suicide of male farmers and farm workers is approximately double that of the Australian male population. There is also a significantly higher number of accidents—that is, death by firearm. You will note in our submission that the number of deaths by firearm accidents in the farming population is 10 times that of the regular male population in Australia. Deaths in car accidents are three times that of the regular male population. This is occurring particularly in remote areas. I have personal experience of a gentleman who lived about 10 kilometres from me. He was under extreme pressure and was the victim of a road accident in which he just ran off the road and into a tree. While you could never prove that it was a suicide, there was no other explanation for why that accident happened other than just going to sleep, and that is happening right across the farming population.

Despite this disproportionate level of depression in rural and remote areas, there remains poorer access to mental health support in these areas. This is last weekend's Wagga *Daily Advertiser*, where I come from. The front page story is about a gentleman who went to a men's retreat, was recognised as having a problem, was sent off to the local health unit at the base hospital, was discharged and then went on to knife someone in an attack in the main street just a very short time later.

**CHAIR**—Mr Brown, for the benefit of the *Hansard*, could you identify that paper?

**Mr Brown**—It is a front page story of the Wagga Wagga *Weekend Advertiser* of Saturday and Sunday, 30-31 July 2005.

**CHAIR**—Thank you.

**Mr Brown**—The point being that, even in Wagga, where there is a mental health unit, it is still obvious from that attack that they do not get it right all the time—that there is a lack of quality in the services provided. Wagga base hospital has around 20 mental health beds available for a catchment of 180,000 people. If you have that part of the state and draw in 180,000 people, it is a massive area. Most of those areas do not have access to mental health facilities within a reasonable distance.

The ratios of doctors, psychiatrists and mental health support personnel to the population is low. We are all aware of what is happening with GPs in the country; the same thing is happening with mental health. Coupled with this is the impact of rural culture on rural people seeking mental health support. Within rural culture mental illness can be perceived as a sign of weakness, thus preventing people from seeking assistance. The provision of mental health services needs to be mindful of this rural culture in order to reach those in need.

New South Wales Farmers Association believes that the requirements for addressing mental health illnesses currently occurring in rural and remote areas are twofold. The first thing to do is to help rural and remote people acknowledge and understand depression with the view to getting them to seek help. The association suggests a rural community education and destigmatisation of depression campaign taking into account the unique rural culture and perception of self. Certainly among my peers the view is alive and well that you should crack it hardy and do it tough—'She'll be right, mate, do it yourself.' I work alone for very long periods of time. It is difficult when you are under a lot of pressure not to have someone to listen to you as a relief valve.

The second thing we need is an increase in access to mental health support. We need an increase in GPs' awareness of depression and its management and we need practice nurses to be trained in basic counselling skills to help share the GPs' workload in the area. You may have seen *Four Corners* last night. It looked at Lake Cargelligo, which is a small town north-west of where I am. The load on the GP in that story was incredible. He is servicing double the number of patients a city doctor would. He is on call all the time and has no replacement when he has to leave for some reason—locums are very hard to come by.

The mental health teams in rural and remote areas should be expanded. The government should consider supporting charity or church groups which offer mental health support. You will

see a good example of that in our submission. The rural financial councillors should be supported, as they are often the first to receive a farmer in despair and are instrumental in helping farmers seek mental health help. The association also feels that the mental health of rural communities would likely benefit from other health workers—for example, pharmacists, nurses, physiotherapists et cetera—being trained in warning signs of depression, referral strategies and communication skills with respect to mental health problems so that they may be able to identify individuals needing help and help them to find it.

Whilst the drought may have a limited lifespan, its ramifications, such as depression and financial hardship and loss—friends, stock and property et cetera—will continue for many years thereafter. Even without drought, rural and remote people exhibit higher levels of mental illness than city dwellers, further suggesting their need for improved mental health teams. These provisions should be considered a necessary adjustment to the rural mental health teams in place rather than a short-term drought requirement. I personally believe that it is very important for the government to act now on recommendations such as these—not just because the need exists now but because I think farmers will be responsive now.

At the Parkes summit in May I saw farmers stand up in front of 2,000 of their peers and talk first-hand about their mental anguish at what they were going through. One example is a friend of mine from West Wyalong. Four years ago his overdraft was \$60,000 and very manageable. Today, with the same size enterprise, his overdraft is over \$1 million. The problem with that is that once interest becomes a significant part of your expenses it is very difficult to recover from, and the mental pressure that goes on from that sort of load is very difficult for people to cope with. They often cannot see a way out other than, of course, the easy way.

The mental health of the rural population is something that the association is taking very seriously. In early June we organised a mental health forum which brought together all the key mental health players to discuss how we could best address the rural mental health issue. The forum included: the Australian Centre for Agricultural Health and Safety, the Centre for Rural and Remote Mental Health, ANU Centre for Mental Health Research, CSU Centre for Rural Social Research, Rural Doctors Association of Australia, Centrelink, the Country Women's Association, beyondblue, and charity groups such as the Salvos and Anglicare. At the end of the day we had created a mental health network complete with a blueprint of key issues and a breakdown of how and who within the network will address them. It is currently in progress. We would be happy to answer any questions you have about our submission or anything else related to this issue. Thank you.

**CHAIR**—I have a question about the gender differences in rural communities. We tend to talk in the male sense, which may be part of culture, but are women also affected by depression and other mental illness as a result of the drought and the economic circumstances of their farm?

**Mr Brown**—I would say very much so. Most family farms operate as just that, where there is always a female member as well. They are put under enormous pressure as well because the farmer—and I do it all the time—tends to come home with the problems in hand and you need someone to let the problems out to and that tends to be the farmer's wife. Also, there are many farm units where the female is very active, if not in complete control, and they are suffering the same problems as males. I apologise for my submission being mainly male oriented but that is because of the way I am.

**CHAIR**—You would have expected that to be the first question I would ask, wouldn't you?

**Mr Brown**—Absolutely. It is completely understood and completely valid. In some cases it is even worse. Because males tend to be stronger, the women can be victims of violence as well.

**CHAIR**—Indeed. You mentioned rural mental health teams. What are you including in that? Are you just talking about the GP and his or her practice nurse, or is there a team? In some areas in New South Wales are there people who go around as a team?

**Ms Casey**—It does vary from community to community but generally the load is predominantly on GPs. From my observation and experience in the last couple of years I have to say though that the Rural Financial Counselling Network has been instrumental in this process. They have been not only the financial counsellors but the emotional counsellors as well. I guess the reason we held our drought summit in Parkes, amongst many other reasons, was that we were seeing those people supporting people in need as needing support themselves. When we saw support services struggling with nowhere else to go we realised that we had a problem of massive magnitude. Those rural financial counsellors tend to work in consultation with local counselling services. Some Centrelink offices have got some fabulous people who almost act in an extension role. It is those sorts of collaborative services that tend to be more powerful than an ad hoc approach, and we really want to see more of those.

**Mr Brown**—You need to understand that, particularly in the area of debt, only about 20 per cent of farmers are actually able to access EC assistance. In the example I gave you, that gentleman needs to find \$8,000 to \$10,000 a year just to pay interest on his overdraft. That puts enormous pressure on people and that pressure goes out right across the community particularly to the rural financial advisers because they tend to be the first point of call. They are put under enormous pressure at times by these people, who see no way out.

**CHAIR**—We understand that 15 to 18 per cent of GPs in rural New South Wales have done mental health training that brings them into the federal government's better outcomes in mental health program whereby they can refer patients to psychologists. Do you have the figures for New South Wales? Are those with this training mostly in the cities, or are they spread out around the country? What is the willingness of GPs in rural New South Wales to engage in these programs?

**Ms Casey**—I do not have the figures with me, but certainly at the mental health forum that we held in early June the representatives from the Rural Doctors Association were telling us of similar statistics. In New South Wales, whilst there are hot spots where doctors are trained up in those skills, it tends to be the rural and remote areas that are suffering in terms of the training in that area.

**CHAIR**—By 'suffering' do you mean they are not getting it?

**Ms Casey**—They are not getting sufficient training to assist them through the process. As Alan mentioned with respect to the *Four Corners* program last night, the load on rural GPs is just so much more significant than on city GPs, because they are never off duty. When you have a GP living down the road or only one GP in the community, it is not a nine to five job,

unfortunately. Whilst a lot of those GPs are accidental counsellors, we really need to see some professional training and development brought into that process on a very regular basis.

**CHAIR**—Is the participation in the better mental health outcomes program where a psychologist can be used for six consultations, then another six consultations if necessary, unheard of?

**Ms Casey**—I do not think it is unheard of. I think we would certainly embrace and support more of it.

**CHAIR**—But you have not heard that there is a great deal of it going on in country New South Wales?

**Ms Casey**—No.

**Senator TROETH**—I am interested in your suggestion about rural financial counsellors, because I am certainly aware of the job that they do. I also know that often they are the first port of call but then they can refer people on to other services. I think in some ways it is a very good suggestion that people can talk to rural financial counsellors initially, but it is placing a tremendous professional burden on those people, expecting them to be emotional counsellors as well as financial counsellors.

**Mr Brown**—But, in fact, that is what they are already doing.

**Senator TROETH**—Yes, I do realise that.

**Mr Brown**—It is important to realise that, while the drought may be ending—we hope it is—the financial drought will drag on the years. The example I quoted you was to illustrate just how long that will drag on. It will go on for years. The financial pressure from this will last probably for a decade for most people.

**Senator TROETH**—In regional hospitals in New South Wales, is there any regular program of visiting psychologists or psychiatrists? I know it is often on a three-week or four-week roster. In your experience, what is the incidence of people being able to use those services in hospitals?

**Ms Casey**—Again, I think it varies from community to community, but those services are being utilised. As a community we probably need to open up a bit more about how much we are using those services. I guess it is a little bit like a budget: if you do not use all of your budget in one year you probably are not going to get it again the next year. Similarly, if we do not have not just farmers but other people in rural communities openly talking about the fact that they are utilising these services, it is very difficult for us to argue that there is that demand there. Unfortunately, within the rural subculture there tends to be a stigma attached to seeing a counsellor or a professional. This is why ‘accidental’ counsellors, such as rural financial counsellors, a hairdresser, a nurse or someone you tend to interact with on a regular basis, seem to be tolerated better; it is talking to someone who does not have that tag attached to them.

**Mr Brown**—I also think one of the problems in the country is that, because there is no immediate access to more sophisticated mental health professionals, doctors tend to take the

chemical solution. I do not think that is particularly healthy. I have an example from the farmers conference we had two weeks ago where a lady I was talking to was in a panic because her husband had just had his dose of whatever he was on increased. As you would be aware with these drugs, when you come off them or go on them, or go onto a heavier dose, the effects can be quite dramatic. She was very concerned about not being around when her husband was increasing his dose—I forget the name of the chemical, but it does not matter. The problem in that case is that almost all farmers have guns because we need them as a regular part of farming. They are too readily available in a situation like that. She was genuinely concerned. She wanted to get home as quickly as possible just to be there while he had this dose change.

**Senator TROETH**—In order to provide help for some of those situations, you have also mentioned the possibility of upskilling practice nurses. Has that been tried at all in New South Wales?

**Ms Casey**—Not to my knowledge, but it may well be happening. We are learning all the time about this process; and, as Alan mentioned, the drought has really highlighted the association's awareness of these issues. I think that as communication and dialogue happens more, we will hear more examples of the positives that are happening so that we can look at applying them in other areas as well.

**Senator TROETH**—From what you have said, you would see as one of the solutions providing a range of informal assistance as well as what is provided by GPs and other health professionals?

**Ms Casey**—Particularly from a referral perspective, yes.

**Senator FORSHAW**—Could I clarify something. In your submission, on page 3, you say:

Research suggests that the changing nature of farming—globalisation, restructuring and downsizing, are all contributing to elevated stress.

I just want to clarify what you meant by 'downsizing'. I have an understanding of what the word means. I used to work for the Australian Workers Union, and we used to have quite a lot of friendly negotiations with your organisation. What are you using the term to refer to there? I understood that farms are essentially becoming larger rather than smaller.

**Mr Brown**—Could I just say that this document was written by a lady who works for New South Wales Farmers Association, and very occasionally errors slip through. You are looking at one.

**Ms Casey**—If I could challenge my chairman—which one should not do—picking up on one of Alan's earlier comments, we are seeing a technological revolution, and some industries are becoming increasingly mechanised, which is leading to reductions in the work force. It does vary from commodity sector to commodity sector.

**Mr Brown**—Also, I assume it could mean that there is increasing intensification, rather than broadacre areas. It could refer to that too.

**Senator FORSHAW**—I assume that it could also mean that farms are getting larger but the number of people, particularly with family farms, is getting smaller.

**Mr Brown**—That is a dramatic effect, and if you watched *Four Corners* last night, you saw a couple of families, who are involved on the side of agriculture, moving away from Lake Cargelligo. I see that quite dramatically in the area where I am. The actual number of people involved in agriculture is going down all the time, but the pressure on those who are still there is not decreasing. It is probably increasing, if anything.

**Senator FORSHAW**—That is the catch-22: economies of scale tell you to get bigger, so you buy the property next door if that farm collapses, but it does not necessarily lead to improvement if the promises are not met.

**Mr Brown**—Buying the property next door is one thing, but then you have to buy machinery capable of handling a larger area. The time window to operate in is the same, so you have to operate much quicker to increase the amount of work in a shorter time. And then you add collapsing income. One thing I have seen in the last four years is that most farmers tend to believe that, when you have a drought, the year after will be good, because time and again that is what happens. So what you see is that people say, 'We have had a drought so next year we will put in a bit extra.' They put in a bit extra and lose that, and then they say, 'It cannot happen three years in a row'—but it did. And now it has happened four years in a row.

**Senator FORSHAW**—That is how your \$60,000 overdraft becomes a \$1 million overdraft.

**Mr Brown**—That is it. You have got to understand that that person's productive capability has not increased at all; all that has increased is his debt. I think that is unsustainable in that case, but that is quite common across the broadacre areas of New South Wales.

**Senator FORSHAW**—You mentioned the network. You said in your remarks and in your submission that there needs to be a 'destigmatisation campaign'. I think those were your words. Could you expand a little bit more on that network that you had—particularly what the New South Wales Farmers, or the NFF or other state farming bodies, are doing to try to raise awareness of the issue and also be involved in education or promotion? Do not get me wrong: I am not suggesting it is necessarily your job. But it would seem that, as you say, charities and church groups should be involved. For instance, I understand that Rotary—one organisation amongst many—is involved in trying to promote education on and understanding of mental illness, particularly in workplaces. I would be interested to hear how you see the future role of the NSW Farmers Association in such a program. Do you think it would be appropriate for a body such as yours to be funded by government to be involved in this?

**Mr Brown**—I will ask Brianna to answer in detail; I will give you a general answer. The role of the NSW Farmers Association in general tends to be as a coordinator and as a focus. We do not have the resources to apply anything very complex on the ground. We tend to organise these sorts of things so that already available resources can be focused where they should be.

**Senator FORSHAW**—Farmers, of course, are members of your organisation and, presumably, that is the first port of call for them for advice and assistance in farming.



**Mr Brown**—It can be.

**Senator FORSHAW**—I am trying to work out how your organisation could be connected to an education campaign. I assume you run other education campaigns on farm safety, industrial relations, retirement, financial management and that sort of thing.

**Mr Brown**—Yes.

**Ms Casey**—To pick up on that network, at our rural mental health forum we held in early June, as Alan mentioned earlier, a range of organisations came on board—from the Rural Doctors Association, to Centrelink, through to the Centre for Agricultural Health and Safety. The common thread throughout all of it was that this issue of mental health is so big that we need to attack it collaboratively but one piece at a time. Our focus in the short term is on depression as a key priority. From my perspective, I found our drought summit historic in that people were openly and willingly talking about depression with their peers. Grown men stood up in an audience of 2,000 farmers with tears streaming down their face and talked about how close the end can seem, how desperate farming can be and how bad they felt that this one drought summit, which was about getting a political result, was the only reason they had left the farm in three months. This is worrying stuff that we need to address as a community.

Our network is about bringing together all of those support and interest groups and identifying a series of actions that can help us take it forward. We have 22 recommendations from the day. One key priority is to address the destigmatisation issue. We see the media as a critical part of that role. We are actually working very closely with ABC regional radio to get five-minute slots for a respected mental health professional on the radio once a week. It might involve someone from beyondblue who provides mental health referral services or a professor or a doctor. They will talk about issues and make sure people are talking about it. They will encourage awareness within the community and encourage people to look out for other signs. We certainly will be running a campaign but, as Alan mentioned, we do not have the resources to really penetrate into the regions where we want to. Whilst we have plenty of ideas coming forward about how to utilise the media, how to utilise each other's networks and how to use our farmers on the ground and fabulous, vibrant communities who can pick this up and run with it, we probably do need those additional resources to make sure it is a whole-of-state and whole-of-mental-health campaign rather than just a depression campaign.

**Senator FORSHAW**—Do you have a written summary of that forum that you can provide to the committee?

**Ms Casey**—Yes, we do. We certainly could provide that to the secretariat.

**Senator FORSHAW**—Can I assume that some of the recommendations in your submission pick up on what came out of that forum?

**Ms Casey**—The forum was actually held after our submission went in. It was useful for us to table some of those recommendations on the day. We were able to say: 'Here's what the association is thinking of doing in this area and here's what we've put to government. Are they the same kinds of ideas that you are thinking of? Do you think they will have the penetration?' We heard some really interesting ideas that day, including skilling up hairdressers in how to

recognise the signs of depression and refer people on. I know that this is very controversial within the medical association. I am sure you have heard more about it.

**Senator FORSHAW**—We have.

**Senator WEBBER**—We absolutely have been hearing about the hairdressers!

**Ms Casey**—I bet. But as humorous as it may sound, as a lady who went and got her hair cut on Saturday I know that you open up to your hairdresser. I do not know why. Maybe it is the fact that they are standing behind you and you feel like you can open up. From my perspective, the more we can do to encourage people to open up about these issues the better. I do not care who it is. I do not care if it is the dog, the hairdresser or the doctor—just talk.

**Senator FORSHAW**—You mentioned medication, and you gave the example of increasing the dosage. But it would be a major concern as well in terms of the actual work involved, such as operating machinery. We know that accidents on farms, through the use of machinery and the handling of chemicals, are serious issues in occupational health and safety. No doubt it is a concern if people are trying to do that work on a farm and are heavily medicated as well. Obviously you focus on people who are operating farms. From your organisation's perspective, what about people who have had to walk away from their farm because they have been deregulated out of industries such as dairying, timber, meat and sugar? These are ones that I constantly hear about in northern New South Wales. They do not necessarily find other employment when they go into town. Do you have any comment about the situation of people who have had to walk away from their property and get out of farming? What mental health issues do they continue to have?

**Mr Brown**—You would be well aware, no doubt, of the restructuring that has been happening in agriculture for the last 20 years or more. There has been a constant movement to larger scale enterprise, and there are always casualties from that. I know quite a few people who have done exactly what you say: they have left the farm. Some of them are fine because they are able to handle the adjustment well, but some certainly are not and they do not handle it well at all. But it is not an easy thing to encompass in a short time, because there is almost an individual effect on them.

I would try to make it clear that we speak for all of rural and remote Australia. We do not confine ourselves entirely to farmers. There are a whole lot of support people. The shearing industry is in absolute decline at the moment. There are some sad cases around that. But it affects everybody. The contractors we use are under extreme pressure at the moment because it is difficult to find work. It is difficult to handle all the regulation that is in place, in New South Wales in particular. But everybody gets sucked into the same problem. Machinery dealers, the whole lot, all get pulled into the same vortex because they swing around farmers.

**Senator FORSHAW**—That is why I asked you the question. I am aware of this from other sources but also from the poverty inquiry—that is, the situation in rural towns and the pressure on agencies, such as St Vinnies, because of cutbacks or the closure of government services which provided employment. As you say, it is not just farmers who are affected.

**Mr Brown**—You would be well aware of the extraordinary difference between incomes in country New South Wales and the city at the moment. You need a lot of money just to live in Sydney, but the difference now in income is quite extraordinary.

**Senator WEBBER**—You mentioned earlier the use of ABC regional radio to get the message out. I want to expand on that and find out about regional media generally: how accepting they are of helping you to get the message out there and how knowledgeable they are of the plight of people in terms of their mental health.

**Ms Casey**—Experience is telling us that the time is right to start tackling this stuff. I do not want to put too much emphasis on the significance of our drought summit in Parkes, but it was a cornerstone, if you like.

**Senator WEBBER**—I am from Western Australia and I know all about your drought summit in Parkes.

**Ms Casey**—It was good to have Jeff Kennett there and to be talking so openly about depression—the fact that it was a figurehead and someone people recognised and that it was okay to talk. When you go to follow-up meetings, not even on drought, it is interesting to hear people say, ‘Did you see Jeff Kennett?’ They are actually talking by accident about depression. The media gave it a great run, and they gave a great run to the fact that we did not just have a session talking to politicians about what we needed from drought; we had a session called ‘bugger the drought’—about how we actually manage the human side of things. The fact that the media picked it up and ran with it was, I thought, historic, really. I think we do have a great opportunity. I know from colleagues in beyondblue that the media have been very supportive of campaigns they are running about talking about depression and those sorts of issues. I think we do have a great opportunity. We need to look not only at radio but also at print media and television. Again, just talking about the issues is an enormous step forward, provided we have those referral services in place, because when you pick up the signs you need to have an understanding of them and an awareness of where to send people.

**Mr Brown**—I think the key thing that came out with Parkes, as Brianna quite correctly said, is that it started off as a political exercise to try to get more assistance for farmers but it ended up very much as an expose of what is happening mentally to people right across the state. The key point is that most, if not all, of this is fixable. This is not intractable; it is not like a cancer that you cannot fix. Sure, there are some people whom you cannot rescue, but I would suggest that most of them are well and truly rescueable.

**Senator WEBBER**—When you deal with regional media do you find that there is an awareness or do you have to re-educate them as well? One of the issues that people raise is that their first hurdle, particularly with people in rural and regional Australia, is to destigmatise talking about it. Do you have to go through that process with the journalists and re-educate them before they can help you get the message out, or do they already have a fair bit of awareness?

**Mr Brown**—The ones I deal with regularly are certainly aware. The problem is, of course, to find a new hook for them to use as a story, which is never easy with an ongoing issue, whereas if you have a particular issue they will usually run with it. They are very cooperative, but it is not so easy just to come up with a new hook. Obviously Parkes was a hook for us for quite a while,

but its effect will pass in that way. It is difficult to get out there and get a story going other than about some bloke shooting himself or some lady driving a car into a tree or whatever. It is difficult to get a hook to get a story going.

**Ms Casey**—That raises that very fine line about the code of conduct that the media has with respect to reporting suicides. Whilst we are encouraging people to talk about depression and how to get help, by no means are we trying to imply that suicide is normal or trying to glorify these issues. It is a really fine line that we have to dance along.

**Senator WEBBER**—In your submission you mention a trial being conducted by Charles Sturt University involving a collaboration between GPs and psychologists, where psychologists work within rural general practice. Could you give the committee a bit more information about the trial, how it is going, how extensive it is and whose initiative it was? I notice you recommend expanding it.

**Ms Casey**—I would love to, but I have not done an update in the last couple of weeks to see where it is up to. We can certainly provide that after the meeting.

**Senator WEBBER**—It would be lovely if you could take that on notice.

**Ms Casey**—Certainly.

**Senator WEBBER**—We have discussed a lot about the impact on individual farmers, and Senator Allison expanded that to, perhaps, the farmers' partners. I was wondering whether the association has done any work on or is aware of the impact that this is having on the children and the extended family network of farmers and their families.

**Ms Casey**—It is a really big issue. We saw that with a lot of young children who are coming along to meetings simply because parents cannot access child care. I am thinking of a good example outside of drought: wild dogs. One of the biggest issues came up for us when we were looking at a baiting program for wild dogs in national parks down south. We met with a family whose son was traumatised from constantly having to see in the paddock sheep that had been attacked by wild dogs. He was traumatised to the point of having nightmares, and he had childhood depression as a result of that. So we are seeing a lot of triggers through some of the more unfortunate sides of farming. Again we need to ensure that we have specialist services not only for adult depression but also for childhood depression. We certainly need to see some improvements in that area. It is a high priority for us.

**Senator FORSHAW**—I would like to follow that up. We know that there are programs run in schools to promote awareness of mental health issues. There have also been submissions made to us about increasing the use of online services and information. Farmers today rely heavily on the computer as well as all the hard work that they do out in the field. Do you have any comment on those areas? Do you see much evidence of programs being available in schools? Obviously, I am talking about schools in rural and remote areas.

**Ms Casey**—I am trying to find the name of a program that is run out of the CSU Centre for Rural Social Research. They have a mental health checklist on a web site that they have aimed at the general public, but that I think they are now tailoring for children as well. Again, we did not

know about that until our forum. It is a matter of getting awareness of those programs out and running. Because we tend to have so much interaction on a rural community basis we need to be aware of them so that we can talk about them as well.

My younger brother is in high school in a rural area. A friend of his was diagnosed with depression. He had no concept of what that meant or how to deal with it. He jumped on the beyondblue web site and found all of these fact sheets designed for teenagers: how to help your friends, how to be a support and the questions to ask. I went home and he had printed off so much stuff, I could not believe it. I thought, 'If only you would apply yourself to homework the way that you have to this.' At least they had somewhere to go.

I am not trying to be trite, but Google is a wonderful tool. You can type in 'depression', 'fact sheets' or 'advice for kids' and this wealth of information comes up. We need to encourage that and hopefully put up some sort of one-stop shop where we can provide a tool to guide people in the right direction. It is a bit like firing a shotgun and seeing what comes out. If we had some sort of central place where people could go and know that they were being referred to the right specialist area, it would be fantastic.

**CHAIR**—I will ask you one final question about what has been described in most submissions as comorbid conditions—that is, people with mental illness who are on medication but often self-medicate through drug and alcohol use because the side effects of medication are not easy to cope with. Are there signs of this in rural communities as well or is this a problem which is more common in city areas?

**Mr Brown**—I think it is alive and well in rural areas. Certainly there are problems with alcohol that are not decreasing. One thing that has changed is that the drink and drive rules in the place where the alcohol is consumed are changing. Certainly the abuse of alcohol is an ongoing problem.

**CHAIR**—But you do not have evidence of—

**Mr Brown**—Not specifically.

**CHAIR**—for instance, problems with people getting services because they have an abuse problem as well as a mental illness problem.

**Ms Casey**—This was raised as an issue in our blueprint. I will read from it because it was based on advice that came in through one of the network participants. It states that one of our key priorities is improved access to drug and alcohol programs and services. It says:

Drug and alcohol services can provide both prevention and care services.

That is critical for us—not only putting a bandaid on the problem but looking at prevention as well. It continues:

There is a perceived gap in drug and alcohol services, particularly in rural areas.

It highlights early identification, recognition and services to assist as particular priorities. It then says:

The network should include drug and alcohol service providers to develop relevant services and resources for the farm sector, and to ensure that treatment services are accessible and effective.

So certainly network participants perceive a gap. I guess the next step for us is to look at whether there are any particular regional hotspots where that gap is more prevalent than others.

**CHAIR**—I want to follow up on your suggestion that practice nurses have training in counselling. How do you see that operating? Would practice nurses simply talk to people who are waiting to see the GP or do you see them attempting to counsel people in sessions per se? Can you expand on whether it works well somewhere where you have drawn this recommendation from and how you see it operating?

**Mr Brown**—I can only make some very general comments because I have not personally seen it operate. You have to understand that GPs are under so much pressure that we see this as an option to align with what GPs do and to try in some way to help people who present with some sort of a problem.

**CHAIR**—So it is the germ of a recommendation at this stage.

**Mr Brown**—Yes, very much so.

**CHAIR**—Thank you so much for your submission and for appearing today.

**Proceedings suspended from 10.25 am to 10.35 am**

**BATH, Ms Nicola Jayne, Manager, Treatment Program and Policy, Australian Injecting and Illicit Drug Users League**

**CHAIR**—Welcome. We have received your submission, which we have numbered 281. Are there any alterations or additions that you wish to make at this stage?

**Ms Bath**—No.

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

**Ms Bath**—I would like to begin by thanking the committee for inviting AIVL to participate in this public hearing today. As you will know from the submission, AIVL is the peak national peer based organisation for the state and territory drug user organisations and represents people who use illicit drugs on issues of national significance. As our written submission shows, there are an array of challenges that people who are living with comorbidity have to manage. In summary, these include but are not limited to inability to access appropriate services, receiving lower standards of care, experiencing a lower quality of life, being misdiagnosed and being treated by services as difficult.

Being dependent on illicit drugs places great stress and pressures on an individual. For example, there is the ongoing threat of arrest, multilayered discrimination and stigma, being at risk of or living with blood-borne viruses, such as hepatitis C, and being disregarded by the broader community. All these cause and exacerbate mental health problems. Many people living with comorbidity report that their attempts to manage their mental health are often wasted. John from South Australia reported the following to AIVL:

Mental health professionals will not treat you or take the proper time to find out what the mental health issue is because you are a drug user and they believe this to be either the underlying problem or that your current drug use will inhibit any medications or treatment. I have lived with depression for many years, since well before I began to use illicit drugs, yet several psychiatrists have refused to treat me because of my injecting drug use. I am told continually to come back to see them when I am not using any more and they will treat me.

Within the alcohol and other drug and mental health sectors there continues to be inability to manage people living with comorbidity, a lack of skills and expertise across the two sectors, insufficient partnership working and the continuing exclusion of consumer involvement.

The research study on barriers and incentives to treatment for illicit drug users that AIVL was a partner in, along with LMS Consulting and the National Centre in HIV Social Research, showed that there is a need for governments to work together to improve the interrelationship between drug and alcohol and mental health disciplines. I have brought one copy of the monograph *Barriers and incentives to treatment for illicit drug users* for the committee but I only have the one, I could not bring any more but I can make more available to you.

**CHAIR**—Thank you.

**Ms Bath**—We are currently working on a follow-up study from this initial one looking at consumer experiences of comorbidity and exploring how mental health may or may not be included within drug treatment settings. You will understand that I am unable at this time to give you the specifics of our findings to date. I can however inform you that there is sufficient evidence to suggest that there is a lack of cohesion in the treatment of comorbidity from both consumer and service provider perspectives. There appears to be a lack of comprehensive models of care across drug treatment, and consumers that are able to access treatment do so by luck rather than by any structured care planning. The final report from this study will be available in mid-2006.

While there is a growing interest in comorbidity across Australia the lives of people living with comorbidity remain unchanged. Being pushed from one service to another, being misunderstood and being mistreated is sadly not uncommon. There is an urgent need to develop holistic models of care that incorporate harm reduction strategies and consumer involvement. Services for people with comorbidity need to be more pragmatic, accept that the use of illicit drugs exists and recognise that there are alternative treatment options available. For many years, the mental health sector has benefited from a vibrant and valued consumer advocacy. Sadly, this has not been extended to drug treatment and those that are living with comorbidity. The expertise of consumers is being ignored and devalued at both individual and collective levels. AIVL hopes that this inquiry will enable this current status quo to be changed.

AIVL recognises the complexities of managing comorbidity. Some but not all people who use illicit drugs experience wide-ranging mental health issues. It is paramount that the drug and alcohol and mental health sectors are supported to develop appropriate services that are well monitored and evaluate and incorporate consumer involvement.

**CHAIR**—Yours is not the only submission to tell us of the difficulties of treatment for people with comorbid conditions. You say there is no cohesion and there is no comprehensive model of care. Is that because there is none anywhere? Is this so difficult a problem to deal with that we just cannot grasp how to do it? Or is it a convenient excuse for psychiatrists and other mental health workers to say, 'Come back when you're not injecting anymore'? How do you describe the problem?

**Ms Bath**—I think it is multifaceted. I think from the drug and alcohol perspective and from the mental health sector there is a lot of underresourcing, and the services themselves are extremely busy. Some models have been developed around bringing together the mental health and drug and alcohol sectors. Within the ACT I understand that there is a good flowchart—'If somebody is presenting with this, refer them here'—and a modelling of trying to bring workers from drug and alcohol into mental health and workers from mental health into drug and alcohol. When I was working on the Comorbidity Task Force, one of the things that we were looking at was how to get these models across the country to get them more publicly known so that other people could start to duplicate them.

So I do not think there is one reason or another. There are some models available, but also the services are so busy that taking on these extra issues can be problematic. Also, though, I think that within the drug and alcohol sector there may be a reluctance to recognise some of the mental health issues that people present with and a bundling of that to always blame that on the drugs



that the people are using and the lives that people are living and to say absolutely: 'If you were to stop X then Y would not happen.'

**CHAIR**—Can you tell us about your work on the National Comorbidity Task Force and about why it was disbanded?

**Ms Bath**—That was a subcommittee of the National Comorbidity Project. We worked together to create a work plan. We got as far as developing our work plan and sought funding to assist us to carry out that work. That was disbanded at that time. There was not sufficient funding for us to undertake that work, which is a great shame. There were some great ideas coming out of that committee, such as looking for valuable models of working around comorbidity and looking at how we could disperse those models across the country. But sadly we were unable to continue with that.

**CHAIR**—What reasons were given for disbanding the task force?

**Ms Bath**—We were unable to do that work without funding to support us.

**CHAIR**—Where does your funding come from?

**Ms Bath**—We sought funding from the national comorbidity money, and that money was not available to us.

**CHAIR**—So the project is still operating; it is just that the task force that came under it is defunded?

**Ms Bath**—That is right. We never had funding for that work. We got together and did our work plan. Then, when we went to seek funding to assist us in actually working on the work plan, that money was not available to us. But I can contact Lynne Magor-Blatch, who was the secretariat for the task force, and get more a substantial rationale as to what happened with that task force, if you would like me to.

**CHAIR**—I think that would be very useful for the committee, as would information about the stage at which you had to finish your work and what the task force might have done had it been able to be funded for a longer term.

**Ms Bath**—That is no problem. I will get that. I will send you the work plan we developed too.

**CHAIR**—That would be very good. Thank you very much.

**Senator WEBBER**—Earlier today we heard some evidence on the particular issue of the treatment that people face in detention centres. I want to turn my attention to people that are in another form of incarceration, prison. As your submission addresses some of this area, I am wondering if you could expand on how we deal at the moment with comorbidity in New South Wales prisons.

**Ms Bath**—I will not be able to give you specifics as to New South Wales. I am actually based in New South Wales but AIVL works nationally. On a national perspective, some of the

difficulties are around continuation of treatment. If people are receiving treatment within the community, that treatment can then be interrupted by or cease due to their going into prison and vice versa: people might be able to access treatment within the prison setting but there is very little throughcare for people on release for them to then access that same treatment. For a lot of prisoners, particularly illicit drug users, when released there is insufficient throughcare, so people are not referred on to services within the community when they leave prison. This is a problem in a whole array of issues and adds to the perpetuation of the cycle of going into prison, back into the community and back into prison. Of course people's mental health problems can be exacerbated within the prison context per se and people can develop mental health issues while in prison that maybe they did not have in the community. We know that the prison environment itself will exacerbate as well as initiate mental health problems such as depression and anxiety.

**Senator WEBBER**—If people do develop those mental health issues in a prison setting, has your organisation noticed whether they then develop any of the other comorbidities that go with mental health issues when people are incarcerated or do they tend to present with those issues before they are incarcerated?

**Ms Bath**—I think it is both. We see and hear of people who have quite complex comorbidity on a scale of one to 10 of mental health issues—people with schizophrenia who are being managed or not in the community, who then go into prison and are also unable to have that managed and then come back out. Within the prison context there is a missed opportunity for getting people on to appropriate treatment and having appropriate assessments. Some of the pharmacotherapies for mental health issues take some time to actually get into the system and work, and prison creates an opportunity for an appropriate intervention to assist in the management of comorbidity.

**Senator TROETH**—You spoke earlier about some general practitioners or people in the medical field not being willing to treat people who at the same time are using illegal drugs. Do you think from your experience that is a widespread attitude?

**Ms Bath**—I think it is a widespread attitude. The nature of illicit drug use is pathologised by many and then there is, within the medical context, actually getting a good quality of care. As with the example I gave of John in South Australia, it is very much a case that if you stop using, this mental health issue that you are presenting with will either go away or will then be able to be treated. It is very common for people to not be able to get appropriate treatment from either a drug and alcohol service, their GP or mental health services. I worked in the UK and can say this is not an Australia only issue. This is an international issue as to the difficulties in managing comorbidity. It is often referred to as being like playing tennis. If it is the case that someone needs to go to mental health services, mental health services will say, 'You've got a drug and alcohol problem. You need to go back to the drug and alcohol service,' so this poor person is just left going from service to service seeking treatment that is not available.

One of the issues around that is the lack of consumer involvement in the development of models such as peer mentors that can assist people to access treatment and also mentors for people that are using illicit drugs: people who self-medicate, people who cope with the physical and mental health issues that they experience on a daily basis. Actually naming it can also be very hard. Going into drug treatment is an issue. Even though some people will go in every day to be dosed, actually seeking treatment can be difficult. There are many barriers to accessing

treatment. We conducted a study in partnership with the South Western Sydney Area Health Service recently. Sadly, I am unable to present the specifics of that data today. We are clearly seeing options for treatment and opportunities for treatment being missed through lack of effective case management within drug and alcohol treatment services. While some may see that there is an array of services available for people who use illicit drugs, actually accessing the services that you need can be extremely difficult.

**Senator TROETH**—Particularly in a coordinated manner.

**Ms Bath**—Absolutely. There needs to be care planning, effective shared care, where a person is treated as a whole person rather than saying: ‘Okay, you’ve got this, so you need to go there. Okay, you’ve got a physical health problem, you need to go there.’ There are very few options for that one-stop holistic service where there is supportive coordinated health care planning.

**Senator TROETH**—For a non-medical person, could you give us a layman’s definition of comorbidity?

**Ms Bath**—Yes, comorbidity is where you have existing drug dependence and a mental health issue.

**Senator TROETH**—Thank you.

**Ms Bath**—Can I also explain to you, through the follow-up study that we have done from the barriers and incentive study, it is clear that another barrier to treatment is that people who are living with comorbidity do not even understand what comorbidity is. It is a term that is used within services that very few people who are actually living with drug dependence and a mental health issue understand.

**Senator FORSHAW**—So that we can get it on the record, can you give us a summary of the Australian Injecting and Illicit Drug Users League? What is its structure and its membership? How long has it been going and what is the specific work that it does? I understand it obviously includes research.

**Ms Bath**—AIVL has been in existence for about 15 years. For many of those years, that has been in an unfunded capacity. Approximately six to seven years ago, AIVL was initially funded by the Australian government, through the hepatitis C section, to undertake educational work. For the past four years we have also been funded to undertake a policy program, which is where I have been working. We produce national education resources for people who use illicit drugs specifically in relation to hepatitis C. We also undertake policy and advocacy work. We undertake research, and we have also just been awarded money by the illicit drugs section to undertake a research study looking at consumer involvement within drug and alcohol treatment settings. The membership of AIVL is made up of the state and territory drug user organisations within each of the states and territories, except for Tasmania and Queensland.

**Senator FORSHAW**—There are no state drug user organisations? Which groups would they be in New South Wales, for instance?

**Ms Bath**—In New South Wales, it is the New South Wales Users and Aids Association—NUAA.

**Senator FORSHAW**—What sorts of formal or informal links do you have to other bodies that are set up to particularly deal with, say, drug and alcohol issues or mental health issues? I am particularly thinking of government or semi government ones that are run out of the public health system.

**Ms Bath**—AIVL has worked in partnership with organisations like the Alcohol and other Drugs Council of Australia, and the Australian National Council on Drugs. Through some work that we have done in the past two years looking at partnerships, we have worked with various mental health national bodies. I am afraid I cannot remember the names of them right now. We work with the national research centres and support our member organisations to continue to develop relationships at the state and territory levels. We often work on national working groups and committees on the whole array of issues relating to the use of illicit drugs and blood-borne viruses. But primarily, we are funded only around hepatitis C issues.

**Senator FORSHAW**—There are a couple of things I want to discuss. There is a statement in the submission; it is on the second page, under the heading of ‘Other issues’. Your submission says:

The issue of self mediation can be ignored by treatment ... Many people self mediate by using illicit drugs to manage the symptoms of their mental health problems.

You then go on to specifically refer—you say it is anecdotal evidence—to people using heroin and cannabis to try and alleviate mental health symptoms. Do you have any specific figures or estimates for the proportion of people you would put into the comorbidity category for illicit drug use and mental health issues? How big a problem is that?

**Ms Bath**—People who are self-medicating?

**Senator FORSHAW**—Yes, and using those drugs to relieve mental illness symptoms as distinct from using them because of a long-term addiction. They may have that anyway.

**Ms Bath**—I do not have specific figures on that. The information that we get around that issue is anecdotal. But I can certainly go away and have a look for you.

**Senator FORSHAW**—Yes, please, because there is evidence put out by some groups to say that cannabis can be of some assistance in pain relief and a campaign is being run to argue the issue that it should be available in certain circumstances to people who are terminally ill. We know that many years ago hallucinogenics such as LSD were given to people who suffered from schizophrenia. Supposedly it was used as a therapeutic remedy, but of course it is now illegal.

The other thing that I want to get a bit more clarity on is that it is being argued that people who have comorbid conditions are, as you said, in that tennis match or that ping-pong match and therefore there needs to be a much greater integration of services. I imagine that a lot of people would also argue that not everybody who is suffering from a mental illness has a drug problem—and vice versa. How do we achieve that, if you like, but at the same time retain the

specific focus on those groups, organisations and services that are working in the area of mental health and on those that are working in the area of illicit drug use or substance abuse—alcohol abuse and so on?

For instance, if you put forward that you have one service where a person can go with comorbid symptoms or conditions, that may not be the best approach for somebody who has a lifelong depressive illness but does not have a comorbid condition. Just to complete this, people who have a mental illness may have other health problems. They might suffer from diabetes or poor nutrition—all sorts of things. We do not necessarily have, and it is not generally argued we should have, an integrated service for diabetes and mental health. The GP is supposedly the person who picks up all of those things and directs them to the appropriate service. Would you like to comment on all of that?

**Ms Bath**—If I start going off at a tangent, you need to bring me back.

**Senator FORSHAW**—I did too.

**CHAIR**—I would encourage you not to go off at a tangent as we have done.

**Senator FORSHAW**—But do you understand the point I am getting at?

**Ms Bath**—Yes, I absolutely do. The reality for some people who are dependent on illicit drugs is that their lives can be quite complex, and they are defined as having complex needs. If we look at drug treatments services—for example, the methadone program—and how they run within Australia, we see that they are run by mental health qualified trained staff. The doctors that they will see will be psychiatrists and the nurses that they are engaging with are mental health nurses. So even within drug and alcohol treatment services there can be better assessment and treatment programs.

I noticed when I was out doing interviews recently—we looked at eight clinics—that there is not a very large skill mix within drug and alcohol treatment services. I believe only one service I went to had a psychologist engaged within that service, for example. Access to social workers and more generic staff is quite limited within the methadone programs. So even within those treatment services that people are accessing every day there could be the opportunity to look at alternative skill mixing within those organisations, not necessarily creating a one-stop shop but looking at how can we get drug and alcohol and mental health working much more closely together. We can start doing better case management, better assessment processes and referrals, and having case management meetings with people involved in the care of one person where people are talking together with the person who is receiving the treatment.

Often people who are drug dependent, particularly those accessing drug and alcohol services, are very disenfranchised within the drug treatment. Accessing the program for receiving methadone or buprenorphine is so important and so vital to these people each day. Putting other pressures, obstacles and barriers to accessing the service can be quite difficult, so it is about easy access, almost low-threshold access to specialist care and looking at how we can better train GPs and generic workers. People who are dependent on drugs access a whole array of services—homeless services, needle and syringe programs. How can we better train and develop the work force that is working with people who are dependent on drugs and also living with comorbidity

to access better referral pathways and work in a more holistic way so that, rather than everybody being scattered, there is better communication and better development to a shared care? Does that answer your question?

**Senator FORSHAW**—Yes, it does. I thought that was what you were probably going to say; that is obviously where one wants to head. One of the difficulties we have—the senate committee or parliament—is the shortage of professionals in these areas. Having sufficient numbers of drug and alcohol counsellors, or whatever, who may be attached to or working out of the mental health unit in a public hospital and having mental health community nurses working or associated with a drug and alcohol centre, is in itself a major issue. I was concerned also that if it is being put that we need to look more at combining these services I can see people who, and I have heard this in the past, go to the psych unit at the public hospital and say, ‘I hate going there because it’s full of junkies’—that is the sort of terminology they use—so that throws up a whole new set of problems. What you have said is worth while.

**Ms Bath**—Adding to that, I think a very underutilised resource is the use of consumers with experience of comorbidity in developing programs such as mentor schemes. Our member organisations across the states and territories have very little, if any, funding to look at the issue of comorbidity. Any work they will do will probably be in addition to what they are funded to do. I hate to refer to when I was working in the UK, but we developed models where peers who were living with comorbidity were trained to assist people; they could do very basic things such as taking people to appointments and getting people accessed into the services that were established. Peer education and peer support is very underutilised. One of the things that can be very difficult for people with very busy and very pressured lives is accessing appointments and turning up to appointments, which gives them the label of being difficult and hard to treat. Often, people forget that they have appointments, feel that it is going to be too hard to get to their appointments or are scared to go to their appointments. Peer mentoring is an excellent way to train peers; to develop models like this across the country. We have drug user organisations established within each of the states and territories that are able to hit the ground running with these sorts of projects.

**Senator FORSHAW**—There is a comment you make on the next page that you have received reports regarding the overprescribing of antidepressants to people who are receiving drug treatment. Could you expand on that? Where is the overprescribing coming from?

**Ms Bath**—Again, this is anecdotal evidence that we receive through our member organisations in the states and territories. There is a vast number of people involved in drug treatment who are getting dosed with antidepressants at the time they receive their dosing for their methadone on a daily basis. They are not educated to understand why they are being prescribed antidepressants. This tells us that there is a lack of engagement between the prescriber and the patient around why they are being treated and what they are being given. People are left not knowing why, but of course they will take the antidepressant because they are getting that medication with their methadone.

**Senator FORSHAW**—Is that through clinics or GPs?

**Ms Bath**—Through clinics.

**Senator FORSHAW**—More generally, what about people who have drug problems or issues trying to find GPs or other services that will prescribe antidepressants?

**Ms Bath**—I do not have evidence to give you today regarding people accessing antidepressants through general practitioners or other medical services. If you would like me to, I can have a look to see what I can find on that for you.

**Senator FORSHAW**—I am not trying to scapegoat them or anything like that, but there may be overprescribing because the patients themselves are seeking out access to antidepressants.

**Ms Bath**—I do not think antidepressants are drugs that people would seek.

**Senator WEBBER**—In your submission you talk about the particular challenges facing Indigenous people. However, I noticed that there is not any reference to the challenges that people face in rural and remote Australia. I am from WA, and most of our Indigenous population is outside Perth. Do any of your member organisations do any work in those places? Are they aware of the particular challenges there? Do they have a view of what kinds of services we need to offer to people in rural and remote areas?

**Ms Bath**—There are significant problems for people living in rural areas, particularly around basic access to drug and alcohol treatment, let alone specialist care around comorbidity. Our member organisations report to us that some people are travelling up to two or three hours a day to be dosed at their clinic. So accessing specialist services around (a) drug and alcohol and (b) comorbidity would be difficult, if not impossible, for some people. It would be easy for me to go back and contact the member organisations for some more evidence and statistics around that, if you would like it.

**Senator WEBBER**—I must admit that I am not aware of anything much happening in Western Australia. I think some of it is done through the Aboriginal medical services, but that is about it.

**Ms Bath**—One of the issues there too is that, in treating people with complex needs, at times specialists are needed. There are a lot of generic general practitioners in the more rural and remote areas, so accessing the specialist treatment that people need would be difficult. But I will go back and get that information to you probably next week.

**Senator WEBBER**—Thank you.

**CHAIR**—I wonder if I can add to the request made by Senator Forshaw about information to do with the use of cocaine and amphetamines in counteracting the extreme sedation and lethargy induced by antipsychotic medications. I think you are the first witnesses appearing before us who have raised this as an issue. There is a lot of talk out there in the community about the problem of people who do not take their medications and, I would think, not a great deal of understanding as to why that might be the case. If you can help us understand that, that would be useful.

You mentioned that only one of the eight centres providing methadone programs had engaged a psychologist. The psychologists told us that they were well placed to deal with comorbidity

because they were clinically trained in both areas—mental illness and drug and alcohol problems. Do you agree with that? Should it be a prerequisite, if you like, for every clinic to have a psychologist available? What is your experience of psychologists and their effectiveness in dealing with comorbid conditions?

**Ms Bath**—There is a great advantage in having a skill mix within drug and alcohol treatment programs. Again I refer to when I was working in the UK as a treatment provider in the National Health Service.

**CHAIR**—Does that mean you are a psychologist? What is your training?

**Ms Bath**—My training is in counselling and clinical hypnotherapy. The skill mix within drug and alcohol programs in the UK is very great: social workers, psychologists and nursing specialists—primary health care nurses and mental health nurses. It is very different here, where it is predominantly just nursing staff within the clinics, for example. There are great advantages in having that skill mix where people can offer differing services. As with anything, it is certainly not one size fits all. Because they have differing skills, knowledge and experience to offer, having a more eclectic group of workers within a treatment service can only be of great benefit. We certainly saw that in the UK, where there was a mix of mental health specialists working with counsellors and psychologists in a partnership framework and people were accessing those services more than they were accessing specialist mental health services.

**CHAIR**—One of the criticisms of the National Mental Health Strategy is that there are no targets, no time lines and nothing to measure what we are doing in terms of its effectiveness. Do you have those in the UK? I know your submission does not go into comparisons between the UK and Australia, but, since you are experienced in this area, do you know if that is the case or not?

**Ms Bath**—I have been out of the UK for five years now. There was a time when I was still avidly keeping up with what was going on in the UK. I have not done that recently. I do not know the state of the mental health strategy or the drug strategy in the UK, but again I could certainly look at those strategies for you and see if there are any time lines, goals or evaluation.

**CHAIR**—We do not want to load you up with an enormous amount of work.

**Ms Bath**—I just need to go away and come back to you.

**CHAIR**—You have quite specialist experience and training, which would be useful to us. Another recommendation that has been made by many submissions is the need for national standards of care. Would this address your suggestion that there be a better mix of people within one setting—under one roof, presumably—who could provide for people with comorbid conditions? Is there in New South Wales or any other state, to your knowledge, a standard of care that would address what you are saying ought to be dealt with?

**Ms Bath**—I am not aware of standards of care within any of the states and territories. That does not mean that they do not exist. The issue around developing those standards of care is that more often than not consumers are not consulted on what those standards of care should be. There is an increasing gulf between what consumers and providers see as appropriate care, good



quality care and standards of care. There is an absolute need. Within generic mental health, as I stated earlier, there is much more consumer advocacy which is valued and seen to be almost like a normal part of practice, whereas within the drug and alcohol sector that is certainly not the case.

There needs to be a greater incorporation of consumers in the development of any national strategies, guidelines and even evaluations, so that the treatment is meaningful for the consumer. A lot of top-down treatment, rather than partnerships, occurs not only between organisations but also among consumers themselves. As I said earlier, many consumers do not even understand what comorbidity is. A gulf exists between individual treatment experience and having input into how to make things better and improve the quality of care.

**CHAIR**—Do you think the overall reluctance of governments in this country to take a ‘harm reduction only’ approach to drug and alcohol treatment is a problem for people who are using illicit drugs—people who may be seen by health professionals as being ‘on the edge’? Health professionals may think, ‘They are engaged in criminal activities and break the law, so we do not want to ask them about what services should be delivered to them.’ To what extent is that a barrier to getting services?

**Ms Bath**—I am sure there are many individuals working in the sector who will devalue people’s experiences based on the fact that these people are breaking the law. There are certainly workers within the sector who see the people they work with each day as nothing but junkies. There is very little value given to the contribution that people can make using their life experiences on how to improve. People who use illicit drugs and who are living with comorbidity have an expertise that needs to be harnessed, embraced and worked with. We are talking about people who have lived the experience, accessed services, know what that feels like and can make practical suggestions as to how services can be improved. Services that have consumer involvement will run better than services which do not. Where consumers feel they have ownership of a service and can contribute to how it is run, that service will have better outcomes not only for the individual but also for the workers. Something we really need to focus on within drug treatment and within services looking at comorbidity is for consumers to be involved in the development, delivery and evaluation of those services.

**CHAIR**—Do you include families and carers in the group that ought to be worked with and consulted?

**Ms Bath**—Absolutely. Many families and carers end up as the primary carers of people who are experiencing difficulties in their lives, be it from drug dependence, comorbidity or physical health issues. Many people who inject drugs are living with hepatitis C. Carers and families need to be embraced in that process too.

**CHAIR**—Thank you for your evidence today and for your submissions. We appreciate it very much.

[11.18 am]

**PUPLICK, Professor Christopher, Private capacity**

**CHAIR**—Welcome. You have lodged with the committee a submission, which we have numbered 226. Do you wish to make any alterations or additions to that document?

**Prof. Puplick**—No.

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

**Prof. Puplick**—I thank the members of the committee for giving me the opportunity to attend the hearing and make a presentation today. After reviewing my submission, I regretted that I did not place more emphasis on the mental health issues faced by Indigenous Australians and people from non-English-speaking backgrounds as they intersect with the criminal justice system. They are doubly, and sometimes triply, disadvantaged in the way they are treated. Their populations are overrepresented in the prison population. As of the last time I looked, I do not think there was any academic establishment in this country that specialised in transcultural mental health. I think that is a serious weakness in the system.

I appreciate that the direct role that the Commonwealth can play in dealing with some of the matters that are raised in my submission in relation to the criminal justice system, and prisons in particular, is reasonably limited. However, there are three areas I want to mention: the first is the better collection and analysis of data, which can be done through the Australian Institute of Health and Welfare; the second is the very important question of access of Medicare payments for people who are in prison; the third is the general recognition of the human rights of people who have been incarcerated, which are always under attack—even at the moment, for example, with suggestions about further eroding their capacity to participate as electors.

I am sure the committee will already have had its attention drawn to the series of articles that have appeared recently in the *Australian* dealing with some of these issues. I will not canvass any of the grounds that were raised there, other than to say that it is a very pleasant change to see a mainstream newspaper taking an interest in some of these particular matters. However, I draw the committee's attention to two recent tragic consequences of the way people with mental illness are dealt with in the criminal justice system. The first case, reported in the *Sydney Morning Herald* on 5 July, is the case of Jeffrey John Hillsley, jailed for 30 years after committing a murder and a major sexual assault. He had been identified on previous occasions as a person who was seriously in need of treatment for mental illness. That was not provided while he was previously incarcerated.

The second case, Scott Ashley Simpson, was reported in the *Sydney Morning Herald* on 16 and 17 July. He was denied hospital treatment for three years despite recommendations that he be treated. He was subsequently taken into Long Bay, where he committed a murder and then committed suicide. I think it is important that the committee have some opportunity to pause and reflect on the general attitude of the so-called tough-on-crime approach, which at the same time

appears to be downgrading the rehabilitation aspects of incarceration and embarking on an almost exclusively retributive rather than rehabilitative policy as far as prisons are concerned.

Finally, I would be most alarmed if we started to go further and further down the American path. There are 50,000 people in the United States in psychiatric hospitals. They have 500,000 people classified as mentally ill who are in their prison system. Prisons are what the American commentator Elliot Curry has called ‘the social agency of first resort.’ I fear we are in a very considerable prospect of adopting that approach unless there are some major policy changes made at Commonwealth and state levels in the years ahead.

**CHAIR**—Thank you for your submission. It is a very well detailed, and I would say a very powerful, document. Can I ask about New South Wales. There has been an inquiry here into mental illness and the prison system—in fact, you document a large range of reports and studies that have been done that point to these problems. What do you think the main barrier is to changing attitudes to mental health in the prison system? For instance, you refer to the Thomas Embling facility in Victoria, which also came up in our hearings in Melbourne. Why is it that we have not had better progress on more humane ways of dealing with people with mental illness and better ways of keeping them out of the prison system?

**Prof. Puplick**—In New South Wales we have more virulent talkback radio. It is the toxic swamp of talkback radio; it is the unbelievable ignorance and prejudice of shock jocks and political commentators in New South Wales which effectively scares governments into adopting a purely retributive approach to prisons and people who break the law. You cannot look at a new facility in the prison system without somebody describing it as a motel or luxury resort. There is no public understanding of the extent to which diversion of people from the prison system who really do not constitute a major threat to the community and who can be managed and treated in an alternative fashion is, at the end of the day, a cost saving to the community. I think there has been a lack of political leadership in New South Wales. Government has failed to respond to most of the parliamentary reports that have been done, whether on the children of prisoners or on mental health in prisons. It is not prepared to invest the money and it is not prepared to take a leadership role, because it fears being pilloried in the press and in the media generally.

**CHAIR**—Please tell the committee what you think is good about the Thomas Embling centre in Melbourne and why it is that in New South Wales the forensic psych unit is within the prison rather than a separate secure facility.

**Prof. Puplick**—I think the question of why there is not a proper, separate forensic unit in New South Wales is primarily just a resource issue. There have been opportunities for the establishment of a secure forensic unit. This matter came up in public discussion, for example, when the future of the Rozelle psychiatric facilities was under discussion some time ago. I think it is purely a resources question that forensic patients have been kept within the prison system rather than any studied and thoughtful decision having been made as to the appropriate way of managing forensic patients. As to the difference in Victoria, bear in mind that Victoria is a state that has actually seen a reduction in its overall prison population because there has been a more comprehensive understanding of the management of people with psychiatric, mental health and developmental issues in terms of diversion from the prison system. The understanding that forensic patients require treatment which is primarily health related rather than custodially focused is the essential issue in the difference of philosophy.

One of the points I make in the submission is that there is a huge difference between health services—and this includes mental health services—delivered to prisoners where the responsibility for prison health rests with the health department of that state compared to health services delivered by a department which is the custodial department of that state. I think that philosophy is critically important in coming to grips with the appropriate treatment for people with the whole gamut of mental and developmental issues in the prison system.

**CHAIR**—You have been into probably most prisons in Australia, according to your submission.

**Prof. Puplick**—A pretty large number of them.

**CHAIR**—Do you recommend that the committee visits a prison? If so, which one should we go to and what should we attempt to discover there?

**Prof. Puplick**—I think it is a salutary experience, indeed, for any person who is an elected representative of the community to be aware of the way in which people are treated. Senators have been making visits to detention centres around the place, which deal with relatively few people. I am not aware of many people who make it a regular part of their representative role to actually look at the conditions in which a considerable number of people are held in prisons around the country.

The prisons vary enormously. Some years ago, Parramatta Jail, which is 130 or 140 years old, was closed because it was regarded as no longer fit for human habitation. The prison population rose so rapidly in New South Wales that within two years of its being closed it was reopened and the only difference was a coat of paint. I think that there are some outstandingly good prisons in terms of their management. There are some extraordinarily archaic prisons. Parramatta is one; Risdon in Tasmania is another.

I think that the committee would be well served to visit prisons. I think it would be quite easy to look at those which have been built in the last five or 10 years compared with those which have been in operation for more than 100 years. The physical design of the prison is a critical element in the management of the prison and in psychological wellbeing. People who are in yards which are exposed to the elements all day and every day and which are nothing but concrete have a very different response in terms of intervention programs from people who might see a few trees or a bit of grass or a bit of shade around the place.

**Senator FORSHAW**—Thank you for your submission. You have dealt with most of the questions I would have asked you in your submission or in answers to the chair, but could you comment further on this issue of the reporting of health and mental illness amongst prisoners? You make the statement:

... statistical material about the health of prisoners, the rates of mental illness or drug-related incarcerations has gradually disappeared from ... Annual Reports of the NSW Department ...

Was it extensively or intensively reported? What is the reason for it? Has there been a reason other than it has just been allowed to drift off in the hope that nobody noticed?

**Prof. Puplick**—I think New South Wales Corrections would say that it is really the responsibility of Corrections Health to report all those statistics. That is correct and you will find reporting in Corrections Health. But, unless you know in advance that Corrections Health is a separate service where you have to go to find information about the health of prisoners, you can go through the annual reports of the New South Wales Department of Corrective Services and in fact find very little. I went and looked online at recent annual reports of most of the other state jurisdictions.

If you look at the annual reports of corrections services, prison services, justice services or whatever it is, you will find that there is very little reporting at all about the overall health status of prisoners. There is a fair amount of material on the web site of the Australian Institute of Health and Welfare. There are, apart from mental health, a whole series of things that really do need to be closely monitored. Information about HIV infections, hepatitis C levels and the re-emergence of tuberculosis, particularly in comorbidity with some of these other infections, is very difficult to find and is not well reported by the corrections authorities themselves.

**Senator FORSHAW**—Is a study actually being carried out? Is there some policy that prisoners have their health assessed, including their mental health, on some sort of regular basis but that the report is just not being made available? Or is it that there is less assessment work being done?

**Prof. Puplick**—There are two things. Firstly, every prisoner is assessed on entry. I think there are some quite significant issues about the degree to which mental health assessments are done, particularly bearing in mind the person who is coming in. If you follow a prisoner through the system, the person who comes from the court into the prison and has a pretty immediate health assessment is often likely to be in a state of shock, often not likely to be in a particularly communicative mood, and the capacity to actually assess anything other than their physical symptoms at that initial point is quite compromised. The extent to which there is a subsequent follow-up to assess their mental health status after they have started to acclimatise to the prison regime is very problematic. There is some data and the prisons obviously need that for their own management. There are regular surveys undertaken by the Australian Institute of Health and Welfare. I think they are done every two years or every four years—I am not exactly sure. Again, there is no national standard; there is no national comparability. Some years ago I was struck by the fact that in many jurisdictions the definition of what constitutes something like developmental delay varies from state and territory to state and territory. You do not know when you are looking at the figures in a comparable sense whether you are comparing like with like.

**Senator FORSHAW**—There was another issue I wanted to raise with you. You spoke earlier about a series of articles in the *Australian* newspaper, which I have also been reading. Those articles pick up, in some respects, some of the submissions that have been made to this inquiry and comments from witnesses who have either appeared, or will appear, before the inquiry. I just wanted to highlight one aspect, which is not so much about prisons as it is about the role of the police. We have had evidence from the Australian Federal Police that they are more and more the first port of call. They take the person to the emergency unit in the public hospital and then they are sitting around for ages. An article from the *Australian* of 28 July states:

NSW Acting Deputy Commissioner Terry Collins told The Australian police were “frustrated” with the growing number of cases and the time wasted dealing with them.

He said NSW Police was mounting a strong argument for changes to the Mental Health Act allowing officers to circumvent hospital emergency rooms and the need for a GP's referral.

"... Why can't we take them direct to the mental health part of that facility?" he said.

The article quotes Dr McGeorge, the Director of Caritas House, as saying:

... he could not agree because, according to his figures, 40 per cent of the people police brought in for assessment were not admitted to hospital.

"If they did that, we would have the wards bulging with people who don't need to be there," he said.

The broader issue is the whole debate about deinstitutionalisation and the effects of that. There have been arguments that we need to reopen a lot more acute care based institutions. Can you comment upon this issue? Should the system be looking at allowing police, for instance, to take people directly to a psychiatric unit rather than through the emergency unit? It seems that they have a real frustration.

**Prof. Puplick**—For nine years I was the chairman of Central Sydney Area Health Service. That health service has responsibility for facilities such as Royal Prince Alfred Hospital, Concord hospital and Rozelle psychiatric institution. I can assure you, having been very closely involved in policy development in those areas, that the pressure that is put on emergency departments by people being brought into emergency departments who in many instances do not need an immediate response to a traumatic event causes those emergency departments to be under intolerable pressure.

It seems to me that some degree of training should be available. This has been a constant issue in the debate about the mental health services but also a constant complaint by the police service—that they are not given enough training and resources to do the training to allow them to identify people whose problems appear to be related to their mental health status. If police officers were able in that sense to do a bit of triaging and divert people away from what we would regard as the traditional accident and emergency services into areas where their mental health could be assessed, I think that would be of benefit not only to the people being assessed but to the people who were otherwise being put under pressure, both as providers and as recipients of services, in the traditional accident and emergency departments.

There is another point about the debate about the reopening of acute institutions. I think the Richmond report has got a lot of stick, some of it unfair, on the basis that it said way back then that you cannot deinstitutionalise people unless there are services in the community that will be there to provide a safety net for them. Governments were happy to empty out the institutions but not to put money into the community based welfare services that were needed. What has become an additional problem since the days of Richmond is the number of people with acute mental health problems, psychiatric problems, which are drug related, which was not at the same level 20-plus years ago when Richmond was looking at his original data.

**Senator FORSHAW**—You are saying that they are coming through the criminal justice system and into prisons in many cases for repeat offences.

**Prof. Puplick**—Absolutely. The identification and management of their psychotic problems is not the same as that of people whose psychoses do not have the same drug interrelationships, but they are all expected to be managed in the same sort of fashion once they are in a custodial setting.

**Senator FORSHAW**—You make a good point that we should have a look at some of these correctional facilities. What is the picture of the availability of specific psychiatric or mental health acute care facilities, if I can call them that, or quasi hospitals, if you like, within correctional facilities? Do most of them have some separate section or unit where these people can be kept and is that an appropriate way to deal with somebody who may have committed a serious offence or a series of offences but has a drug and mental illness health problem as well? There has to be some facility somewhere for them. If it is not a psychiatric hospital which is for the general public then what is it?

**Prof. Puplick**—There is really a mixture of about four. There is the traditional prison hospital, in which both mental health patients and patients whose problems are non-mental might be mixed. There are occasionally specialist units, which are sometimes used in this way and from time to time can be opened and closed—for example, at Long Bay there has traditionally been a specialist area for prisoners who are HIV-positive, and very often there was an intermingling of those. Then there are secure units within established public hospitals—that is to say, secure locked-down wards within public hospitals. There have also been, and there are planned to be, specifically dedicated forensic units in some areas. So each state and territory, depending on size, resource and policy, makes use of a variety of those four primary responses.

**Senator FORSHAW**—Is there a preferred model for a correctional facility or is it a combination of all of those but at a much better standard?

**Prof. Puplick**—I think it needs to be a combination generally, but there must be a separation of forensic patients—after all, forensic patients, by definition, are people whose criminal behaviour is of such a nature that they pose a threat to other people, whereas most people in the prison system with mental health issues are primarily a threat to themselves rather than to others.

**Senator TROETH**—You mentioned in your submission that New South Wales is incarcerating forensic patients in clear breach of domestic legislation. Could you tell us about the nature of that breach and why no action has been taken in view of that contravention?

**Prof. Puplick**—The formal terms of the legislation—I forget the exact name; I think it is something like criminal justice (mental health) legislation, but I can get the exact terms—in fact require that forensic patients be dealt with in dedicated forensic units. That is simply not being done, and it is not being done purely for what the government would claim to be resource questions, but I am sure that if anybody took formal legal proceedings to test that matter the government would be on the short end of that argument.

**CHAIR**—Who would need to raise the matter in the courts? One can hardly imagine people with mental illnesses being able to do that.

**Prof. Puplick**—It was really interesting that the only way in which we got condoms into the prisons in New South Wales was for a group of prisoners to take legal action against the state

government for its failure to adhere to its duty of care. While the case was before the courts, the government simply gave way and condoms were introduced. They were only introduced after legal proceedings were commenced by a group of prisoners. I am sure that for scheduled persons who are under forensic control there would be a role for the Office of The Public Guardian, or whoever it is that is legally responsible for them, in the situation where they have been designated as forensic patients.

**CHAIR**—Did the shock jocks give the government a hard time over the condoms as well?

**Prof. Puplick**—Not so much, but it was certainly an issue that they made some considerable fuss about. The difficulty that they faced under those circumstances was that the degree of evidence was enough to penetrate even some of those impenetrable areas.

**Senator WEBBER**—Professor Puplick, you make reference to the Department of Corrective Services 2003-04 annual report, in which the commissioner noted that the ‘psychological profile of inmates is becoming increasingly marked by mental illness’. Can you expand on that? Is there any data that will tell us what that increase is? What, in your view, is that due to? Is it due to the fact that we do not know how to treat these people, so we lock them up; or is it due to society seeing an increasing prevalence and awareness of mental illness?

**Prof. Puplick**—As to the data, you can certainly look at some of the material produced by the Corrections Health Service in New South Wales over the years, which I think would indicate the increase in the numbers of people with mental illnesses coming into the criminal justice system. Although it is episodic and patchy, New South Wales at least has a reasonable data set going back over quite a number of years. Reviews undertaken in the early 1980s attempted to assess some of that. I had access to some of that material when I prepared my report for the New South Wales government in 1984 on developmentally delayed prisoners and their treatment.

As to the why, I think there is a whole complex of reasons. The first is that, in that sense, the prison population reflects the general population. There appears to have been an increase in the diagnosis of people with mental illness in the community, so it is not surprising that that is reflected, particularly the extent to which mental illness may be exacerbated by problems of low socioeconomic status, which is also reflected in the prison population.

As I mentioned earlier in response to Senator Forshaw, there are changes in the interrelationship between drug abuse and mental illness, which are being reflected in obvious parts of the criminal justice system. As I mentioned briefly, and should have elaborated on in my original submission, the prison population increasingly sees numbers of Indigenous Australians and people from non-English-speaking and culturally different backgrounds coming in. A lot of those people are presenting in situations where their adjustment issues in the community, or their capacity to function effectively in the community, have been weakened by a whole series of social and family breakdowns and the intergenerational changes which take place in children of recently arrived migrants. So there is a whole series of things feeding in.

The other is the question of people who are brought into contact with the prison system because they are homeless. There is an increase in homelessness, particularly when there are campaigns from time to time to clear homeless people off the streets and to make them disappear—we did that brilliantly for the Olympics, let me tell you. When there is a campaign to



make street people disappear, where do they go? They are eventually driven into situations where they come into contact with the police. The police in frustration have no alternative but to put them somewhere where they are regarded as being secure and, hopefully, capable of being treated. All of those social pressures just drive more and more people towards the prison as a health facility, when it is not supposed to be a health facility.

**Senator WEBBER**—Indeed. Accepting that some people end up in the prison system, one of the issues that one of our previous witnesses raised was the lack of continuity of care for someone who is mentally ill in a community setting and who ends up in prison or for someone who develops a mental illness whilst incarcerated and who is then released. I was wondering if you are aware of that issue and whether you would be prepared to comment on it.

**Prof. Puplick**—It is a major issue. Its most stark manifestation is in deaths by way of overdose. Prisoners in Australian prisons who want to have access to drugs can get access to drugs. They use regularly in the prison; they have a habit; they come out of the prison. The most risky time for them is the first two or three weeks that they are out of the prison, when, continuing their habit, they can suddenly find that they have a hot shot—and you have a death by overdose. That is because the step-down management is simply not in place. Mark you, it is extraordinarily difficult to put it in place, because, unless you have a regime that compels people to maintain contact with a health facility, the last thing they want to do is to continue to have an ongoing relationship with government or governmental authority.

The same applies, of course, to the management of mental health, which is why you have such high levels of recidivism. It is also why you have people leaving prison with profound psychiatric and mental health problems who immediately come back into contact with the system, particularly in terms of some violent crimes. Everybody will argue that an effective step-down—an effective method of maintaining contact with ex-prisoners—is important. It is easier to do that when you have a parole situation in which people can be compelled to go back to prison unless they attend these facilities in the community on a regular basis. But the majority of people who are simply released, although opportunities are presented to them, do not take them up, and there is no easy way to compel them to do so.

**Senator WEBBER**—Finally, I want to return to the issue of Indigenous people. I am from Western Australia and one of the largest regional prisons we have is Roebourne Jail in the north-west, where it is highly unusual to have a white inmate. In fact, you would be lucky if you found two in the entire prison population on any one day. Most of the Indigenous people that are incarcerated there have, obviously, been removed from their family and taken a long way; the journey has been quite extensive—some thousands of kilometres on some occasions. That, to my mind, would certainly exacerbate any underlying mental health issues that those people would have. Are you aware of any more-appropriate ways to deal with these people? We have had lots of reports about deaths in custody—about all sorts of things. They have stopped dying in the numbers that they were, but we do not seem to be getting anywhere in terms of treating them and keeping them out of prison.

**Prof. Puplick**—In my period in the Senate, every time there was an Indigenous death in custody Senator Collins used to make some parliamentary statement about it and analyse some of the issues. If you look at the ongoing reports of Indigenous deaths in custody, the majority of interventions which have reduced deaths in custody have been interventions with the physical

nature of the incarceration—removal of hanging points, and greater supervision—rather than interventions with an individual to address the mental health issues per se.

**Senator WEBBER**—And addressing the issues of how we end up there.

**Prof. Puplick**—These issues are particularly difficult within the prison system because they are exacerbated by the pressure on people to form gangs, which are a necessary part of the survival mechanism. As a result, in all prisons with a diverse population very often you will find that there are gangs based upon some degree of ethnic solidarity. That often makes things worse and more difficult to penetrate and deal with people on an individual basis as patients. I am not aware of any really comprehensive intervention strategies in relation to mental health for Indigenous people and people of non-English-speaking backgrounds in the state of New South Wales which have been adequately resourced to do the job that is required.

**Senator WEBBER**—I am not aware of any in Western Australia. Given the percentage of the prison population that these people make up, it is a little confronting. I would not recommend visiting Roebourne, that is for sure. It is very depressing.

**CHAIR**—Thank you for appearing before us today and for your submission. It has been very useful to the committee.

[12.02 pm]

**JORDAN, Ms Amanda, Consumer Representative, Centre for Eating and Dieting Disorders New South Wales**

**LEAHY, Miss Judith Louise, Adviser, Centre for Eating and Dieting Disorders New South Wales**

**MAGUIRE, Ms Sarah Louise, Eating Disorder Service Development Officer for New South Wales, Centre for Eating and Dieting Disorders New South Wales**

**RUSSELL, Associate Professor Janice, Director, Eating Disorder Program, Centre for Eating and Dieting Disorders New South Wales**

**KOHN, Dr Michael, Medical Director, Eating Disorder Program, Children's Hospital at Westmead; and Medical Director, Meridian Clinic**

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

**Miss Leahy**—I am from the Central Coast of New South Wales. I coordinate an early intervention outpatient service for people with eating disorders. It is the only one of its kind in Australia. I am a dietician and public health nutritionist.

**Ms Jordan**—I am a social worker. I am also the founder of the consumer organisation the Eating Disorder Foundation of New South Wales.

**Ms Maguire**—I am otherwise known as the eating disorder coordinator for New South Wales. I am a psychologist.

**Prof. Russell**—I am a clinical associate professor with the discipline of psychological medicine at the University of Sydney. I am also the director of the Eating Disorder Program at the Missenden Psychiatric Unit at Royal Prince Alfred Hospital and the Northside Clinic, Greenwich.

**Dr Kohn**—I am a paediatrician. I work as a senior staff specialist at the Children's Hospital at Westmead. I consult to the eating disorder programs both at the Children's Hospital at Westmead and Sydney Children's Hospital. In addition, I am the medical director for the Meridian Clinic, which is a private service that supports young people and young adults with eating disorders. I am also a senior clinical lecturer at the University of Sydney in the faculties of medicine and education.

**CHAIR**—I apologise at this stage for Senator Troeth, who has had to go off and find a doctor—even though we obviously have doctors in the house! You have lodged a submission with the committee which we have numbered 307. Are there any alterations or additions you want to make to that document at this stage?

**Ms Maguire**—Just our testimony today.

**CHAIR**—I invite you to do that now. Is everybody going to speak?

**Ms Maguire**—Amanda, who represents the consumers, is going to speak for the first minute, and then I am going to speak for the remaining four minutes. We are trying to keep it to five.

**CHAIR**—Excellent. Thank you very much. We will go to questions after you have done that.

**Ms Jordan**—Let me introduce you to Christie, a young woman of 33. Christie wants to die. You see, Christie would eat not just her meals but all the leftovers from the fridge. She started sneaking food from work, from the supermarket, from the corner store: ‘A nice Indian chap. Always so sweet to me. Never steal from him. Soon, steal the food, smile sweetly but pay for the chewing gum. Phew! Almost got caught. Must stop. At home, sneak the food into the house. Close the bedroom door. Out come the takeaway Thai, the bread rolls, the chips, the lollies and the ice-cream. The phone rings. Ignore. What else in the house? Leftover lasagne, apple crumble, half a tub of yoghurt. Frantic. Eat as much as I can. Anyone see me? Feel so full. Feel awful. On to the bathroom. Force myself to vomit. Wretch till I ache. I am worthless. I am vomit. Clean up. Bedroom. Sleep. Hope I never wake up.’

What happened to Christie? Is this simple greed? Is it laziness and selfishness? Is it a weak personality? Christie in fact suffers from a mental illness—bulimia. What were the origins of this, the bits that I have left out of her story? As a child Christie was sexually assaulted by her grandfather. She told her mum. The tragedy was that she was never believed. Christie never again felt safe. She felt dirty and worthless. Whatever she tried to do in her life could never erase these memories. She learned to despise her body, to treat it badly and to punish it. Maybe then someone would understand her pain, someone would be there for her.

**Ms Maguire**—As our submission outlines, eating disorders are not rare. They are suffered by children, adolescents and adults. Approximately five per cent of people will suffer an eating disorder during their lifetime; that is one in 20 people, more than will suffer breast cancer. In New South Wales and indeed around Australia there is a lack of essential services across all areas. Few services exist and they are too sparsely distributed.

With the current level of government funding and commitment, we are unable to treat eating disorders effectively and unable to make any sort of impact on their prevalence and chronicity. Knowledge of and training in how to identify an eating disorder at an early stage and deal with it within the health system, the school system and the wider community are generally very poor. This is a direct result of a lack of funding for education and training.

In New South Wales there are eight area health services. Two have no eating disorder services whatsoever and two have assessment clinics only, with limited capacity. Of the remaining four, only one provides adult and child services; the other three have either adult or child services completely absent from their mandate. And all have a limited capacity, meaning that none can provide adequate treatment. Accessing treatment is further complicated in New South Wales by the fact that most services are so stretched they are unable to accept out-of-area referrals.

Sufferers of eating disorders, their families and their clinicians come up against five main obstacles: (1) there are no services at all to refer to; (2) where services do exist, they are de facto, haphazard in their origins, incapable of treating the illness spectrum, or the waiting list is months long; (3) services are almost all non dedicated and therefore constantly under threat; (4) there is poor staffing across the board; and (5) there is no funding for consumer support services. In Victoria, South Australia and Queensland, the state governments all fund their eating disorder consumer support networks. In New South Wales we do not. This means that at present we are providing a piecemeal, largely uncoordinated answer to this huge problem.

People with eating disorders rarely get seen until they are severely ill. They move in and out of services, from one area health service to the next, for years on end, desperately trying to access an effective treatment. Health professionals and the few dedicated consumers are stretched to breaking point trying to provide what they know to be totally inadequate treatment for the many and in the process benefiting very few.

While we do not have any dedicated funding in this state, what we do have are dedicated people. We have expertise. There are a significant number of individuals working within the health system in New South Wales with between 15 and 30 years of experience in the field of eating disorders. Several are world-renowned experts, some of them at this table. Through the Centre for Eating and Dieting Disorders we have created a statewide network of trained clinicians. Even in those area health services where there are no services, we have identified a professional to progress the situation.

We have managed to procure the position of a statewide coordinator, or service development officer, for New South Wales which is funded through the Centre for Mental Health. The funding is not recurrent at this stage. It is the only funded eating disorder position in the state. This person coordinates the statewide network and is ready to coordinate service development when funding is made available. An advisory group comprised of about 10 clinicians and consumers from the statewide network has consulted to the Centre for Mental Health for the past four years on developing a service plan for eating disorders. It is ready to be rolled out when funding is made available.

Fifteen years ago a single dedicated consumer started, out of her lounge room, a consumer support network for persons in New South Wales who were suffering eating disorders and for their families. That organisation is still in place and still in her lounge room, and with no government or formal funding it manages to provide a part-time phone support line and a referral service for New South Wales. In collaboration with the eating disorder organisations from every state in Australia, the Centre for Eating and Dieting Disorders has developed a national strategy for the prevention of eating and dieting disorders. It is currently with the Commonwealth government, yet to be funded.

Although in most area health services there are no adequate treatments, through the work of a few dedicated individuals three successful models for treatment are currently in place in New South Wales: an adult model able to treat people from first diagnosis through to maintenance; a child and adolescent model providing family based therapy with in-patient support; and an early intervention outpatient service for all ages to capture people before they are so sick that they need hospitalisation. If these three services had funding and if they were located in the one area health service, they could provide adequate treatment across the illness spectrum. Each of the

area health services in New South Wales requires each of these three services to be able to treat effectively. Whilst these three services exist, most have no funding and, as all are informal, they are constantly under threat. Whilst all three try to work collaboratively, they are in separate area health services, making it impossible to provide a continuum. The effect of this sort of system on sufferers and their families is harrowing; on clinicians, it is exhausting and often defeating.

But today we want to leave in the forefront of your mind what we do have. Given the very limited resources we have had to work with, as a group we have put an emphasis on getting organised. We have a coordinated network of professionals in place throughout New South Wales. We have at this stage a state coordinator in place, needing recurrent funding. We have a consumer support network needing funding. We have a service plan developed with the New South Wales Centre for Mental Health ready and needing funding. We have several successful treatment models needing funding, and we have a national strategy for early identification and prevention awaiting funding. We have the expertise, we are organised, we have done the planning and we have set up the formal processes necessary for coordination as a group across the state.

Without funding and resources, we can do nothing more than continue to provide what we know to be insufficient, albeit quality, care in a piecemeal fashion across New South Wales. What we need now is funding so that we can build infrastructure to provide services for and to prevent this common and often deadly group of illnesses. Eating disorders need to become a priority for health departments at the state and national levels and to be funded accordingly.

**CHAIR**—Most of your problems seem to be about funding. Can you tell the committee how much money is required?

**Ms Maguire**—That is a good question. I suppose we have been discussing that question with the Centre for Mental Health and the Department of Health in New South Wales for a number of years. There is a constant pressure for us to move that figure in a downward motion.

**CHAIR**—Which figure is this?

**Ms Maguire**—How much funding we would need across New South Wales—

**CHAIR**—Which is?

**Ms Maguire**—I do not know that we can put a figure to that at this time. We have a service plan with the Centre for Mental Health which outlines having an area coordinator—an eating disorder coordinator—in each of the eight area health services to work with existing general services to try to ensure that eating disorders become core business for mental health. This will partly solve the problem. If we had an area coordinator that could at least mobilise and train and create policy for what is existing, this would partly solve the problem. But it is not going to be solved until there is dedicated funding for services that are going to be able to treat eating disorders. There are a number of reasons for that, which I am sure the committee can go to.

**Miss Leahy**—I will give an example. The early intervention eating disorder service that I operate is a three days a week service. It has 1.8 full-time equivalent staff: a clinical psychologist, a dietician, a family therapist and a coordinator—me. We function on \$125,000 a

year. There are eight area health services. For just a very small early intervention service, times eight, that is close to a million dollars.

**CHAIR**—And that would cover the whole of New South Wales?

**Miss Leahy**—If each area health service has its own early intervention service—that is only a three-day service—and we have got 25 people on our books at the moment. Our criteria is that we only see people who have anorexia nervosa for less than one year, or bulimia nervosa for less than five years, because we had to draw a line somewhere. That is only a small picture of the whole continuum of care for eating disorders. That is just the early intervention—let alone day programs, let alone in-patient treatment. In-patient treatment is the most costly.

**Ms Maguire**—On average, it costs \$25,000 per person to be treated. We have estimated that we need at least six intensive beds for each area health service, and then we need a day program that can support between eight and 10 places for adults and a similar number for children.

**CHAIR**—Is it the case with this disorder that early intervention would avoid the need for in-patient services, and to what extent do you assess that to be the case?

**Prof. Russell**—It does not, unfortunately. It is very helpful. You could think of it as a sort of mountain or pyramid, but there is still a group at the top who do not seem to respond to early intervention, or it does not get provided early enough. They are very difficult illnesses. With anorexia nervosa perhaps 20 or 25 per cent of people do not recover and develop a chronic form of the illness—they do not all die of it—and they are a continuing drain on the health system.

**Ms Maguire**—There is evidence that if it is captured within the first six months, there is a better response, a shorter duration of illness, and less burden on services. Unfortunately, we do not have anywhere to capture it within the first six months at this stage. That is part of the problem, and that is why the national strategy for early identification and prevention was written.

**Miss Leahy**—With early intervention, it does not mean that it has to be brief intervention. We still get young girls who are still very sick medically, and they require in-patient treatment because their heart rates are so low or their blood pressure is so low that they are at risk of collapsing or dying of cardiac arrest. There is definitely still a huge place for in-patient treatment—even as part of early intervention—because they are so medically at risk of dying.

**CHAIR**—So some who need a bed need it for physical reasons rather psychiatric—

**Ms Maguire**—Yes, medically compromised. Usually in-patient admissions are for the most medically compromised individuals. Now that we have this continuum of care which provides for in-patient for the most severely ill, day programs to target the core pathology, and then out-patient for maintenance and follow-up, in-patient admissions can usually be used just for medical stabilisation. Would you agree?

**Prof. Russell**—Not entirely. I think some people need psychiatric help. There is a very high comorbidity. A lot of the patients are depressed or anxious, particularly, but there are other psychiatric conditions that complicate eating disorders. It is probably in that 20 to 25 per cent

where people require intensive psychiatric help for a while before they can move on to a less intense day program.

**CHAIR**—You say in your submission that the incidence of eating disorders predates the current cultural obsessiveness with thinness. I think that is the way you expressed it. Does this suggest that that is not an issue? How close are we to understanding what gives rise to eating disorders?

**Ms Maguire**—Everything we are going to present today is compromised by the fact that the amount of money being put into research is very poor. So a lot of the data that we have used comes from overseas studies. We have used as much from Australia we can. We obviously pick cultures that have a similar socio-demographic makeup. One of those areas, of course, is going to be what leads to the onset of an eating disorder. Yes, descriptions of eating disorders predate our current obsession with and culture of thinness; however, there are no epidemiological studies predating about the 1970s, I think.

**Prof. Russell**—No, Lucas in Minnesota looked at the prevalence of eating disorders; they have certainly become very much more prevalent from the 1960s and 1970s—particularly in the seventies, eighties, nineties, and it sort of plateaued in the nineties to be quite high. But there certainly was a steep increase around the time of Twiggy, I suppose. That was a very socio-cultural factor, because dieting is often how these things start.

**Ms Maguire**—One of the things that research has proven is that dieting is the single biggest predictor of the onset. It is a risk-taking behaviour in adolescence. If you are in that age group that is at risk and you are engaging in dieting it is like any other risk-taking behaviour. It is like using drugs or smoking or drinking. That has been demonstrated quite clearly—

**Senator TROETH**—In the sense that it becomes an addictive behaviour—

**Ms Maguire**—Some people use that terminology, yes, that it can become addictive behaviour. Certainly there is some good research coming out of Australia about the levels of dieting in schools. As you would have read in the submission, 47 per cent of school-age girls admit to engaging in extreme dieting, that is, laxative abuse, vomiting and/or complete fasting.

**Dr Kohn**—To further add, I think that what is core to a person who develops any disorder is stress and in today's society there is an emphasis on thinness that leads to dieting that functionally assists the young person to cope. Hence it becomes a valued pattern of behaviour that is hard to change. With that pattern of behaviour developing over time there are structural brain changes as well as emotional coping changes. It gets pretty intransigent and that is why the person who has an eating disorder perpetuates it. That is why, even though you can point out and you can rationalise or intellectualise with a person, they are unable to change. It truly develops therefore into a form of a mental illness requiring increased support.

**CHAIR**—Is there also a physiological element of addiction? You hear about runners, for instance, who become addicted to adrenaline. Is there also an addiction in this case? Is there something going on in the body which, once you start that dieting process, perpetuates it?

**Ms Maguire**—There certainly is—



**Prof. Russell**—There is a critical weight. For instance, with anorexia nervosa when the body mass index drops under a certain level the whole situation becomes self-perpetuating. The stomach empties slowly so the person does not want to eat even though they may realise that they need to eat or they may even be afraid of the physical dangers. But because the stomach is emptying slowly it is very difficult to eat a sufficient amount to gain weight. They may become hyperactive due to the drop in leptin levels in the blood and they develop a sort of restless hyperactivity—which in rats is so that they can seek out food, I suppose, as an atavistic response—and that also contributes to the weight loss: their hyperactivity and not been able to eat. Then a very perseverative repetitive thought pattern develops with starvation so that the young person thinks about food all the time—although they may superimpose the obsessive feeling that they will not eat the food—and they think about food and not eating constantly. So you have this combination of things. There are some other chemical and biochemical things happening that make people feel slightly ill and not like eating. That is why a lot of help is required if someone drops under that critical level. With young people, with teenagers, and with young children they can become medically compromised rapidly. Older patients are more adapted to their situation so they do not present so dramatically with medical compromise.

**CHAIR**—What is the mortality rate of those who are identified?

**Prof. Russell**—It is 20 to 25 per cent in 20 years. It is a premature death because they are in their thirties. Definitive treatment does standardise mortality rates substantially.

**Dr Kohn**—I think this gets back to something that you raised earlier, Senator Allison. We know now that some treatments do work and we are much more confident as professionals to be able to say that if you come into our care and we are able to offer you these services this is what the outcome looks like for you. That is quite a paradigm shift to what was possible in the way treatment for people with any sort of—

**Ms Maguire**—And that is for the last ten years really, isn't it?

**Dr Kohn**—Yes.

**Senator TROETH**—I would like your opinion on the attitude to eating disorders among health professionals apart from those intimately concerned with your field. If a young person presented to a GP with this problem, could you give me some idea of the range of reactions?

**Ms Maguire**—Yes, I can. We ran a GP project that was funded for just two years through the Centre for Eating and Dieting Disorders—it did not get recurrent funding. It had a very good outcome. We trained 40 GPs across New South Wales from the north to the south through distance education in how to deal with eating disorders and how to treat them within an outpatient setting as a GP—except of course all the cases that you have heard about that have to get referred on.

If we can manage some of the cases at the GP level—which, with support, can be done for some persons—then that obviously would be a huge reduction in cost as well as beneficial for the individual. You are going to get a range from complete denial that there is any problem whatsoever, regardless of the fact that the person weighs 32 kilos and is in your rooms. I think Amanda should speak to this in a moment, because she represents consumers and the way that

they get treated when they present to health professionals. That is something that she knows about. You are going to get complete misunderstanding of the issues—the usual thing is ‘Just eat!’—through to people who actually have a very good understanding. They are few and far between, unfortunately, but have a very good understanding of it as a mental illness and as a disease, and have some understanding of the medical complications and what they need to do when they see those medical complications in their clients. Some, usually those who have gone on to get postgraduate training in mental health, can provide counselling. That is very rare. That is one of our biggest problems: just finding a GP. I have spent six months with one family in Port Macquarie, just trying to get them a GP.

**Miss Leahy**—I would just like to add that half of our referrals actually come from parents and people who have eating disorders. The other half are from health professionals, so that is one way that we can help educate the GP who may be caring for the person.

**CHAIR**—Miss Leahy, what did you say the problem comes from? ‘Half are from parents and half from’—

**Miss Leahy**—Not everyone goes to their GP anyway, so we get referrals straight from the person.

**CHAIR**—‘Referrals’, I see. I misunderstood what you said.

**Ms Jordan**—From the consumer point of view, it has really concerned us that so few GPs have had specific training in this area. One of the things that can happen when you are a patient with an illness like this is that you experience people trivialising what is happening. They see it as a lifestyle thing; they see it as a self-imposed regime of starvation which is connected with your personal vanity and your desire to look good. They do not really understand that you are living in a particularly private hell. Part of the reason that you choose eating is that it enables you to focus on that 24 hours a day, seven days a week in this forlorn attempt to escape the problems that really are underpinning the whole disorder. You go to a doctor and you find—for instance, with the Medicare rebates at the moment—doctors do not have the time to enable you to feel safe and then able to say anything beyond the fact that you feel bloated, you have diarrhoea or whatever else. You just do not have the time to build up the relationship that is at the core of being able to divulge the true nature of your problem. It is an illness with so much stigma. There is so much ignorance about it that it is almost like, when you present to a health professional, you feel you have to tell them ‘Hey, this is what it is really like.’ It is not like *60 Minutes*; it is not like all those tabloid articles in *NW*; it is not just about dieting.

**Ms Maguire**—It is also an illness group that can actually be reasonably easily identified if people know what to ask and know what to look for. We have those indicators available. There is also a questionnaire that has been designed specifically for GPs that consists of five questions. You will pick up 75 to 80 per cent of cases from those five questions if you know to ask them. It is simply a result of lack of money for education and training. That is it.

**Prof. Russell**—Can I also add that psychiatrists are generally fairly antagonistic. They do not know anything about it and there is not of training—there is some at the institute now. There are usually not a lot of opportunities to learn about eating disorders, since half the registrar positions are not filled and hospitals do not really want to employ registrars. There have been a lot of

problems with accessing people to train in eating disorders and for people to access training, should they want it. What happens is that those who do not have training tend not to diagnose the problems and tend to be a bit antagonistic. I think that extends to other healthcare professionals who have not had that sort of exposure.

**Ms Jordan**—I think it is not just the problem with GPs; it is that as a patient you are so embarrassed by aspects of your behaviour and you feel so maligned and misunderstood that you hide your problem and you do not really tell it the way it is.

**Prof. Russell**—So it takes a lot of skill, and that is really what is not being taught. When you have facilities running down, you are not then in a position to be training people to learn about these very difficult conditions. We are talking about a whole spectrum. A lot of the attention has been on anorexia nervosa, which is in fact the rarest and yet it is still very common. One in 200 girls aged 15 to 18 have anorexia nervosa, according to the big epidemiological study in Minneapolis. But many more people have bulimia nervosa, which is what Amanda was describing, and a lot of people have a combination of both, so they are in big trouble medically. Then we have people who do not quite meet the criteria for each of those conditions but are still quite troubled by their illness and may in fact be physically ill.

**Ms Maguire**—A recent study has demonstrated the same level of mortality and the same risk of suicide in those subclinical cases. There is a problem with the diagnostic criteria for eating disorders. ‘Clinical’ does not necessarily indicate ‘severe’. Severity is across the spectrum.

**Senator WEBBER**—I am from Western Australia, so the delivery of services in New South Wales is a bit of a modern mystery to me.

**Ms Maguire**—You recently funded an outpatient program for bulimia nervosa.

**Senator WEBBER**—Absolutely.

**Ms Maguire**—It would be fabulous if we could get something similarly funded here.

**Senator WEBBER**—Picking up on what you were saying before—

**Senator FORSHAW**—We could ring the new Premier.

**Senator WEBBER**—Yes, you could. You have one now.

**Senator FORSHAW**—He is the former Minister for Health.

**Senator WEBBER**—One of the experts we used to have in Western Australia only developed his expertise because one of his daughters developed an eating disorder.

**Ms Maguire**—It is a common story.

**Senator WEBBER**—Otherwise that would not have been an area that he would have considered. Earlier you said that of the eight area health services only four offer some kind of treatment.

**Ms Maguire**—Yes. There is really only one that offers a child service. What is the youngest child you have?

**Dr Kohn**—From seven and up.

**Ms Maguire**—This research is a little dated because it is about 10 years old, but it shows that for most who access treatment as adults there can be a very long duration of illness before people get to treatment, partly because of all the questions that you have raised, and partly because of the pathology of the illness. The individual can want to hide it not only because of the pathology but also because of the response they are going to be met with in society when they do come forward. Can you redirect your question?

**Senator WEBBER**—I was only halfway through it, so I do not blame you for getting lost.

**Ms Maguire**—That is why I do not know what it is! I am sorry.

**Senator WEBBER**—So you only have four that offer some kind of treatment.

**Ms Maguire**—Yes.

**Senator WEBBER**—Correct me if I am wrong, but you are saying that most of them cannot accept any out of area referrals. So what happens to the rest of the people?

**Prof. Russell**—They have to get private health insurance. If they have not, and not many people have really, they do not get treatment.

**Ms Maguire**—They either stay at home and die or stay ill.

**Senator WEBBER**—So they are consigned to a life of illness without treatment.

**Ms Maguire**—Yes, or they get private health insurance.

**Ms Jordan**—We in the Eating Disorders Foundation have the example of families who have had to sell the family house to pay for their daughter's treatment. In fact, one of our board members recently had to down-scale to pay for her daughter's treatment, which was prolonged. It lasted over a year.

**Ms Maguire**—The average duration is five to seven years for anorexia nervosa and nine years for bulimia. They are long illnesses.

**Senator FORSHAW**—I was going to ask you to repeat the figures to do with the four areas out of the eight but I notice that you have in your submission a summary of each of the areas. Has any reason been given why there is no funding for similar services in the other areas?

**Ms Maguire**—There are no dollars.

**Senator FORSHAW**—So why have they chosen, for instance, that the Central Coast has a service or that the Sydney west area has an acute care service but others, such as the greater western area, do not?

**Miss Leahy**—On the Central Coast we are funded through allied health, we are not funded through mental health at all. It could be a case of funding, but it is often a case of priority. There are a lot of other very worthy mental health issues, not just eating disorders. It is not seen as a priority. As I said, we have a lot of people with 15 to 30 years experience and well-known experts et cetera. We have been working very hard at trying to make it a priority in area health services and at the state level. In my area I was able to make a case through allied health. I think Nowra and Illawarra are funded through allied health as well and not mental health.

**Senator FORSHAW**—Would these decisions be made by the local area health board, not necessarily by the department?

**Miss Leahy**—Yes, that is right. It is only up to someone to make a case in their area health service as to whether they will be funded or not.

**Senator FORSHAW**—I thought your initial submission and the summary were very detailed. Is the category, Eating Disorders Not Otherwise Specified, the subclinical range? Are there any others?

**Ms Maguire**—That is the subclinical range. As we said, there is a problem with the diagnostic criteria. They are being revised for the next edition of the diagnostic and statistical manual. EDNOS is a category for everyone who has an eating disorder of significant severity, such that it requires treatment, who do not meet the criteria for bulimia nervosa and/or anorexia nervosa. It includes binge eating disorder at the moment.

**CHAIR**—Does it include a child who will only eat peanut butter sandwiches?

**Prof. Russell**—No, that is selective eating. That is a bit different and I think it is handled quite well by paediatricians, dieticians and also fussy eating. I do not think they are really in the spectrum, but those kids not infrequently go on to get anorexia nervosa later on.

**Senator FORSHAW**—There is the other issue of obesity. There is a lot of talk and coverage of that. It is linked to diabetes and so on amongst young kids. Is that the other part of what should be an integrated program of education and support or does the whole area have to have its own focus distinct from obesity which does not necessarily pick up mental illness?

**Dr Kohn**—That is exactly right but I think it is a core question and it gets back to what is core in disordered eating. It is about coping with stress through changes in your eating behaviour which becomes a pattern where you need to do it to feel okay. It is a dependency. It is much more common to overeat. As you have alluded to, that epidemic we now have of child and adolescent obesity is huge but we are finding that in approaching treatment in the same way we are having an effect. In other words, we are containing the eating behaviours first. Sometimes, for some of the obese children that we are treating, we actually do bring them into hospital as well because they have literally morbid obesity even as children. Then we are providing a family

and structured support to change the behaviour and, in that context, the young person is able to change and grow out of that eating disorder and is able to manage their weight.

**Senator FORSHAW**—Is there a high correlation between anorexia or bulimia and smoking amongst teenagers or not? I think I heard that somewhere and I wanted to clarify it.

**Dr Kohn**—Definitely not. When we treat anorexia in a medical setting, the patients do not smoke. When we treat anorexia in a psychiatric setting, the patients smoke because in psychiatric settings they are also smoking.

**Ms Maguire**—There is, however, some research into dieting and smoking in young girls that shows that extreme dieting and smoking—because of course smoking is an appetite suppressant—go together. They can suppress their appetite through smoking. I think that question ties in nicely with the one asked previously. Yes, we do need to coordinate with the obesity experts and the obesity treatment programs that are in place. I do not know that we are necessarily going to be able to treat these two disorders in the same place—although Michael has testified to the fact that they can be done in the same place.

We are talking about a mental illness when we talk about anorexia nervosa, bulimia nervosa and EDNOS. That is part of the reason why we wrote the national strategy. It is at that sort of umbrella level that we should be coordinating with the people who are treating obesity, to make sure that our messages are not competing with each other. And, where we have a direct crossover with each other—that is, dieting, which can lead to obesity and to our definition of eating disorders—we need to be working with them to make sure that we have effective intervention and effective prevention.

**Miss Leahy**—In my other two days a week I also work as a dietician and public health nutritionist in obesity research. I have been involved at the state level in the Promoting Healthy Weight policy. Just recently, when they were looking at strategies for treating obesity, the whole issue of body image and self-esteem was not mentioned. So it is really important that the people who are looking at the obesity issue talk to the people who work on eating disorders, because at the core of preventing both obesity in children and eating disorders in children is promoting healthy weight, healthy attitude, healthy eating and healthy physical activity. They are actually on the same team. It is just that, as time goes on, they diverge. So I think it is really important that mental health is raised as an important issue in the obesity debate and not excluded.

**Prof. Russell**—Could I also add that many of our sickest patients with eating disorders have actually been previously obese.

**Senator WEBBER**—I want to return to the case of the child of seven. How do we treat someone with something like this who is seven, and how do we end up with a seven-year-old who has such a core problem that they develop a diagnosed eating disorder at the tender age of seven?

**Dr Kohn**—At the Children's Hospital at Westmead this year we have seen three boys aged seven, and that is not uncommon. In that preadolescent age group, the ratio of females to males is about one to one; in early adolescence it is about 10 to one; and then in adults it is about 20 to one. So it is not so uncommon to see males. Younger people do require a different

way of support. They are very concrete and rigid in their thinking, so they are more easily stuck and less experienced, with fewer skills to motivate them to change. So, yes, it is definitely again a matter of family support.

We have not alluded to some of the other aspects of care: around medication and other ways in which we are able to support young people and adults with eating disorders. I think it is just a matter of having those structures in place and dedicated resources so that again, over time, you can lead a person back into the mainstream, regulate them around their eating and support them about developing coping strategies to function independently.

**Miss Leahy**—In the early intervention service, 10 per cent of our people are under the age of nine and 25 per cent are under the age of 14. So we have a compulsory family therapy for all of those children and their families.

**Senator WEBBER**—Are we picking up all of these young children?

**Dr Kohn**—I do not think so. Certainly we have some school based data from Melbourne that would show that, no, there are very few—a significant number but a minority of patients who identify themselves in cross-sectional questionnaires as having an eating disorder—who have had any form of support.

**Ms Jordan**—We ran a conference for preschool teachers and family day workers, because they were picking up all these children who were refusing to eat their sandwiches because they did not want to get fat. So there are messages that go back to three-year-olds, four-year-olds and five-year-olds. I am not saying that they have eating disorders, but they are definitely an at-risk population, and we have a whole group of professional people out there, even in education, who do not know what to do and who need advice and education.

**CHAIR**—Does any of this stem from a change in family practices of sitting down together around a dining table each night and sharing dinner?

**Prof. Russell**—I believe it does, yes. I believe families are very disorganised about that.

**Dr Kohn**—It is just one of those things that make you more vulnerable: the fact that there is an emphasis on thinness, the fact that there is less structure and regulation around eating. All of those things allow the pattern of eating disorder behaviour to develop more easily. Again, that is our explanation of why we are seeing younger and younger people becoming symptomatic and presenting with anorexia.

**Ms Maguire**—There is only one cultural ideal at the moment, and we need to create another ideal for young people that is not about being thin and beautiful and famous and rich and all the things that people think thinness brings them. We do not have that yet.

**Prof. Russell**—That is important in terms of prevention, because really the only prevention programs that have been shown to work are the ones that work on the self-esteem of the participants, and they do not seem to go on working; they really have to be continually set in place. All those that teach kids about eating disorders are about as successful as campaigns to stop them from smoking and using drugs—

**CHAIR**—Which is not.

**Ms Maguire**—It is more non-specific—

**Prof. Russell**—It tends to glamorise the problem, too.

**Ms Maguire**—We do have programs that have been proven effective and they have been developed in Australia. We just do not have funding to implement them.

**CHAIR**—That is probably a good point to finish on.

**Ms Maguire**—Could I just say one more thing? Can I get you the figure that you asked for at the beginning, of how much money it would take?

**CHAIR**—Yes.

**Ms Maguire**—The service plan does outline what we need to do in New South Wales, so we have the document there that outlines what we need to do and how much it will cost.

**CHAIR**—You have not provided the service plan per se in your submission, have you?

**Ms Maguire**—I think I did send it as an attachment, didn't I? It was under review.

**CHAIR**—We will check. If we do not have it, we will let you know and ask for it. It is not a huge document, is it?

**Ms Maguire**—We can summarise it for you.

**CHAIR**—I think it would be good for the committee to have some idea of what such a plan would look like. I thank you very much for your submission; it is a most interesting subject and we were pleased that you made the submission to us.

**Proceedings suspended from 12.46 pm to 1.39 pm**



**CASSANITI, Ms Maria, Consortium Member, Multicultural Mental Health Australia**

**GRIFFITHS, Ms Meg, National Program Manager, Multicultural Mental Health Australia**

**PROCTER, Associate Professor Nicholas, Adviser, Multicultural Mental Health Australia**

**CHAIR**—Welcome. You have lodged a submission with the committee, which we have numbered 200. Are there any amendments or additions you want to make to that document at this stage?

**Ms Griffiths**—Yes, we would like to submit some additional material to the submission. It relates to the section headed ‘People from diverse backgrounds with mental problems in criminal and immigration detention’ on page 18 of the submission. It contains additional recommendations developed in response to the report of the Palmer inquiry, which was released after our submission was completed.

**CHAIR**—It is the wish of the committee that that be accepted.

**Ms Griffiths**—We also have three documents, which were extensively referenced in our submission. We thought they may be of some use to the committee. They are: *National Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*, which was developed last year and released late in the year; *Reality check*, which is a publication of MMHA dealing with the experiences of culturally and linguistically diverse consumers; and *In their own right*, which was a similar research project that dealt with carers.

**CHAIR**—Thank you very much. I now invite you to make a brief opening statement, after which we will go to questions. Do you all wish to speak, or will it just be you, Ms Griffiths?

**Ms Griffiths**—Yes. Thank you for inviting us here today. Multicultural Mental Health Australia said in its submission that Australia is one of the most multicultural communities in the world, and that diversity is one of the great strengths and joys of our community. However, diversity brings with it the challenge of meeting the needs of a community where one person in six speaks a language other than English at home and where 2½ million people were born in countries where English is not the primary language. Australia’s multicultural communities are not homogenous. They have various risks and protective factors for mental illness and, within communities, there are groups with special needs and particular risks. Based on the 1997 national mental health survey, we estimate that more than 250,000 first generation adult Australians from diverse backgrounds will experience mental health problems in a twelve-month period.

In this opening statement, we would like to highlight the main initiatives that Multicultural Mental Health Australia believes are essential to improving the mental health and wellbeing of Australians from diverse backgrounds. Before we do that, however, we would like to stress that the information we are providing here and in our submission is based almost entirely on the priorities identified during the development of the *National Framework for Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*, which I have just

referred to. MMHA undertook the development of that document for the Australian Health Ministers Advisory Council and the National Mental Health Working Group during 2003 and 2004. Nothing that we are saying has not been said before, and it is important to acknowledge that substantial work has been done to identify issues for people from diverse backgrounds and to develop potential strategies to deal with those issues.

What distinguishes multicultural mental health is the need to understand the role of culture in the accurate assessment, diagnosis and treatment of mental illness, and the importance of establishing culturally appropriate models of care across Australia. So the first issue we would like to highlight is the need to provide equitable, accessible and culturally appropriate mental health and wellbeing services for people from diverse backgrounds and to deal with the variable availability of services across Australia. In many jurisdictions, services for communities from diverse backgrounds are funded on a project basis. Where long-term structural development is needed, this sort of finite funding not only fails to address inequity but often contributes to the lack of consistency and equity in service provision and raises community expectation which is unable to be sustained. We would also like to make the point that, if mental health service delivery for diverse communities is to improve, we need to focus on moving towards agreed and common targets of service availability and utilisation. Performance indicators and appropriate outcome measures need to be developed and agreed, and current lack of benchmarks addressed.

Our next point is the importance of cultural competency training and clinical support for all sectors of the work force. Cultural competency requires an understanding of culture, its impact on human behaviour and how that behaviour is interpreted and evaluated. Currently, cultural competency training is characterised by a lack of guidelines for culturally competent practice to complement the national practice standards for the mental health work force, a lack of any standardised measures to assess cultural competency, a multitude of training providers and cultural competency training packages around the country, and little or no accreditation or evaluation of training against agreed national standards.

To improve cultural competency we recommend a national initiative to develop and support the national practice standards as they relate to diverse communities. This would complement the existing practice and the service standards, making them easier for mental health services to implement in relation to diverse communities, and making it easier to identify the need for culturally relevant resources for practitioners.

It is estimated that 75 per cent of mental health care is provided in the primary care sector, with limited access to specialist support. The primary health care sector, including GPs and other primary care providers such as emergency departments and community health centres, is ideally placed to identify people from diverse backgrounds with mental illness and to intervene early in the course of their illnesses. Those GPs and other primary care providers need cultural competency training and the support and backup of specialist referral services. For general practitioners and allied health professionals, the Better Outcomes in Mental Health Care initiative should be enhanced to provide training and consultation in cross-cultural assessment and to improve capacity to diverse communities.

In small and close-knit communities stigma reinforces social isolation and prevents help-seeking. There is an urgent need to increase understanding of mental health and mental illness in multicultural communities to reduce the stigma around mental illness, which affects not only

consumers but also their carers and families. This requires community awareness programs, good community information and adequate information on rights, complaints and appeal mechanisms. Supporting participation of people from diverse backgrounds with mental health problems requires resources. Mainstream consumer and care organisations need to be expanded, resourced and developed to include people from diverse backgrounds and to effectively express at the policy level the issues that affect those communities.

In our submission we also discuss the issue of refugees, asylum seekers and people in immigration detention. Professor Procter will be happy to discuss this further during questions, but at this point we would like to reiterate that it is the experience of MMHA consortium members providing clinical services to these groups that many are suffering from adverse mental health because of their experiences. We endorse the recommendations of the Palmer report, but believe that it has failed to recognise several important areas, which we have covered in the additional information we have presented today. We believe that only by establishing a truly independent, multidisciplinary mental health panel which includes experts in multicultural mental health can the potential to deliver adequate care be maximised.

In conclusion, MMHA believe that the framework for implementation of the National Mental Health Plan provides a blueprint for the development of multicultural mental health services and charts the way forward. But to achieve its potential it must be supported by a national dissemination and implementation strategy and resources for national initiatives, and work to develop multicultural mental health services across Australia to an agreed level of service delivery. We would like to stress that the mental health and wellbeing of all Australians, including people from culturally diverse backgrounds, is the responsibility of everyone in the mental health sector. The framework is there; what remains is the need for concerted and coordinated action across Australia supported by resources and goodwill over a sustained period.

**CHAIR**—You referred to the need for an independent panel. Do you see that as an ongoing body? Or do you see it as a panel which would conduct a broader inquiry, such as a royal commission, into the situation for those people in immigration detention?

**Prof. Procter**—I see it as something that is ongoing and deliberately multidisciplinary. I think the recommendations of the Palmer report are positive in terms of having such a panel constructed and reporting directly to the Ombudsman. It would be a panel which would open new lines of communication within the current and existing structures, which to date have been impenetrable.

**CHAIR**—Is there a similar model which you can point to that would help us understand what you mean?

**Prof. Procter**—There is no similar model because we do not have a similar system elsewhere, such as a facility that is not regulated for national standards in mental health care. What we require is a system that would enable people from psychiatry, psychology, nursing and the social sciences to be able to assess, design care and treat people with mental health problems and mental illness who are inside immigration detention and, indeed, to have some deliberate oversight over the care and comfort needs of people released from immigration detention into the community.

**CHAIR**—A number of submissions have suggested that the health of people in detention, whether it is in the prison system or in immigration detention, should be managed by the Department of Health and Ageing as opposed to the Department of Immigration and Multicultural and Indigenous Affairs or another department. Do you agree with that? Should this be something that is jointly managed? I guess the department of immigration has the appropriate cultural expertise, but do you agree with the proposition that it should not be up to either the providers of the detention service or the criminal justice system to deliver health care to people in their care who have a mental illness?

**Prof. Procter**—In principle, yes. I think that, whoever they are, the attending mental health service must be operating with the national mental health standards and particularly the framework document that we have submitted today at the very forefront of their practice. They must be emotionally and professionally calibrated with the intention of those two documents, and they must be willing to free their vision from existing paradigms and structures. I happen to believe that mental health care for immigration detainees is everybody's business, but I strongly believe that the multidisciplinary panel should oversee the mental health care that is delivered to immigration detainees and, indeed, scrutinise the people who are delivering it.

**CHAIR**—The first witness we had today described circumstances in which he was pretty much the only person in immigration detention at Villawood, I think, to speak good English. He therefore found himself being the one to assist detainees in talking with the centre and with the department, and for his trouble he was effectively put into a form of isolation, if not 100 per cent isolation. In your experience, is this what is happening in detention centres? Is it common for people who speak out and are of assistance to other detainees to be treated like this? I think in his case he triggered a one-day hunger strike.

**Prof. Procter**—In my experience, I do not have any first-hand knowledge to comment on whether or not that is common. But what I can perhaps offer to the committee is the knowledge that there are no independent interpreters operating inside immigration detention. So the primary function of your earlier witness was around relaying information between two languages. Currently there are no independent interpreters, and I think that is a real problem for people who want to discuss either their legal status or their mental health problems—or whatever the matter might be.

**CHAIR**—So you would see this panel providing interpretation and translation services?

**Prof. Procter**—Yes, certainly.

**CHAIR**—Independent of the department that is locking these people up?

**Prof. Procter**—Yes, absolutely. I would also see support structures and mechanisms for those interpreters such as debriefing and other support services that they might need in the course of their duties. Finally, I would also like to see an emphasis being placed on the employment of interpreters and translators who are NAATI accredited at level 3, which is the highest accreditation. This is due to the complex nature of mental health issues and the metaphors, the language and the cultural formulations, if you like, that are required to explain symptoms and better diagnose and treat problems.

**CHAIR**—Members of the committee will be familiar through the inquiry into aged care with the argument that once people become elderly they often forget their second language and revert to their original tongue. Is it the case with mental illness as well?

**Ms Cassaniti**—Yes, very much so. This situation may also occur with all patients who have a language other than English. Under stressful circumstances they have been shown in a clinical situation to lose their ability to use English. Also, if English is not their first language, they may not have the vocabulary that goes with the clinical discussions that are taking place. So this issue has to be considered for people across the ages.

**CHAIR**—Are there any cultural impediments in groups to understanding mental illness? I can think of some cultures where this is not seen as a medical or a mental health problem. To what extent does the health sector understand those problems? Often, in my experience, it leads to people not wanting to seek help, family members wanting to cover up and keep the person at home and that sort of thing.

**Ms Griffiths**—There is a great deal of stigma attached to a diagnosis of mental illness in many communities, but there is also the added complexity of the simple lack of words in many languages for many of the issues that mental health practitioners talk about and understand. In many languages there just is no word to translate. There are also many cultural understandings of behaviour. What we call the explanatory models of behaviour or of illness vary from culture to culture, and that is part of the issue that we have raised in our discussion of cultural competency. While practitioners may not be aware of the exact construct of illness in every culture, they need to be aware that when someone is from a culture different to theirs practitioners need to temper their understanding of an individual's behaviour, presentation or description of their symptoms simply because they come from a different cultural construct when they describe that situation.

**Senator FORSHAW**—The first full paragraph at the top of page 13 of your submission refers to the activities undertaken by multicultural NGOs. It says at the end of the paragraph:

... many NGOs—

I am assuming that means multicultural NGOs—

see themselves as reluctant players in mental health service provision, with no organisational structure by which the mental health sector can provide them with support.

Can you expand on that a bit? Do you see scope for assisting those NGOs or community based organisations to take on a role, obviously with the appropriate support and funding, and how might that work?

**Ms Griffiths**—In many communities the NGOs, particularly the multicultural NGOs, provide community based support and a range of services in a range of areas outside health to large numbers of people—

**Senator FORSHAW**—Sorry to interrupt, but they are in fact very well organised in some of those areas.

**Ms Griffiths**—Yes, and they are very close to the communities which they serve.

**Senator FORSHAW**—For obvious reasons, yes.

**Ms Griffiths**—I think that there is potential. It is certainly one of the planks of the framework that we have referred to that the health sector needs to engage in partnerships with those organisations. They need to recognise the expertise and the connections that those groups have with the community and join with them. There is also a need for the community sector to understand the health system in a much more thorough and comprehensive way than perhaps it does at the moment so that they can assist people to negotiate it. This morning we heard people talking about the complexities of negotiating the system. That is obviously a very difficult thing to do for many people who have good English and it is an even more complex issue where English is not your first language.

**Senator FORSHAW**—I suppose I am wondering why that is the case when those groups are very good at organising, providing advice on and assisting in a range of other activities—and I am not being critical—particularly housing issues and support services for welfare and aged care. I am aware of many communities that have developed their own aged care services—nursing homes and so on. It seems to me to be a tremendous resource in many of the community ethnic based organisations. Why is there this gap, then, in this particular area?

**Ms Cassaniti**—I do not think there is a gap in some areas. In some of the states those partnerships have been fostered really well with some of the communities, and some of the models used have really gone into the existing structures and that has worked well. I would not say that we are not doing that at all, because we are, and in some areas we are doing it really well. It is about how we do it across a nation and how we improve that. The models are there and they are working. One thing that I think is lacking, nearly 15 years down the track from when transcultural services began in Australia, is adequate resource allocation. We have, I guess, exhausted some of these communities in coming into partnerships, being involved in translations and being involved in trying to do mental health literacy for no extra funds. They have been willingly doing that, but I think it has come to the point where we have to organise it and resource them well when they come in and enter those partnerships. I think that is what is lacking.

**Senator FORSHAW**—It may presumably also reflect the fact that if there are problems in a lack of these services in the general community they may well be magnified in communities of high ethnic concentration.

**Ms Griffiths**—I think that, in some ways, perhaps some of the organisations reflect the lack of understanding of mental health issues that are prevalent within the communities. There is a level of reluctance to deal with mental health because of the fear, the stigma and the other things that are associated with that lack of very developed mental health literacy.

**Senator FORSHAW**—What about GPs who are themselves of a non-English speaking background who may well be working in parts of the country where many of their patients are of other nationalities? Are you aware of the level of understanding amongst those GPs of mental health issues? This is an issue that we talk about generally amongst GPs.

**Ms Griffiths**—I think there are two issues. One is that, yes, there are bilingual and bicultural GPs who work in areas where there are diverse communities. For the people with whom they share the culture that is an advantage, but unfortunately that is not always the case. There may well be concentrations of many languages in an area, so you may not always get the language and cultural match. The second thing is that it is our understanding that in some communities people are reluctant to use a general practitioner who may be an integral part of their community, simply through issues of stigma and privacy. So there are complex issues around that. That would be so, particularly in small communities, where many people are connected and know one another and live locally. I think it would be amplified in rural areas. But there is great potential in the Better Outcomes in Mental Health Care initiative to support GPs. As with many practitioners in the field, there is a need for a cultural competency and a cultural understanding and for support at the referral level with assessment, diagnosis and treatment planning. Those services are available in some states and are offered as a consultant service to the sector. There is no reason for that not being extended to general practitioners in the same way as they currently receive psychiatric assessment assistance through that program.

**Senator FORSHAW**—On page 17 of your submission a subheading refers to ‘Issues for carers’. Are you talking particularly about carers who are family members or is there a broader definition? Could you comment on the ‘lack of understanding of the western construct of a carer’? I think I know what you mean; I suppose I would just like to have some explanation on the record.

**Ms Griffiths**—We did a study a couple of years ago with Carers New South Wales, which is one of the documents I provided to the committee today. The organisation that was conducting the research for us asked people what their needs as carers were. Many of the people that they spoke to did not see themselves as carers; they saw themselves as wives, brothers, mothers, sisters or whatever. They did not have that understanding of the term ‘carer’ that we have created and therefore they had no real understanding of having an entitlement or of having needs in their own right. There is an issue, again, around the cultural understandings of the roles that we describe. I think it is important for practitioners to understand the role of family, the role of women and the traditional expectation on women to be carers. It is important to a cultural understanding of illness and to dealing with families.

**Senator FORSHAW**—On page 16 there is a statement that says:

In many CALD communities the concept of recovery is rare or unknown. Mental illness is seen as a lifetime disease from which consumers do not recover.

That is not necessarily exclusive to culturally and linguistically diverse people, but could you expand on what you mean by the concept of recovery being rare or unknown? Are you talking about a cultural understanding or is it a general view that once you have a mental illness you have it forever?

**Ms Griffiths**—People from culturally diverse communities have expressed just that: once you have a mental illness you have it forever—you are a person with a mental illness. The concept that has currency in the current consumer movement of moving towards recovery is less well known. It is something that would be required in any program to increase mental health literacy.

**Senator FORSHAW**—What you are saying is that the belief is more intense and widespread. I suppose I had in mind the question of whether there was a cultural element whereby some communities felt from their own experience or from the history of their country that this was the way it is being treated and therefore that is the way it is.

**Ms Cassaniti**—In some but not all cultures there is the idea that people who have mental illnesses get locked away forever, which equates to them never getting better; they basically stay unwell. A lot of those ideas stem from that—and it is not all cultures. The views of immigrant communities that have been here for a long time are more in line with mainstream cultures. They realise that recovery is part of the mental health system. It does vary.

**Senator WEBBER**—Continuing with the role of the family and carers, to what degree is there conflict as we go through a generational change? I can understand the stigma with original arrivals to Australia, but it seems to me that you have some generational conflicts too. If that culture has a stigma about mental health, as people are becoming more anglicised and more exposed to being open about it, does that create—

**Ms Cassaniti**—It can, but stigma is alive and well even in mainstream communities.

**Senator WEBBER**—Indeed.

**Ms Cassaniti**—It depends on how much the child of the first generation has acculturated as well, how much they know about mental health and how much their views are part of mainstream versus part of their family's cultural views. It is different for different families.

**Senator WEBBER**—That is what I am trying to get at—whether they have the general stigma that those of us on this committee may well have versus—

**Ms Cassaniti**—The answer is that it varies from individual to individual—it depends on their own world view, what they have learned about mental health along the way and how much they have been exposed to the mainstream culture. You have to understand that mental health in its own right is a culture.

**Senator WEBBER**—Absolutely.

**Ms Cassaniti**—I guess it just depends how much the second generation has entered into that. Of course, if you take the example of myself, if I had a family member that had a mental illness, of course my family is going to know more simply because of my life's circumstances. But if it is someone else that has not had as much exposure to mental health issues, we do not know. It does vary. Certainly in the cases that we see and the psycho-education programs that we do, it varies from person to person and from culture to culture.

**Ms Griffiths**—One of the roles that Multicultural Mental Health Australia has is that of an information service. We frequently get inquiries from the children of people with a mental illness. They serve a very useful and very valid role in mediating information. We often have emails from people which say that their mother has been diagnosed with depression and they need some information in a certain language. Frequently they will find information from a range of sources and then, one presumes, take it back and explain it. There are also issues for second-



generation people. There are particular stresses related to being a second-generation person in that they frequently have a different expectation to the more traditional families. For them there is often a stress around which role they play.

**Senator WEBBER**—The competing expectations.

**Ms Griffiths**—Exactly, the competing expectations.

**Ms Cassaniti**—For children who have parents with mental illness, the small amounts of research that we have done has indicated that there is a lot of stress on them in terms of them having to take on parental roles because of the language barrier of their parents. They as carers become very stressed and sometimes that is at a young age because of having to interpret for parents or for grandparents et cetera.

**Senator FORSHAW**—Can I just jump in and ask how this compares to other health issues and illnesses—the ability of people to get information on mental loss as compared to cancer or pregnancy or other public health issues?

**Ms Cassaniti**—For carers in general?

**Senator FORSHAW**—Carers and even, as you said, the children of families.

**Ms Cassaniti**—I think stigma is the big issue.

**Senator FORSHAW**—But is there much information available—

**Ms Cassaniti**—In different languages?

**Senator FORSHAW**—in different languages, yes.

**Ms Cassaniti**—There is, but once again you have to remember that there are lots of language groups in Australia. Certainly when we have had the opportunity to translate information and make it culturally and conceptually appropriate for communities, there are a lot of communities that go without that information. Even if you were able to have the funds to provide information for 20 communities, there are communities that go without that information. But certainly, as Meg was elaborating, for children who have the English language ability they can access information and then interpret that for their families.

**Ms Griffiths**—I think it is fair to say, too, that there is a lot of duplication. There are a lot of organisations developing materials on top of one another, and the information that is around is of very variable quality. To answer your question specifically in relation to physical illness—

**Senator FORSHAW**—I suppose I was thinking of those public education campaigns on key issues of cancer, diabetes or whatever and how mental illness compares in terms of the accessibility of information.

**Ms Griffiths**—Probably the answer to that is that it has been less coordinated.

**Prof. Procter**—In addition to those comments, I think that the penetration of that material into the mainstream is far more problematic for mental illness and mental health issues than it would be for asthma, diabetes, heart disease and other more common, acceptable illnesses and complaints. Again, the penetration into the mainstream mental health system about specific information for linguistically and culturally diverse communities is a real problem.

**Ms Cassaniti**—There was a campaign done a couple of years ago in 15 languages informing parents about child and adolescent issues. That went down really well and was welcomed by the targeted communities. We know that we got a rise in our clinical calls and inquiries. Those increases in the clinical referrals have continued over time because of that information that continues to exist in a translated form. The campaign itself began on radio, but it has continued in written and audio translations. So where we have the opportunity and resources it goes down really well.

**Prof. Procter**—It might also be useful to very briefly draw the committee's attention to a MMHA project that has just been completed. It is a project on depression information, the use of antidepressant medications for people released from Australian immigration detention centres who are Afghan. That has been successful because it was able to penetrate regional communities and some small groupings around Sydney and inner Adelaide but will have national reach because of the dissemination strategy, which is both electronic and paper based. We can forward the committee information about that through the secretariat.

**Ms Griffiths**—It is important to say that one of the planks for the framework is that there is a need at a national level to provide consistent, high-quality mental health information in a range of community languages, and not just through paper based material but through a range of media. While people may have problems with English, many people also have problems with reading their own language. So it is important that we acknowledge that there is that need to have audio based material as well.

**Ms Cassaniti**—It has to be multifaceted. It works really well. We have evaluations indicating this from different campaigns that have happened.

**Senator TROETH**—I am sorry to have missed the earlier stage of your presentation. I understand that, rather than a mental health commission, you would like to see a panel appointed.

**Prof. Procter**—Just for clarification, this would be in relation to the multidisciplinary panels?

**Senator TROETH**—Yes.

**Prof. Procter**—This is about the assessment and treatment of people inside immigration detention. To briefly recount some of my earlier comments, it is really about scrutinising the mental health care that is delivered to people inside immigration detention centres and indeed the people who deliver it. Fundamentally, the arguments that I would like to bring to the table are that, up until now, immigration detention facilities have been unregulated by any form of scrutiny of national mental health standards. The landmark decision earlier this year by Justice Finn in the High Court made some very clear and direct references around that—the failure of national mental health standards in the Baxter centre. Reiterating earlier comments, I believe that

people who are involved in the assessment, treatment and care of people with mental health problems in immigration detention, or upon their release into the community, must be professionally and emotionally calibrated with the national mental health standards and the national framework document for implementation of the national mental health plan, which we have tendered as an additional document for today's meeting.

**CHAIR**—We probably have to finish there. You gave us a copy of the multicultural Australia document. I just had a quick look at it and it seems like a fine document. Two years on, how far are we in terms of implementing what is in here?

**Ms Griffiths**—The document was published late last year. It is yet to be supported by an implementation strategy.

**CHAIR**—I will put it another way. How confident are you that by 2008 we will have achieved all of these performance indicators, objectives, funding models and so forth?

**Ms Griffiths**—I guess it depends upon goodwill and commitment. I think it would be a very ambitious agenda to achieve it by 2008.

**CHAIR**—That is what it says—2008.

**Ms Griffiths**—It really refers to the National Mental Health Plan being from 2003 to 2008, rather than our framework. As we have said, if it is supported by an implementation strategy, action and commitment across the jurisdictions, good progress could be made by 2008.

**CHAIR**—One quick last question, Senator Webber.

**Senator WEBBER**—Yes; we are running a bit behind time because we kicked off a bit late. Earlier you referred to the better outcomes program. A lot of people talk about that as being something that we can hinge a lot of treatment on, particularly in regional and remote Australia. I am just wondering how realistic that is, given the fact that only 18 per cent of GPs have done the first six-hour stint of training. Very few of them then go on to do the 20 hours which enable them to deliver the counselling and what have you. If we are going to look at the issues that you have raised then it seems to me that we have to add more to the 20 hours. Personally, I do not think 20 hours is enough to become a fully-fledged counsellor when people can spend six years at university learning how to do it. That is my personal view. How realistic is that, or is there a better way of making sure that we get that training in early?

**Ms Griffiths**—I think that, within the context of the program, it would be a start to include a component of cultural competency training within the initial training, the ongoing training program, and also the support training for allied health providers, who are the supplementary component of the program. As I understand it, the program also has phone, fax and email support where people can get psychiatric advice. Our proposal is partly that that would also be possible with the existing infrastructure that we have in some of the states. Those states support their rural areas in clinical support, assessment and treatment planning. So, with enhancement, there is no reason why that sort of service could not be offered to general practitioners. The issue of the 18 per cent is obviously problematic.

**Prof. Procter**—Even supplemented with telepsychiatry, appropriate supervision and mentor relationships, I still think it is a big target and one that will be difficult to reach.

**CHAIR**—Thank you for coming today and presenting your submission to us; it has been very valuable.

[2.23 pm]

**BRODATY, Professor Henry, Private capacity**

**McKAY, Dr Roderick, Chair, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists**

**CHAIR**—I welcome Professor Brodaty and Dr McKay. Do you have any comments to make on the capacity in which you appear?

**Prof. Brodaty**—I am a professor at the University of New South Wales, in the field of psychogeriatrics.

**CHAIR**—You have lodged with the committee your submissions, which we have numbered 219 and 398 respectively. Do you wish to make any amendments or any additions to those documents at this stage?

**Dr McKay**—No.

**CHAIR**—I invite you both to make a brief opening statement and then we will go to questions.

**Prof. Brodaty**—Thanks for the opportunity to speak to you. In old age mental health we see there are a number of disparities. There are disparities in the number of services provided for older adults versus younger adults. If we look at the percentage of the population aged over 65, which is 13 per cent, versus the percentage of the budget, we see disparities in most states. There are disparities in older people's access to private psychiatric services. In an analysis of Medicare data, Draper and Koschera in 2001 showed that older people were likely to get about one third of the services that they should be getting proportionate to the population. It is not because they are less sick mentally; it is because they are getting fewer referrals. One of the things about Medicare data is that you can look at the duration, because psychiatry items are strictly on the amount of time a person spends with a psychiatrist. The consultations they receive in private office practices are shorter. Generally they are getting less in the way of talking treatment and more in the way of drug treatment, which may or may not be appropriate.

There are disparities on a state-by-state basis. A forthcoming analysis by O'Connor and colleagues that is coming out in the *Australian and New Zealand Journal of Psychiatry* shows quite marked disparities in the per capita spending on mental health for older people across the states and territories. Victoria is doing very well and New South Wales is not. That is one area. The other area is policy holes. We know that the percentage of elderly—this is now becoming a cliché, but it is true—is going to rise rapidly. Currently 13 per cent of our population is over 65. We will be at 20 per cent by about 2021, and that will plateau around the early 30s by about 2050.

What is even more dramatic is that the percentage of very old people, those over 80 or 85, will quadruple in the next 40 or 50 years. So we will go from about two per cent over 80 to over eight

per cent over 80. The average life span of kids born in 2050 will be in the early nineties for males and females, whereas a boy born today would live to close on 80 and a girl would live to her early eighties. Life span is gradually increasing, fertility rates are gradually dropping and the percentage of the population is dramatically ageing. Policy has not been good at reflecting that.

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

People are working on it at a state level. Victoria and, I think, Queensland have a policy for psychogeriatric services. Rod is chairing the committee which is developing that in New South Wales, and I am sure he will talk to you about that. It is not coordinated. There is nothing to specify what is Commonwealth, what is state and how to work together, and there is a real lack of thinking about the future. We are way behind now. If this greying of Australia is happening, not having a policy in place is going to have a major impact. We currently have about 75 people of working age, 15 to 64 inclusive, for every person with dementia. That is going to change by the time I have grandkids to about 25, so there will be one third of the number of working age people to support every person with dementia. We could look at similar statistics for the number of working age people to support people with any age related problem.

Mental health problems in old age are different. It is not that older people are just adults grown older. In the same way that child and adolescent psychiatry is qualitatively different from adult mental health, in old age mental health there are qualitatively different conditions, different reactions to medication and different treatment strategies. Old people do not do well in mainstream psychiatric services. The clinicians are not particularly interested in older people. In psychiatric wards they often get knocked around by younger, violent psychotic patients. There are strong arguments for having dedicated, discrete services for older people, as we do for children and adolescents.

**Dr McKay**—Thank you for the opportunity to discuss the concerns the New South Wales branch of the faculty has regarding the mental health care of older Australians. The major messages can probably be summarised in a simple statement that, within the underresourced mental health services across the lifespan in Australia, the elderly have the least access, the least developed services and probably the most fragmented framework for financial and policy responsibility. The outcome of this is that, despite good evidence for the efficacy of mental health services for older people, the elderly are particularly disenfranchised from adequate mental health care. This appears particularly evident in New South Wales. Our submission and that also submitted by the national faculty include specifics regarding the extent of these problems and models that can be used to improve services. But those specifics almost overlook the magnitude of the problem.

Older people have particular needs with regards to their mental health care. The range of mental health disorders seen in younger people is still present but becomes complicated by dementia, physical frailty, medical illnesses and other losses of late life. The elderly and their carers are a lot less vocal in demanding services than younger people. Although GPs are central to the care of such people, they need specialised support. Adult mental health teams have very limited capacity in either resources or knowledge to provide this support. The consequences are often all too grave for older people with a mental health disorders and for their carers. They are also grave for the cost of providing health care because under treated mental illness increases the likelihood of carer depression, of premature residential care placement and of poorer prognosis for physical health problems, such as heart disease or strokes.

In New South Wales there is a marked shortage of in-patient resources of all types. There is an even greater, severe shortage of resources to manage older people with mental illness in the community. As a consequence of this, older people with mental illness do not have access to a comprehensive range of mental health interventions. Some areas have no access to specialist mental health services for older people.

Although New South Wales possibly is in a worse situation than other areas of Australia, we believe it does reflect national problems. Mental health policy is largely focused upon the needs of relatively robust adults, with more recent attention given to the needs of children and adolescents. The third National Mental Health Plan acknowledges the elderly as a priority group, which is welcomed. However, there needs to be an insertion of the effort and resources required to develop this recognition into a coherent plan for comprehensive mental health service provision to older people across the nation. It also requires the development of effective linkages between mental health and ageing related planning, funding mechanisms and information systems. These linkages are currently extremely limited and lead to a constant deflection of responsibility both within and between all levels of government. They also lead to excessive inefficient demands upon clinicians and managers for data collection and other accountability measures. They prevent coherent service development.

These issues are particularly problematic for individuals with mental illness associated with dementia. It is estimated that one per cent of the population will have dementia in coming years. That is the same percentage of the population as people with schizophrenia. If you think about the imbalance in resources put to the two conditions, it is quite frightening.

There are evidence based models of care for older people with mental health disorders. The recent Australian Mental Health Outcomes and Classification Network report analysed for the first time the outcome measures for consumers of public mental health services in Australia. They showed that those services that are there for older people are seeing people who are just as severely unwell as services for younger people, and they improve patient outcomes, both in the community and for in-patients.

There have been good Australian and international projects and research that demonstrate effective service models. What is required is a national vision of the elderly, no matter where they live, no matter what sort of accommodation they are in, having access to effective mental health care that includes the range from health prevention and promotion, a range of specialised ambulatory and in-patient services and support with effective service evaluation and research.

There is a hint of this vision being born. It now requires careful nurturing and growth into a real system. I hope you will provide recommendations that can assist this to occur.

**CHAIR**—I am sure we will with your help.

**Senator FORSHAW**—Can you give us a little bit more information about the New South Wales government's plan for mental health services released in March 2005? I understand the state government representatives are coming to appear tomorrow. You comment that there was funding for only one older persons mental health inpatient unit in the Illawarra and no funding for any other places. Were proposals put for a number of these centres? What do you see as the need? Can you give us the scope as to how many need to be provided?

**Dr McKay**—New South Wales Health has got a planning document which estimates the service requirements for different age groups including the elderly. That document largely excludes estimates of the needs of people with dementia mental health problems, so it has a large hole in its estimates as to the elderly to start off with. Against those estimates in the community the levels of resources older people have are at or under about a third of the resources that children and adolescents or people in the general adult range have. In-patient resources are extremely patchy with a mix of old facilities for longer term care, which are mostly for people who have had mental illness for a long time, and a very patchy scattering of acute units. I think the estimates are something of the order of about 50 per cent of what is required but those estimates do not take into account the needs around dementia.

**Senator FORSHAW**—Is that because it is seen to be a Commonwealth responsibility?

**Dr McKay**—I think that has been because there has not been coherent planning at a national level or a state level as to responsibility. It is not just between the Commonwealth and the states; it is even within the Commonwealth and within the states—is it an aged care medical problem versus a mental health problem?

**Senator FORSHAW**—Yes, you make that point in your submission.

**Dr McKay**—It continually blocks things. There is as a recognition at last within New South Wales that they do need to plan and include estimates around dementia, but there is a lot of politics to go on before we see that.

**Prof. Brodaty**—Maybe I should mention the Illawarra. That was the only Commonwealth initiative. There are other psychogeriatric units around the state for aged care mental health but this one was funded through Commonwealth moneys. It is the only one that was funded by the Commonwealth.

**Dr McKay**—That is community PGU. In the last budget the state put out funding for one in-patient unit in the Illawarra.

**Senator FORSHAW**—Yes, that is what you say in your submission.

**Dr McKay**—There is a need for a number of units across the state. I could not give you the exact number. I would say you probably need five to 10 additional units across the state.



**Senator FORSHAW**—You have put in your submission that this is what they have put into their plan for the next four years. I suppose I was looking to see if you have a blueprint or a proposal as to what you believe is required.

**Dr McKay**—The state plan has got a proposal. The biggest need is not so much in in-patient care, although it is desperately needed; it is in the community where you have areas with no-one on the ground. Where I work, the biggest team is five or six people, whereas in comparable areas in other well resourced states or overseas you would be having for that size of population something like 50 to 100 people in the community.

**Prof. Brodaty**—There is no shortage of plans. I wrote a plan for the state in 1997. I chaired a committee, and the report was shelved in 1998. It never saw the light of day.

**Senator FORSHAW**—So that was a plan for older—

**Prof. Brodaty**—people's mental health. It was for the state. It had numbers of beds, numbers of community staff—chapter and verse. That was shelved. Now there is a new regime in place. Rod is chairing the next committee providing the next plan. There is a lot of goodwill and hopefully it will come through. We can write these plans and we have got the benchmarks; we know exactly how many per thousand elderly over 65 or 70. There are well documented benchmarks for what services should be available. The resource formula plan that the state has does not have dementia. We have been told for the last 18 months or two years that that is being revised to include dementia, and we are awaiting that.

**Senator FORSHAW**—Will that in-patient unit be targeted at people who would otherwise be in aged care facilities or nursing homes or will it include older people in the community who may need in-patient care?

**Dr McKay**—There is quite a variety of different models in terms of who ends up in an in-patient unit. Mostly it would be those who are in the community and there would be a proportion of people who are in residential care. The majority of them would be in the community.

**Senator FORSHAW**—When will your committee's work be finished?

**Dr McKay**—The plan is in a late draft form that needs to go through a series of approval processes. The resource allocations are, at this stage, three or four years old, and that is accepted state planning. The people from the New South Wales government should be able to give you those figures tomorrow.

**Senator FORSHAW**—I will try.

**Dr McKay**—A new allocation of funding of \$10 million was announced recently. We are told that there will be a proportion for older people.

**Senator FORSHAW**—Did you say \$10 million?

**Dr McKay**—It will be \$10 million across the age range. We have been told there will be a proportion for older people, but the details have not been released.

**Senator FORSHAW**—Thank you.

**Senator TROETH**—I note your comments regarding funding at both federal and state level. In very broad terms, I take it that it is not something as simple as provision of funds at Commonwealth level and provision of services at state level. It must be more complex than that. I would like your views very simply on how that works and your recommendations for addressing this issue.

**Dr McKay**—I think one of the problems is the lack of linkages between planning within ageing and planning within mental health. At a Commonwealth level, I went to a meeting about three years ago that tried to get together state and Commonwealth planners regarding aged care and mental health. I was told they had tried to hold this meeting a couple of years earlier and there was just so much intransigence it could not be held. Once it was held, it was very pleasant and recommendations were made. Those recommendations have vanished and there have been no further meetings. There are no formal linkages that I am aware of between aged care planning and mental health planning at a Commonwealth level. There are no formal linkages at a state level. Fortunately, currently there are people at the state level who have worked in both departments and some of these linkages are starting.

No formal linkages have resulted in things like information systems that do not talk to each other and clinicians having to fill in the same sort of information twice. It has meant that aged care sees this as a mental health problem and mental health sees this as an aged care problem. That happens at the national level when thinking about where the resources should go and it happens right down to the services on the ground. At that level, you may have an older person with a mental health problem who is told by the mental health service, ‘Sorry, you’re over 65, go to the aged care assessment team’, and they will say, ‘You’ve got a mental health problem, go to mental health.’

**Senator TROETH**—Obviously the recommendations that you put forward to address those issues would target those particular things you just mentioned.

**Dr McKay**—Yes.

**Prof. Brodaty**—Could I put some flesh to these abstract notions?

**Senator TROETH**—Yes.

**Prof. Brodaty**—If you are a 25-year-old man with schizophrenia who is wandering the streets naked or is aggressive or violent, pretty soon the police and people will come and you will be taken to an emergency department and you will be admitted. If you are an 85-year-old person with depression and you are not eating or drinking and are socially withdrawn and hidden away in a house, no-one will come. If you do turn up somewhere, it is not that urgent. You are not a danger to somebody else and, as long as you are not suicidal, you will probably be managed at home. Older people are less visible with their mental illness than younger people. They are more easily tucked away and services are not developed. We are talking a rational plan which cuts across state and Commonwealth to look at all of those services and what is needed.

**Dr McKay**—At a state and Commonwealth level there needs to be some sort of standing working party or group that acts as the link with the different planning departments, so that it is not forever someone else's problem. There have to be similar linkages at a local level as well.

**Senator WEBBER**—I must say, Professor Brodaty, you described my grandmother to a T when you were talking about that. Fortunately, she ended up with assistance, because she had a family that suddenly realised she was losing weight and all the rest of it. I was just saying to Senator Forshaw that I think it is because of social isolation. All her mates in the area got old and died, and she was at home on her own. Now she is in a hostel dealing with people with dementia. It does not seem that there is much good news there.

You mentioned earlier the conflict, in dealing with older people, between talking and drugs, and whether they get the right balance. How much of that do you think is because of the lack of support and training that we give to GPs? If most 85-year-olds are like my grandmother—the only medical professional she ever dealt with was her GP.

**Prof. Brodaty**—I think there is little doubt that GPs are under-recognised. It is tough on GPs—

**Senator WEBBER**—Yes.

**Prof. Brodaty**—It is easy to slam GPs when we are coming from a narrow specialty.

**Senator WEBBER**—That is what I mean by 'lack of support' for them.

**Prof. Brodaty**—It is not just GPs; it is public awareness too. They are feeling depressed that life is not worth while, and they think, 'What do I expect? I'm 85.' They do not recognise themselves that it is a depression. There are a number of barriers. One is that the person is not aware, or the family is not aware, that it is a mental health problem that is possibly treatable. Secondly, the GP is not aware and they put it down to 'just old age'. The next barrier is that they might diagnose something but think, 'What can I do?' and so have a nihilistic attitude and not provide treatment. The next barrier is that they do not get referred for specialist treatment. So there are a number of barriers.

There are programs to improve GP recognition and management of depression—that is the SPHERE program, which has had some success. Certainly there has been talk in various circles about having some specialty program for GPs to do with old-age medicine, including mental health. They would get some extra incentives for doing that. GPs are critical, and I agree: they are the corner shop; they are the most accessible health professional.

Psychiatry is stigmatised in the general community anyway, but amongst older people it is worse. Fifty years ago, if you saw a psychiatrist you were crazy, and if you were crazy you ended up in a lunatic asylum. If you went to a lunatic asylum, you never came out. Old people often have these stereotypes about seeing a psychiatrist. They are really frightened. It is really important, I agree, about GPs.

**Senator WEBBER**—Would a special program for GPs assist, do you think?

**Prof. Brodaty**—If there was incentive for them.

**Senator WEBBER**—Absolutely.

**Dr McKay**—It is also that the GP needs to know they can get help if they then need it. I think one barrier to GPs putting their hand up to say they are interested is that they are concerned that, once they are interested, then they get more people with those sorts of problems. And if there is no support around them, they are not going to put their hand up. It is just inviting more problems which they are not resourced to deal with.

**Prof. Brodaty**—We know that in nursing homes some patients cannot get a GP to come and see them. Nursing beds are hothouses of psychiatric pathology. You could go into a nursing home at 5 o'clock and there are people hallucinating, people who are delusional, people with major depression.

**Senator WEBBER**—There are people assaulting one another at my grandmother's.

**Prof. Brodaty**—Yes. In a survey we did into rates of psychosis in nursing homes in the eastern suburbs, we found that it was 50 per cent. There is a lot of mental illness there which is undertreated.

**Dr McKay**—We would not tolerate the conditions in nursing homes in terms of mental health care and general care if they were in a younger population.

**Senator WEBBER**—What, then, are the added problems or risks for older people in smaller communities, where we do not even have a nursing home that we can put them into to make sure they are at least housed, fed and looked after? What do we do about them?

**Dr McKay**—In some ways, smaller communities may almost have less of a problem than bigger communities, because there is more acceptance that, once someone notices a problem, it is their job to solve that problem rather than it being potentially someone else's problem. I can think anecdotally about people who do fly-in, fly-out services to the country. They enjoy that work and comment about it. It seems to work better in the country than it does in larger centres. It does need to be worked on for smaller centres, very definitely, and models have to be developed. But I think that in some ways, with a little bit of resources, there may be easier models to develop to get things working well in the city.

**Prof. Brodaty**—There are big problems in rural centres, in small towns. There is emigration of younger people and there is often immigration of older people, retiring there. There is disproportionate ageing of many of the smaller communities. Older men will stay on their farms once their wife dies; older women will not stay on their farms once their husband dies. So there are a lot more older men as well. People present later with their psychiatric illnesses. They are more stoic, they are more accepting and they feel that they should be able to manage—there is this culture of independence and stoicism in the country—perhaps more than people in the city. There is a lack of services. There is often no specialist for hundreds of kilometres unless you have someone who flies in. There are the problems of familiarity, of not being able to confide in the person you play golf with or have a social evening with because he is the only doctor in

town. So there are a lot of special problems in rural areas that make them quite different—a lot of advantages too, but I am highlighting the problems.

**CHAIR**—Professor, you say in your submission that there has been little or no attention paid to the prevention of psychiatric disturbance in older people and you talk about reducing the risk of the onset of depression through physical exercise and so forth. Where is that kind of preventative work best done? How do you go about it?

**Prof. Brodaty**—I think it needs to happen at a local level, working with communities. There is only one study I know of that empirically demonstrated that that had some effect, and that was by Robert Llewellyn-Jones here in Sydney in 1999, published in the *British Medical Journal*, looking at a community in north-west Sydney. It showed that attention to a number of details, including promoting exercise programs, working with general practitioners and providing more social outlets, actually decreased the average level of depression in that small community.

We also know that the commonsense things that are advocated, like exercise, socialisation, trying to break down barriers and stop people being isolated and lonely, do good things for depression—for dementia as well: they have some effect in preventing or delaying the onset of dementia. They are also good for general physical health. Certainly, exercise is good for osteoporosis and the heart and so forth. As for how to organise that program: if we run it from a Commonwealth level down, I do not know the literature on this, how this would work. It really has to be done, I think, working with communities to do it at a local level, perhaps facilitated from a higher level.

**CHAIR**—But, if you think about policies with regard to older people, we pretty much got rid of the hostel system, so now most residential aged care is for the very frail and we encourage others to stay at home for as long as possible. Are we simply increasing their isolation and the lack of care and attention they get by doing that? Is it enough for them to have the occasional HACC service, such as Meals on Wheels? Does there need to be a halfway house, if you like, between living at home independently and the higher level of care that is provided in residential aged care?

**Prof. Brodaty**—I have been talking mainly about healthy older people and preventing them getting sick. I am not really into that end of residential care. If you do a survey of older people and ask, ‘What are your needs; what are the things that really matter to you?’ No. 1 is transport. It is really hard for them to get to places, to do things, to be with other people and to engage in other activities. Having transport that is older people friendly is just as important as many aspects of providing health care.

**CHAIR**—Dementia: is this regarded as a mental illness? Are we clear about that or not?

**Prof. Brodaty**—The legal definition, at least in this state, does not define dementia as a mental illness; it defines it as a mental impairment. That was a decision by Justice Powell in about 1981 and led to the guardianship legislation coming in. We who work in the field do not make that distinction. We know that all mental illnesses have a substrate in the brain. We know that dementia is an illness of the brain and that dementia is complicated in nearly all people at some stage by what would be seen by anyone as mental illness—things like delusions,

hallucinations, depression and anxiety et cetera. So it is a bureaucratic dichotomy; it is not a clinical dichotomy.

**CHAIR**—Is it true of dementia that people are more likely to be medicated than to get some other form of psychosocial support for that problem?

**Prof. Brodaty**—Undoubtedly.

**CHAIR**—And what does that mean in terms of people's life expectancy and the progress of dementia?

**Prof. Brodaty**—There is some evidence that people with dementia who are placed on antipsychotic drugs have an increased rate of stroke and an increased rate of death. That is some recent data that has come out in the last couple of years. I do not think there is any such data about antidepressant drugs or sedative drugs having any effect on longevity or having other adverse effects like that. In general, if a doctor is asked to see an older person who is parading some abnormal behaviour, it is a lot easier to reach for a prescription pad than it is to sit down and take a full history, look at the precipitants for the behaviour, do a behavioural analysis, work out a behavioural program, perhaps get in a psychologist or a clinical nurse consultant to work with that family or work with the nursing home staff to devise a program, monitor it and then see if that has some effect. But that would be the treatment of choice for most people in the first instance.

**CHAIR**—It seems not too different from the problem that young people experience when they are forced to use the adult mental health services in Victoria. We heard that the practice of being able to sit down and talk with young people and talk them through a particular episode was more important, and that sedation and visiting an emergency department—possibly even being tied to a trolley—were in fact damaging to whatever their mental condition was.

**Prof. Brodaty**—In 2003, Brodaty, Draper and Low published a model of providing services. We had a triangular model with seven tiers. The top tier was the most intensive, for people who were very violent and needed to be in a high security unit. The bottom tier was prevention of having any mental illness at all. Then there were intermediate tiers, which would be aimed at educating families or educating GPs or other primary health care workers or to providing specialist mental health services in the community, in-patient services and so forth. Our argument was that if you provide more at the lower level—the lower tiers—of intervention, prevention or education of families and GPs, you can prevent the demand for services higher up the pyramid. We would like to test that model, and we have some proposals to do that. Intuitively it seems right.

**CHAIR**—To go back to Senator Webber's question—and this is something I have wondered about for some time—regarding the mental health of a person who does not have dementia but who may be in residential aged care amongst others who do have dementia or another mental illness: is that likely to exacerbate their problem or give rise to the onset of some sort of anxiety or other disorder? Is being around people like that a stress on mental health?

**Prof. Brodaty**—I think most older people who are cognitively intact would prefer not to be in a residential setting with people who are not.

**CHAIR**—And, in your view, is that separation appropriate?

**Prof. Brodaty**—Yes. I think segregation is the way people are going.

**Dr McKay**—The Netherlands have a clear system of segregation, which they are very happy with, where they separate out people with physical ageing problems from those with dementia or mental health related ageing problems. On a brief visit there, I found that they were very happy with that system.

**CHAIR**—Is it happening in Australia or not? Or is this not something we are working towards?

**Prof. Brodaty**—Most nursing homes, if they are large enough, will segregate their units. The move now is to have smaller units; so to have units of, say, 16 beds, to make it more home-like; to have a kitchen and a sitting room and to not make it institutional. So you can have large nursing homes but subdivided into small units. Then you have the capacity to divide people who are severely impaired from people who are not impaired from those with severe behavioural disturbances. So there is some capacity to do that.

**Dr McKay**—There is no systematic encouragement—

**Prof. Brodaty**—Not systematic.

**Dr McKay**—for it though. So best practice I think is seen as that, but unfortunately best practice occurs in pockets rather than being widespread.

**CHAIR**—And depends on the views of the director of nursing or whoever else is running the place?

**Dr McKay**—Yes.

**CHAIR**—Thank you very much for those two submissions and for coming along today. The committee appreciates your efforts.

[3.00 pm]

**JOHNSON, Mr Andrew, Director, Australian Council of Social Service**

**MACFIE, Mr Gregor, Policy Officer, Australian Council of Social Service**

**OWEN, Mr Alan, Health Policy Adviser, Australian Council of Social Service**

**CHAIR**—Welcome. You have lodged a submission with the committee which we have numbered 457. Do you have any alterations or additions you wish to make to that document at this stage?

**Mr Johnson**—No.

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

**Mr Johnson**—We want to thank the committee for the invitation to appear before it today and for making it possible for ACOSS to attend the meeting in Sydney. I want to first introduce my colleague Alan Owen. As stated, he is the Health Policy Adviser but he has extensive experience in mental health. He currently sits on the New South Wales Mental Health Review Tribunal and the New South Wales Guardianship Tribunal. He has been a mental health worker and is an expert in mental health systems. ACOSS is the peak council of community services in the welfare sector and the national voice for the needs of people affected by poverty and inequality. The outline of our submission deals with three key areas. These are: the link between mental illness, poverty and disadvantage; equity and access in the health system; and priorities and planning for better mental health care.

In relation to poverty and mental health, you would have heard in many other submissions of the statistics of people affected by mental illness. Within those statistics we wanted the committee to be aware that mental health disorders are much more prevalent amongst income support recipients than nonrecipients. Almost one in three income support recipients, more than 30 per cent, have a diagnosable mental disorder in any 12-month period. This translates to approximately 700,000 people on work force age payments. According to the government's own data, 45 per cent of sole parents on payments experience a diagnosable mental disorder.

In relation to equity and access, we must ensure that people with a mental illness not be placed at risk of poverty and disadvantage. Responsibility for mental health needs to be spread not only across the broader health system but across many other services and programs. This requires a range of policies across government which address income support, employment assistance, housing and active antidiscrimination measures, as well as access to health, rehabilitation and community supports services. ACOSS is concerned about the proposed changes to eligibility to the disability support pension and to payments to sole parents. Post July 2006 at least 60,000 people who apply for the DSP will be \$40 a week worse off while sole parents with school-age children will be \$20 a week worse off.



While we support the government's increased investment in services such as open employment, they are clearly not enough to ensure that people with mental illness will receive the supports and services they need to assist them to get job ready. Many of the people who are affected by these changes will be people with mental illness. In fact, 25 per cent of those currently on DSP have, as their primary disability, mental illness. Many more recipients suffer mental illness in addition to their primary disability, let alone the figures that we referred to earlier in relation to sole parents. Many people with mental illness find compliance systems difficult and extremely stressful. Therefore, it is vital that the government ensures that the welfare to work legislation enshrines protection within the legislation itself for people with mental illness. To assist people to enter the work force there needs to be greater recognition of the discrimination faced by those with mental illness. Further, employers need to gain greater access to information, services and programs that assist them to support people with a mental illness.

Turning to health system reform, the achievement of the aims and objectives of the National Mental Health Strategy is contingent upon a general health care system which is supportive of these objectives. Basic health services—for example, counselling services—are highly restricted within the public system but available to those with sufficient private means and/or private health insurance. Many people in rural and remote areas and Indigenous communities miss out on services like psychiatry and the mental health services provided by GPs because of the maldistribution of the health work force.

The specialist mental health sector is at the receiving end of the failures in other sectors. There is real danger that a simplistic call for more beds, in the context of little or no extra funding and an inadequate model of care, will mean that resources are sucked out of the places we want them to grow in: community rehabilitation, primary mental health care and non-government agencies. In a recent ACOSS study, the community and welfare sector clearly indicated that clients' needs are becoming more complex, largely due to mental illness. This indicates the need for greater support for the sector, which is facing greater demand on its services. A lack of mental health services and support was frequently reported by the respondents as a major issue facing their services.

Governments must take a lead in the development of strategies to address the significant issues faced by the sector, which include shortages of staff, lack of resources to train and attract staff, and the low status of jobs. Government policy must remain focused on supporting the delivery of mental health services for a community in primary health care settings. There is an ongoing need for initiatives and incentives to achieve better integration between the public mental health sector, private psychiatrists, GPs, NGOs and others—for example, community health. The next step would be the gathering and disseminating of systematic evidence on what already works in practice and how it can be rolled out to settings where integration is poor.

**CHAIR**—Do either of you gentlemen wish to make any remarks?

**Mr Macfie**—No.

**Mr Owen**—No, we were going to jump off from there.

**CHAIR**—Can I start by talking about the link between mental illness and poverty. Is it to some extent a chicken-and-egg situation? If you are poor, are you more likely to develop a mental illness? Or, if you have a mental illness or a predisposition to one, are you more likely to be poor? Or is it both?

**Mr Johnson**—I think the short answer is that it is both. I may leave it up to Alan to go into more detail, but I think we too often forget about the strains and stresses of doing it tough—about the lack of opportunity and the stresses of not being able to make ends meet. That is one of the biggest factors in seeing that there is a greater incidence of mental illness.

**Mr Owen**—I guess that is to echo what Henry Brodaty said earlier: often the opportunities for things like good transport or opportunities for physical activity and the things that help people to promote their health are obviously less accessible to people on low incomes. Physical activity is an interesting one, where there is a real effect for how close you live to the coast for how much physical activity you are likely to engage in. That is interesting, because clearly people with more income are the ones who do live in the places where the opportunities are greatest. So it is a chicken-and-egg thing.

**Mr Macfie**—I will just jump in there as well. I think obviously the manifestations of certain mental illnesses like depression or anxiety can be a long time coming, in a sense, so it can be difficult to measure what effects, for example, reductions in income might have on mental illnesses of that kind. But there are studies that show that reductions in income add to family stressors—the amount of time that parents can spend with children, where they are actively looking for work and cannot spend time with children, and the relationship between that and the developmental problems that children can develop, which in itself is a precursor to things like problematic drug and alcohol abuse.

**CHAIR**—Indeed. We heard this morning from the eating disorder group about the description of the kind of often chaotic family environment that gives rise to an eating disorder in young people—quite young people, in fact. Is that something that you can also attest to? Does poverty come with a bit of chaos, as it were, in the home environment? I think we certainly realise that that is what is happening with people who are periodically homeless and who do not have secure jobs or accommodation. But do you sense that that is what is going on in families as well—that eating patterns, for instance, are not well established and that perhaps other routines are not there, which might give rise to mental health problems in young people?

**Mr Johnson**—Firstly, just look at the instance of a sole parent who may be escaping domestic violence, who is having to try and get accommodation, is dealing with an AVO, is actually having to shift around plus deal with her own needs and the needs of the children. During that time it is high stress, so there is often routine that is lost, as you have pointed to in issues of housing. Also, there are many stories that have been given to ACOSS about how difficult it is to keep a routine going with people with episodic mental illness and the supports and services that they are able to get. Unless they have very close, supportive family around them, there are many opportunities that they miss out on in terms of the care, support and services that they need.

**CHAIR**—What does that lead you to suggest ought to be government policy in terms of reducing poverty? Where should government be starting, policy-wise?

**Mr Johnson**—I think first and foremost it is about taking an overall strategic approach. Other countries—for example, Ireland—have looked at national poverty strategies, where they have looked at having targets to reduce overall poverty. In fact, in Ireland, as you would know, they had a benchmark of five per cent and it was so successful that now they have reached five per cent and they are looking at two. Whether you are looking at poverty as a whole or—and my colleagues can talk more specifically about this—mental illness, there needs to be a comprehensive approach across all departments and all sectors to ensure that we do have the targeted supports and services that are needed, not just in particular areas but integrated across the sector. I am sure that Alan and Gregor could talk more specifically about those kinds of approaches that we also need to take to mental illness.

**Mr Macfie**—I support a situation where there is a certain amount of income support, where people's requirements in looking for work and what have you are tailored to the individual, where they have enough to at least live on and where there are some basic services available. They are the foundation stones, I suppose. Work is one of the protective factors, if you like, in avoiding poverty. For those who cannot work, or who need assistance to find and maintain employment, then that obviously needs to be one core aspect of the response.

**Mr Johnson**—Certainly that was found in Ireland, that having payments at a level above poverty level was one of the core principles in ensuring that it could reach its target. But, as well, it was having this integrated approach to tackling the system as a whole.

**Mr Owen**—I sometimes sit on tribunals. We look at making compulsory treatment orders for people who are at the end of their tether. What you really look for, and you very seldom get, is an integrated plan where the case manager is trying to get them into a TAFE course, where they have done the advocacy that will get them into affordable public housing that will then allow them to have the means of getting around to opportunities to exercise or entertain themselves. We are often just limited to rubber-stamping a plan that just says: 'You will turn up to get your treatment, and the service will provide some basic education for you and your family. End of story.' I think there is a lot more room in there, especially for state authorities, to be mandating plans that have broader aims than simply complying with your treatment, because often that just compounds people's resistance to treatment.

**Senator WEBBER**—When the committee took evidence in Melbourne, at one point we were talking to a group of young people who had been through severe episodes of mental illness and therefore were receiving government benefit, but some of them were four years into the recovery process and were now able to re-enter the work force. One of the issues they raised that was a real concern to them was that they did not necessarily feel confident about being able to work full time. They wanted to be able to give that a try, but they did not want to risk having to become as unwell again as they had to be to go back onto benefit and therefore have to then go through another 4½ years of treatment to get back to where they were. So they were not prepared to take the risk of re-entering the work force. Can you comment on whether that is just that group of people that we met, or whether that is a more general concern?

**Mr Johnson**—It is a more general concern about how the welfare payment system is managed. A lot of people, particularly those with mental illness or a disability, are saying that it is particularly difficult to re-enter the work force if the supports and services are there, if the places are actually there for people to get assistance. One of the things is the barriers that people

face. You were talking about the innate nature of their illness, but there are also the barriers they may face within the work force which exacerbate someone's experience. Someone could get to the point of being job ready, enter the work force and have a particularly bad experience. This then sets them back all over again.

This is within the context of the new proposals, whereby you have somebody who would have been on a pension and who is now on Newstart, which is a lower payment with greater requirements. What we had mentioned or read into the record is that with lots of people with mental illness, the fact of obligations and the pressure of that system retard their progression. This is why we are calling for greater flexibility, for recognition of the difficult circumstances that people with mental illness actually face and, most importantly, the barriers within the workplace.

**Senator WEBBER**—One of the other witnesses we heard from was the author of an overseas study that was looking at the transition of people with mental illness into the workplace. They looked at rejigging the kinds of support they offered, getting away from the whole sheltered workshop model and trying to support these people and placing them in mainstream employment. They found that as long as you provided ongoing support, these people with, in some cases quite severe, mental illness were just as likely to stay in the work force as lots of other people. At the end of a five- or 10-year cycle, 50 per cent of them were still in employment, but the key to that was ongoing support and always having someone there to nurture them through the process and to be on call. It seemed to me that, in the long run, it would cost government less than providing the benefit structure and constantly allowing people back onto full-time benefit. At least these people are earning money and paying tax.

**Mr Johnson**—The Australian government has the opportunity now, in relatively good economic times, to invest to ensure that people are able to participate. There is an economic dividend for all of us and for the individual and, most importantly—particularly for people with mental illnesses—there is also an element of participation and involvement with the community through work where it is possible. It really points to the need to have greater investment with employers, so the employers have the tools and the knowledge of how one can have a person with a mental illness within the workplace. As you rightly pointed out, it is about ongoing support, but it may also be about having mentoring within the workplace. There are other models around within workplaces to make it beneficial both for employers and, more importantly, for the individuals in the workplace.

**Mr Owen**—There is an interesting example from one of the other areas where I work, which is the University of Wollongong. We have been feeding off part of the national mental health plan, so I should disclose my interest in being a beneficiary of the plan. We evaluated a set of mental health integration projects and three eventually got up. Planning in mental health is notoriously hard, as Henry Brodaty and the others before us were saying. After a period of about two years of planning, we eventually had three projects, one of which was in the Illawarra district. They came up with some very interesting and innovative models. They were able to be innovative because there was pooled funding, they were cashed up to the national average and they could actually plan on the basis of a level playing field.

They came up with an interesting little project within their overall mental health integration project, where they were looking at rehabilitation assistants, within a mental health service, who

were former consumers and, in most cases, current consumers of the mental health service. They were actually employed to be rehabilitation assistants to other people within the service. That was possible mainly because there was a larger structure that it was planned within. It was not just up to the area health service to think it was a good idea; it was all part of a tripartite agreement between the Commonwealth, the state and the local area, and it gave a frame of reference around a whole bunch of things in the name of mental health. It was much broader than any of the single programs might have been able to achieve in and of themselves. It made that direct nexus to employment. Maybe they might not want to be employed in the mental health arena; it might be better for them to be employed elsewhere. But, within the limitations of what they could achieve within the mental health service, it was an interesting experiment and it worked. We were able to show, through the evaluation, that it did no harm and it was cost neutral, I suppose you would say in summary.

**Senator WEBBER**—The ongoing support that this study looked at—and it was obviously part of job placement—mirrored what was found by one of the other Senate committees in a recently completed inquiry into cancer treatment. They have come up with recommendations around whole-of-patient treatment, so you look at all of the issues. Obviously for someone with mental illness it would be housing, employment and a range of things, rather than just treating their events of psychosis or what have you, which obviously would help them in terms of long-term recovery. I was wondering, as much for my information as for anything else, if there is any known linkage between generational unemployment—from one generation to the next—and mental illness, given the social isolation and the lack of role modelling that tends to happen with generational dependence on government benefits.

**Mr Macfie**—Certainly, in preparing this submission, that was not something that we came across. I am not sure if there is even research on such a thing, but I think it is pretty well established that there is a generational effect with unemployment, obviously, and that people growing up in jobless families tend to be jobless themselves in the future. I suppose it links back to what we were saying about the stresses and strains of not having work in a culture where work is one of the major ways in which we engage with the community, and also in terms of access to independent income, as well as the stresses and strains that come from living in poverty. That is all I can add to that.

**Mr Owen**—Some work we did in another domain was for the Victorian government, on health strategies for health gains for kids. It was interesting that one of the subsections of that was the strategies you could adopt where the children of people with mental illness were at risk of self harm or harm from the mentally ill parent. It was interesting that the Victorians were keen to pick up on those sorts of strategies. Some of them got built into their most recent budget. There is evidence that further upstream work on trying to improve parenting within a population of people with mental illness will have a positive impact on the next generation. I guess it is fairly obvious, but there is some evidence behind what is obvious.

**Senator TROETH**—I want to ask you about your claim that the MedicarePlus safety net is contributing to price inflation of doctors' fees and distributing benefits inequitably, and your similar comments on the safety net payments. Is that because you would consider that higher income groups visit doctors at a greater rate? What would your reasons be for saying that? I wonder whether you have completed or reviewed any research to arrive at that conclusion.

**Mr Macfie**—It was certainly researched by the Australia Institute. It was looking at some of the health insurance data to see where the money was flowing. But primarily it was to do with the distribution of the health work force. This is one of the larger problems with fee-for-service medicine, as it happens, in terms of the Commonwealth contributions. People can only use doctors if the doctors are there to use. We know that the distribution of the health work force tends to be concentrated in particular areas—in the major cities and other places where incomes tend to be higher. We also know that in other areas, like some rural and remote and regional areas, access to doctors and therefore to the money is limited. We did not quote the Australia Institute figures in relation to the health insurance data, but I guess it is a conclusion that we have drawn from the distribution of health work force.

**Senator TROETH**—What about the private health insurance subsidy, on which I think you have made similar claims?

**Mr Macfie**—In a sense it is the same issue at one level in that, obviously, to benefit from the holding of private health insurance, you need access to specialists or private hospitals where there are specialists. We know that private hospitals are again concentrated in areas of major population. In rural or remote areas those services simply are not there. We have certainly done work looking at surveys on who does and does not hold private health insurance. It is skewed towards higher income groups. Lower income people do not have the benefit, if there is a benefit, of private health insurance in terms of accessing private hospital care or ancillary cover for things like counselling services and what have you.

**Senator TROETH**—I could probably get some figures which would dispute some of that in that some of the highest levels for those taking out private health insurance tend to be in middle to lower income electorates.

**Mr Macfie**—It is interesting and quite important, I think, to look at the age distribution in relation to private health insurance. It is certainly true that some of what you might call lower income groups hold private health insurance, but it is usually concentrated in older age groups. They have had private health insurance for a very long time prior to the introduction of Medicare and have maintained it. Obviously there are increasing government subsidies to maintain that private health insurance. In the lower age groups, whilst we have not done work in relation to electorates, certainly in terms of across the community you will find that the more income you have, the more likely you are to have private health insurance.

**Senator TROETH**—So do you believe the MedicarePlus safety net is achieving its objectives or should it be abolished?

**Mr Macfie**—I think we have argued elsewhere that, because there are flaws, I guess, in fee-for-service medicine in that people do have the reality of copayments within the system, it is important that there is a safety net for those who have very high out-of-pocket costs in relation to their health care. What we argued for was really a renovation of the old system, combining the Pharmaceutical and the Medical Benefits Scheme safety net. We argued for doing some research on what the impacts of copayments are on lower income and I guess middle income groups so as to try and set a benchmark for the cut-offs for that safety net. If we still have fee-for-service medicine with patient copayment gaps, it must also be linked to the Medicare benefits schedule

and the PBS benefits schedule so that it is not an open-ended system which covers 80 per cent of all out-of-pocket costs no matter what they are.

It was an argument for government, in a sense, setting a standard and saying, 'We don't support the charging beyond this amount for this service.' Where that standard is set is an issue for the government, on behalf of the community, to argue with the medical profession and the pharmaceutical companies regarding what is a fair price for the service or the good that is being provided. What we were concerned about was the open-ended nature of the 80 per cent rebate. That is not to say that people may well have benefited from the safety net—and indeed many must have—because the cost of it has increased, as was predicted. But the people probably benefiting are those using specialist services and those types of things, not GP services and those sorts of things.

**Senator FORSHAW**—When reading your submission, I was reminded of a lot of the evidence that we heard when I was on the Senate Community Affairs References Committee inquiry into poverty where we were constantly told by various organisations, including St Vincent de Paul, the Salvos et cetera, of the increasing number of clients they were seeing who had a mental illness in addition to other difficulties such as housing et cetera. We were also told that they had been required to provide an increasing range of services of a more complex nature or to assist in legal and financial matters and so on, so they were becoming the first reference point, if you like, rather than the more traditional government areas. That is a comment, but I have a question which, to some extent, flows on from that and from your submission where you state, on page 2:

Calls for major increases in the mental health budget must be weighed carefully against other options, which may help lower the incidence and severity of mental illness and its impact at the individual and community level.

I am assuming that you are not saying there should not be any increase in the mental health budget, but I would like you to expand on that. I do not think we have had anybody say to us that there should not be any more money going in. In fact, everyone—the Mental Health Council and others—is saying there needs to be a tenfold increase, that massive amounts of money need to be put in, both in the community based services area and in the provision of more acute care facilities to overcome this problem that has occurred with deinstitutionalisation and the lack of community based services. Could you expand on your comment? You are saying there are other options. What are you pointing to there?

**Mr Macfie**—We are not saying there should not be more money.

**Senator FORSHAW**—I did not think you were.

**Mr Macfie**—We have not devised a certain amount of money that does or does not need to be spent on mental health services per se. What are we talking about when we are talking about mental health services? What are we talking about when we are talking about a mental health system? It is very difficult to compare things internationally as well. The point we make is: let us look at how well we are travelling in relation to some of the preventative and early intervention stuff. Let us get some studies and see whether people on certain levels of income, for example, may not fall as far as those people who have lower levels of income in relation to mental health outcomes as a priority. It is really about thinking through where you might want to put

investment to get the best outcomes, so that we are not, in a sense, putting good money after bad. If, for example—as I guess we are implicitly arguing—you reduce the incomes of certain people through the proposed changes to the disability support pension, that adds to stresses and to the difficulties in accessing services and all the rest of it. Is it better to put the investment in there in terms of mental health outcomes, as opposed to putting it into services for those who get to the acute end?

Another thing—and Alan can talk a bit more about this—is that, even though there is a lot of talk about the community based approach to mental health support and intervention, we have a resource allocation system that still funds the acute end of the system, and that is when people actually get the affordable supports—it is when people get what they need. What we are arguing is that there needs to be a much more thoroughgoing understanding of whose role it is, who is responsible for what, and where, and what they need to support it, linked in with population planning around what mental health needs are and who is best able to support them in a cost-effective way.

**Mr Owen**—One of the interesting angles on all of this came from an article by a mental health adviser, Harvey Whiteford, and Bill Buckingham in the *Medical Journal of Australia* earlier this year. They looked at the changes in the funding of mental health services and concluded that they had kept pace with general health spending. My sense of what they were saying was that mental health was not really the poor relation; mental health was just poorly planned and poorly integrated and that therefore the bang for the available dollars was not coming through. I guess that is a slightly different argument that we put from the one saying—

**Senator FORSHAW**—When was that?

**Mr Owen**—It was in the MJA. I can table it.

**Senator FORSHAW**—Is it referred to in your—

**Mr Owen**—No, it is not. It is an issue of the *Medical Journal of Australia* of, I think, February 2005. I can table that, if you like. There is an interesting editorial by Gavin Andrews in there as well.

**CHAIR**—Does it look at overall spending on mental health and compare it as a proportion of the disease burden, as it is described?

**Mr Owen**—Yes. Harvey Whiteford and Bill Buckingham make the point that the proportion of the disease burden is probably the only statistic where you will see mental health falling behind the general spending. In the article, they say there are no reliable international benchmarks by which to judge Australia's relative investment in mental health, but if you put substance abuse and dementia in with mental health you are actually up to 9.6 per cent of health spending.

**CHAIR**—That it ought to be 9.6 per cent of health spending?

**Mr Owen**—Their argument essentially is that that is about right, although it is hard to see that by way of international comparison.



**CHAIR**—But you do not think that is the only kind of measure one should consider?

**Mr Owen**—You have to look at how people are experiencing the services they are getting on the ground and, clearly, that is where the message comes through. The way that the services are organised, the models of care and the resource distribution within a state, or even within an area, is where the problems emerge. I put that all back to the difficulties of how to plan a mental health service within a context that has to be much bigger than mental health. Often within the mental health sector you have a much more separatist mentality. You can get a memorandum of understanding but, in practice on the ground, there has to be the model of care that will actually support a broader view. Often, the model of care only supports the crisis end—understandably, because that is the pointy end—but we will never be able to stem the flow further upstream unless we are actually looking at mental health in that broader health context and the health and welfare context. I tend to be a bit disloyal sometimes to my background and to mental health colleagues but, to me, the problem is more about how to plan, how to manage and how to develop better models of care, rather than just about needing more money. Historically, we have just seen that more money equals more acute care beds, where we are waiting to collect people at the end of a process rather than looking at how to stop that process further upstream.

**CHAIR**—Indeed. Thank you for your submission and for appearing today.

**Proceedings suspended from 3.39 pm to 3.53 pm**

**COLLINS, Mr Brett Anthony, Spokesperson, Justice Action**

**STRUTT, Mr Michael, Researcher and Spokesperson on Forensic and Criminological Issues, Justice Action**

**CHAIR**—The committee has received your submission which it has numbered 174. Do you wish to make any alterations or additions to that document at this stage?

**Mr Strutt**—I would like to make a minor addition where the submission refers to the support in principle that Justice Action offers to grassroots mental health advocacy and activism groups. We mention Support Coalition International in the US, Mad Pride in Canada and an organisation in the UK whose name escapes me right now. I would like to add insane australia to that list as a grassroots organisation that we support.

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

**Mr Strutt**—First of all, Justice Action is a prisoners' activism organisation. We speak when we can on behalf of prisoners and we are made up largely of ex-prisoners. We are a penal abolitionist organisation. We believe that the institution of prison should be abolished, so in general we are against the institutionalisation of people. As a result, you might expect us to support the movement of the mentally ill out of the prison system.

We have had considerable experience with prisoners and ex-prisoners who have been diagnosed as suffering from a mental illness. A fair amount of our case workload comes from complaints from prisoners about their mental health care and their treatment in prison if they are designated as mentally ill. A high proportion of released former prisoners who seek assistance from us or who join us and assist us have been diagnosed as being mentally ill. One of our most outstanding caseworkers is a man who was assessed by several psychiatrists as being too mentally ill and too dangerous to ever be released. Laws in New South Wales were passed specifically against that man to keep him in prison indefinitely. They were struck down by the High Court and he was released. Since then he has been an upstanding citizen and an energetic advocate for the rights of the disenfranchised. He has been a skilled, patient and compassionate caseworker and mentor and he has never shown any inclination to repeat the sort of violence that landed him in prison, in spite of the claims by several supposed experts that he would. His only trouble with the law since he got out has been in connection with his political protest actions. So that is partly where we are coming from with regard to our support for people designated as mentally ill.

We agree that trans-institutionalisation has resulted in a large number of people with mental illnesses being warehoused in Australia's prison system, where they are more vulnerable to abuse, they cannot exercise choice over their therapies or their therapists and they are subjected to conditions that are likely to cause or aggravate their mental disorders. For instance, I believe you heard statements from Maqsood Alshams this morning with regard to the indefinite detention of people in immigration detention centres and the effect that has on mental illness.

Forensic prisoners in the prison system are of course also subject to what really amounts to indefinite detention in a lot of cases. There are three hurdles that they have to cross in order to get released at the end of their sentence. They have to satisfy psychiatrists that they are fit to be released; they have to satisfy the bureaucratic hurdle, which is the Mental Health Review Tribunal having to sign off on their release—I am sure there are people here who could fill you in as to their criteria more adequately than I could; and finally, the health minister has to sign off on their form before they can be released. That, in essence, constitutes an indefinite detention that basically puts those prisoners in a very similar situation to the one that Maqsood described for immigration detention detainees this morning.

Those who have mental illnesses but who are not necessarily subject to that sort of indefinite detention are inclined to serve out their full prison terms because of behavioural problems and difficulties they have negotiating the classification and parole system. As a result, when they are released they are pretty much dropped onto the street with very little support whereas, for instance, somebody who is released on parole can expect to have more support from parole officers and things like that to help them to reintegrate into society. Those released at the end of a complete sentence are at a disadvantage in that regard, and that disproportionately includes those who are designated as mentally ill.

I would also point out that the standard methods that prison systems use to deal with those who are allegedly mentally ill include segregation units, safe or Muirhead cells—you might have heard that term for cells for people who are designated at risk of suicide—and forced administration of psychotropic medication. I do not believe these are really therapeutic or primarily aimed at the benefit of the prisoners. In fact, primarily they are aimed at making prisons themselves easier to manage. An illustration of that recently came up in the New South Wales parliament when the Minister for Justice answered a question from a member of the Legislative Council, Lee Rhiannon from the Greens. The minister described how one particular prisoner is essentially designated as mentally ill for the purposes of administering psychotropic medication to him, but when they want to throw him into a segregation unit for being disruptive he is designated as being mentally healthy. Basically, they find the appropriate person to make the appropriate diagnosis according to their management requirements, not to the health and wellbeing of the prisoner. That is fairly typical, I think, of how prisons administratively manage those designated mentally ill.

You probably would have or will hear members of Justice Health suggest that moving Long Bay hospital facilities just outside the wall will somehow improve the situation for forensic prisoners. I think that is a pretty ludicrous suggestion and, again, it is primarily aimed at improving the work conditions of Justice Health employees and making it easier for prison administration to do their job. It is my understanding that the Commissioner of Corrective Services, Ron Woodham, is very keen on getting the mentally ill out of prisons, largely because of the administrative overhead that they place on Corrective Services.

Our casework has brought us into contact with quite a number of prisoners—and not just prisoners; people who are subject to an involuntary detention by our health services rather than the prison system. One example is that, following the Kariong juvenile detention centre riots in 1999, a young—

**CHAIR**—Sorry; is that Kariong?

**Mr Strutt**—Yes, it is just a little bit north of here on the Central Coast. Following the riots in 1999, there was a 16-year-old Aboriginal detainee whom the youth workers at Kariong had decided was the major management problem at Kariong. They refused to return to work while he was on the premises. As a result, he was transferred to Parklea adults' prison, where he was kept in a segregation cell, stripped to his underwear and kept isolated in the cell for several weeks, and he was heavily dosed with antipsychotic medication. That is where he spent his 17th birthday. To his knowledge at least, he has never been diagnosed with any mental illness at all. It seems that that whole procedure was done entirely for management purposes, not for therapeutic purposes.

New South Wales prisoners are still used as captive populations of guinea pigs by mental health researchers. For instance, Eli Lilly has got the cooperation of Corrections Health to test the washout rates for olanzapine, Zyprexa, from prisoners at Long Bay Hospital. In return, they have provided exercise equipment for Long Bay Hospital. That is what we know of. I believe that there may have been other incentives as well, but they are allegations rather than stuff that I have had confirmed.

Mulawa inmates a few years ago were subjected to trials of what is largely regarded as a quack therapy: eye movement desensitisation and reprogramming for post-traumatic stress. Even according to the proponents of EMDR, the people who are subject to that are likely to go through very stressful situations. Supposedly it recovers suppressed memories, which is why a lot of people consider it a quack remedy. But, in any case, it has been associated with traumatic responses. But, after the people conducting the trial left the prison at the end of a working day, those women were not offered any support. When they started to exhibit signs of trauma, the Corrective Services officers on duty did what they always do to make sure that people do not commit suicide on their watch and basically threw them into the strip cells. Whatever the intent of the people authorising that might be, the prisoners themselves generally perceive that as punishment, and they will often hide the symptoms of their distress to avoid being put into a strip cell, a Muirhead cell.

So, given the appalling treatment of the mentally ill in our prison system and our implacable stance against the institution of the prison industrial context, you might expect that we would be in favour, for instance, of the thrust of several articles in the *Australian* over the past few weeks—that is, that the Richmond report should be reversed, trans-institutionalisation should run the other way and the mentally ill should be transferred back out of the prisons and back into whatever the modern, politically correct term for asylums is. That is not what we support at all.

In fact, we receive complaints about the way people are treated in the health system as well. For example, we have received reliable reports of abuse of patients from staff at the Bridge facility for people with AIDS-related dementia. I myself have witnessed the abuse of demented patients, both in the Royal Adelaide Hospital and in St Vincent's Hospital in Sydney. As you probably know, antipsychotic medication is not indicated for people with AIDS-related dementia, but it is used to control people in institutional settings. At least one person I know of was very heavily dosed with antipsychotic medication and strapped to his bed, basically. He did not want to be there, he did not need to be there, but they decided to keep him there—and, to make him easier to manage, they used the physical and chemical restraints available to them.

So we do not support a reversal of deinstitutionalisation; we support the proper implementation of the original recommendations of the Richmond report, which were succeeding in Sweden and Denmark at the time that Richmond was preparing his report because they were properly funded and properly implemented. They have never been given a chance in this country and I think it is about time that they were.

It is worth keeping in mind that at about the same time that Justice Nagle was carrying out a royal commission into the treatment of prisoners in the New South Wales prison system, Justice Slattery was carrying out an inquiry into the treatment of patients in the Chelmsford psychiatric hospital. It would be six of one and half-a-dozen of the other to decide where the worst abuses were happening at the time.

So we do not support hospitals in preference to prisons for those designated as mentally ill. We do not at all support compulsory involuntary detention or treatment for those designated as mentally ill. It is also worth pointing out that Dr Harry Bailey at the Chelmsford hospital who was most famous, or infamous, for his deep-sleep therapy, also carried out involuntary leucotomies and electroconvulsive therapy upon people, including remandees, who were referred to him by the courts—it was not just patients who went there for treatment for mental illness.

As I was saying, Chelmsford is not a thing of the past. As well as our own experiences, you will find reports from the South Australian Ombudsman about the abuses of the mentally ill within public hospitals in South Australia and reports from the Victorian Health Services Commissioner of abuse by staff of the mentally ill in public hospitals in Victoria. We certainly receive reports of the abuses of the mentally ill in hospitals in New South Wales.

Rather than reversing deinstitutionalisation or reversing the flow of transinstitutionalisation, Justice Action calls for the proper funding and implementation of the Richmond-style recommendations. There should be a variety of measures to assist those with mental illness to live in the community, based on their needs, from home care to various levels of supported accommodation to more mental health response facilities.

I have had experience of trying to get community mental health teams to attend mental health crises and have found it an utter waste of time. I think you would find that the reason the police are so often called into situations like that is because they are the only people who respond to situations like that. They are certainly not equipped to deal with it, despite the fact that you will find a lot of carers' groups praising them for their ability to do so in some cases. Of course, there are other people who they have shot so they are not necessarily the best, most appropriate people to call on in those situations. Respite care facilities for carers as well are particularly important.

There should be funding for a wider range of therapeutic options—rather than recourse to pharmaceutical therapies—ensuring that people get access to treatment that is personally and culturally appropriate. That includes people in regional areas and people from non-English-speaking backgrounds, particularly Aboriginal people, who are more likely to be diagnosed with a mental illness and are less likely to make appropriate use of facilities that are available for people with mental illness.

I would also really like to see more recognition of what a psychoanalyst by the name of Craig Sanroque has stated after he has spent time working with regional communities in the Central

Desert area—that is, the recognition that in a lot of cases the experts cannot do anything constructive, but they are still under a lot of pressure, not least from their own professional training and from carers and the community in general, to do something, no matter what. In a lot of cases they cannot do anything useful. It really needs to be recognised that sometimes it is better to do nothing than to do something that is harmful. A lot of particularly coercive mental health care is harmful and not helpful in the majority of cases.

One of the recommendations I would really like to see out of this inquiry is funded measures to stop and reverse the rise in vilification and discrimination against the mentally ill which, it seems to me, is currently under way in Australia. It should include education programs and, where necessary, antidiscrimination legislation and oversight of antidiscrimination practices regarding the mentally ill. There have been campaigns in the Murdoch press and on current affairs television lately which have tried to misleadingly overstate the dangerousness of the mentally ill to try and create a moral panic whereby we can implement a New York style Kendra's Law which would be extremely invasive to the privacy of the mentally ill and would result in more people being subject to compulsory treatment and detention.

That is certainly not what we need. I do not think that there is any evidence that mentally ill people are more dangerous than people who are not mentally ill that bears up to any sort of statistical examination at all, and I really think it is about time we stop pretending that there is. There are well-funded organisations in America, like the Treatment Advocacy Centre, who are promoting and highlighting all cases in the media where mental illness can be linked to violence. The media there clearly have an agenda and it seems to me that their actions are now being picked up in Australia. That disturbs me a lot. I would really like to see pre-emptive action taken to stop that sort of vilification and stigma being put on the mentally ill.

At this point I would also like to remind honourable senators that at least two of your colleagues have in recent years committed serious offences while affected by mental illness. One senator was founded in a car parked in bushland with his children, with a pipe from the exhaust leading back into the cabin. He was later found with his wrists open in a bath full of his own blood. Another assaulted a female senator while under the effects of alcohol, which he seemed to have been abusing apparently as a result of a depressive illness. Both senators seemed to have depressive illnesses. Neither of those senators was scheduled, imprisoned or made an involuntary psychiatric patient, to the best of my knowledge. Neither of them was coerced into undergoing any sort of therapy that they found to be unhelpful or abusive. I did not hear any politician suggesting that they should be locked up to keep our streets safe. I did not hear the media vilifying them or claiming that they were threats to public safety. They were given support to overcome their afflictions. They were provided with sufficient flexibility by their parties and by the parliament to return to their duties when they were able and to deal with their medical problems and resume their places as constructive contributors to the federal parliament. If such an approach is appropriate for Australian senators, I cannot see why it should be considered too good for those of us who elect you.

**CHAIR**—I am not sure that I would agree with you about vilification by the media. However, you are right on the other points. Thank you for that. We have heard evidence from people that, bad though you describe the prison system as being, it is better than being out there in the community where there are no services at all. The attitude is that at least if you go into prison you will be fed, you will have some shelter and someone will worry about your mental state.

Have you heard of instances where public displays of violence or somehow disrupting the peace have landed people in jail and that has been the intended outcome?

**Mr Strutt**—I would suggest that that is very much overstated in the public discourse, but there are cases where it is true. Inasmuch as it is true, I think it shows the inappropriate way that resources are directed. It is not cheap to keep people permanently locked up in a prison or a hospital. If those resources were directed to community facilities along the lines of those that I have already outlined, the results would be far better both in outcomes for the mentally ill and for the human rights of the mentally ill. People who work in hospitals and prisons, regardless of some of the stereotypes that even we at Justice Action might be prone to use, are human beings, they do have compassion and, yes, they do care when they see somebody who is suffering from mental illness. But they are under a lot of pressures, due to the structure of their workplace. If you see a friend who is depressed, you will probably want to spend some time with them, talk to them and support them however you can. If you are a prison officer and you see a prisoner who seems to be seriously depressed, you might want to do that but your No. 1 priority is to make sure that that person does not kill themselves while you are on duty. So basically you put them in a strip cell. For all the talk about the care and attention they are getting in prisons and hospitals, the way those institutions are structured means that they are not getting the appropriate care and attention.

**CHAIR**—Perhaps it is an indictment of the services that are not available rather than those that are.

**Mr Collins**—I have a good example in relation to that comment. A man came into our office just last week, and he had done 27 years in jail. He was never convicted of a crime; he spent most of his time in a mental institution. He came in—

**CHAIR**—Was he unfit to plead?

**Mr Collins**—That is right. He is homeless at the moment. He moves up and down on the trains, and he came in absolutely depressed. He was dirty, he had had no food—he had nothing at all—and he came in to see us. We put him in the shower, and I gave him a big hug. We gave him a base, which cost him nothing and it cost the community nothing at all. It meant that he had a place to come to, and he knew that he was safe in the community. We gave him a shower, made him feel good and made sure that he knew that he had a place to come back to. When you think about what this man's 27 years in jail is worth, if you add that up at \$70,000 a year, it is a lot of money—it is millions. Yet there is no money for the man at all for accommodation. We do not have any free accommodation to give that man. I always say to them: 'I'm really sorry that we don't have a place to give you. We have no place for you.' In fact, he should be living with us; that is the truth of it. We should have accommodation for him, but all we can offer him is a place to drop in where he can get sympathy and he is not going to be entirely alone. And that happened last week.

**Mr Strutt**—I would like to say at this point that I am proud of the way that Justice Action does deal with former prisoners with mental illness. We offer—and we have virtually no resources at all—what you might call a psychosocial approach, and above all we offer acceptance and we listen. We do not try to objectify the people; we do not see them through the prism of their mental illness; we do not delegitimise everything they say on the basis that they

lack insight into their condition. We treat them as equals, and I think that gets quite good results, at least when you compare it with a lot of institutional solutions that are on offer.

**CHAIR**—So how are you funded?

**Mr Collins**—We fund ourselves out of an organisation called Breakout Design and Print, which does a lot of printing for community groups and unions. From the profits of that, we pay for Justice Action, and that is our base.

**Mr Strutt**—But we are largely a voluntary and unfunded service, and we find it very hard to find resources for just about everything.

**Mr Collins**—It has been running for 21 years. At different times we have run halfway houses. We have had a mentoring program, and it is still running, and we also take people on community service orders from the courts. We get them involved in mutual support, and volunteers come in to mentor them. I am an ex-long-term prisoner—I was 10 years in jail—and spent some time during the period that Michael was talking about with Justice Nagle. In fact, in my particular situation I was brought before a psychiatrist because I was seen as a troublesome prisoner, an intractable prisoner. There was evidence given before the Nagle royal commission that a psychiatrist, Bill Lucas, had said that I had been brought before him for reasons other than my mental wellbeing. To him it smacked of Solzhenitsyn's *Gulag Archipelago*. These things occurred then, and certainly I am a person who was represented with that attitude.

**CHAIR**—Professor Puplick said this morning that, in his view, the reason we have not managed to reduce the rate of incarceration in New South Wales—I think there are now 9,000 prisoners—is due to the efforts of shock jocks in New South Wales. Would you agree with that?

**Mr Strutt**—If there was one simple answer to that, I would certainly be focusing on it.

**CHAIR**—I am not suggesting that it was quite that simple, but in terms of attitude and why this government does not do something to reduce the prison population, do you think that is at least a factor?

**Mr Strutt**—Yes. But I also think that it is actually easier for politicians to talk in the simplistic sound bites that shock jocks provide, so you could say that the politicians are responding to the shock jocks or the shock jocks are responding to the politicians. I would not try to finger either of them; I think it is a symbiotic relationship.

**Mr Collins**—One aspect is worth looking at, and that is that there is a refusal by prisons or institutions to allow the media in to see who are inside, so you have an opportunity for the media to objectify the people who are inside as to acting as though they are some sort of subhuman species. That operates against the people inside and yet it is said that it is for the purposes of their privacy and that prisoners and people in psychiatric institutions do not want to have their situations exposed. That is not true. It protects only the administrators. So, at the stage at which we have an opportunity for the media to go in and see the people inside the jails, it breaks down those stereotypes.



Likewise for family members and the community generally. If they have access to the institutions, a whole lot of things happen straightaway. The first thing that happens is that you end up breaking down the stereotypes and the people become part of the community, which of course they are entitled to be. Another thing is that you have a measure of community involvement in the institutions. With that access, our community members are more aware of who is in there and you break down those stereotypes, and then the shock jocks do not have as much leverage as they otherwise have, because other people then say, 'No, I know them,' and speak about the person who is presented as such a stereotypically dangerous person.

**Senator FORSHAW**—One of the propositions that are constantly put is that, in order to remove the stigma of mental illness, we have to recognise that it is an illness in the first place, like any other illness. Following on from that, there are many who argue that we do need hospitals or hospital units that are specifically dedicated to treating people suffering from a severe mental illness. Part of the debate that is going on at the moment is that one of the results of deinstitutionalisation, post Richmond et cetera, is that we push too many people out into the community without adequate community services. You have been very forthright in your view that, as I see it, you do not see any place at all for psychiatric hospitals or psychiatric units per se. I want you to clarify that.

I also ask you to clarify your comment in the submission, which reads:

The endemic institutionalisation of those designated as mentally ill ...

I would argue with you to the point of saying that there is still stigma associated with mental illness and there is a lot of work to be done in the general community. I would also argue that it is at least better than it was 30 or 40 years ago. I say that from the personal experience of having been associated with people who suffered mental illness for probably 50 years or more. Can you concede that the sort of work that beyondblue and others are doing is actually beneficial and that we are not getting increasing vilification or endemic institutionalisation, despite all of the problems?

**Mr Strutt**—If you take it over maybe more than a 30-year time frame—if you go back to the sixties or seventies—then, yes, the stigma associated with those who were designated mentally ill was as bad or worse than it currently is, but by the end of the eighties and in the early nineties the situation was improving. It is actually deteriorating again. It is partly a media push of the sort that we are seeing in the *Australian* to try and associate mental illness with violence and to blame the mentally ill. Links are made between amphetamine use and supposed increasing rates of mental illness. I notice that they do not talk about that when they are prescribing amphetamines for kids suffering from ADHD, but I suppose that is another issue.

I would like to clarify that I do not say that there is no place for psychiatric hospitals. I do suggest that there is little or no place for forced detention in psychiatric hospitals and certainly not forced or long-term detention in psychiatric hospitals. We could do with more emergency beds, certainly more respite beds, for the very small number of mentally ill people who may be better able to be supported in such facilities than they could be with properly supported community facilities. That is not saying that, for instance, if the hospital system had received anything like the funding and the attention that the prison system has received in New South Wales over the last few years, the situation still would not have been better for the mentally ill.

I would prefer not to comment on specific organisations like beyondblue, but I find that in general most of those organisations—insane australia is one exception I have mentioned—are not seriously addressing the issue of stigma for the mentally ill. Simply calling it an illness is, to me, euphemism shifting. Once it has been used for a while it becomes just as bad in the public mind as if you called it criminality or something like that. It is a bit like the euphemisms they used to refer to people of colour over the years: it is good for 10 years then it has negative connotations and they shift to another one.

**Senator FORSHAW**—I will give you a personal example. When I went to school in the sixties, for any child who had a family member who suffered from mental illness there was an incredible burden and an incredible stigma if that got out publicly. They were shit-scared of that—excuse the expression. Today at the schools my children go to there are programs where they discuss depression. I am not saying the stigma is gone, but there is a greater awareness amongst that generation that this is something that children and teenagers may suffer from and they discuss it amongst themselves. That is the sort of improvement I am trying to get at.

**Mr Strutt**—In the sixties to be diagnosed or to receive a label of mental illness was less common. A lot of people talk about the plague or the epidemic of mental illness. There is certainly an epidemic of diagnosis of mental illness and particularly of children with mental illness. My understanding is that George Bush has recently announced an initiative where he wants to subject every schoolchild in America to mental health assessment. Of course that will result in a massive increase in the number of people designated mentally ill. Inasmuch as the more people who are designated mentally ill the more people will know somebody or will be designated mentally ill themselves, all things being equal that is going to tend to reduce the stigma. It is going to be less ‘othered’, whether the reason for that is really that people are concerned about the stigma or that people are concerned about being able to get away with prescribing SSRIs in spite of the evidence against their prescription use, for children in particular. You would be aware that that is now banned in the UK. Again I will not mention the particular group you mentioned before, but it seems to me Australian psychiatrists are flat out offering apologia for prescribing those pills, and it is not based on evidence based medicine at all.

**Senator FORSHAW**—One other issue I want to try and clarify is something I noticed in your submission. You refer to as a serious failing:

The acceptance of the dubious diagnosis and untested opinions of mental health experts ...

Then you call for:

... the rejection of psychiatric or psychological expert opinion in criminal proceedings unless supported with considerable experimental or actuarial data.

Later in your submission you refer to the case of Michael Kelly. You refer to how the tribunal, which is made up of an expert forensic psychiatric team, has determined that he is no risk to the community, but the Minister for Health refuses to let him go. It seems on the surface to be something of an inconsistency that you say in one set of circumstances—the tribunal case for Mr Kelly—it is appropriate to rely upon expert psychiatric opinion but in criminal proceedings at the outset it is not. Could you comment upon that.

**Mr Strutt**—For a start I would suggest that on an individual basis, as opposed to an actuarial one, psychiatrists are very poor at assessing the likelihood of anyone, designated mentally ill or not, to do something dangerous at a later date. Given that their hit rate is so poor—again, a Justice Action member who was designated too dangerous to ever be released is our personal experience of that—I do not think there should be a presumption on keeping people in prison because they have been called ‘dangerous’ or they have not been called ‘dangerous’ by a psychiatrist.

**Senator FORSHAW**—We know that in committal proceedings and in trial proceedings a magistrate or a judge might call for a psychiatric assessment and, from what I gather, you are concerned about that; you are opposed to it as a matter of broad principle. But then later on you seem to rely upon the same type of evidence as a basis for a person being declared that they are not a danger to the community and that they should be able to be released, despite what the minister thinks. I am just trying to sort out the dichotomy there.

**Mr Strutt**—First of all I will say again that we are an abolitionist organisation; we do not think people should be imprisoned for being mentally ill, generally speaking, or as punishment for criminal acts. But, given that we do imprison people for criminal acts, it is a very different thing to imprison people for what they have done than to imprison them for what psychiatrists say they might do. That is the distinction that I would like to make in that case. By the same token, having a psychiatrist say that somebody should be released because they are not dangerous or arguably not criminally responsible for what they have done is seen, I think, in society—with some justification in a lot of cases—as being a loophole whereby a lot of people can escape the consequences of their criminal acts. I am certainly not going to say that everyone who commits an act designated as criminal has equal responsibility or equal ability to choose to do or to not do that criminal act, but I do not think psychiatrists are the right people to be putting themselves in the place of the courts and saying that a person should be detained or should not be detained based on their level of culpability. I do not think psychiatrists are able to determine that.

**Senator WEBBER**—Your submission talks about some of the roles you think people should not take on, and that is fair enough. I was wondering, therefore, whether you could comment on what role, if any, carers should take on.

**Mr Strutt**—That is a really difficult one. Carers are obviously—particularly if we are talking about families, but even more so if we are talking about communities—the first line of support for people designated as mentally ill. They need more support in doing what they do. But, largely because of the stigma—as Senator Forshaw mentioned—attached to families or communities that have members who are mentally ill, because of the extreme stress, distress and disruption that can be caused in caring for a family member who is mentally ill and the lack of appropriate support services, the relationship between carers and those that they care for can very quickly become pathological—maybe not quickly, but certainly after 10 years it can. Often it seems to me that carers, in the name of being able to care for their loved one with a mental illness, are calling for the rights of that person to be taken away to give them more power and control over that loved one.

Although I am loath to mention cases by name, one that is already in the media a lot—so I will mention it—is that of Cornelia Rau. We noticed that she does not want to speak to her family.

One thing to keep in mind, of course, is that the media seem to forget quite often that she got to where she was because she was running not from an immigration detention centre and not from a Queensland watch-house but from mental health hospitals, and it is my understanding that she is on the run again right now from mental health hospitals. Getting back to your point: the media are very happy to go to her sister, whom Cornelia apparently refuses to talk to, and ask her what Cornelia's situation should be.

When Cornelia made her first press conference after being released, her sister was interviewed by the media and, rather than comment on what Cornelia had said on the basis of what had been said, she basically stated that the things she had stated at the press conference was evidence of how ill Cornelia was—in other words, she was delegitimising Cornelia's complaints, which to me seemed quite valid. I do not know exactly what it was about Cornelia's press conference that made her sister convinced that she needed more care. Her sister has recently said that there are problems with laws, because now that Cornelia has escaped to Victoria she cannot be deported back to a mental health facility in South Australia. Cornelia clearly does not want to go there.

To me that is indicative of the sort of pathological relationships that can develop. To be a carer is extremely stressful. I have had enough limited experience myself with people with mental illness who are important to me—trying to care for them—to know how easy it is to try to take shortcuts. Not to put too fine a point on it, it can be abusive towards the person that you like to imagine you are caring for. Because of the lack of support that carers receive, often they will seek second best; if they cannot get support, they will seek power.

The other thing, of course, is that carers organisations, in my opinion, are increasingly becoming captured by the pharmaceutical industry. Schizophrenia Australia receives considerable grants from Eli Lilly and SANE Australia receives considerable grants from other drug companies as well. In a sense, there is a bit of a convergence of interests between those two groups. They both have their own agendas and unfortunately those agendas do not necessarily always result in the empowerment of mental health consumers to enable them to exercise choice over the sort of care they receive.

**Senator WEBBER**—But is there a way of finding a better balance? When the committee had a hearing in Melbourne we met with a group of young people who were at various points of distress and process through the mental health system. They talked very openly about how important it was for their families to be involved in their treatment—particularly their parents—and that they wanted them there, they wanted their support, they wanted an organisation that would look after them and help them understand what they were going through.

**Mr Strutt**—Yes, as I was saying, I think carers should be given support to care—respite care is probably one of the very heavily neglected areas—and other community facilities. Again, mental health response teams who do not wear blue uniforms and carry Glocks would be a very useful thing for families to be able to call on when need be. But I also think that some carers are actually calling for solutions that may or may not make their job easier, but I cannot see, whatever their individual situation might be, that systematically it will improve the situation of mental health sufferers.

**Senator WEBBER**—This morning, as Senator Allison mentioned before, we received some evidence from Professor Puplick. One of the discussions he and I were having was about the

Indigenous prison population and particularly the efforts that are being made around deaths in custody. Whilst the number of deaths seems to have gone down, we still have a significant problem. He suggested that in his mind the number of deaths in custody had been reduced because of changes that have been made to incarceration processes and facilities and not due to the improved way we treat those people.

**Mr Strutt**—That is true. I have a paper here. Unfortunately, I cannot hand it over because it is the only copy I have. It is called ‘Ethical issues and the prevention of suicide in prisons’. It is written by Douglas Bell and it appeared in the *Australian and New Zealand Journal of Psychiatry* 1999, Volume 33, pp 723-28. It discusses the way in which prisons are reasonably good at preventing prisoners from committing suicide on their watch—at least post Muirhead. Although I would dispute that the Aboriginal deaths in custody rate has been significantly reduced, the overall death in custody rate has been reduced since the implementation of the Muirhead recommendations.

What we have also seen, at least in the Victorian inquiry into the Deer Park women’s prison, is increased levels of suicide, self-harm and overdose in the period immediately following release. I am not aware of studies into other prisons that replicate that, but I think that is due to lack of studies rather than it not happening. To me, it indicates that these measures that are being taken to prevent them from committing suicide on the watch of the prisons, if you like, are not improving their mental health situation. They are physically preventing them—they are not improving anything.

**Senator WEBBER**—Indeed—that was the point he was making as well. Thank you.

**CHAIR**—Thank you, Mr Strutt and Mr Collins, for your submission. It was another perspective in our so far very diverse inquiry. Thank you very much for making it.

[4.40 pm]

**CHAMLEY, Dr Wayne Alfred, Treasurer, Broken Rites Australia**

**PENGLASE, Dr Joanna, President, Care Leavers of Australia Network**

**SHEEDY, Ms Leonie Mary, Office Manager, Care Leavers of Australia Network**

**CHAIR**—I welcome representatives of Broken Rites Australia and Care Leavers of Australia Network. We apologise for keeping you waiting a short while. For the Hansard record, could I ask you to state your full name and the capacity in which you appear today.

**Ms Sheedy**—I am the office manager of CLAN. I am a counselling support worker.

**Dr Penglase**—I am the president of CLAN and the cofounder with Leonie of CLAN—Care Leavers Australia Network.

**Dr Chamley**—I am representing Broken Rites Australia, which is a national organisation. I am the treasurer of that organisation. It is a non-government organisation which advocates for victims of abuse, particularly people who have been in the care of church and other religious organisations.

**CHAIR**—You have lodged with the committee your submissions, which we have numbered 340 and 400 respectively. At this stage are there any alterations or additions to make to those documents?

**Dr Penglase**—No.

**Dr Chamley**—I actually put in two submissions. I am here to talk to the Broken Rites submission, but I put one in in my own right. There is one section of that which is relevant to some of the matters I want to discuss today. It is the section dealing with national intervention schemes. In that document it is addressing term of reference (d).

**CHAIR**—What we usually do is give an additional submission the letter 'A', which is probably what has happened.

**Dr Chamley**—I would like to submit a supplementary submission, which is 90 per cent done. I will have it to the secretariat by the end of the week.

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

**Dr Chamley**—I will be brief. I would rather have questions than talk to you. Just as a bit of background, I am actually employed by Healthscope a couple of days a week at two of their private clinics. Healthscope appeared before you in Melbourne. I am on the board of the Mental Health Council of Australia. I am on the advisory committee on mental health to Minister Pike,

the Victorian Minister for Health. I am an accredited health surveyor. I survey psychiatric hospitals right across Australia, so I have a fair opportunity to see what goes on in both the public and the private systems. I really just want to put two statements on the record. One is the statement that is at the top of my Broken Rites submission. They are words of Sigmund Freud and they were probably written around 1870. He said:

... all these grotesque and yet tragic incongruities—

and the words in brackets, ‘child molestation/child abuse’, are my words—

[child molestation/ child abuse] reveal themselves as stamped upon the later development of the individual and of his neurosis—

no ‘her’—

in countless permanent effects ...

Then there is an interesting statement from Martin Teicher, who has looked at child abuse for all of his professional life. He is an American psychiatrist. Note that Freud talked about neurosis; Freud was talking about the mind. In 2000 Martin Teicher said:

Because childhood abuse occurs during the critical formative time when the brain is being physically sculpted by experience, the impact of severe stress can leave an indelible imprint on its structure and function.

He is talking about the brain.

Such abuse, it seems, induces a cascade of molecular and neurobiological effects that irreversibly alter neural development.

They are 100 years apart. We have moved from a mind view to a brain view, and it is important for me to elaborate on that later on.

**Dr Penglase**—I will also be brief, because we would rather you ask us questions. I want to refer to our submission. There is one point we raised, which I would like to reiterate. It is on page 4. We state:

Even the terms of this current inquiry into mental health still fail to recognise that care leavers constitute one of the most marginalised, as well as the most numerous, of all disadvantaged social groups.

Those terms said that a particular reference will be made to:

... 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 ...

Care leavers are not included as a category. We started CLAN to try to raise public awareness that we are a category—a very distinct and specific category—of highly disadvantaged people in the population because of our childhood experiences. We would fit into some of those terms:

‘socially and geographically isolated’, very often; ‘complex and comorbid conditions’, very often; and ‘drug and alcohol dependence’, undoubtedly.

For those of you who do not know what CLAN are or what we stand for, we are the forgotten Australians. The report of the inquiry last year, the inquiry into children in institutional care, called us the forgotten Australians. There were half a million of us in the 20th century. We have been forgotten—hidden and having fallen through the cracks of history—but we are here today. The 20th century is a long time, but if there were half a million over the century, I would estimate that there must be at least half of that number still alive—plus our children and grandchildren who have suffered very profoundly from our experiences. Leonie will tell you a little about that later on.

We started CLAN in 2000 entirely as a voluntary exercise. We worked voluntarily; we were not funded in any way. We still have no ongoing funding, but we had no funding for 2½ years. We are the only voice of care leavers in Australia. We are a national group; we have one little office in Bankstown and very little funding. We are the only voice of care leavers by care leavers. There are very, very few dedicated services for us in Australia. We are still waiting for a response to the Senate report; it is nearly a year. You probably all remember 30 August last year—we certainly remember it—when senators cried and we cried. That was our day; we were finally recognised, but we are still waiting.

We are trying to address the needs of so many damaged people, and there are no dedicated services. Both our submission and Wayne Chamley’s submission ask you to please read the *Forgotten Australians*. There you will see what the mental health consequences are for people like us. I am going to flog my book too, because I have written a book based on it and you can buy it in the shops. I have a press release, if you want to put it on the record. It is the only thing written about our history. It is a bit more accessible than a Senate report, although that is a really wonderful Senate report. It is comprehensive, clear and unequivocal, but in my book I tried to go behind the report and say, ‘What is this about?’

**CHAIR**—What should a service dedicated to care leavers look like?

**Dr Chamley**—I think you have heard several times from several people that there is a real need to redesign the front door. The standard hospital type set-up is not the way to provide for these people. The public system is under such strain that very few of them get in anyway. My view is that virtually every one of them—and there are probably tens of thousands—has some level of mental illness. The extreme cases are those with post-traumatic stress disorder and borderline personality disorder. I hate that term; I think it should be a ‘borderline disorder’, but that is what the DSM-IV, the psychiatric classification, calls it. Then there are the people who are comorbid; they have both of them. Without treatment—and the treatment is a mixture of medication, in some situations, and long-term psychotherapy—these people will stay on the edge, and the suicide rates will go off—

**CHAIR**—I can understand your comments about the inadequacy of the current system. Every one of our submissions has drawn attention to that. I do not think there is any question in anyone’s mind that our mental health services are inadequate. Can you spell out why it is that your group, in particular, needs a specialised service?



**Dr Penglase**—Perhaps I can answer that. Firstly, it is because all of us as children lost our parents. That is the most profound blow that can happen to any child. We seem to understand, quite rightly, that for the stolen generation that was a catastrophe beyond imagining. It happened to us too. Many of us who ended up in the state system were taken from our parents with no explanation. Many of us were not; we were simply placed in a home. So we grew up without our parents, with no parental care—not only without our parents but in an institution.

**CHAIR**—Are you suggesting, therefore, that psychologists, psychiatrists and mental health workers generally would need to have a level of specialisation related to that?

**Dr Penglase**—Yes.

**Dr Chamley**—Absolutely.

**CHAIR**—At the present time are there any working in the field whom you would describe as specialising in this—

**Dr Chamley**—Victoria has the Spectrum clinic, which is the only one in Australia. Every capital city has to have a Spectrum clinic. It just so happens that the Victorian government wrote a deal to set this up, but why haven't other governments done it? It may be something where the Commonwealth can step in and say, 'We will set up the Spectrum clinics.'

**CHAIR**—I imagine that the people who belong to your organisation and are in this category are spread around Australia; they are not just in Melbourne.

**Dr Penglase**—All around, yes.

**Ms Sheedy**—To answer the question as to whether there are any specialised people who know about this, there are very few psychologists and therapists who understand this. Joanna and I both attend therapy and we are very fortunate, very lucky, in that we have managed to find people who understand this history. But that was through trial and error of my own. I went to people and tried to get help for my issues. I am one of seven Sheedy children who went to a total of 26 Victorian institutions. Growing up in a children's home with 100 other hurt, damaged children does not prepare you for adult life and to be an emotionally stable person. Nobody has cared about the 13 years that I spent in an orphanage, separated from my parents and not knowing what a parent was. Are you a Victorian, Senator Forshaw?

**Senator FORSHAW**—New South Wales.

**Ms Sheedy**—Are you a Victorian?

**Senator WEBBER**—Western Australia.

**Ms Sheedy**—Lyn, do you remember those John and Betty books from Victorian schools?

**CHAIR**—Certainly.

**Ms Sheedy**—When they were read to us in Geelong I used to wonder what was a mother and what was a father. ‘John can throw the ball to mummy.’ Do you remember the words in the reader books? I used to sit there and think: ‘What is a mother? What is a father?’ It took me a long, long time to figure out what a mother and a father were. It is very hard to be a parent coming from this background and we are very fortunate. I pay \$180 a week in psychotherapy fees. I cannot get any of that back from Medicare. Joanna, do you want to add your bit?

**Dr Penglase**—Yes. I have been seeing a psychoanalyst for 10 years and she saved my life. I really can say that quite unequivocally, because I was in a very bad way when I found her. She understands because she is a psychoanalyst, and I think anyone psychoanalytically trained, or with any sort of psychoanalytic understanding, understands these issues.

**CHAIR**—So she is a psychologist?

**Dr Penglase**—No, she is a trained psychoanalyst. She is also—and this is the point I want to make—a medical doctor. Lucky me! Psychoanalysis every weekday: that is how psychoanalysts work. How could you afford it? You could not. But I am fortunate that she is a medical doctor as well as an analyst. I am therefore entitled to see her on Medicare—but only because I qualify, because of my diagnosis, for an item 319. As Wayne said, we need therapy. One way to go is to drop the rule that psychologists cannot be refunded by Medicare. It would not be everybody; there would have to be a certain level of training, obviously, but it is not right that Leonie has to pay and I do not. I pay a small amount, but nothing like what Leonie pays. It is only because of the medicalisation of mental illness that this is possible.

I have not been helped by my analyst because she is a medical doctor. That has nothing or very little to do with it. She has never given me drugs because she does not work like that. Psychoanalysts do not, generally, as far as I understand. The reason she could help me is that she understood that I had suffered the blow as a child of losing my parents and then being brought up as if that did not matter. That is what happened to us in homes. Nobody asked Leonie: ‘Do you know what a mummy is? Do you know what happened to your mummy and your daddy?’ We were brought up having to deny that it mattered. That is why we are so damaged and that is why we really are a special needs group—and there are tens of thousands of us. It would not be rocket science to train people in the field of mental health therapy to understand these issues, because bonding and attachment are things that first-year social work students know about. We talk about that all the time but we do not seem to connect the lack of bonding and attachment—the loss of our parents from our lives—with the consequences for us later.

**CHAIR**—What are those consequences? What is the range of illnesses?

**Dr Penglase**—Post-traumatic stress disorder

**Dr Chamley**—In my paper I think I listed five. These people, for instance, have a very high instance of anxiety and depression, all manner of phobias, post-traumatic stress disorder, borderline disorder—I hate the personality side—and comorbidity. Can I just add to that that another way to go is to broaden the diagnostic categories that allow access to item 319. At the moment there are only three diagnoses that mean you can access item 319. If it were broadened to these various things—

**CHAIR**—What are those three?

**Dr Chamley**—I cannot remember off the top of my head, but they are within these. Four of these are not accessible, so that is another way to go.

**Dr Penglase**—They are borderline personality disorder, untreated eating disorder and sexual abuse as a child. They are the three and it is a narrow category.

**CHAIR**—Is this principally for GPs to access, or psychiatrists?

**Dr Chamley**—It is for psychiatrists also. The GPs will not touch it because it involves too much time. They will give cognitive behaviour therapy but they will not give psychoanalysis, nor should they.

**CHAIR**—They are not trained to do that. Would you like that extended or other items like this brought in?

**Dr Chamley**—Joanna showed one way—allow more professionals to get into the treatment—but the other way is to broaden the diagnostic category to allow access to item 319. There is a need to consider what has happened—and it is very recent history—what is happening and what may happen. What is happening—and you have heard it—is that we have this wave of dual-diagnosis young patients with mental illness and comorbid drug and alcohol abuse. I think you had Ruth Vine here. Fifty-six thousand people went through the doors and 20 per cent of them are dual-diagnosis patients. Thirty-seven per cent of those are on cannabis, about 30 per cent are on alcohol and about 10 per cent are on pills.

I asked Pat McGorry, who also presented the other day: ‘Pat, I’m going to the Senate hearing. What is the proportion of these young people that you are treating who have a history of abuse?’ It is 25 per cent. We still have in this country, which nobody is talking about, one in four girls and one in eight to 10 boys being sexually abused. That has been repeated time and time again by the forensic psychiatrists. It is just not talked about.

**CHAIR**—In a way those people lose their parents too, don’t they?

**Dr Chamley**—They do and it drives them. I am convinced that a big number of them start to self-medicate and it is never diagnosed. That is why I said, in this section of my other paper—339, or whatever it is—that we have to roll out a national early intervention scheme. Pat McGorry argued for it from 14; I am arguing for it for the first 20 years of life—you have to capture the young kids. If they experience this terrible situation, you have to intervene. Child and adolescent mental health has to be brought into it as well. If we do not, we will write off a huge proportion of the next generation. They are already starting to have children. You can go to towns like Seymour and Foster, down near Wilsons Promontory, and they are full of comorbid parents with toddlers. There is street after street of these people. When they fall over they get on the drugs, and the town comes in to stabilise the kids rather than have them go off to DOCS. We have to roll out some sort of a national scheme.

**Senator FORSHAW**—I will be quick because I know Senator Webber, particularly, has some questions as well. There are two statements in your submission under the title ‘Modes of care available to care leavers’. The first reads:

In addition there is systemic failure on the part of organisations that in the past accepted these Australians and child migrants into care, to come to any appreciation of their real treatment needs.

You refer to the Salvos, the Anglican and Catholic churches and state government agencies. On the next page, the second statement reads:

... the current modes of treatment being offered to abused care leavers by religious organisations and by some state government agencies are totally inadequate ...

Could you expand on what you are saying there? From what I gather, first of all there is a misunderstanding or a lack of recognition of what the proper treatment should be and, secondly, there are some treatments, programs or whatever in place, but they are misdirected and inadequate.

**Dr Chamley**—Yes. They do not recognise the long-term need. They see it as: ‘Oh, settle him or her down with six visits to some barefoot psychologist’—who might have only left university a couple of years ago and happens to have got a job up in Albury. And when these people go to that sort of person and all this stuff is brought up, nothing is resolved, so they go home and start percolating. And some of them jump out the window; that is the tragedy.

**Senator FORSHAW**—And are these being offered by the religious organisations as part of the total compensation package, if you like?

**Dr Chamley**—As part of their initial response. The Catholics do it and the Church of England look as if they are going to start.

**Senator FORSHAW**—So what do they actually do? Do they refer people?

**Dr Chamley**—They tell the person that they will pay for six sessions with a psychologist.

**Senator FORSHAW**—Okay.

**Dr Penglase**—We need to state this: it is not proactive; it is reactive. If someone turns up and says, ‘I’m really angry at what your organisation did to me,’ then the damage control comes in and they say, ‘Oh, six sessions.’ There is a lack of proactive services.

**Senator FORSHAW**—And you are also saying that it is not properly structured?

**Dr Penglase**—It is a reaction.

**Senator FORSHAW**—I at least know of one through the Catholic Church, because I know some lawyers who are involved in this who have arranged for their legal teams to put together compensation packages and spend a lot of time negotiating and coming up with some sort of

settlement. It seems that maybe there is effort being put into that side of it but not too much being put into this aspect.

**Dr Penglase**—That is the operative word: lawyers. Why are lawyers involved? It is damage control. It is: ‘How little can we get away with?’ I am sorry if that sounds cynical. We deal with that at CLAN all the time and Wayne deals with it at Broken Rites.

**Senator FORSHAW**—I would have thought that the whole response should include using the appropriate means and services to ensure that whatever treatment and programs are delivered to deal with these issues are properly thought out.

**Dr Penglase**—But there is no acknowledgment that there is a need. It is entirely reactive.

**Dr Chamley**—To add to what Joanna is saying, I think there is actually denial. There is still denial that this sort of stuff went on, and so the response is to get the person out the door as fast as possible.

**Senator FORSHAW**—Throw a bucket of money and that is it?

**Dr Chamley**—Yes.

**Dr Penglase**—We need to stress this: we are not just talking about abuse here. The people who go and try and get some compensation usually have been sexually or severely physically abused, for example. But there are legions of us who never had that happen to us. There is no acknowledgment by any of those organisations that ran homes that it was an appallingly neglectful system and they knew it at the time. They knew that it was bad for children. It was cheap, and the governments liked it because it was cheap too.

**Dr Chamley**—I gave that comparison of figures. The barefoot psychologist arrangement might cost the church \$2,000, but when they get a Vietnam veteran in for the PTSD treatment they spend \$84,000 on him and his family. That is the scale of difference.

**Dr Penglase**—That is what we need.

**Senator FORSHAW**—My final question is: do your organisations have groups like Recovery, which is now called GROW, that exist for people who suffer mental illness for other reasons not associated with being in institutional care? Do you have those sorts of groups? I hate to use the expression ‘self-help groups’, but they are structured along the lines of people who have suffered mental illness who come together within communities.

**Ms Sheedy**—I am the only paid worker for the whole of Australia in CLAN. People ring me up, and they can barely believe that there is a support group for them—that there are people interested in this story. I spoke to a 77-year-old lady today. She said she has never seen her half-siblings since she left St Joseph’s Orphanage at Cowper. She said: ‘Nobody could see me hurting.’ I asked: ‘Could you go and tell your doctor about CLAN and that you’ve been raised in an orphanage without your family?’ She said, ‘He’d just laugh at me. I wouldn’t bother telling my GP.’

**Senator FORSHAW**—I suppose I was looking at networks of people.

**Ms Sheedy**—We do not have the resources!

**Senator FORSHAW**—I need to ask you about this because it is something that is available in other areas.

**Dr Penglase**—We got some funding from the federal department as a result of the Senate inquiry and the pressure of the senators, who went into bat for us and got us a bit of money for counselling. We are struggling to keep our doors open. We are about to employ a counsellor one day a week to take some of the load off Leonie. But that is as much as we can manage. That is why we need services.

**Ms Sheedy**—We can listen to their story, we can help them to get their state ward file, if it still exists, and we can refer them to the home that they were raised in to get their home records, if the records still exist. If they are a Victorian state ward we can tell them that there is counselling and that they could get maybe 10 sessions from the Victorian government. The Victorian government allocated \$70,000 for state wards to get counselling.

**Dr Penglase**—A year.

**Ms Sheedy**—In New South Wales there is no money for counselling. Queensland has services, but if you live in Queensland and were not raised in a Queensland home you cannot utilise those services up there.

**Dr Penglase**—They only have those services because of the Forde inquiry of 1999, which showed what an appalling system it was. There had to be some reaction to that report.

**Ms Sheedy**—We are doing the best we can with what we have.

**Dr Penglase**—There is no national response. That is what that Senate report said was necessary.

**Dr Chamley**—Broken Rites is not a coalface organisation. We do not provide any services; we provide a lot of advice. We will represent people at mediation and in making criminal statements. We do a lot of work with the police. We do a lot of work with the media and we do submissions and that sort of thing. We refer people on. We have a policy that we will not take any money from any state government or any church because we are always at war with them. We will call a spade a spade, and if the cameras happen to be perched on the bishop's doorstep, so be it. That is the way it is. We will move now into the United Nations forums, because these Senate committees let us get human rights issues on the deck.

**Senator WEBBER**—Dr Chamley, I also want to pick up on the comment in bold in your submission about the current modes of treatment being offered to abused care leavers by religious organisations and some state government agencies. Obviously the way religious organisations are choosing to deal with this tragedy is grossly inadequate. I do not want to reopen that debate. One of the things it seems to me that we do not really discuss with the issue of care leavers but also with the issue of child sexual abuse is the impact that is going to have

when we finally address it within state government institutions, be they institutionalised care or state government schools as opposed to religious based schools. That is going to involve a much larger group of people. That will eventually happen. Are there lessons we can learn about how to handle that when we get to the point where we have to address those people's needs as well?

**Dr Chamley**—I am not sure of the question. Certainly, we need an early intervention program—a national program, funded nationally. Get rid of the public servants and the state governments and DOCS and all these groups. We need a nationally funded, national early intervention program that covers the first 20 years of life. Put the money at the front end of families and expect that spending on prison systems will go down. Invest at the front end and you will see the savings a few years down the road at the back end. You will see less comorbidity. You will see fewer people entering the prison systems, because their psychiatric illness will be diagnosed and they will be managed. The emotional landmine that I speak about will not go off. It will not go off. That statement about the 30 care leavers, with 20 of them doing time for murder, is a clear signal to me of what is going on. That is a key thing: to roll out a national program, nationally funded, with an independent medical board or whatever. But get the state governments out of it.

**Senator WEBBER**—Fair enough. Going back again to the list of illnesses for the care leavers, roughly what proportion of care leavers present with comorbidity problems?

**Dr Penglase**—That is a good question; if only we had some research. One of the major issues that I would like to see a recommendation about is that there is no research. I am struck by this particularly when I read in the paper statistics about the Aboriginal population and how their standard of living is far below the Australian standard of living. I believe that if we could take the statistics for older care leavers across Australia—if we identified care leavers and looked at all the same markers—we would find that they were a similarly disadvantaged group. That is because, in one sense, they have very similar childhood experiences, and the fallout is the same. We know anecdotally in CLAN how ill the people that come to us are, and about their family circumstances—early deaths, suicides and all that stuff. I have had someone say to me, 'My brother died of his childhood.' I knew exactly what she meant. But this is not documented. There is no research. We never ask people.

What gets missed—for example, by the previous witness today—is that a lot of the people in prisons are care leavers. It is well-documented—because they are a captive population you can document it—that 30 to 35 per cent of prisoners are care leavers. There is a progression from care through to juvenile justice through to prison. We do not ask the people using all the health and mental health services, 'Are you a care leaver?' We do not ask the children coming into the care of DOCS—the same children whose need for early intervention we are talking about—what their family backgrounds are. This is the research that needs to be done.

**Dr Chamley**—And the simple way to start that is through recommendation 31 of *Forgotten Australians*. Every government form—prison forms, Centrelink forms, the whole caboose—should give an opportunity for a person to voluntarily disclose whether they are a care leaver or not, by marking 'yes' or 'no', so that we start to build up the database. Then you can cross-reference who is in prison, who is using public mental health services and who is in public housing. There would be issues about confidentiality, so you would select the people that had

access to that database. It is done for suicide analysis and I think it can be done for care leaver analysis. You have got to have that key thing: get it on the form and start to generate the data.

**Dr Penglase**—But it would mean taking it seriously, you see, and that is what governments and the past providers, which are churches and charities, will not do. They will not take this seriously. And yet this is our population. They are Australians, and it is having a very serious effect.

**Senator WEBBER**—In a way, that is what I was alluding to before by saying that when we get into really confronting what has happened in state government instrumentalities is when governments will take it seriously, because they will then have to be accountable for their own actions no matter what their political persuasion.

**Dr Penglase**—But there is plenty of evidence in *Forgotten Australians* about what state governments did to the children in their ‘care’.

**Senator WEBBER**—Indeed.

**Dr Chamley**—It needs to be appreciated that New South Wales DOCS did not even care to put a submission in.

**Ms Sheedy**—Neither did South Australia and Tasmania.

**Dr Penglase**—They just say: ‘It is the past. We do things so differently now.’ Did the past not have any consequences? Apparently not. And yet the kids that they are now dealing with come from care backgrounds very often.

**Ms Sheedy**—We have members in CLAN who have had three generations of family in care. A young man came to my office—he drove from Queensland down to Sydney. He is 38 years of age. He was in 12 children’s homes in New South Wales. He has been in 14 jails in Australia. He is 38 years of age.

**Dr Chamley**—I just happened to be in the office that day. He is the classic borderline personality disorder. I could pick him from 100 miles away.

**Ms Sheedy**—How he deals with his pain is not aggressive. His mother was ill for 12 months and died one night. He was found at the feet of her dead body and was then taken into care. He now deals with his pain by going to sleep. When any stressful time comes up he yawns and says he is tired and starts to pretend that he wants to go to sleep. Nobody has ever addressed the pain of finding his mother dead in the morning. She had been dead for 24 hours.

**Senator WEBBER**—I have one final question because time is getting away from us. You mentioned before that there is only the one specialist service and that is the Victorian clinic. I was wondering if you could tell us a bit more about that clinic, and whether you think that it is the right model or whether we could do something better than that to provide those services. Your recommendation is that we have a national approach. Are you happy with that clinic and that it be replicated around Australia, or is there something even better?



**Dr Chamley**—It is a very good clinic. I should point out that there are a couple of psychiatrists at the Black Dog Institute who are interested in these areas. They do not have an established clinic. Mood disorders are the big focus there, but there are a couple of psychiatrists who have a particular interest. Spectrum is the only one dedicated. There is a way of improving it even more. The current arrangement with Spectrum is that the person who is referred there—they will do an assessment and work out treatment plans et cetera—has to already have a caseworker. That means that persons who have not already gone through the front door of the public mental health service, and therefore have not got a caseworker, cannot go to Spectrum. There would be an arrangement possible where GPs would refer to these types of clinics and, now that there is the possibility of wider access to interested psychologists, they would come in as a quasi-caseworker. The initial thing is to get the assessments done.

I will give you an example of an amazing case. Heather Osland was released from a Victorian jail two weeks ago but her case is not over. This woman was in the most abusive marriage and was convicted of murdering her husband even though she did not strike him, her son did. She appealed the conviction to the High Court and lost. She was convicted and sentenced to 14 years. She spent ten years in prison. I went to a breakfast that was to raise money for her and I spoke to the caseworker that has been driving the Heather Osland recovery fund. I said, ‘Has Heather ever been diagnosed?’ She said, ‘No.’ In 10 years in the state legal system, nobody ever did an assessment or a diagnosis. Can you believe it? She came out of prison and was then diagnosed. She had years of sexual abuse, bashings and rapes. She could not escape the hideous man she was married to because of the children. She was always fearing that he was going to get stuck into the kids. In ten years of incarceration not one minute was spent diagnosing her mental status. I just find that to be total negligence on the part of the correctional system.

**Dr Penglase**—Did anyone ever ask her about her childhood experiences? There was a reason she got involved with an abusive husband. It does not just happen.

**Ms Sheedy**—I have probably spoken to 1,500 people around Australia in the last five years. It is very lonely and isolating working in that office by myself. I can talk to any homie who has been raised in any home, but the people who really affect me are the children of homies. The damage that has been passed on to our children is really hard to listen to.

**Dr Penglase**—So that brings us to the present, and those children have children.

**Ms Sheedy**—Yes, and they are very angry. One 45-year-old woman from Western Australia rang me, and she was so angry. She said: ‘I didn’t grow up in an orphanage, but it certainly felt like it. My mother had a strap around her neck. Every day she acted like a nun.’ This woman was not even raised in a home, but look at the damage that has been done to her. A 75-year-old lady from the Blue Mountains rang me up when she found out about CLAN. Her mother had been at the Parramatta Girls’ Home, and she said to me, ‘I’ve read the stories in the newsletters, and now I understand why my mother couldn’t show me love.’ At least she has some understanding, but our history is invisible. Our children do not know what we went through. How can they understand why we are not very good parents sometimes. This is really Australia’s grubbiest little secret, and it is time that what happened to us was exposed. I am getting fed up with government silence; I really am. We are doing the work that every state government should have been doing 50 years ago for us. It is really criminal. I do not know why we have not taken up

class actions and sued every state government for their neglect of us. We are so damaged we cannot do it. We are too damaged.

**Dr Penglase**—We cannot do it. We cannot speak up for ourselves because of our childhood experiences.

**Ms Sheedy**—We are so ashamed of how we were raised.

**Dr Penglase**—That is why it really is appalling the way there is no willingness to acknowledge what governments and churches did to so many Australian children, and that is resounding through our society still. It is having a major effect on mental health incidence.

**CHAIR**—Dr Chamley, working with children is the early intervention that you talked about. Do you see that as being an important step to break the cycle, as it were?

**Dr Chamley**—Yes, in the first 20 years of life. I will just add to what has been said. Of any nation on the globe, this country has the dubious honour of putting the largest number of its children into care. The Irish system managed to put only 164,000 kids into care; we managed to put 500,000 children into care. What an honour.

**CHAIR**—Did we not take some of the Irish children as well?

**Dr Chamley**—Very few. We took 7,000 child migrants but very few were Irish. In the 1993-94 United Nations national wellbeing report, we rated No. 1 on the level of child abuse. That is because we are mandatory reporting, but it is still not a great statistic. It is appalling.

**CHAIR**—There is reporting, but by and large there is not much follow-up.

**Dr Chamley**—What I will put in my supplementary submission is that there is a brain basis to a lot of this. The neural development of these people is compromised. Some of their brain centres do not develop properly; therefore, they cannot control their anger et cetera. If you can imagine a square metre of gauze with one centimetre holes and a square metre of gauze with one millimetre holes, there are many more interactions in the tighter gauze. These people do not go from one centimetre or one millimetre; they do not rewire. Evidence now coming from medical imaging studies shows that, of the key centres in their brains, the ones that control aggression, vigilance et cetera are compromised. It is going to be a lawyers' picnic in a few years time, as they get the medical evidence.

**Ms Sheedy**—And when our children arise to say, 'How could we be treated like this in this country?'

**CHAIR**—That is probably a good point to end this afternoon's session. I thank you warmly for making the submissions and for appearing before us. It must have been difficult in some instances for you to do this, and we appreciate it very much.

**Dr Penglase**—Thank you for the opportunity.

**Dr Chamley**—Thank you.

**CHAIR**—I thank all the witnesses who have given evidence to the committee today.

**Committee adjourned at 5.29 pm**