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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

(Subcommittee)

Reference: Mental Health

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CAIRNS

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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, Humphries and Moore

Terms of reference for the inquiry:

To inquire into and report on:

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

(a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

(b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

(c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

(d) the appropriate role of the private and non-government sectors;

(e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

(f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

(g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

(h) the role of primary health care in promotion, prevention, early detection and chronic care management;

(i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

(j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

(k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

(m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

(n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

(o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

(p) the potential for new modes of delivery of mental health care, including e-technology.

WITNESSES

Subcommittee met at 9.09 am

HARRIS, Ms Philippa Joan, Coordinator, Mental Illness Fellowship North Queensland Inc.

TYSON, Ms Lynette, President, Mental Illness Fellowship North Queensland Inc.

CHAIR (Senator Allison)—I call the committee to order and welcome those present today. This is the 10th hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March 2005 and will 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 contempt of the Senate. The Senate prefers all evidence to be given in public, but under the Senate's resolutions, witnesses have the right to request to be heard in private or in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

I now have pleasure in welcoming representatives from Mental Illness Fellowship North Queensland. You have lodged with the committee a submission that we have numbered 116. Do you wish to make any changes or additions to that document at this stage?

Ms Harris—No, thank you.

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

Ms Harris—We would like to thank the Senate select committee for inviting us here. It is the first time we have ever had an opportunity to appear before such a committee, so we would ask that you excuse us if we do anything wrong or say anything inappropriate. In some ways, it is also recognition of the difficulties that we have in Far North Queensland and North Queensland in being so far from the centre of government. For us here in Cairns and in Townsville, we are further from Brisbane than the folk in Brisbane are from Sydney, Melbourne and Canberra. The distances are quite difficult and it increases our problems when we are dealing with mental illnesses and individuals who live with mental illness.

The Fellowship has been responding to the information support needs of people with mental illnesses and their families for more than 20 years. From a handful of very desperate family members, the organisation has grown into one of the largest non-government mental health service providers in Queensland and certainly the largest in North Queensland. We have a financial membership of over 300 people and organisations, so we estimate that we represent over 1,000 people with a constituency in Far North and North Queensland of over half a million people. The area that we cover geographically is over one million square kilometres.

Over the years the Fellowship has become highly regarded locally and regionally and by national bodies as a leading promoter in providing individual support and services for people with a mental illness, for innovative project development, for progressive thinking and service

delivery, and for its commitment to the wellbeing of individuals and families in North Queensland.

Our written submission focused on our experiences in developing innovative and successful services and seeking adequate funding and the issues around the sustainability of those services to meet the needs of our community. We could just as easily have talked about the number of people with mental illnesses in jail, the desperate need of safe, affordable housing for people, the issues that hamper people with mental illnesses from seeking and attaining employment, the discrimination and stigmatisation that still exists in our communities, in the media, in government and indeed, in health services in general. We could have been speaking about the sexual, emotional and physical abuse of people with mental illnesses again within health services as well as in the community. We could have talked about high suicide rates, the lack of early intervention services in North Queensland, the lack of rehabilitation services and the lack of health promotion services for people—the fact that we are unable now to get into primary and secondary schools to provide appropriate information to those vulnerable years of years 10 to 12, so that people understand a little about mental illness and know where their services and support structures lie within their own regional and rural communities.

There is a whole list of things we could have talked about. However, we have chosen instead to highlight a couple of very significant issues around the provision of rehabilitation and support and services for people within their local communities. Rehabilitation from an episode of acute or an extended experience of mental illness takes time, but most of our clinical services are geared to statistical analysis such as increasing throughputs, measuring clinical outcomes and counting exit activities. Though pushed in this direction by our government funding departments, we find that community based organisations like the Fellowship still prefer to be very people focused, asking the person how they are going, asking the family how they are going, and hanging in there until they say that they are going okay.

One way of supporting people with the management of mental illness and recovery is to increase the support services which focus on increasing understanding or mental health literacy and rehabilitation in the person's own home, in residential facilities, but also in acute care facilities. In Queensland, much of this work is undertaken by health care professionals—mental health nurses, social workers, psychologists and occupational therapists—under the direction of psychiatrists. The Fellowship believes that these highly skilled people are expensive practitioners, but they are essential in assessment and treatment and in treatment planning and evaluation. Much of the day to day support for people, and in particular psychosocial support and treatment, is better undertaken by less qualified but perhaps more suitably experienced people who are well supervised and supported within the community. This includes people who experience mental illnesses themselves and their family members. We find that those sorts of services are very patchy across Queensland and certainly almost nonexistent in North Queensland and Far North Queensland. Where they are in existence, there is a significant imbalance in the power. The power still remains with the medical model and the government medical systems.

The Fellowship would like to see a significant increase in the operation of residential and community based rehabilitation and recovery programs by specialised community mental health services through an increase in the overall funding and a diversion, perhaps, of some of the existing funding from the expensive inpatient facilities. The Fellowship also believes that

positive long-term outcomes appear for families and communities that are educated and skilled in identification of mental health issues and how to respond to them successfully. As leading innovators and deliverers of mental health education in North Queensland, we believe that additional funding in this area will provide significant cost benefits not only in health and welfare but also across society.

Finally, the Mental Illness Fellowship is encouraged by the recent state and national interest in mental health and mental illness. The Senate inquiry, like its predecessor the Burdekin inquiry into the rights of people with mental illness, is providing Australians with an opportunity to highlight some of their concerns, discuss some of the issues and also to provide some possible solutions. We certainly look forward to the outcome of this Senate inquiry and hope that it will have a positive impact on the people that we care so desperately about.

CHAIR—Thanks very much, Ms Harris. I should indicate at the outset that we are currently here as a subcommittee of the committee. We are expecting Senator Moore to join us shortly. Senator Garry Humphries is the other senator who is here today.

I will start with your evidence that funding restrictions over a number of years have meant that programs have slowly died. What sort of advice have you been given as to why this is? Is it simply the new way of doing things, which is that you have to keep applying for grants every year or two? Can you describe how difficult that is and what that means in keeping staff and volunteers and your service running?

Ms Harris—I have done up a schedule of the funding that we have received from major sources—which is for us Queensland Health—since 1991. That shows that, although there have been some increases in funding over the years, the increases have not kept pace with even CPI. For example, since 1995 our increase to the year 2003 was 10 per cent—that is 10 per cent of our funding. That was our only increase. However, during that time, our service demand increased by 600 per cent. We have had a tremendous increase in the amount of demand for services and that has not been mirrored by the funding.

Originally we were funded on an annual basis. We would put in our funding submissions in the hope that we would get what we asked for. Usually we did not, and that was never a surprise, but it was always disappointing. As a community based organisation, we try to be honest and diligent in our figures. We put in what we think we need, not what we would like to get. I think there is a significant difference in that. I do not know that that is necessarily the way those figures were received at the other end in Brisbane.

In that time we have been able to put through a number of changes. We have had many restructures and many long and heart-wrenching discussions with our membership and with our staff. That has resulted in our cutting staff hours and services in order to remain financially viable. As a community based organisation, we are not allowed to operate in deficit, so it was really important that, at the end of each financial year, we were still more or less in the black.

In 1996 we had six full-time staff; now we have four part-time staff. That has meant a significant reduction in the hours that we are available to support and service our community. It has also meant that many of our staff work numerous hours of unpaid volunteer time. We put a growing emphasis on the volunteers that we have. We are having to become more professional in

the recruitment of volunteers because we are asking them to do more and more complex tasks. As an organisation, we have maintained that face-to-face, one-on-one service delivery must be done by professional, qualified staff. A lot of our education is done by volunteers, particularly volunteers with experience in the mental health sector—that may be consumers of mental health services or family members. We find that this is the best approach to use.

Over the years, that reduction has meant that we no longer provide a rural outreach service, which at one time was going to more than 32 different centres throughout North Queensland. We were providing education to 28 high schools in that area in places like Mount Isa, Longreach, Moranbah—which is a small mining town—up on the Tablelands at Atherton and Mareeba, up into Mossman. We were able to provide vital mental illness education and information to those high school students. They no longer get that.

CHAIR—Your services were not placed with services from another organisation?

Ms Harris—No, they were not.

CHAIR—There has in fact been a decline in the availability and some of those services are not provided at all. Is that correct?

Ms Harris—That is correct. Part of the function of the rural program was to encourage community development. From the beginning of the program, we saw that some communities were able to see what could be done. With support and a lot of energy from the community we were able to generate opportunities to start little services of their own. We see that certainly across the Tablelands where a number of services have been provided that were not in existence when we started. That was part of our goal. Apart from local initiatives where perhaps a service provider goes into high schools, I am not aware of anyone else who goes into high schools to provide this specific mental illness information.

CHAIR—Can you tell the committee more about the learners permits for parents program? The committee is very interested in innovative programs, particularly the ones that work. Can you tell us about it. Was it evaluated? Is it the case that it is now being picked up if it was evaluated successfully? Can you fill us in a bit on that program?

Ms Harris—The learners permits for parents program was a community based initiative, having recognised where a parent had a mental illness. Families with children who had ADD, ADHD or conduct disorder had very little service as far as their parenting was concerned. The community in Townsville got together with educationalists and mental health service providers to develop and design a parenting program that met their very specific and very complex difficult needs. The program had evaluations written into it. There were pre and post tests for the parents who underwent the pilot programs. The results of those evaluations were very positive. We used the tests that were used by the Triple P Positive Parenting Program, which is the parenting program that is supported by the state and federal government. Our outcomes with these particular families were much better than those of the triple P program that also purports to be able to support those families.

In our case, the families that accessed the pilot programs were very much self selected. We had people with very extreme behavioural difficulties. We had parents who had been mentally

unwell for many years and children with conduct disorders who ranged in age from three to about 15, I believe. There was quite a broad range of issues. When the triple P program was evaluated for the same population, it had a very limited number of people. The children, I believe, were in the age range of two to five. They were dealing with a narrower range of difficulties than we would have anticipated. Our program came out as being more successful than the triple P program.

CHAIR—When you say it came out as being more successful, was it the evaluation—

Ms Harris—Yes, the evaluation. We used a DAS score as one of the tools, which is a depression and anxiety scale. We used a range of other scores as well, but we have not had the resources to do the final analysis of the data that we have collected.

CHAIR—Have you requested that state or local government, or whoever you think appropriate, should do that work? Did they agree?

Ms Harris—No. We have had a lot of emotional support, pats on the head and encouragement from local and state government, but when it has come to funding—and we have applied to the department of families, to health and to education—we have not been successful. We have applied also to about 10 to 15 philanthropic organisations for funding. Whilst we have received little bits here and there, there has been nothing to do what is required, which is to fully evaluate the program and to develop a roll-out plan so we can get the program running not only in North Queensland but also, of course, across the state and the rest of Australia.

CHAIR—Are you able to give the committee more information about that program? It might be useful to us.

Ms Harris—I will certainly be very delighted to give the information kit we have to you.

CHAIR—Excellent. There has been quite a lot of debate about medication for young people with those kinds of disorders. The minister for health announced the other day that Ritalin would be added to the PBS list. Can you indicate whether your work resulted in less need for medication?

Ms Harris—We have not been able to make that type of analysis, but with the use of stimulate medication in children with ADD, ADHD and conduct disorders, we would anticipate that a lowering of stress in their home environments, which our program aims to do, would assist the child. Whether that would translate then into a reduction in medication is difficult to say. There is a lot of debate around the use of stimulate medications in children and whether it is of assistance. We feel that in many cases it can be useful, but certainly not in all cases.

Senator HUMPHRIES—Thank you for those comments about the programs that you have run. I was particularly interested in your comments about the rural outreach program. You mentioned that, when it was operating, you had been able to get psychiatrists to take part in it and even travel with you in different parts of Queensland. What is the availability of psychiatrists here in Cairns, for example, both in the public and the private sectors? Can you give us a picture of that?

Ms Harris—I just need to correct you. It was actually consumers of mental health services, so people who had experienced mental health services, who travelled with us rather than psychiatrists. Because I am not resident in Cairns, I cannot tell you how many psychiatrists there are in Cairns.

CHAIR—We have a request from Channel 10 and Win TV to film proceedings. Are there any problems with that from your point of view, Ms Harris and Ms Tyson?

Ms Harris—I do not have any problem at all.

CHAIR—Excellent.

Senator HUMPHRIES—I am glad you clarified that. There were no psychiatrists working with you in the rural outreach program?

Ms Harris—No, there were no psychiatrists working with us in that program. There were people who experienced mental illnesses themselves, so people with schizophrenia et cetera.

Senator HUMPHRIES—You said in your submission that you developed an outreach program in which professional mental health staff and individuals travelled throughout North Queensland. Who were the professional mental health staff?

Ms Harris—The professional staff included social workers, psychiatric nurses and psychologists doing the program at various times.

Senator HUMPHRIES—Coming back to the question of psychiatrists, we were told in both Sydney and Melbourne that approximately 95 per cent of the private sector psychiatrists in those states were to be found in the CBD of Sydney and Melbourne. We know that most of the remaining five per cent are usually in metropolitan Sydney and Melbourne. There is a very poor balance between city and country. Do you have any idea about the availability of psychiatry outside Brisbane—in Queensland's case?

Ms Harris—Perhaps I can talk just about Townsville, the area with which I am more familiar. In Townsville we have a number of private psychiatrists, the majority of whom work in the government sector but have a few hours that they put aside for private work. We have three private psychiatrists who work in the private sector full time.

Senator HUMPHRIES—Were those people available to work within your rural outreach program in terms of linking back up with people that you were dealing with outside Cairns or Townsville?

Ms Harris—We would certainly refer to those psychiatrists, both in the private and public sector, where there appeared to be an appropriate need.

Senator HUMPHRIES—I was interested in your comment about how you could effectively put a large part of the work that you were doing with people affected by mental illness into the hands of those psychologists and other professionals and the carers and supporters. Obviously that is a model that we need to explore very fully, given the unavailability of psychiatry,

particularly private psychiatry, outside the CBDs. Will the package that you are going to give us describe how that relationship with professional psychiatry works?

Ms Harris—The information package that I have here is specifically around the learners permits program. As to the provision of services in the community by people other than the medical profession, I can certainly gather up some information for you and provide that to you; that will not be hard at all.

Senator HUMPHRIES—That would be very interesting. Thank you for that. You said that you used to run programs educating people about mental illness, risk factors, stress issues and so on in 28 high schools around North Queensland mainly. That was conducted by carers and consumers, including psychologists as well?

Ms Harris—Yes.

Senator HUMPHRIES—Did you have an evaluation of how well that kind of work was received?

Ms Harris—We get evaluations of the high school program from the teachers and the pupils indicating their increase in understanding about mental health issues from before to after the lecture or information that they receive. We do not have any structure in place to measure longer term benefits from that program.

Senator HUMPHRIES—There was a program conducted in schools in the ACT about which we took evidence some time ago. It suggested that the school program they were running was good in certain respects in the education of young people but only moderately successful when it came to reducing stigma among students and fairly unsuccessful in encouraging people to seek help if they felt they might have a problem themselves. Do you have any indication of how your program dealt with those issues?

Ms Harris—We found that, in the short term, there was certainly a reduction in the stigma that young people had against mental illness. By identifying a range of people in local communities and further afield, we found that people were able to access their GP and know that he would be able to support them and provide information and assessment about their potential for having a mental illness.

With that program, the stories themselves perhaps best illustrate how it can have a positive impact on a young person. One story that immediately springs to mind is of a couple of sessions we did in a high school in Mossman, Far North Queensland. The person who was co-presenting with me at that time was a woman who had many years of substance abuse and schizophrenia. Her personal story was a major part of the program—the part that probably reduced the stigma most in the eyes of the young people. The major part of her story was about her substance abuse and her improvement since she had stopped taking illegal substances. We went back to that school 12 months later and were taken aside by one of the teachers and told how, in subsequent months, a number of the children, and one in particular, had said how they were no longer using substances because of the concerns that had been raised by this person. One particular young man said, ‘I’d never taken it, but I was offered it. I wouldn’t take it now because I am so aware

of what could potentially happen.' That is the anecdotal evidence we have. We certainly have many of those sorts of stories.

Senator HUMPHRIES—You mentioned the policy that is coming through at the moment with respect to funding of mental health services. As you put it 'large national bodies, often without experience in mental health are taking over service delivery'. What specifically is happening in Queensland in that respect? What are the large national bodies that are taking over service delivery here?

Ms Harris—The church based generic services, such as Blue Care, Anglicare or Ozcare. Whilst they have a very enviable reputation in many fields, mental health is not an area in which they have a history of working. However, what we are seeing I believe is that it is useful for governments to head in that direction when they wish to provide a state based service. Providing one state based service obviously is economically a good idea for them. However, what we see happening over time is that those services will end up not being as specialised as they were previously. Where it was a mental health family support program, it becomes a family support program that takes people who perhaps are not dealing with mental illness in their family. If it is a respite program, then the respite tends to become general respite and not specific respite for people with mental illness.

We have seen this with a program that was developed specifically to look after the needs of children of parents with a mental illness. The program was developed as a community initiative with a range of stakeholders involved, but was then taken over by a large national organisation. Initially it ran very well for four years. Changes were made in the structure of that organisation. It no longer was a separate entity; it came under a larger heading. The qualifications of the staff employed for that program were dropped and the capacity of one person to manage that program was extended so that they managed three programs. We now have a program that does not do what it originally set out to do, but it meets the needs of a whole range of people who do not have mental illness as well as a few that do.

Senator HUMPHRIES—Is that a symptom of cutting back on spending on services, do you think, or is it just that those organisations are not as sensitive to those nuances?

Ms Harris—I suspect it is both. I suspect that bigger organisations have bigger overheads and their cost cutting comes at the bottom. Small organisations have small overheads and our cost cuttings come at the top. When we are looking to save money and to manage, the last thing that we will do is cut services. The last thing that we will do, not the first, is reduce the positive impact that we can have on individuals and families.

CHAIR—You have left a lot of questions hanging in the air in terms of what is not in your submission. With respect to safe and affordable housing, what happens here when people come out of acute care? Are there places for them to go? To what extent is this a problem?

Ms Harris—In North Queensland we have acute care facilities in Cairns, Townsville and Mackay. In Townsville there are no specific transitional beds available. In Mackay we are in the process, with a number of other organisations, of opening a transitional accommodation program for people coming out of acute care. In Cairns, I am unsure and I could be corrected on this, but I do not believe that there is a facility.

When people leave acute care settings, many of them return to families. Often the families are not prepared, not educated, not trained or even informed as to how they are best able to support the person who comes out of hospital. Those who do not have family to go to often end up going into boarding houses which are totally unsuitable for people with mental illness. In this day and age they are usually discharged very quickly when the crisis is over but not when they are stabilised. We see a revolving door syndrome where people are discharged far too early for the stabilisation of their symptoms and within a short period of time become unwell again and then are readmitted to hospital. Stable, affordable accommodation seems to be one of the things that underpins recovery from mental illness. Where that is available, we see some major improvements in the whole of life expectancies of individuals.

In Townsville we have been fortunate with the Fellowship to develop two different programs. One is a residential rehabilitation and accommodation support program. It only has the capacity for four people, but those four people usually have very complex needs. Over time, all of them, without exception, improve well enough to move into their own accommodation with continuing support not from just us but often from other agencies that we have been able to have them networked into. We also have long-term housing that provides permanent accommodation for people. Because it is safe, affordable, good quality housing in areas that people enjoy living in and in decent neighbourhoods, the people in them almost invariably do incredibly well.

CHAIR—Thank you very much for your evidence, Ms Harris and Ms Tyson. Thank you for coming. We will see what we can do with the evidence you have given us about the programs that are not now being delivered. It is very important that we understand what options are not being taken up.

Ms Harris—Thank you.

[9.44 am]

MILLARD, Mr Mark William, Service Development Coordinator, Cairns Integrated Mental Health Service

CHAIR—We have had a slight change in the order of witnesses. We will fit in just a very short session. I invite Mr Millard to come to the table. Thank you for agreeing to this impromptu session for the committee. I should indicate that we had a conversation earlier about a local matter with regard to people coming out of acute care. I invite you to explain that situation to the committee.

Mr Millard—Thanks very much, Senators, and the rest of the committee. There are some documents as well which I am happy to provide to the inquiry, but obviously that will have to be after the event. In brief—and I will try to be brief—we have had a unique opportunity here in Cairns to redivert some funding from a Queensland government election commitment from what may have been—it was not well specified—additional acute style facilities to a range of community options with a local community committee. There was some significant assistance from the Mental Illness Fellowship's Victorian organisation, because they have a model similar to this working in Shepparton at the moment.

We are looking at developing a range of intensive support and rehabilitation options to help people make the transition from acute care back into a more integrated life in the community. Essentially, that is really about facilitating people's recovery processes by providing additional interim levels of support. Those levels of support are interim in the sense that they are somewhere between acute care and normal community life. For many people they involve a residential component that we will provide. They also involve interim care in the sense that we would be providing skilled and trained support but not necessarily full on clinical staff. We intend to engage with non-government organisations that can demonstrate sufficient capacity in skills and models to deliver large components of those services. We are also planning to enhance our own rehabilitation and support clinical services to work in partnership with those.

Each person receiving this service would be offered a team of people who are available to support them, including a range of non-government professionals like the people who currently work for organisations such as the Mental Illness Fellowship. We plan to offer one transitional residential which would cater for up to eight people. That would be relatively short-term stays. The average we would be aiming at would be about six weeks, but we would not kick anyone out on the day after six weeks. The aim of that place is essentially to provide a level of intensive, on the spot support to people to help them make that transition.

At the same time we support families. One of the examples we were giving in our spiel about this was that someone may need this place to stay for three or four weeks while the family is helped to adjust to the fact that this person with an illness is coming back into the home, even though they are clinically well enough to be in the community. Other options, of course, are people who have nowhere to go or people who would be in a very unsatisfactory environment, such as a crowded boarding house, overnight hostel or something like that.

I have mentioned short-term accommodation. We are also enhancing our rehabilitation options to provide a range of residential rehabilitation. We are hoping to do that in dispersed units in the community—normal units that we will buy and offer to people for periods up to two years, hoping for an average of about nine months. Those people would receive an intensive level of clinical input and also an intensive level of support from a funded, non-government partner. We are trying to provide a package of supports around people. The crisis in acute care that has been spoken about so frequently lately is also in a sense a reflection of failure of other levels of care, because people do not get to that acute care end of the spectrum unless a whole range of things have failed earlier on. We believe that the right way to address that is not by the provision of more acute care facilities or more secure facilities, but in fact to achieve more successful outcomes with people early on in their experience of illness. There is a lot of evidence internationally that suggests that that can be achieved and that it does reduce the need for acute care down the line.

If that seems reasonable as a summary, I will provide to you a business case to you that outlines the proposals in more detail. It is a unique opportunity in Cairns that has come about by a combination of political factors at a state level and some local innovators being in the right place at the right time. We are hoping that we can develop something that will shed light on these national issues.

CHAIR—Are you encountering some problems in this respect?

Mr Millard—We are. Essentially our biggest difficulty at the moment has been with the community and the Cairns city council's acceptance of the appropriateness of this kind of transitional residential in a community setting. We have just recently had an application rejected to use a particular residence. We are looking around at other options right now. We feel that, for this to be achieved, it is important that there is leadership throughout the community and an acceptance, I guess, of the appropriateness of people to receive this kind of transitional support in normal community settings. These are not people who would otherwise be in acute care; they are people who have been judged to leave acute care. They are well enough to be in the community and we are just trying to provide a better level of support—a more appropriate, and I think a more specialised, level of support. I heard what the previous submission said about the need for specialised support for people with mental health issues. That is what we are trying to provide in our community and we need support from civic leaders to achieve that.

CHAIR—It is stigma, it is fear, it is a community that does not necessarily think it wants to live alongside people with mental illness, and yet it does. Would it be fair to say that that is the case?

Mr Millard—Yes. I have had the fortunate and unfortunate experience of going door-to-door as part of our preliminary for this project to talk with residents. A lot of positive things came out of that. A lot of people said to us, 'We understand what you want to do. We understand the need for this, but we don't want it anywhere near us.' A lot of the attitudes that came out reflected misunderstanding. They reflected some of the ways that the media report and treat issues surrounding people with mental illness. They reflected fear of the unknown, fear of uncertainty. It has been a difficult exercise, but we have learned about community attitudes. There is still a lot of stigma, a lot of fear and a lot of misunderstanding out there.

CHAIR—We have to dispel some of that.

Senator HUMPHRIES—With respect to the clinical support you are hoping to provide, would that be psychologists and psychiatrists? Who would that be in terms of the clinical support you would provide through your teams?

Mr Millard—In the proposal for the project, we intended to provide access to a full multidisciplinary team. People receiving the service would receive clinical case management, but it would be mobile and on an as needs basis. They would have access to a case manager who would be a mental health clinician. The whole clinical process would be overviewed by a consultant psychiatrist who would be the head of that team.

Senator HUMPHRIES—Do you have people lined up to do that job?

Mr Millard—Yes, we do. In the plan we are developing, we will enhance an existing intensive support team to provide a broader level of input. Significantly, we are planning to fund a major non-government organisation to also work with that team around people—so they will be getting a range of supports. We are hoping that we will be there as providers of intensive and appropriate clinical service, but we will not be dominating the whole picture, if you like. There will be this other level of support around people to help them do the every day things that are involved in getting your life back together.

Senator HUMPHRIES—Have you or your organisation provided this kind of support or project before?

Mr Millard—Our intensive clinical teams have attempted to do this before. They have tended to be swamped by both demand and the lack of additional resources. Having a residential component is often an issue. It is very difficult to work with someone on a rehabilitation plan. They may be living in a crisis hostel where they get kicked out every day and have to live in the parks and come back at 8 pm for their evening meal and a bed. They may not have a hostel at all; they may be living in the park. We have tried to do this before, but the difference now is that we are engaging a major NGO to provide what is generally called psychosocial rehabilitation services which should, in theory, allow for a much more intensive level of support around a person and allow us to focus on the clinical work and integrate that, if you like, with the more social aspects of rehabilitation.

Senator HUMPHRIES—We wish you all the best in that endeavour.

Mr Millard—Thanks very much, Senator.

CHAIR—Very worthy indeed. Thank you very much for appearing.

[9.55 am]

JOHNSTONE, Dr Julie, Private capacity

CHAIR—I now welcome Dr Julie Johnstone. Thank you for your indulgence, Dr Johnstone. The committee has your submission which it has numbered 4, so that means you got it in very early. Thank you for that. Are there any changes or additions you want to make to that document at this stage?

Dr Johnstone—No.

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

Dr Johnstone—Thank you for this opportunity for me to appear before you today. It is a great sense of relief to me that this commission has been appointed as what I witnessed as a trainee nurse doing stints in psychiatric wards deeply disturbed me. I felt personally responsible to address the ethics of practice in a deep, practical and constructive way. I undertook this task over five years as research for my PhD.

I want to raise with you briefly today three questions that I addressed in that research: what are the problems consumers identify in psychiatric services? What accounts for these problems? How might these problems be addressed? The problems consumers identify in psychiatric services are the way patients are treated. There are problems with service provision, as you have heard from lots of people over the time you have been doing this. People such as David Webb, Merinda Epstein, Cath Roper and others such as Isabell Collins, Keir Saltmarsh and Dr Robinson provided you with some insights into the problems of accessing and receiving mental health services from the patients' point of view. These accounts on their own do not adequately portray the systemic and institutionalised discrimination, stigma and abuse which consumers of psychiatric services experience.

Research indicates that consumers experience more stigma and discrimination from professionals in psychiatric services than from anywhere else in society. The negative attitude and stigmatising judgment that accompanies being diagnosed as mentally ill presumes incompetence and treatment is delivered coercively. Such a treatment culture is itself problematic in that it fails to regard the patient as a person.

What explains the present problems, the three sites of confusion? The way that patients are treated begs the question of how patients are conceptualised in psychiatric services. The question is not addressed directly in psychiatry, but it is a product of the theory and methods the professionals utilise. Psychiatric theory and practice rely on diagnosis to explain psychiatric problems. A consequence of this reliance on diagnosis is a methodological confusion, in that the patients themselves are objectified as pathological. This means that the subject is mistaken for an object.

The lack of a method for understanding means that the failure to recognise the patient as a person occurs twice: first, if the person's problems and concerns as they themselves see them are not taken or recognised and, secondly, through the medicalisation of a person as a mental disorder. This process means that the person is erased and overwritten as a mental disorder and as such eliminated as a legitimate human being. The shift from being a legitimate human being to being diagnosed is important as this is the site where the person is lost. It seems that the person is the diagnosis in the eyes of the clinician, of mental health services, of the public and in their own eyes.

Systemic confusion is also evident in one's professional identity, which blinds one to the limitations of the perspective that it offers and that it might impose on those subjected to it. This confusion means there is a reversal of responsibility. Instead of gaining insight and understanding into their patients' distress, professionals demand that their patients view their symptoms in terms of the professional perspective. This is in addition to the complete loss of power for those subjected to the total authority invested in mental health professionals for the provision of care. Confusion is also evident in the contradiction of care and control central to the crisis in psychiatry internationally. The concept of risk classification has become the means by which professionals justify their decisions. Risk provides little understanding about the meanings and significance patients themselves give to their illnesses.

The solution is understanding and respect. For psychiatric patients to be treated as persons, a reconceptualisation of the patient is required. It is only when consumers are recognised as legitimate subjects with legitimate voices that there is a possibility that the demand for respect will be met. Legitimacy is available through understanding. Understanding requires listening for the meanings and significance that a situation has for a person. The failure to listen is experienced as a failure of respect. That is because a person's identity is embedded in a narrative. It is through narrative that we place ourselves morally and ethically in the world. It is the narrative identity that provides an ethical and moral frame for the interpretation of the self, and this informs self-esteem. This is true for consumers, professionals and all of us.

The importance of the narrative method is in the recognition of the ethical subject. The conception of the ethical subject legitimates and supports the consumer movement's demand to be listened to. The concept of the subject as a narrative identity as opposed to a diagnostic identity is not to do with listening to the narrative as such, because people may not be articulating that, but is to do with providing recognition for the subject as a legal, ethical and social subject, which is how a person develops a sense of self-respect.

Failing to listen denies the benefits available for both parties, as it is in listening to one's account of weakness—or just being with that—that reserves of great strength are revealed. The ethical encounter is where the human spirit or subjectivity is revealed; it is in the face-to-face relationship, the space of subjectivity, where something is possible—something unexpected, creative and transforming for the person. The self-esteem available for both consumers and professionals alike in this model of understanding requires professionals to be prepared to relate with an empathetic attitude, where the other is as esteemed as oneself.

This model of care presumes equity and provides a framework for understanding behaviour that would otherwise seem bizarre. These skills and core competencies address the confusion about the values, attitudes and skills required to work in mental health. Developing these skills

in collaboration with consumers has the potential to provide a new direction for service standards, qualities and outcomes in mental health internationally.

In conclusion, there is a conflict of interest in psychiatry. Acutely distressed persons want to be heard and listened to, so that what they say may be taken not as a form or a symptom to be diagnosed but as an account of a person. Consumers themselves say that healing comes through the telling of the story. This research has highlighted that the failure to listen to patients constitutes a failure to provide ethical services. Conversely, the recognition of the patient as a narrative subject in acute psychiatric services would provide an ethical response to the demands of the consumer movement. This ethic would require the introduction of the practice of listening to consumers as the means to recognise the ethical, legal and social subject. The narrative method offers the possibility of transformation for the patient, the profession and the service, but such methodologies are insufficient in themselves. The recognition requires a professional commitment to a practice in which psychiatric patients are regarded with respect. Only then is there the possibility of transformation, not only of the person in receipt of services, but of the culture of service delivery as well. Thank you.

CHAIR—Thank you very much. The committee has heard from a lot of consumers and it has heard about consumer issues. We heard, psychiatrists in Sydney, I think, saying that we should not be too reliant on consumer views and so on, so I think we are immersed in this argument about the importance or otherwise of consumers in the delivery of services, and your evidence is very useful to us in that respect. But, if I may make a comment, it draws on studies and work that has been done years ago. A lot of it comes from Victoria—presumably you were in Victoria at some stage. How is it that this has taken so long to penetrate the thinking of those who deliver mental health services?

Dr Johnstone—I do not think it has yet. I think it is in the first and second and not even quite the third National Mental Health Strategy, but it has not broken through in practice. It has, in that there are consumer consultants on wards, but it has not radicalised things. The service model of provision is still the same. Talking about that acute care model, patients say they are harmed by that. So we can say that these people are mentally ill and we do not take what they are saying too seriously, but we have done that and it is counterproductive for everybody to not actually take that seriously. That is what I attempted to do, but then where do you go with that? It is a matter of making a change in service delivery.

I have really been very encouraged by lots of the presentations that have talked about the need for community preventative strategy, and I think that is the way to go ultimately. I think there needs to be a radicalisation of what service provision in acute care is about. I listened to Dr Robinson talk the other day about the crisis in accident and emergency, and these kinds of issues are relevant. Ideally, the clinical model—the acute model—could be a place where people in a crisis are given support—but in a much more therapeutic way. She even mentioned how, when people are brought into the hospital, straightaway there is a change. That is the thing: it is our attitude. We can create the frame. An ambulance officer I know from Melbourne talked about how he would pick up someone with a mental illness to take them to the hospital and, although the guy would be absolutely fine, there would be 10 people waiting to jump on him when they got there. He said, ‘I was afraid. How was this guy feeling?’ It is the attitude that we have. We have to set up frames.

There is another example, in the US. An institution there was closed down because they were using so many coercive measures that they got into trouble because they had harmed people. Following legal proceedings and things, they were shut down, so they had to revolutionise their way of approach. They had to do something, so out of necessity they completely changed the way they approached things. They were providing the same service, but it was the way they did it. This is the same. We can offer people support in acute phases, but it is how we do it. It is the attitude that we bring that creates the space. We are responsible for creating a space where people feel safe, people who are in a crisis or already not managing how they are feeling and coping. We are not doing any better, with the way that we are jumping on people—that is literally what happens. I am sure you have heard that from people.

I really wish you could have spoken with Jon Kroschel, one of the consumers that I spoke to over five years ago. Jon is doing fantastically. He is doing innovative things at the Alfred Hospital in Melbourne. He is the director of participatory action and social research there, and he has just plodded along, doing his thing with commitment. He said, 'If you complained or said, "I feel this way or that", you know, you'd be jumped on, injected and stripped.' That is the reaction. You could not say, 'I'm feeling like this.' There is no recognition of normality in acute care, because there is a defensiveness and a fear.

In a professional setting, people need to be skilled in order to be at ease with their own reactions to things. Both parties need supporting, and that is just how it is. Even from the research that has been done on nursing, there is a fear of hearing stories, because they are about abuse. What do you do with that? It brings up people's own issues, so you then have two people not coping—this is what is happening—so there is a withdrawal from people, because no one is skilled to deal with what is coming out.

There is a section in my research, at the end of the eighth chapter about social recognition, and it looks at the issues that are about abuse. There is lots and lots of evidence that those people with so-called 'untreatable mental illness' have been abused, and there is no facility to deal with that. This is why it is so frustrating; we say it is mental illness, but when they have come out of it—and who knows what has gone on—people do not have a voice. These are things that people do not talk about. They are shameful. You do not speak about them. People manifest them through not coping, and then they are not given any support because everyone is too afraid to deal with the critical issues.

CHAIR—In fact, you could go back to the childhood of a lot of people with mental illness. The committee has heard evidence about the numbers of people abused as children and the number—

Dr Johnstone—Absolutely.

CHAIR—There is that lack of respect. Even if you are brought up, as we heard from some witnesses the other day, in institutional care, or if you are, in some circumstances, fostered out, that lack of respect can stem from a very early age.

Dr Johnstone—Absolutely. And then the same kinds of abuses happen in psychiatric hospitals. Again, people take that on in a very personal sense, thinking, 'I'm not worth anything,'

so nothing positive can come out of that unless there is a new experience so that people can step into who they are.

Senator HUMPHRIES—You got your doctorate in 2002, is that right?

Dr Johnstone—I handed in my doctorate in 2002; I actually graduated in 2003.

Senator HUMPHRIES—Have you practised in psychiatry since that time, or are you still studying?

Dr Johnstone—I am in Weipa at the moment, and I have been nursing in the hospital. But there are no mental health services up there, so I have been doing lots and lots of counselling with people and having great responses from people. Also there is an Indigenous youth hostel up there. All the Indigenous youth who want to attend school stay at this hostel, and there are lots of crises there, because they have all come from remote places. I have been working with those students, and I have seen miracles happen in their lives.

Senator HUMPHRIES—You have been working as what—as a psychiatric—

Dr Johnstone—As a counsellor/consultant/psychologist, yes.

Senator HUMPHRIES—I am asking those questions, because you are presenting a view about psychiatry particularly which is fairly radical. It is very different from the mainstream, and I have a lot of problems with the way mainstream psychiatry has dealt with the issue of mental illness, and I suspect that is really very much at the heart of the issues we are looking at here. I am trying to understand what it is that leads to that failure among psychiatrists to listen to the narrative. Would you see the training of psychiatrists as the major problem, or is there a culture of psychiatry which leads to this sort of failure to understand the complete person that they are dealing with?

Dr Johnstone—For me, seeing it as I did, as a trainee, I was so disturbed that it kind of changed me. I felt, 'I have to understand this and do something about it.' So that is where I went in my research. I actually looked at what consumers were saying. Then I looked at psychiatric theory, practice and policy, at the law, at critics, at RD Laing's incredible work, at what I thought was missing and then at what I think needed to happen. There are two chapters—chapter 2 is theory and chapter 3 is practice—where I try to get an understanding of where it came from.

There are three confusions that kind of came together for this paper. Methodologically, there is a problem, in that there is only one method in psychiatry: that is, that there is a reliance on diagnosis. That is because of two other things, but it is much bigger. It is in terms of the role that they fit into, and I have addressed that in terms of a government role that psychiatry has become part of. That is addressed as well in the policy chapter.

Method is one element. There is only one method, and it is explanation; there is no method of understanding. There is confusion: what happens for professionals is their professional identity limits them and stops them from seeing the limits of their own point of view. That is why I say there is confusion. They expect the patients to have insight into their professional perspectives, which is a complete reversal of their responsibilities. How come they expect the patient to

understand psychiatric diagnosis but they do not try to understand the patient themselves? The third thing is the whole concept of risk, where the psychiatrists' decisions have become about risk, so that justifies their decisions and what they do. The lack of a method involving understanding means that the person is not considered equal. Anyone who comes in is considered incompetent. There is this kind of attitude that you are not quite a total human being. There is a lack of respect.

Senator HUMPHRIES—I am trying to put myself in the shoes of a psychiatrist who is dealing with that situation and is trying to understand what goes on and I am trying to understand why they might not listen to that narrative. I suppose one perspective is that they would deal with people who are, at one extreme, completely psychotic and unable to have a narrative that is understandable—

Dr Johnstone—Yes, and that is the case—

Senator HUMPHRIES—But their work would take them through to people who are ill and who are quite manipulative and whose narratives can be quite self serving and designed to draw the doctor in, in a way that is meant to entrap them.

Dr Johnstone—Even that is a demonstration of a need. The point is to read under that, if you know what I mean. That is the skill you are meant to bring to the task. My research refers in a very practical sense to what happens. The psychiatrist makes the judgment in a matter of seconds, and he spends the next five or 10 minutes with the person finding evidence to support his decision so that he can write it up in a professional way, and that is what he does.

Senator HUMPHRIES—Why do you say that? Is that your observation of what happens?

Dr Johnstone—No, that is from my study. I have studied everything. That is what I was doing. I was trying to find out what was going on. That even comes from accounts of doctors themselves. Support for what I am saying, where I get it and who said it is all there in chapter 3.

Senator HUMPHRIES—I suppose there is very little we can say in defence of a psychiatrist that does that; unless they are extremely good, they are obviously—

Dr Johnstone—But that is how they think. It is a way of thinking. It is not something that would justify a defence. That is how they function as professionals; that is how they think. That is the job they are given to do. They are given the task of diagnosing people. That is the responsibility of the state. Treatment is meant to follow diagnosis, so without a diagnosis there is no approach available. The trouble is that it becomes about the diagnosis instead of being about what precipitated this situation. That is the problem. Our whole service system is about attempting to respond to this add-on which comes with a whole lot of other burdens, but it adds on to the burdens that are already there. Nobody benefits out of it, apart from the fact that it does give a handle to those who can cope with putting that diagnosis into perspective. But for people who already have no reserves that just becomes another mountain.

Senator HUMPHRIES—Would you see this problem—with psychiatrists taking this approach which is not sensitive and does not put respect for the person at the centre of the

paradigm that they are using—as a problem that then filters down to other workers within the system?

Dr Johnstone—Yes.

Senator HUMPHRIES—I am thinking particularly about psych nurses on a ward who call the guys with muscle to put someone who is behaving a bit strangely in the time-out room or whatever. Are they inheriting that sort of extremely suspicious precautionary approach: 'If there is anything wrong, let us deal with it in a coercive way'? Is that the problem, or is there also a separate culture within psychiatric nursing which is a problem?

Dr Johnstone—It is the same culture. That is the problem. It is the same model, you see. It is a medical model used by both professions, which are allied, so therein is the problem.

Senator HUMPHRIES—You paint a fairly grim picture of what goes on in Victoria. You point out that Victoria has the highest rates of those with psychosis experiencing marginalisation or homelessness, and you refer to things like their having 29 per cent fewer inpatient beds than the national average.

Dr Johnstone—I only mentioned that because they were skiting. I wanted to point out that there is another side to this.

Senator HUMPHRIES—We heard lots about skiting in Victoria when we were there. You say that is a myth, that we should dismiss treating Victoria as a place where leadership is being shown in mental illness treatment?

Dr Johnstone—It confuses me, because there is all this leadership but it is going nowhere in terms of revolutionising the service itself. I would love to talk with you about the whole thing. Rather than having funding in one place, I would like to just pull it all out and spread it right over the community. The contributions from Hume and Port Phillip show fantastically innovative work. If we put all the resources in various things and then supported people who needed support, that would make a difference. Consumers talked about the need for respite and true asylum, and it was just like, 'That is what people want—somewhere safe and nourishing.' If we could have places that were truly like that available across the nation, so that when people got into a crisis there was a place to ground themselves, with the kind of support that was being talked about just before—all that support—it would be great. We need to spread all the resources right across the community so that people do not get into this state and so that there are places for people to go, no matter what their issues, to get support.

I do not care about the level of registration that psychologists possess. There is research about unregistered psychologists that I will not go into now, as it is beside the point, but just talking to someone is so healing. You do not need to be registered. That is a terrible thing to say, in terms of professional registration, but at the same time, let's get real. The other thing about mental illness is that we talk about it as if it is a couple of people over there. Look at the stats: it is everybody. It is not just a few over there, it is everybody! What are we talking about? How are we fooling ourselves? What are we so afraid of? Ourselves!

Senator HUMPHRIES—I had better shut up while I am ahead, in that case.

CHAIR—Perhaps by the end of this, Senator Humphries, we will be talking about ourselves.

Dr Johnstone—No, but you know what I am saying—that it is not limited to a select few who are no good. The other thing is that it is about the model. We talk about this model; it is the model that is wrong. We have the drug and alcohol social model, and people understand drug and alcohol from that. It is no different with mental illness, and that is where we have become all mixed up, because we want to call it just medical. The argument has been that then people will not be stigmatised. That is actually not the case. There is research that the opposite is true. If it is biological, you have no hope. There are some fantastic quotes from Fancher in my research about that; he puts it so incredibly that there is just no hope if it is in your genes. It is not the case—it is a little bit, but there is lifestyle. You have heard about the levels of abuse. I spent most of my time crying while writing my research because I was listening to stories of abused people.

I did another research project before this one, looking at women who were considered mentally ill. Every single one of them said they had been abused, and nobody had listened to them. They started having what was considered mental illness—they were having flashbacks and crises. Something had happened in their life, and something had triggered the re-emergence of their experience. They were in crisis, and they were called mentally ill. They were put into hospital and locked up. Sometimes something else had happened, because there is violence, trauma and abuse in the service itself, and nothing is dealt with.

CHAIR—Yesterday's evidence from the Sisters Inside, including from a woman who had spent some time in a closed unit in a prison in, I think, Brisbane, brought us pretty much to tears too, so you might find that interesting reading.

Dr Johnstone—They put people in isolation rooms, and then they head bang. They are so distressed by it that they bang their heads, but still no one questions the practice. There is some relevant evidence in chapter 8, in that last section on social recognition, where people talk about a very practical part of the two issues in this. They say that the worst thing you can do for people who are in that state is to isolate them, and that is what we do as standard practice. When does someone question this? When do our practices come under question? Now. A new model is needed. I am not saying that the psychiatrists' model does not have a place. Let them do their job, but do not leave that on its own. Introduce, alongside it, this supportive and listening model, and do not let the attitude of this current practice continue. It has to stop.

CHAIR—Dr Johnstone, we will have to leave it there, thank you very much. It has been a very interesting and useful submission that you have made to us.

Dr Johnstone—Thank you.

CHAIR—Thank you again for doing that.

Proceedings suspended from 10.27 am to 10.49 am

O'TOOLE, Ms Catherine, Manager, Advance Employment Inc.

CHAIR—I welcome Ms O'Toole to this committee hearing. The committee has not received a submission from you. Thank you for appearing nonetheless. Could you make a brief opening statement after which we will go to questions.

Ms O'Toole—Advance Employment is a community based organisation funded by the Department of Employment and Workplace Relations. Our role is to promote, encourage, assist and support job seekers to improve their mental health in order to achieve meaningful, open employment through employment related opportunities. The points I intend to raise this morning are related to the achievement of open and meaningful employment for people with poor mental health. The philosophy behind Advance Employment has changed in the last 2½ years and just grown and moved from where it had come from. In the last 12 months, we have been actively, systematically and very consciously removing the words 'illness' and 'disability' from our language.

It is my opinion that the meaning of open employment is not widely understood within the community and mental health services in Queensland. What I see is a service based on a medical model relying on drugs alone to bring about change in the individual's life and this simply is not working. This is probably clearly substantiated by studies that show that by the year 2020 mental health services will be eating the largest part of the mental health budget. Why we continue to use the same practices when we do not get good outcomes is a question that I find intriguing.

I am very honoured to be invited to speak here today because Advance Employment is a very small organisation. We have four full-time staff and two part-time staff. It is really pleasing that we have been given the opportunity to speak. I would hope to see this inquiry as inciting some form of revolution within the mental health sector as opposed to a bandaid approach.

There are a few points I would like to raise. The first is the issue of language. The negative use of language in the system—that is, mental illness and disability—are very negative and infer that a person is unable to work successfully as he/she is sick or incapable, whereas my experience has been quite the opposite. The use of positive language assists in stimulating a feeling of ability, not disability; a feeling of worth, not unworthiness; a feeling of self-belief rather than uselessness. The focus needs to be shifted from an illness perspective to that of living a life where one achieves the optimum level of mental health in order to live a meaningful life, of which employment is a large component. I believe it is fair to argue that drugs alone will not and do not bring about this change.

I now wish to speak on medication. Many of the job seekers that I work with are, I believe, seriously overmedicated, which does keep them docile and able to be controlled, but makes achieving open employment very difficult. Surely this is not what life is about. Doctors and allied health professionals need to understand the connection between medication, if it must be used, and the person's ability and right to work.

I believe that the role of the Queensland government integrated mental health services in the Townsville region where we work is to assist people to live effective and meaningful lives in the

community. Therefore it is crucial that the services offered are tailor-made to achieve this aim. Effective and meaningful lives are created in a major way by inclusion in the labour market. Whether we agree philosophically or not, that is definitely how our society is structured.

Many people who have been receiving mental health services have not worked for very long periods of time or may have never worked. In the last 2½ years a lower age group of people have been using our services, which is a worry in itself. When you have people who have not worked for large periods of time or have not worked at all, it is very important that a certain focus of service delivery is taken. This is particularly relevant given the current Welfare to Work budget. People delivering mental health services need to genuinely believe that their clients are capable of and deserve a better life and as such offer a service that concentrates on the following issues and not just a medication regime: activities that foster and develop self-esteem and self-belief; regular and ongoing reality checks, including the development of goals and objectives; education on how to make informed choices and decisions; and to think and behave differently. If we think the same way, we operate in the same manner—nothing changes. People need to learn how to take responsibility for their own life. It is a common belief that people with mental health problems cannot or are not capable of taking responsibility for their lives. However, I believe that maybe it was because they did not take responsibility for their lives in the first place that may have contributed to their mental health state. This is a view that I have also noted in reading books written by Dr William Glasser. These people need to establish and maintain appropriate diet, exercise, sleep/rest patterns, including the appropriate timing of medication and learn to live in a clean and safe environment. Some people who have been living in institutions for some time have not learned basic life skills. These skills need to be learned.

In terms of the Welfare to Work budget, I find the ideology behind the document is reasonably sound but I am just concerned at the level of thought that may have gone into how this may be achieved, particularly in the case of people who are on the disability pension and are now being significantly moved to Newstart payments. The outcome for us and how that impacts on us as an agency that is required to deliver employment services for people on the disability support pension or people on Newstart is quite significant. Whilst people are being asked to go back into the workplace, the federal government has capped our numbers. These people will then be pushed, and I say 'pushed' quite meaningfully, into Job Network agencies who do not have the expertise to work with people with mental health issues or even people with other disability types.

One would imagine that one of the key areas, living in Townsville, which is fundamentally a large government employment based city, would be that we would have opportunities to get jobs for people in the government sector. I can assure you that this is not the case. For us to get employment in the government sector for our clients is near impossible. Our employment comes from the private sector. Maybe it is time to introduce a positive discrimination for people with disabilities. This has been done for women and Indigenous people and works successfully.

Housing is an issue. When a person is trying to achieve open and meaningful employment, living in a boarding house is not in any way conducive to achieving an employment outcome. The people that I see go there have generally just come out of hospital, as previous witnesses have said. They may have dual diagnosis or drug and alcohol problems. They go into a boarding house and the predators are there waiting on the steps when they get there, which I think is very sad.

I hear people from Queensland Health talking about why things cannot be done—'We do not have enough money' or 'We do not have enough staff'—and I just get a bit tired of it. Maybe this is about being more creative with the money that we do have. Maybe this is about looking at how we do things differently. I believe, deep down, that the issue is walking alongside the person who has a mental health issue, listening to what they have to say, identifying the barriers for employment and then working with that person to put strategies in place to overcome the barriers.

Our agency is capped at 78 in Thuringowa, a town of the size and population of Townsville—a drop in a very large pond. I consistently have a waiting list of 25 to 30 people. It is soul destroying for me because, for a number of people that come along, their needs are so great initially. Open employment down the track is definitely possible, but we do not receive enough funding to allow us to put the programs in place to assist these people to get to that place. One of the things this committee might consider is that mental health does not discriminate. Every single one of us at some stage in our life will have mental health issues.

I talk about mental health as opposed to mental illness, and I feel very strongly about this. Our organisation recently this year had a review from a private organisation. We are accredited against the 12 disability standards. An independent auditor came in May this year and audited us with our clients against every standard. Probably the standard that sits dear to my heart is valued status, standard 6. When these audits are carried out, they write verbatim what people say, and these are just some comments that people have made:

> Getting a job has given me confidence I never had before. People here value what you are. They treat people with so much dignity, I notice how they treat people with really serious conditions, much more serious than mine, they treat everyone with the same care.

Our job seekers make these comments about our staff. I am very proud of that, and as an organisation, I think we should be; that is what we strive to do. Out of the 78 clients currently on our books, 85 per cent of those are working. The client base that we have consists of people who have numerous diagnoses. I sometimes wonder whether it is just give them all the diagnoses and hope that we will hit the base somewhere. We have people with schizophrenia, bipolar, major depression, post-traumatic stress disorder, borderline personality disorder—a number of those things. As an agency, we are not terribly concerned with their diagnosis. As an agency, we are concerned about how we can get this person from where they are now to where they want to be, and employment is definitely a key in any recovery process. Recovery is ongoing; life is a journey. I guess, for us, the benefit of our organisation is that we support people. We not only get them a job but also we stay working with them until, hopefully, we get them to a point of independent where they can move on and look after themselves in employment. Just for clarification, open employment means that our job seekers apply for any job that any of us could apply for, assuming they have the knowledge, skills, abilities and attitudes to do the job. It is a very competitive marketplace out there.

One thing we have tapped into, or tried very desperately to tap into, is the DEWR Employment Innovation Fund. I am trying to get some money to set up an integrated team approach with Queensland Health professionals, and I have the support of the director of integrated community mental health services in Townsville. We are trying to ensure that employment is put on the agenda very early in the piece. Just because somebody has a crisis in

their life does not mean that they are on a death sentence and they will never work again. If employment is not talked about, if it is not given some attention in the planning and goal setting, then from my experience it does not get raised, and with some of the clients I have dealt with, that has been 20 years. We currently have a man working who has not worked for 20 years, and he is now working very successfully with our support. Unfortunately for this poor man, who is now in his fifties, he was a qualified tradesperson but he has lost those skills. We are working with him on building those up. Yes, he does have some unusual behaviours and he does say some unusual things, but don't we all? He is a very valued employee. We have an employer in Townsville who has a pool business, and he employs four of our job seekers. He has commented publicly in our newsletter that his productivity has increased since our job seekers have been with him. They do not take sick leave; they value the opportunity of a job, and they take it seriously. They are not looking to get a job today, leave tomorrow and get another job; they are looking for some security in the employment market.

I see that we are a very small cog in a very big wheel, but I think we are playing one of the major roles because society values people who work, and people who work value themselves. This is an issue that needs to be addressed. Primarily, if I can say anything, I ask: why are we capped?

CHAIR—Thank you so much. With respect to the value standard that you are so proud of, would it be fair to say that you get those comments because people's experiences in mental health services show that they are not valued? Our previous witness talked about this at some length. Do they share with you their dissatisfaction with the services they have had in this respect?

Ms O'Toole—They do, and we have direct connection with the services because, as I said, the job seekers who come to us are people who do not have family support. They are in the mental health system. They are case managed, which is a term I hate. When we can get their case manager involved, and if they are a person who genuinely believes that this person can achieve, we have great success. I can only really quote one great story there, but at least I have one. When we cannot get those people involved, yes, it is difficult. For example, I had a man the other day who is in his fifties and is a recovered alcoholic. He has lived on the streets, he has a had a life you would not want. We have just got him into work, and he actually gave us the job lead, which was even better. We went around and got him a job, and I asked the case manager if he would assist us in getting him to and from work—no, he would not have time! We are a small agency of just six people, including two part time: we can do it, why can't he? He is in a big government organisation. Yes, I do hear that. I hear people say, 'They don't help me.' I hear people who say they really value working with their case manager, but they are few and far between. They are always busy; well, aren't we all? Our job seekers talk about the fact that they feel like numbers or objects. I say that we are working with people, and people cannot be pushed around. People cannot be categorised as one size fits all. It simply does not work that way. Unfortunately that is the approach that has been taken with our funding regime at the moment.

CHAIR—Let us talk about that. How is the cap of 78 derived?

Ms O'Toole—It was derived from the 2002 statistics. We have to do statistics. We were with the Department of Family and Community Services, and we do extensive paperwork in the gathering of data. Whatever numbers were on our books at that time, they did an average and

said, 'That is how many clients you can have.' Prior to this capping, we were on what was called block grant funding, so we received X amount of dollars every year. Our organisation was established in 1996, but we have not had a one cent increase until now. We have just finished block grant in June this year, and our money did not increase by one cent. Wages increase every year, the cost of living increases every year, overheads of running an organisation increase every year. We are now on what is called a case based funding model with which I do not have any serious problems. We are funded on the needs of the individual. As long as there is some flexibility when people deteriorate so that we can get more money to keep them buoyant and balanced and in work, but that remains to be seen just how well that will work. That is just a figure that has been plucked from somewhere.

CHAIR—This funding system seems to me to encourage you to drop off support for people perhaps too early. Let me see if I understand how it works. You have the 78 people on your books, and as soon as they are deemed to be independent, which may be after they have had a job for two or three years—would that be fair—

Ms O'Toole—Yes, we have 18 months to get the person a job, so they come in, register, and they are with us for 18 months. If they do not have a job the government will exit them. If we think that within six months we can get them a job, we can keep them with no funding.

Senator HUMPHRIES—After that 18 months, do you mean?

Ms O'Toole—Yes. We are paid 10 payments in 18 months. The belief is that those 10 payments cover 18 months of service. It does not, but anyway, that aside, when the 18 months is up, if they do not have a job, they have to go or we demonstrate that we can get them a job within six months—

CHAIR—If you get them a job in the first couple of weeks, can you then use that funding to support them in their workplace?

Ms O'Toole—Yes, we can. We keep them going until 12 months. In the 18-month period, if they have demonstrated 26 weeks of work, then they can stay with the agency and then we do a claim for disability maintenance funding. At this point, that is for however long it takes.

CHAIR—What is the average? What is the typical length of time that support is needed, both for getting a job and supporting in that workplace?

Ms O'Toole—We would see our clients weekly, on average, early on in the piece, for one hour or may be a little bit more. We have a very personalised approach. It is a very holistic approach. We look at social behavioural problems. We look at cognitive areas, like how they learn, and what sort of assistance they need to learn new tasks. We look at physical disabilities or needs that people may have. Then we look at the special assistance. We provide what is termed non-clinical counselling, which is just about talking to people and getting to know where they are at and what they need. We give them strategies to assist. Once they are employed, it really depends. We have one guy whose employment consultant would work with him for anything up to three hours a week but not on the job. We disclose, but he contacts her very regularly, and he is a great worker. If he did not have the employment consultant to work with, I doubt that he would maintain his employment as well as he does. But he is very capable.

CHAIR—Governments are not known for signing open-ended cheques for services. You have 25 or so people on your waiting list; what sort of arrangement do you think would be better than the one you have to allow you to reach all of those people that you need to, but not building, if you like, an unnecessary cost into the system? How should the Commonwealth do this differently to make sure there is no waste in the system?

Ms O'Toole—I guess one of the issues is the job preparation or the job readiness side of things. With my current list, I have very needy people. I would like funding to allow us to run a program for which I sought funding from the state government last year. We ran what we called a vocational skills development course, and in that looked at things like communication skills, problem solving and goal setting, and we did a people skills program. It covers resume development, but we do that aside anyway. Looking at my current list, if I had the funds to run that, by the time those people were ready to come online, it would be much easier to get them work. Even in that process, in doing that course, I could get them out job searching and working with someone. It is not that I cannot run it, I just do not have anyone to run it because I cannot afford to pay anyone to run it, and it is not expensive. An amount of $30,000 would cover that for one year, and I could run several of those programs in one year.

CHAIR—Let us press this point a bit more. How would you develop a formula or an arrangement with you that would be acceptable to governments and make some sense, so that you do not have those people on the waiting list when you could be providing them with services and getting them employed? Like any other agency, the Commonwealth will not give you whatever money you say you need. How do you develop a system where you can cope with that?

Ms O'Toole—I could demonstrate quite clearly over the past 12 months what our waiting list has been. I could demonstrate clearly enough that we could have our outlet capacity increased from 78 to, say, 98, because I have had a consistent waiting list.

CHAIR—You think that is what you ought to be able to do?

Ms O'Toole—Well, if we can demonstrate it, yes, I think that is fair and reasonable. That allows another employment consultant to be employed to look after those people. I realise that there is not a bottomless pit of funds, but if you look a little deeper into the welfare to work budget, what is proposed there is when we cannot take them, they will go to Job Network, but they are not necessarily the people with the expertise to deal with those clients. The other issue is that we are accountable and must be accredited against the disability standards; they are not.

CHAIR—Job Network is not?

Ms O'Toole—No, they are not. I am not saying that there are bad people in Job Network. There are some very good people in there, but they are coming to us to get us to run disability awareness training for them, which is fine, and I am happy to do it, it is a fee for service basis, but they are saying at the end of the day we do not want to work with these people, particularly our clients. It is about the fear; they do not understand that we are talking about people. They are fearful of what might happen. These are cultural values and belief systems, and it is very hard to change.

CHAIR—It is very interesting that you say you are not interested in the illness or disorder as such, and that you treat everybody the same. Nonetheless, is it more difficult to place people with those low prevalence mental illnesses: schizophrenia, bipolar and so on? Do you find that placements are of shorter duration or that there are greater difficulties with those clients?

Ms O'Toole—On the surface I will say no, because our focus is about what a person can do, not what they cannot do. Our marketing is not about medical terms; our marketing is about this person may become anxious in a new situation. This person may become withdrawn if they are starting to become unwell; we learn to read the symptoms. So we care very careful about the language we use. We are about promoting the skill base, and we know that our agency must maintain its credibility. We do not want to set up our clients to fail. Our marketing is clearly about what demonstrable skills they have. We have job seekers in our organisation who have all but got a PhD or have had a PhD in physics, engineering, to teachers, labourers, gardeners and that sort of thing, and a whole range of occupations in the middle. As I said, mental health does not discriminate. I guess the problem with the people that come to us is that they do not have meaningful relationships in their life. They do not have people standing beside them. No, I do not find that.

CHAIR—Your agency is something of a substitute for them in many instances?

Ms O'Toole—I suppose it is. We care, and we believe in our people. We believe that they can do what they want to do. I had a woman who came to me once and said, 'I am looking for a cleaning job'. She happened to have her resume with her, and she had university qualifications. She was an Indigenous person, and I said, 'I think you're going to be bored.' She said, 'No, I don't want anything with responsibility'. Well, she is now working in a government position. I did not go down the cleaning road. She was absolutely terrified, and with the right support and the talk with her and the building of her confidence and the belief in her, within three months she was working in a government department doing an excellent job. That is the stuff people need. I have a young fellow who is 34 and has never worked in his life. He is sleeping half of his life away. Why is he doing that? He is over-medicated to death. He has never learned to take responsibility for his life. When he was in the acute unit, the doctors told his parents that that was as good as it got, and he was a zombie then. He is a bit better now, but that is not as good as it gets. This boy has done university studies. He did not finish his course, but he has a brain. He is a very intelligent young man, but he needs to learn to live again. We are the only ones who are helping him in that way. How do you get a job for someone between 1 and 5 in the afternoon, because they get out of bed at one o'clock? Where is the support that says there is a better way to live? He had not even realised that he was sleeping his life away until I said to him, 'Half of your is spent in bed.' I think that is tragic for a young man. Every day that goes by is not coming back, that is for sure.

Senator HUMPHRIES—Obviously you would like to have more money to provide more places, but would you feel that it would be more flexible for you if you had the same amount of money but did not have a cap on the number of people that you could deal with? If you were given a global budget and told you had to deal with a minimum number of clients but the maximum number depended on how you could manage your budget, would that be a better arrangement?

Ms O'Toole—Actually I like the new budgeting system because we have been so underfunded and we are now at a realistic level. What I like about the new budget is that we can make an assessment of the needs of the individual, so with people who are not very needy, we provide that amount of support. With those who are really needy, we get more money and we can provide that. The money is important, and we have to have it, but to me it is about how we get creative in delivering a service regardless of how much money we receive. We did it before on block grant, and we will do it now, but we do things differently.

I do a lot of reading and a lot of research, and one author whom I have read widely is Dr William Glasser. If you want to read a very good book, he has just written one in 2003 entitled *Warning: Psychiatry is Hazardous to your Mental Health*. That is an exceptionally good book. We are working through his DVD at the moment on choice theory. He is a psychiatrist of 40 years standing and has not prescribed medication. His theory is that it is about people and their story; they are obviously desperately unhappy, and our brains are very creative when we are desperately unhappy. I see that every day, but when you talk with people and you tell them, 'You can do it; let's work on how you can do it,' they turn around.

Senator HUMPHRIES—What do you say to employers to whom you want to introduce a job seeker? Do you give them details of their mental illness? You do tell them that they are mentally ill; you do not deceive them on that score?

Ms O'Toole—Oh no, we say they are with Advance Employment, and Advance Employment is called, for want of a better term, a disability open employment service, and we work with people with mental health issues or concerns. We do not talk mental illness definitely. We do not use medical terminology. We do not say, 'This person is schizophrenic,' because I can tell you now that we would not get our foot in the door.

Senator HUMPHRIES—Would employers want to know that fact? Do they ask you, 'What is exactly wrong with this person?'

Ms O'Toole—We will tell them what their symptoms may be. If I have sugar diabetes, I do not go and say, 'I have sugar diabetes; can I have a job?' This is the problem. The misconception is that someone with schizophrenia is going to be an axe murderer. Well, let me tell you they will harm themselves before they will harm you. They are people; they have feelings. I do not want to go out there and say, 'Here's Fred Bloggs; he's got schizophrenia. Do you have a job for him?' They will say, 'No, go home'. We say, 'This is Fred Bloggs; he has been a tradesman in the past. He has a fitting and turning qualification but he has not worked for a long time. However, he can do trades assistance work, he can do whatever he can do. In terms of support that he may require, you may notice that he becomes anxious if he is put in new situations. If he is not particularly well, you may notice that he will withdraw.' Then we tell what our service does, which is provide the support. We say to employers that this is open employment, this is about earning money, so our clients are clearly informed that open employment has sets of responsibilities. We must be fair. We are about normalising in our agency, not about making special things happen that are not meaningful. We want it valued, and we want it meaningful.

From that perspective, we do not have any trouble in the private sector. I do not know what is wrong in the government sector. In the government sector, they pay people inordinate amounts of money to photocopy and file. I have a number of people who have administrative skills that

could be built on but there is no initial opportunity of coming into an office where they could do telephone work, filing, data input, photocopying, whatever sorts of things that are at AO1 or AO2 level, with the opportunity to a career path. We are not about getting jobs for jobs' sake. Because I have so many young people coming through now, I am very focused on career path. My background is vocational education and training, so I know something about that. I want to see people creating a life. We do not just go looking for cleaning jobs because they are easy; we do not do that.

Senator HUMPHRIES—Those openings are not available in government agencies as a rule, are you saying?

Ms O'Toole—No, we cannot get in. We cannot get jobs in government departments. Townsville is full of government departments. We cannot get a job in Queensland Health—hello!

Senator HUMPHRIES—Are these state government departments or federal ones as well?

Ms O'Toole—Both. DEWR is in our town; we have a big department of DEWR who are now looking after us. They know clearly what we do; they know clearly the struggles that we face. I am extremely fortunate; I work with a group of people who are as passionate as I am about what we do, and they care. It is not work for us. It is work, we get paid, and we are very well aware of it; we do not get paid that well, but we are very well aware of it. We love what we do, and the rewards are in seeing people grow, develop and change.

Senator HUMPHRIES—You mentioned that you have one client whom you need to support for about three hours a week. What kind of support does that entail—talking to them?

Ms O'Toole—Yes, working things through. This person has obsessive compulsive disorder problems, and it is the consistent checking. Consistent checking at work will lead to loss of job, so we get him to save it up and do it with us—and it works! We are working through the issues with him. Why would you need to check back so many times? You have the ability, you have the knowledge, you have the skills to make that decision yourself. So we have to work through building all those things that allow that person eventually—and he is getting a lot better—to come to the point where he does not need so much support. But if you have been with agencies who have been supporting you just to give you medication, just to give you a number, just to put you in and out of hospital, when you work with an agency that is prepared to stand by you and work with you, you do not want to let go in a hurry. We have to be very, very careful how we move people through the system. I may perceive that they are extremely competent and capable and do not really need our support, but if they think they need it a bit longer then I do not want to undo a good process. We will continue, but bearing in mind it is very hard for me then, because I have 25 people sitting at the other end wanting to come in. It is a lot of what I call ethical and moral judgment that has to be made on my part as to how things go, and I take that very seriously.

The other thing we do not do is judge people. I do not care what they are told they have, I am interested in if they have a willingness to work; and if they have a capacity and a willingness, we can do it. That is all it is about—attitude is the key. But I need support from the services within Queensland Health that these people work with to do the things that we do not have time to do, like teaching life skills. People do not wake up after a bout of illness learning, 'I will just wake

up today; I know how to make a good informed decision.' They have to be taught those skills, and that takes time and consistent reinforcement. These carers and case managers spend a lot of time with these people. They could really help us.

CHAIR—Thanks very much, Ms O'Toole. That was terrific.

[11.26 am]

BAILEY, Ms Jenine, Indigenous Researcher, Rural Health Research Unit, James Cook University

CHAIR—Welcome. We are sorry to keep you waiting.

Ms Bailey—It gave me a chance to look over my notes.

CHAIR—Would you introduce yourself, please?

Ms Bailey—I am an ex-mental health worker in the Townsville region. I am a Jagara Aboriginal woman from the Brisbane area, and I have been working within the Townsville community in the Aboriginal medical service up there for about 4½ years. I just bring along my experiences within that role today.

CHAIR—You have given us a submission which we have numbered 93. Are there any changes you want to make to that document at this stage?

Ms Bailey—No.

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

Ms Bailey—My particular interest and experience has been in culturally appropriate policy development, implementing and coordinating culturally appropriate programs. My main outputs have been the development and implementation of a range of community based mental health strategies to be used by youths and adults within the Townsville Aboriginal and Islander Health Service. I have also had experience in the development and educational activities for workers within the community controlled services, basically in-service training programs for workers who do not come across mental health patients or clients very often and how to deal with them and not think that they are under the influence of anything—just basically to keep them calm and to refer them on.

I have a bit of a theme for today which I have titled, 'You're not listening to me; Aboriginal mental health is different,' so to understand it. I will talk briefly across the concepts involving and understanding community based serviced delivery and practice within Aboriginal mental health, and also about the conceptions and visions of culturally appropriate practice for workers, and what is not working in Aboriginal mental health, and basically the experience of it.

Aboriginal people do not necessarily define Aboriginal mental health as a sickness or disease, although it is sometimes misdiagnosed as such by medical professionals. This is largely due to the poor understanding of aspects pertaining to the culture of Aboriginal people. The question concerning Aboriginal mental health is imbedded in a larger set of questions relating to culture, cultural differences, historical events, social and cultural change, and coping mechanisms. While primary health care services and health authorities provide extensive services, the Aboriginal

mental health work force lags far behind in both quantity and quality. This is one of the major factors contributing to the poor health status among the Aboriginal population currently.

When considering any formal program development and delivery intended for Aboriginal workers to use within the community, it is vital that the program embraces the Aboriginal definition of health, which is holistic. Basically, health does not just mean the physical wellbeing of the individual but refers to the social, emotional and cultural wellbeing of the whole community. This is a whole of life view that includes a cyclic concept of life-death-life.

Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the whole total wellbeing of the community—that was NACCHO. Therefore the concept of health and its meaning to Aboriginal people is multidimensional and embraces all aspects of life and living. It is an holistic health perspective underpinned by a sense of community that forms a sense of identity.

Within my experience, mainstream health services have failed to provide adequate services for Aboriginal people. There are still problems in relation to understanding Aboriginal concepts of mental health, Aboriginal history, failure to understand culture, incarceration and western dominated models of care that have resulted in further disempowerment. Aboriginal primary health care delivery is focused mainly on disease control or public health frameworks. Therefore the concept of Aboriginal mental health should be at the forefront of the national focus of health and service delivery, where it is essential to identify and quantify health status in order to implement appropriate services to adequately address the community's need.

Appropriate health services are needed to deliver preventative measures and strategies of population behaviour and change. Currently mainstream health services and health authorities provide extensive services compared to Aboriginal health services, which lag far behind the rest of Australia in both quality and quantity. This factor compounds the problems of ongoing poor health status among the Aboriginal population. Aboriginal mental health care needs culturally appropriate action to identify current as well as future gaps within the care and service and delivery. The need for an improved Aboriginal mental health service will provide a much needed practice and understanding as well as provide culturally appropriate methodology, ethics and protocols to ensure the provision of the highest quality services for the Aboriginal community. The implementation of culturally appropriate practice for positive change, which does not wholly concentrate on the Aboriginal definition of health, will enable Aboriginal and non-Aboriginal workers to understand the relationship between health, health care and the broader social processes, which in turn will reflect in their practice.

As an Aboriginal mental health worker, I have experienced first-hand the frustrations related to access and/or deliver of culturally appropriate mental health services to the community, when continually confronted by obstacles, gaps or lack of capacity in service delivery that hinder my work practice. These obstacles include lack of funding and/or inappropriate recognition for Aboriginal mental health, inadequate support from mainstream mental health workers and services, the stigmas associated with Aboriginal mental health, misunderstanding that Aboriginal mental health and the concept of health is different to western concepts of health and therefore there are different needs, and no recognition for cultural mental health differences between different Aboriginal communities.

A critical approach to Aboriginal mental health delivery is needed, consisting of positive insights into the broader concept of Aboriginal mental health and health wellbeing, which will assist workers to identify and explore innovative ways to develop and implement effective mental health service delivery methods. Approaches should encompass holistic health promotion, research strategies and preventive strategies in addition to the delivery of primary health care models of care. The needs, interests and priorities of families, individuals, communities and services are at the heart of education for mental health and support programs. Involvement and choice by the Aboriginal community are fundamental to effective services—that is, listening to and talking with the community is essential. The criteria for embracing an holistic and spiritual wellbeing for each individual, which is the whole community, requires implementing a mental health holistic framework incorporated with capacity building strategies for change.

The central role for delivering any mental health program is to extensively evaluate and analyse the needs and gaps within the current service delivery. This is to define, implement and market an appropriate framework which enables the needs of the Aboriginal community to be met through culturally appropriate service delivery. Four aspects of it include: basically examine the current curriculum within the Aboriginal health service programs; identify existing gaps identified by the Aboriginal community and services; develop recommendations to increase Aboriginal mental health capacity; and implement them into service delivery.

Identified best practice and guided principles for policy and delivery of mental health services for Aboriginal people are drawn from the voices of Aboriginal people who have articulated their concerns about the status of current services available for Aboriginal mental health. In retrospect, the delivery of culturally appropriate services is vital. In conjunction with these principles, effective Aboriginal mental health framework incorporates an holistic health focus to develop holistic service delivery and culture within Aboriginal services, as well as mainstream services that promote and enhance cultural appropriate service provision; increases the development of greater awareness in Aboriginal mental health for workers in mainstream mental health services—and that is mainstream community; provides leadership in the development and promotion of high quality culturally appropriate mental health services, and the implementation for continuous improvement in current best practice for sustainability; and promotes ongoing collaboration with Aboriginal mental health services as well as mainstream services for the delivery of culturally appropriate current best practice.

Thus, through these principles, using culturally appropriate service delivery and program development and provision, focus on Aboriginal mental health service monitoring and evaluation will all be strengthened. Within Aboriginal culture, one person's dysfunction has far-reaching effects to the extent of families and ripples across the whole community. However, Aboriginal Australian communities are no different in the basis of family values and beliefs, even through their disconnectedness through dysfunctions. Cultural ties are strong and bind the family together. Within Aboriginal mental health, when somebody has a mental illness, the community actually does bind together. Currently, because there is such a stigma attached to it within some communities, the culture is sometimes lost.

What is not working in Aboriginal mental health? The current lack of service provision has been identified as a contributing factor for workers within the Aboriginal mental health sector. Currently, within mainstream services and within the national focus to address mental health

practice there is still a high level of ignorance and misunderstanding pertaining to the culture and intergenerational impacts on Aboriginal people's health, and that is culturally inappropriate and poor service provision. This misunderstanding and ignorance affects not only the individual but also the community as a whole; therefore it is recommended that identified proposals need to be taken into serious consideration, with greater recognition, national awareness, greater funding opportunities and job strengths, implementing mental health training and learning culture within Aboriginal services, providing leadership in the development and promotion of high quality mental health service delivery and the implementation of a continuous improvement process.

To conclude, it is envisaged that the objective of recommendations for the mental health committee is to provide a greater collaboration of mental health partnerships across the community, together with a national focus, which is to enhance the Aboriginal mental health capacity within primary health care delivery. Therefore, it is vital that these services are to be delivered by Aboriginal workers for the Aboriginal community. While ever there is a blinkers-on approach that hinders or impinges on the attitude to the impact of past histories, there will be a continuing lack of culturally appropriate service provision and delivery by workers.

Senator HUMPHRIES—Can you give an example of a preventive strategy with respect to mental health that would be useful in the context of Aboriginal communities? I think you called for there to be a development of preventive strategies in respect of Aboriginal and Torres Strait Islander communities. Can you give an example of the sort of thing you are looking at there?

Ms Bailey—Across the board, like for education as in prevention; more experience for Aboriginal workers to be put into mainstream services. For instance, in Townsville at the Integrated Mental Health Service there are half a dozen compared to those in mainstream services. I was a mental health worker within the Aboriginal mental health service, which is not Queensland Health, and I used to work and co-case with them. We must get the prevention awareness out into the community with the promotion of health education. Mental Health Week is once a year, but we always felt that that was not enough to get across to the community the mental health issues for Aboriginal people. Quite often I went on the radio and organised video promotion and produced pamphlets. I developed the in-service training for the staff at the Townsville Aboriginal and Islander Health Service, TAIHS, so if somebody with a mental health problem came in, they did not get frustrated or scared. We put in these little components to help people understand the complexities within Aboriginal mental health; there are special needs, and it is different to mainstream mental health.

Senator HUMPHRIES—That is what I am trying to get to understand. I am not sure how the Aboriginal approach to mental illness is different from the medical or mainstream model. Suppose an Aboriginal person came through the door of any sort of service in this area, and there was a person with a culturally sensitive understanding of those issues to help them, what would be different about the way that they would treat or deal with that person's illness? How different is it to a conventional approach?

Ms Bailey—Basically in the communication, for a start. There are people from the urban areas and those from, say, Alice Springs, who are very cultural. A male would not communicate with me, a female worker. He would say the right things; he would agree that pigs fly, basically, because there is a communication breakdown. You would actually have to bring in a male worker or even just a man to talk to him. There are those complexities in our culture. It depends

where that person is from. The same applies to a woman speaking with a male psychiatrist; she would not feel right. There were times when I had the whole extended family, including an aunty, an uncle and cousins, because they take it all on. It is not just a one on one with the psychiatrist, it is a very big family group, and they will have a family meeting about it. It is just that understanding that it is just not one person going through the mental illness; it actually involves the family, and therefore it ripples out into the community. It just depends on the person who walks through the door. You must be aware of that. Torres Strait Islanders are different from Aboriginals, and it depends where the community is from. Just because they are an Aboriginal does not mean that way of treating and therapy, or applying strategies for care or whatever, will work for them as it does for somebody in Alice Springs, for instance.

Senator HUMPHRIES—Did you say before that, in some Aboriginal communities, mental illness is not recognised as a disease or an illness?

Ms Bailey—It is not classed as a disease or illness, because that is a very clinical description. For example, if somebody is hearing voices or hallucinating, a psychiatrist may think they are hallucinating or hearing voices, but they may be talking to their ancestors. I have had clients who have been diagnosed as schizophrenic or having auditory hallucinations, but it was actually like a grandfather coming back to him, and it was a men's business thing, and he went back to his country. I was off that area then—that went to another worker back in his country, and it was taken on from there. There is a very grey area that people must be open to understand and to be able to listen to it. People believe it within their culture, and when someone comes in from a remote area who is experiencing problems, trying to explain that to a psychiatrist even in Townsville, let alone Brisbane or Melbourne, they just do not have that understanding.

Senator HUMPHRIES—Are Aboriginal communities, particularly those outside urban areas, usually very supportive? If you need to give a person community based assistance, are you able to find that kind of support that you need in Aboriginal communities?

Ms Bailey—Within our networks at each of the Aboriginal communities, yes, because all of the communities that I have worked with, going up to Hopevale and out to Alice Springs, are very connected to know who is doing what and co-casing and making sure that they are basically taking care of their own. The networks are very strong within the Aboriginal communities. Within Townsville, we like to keep up to date with what each other is doing. Even though I am not a mental health worker at the moment—I am actually an Indigenous researcher—mental health is part of my holistic program, that holistic framework of my work.

I am still in the link with the integrated mental health unit with the TAIHS medical service. I am still in amongst that, because I have them networking and that knowledge of who to contact. I used to go out to the correctional centre and would know who to tap into for support. Support services are vital within Indigenous communities and services, and also culturally appropriate support services. Put the Aboriginal people in there; do not put mainstream people to deliver those services for Aboriginal people. Therefore you have the educating of the Aboriginal people to get those support services, so it is a domino effect, and you just have to be patient and have the necessary funds.

Senator HUMPHRIES—It might be difficult to generalise, but do you think that the stigma of mental illness is as strong in the eyes of Aboriginal people as it would be in the mainstream Australian community?

Ms Bailey—Very much so. It is an uncomfortable word. They do not shun people; they do not say, 'Oh, that one's a bit womba,' which is a bit crazy or mad. People know within the community who is what and if they are unwell or things like that. There is also that underlying stigma, though, that it is a bit shameful. It is the access to services—if they go to see a psychiatrist, they like to keep it private. I used to do a lot of home visits. I like to empower them to come out and see me, but I also do not want to shame them and make them just stay at home. Yes, it is there, especially when there is still that breakdown or grey area within mainstream people and Aboriginal people. A lot of people still shun them, so I have come across situations where it is still a stigma. That word is used, but it is like the word 'private'—they shun it. It is another stigma word—private health is a white man's term, like private hospitals. Aboriginal people do not overly access private hospitals because of the stigma attached to the word 'private'. That is also part of my PhD. Whether that is an economic issue, because they cannot pay into medical services like MBF because they cannot afford it, or for whatever reason, that is another kind of stigma. Of course, it differs from community to community. Not all Aboriginal people feel like that.

CHAIR—How does your training allow you to deal with the Western medical model and what you described earlier about how voices can be interpreted as speaking with ancestors and so forth? Are you suggesting because that is a possibility within Aboriginal culture that this is not a problem, so people still come to you, whether it is the whole family or the individual, with a problem that they want you to solve?

Ms Bailey—I do not think you can ever solve it. We can help and guide them.

CHAIR—How do you marry those two quite diverse attitudes to psychotic illness, for instance?

Ms Bailey—It is very hard. Like I said, it depends on the level of the problem that this person is experiencing as they present to you. It would be a lot easier if the person is a woman, because then I could work a lot more intensely with her. But if she was from a remote area and she is more for the full-on cultural—

CHAIR—Let me phrase this another way. If you are working with someone who, in your words, is full-on culture, meaning that they are still very linked with their culture still, I presume—

Ms Bailey—They are very spiritual.

CHAIR—Is there a point at which Aboriginal people say, 'Our belief systems and our speaking with ancestors and so on is out of control and we can no longer explain it this way or we can no longer cope with it that way, and now we need help for this,' and that is why they come to you? Is that what happens? Is it the more extreme end of the symptoms of mental illness that you are involved in?

Ms Bailey—In my job right from the beginning I was involved in co-casing to checkups with the psychiatrists throughout what I called their episodes. If somebody was experiencing a mental problem, or psychosis, depending on the level of the problem, the worker would have to make a judgment of how much of a cultural issue it is. It is a very fine line, and that is why I find it hard to separate, because you really cannot. Yes, there are cultural issues that you have to abide by and acknowledge and fully support—and, again, it depends where that person is from as to how much you do—but there is also the duty of care as a worker to implement these other clinicians, such as psychiatrists and others, to intervene to help with the case. Again, that depth would have to be based on how the individual presented. I have worked with many of my clients from day dot, from the time they were put in the unit. The integrated mental health workers were the majority of those who worked with them through Queensland Health.

CHAIR—Is this an inpatient facility?

Ms Bailey—Yes, the mental health unit in Townsville. The integrated mental health or Queensland Health workers would work with them, plus with the psychiatrists and with me co-casing on the outside and we would do case management. Once they get discharged and come back into the community, then it is swapped around. Then it is me working intensely with them, then the integrated mental health workers co-casing, and then the psychiatrists. We worked on a par, because when they are in the facility with the Queensland Health workers—like I said, there is only a handful of them in the Townsville health district area—it is pretty full on. They operated with a shared psychiatrist through Queensland Health who would come into the Aboriginal medical service once a week for four hours, which was just not nearly enough for the contact time that the Indigenous mental health patients required. I was turning people away three or four months before they could see him, because it was just booked out weekly. To answer your question in a long way, again it would depend on the depth and the intervention of all the workers co-casing with that patient to discuss implementation and intervention strategies of how we would proceed. We would all work with the patient.

CHAIR—It sounds enormously difficult.

Ms Bailey—It was complex, and it still is, even to the workers, and there are not nearly enough male mental health workers out there, especially for the number of Indigenous men who come in. With all the issues surrounding mental health, you have got substance abuse and alcohol that exacerbates the problems. It is an ongoing circle. It is something that you cannot solve, but you deal with it and just do your job as best you can.

Senator MOORE—I do apologise for my lateness. There are so many questions, but thank you for your submission in which the common theme was you need more help. In every recommendation, you need more.

Ms Bailey—Yes.

Senator MOORE—In terms of people in the community who voluntarily come to see you, is there an acceptance that the kinds of services, limited as they are, can be effective? Do people voluntarily come or do you usually see them after they have already been caught up either in the police system in Townsville or in the process? Do people identify that they need help or do their family members identify it quite openly?

Ms Bailey—Yes, I have had that—quite a large number, actually. Usually they come in because they are just stressed out and they do not know how to handle Tom, Dick, Harry and the kids and this and that, and they are really, really stressed out. Also they are referred through the police service. I am often called out to talk to people, and I used to get called out for all the social workers at the Townsville Hospital. I was brought in through the correctional centre to work with the women's secure unit to do counselling. That was done as a loop outside of the correctional circle. I was more in the community, so once they got out of the corrective institution area and into the community I was their first link out there.

Senator MOORE—When they were being released?

Ms Bailey—Yes. I went there once a week, so I was linked into all the services to a certain extent, and, like I said, I still am. It was good that they voluntarily did come in. Family members would stress to me the various issues that would help their son or daughter, and I would go out and talk to them. We would develop a rapport, and I would refer them to the psychiatrist, psychologist or ATODS, Alcohol, Tobacco and Other Drug Services—to whatever services I felt they needed, including support services—as well as co-case them personally. I did my own case management of them. Like I said, it was good if they came voluntarily, but on the other hand a lot of times I had to find out, and I received a lot of referrals from the doctors at the medical service.

Senator MOORE—From the Aboriginal and Islander medical service?

Ms Bailey—Yes.

Senator MOORE—Did they work closely with you?

Ms Bailey—Yes, that is where I was working at that time. Another link I had was with the Child and Youth Mental Health Service. They had the children, I had the parents and the family to work with; so we could integrate. There are linkages across the board. Again, it just depended on what was presented to you, and you just did the support mechanisms that were needed for that client.

Senator MOORE—With the linkage with the correctional centre, if the people, mainly women, in the correctional centre were going to be released in the Townsville or Palm Island area, you could keep that immediacy, but what happens with people who were released and returning to the community outside Hughenden or something like that? How do you keep that sense of support with someone who is leaving Townsville and then often just disappears?

Ms Bailey—A couple of times I did teleconferences to introduce the people. I actually referred them to services or workers to meet them once they got there, to basically start that. Before that, you would discuss and co-case what I had done with the person within the facility and, once they were released, in the community. You put the strategies in place before they get out. You have a fair idea of their release date, so you make sure that things are in place so the person is not left out in the cold and lost and therefore may get up to mischief again. That can be done by working with counsellors in the corrective services. The inmates were quite open with me because I was not in the corrective services. I am unbiased in that respect, and they were quite open with me. I only worked with the women's secure unit. Because I am a woman, I could

not work with the men, unless something came up with one of the males and they agreed to talk to a female worker. In the little medical service in the institution they would have to talk to a woman counsellor, and a lot of the men shut back. It is that cultural difference again. I was not in that link of the correctional centre, so unless they agreed it would not happen. I did have a few, but I was mainly in the women's secure unit for that reason. I respect the cultural position.

CHAIR—Thank you very much, Ms Bailey, for coming along today. It is useful, and I think you are the first witness we have had who has focused on Indigenous mental health issues, so we thank you for that.

Ms Bailey—Okay, thank you.

[12:07]

KNOWLES, Ms Leanne, Manager, Social Health Unit, Wuchopperen Health Service, Cairns

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

Ms Knowles—Before I start, I would like to acknowledge the traditional owners of this place. I know there is contention about who the traditional owners are, but I need to state that acknowledgment, because I am not from here. I am here today speaking on behalf of our Aboriginal and Torres Strait Islander community through users of our social health service as well as connections with the wider community. This brief report—I hope it goes for only about four or five minutes—is compiled with input from colleagues, including Aboriginal doctors, counsellors and health workers, and anecdotal evidence from our work with our community and their interaction with mainstream mental health services.

I guess our social health unit is an integral part of our wider health service, commonly called AMSs across the country. We have 28 staff members, 27 of whom are Aboriginal and/or Torres Strait Islander. We have a really good gender balance and a cultural balance between Aboriginal and Torres Strait Islander, as well as a balance of younger and older workers. Notwithstanding the antidiscrimination laws, I guess for users of our service that gender, cultural and balance of younger and older workers are actually essential elements for our service. Our programs include counselling and support service, which incorporates a kid's cultural program, a men's peer support group, project 300 support for people with a disability who have been deinstitutionalised, family support services, prevention of family violence, child wellbeing services, drug and alcohol services, as well as sport and rec programs with an emphasis on social outcomes.

To our community, health or wellbeing encompasses the realms of social and emotional health, physical health, cultural and spiritual wellbeing. Many people who access our services have multiple issues of a complex nature and long-term support is often the only option. Indigenous mental health issues are a significant element of Indigenous health disparity and, given that for any community poor health outcomes are inextricably linked to socioeconomic and sociopolitical circumstances, we have a responsibility to find extra resources or share the ones we have more equitably to make inroads into our community's health.

Our Cairns based service—I have put a title at the top of 'Advances to Strengthen'—in Queensland Health's community mental health services have made quite decent connections within the last 12 months. We have some workers spending time in the other's workplace. One of our workers assists in the weekly reviews of Aboriginal and Torres Strait Islander consumers, most of those being inpatients at the time. A psychiatric registrar runs a clinic from our social health centre once a month. It is interesting that it is a psych reg and not an experienced psychiatrist, given the community that we are serving. We have been able to make some really good personal connections, which are always conducive to better ways of working together. The

recent development of enhanced services to Cairns, which are long overdue, are of course a huge advantage to our community.

We do have to highlight the following general trends in mainstream mental health service delivery that continue to impact on our community. I say at the outset that the following issues do not apply to every individual worker within mental health. As with any service, there are fantastic workers and there are not so good workers. I guess overall is the application of a biomedical model. Our people need to be assisted in a holistic manner in recognition of the fact that each person is part of a family and community system. Mental health often acts as gatekeepers who promote a reactive service delivery. Sometimes to be seen by mental health professionals, you must be seen and assessed by the crisis assessment and treatment team—we believe the name says it all. Reiterating a statement made by the Office of Public Advocate in their submission, people need to become extremely unwell before they actually get assistance.

There is a disregard for the concerns of community workers and sometimes consumers. An example of that was a young man whom we were working with whose behaviours were becoming increasingly challenging for his family. It was difficult to get him seen. We had to apply a justice examination order, and there was no real assistance for that young man until he became acutely unwell and actually was at risk of being incarcerated. He was finally judged to have been unwell at the time and was not, thankfully. That is not an isolated case.

I guess also for us abused children are often not considered a mental health issue, even though there is that strong correlation between childhood abuse and adult mental illness. With respect to dual diagnosis issues—and I am sorry to be reiterating this, because I have just heard a lot of this before from the previous witness—particularly for our people with a diagnosis of a personality disorder and/or substance misuse and/or axis one psychiatric illness are not typically offered treatment by mental health services. Long-term support would be required. This begs the question, of course: are they resourced enough to offer long-term support? There are often onerous expectations put on community organisations, and there is a definite need for ongoing collaborative ways of working to prevent relapse.

The physical environment, I guess, is not conducive to healing for some of our people. I can only speak for the mental health office here in Cairns, but it lacks a welcoming environment. It is often closed to making personal connections, and many people who access our services now have stated that they will never go to mental health again, so I am not sure whether that could be construed as evidence of iatrogenesis.

Some of the solutions that we would put forward would be to strengthen the Indigenous primary health care services, specifically around male health, because of our poor outcomes for our men, including our prison population. We need to strengthen the Indigenous work force, which is what Jenine mentioned before. An example could be scholarships for counselling or psychology or social work. Again, there is an absolute deficit of men working in the social services. Also, as far as the work force is concerned, we need to recognise the clinical and cultural capacity of Indigenous mental health workers within mainstream to direct and guide service delivery for Indigenous service users. We need to improve the cultural competence of mainstream services by increasing Indigenous health curriculum in mainstream courses: for example, recently the Committee of Deans of Australian Medical Schools has recognised the Indigenous health framework for all medical schools. There is a need for improved education for

all Australians to address poor perceptions of what constitutes mental illness, but also poor perceptions of our Indigenous communities.

I guess, by far for me, the most important solution is that we require a two-pronged attack: one would include all of the above that I have just said but the other requires an abundance of time and effort—read resources, dollars, however you like—applied as universal supports to our newest Aboriginal and Torres Strait Islander citizens who are in utero at this very minute. In keeping with the national mental health agenda of promotion, prevention and early intervention, let us strengthen safe, happy and healthy environments for our children. This will require resources but will go some way to reducing the impact of social determinants of health.

In conclusion, as stated in a recent United Nations report, Australia's Indigenous peoples may constitute the most disadvantaged community in the world today. Evidence of this is borne out in the document recently released by the Productivity Commission in Canberra re Overcoming Indigenous Disadvantage: Key Indicators 2005. I believe all tiers of government need to work with communities to address these issues that shame us as a nation. On the issue of mental health in particular, people living with a mental illness are already marginalised by society. These problems are compounded when it is the lived experience of Aboriginal and Torres Strait Islander people.

CHAIR—Thank you. With respect to the physical nature of mental health services and the fact that you say they are unsuitable and unwelcoming often, can you point the committee to a service that you think pretty much has it right in terms of the environment, and how different that is from mainstream, for want of a better word?

Ms Knowles—I cannot say for very many offices. I just know about the office here in Cairns, where you are speaking to somebody even in reception through glass or a screen, and there are keypads on every door. We do have security systems in place in our service, but not to that extent. To help people, you need to make that personal connection, and it is really hard to make a personal connection in an environment that is not conducive to healing. When I have gone there with people, there has been very much a feeling that already you are being shown that we expect you to actually misbehave and we expect that we need to keep this barrier between you and me, and that in an immediate sense is an affront.

CHAIR—The committee has had a lot of evidence over the last couple of days about the link between abuse as a child and mental illness, both in childhood and throughout life. You said that abused children are not seen as a mental health issue. Are you saying that there is no assistance for children who have been abused?

Ms Knowles—There is some assistance. I would not like to say that all abused children are toddled off and told, 'Until you become an adult do not come back to us.' It is often at the high end, where kids have been badly abused, that kids are showing affective disorders already at a young age. Sometimes for children who have been taken into the care system where they do not have those social, emotional or physical injuries, there is not really that immediate support, and it is often seen as somebody else's responsibility rather than mainstream.

CHAIR—Seen by whom as someone else's responsibility?

Ms Knowles—The Child and Youth Mental Health Service have actually put some cases to us.

CHAIR—Can you cope with those?

Ms Knowles—I think it all goes down to resources again. We could have an awful lot of workers working around the clock. There is just such a huge need.

Senator HUMPHRIES—I want to ask about medication in the treatment of Aboriginal mental health. Are there any cultural issues that affect the access to medication by mentally ill Aboriginal people and are there economic issues about being able to access medication?

Ms Knowles—The economic issues certainly take precedence. I know that, for a lot of people, there is almost a sense of having to give up if they have to go on medication. I am not sure how you would fit that with a cultural imperative, but certainly the economics are a huge deal. Even when they are supported medications and they are on the PBS, that is still an issue. I guess that sits with the co-morbidity kind of thing around dual diagnosis with substance abuse as well.

Senator HUMPHRIES—When you say they are giving up, it is an ultimate capitulation to Western medicine. Is that how they see it?

Ms Knowles—In some ways it is, and I think for some of the people that we work with there is that sense that they should be able to do it on their own without taking the medication. I think sometimes the medication is seen as, 'Oh yeah, okay, I really am psycho. There is something really dreadfully wrong with me.'

Senator HUMPHRIES—Is there a role for educating or informing Aboriginal people about the valuable role of medication?

Ms Knowles—Most definitely. It is not something that we jump out and promote, saying, 'You need medication'. We also have what is called a social and emotional wellbeing clinic. One of our doctors, who is extremely interested in the social and emotional wellbeing side of things, runs a clinic from our social health building on a weekly basis, and that is a chance for a person to sit down with a doctor as well as their counsellor or their usual support worker to discuss things like that and to talk about the possibilities of medication.

Senator MOORE—What region does your health service cover?

Ms Knowles—We cover Cairns and district.

Senator MOORE—Under 'district', because every organisation finds things different—

Ms Knowles—Yes, they do. I guess some of our services are actually regional, so where they come from depends on the funding. Some of our child wellbeing services, where we are working in partnership with the department of child safety, are almost down to the Innisfail area and north to Mossman and up the Tablelands. That is a fairly fledgling service at the moment. Our sport

and rec programs are attached to the old ATSIC regions which also reach out from here to Croydon, north to Mossman—

Senator MOORE—Up the cape?

Ms Knowles—Not really up the cape but, yes, Croydon is about the northernmost part.

Senator MOORE—How far west?

Ms Knowles—I am trying to work it out. Croydon is north-west of here, I guess.

Senator MOORE—I will ask the same question that I asked the previous witness about how people get to know about you and whether they voluntarily come. Do you find that many families come to your service because they know about it and because they have an issue with themselves or a member of their family or is the majority of the access through people who have been picked up in other parts of the system and they know that you exist, so they refer?

Ms Knowles—I would say generally people are picked up in other parts of the system. We work really closely with the doctors and with Kiddies Clinic, but I guess because we do not just offer mental health services as such and we do not like the tag mental health, but because we do not just offer counselling and support, people could come in because they know we are helpers in some ways. If we cannot help them with something, we can broker that support. That support includes a diverse range of things, such as coming in with a letter to serve on a jury and not knowing what the heck it was, but knowing that it was a government letter and that they could be in trouble to writing letters of support for people with no literacy skills. Other people who do not even go to our medical clinic have fronted up at the hospital and a doctor has told them that they should get some assistance, so they come to us.

Senator MOORE—Where do you get your funding from?

Ms Knowles—Various sources. We like writing reports to everything—

Senator MOORE—Will you actually provide that to us separately rather than take time now, because one of the things we are coming across all the time is that services are having to access funding in a range of different ways, which creates another workload on them. Just as an example, because your service is so diverse, would you be able to provide out of session where you get funding and the terms of that funding? That is the other thing: it seems to me that there does not seem to be a single funding unit that funds for the same period of time. That would be useful, and no doubt we will get back in contact with you, because there are lots of questions, but it is a bit limiting.

Ms Knowles—I could send that to you.

Senator MOORE—That would be lovely, Ms Knowles, just to the Secretariat.

Ms Knowles—Okay.

CHAIR—We do have a few more minutes. Can you tell the committee about your involvement with Project 300, the Queensland government's project that funds people coming out of acute care, as I understand it? What have you used that for, how successful was it and is it your recommendation that that be more broadly applied? There seems to be no certainty about its future.

Ms Knowles—Yes, and that worries me a little, I guess. There are still three men that we support; two of them live with schizophrenia as well as substance misuse and one guy has an intellectual disability as well as schizophrenia. It is really hard for us to even imagine those guys being institutionalised now that we have been supporting them for three or four years—it might even be five years. One guy that we support came out in the first round. I know that the government's target was 300; I am not quite sure whether they actually reached the 300 in the end. They are very individualised packages. They range from 52 hours of support a week to 10 hours of support a week. They are very individualised. That support often goes across the weekend. It could be very intensive, helping to go shopping, helping with all the budgeting issues as well as getting meals and helping clients with diabetes. It is very diverse.

CHAIR—It is not easy to imagine those people being in institutions now. Can you expand on that a little?

Ms Knowles—We have been able to work with them so well—we see them when they are extremely well and we have also seen them when they are not so well. It is hard to imagine, especially with the guy who has an intellectual disability. There were just no supports for him in the community at that time, so his behaviour has become more and more unmanageable. Having known them for so long now, I guess that is what makes it hard to think that they would have been institutionalised.

CHAIR—They came out of institutions and were for a while unsupported, and then this project allowed you to take them?

Ms Knowles—No, the support packages were already there, ready to be wrapped around them basically on release.

Senator MOORE—Are they all in Cairns, in the city?

Ms Knowles—Yes. One of them at the moment unfortunately—I will not say, but he is not in Cairns at the moment.

CHAIR—You said unfortunately they have not been supported for some time.

Ms Knowles—I guess before they were institutionalised they must not have been supported around their mental illness.

CHAIR—I understand. These three people are all Indigenous?

Ms Knowles—Yes.

CHAIR—Which is why they come to your service?

Ms Knowles—Yes.

CHAIR—Were you asked for an evaluation of the program?

Ms Knowles—Yes. There is an ongoing evaluation program that was done—I cannot remember who it was done through, but we picked one of the people and we reported on that every six months for a while. I could find out that information.

CHAIR—And that evaluation indicated that the program was working?

Ms Knowles—I do not recall actually seeing any reports back on that, so it may still be ongoing. It was quite a longitudinal study, but I am not quite sure for how long.

CHAIR—Are there others in institutional care at present who could also be assisted to live in the community?

Ms Knowles—I am not aware of them on a personal basis, but I know there were more to be considered, because I think the government got to about 269 or something like that. They did actually target 300, and I am not sure what the hold-up is any more.

CHAIR—We were told in Brisbane yesterday that it can be very difficult for people to get out of institutional care. Is that your experience also?

Ms Knowles—Yes. There is an instance at the moment with a young person who may be requiring institutionalised care simply because family and community are starting to just not be able to manage this young man's behaviour. He has no insight into his behaviours. Whether or not he has a mental illness, I am not so sure, but there is a dearth of places where some people can at least get some respite care to give the community and family a bit of a break, and that is something we have noticed in the last 12 months or so with a few people who do not fit the requirements for an old people's home and they need constant care. When the family is unable to cope, where do they go?

CHAIR—Thank you very much, Ms Knowles, for appearing at our hearing today. We appreciate it.

Proceedings suspended from 12.30 pm to 1.33 pm

LINK, Mr Johnathan Roy, Community Liaison and Development Officer, Royal Flying Doctor Service

CHAIR—I call the committee to order and welcome the representative from the Royal Flying Doctor Service. I invite you to make an opening statement, after which we will go to questions,

Mr Link—I would like to thank the traditional owners for being able to speak today on this land on which we meet. I am a descendent on my father's and grandmother's side of the Kuku Yulanji tribe, which is between Mossman and Cooktown. I am also a descendent of the Ngapuhi from Te Atatu, Auckland, New Zealand on my mother's side from my grandmother. I reside in Cairns, I moved here in January 2003. I have worked for the Flying Doctors since August 2003. The psychologists and I are funded by the Department of Health and Ageing through the Regional Health Service. We are funded until 2008.

The duties of my role are to engage with community representative around building relationships and forming partnerships with the Royal Flying Doctor Service, and to inform families, especially men and boys, about accessing health services, in either general or mental health. Men are less likely to access these services immediately but will do so when the troubles begin or something serious such as measles, gland swelling or bleeding affects them or when they are feeling slightly depressed. Forming men's groups through active participation and community consultations with councils, elders, health, education, justice and community members as well as industry makes living in these communities an experience that many urbanites would like to experience. For example, in communities there are no appointments, people just turn up. My role also includes promoting continuity of mental health support within these small towns and being a vital link between the community, the hospital system and the individual.

The RFDS Cairns based mental health program began in 1995. We received federal funding under the Regional Health Service in 2000. My position was appointed in August of 2003 and renewal funding for the Regional Health Service program, which includes the psychologists and me, will continue until 2008. We have recruited one mental health professional and another is getting close to commencing.

The monthly psychological services access 11 towns, five in the Tablelands area and six in the cape. We also participate in field days and clinic runs. On field days we go out and meet with station and property owners and they are interested in getting support through the Flying Doctors for emergency and evacuations. There will be a pilot, a nurse, a community development officer and a doctor. Most of the property owners will want to know about communications, to have those lines open for where we are going to meet for evacuation, and the pilot will also talk about issues of airstrip maintenance. If we know there is a danger are not going to risk our lives to save someone else's. People who work on the properties need to know how to handle or manage stress, so we will also cover that component. Flight nurses will discuss bandaging, CPR and general health issues.

Some of the projects in which we have been involved include one in mental health literacy which we launched in 2003 called Grapple: Coming to Grips with Mental Health. I have been

facilitating that with the Indigenous health workers in the clinics so that they get the terminologies. We have established men's groups. There are a lot of issues out there and men do not access health even when they are on death's door. This is letting them know that they do have support through the health workers, through community representatives and people like myself who engage with individuals in the community.

Other projects include mental health capacity, peer group training, professional development opportunities, suicide prevention and mental health capacity building. In that arena we are wanting to train people in the community so that we can support them. Rather than us coming in and being fly-in, fly-out services, we want to turn things around so they become community controlled.

Related to this involvement is the use of the Royal Flying Doctors Service in critical management of mental health clients on the cape, for example, primary health care clinics and mental health emergency evacuations. The doctors will do the intervention and organise a Queensland ambulance to meet us when we do arrive so that there is a care plan in place before the client even alights the aircraft. Another service is the Matilda Regional Health Services at the Longreach base. They have two psychologists, one team leader and a service coordinator in allied health. The RFDS have another base in Mount Isa. There is a Queensland funded mental health program called Mount Isa Minds. They have one community liaison officer in general health and they are funded through the Commonwealth PHCAP. There is a team leader and a community development officer in mental health who perform a non-clinical counselling role as part of the Mount Isa Minds program.

CHAIR—In terms of the concept of community liaison and people in communities, how do you identify these people?

Mr Link—I have been travelling to these communities for two years now and through meeting people in their homes, at the clinic, whatever the organisation, we try to express that individuals need to take control of their community, especially in their homes. For example, if I was going to your place, you would not expect me to come and invade your home. It is the same principle of us coming into a community and trying to tell them how to be. My role is to give them an opportunity to see that there is support. You are not going to always have the answers within communities, especially around raising awareness issues. Mental health is a stigma in Indigenous communities, so my role is to just be a person who will listen. That is a very important factor there. The communities tend to be reactive rather than proactive; if there is an issue there they tend to act on it straight away without actually coming together as a group. Listening to them, showing that you are transparent and not promising things that you cannot deliver are important. I believe I have made inroads there.

CHAIR—What sort of people agree to become community liaison officers?

Mr Link—You want to achieve things personally. Everyone has goals of some kind.

CHAIR—I thought you went into communities and you trained community liaison people to fulfil that role.

Mr Link—Some of the difficulties there is that not everybody wants to partake in their community events or activities. I listen to what people want. If they are wanting to start up sport and recreation, we try to support them around that and refer them to other networks.

Senator MOORE—Do you talk to Aboriginal health services so that when you go into a community there will be people who are already working in the field that you link up with?

Mr Link—There are not many community development officers in these communities. You cannot get sport and rec people. You cannot even get a youth worker.

CHAIR—The service I had in mind for the Royal Flying Doctor Service is a very small plane with a couple of people and a pilot going out into areas where there are very small communities and not much by way of services. Is that an accurate description of what your service looks like? Is there a scheduled flight into Mount Isa?

Mr Link—Our services are based around fortnightly services. We have a weekly run-in with our medical officers or MOs, as we call them. They go in and stay for three or four days at a time. I am responsible for four communities and the psychologist is responsible for eleven—and that is per month, so you can imagine the amount of air time and time on the ground.

CHAIR—Do you also transport people who need acute care?

Mr Link—The regional psychiatrist, who does three monthly visits, passes that information to our psychologist who then ascertains whether I need to intervene in a culturally appropriate manner. I have so many things that I wish to tell you, but it is hard to define them. When I do go into a community, the first thing I do is notify the council prior to my visit and explain why we are coming in there.

The chairperson of Apunipima Cape York Health Council said to me last week, 'It is good to see that communities have now accepted you.' It has taken me two years to be accepted. As an Indigenous man who is not actually from this area and does not even speak the language, it is paramount to relate with people. These people can see that I am actually engaging and having that connectedness. When people come down from the cape to go to the mental health unit, there are not many male mental health workers, so I am trying to push for people in the community to get their qualifications or at least look at something different, rather than CDEP all the time.

CHAIR—What qualifications do they need to do the sort of work that you are doing?

Mr Link—You need to be qualified in health work to at least the certificate level. You can get that through the institute that I attended for three years up in Batchelor. I qualified with a degree in Indigenous mental health, which is a two-way learning process.

Senator HUMPHRIES—Can you give me an idea of how the services supplied by the Royal Flying Doctor Service break up between Aboriginal and non-Aboriginal people? Would they be two-thirds to one-third or fifty-fifty?

Mr Link—The majority of communities on the cape are 98 per cent or 99 per cent Indigenous. The tablelands tend to have a non-Indigenous focus—there are rural properties and that sort of thing.

Senator HUMPHRIES—I was thinking of the whole of the Royal Flying Doctor Service. Obviously a lot of non-Aboriginal people are dealt with by the service across the board as well, but the communities that you work in are almost exclusively Indigenous?

Mr Link—That is correct.

Senator HUMPHRIES—We have heard evidence already today about the difficulty associated with delivering mental health services that are not sensitive to cultural issues—male health workers trying to give support or services to a female Indigenous person and things like that. Is that so serious in your view that it really is imperative that all of these services—the mental health services at least—be delivered by an Indigenous person or are some of these services capable of being delivered by non-Indigenous people?

Mr Link—You have to remember that we are actually on their homelands and the right cultural intervention is for men to do men's business and women to do women's business. If a family has four daughters and a grandmother and they ask me to intervene with them, I get myself a health worker to sit in with me. That is the culturally appropriate thing to do. It is part of protocol and law as well.

Senator HUMPHRIES—It would be very hard for a white female doctor, for example, to come in there and deliver that service presumably?

Mr Link—It is about building that relationship up. When you first go to a strange doctor, you are not going to open up straightaway. Most people do not. With an Indigenous context, you are looking at things like guilt and shame and those things. Interaction with eye contact is important. With Indigenous mental health you have to look at the holistic view.

Senator HUMPHRIES—When somebody is very mentally ill—psychotic or something of that kind—do you provide a service to bring them from their community into a place where they can be hospitalised or see a psychiatrist or something of that kind?

Mr Link—Queensland Health have a visiting regional psychiatrist, Dr Ernest Hunter, and he will do a diagnosis there and then contact Weipa Mental Health, Cooktown Health Services or the Royal Flying Doctor Service, where we will provide ongoing care via the psychologists through our allied health team.

Senator HUMPHRIES—Is it rare for a person to be flown off to Cairns to be hospitalised or something?

Mr Link—No, it is not rare.

Senator HUMPHRIES—You mentioned Ernest Hunter—he is a psychiatrist who works in the Weipa area?

Mr Link—He looks after the Top End and he has done a few things in the Northern Territory and Western Australia as well.

Senator HUMPHRIES—One psychiatrist does all of that area?

Mr Link—He did that formerly—and with that disaster that happened with the tsunami Dr Ernest Hunter was a team leader there.

Senator HUMPHRIES—So that level of support is pretty thin on the ground?

Mr Link—It is, yes. So we want to train people in communities so that we can support them through our interventions.

Senator HUMPHRIES—You mentioned that you were recruiting two new mental health professionals and one had already started and that was a psychologist. What will the other one be?

Mr Link—The two mental health professionals will be travelling into the tablelands and the cape area, which will then free up a bit of time for the psychologist, who happens to be my team leader.

Senator HUMPHRIES—Will the other worker be a psychologist as well?

Mr Link—Not necessarily. We will be employing two mental health professionals. These can be from the social work, psychology, psychiatric nursing or occupational health field with a counselling/mental health background. One appointee is a nurse. We are still to appoint the second position.

Senator HUMPHRIES—Has it been difficult to recruit people for those sorts of positions in the past?

Mr Link—Yes, I would say so. Not many people want to work up in the cape. Everyone wants to stay around the cities and that sort of thing, but I love this work. I think there should be more advertising for mental health professionals, because of the issues that are happening up there.

Senator HUMPHRIES—If government could do one thing to improve the quality of service that is delivered into Indigenous communities, what should that be?

Mr Link—I would like to see cultural schools, I would like to see drop-in centres for youth, elders and people in the middle age groups. I would like to see traditional healers and elders having a bit more input into the way people feel. There is a big gap in the way our people interact with each other. Also I would like to see more money for health workers and a health worker exchange program. When nurses have holidays, there is always a replacement, but there is nothing there for Indigenous health workers. If you could implement and fund that particular initiative, that would be great.

Senator MOORE—We have the dot points here about what the service provides. Could you pick one of your communities and tell me the kind of work you are doing with them—to put the general things you have spoken about into a personal context?

Mr Link—If we look at the community of Lockhart River, I have engaged with the mayor and the CEO, community development officers—male and female—and the men's group. I also engage with the women's group now and then, upon invitation, and the clinic.

Senator MOORE—How often would you go to Lockhart River?

Mr Link—I go there once a month. The community have asked me to stay overnight, which means I am able to do more activities and more interventions and show them that I am supporting them, rather than just flying in and flying out.

Senator MOORE—The Queensland state government have focused on Indigenous communities, particularly in the cape, in relation to a whole range of things to do with domestic violence and alcohol dependency. Within those programs, is your service used as part of the general involvement, say on the issue of domestic violence?

Mr Link—That is the role of the psychologist and myself, but mainly the psychologist. We will talk around issues around the family, communication, why there is a breakdown. If there is extended family where the issue is happening, we talk about support there.

Senator MOORE—Is the Royal Flying Doctor Service, and in particular the mental health unit, part of the overall community response?

Mr Link—Yes.

Senator MOORE—Is Batchelor the only place that has that specialist degree in Indigenous mental health studies?

Mr Link—I believe the Batchelor Institute is the only Indigenous college or university in the world, with over 31 years of delivering education. The program could do with a bit more support. I started as a generalist, in general health. From listening to people's problems, I thought I would transfer over to mental health and get into that area. Since I have been up here there has only been a handful of male mental health workers or professionals. I can probably count them on the fingers of one hand. We need to increase that number and perhaps promote that nationally.

Senator MOORE—In terms of promoting this area as something people can do as a career or as a job, is that part of the role as well, to encourage people to look at working in the field?

Mr Link—When I engage with the Indigenous health workers, I look at their personal development not just in a workplace way, but also as a mate. I look at how they are dealing with the issues out there. I just support them. You like to have a good yarn with people you only see now and then. It makes them feel good and they want to know what is happening in the wider world. I support them for further professional development because sometimes you might not get that in Queensland Health. I think you get only 10 days a year for professional development.

Senator MOORE—That is about right.

Mr Link—You are limited with what you want to learn. In the remote context, there is little opportunity for health workers to go out and gain further knowledge.

Senator MOORE—Do you get a good network going amongst yourselves?

Mr Link—Yes. I think the health worker network should be in line with the nursing stream.

CHAIR—Where do you physically work when you go into a community? Is there a centre that you see people in or do you go into the community wherever people are?

Mr Link—That is a good question. Because I am health related we mainly work from the clinic. Once we have met with the director of nursing, I will go out and meet with other stakeholders. They are not the only organisation in town so you need to link up. I deal with men's issues so I try to work with all the stakeholders in the community.

CHAIR—Describe a day for us. When you arrive in Mount Isa, what do you do first?

Mr Link—I would love to go to Mount Isa but I do not go to Mount Isa.

CHAIR—Lockhart River.

Mr Link—I am mainly for the cape area. We will turn up to a community, do our meet and greet and then I will just go around and catch up with the clients that I need to counsel. The other side of the coin is that I will catch up with people like the community development officer and talk about how we are going to engage these guys into the next activity. Last year I did one in Lockhart River, it was called alinya, which means feeling good, and I contacted all the big businesses in Cairns to get their support through prizes. I had an airline fly freight up and provide $500 to the activity. We got media exposure through written and audio, just promoting the community and saying that they are coming together as one to make betterment for all. This particular activity brought 120 men on the books, which you do not see very often in one community or any community.

CHAIR—What do you mean by bringing them onto the books?

Mr Link—I put on a fishing competition and fishing is a lifestyle up in the cape. To enhance that I sought support from big business through prizes and monetary things and brought the guys together. The whole initiative was to bring young boys and men together, because men and boys do not really talk much these days, especially in the community, so it was building that cultural strength within and getting them to communicate and work as a team. We had two barbecues. They had a weigh-in. They had to come back to weigh the fish. We had prizes for the biggest, the heaviest, the longest, whatever sort of fish. Every person who had participated was given a prize. Mind you, it was the same night as the state of origin so it was very hard to keep the men together around that time.

Senator MOORE—Good luck.

Mr Link—It did not need luck because we made a time frame you had to be there and you could not go until it was finished. It was very successful. Out of that, the community of Lockhart have now started up a crayfish industry and of the 32 participants, 24 have qualified with their dive tickets through DPI. The community are now looking at doing ventures and enterprises, going forward and addressing the issues that are happening in that community.

CHAIR—That sounds like very sensible, innovative community development and even economic development, but for you is that a preventative measure? Is this something you do to reunite communities or to bring groups of people together so that they do not become mentally ill?

Mr Link—I think early intervention is probably the way to go, to identify when somebody is going through a situation.

CHAIR—Could you do that? As part of the fishing competition, did you discover who was having problems with mental illness?

Mr Link—The best part about that is when we were talking about mental health issues, men started to raise things that were not pleasant to the ear, but they were actually taking control and owning that issue, which does not really happen very much in communities. Whether you be in this community or in the mainstream, people tend to point at it rather than take ownership of it. It is good to see men now addressing those things.

CHAIR—Can you give the committee some real examples of what sort of things were brought up?

Mr Link—They are talking about bringing in the curfew system, and children are children: they are adventurous. I think there is a level of protocol that people need to follow. When you were growing up you would listen to your parents and the same thing should happen in communities. We need to re-skill our families and our parents on how to interact with their children. For example, I am a stepfather of nine and none of those children are wayward because there is communication, support, caring and listening. We should try to transfer those skills across the community. We are not trying to turn all communities into mainstream; they still have their own identity.

CHAIR—In a sense, you go with the flow, do you? You are part of a conversation and some of those men talk about parenting and curfews and their relationship with adolescents, and that allows you to then start talking about parenting models and so on. Is it fair to say that is what is going on?

Mr Link—To a certain extent, yes.

CHAIR—Do people raise specific mental health problems? Do they identify them or does this take a long time to come through those kinds of conversations you are having?

Mr Link—I think everybody on the panel understands what is happening in Indigenous communities with, for example, the stolen generation, those things that happened back in the sixties through the missions and that.

It would help if communities could come together and look towards the future for their children in terms of health, education, business and career. They have to think about the epidemics that are happening out there. You have probably heard about petrol sniffing and all of that. There are no sport activities going on. I can go to a movie tonight but what is happening out in the community? There is no movie showing tonight. There is no dance you can go to. It is all about getting funding so they can actually put it on. There are no BMX tracks and those sorts of things. The kids have nowhere to go so they ride around on the roads and that is not very healthy, especially when you are supposed to be wearing a helmet which is not seen in communities. You are looking at all those issues. As an outsider, you tend to take your own agenda into communities and I think that is the wrong practice. I think it is about working in a shared way, listening and working hand-in-hand in partnership, walking along, not behind or in front.

CHAIR—We have heard a lot in this inquiry about housing and how safe, affordable housing is critical to people who have a mental illness. We know that housing overcrowding has been chronic for a long time, and is very serious in Aboriginal communities. Are you able to tell the committee what impact overcrowding has on mental health and the way in which Indigenous communities can function? Is it a problem? Is that a root cause of some of the mental health issues that you see?

Mr Link—That is just one of the problems. In terms of overcrowding, how can you have confidentiality when everybody knows each other's business? There is no time out, there is no respect, there is no personal space for an individual to address these things. There is nowhere in a home or a house out there that a person can just go to and have time out in a room. That is how I see it. You have to get the department of housing to build some more homes out there. The hardest part too is that there is no home ownership out there, so how can anyone feel good if they do not own the home that they are living in to raise a family, so that the children come back and know that that is their home? Coming back to community is different from coming back to your home.

CHAIR—That is an interesting issue that you raised about children and where they come home to. In another Senate inquiry we heard that up in Arnhem Land there were children who slept in different places routinely throughout the week. This was a dry community. We asked why it was that it was still necessary to have breakfast programs for children in a school in a community that seemed to be functioning very well. The answer was that houses are not necessarily places where meals are prepared. Is that your experience as well?

Mr Link—I cannot speak on behalf of that because I had a different upbringing. I have always had breakfast every morning with my family.

CHAIR—It was not so much whether you had breakfast or not but, where you have housing overcrowding, do those houses simply become dormitories? Because of the overcrowding, what does that do to the sense of home, for children in particular?

Mr Link—I come from a very big family myself and visiting my elders, my grandparents, on the weekends you would have about 20 or 30 people staying there anyway. That was on an urban site in Brisbane. It is no different from being out in community; it is just that you do not have as many services or the luxuries that you have in mainstream cities. But with overcrowding,

children are not able to go to bed when it is 9 o'clock or whenever; it does not really happen. That is only my opinion.

CHAIR—That is all we are asking you for, your impressions.

Mr Link—I would like to see it all change but that will probably take a couple more generations through raising awareness and supporting people who are experiencing these mental health issues.

CHAIR—If there is nothing else you wish to tell the committee, we will thank you for your input.

Mr Link—The reason mental illness strikes Indigenous people is because there is a lack of jobs and employment. Skilled people have no jobs to go to. You train people in communities but realistically they are not going to have a job to go to. You therefore have this over-resource of skills but no jobs for them to act on. I stated that to the education minister in the Northern Territory and funnily enough a few months later an injection of funds went into the Northern Territory into some of these remote areas.

CHAIR—What happened to the funds?

Mr Link—There was a boosting of funds into communities. This is what I want to try to do today. I hope you can inject more funds for Indigenous people so they can handle these issues. I am only there for support through the Flying Doctor Service, so please put the money in. Thank you very much for your time.

[2.10 pm]

WILLIAMS, Mr Craig Anthony, Chief Executive Officer, Far North Queensland Consortium for Social and Emotional Health and Wellbeing Ltd

CHAIR—Welcome, Mr Williams.

Mr Williams—We are what is known as a regional centre. Our organisation looks at work force issues in and around the areas of social and emotional wellbeing, or what you are calling here mental health. We have a board made up of organisations as compared to individuals. Our organisational board is made up of the Torres and Northern Peninsula Area Health Council, the Wuchopperen Aboriginal Medical Service who you had there this morning, the Townsville Medical Service, the drug and alcohol service for Cairns, the Townsville-Thuringowa Community Justice Group, the Mackay Medical Service and Mamu Health Service which is the Innisfail Medical Service.

As part of a regional centre, we cover an area from the Torres down to the eastern cape down to Mackay, out to Croydon, just west of Mount Isa, back up the western cape, back up to the Torres. We cover 11 of the Aboriginal DOGIT communities, or councils as they are called these days, out of the 14 in Queensland. In my area I have the largest number of Torres Strait Islanders and the second largest number of Aboriginal people in our community in what we do and what we cover. The area is approximately the size of Victoria and a half. It is only a small area and I have a staff of about eight to do it all. I am quite happy to be here.

The other presenter was supposed to be Nyrell Pattel, unfortunately Nyrell is doing some training for us so she sends her apologies. She is the author of a lot of the information that you received the other night and today. I am going to do my best to answer a lot of the detail. I have a fairly good understanding of it, but you may want to come back to us for clarification on some issues.

CHAIR—Thank you very much for appearing today. We appreciate it. Did you wish to make another statement about your submission? If you do not want to do that we can go straight to questions.

Mr Williams—I just wish I had more time. What you have heard not only today but in the past week and in last couple of weeks that you have been travelling, is that probably a lot of the same issues have been brought up time and time again. What we do is look at these issues from a work force perspective and we try to solve the issues that are pertaining to the work force, and not to the client as such.

When we talk about our issues, I think you will actually find a different perspective, more so than the client perspective that Jonathan Link has given you. I do not want to talk about how overcrowding is affecting the mental wellbeing of a person. I would like to talk about how overcrowding is affecting the wellbeing of the worker, what skills the workers are lacking, and the issues around the professionals that are moving into our communities. How do we actually have a better understanding of the skill level that the worker has? And that applies to both

Indigenous and non-Indigenous workers. If you have a look at the documents, we identify a big gap in there which is therapy; it is a huge gap. We have to take this to whoever and start slapping them in the head to say: 'Hey, it's time to wake up.' Having psychologists, psychiatrists and social workers is fine but you are missing out on something, which is about the healing of our people. That is what we are missing.

CHAIR—Can you tell us who the consortium is?

Mr Williams—The consortium has been funded under the regional centres through the Department of Health and Ageing. The funding originated from the *Ways Forward* document.

CHAIR—Is it a consortium of service agencies?

Mr Williams—It is a consortium of organisations that come together that have the same focus, which is the social and emotional wellbeing of the work force. We cover all the vocations. Just on my board we would cover approximately 1,500 people, including Queensland health workers, community workers, social justice workers, drug and alcohol workers in the community sense; that sort of stuff. Where would you like to start?

CHAIR—Wherever you want to take us.

Mr Williams—Let us look at the first one. We also had a look at the 17 agenda items that you were talking about in your discussion paper. We thought it would be a waste of time talking about all of them for the 45 minutes that we have to present. We have targeted about six. I am not going to have enough time to talk about it all so we will skim over the whole lot and then come back to it.

The first issue is 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 objectives, and the barriers to progress. Because we come from an holistic context when we look at mental health, we are trying to say that mental health is only one issue with our society. If you are only going to target mental health, you have to look at the stuff about welfare reform, about the wellbeing for us when we get employment. We are supporting a group that is full of poverty and has no future and saying, 'Let's put a bandaid on this,' when we should be looking at it holistically. We cannot just say, 'Okay, let's put money into mental health.' We need to put money into mental health, training, infrastructure and housing. We need to have an holistic view. We have to stop this, what we call, very white western view of siloing. We need to break that. We need to start saying that if you are going to pour money into a community, make it a community focus and responsibility.

We have a tendency to say to the communities, 'Here is $100,000; go and build yourself a community healing centre.' We have done that in the state. We have five communities up there with healing centres but no programs. We have the infrastructure; we just have no programs to go into it. If drug and alcohol try to get into it, what they are doing is just sliding them across. Because it is funded from a different organisation, they are not supposed to use that facility. We are siloing again. We have got to look at the holistic view of it. We have to look at how we actually implement a strategy that says: 'Okay, you talk about housing, unemployment, training; you talk about what we are talking about here, mental health or wellbeing. How do we develop a

strategy based against the community needs?' We are dictating from the top down; it should be the opposite way around. Those who are in the community should be dictating to you at the top to say what they require.

Having said that, here is the trick. We have a whole heap of communities out there that are screaming at you and I am sure you have heard it all week. They are saying, 'We need more of this, more of that, more of this, more of X, Y and Z.' The problem is that they do not have the ability, or the knowledge of the content, to actually turn around and say to you constructively, 'This is our plan.' That is what you are missing. You are missing the communities coming to you and saying, 'This is our plan.' They are coming to you in the same format that you go to them, in silos. They are saying: 'We need more money for housing. We need more money for mental health. We need more money for training'. You reject them if they come to you with an holistic view.

The second issue is about the advocacy of various models. The Western world view is that held by the dominant society. We are talking about the Western world view of how you verify our industries. Diagram 2 on page two explains what western self is. When you implement policies and programs, when you talk about what is going to be capable for our communities and for our people, you come from this model. This model is so limited in what you do. I will give an example.

Looking at this model you have the physical, the emotional and the wellbeing, then on the right hand side you have the adolescent, the child and the adult. This is how your funding rolls out: you say, 'Okay, we're going to fund a medical service for diabetes in adolescents.' You look at the physical and you will give a dollar to the medical service for every adult in respect of whom they do a program. In the mental state you look at psychologists or psychiatrists and you say, 'Okay, we're going to do a program for adolescents,' so you give them a dollar for each adolescent they see. We are saying that the holistic view of Aboriginal people is greater than this; this is limited. What you have done is siloed our industries. You have based it against your model and tried to fit a square peg into a round hole. It will not work. It has not worked for 200 years. If it worked, it would be fixed. It is about time that somebody actually stood up and said that is not working, so what do we need to do?

Senator HUMPHRIES—How should it work in your opinion?

Mr Williams—On page four you will see what we call Aboriginal self. A lot of people have been talking about this, and you have probably heard it today. We come from an holistic culture. We come from the land. We talk about country and about family. That is what this is. For most of you here, or I dare say all of you here, this would be the first time you have seen Aboriginal self on paper. It is actually written by Nyrell. Love her, hate her or whatever, Nyrell is actually one of the very few Aboriginal therapists. She is doing a PhD through the Centre for International Mental Health in Melbourne which blows every other Aboriginal program or qualification out of the water. How high and how much has this has actually been recognised by that university? The Associate Professor himself is her supervisor, so they are taking it seriously.

Here we talk about the emotional, physical and mental 'self' in Aboriginal terms and we call that spiritual self. It is not Christianity, religion, Buddhism or whatever; it is about us having our spiritual being. Who are we? How do we fit into the world under ourselves as a physical

presence? We then go into the child, the adolescent and the adult. It is our cultural lineage. That talks about us linking back to our community, linking back into our understanding of who we are and where we stand in this community and in this world.

We then have what is missing from your model and that is the past, the present and the future, which is encompassed in vision. 'Encompassed in vision' means what we used to call the dreamtime, but the alternatives out there have grabbed this terminology and called it dreamtime living and dreamtime visions and all this, so they have bastardised the term for us as Indigenous people. What was quite unique to us has now been bastardised and taken on. We are now moving towards the terminology of 'vision.' Vision, that is the past, the present and the future; it is what our stories were which were basically our ethics, morals, standards and laws. We did not just wake up yesterday and say, 'Okay, we're going to follow laws;' our laws go back 100,000-odd years. That is what that is about.

This is where it gets all tricky because we actually encompass that in the land. We do not look at land as a value, we look at land as mother earth, and we do it because it is actually encompassed in all of that. When we talk about spiritual self, our cultural self, our dreamtime or vision, it is because our connection to land is who we are. We cannot separate any of that. We cannot take away the cultural aspect of it, we cannot take away the vision because we end up with broken people. We do a full two-day workshop on all of this and we go into this in greater detail. We have come in now and distorted all of this.

We talk about one of your dot points here about the incarceration rates. When we look at this, when this is distorted, when these people present to the psychologists, psychiatrists, the social workers, the legal system, these people are diagnosed with borderline personality disorder. That is because your DSM-IV, your limitations of your training, the western world training of psychology and social work, is based against the western perspective. I do not know if you are social workers, psychiatrists, psychologists. I hope you are because I think you will understand what I am talking about. When these people present with borderline personality disorder you turn around and say to them they are untreatable. Under our models they are treatable.

Senator HUMPHRIES—Can you take a person with borderline personality disorder and tell me how the treatment under this model would be different to a western model?

Mr Williams—Go back to the two sections on page 2. When a psychologist or psychiatrist is trained under western theories, they look at that area. They look at you as the physical, the mental, the emotional and they look at you as the child, the adolescent and the adult. You are missing the linkage back to history. We start with the history.

Senator HUMPHRIES—Go to the level of what actually happens. There are two people that have come through the door, one an Aboriginal man and one a non-Aboriginal man, and they both have borderline personality disorder. What happens to them?

Mr Williams—They will get drugged if they go to a psychiatrist.

Senator HUMPHRIES—The western man does?

Mr Williams—Both of them, because nobody is talking about what we are.

CHAIR—What should happen?

Mr Williams—We can only talk about the Indigenous person in this case because we do not get paid to do anything else other than that. The Indigenous person would come to our service and we are doing it now through some of our programs: we talk about their past and how the past has affected them. We are talking about transgenerational trauma here. When we talk about borderline personality disorder we are talking about the effects of transgenerational trauma. We have seven generations of people here in this country that are absolutely falling apart, hence the reasons for high incarcerations, drug and alcohol issues, the whole lot. We work on how they have been brought up through those transgenerational issues.

Every Aboriginal person, regardless of who they are and what they say, has been brought up under some sort of influence under that. My issue was that my mother was part of the stolen generation. Look at the spiritual one, the full Aboriginal self: she has no connection to culture. She has no connection to the vision, so she has brought me up with having no culture, no vision, no nothing. I have been isolated. When these people come in we talk about how they put that back into it. That is why services like Link-Up are important because we are actually giving them back their culture and their vision.

Once we have finished talking about the past and why they are actually at this level we can then start to work on other areas of them: the childhood, how was that affecting the child, how did that affect the adolescent, how does that affect you now as an adult? Then we work backwards down through your emotional, your mental and your physical.

Senator HUMPHRIES—Using western jargon, it would be cognitive behaviour therapy? You are talking a person through what has led them to that. You would be less likely to medicate them than under the western model.

Mr Williams—We run the personal support program, which is about taking those that have gone to Centrelink and been on unemployment benefits, and they are at a level in their life where they are not capable of getting a job but they are not at a level that puts them on a disability pension, for example. They are in limbo. We take these people through this process and it is working. We bring them in and ask them, 'Where do you fit in this process? How are you limiting yourself? What are the triggers and indicators that stop you from presenting yourself as a whole person out there?' We start from there and we go backwards.

Senator HUMPHRIES—These treatments are more likely to be in a non-institutional setting, they are not likely to be in a hospital or a psychiatric ward. You are more likely to do it out in the community?

Mr Williams—This is why Melbourne University is jumping on this, they want to roll this out through their psychology and psychiatry programs. We need to get to that realm where we as Indigenous people recognise this as a whole discipline that is missing. We need to train our people up in that discipline which is therapy and train up against these models. This model here talks about the holistic person and how that rolls out in not only themselves but their family and their community.

One of the committee was nodding before, so I am assuming you were some sort of psychologist—

Senator MOORE—Social worker.

Mr Williams—I can guarantee that you have had people present to you, you ask the question and then they talk about my uncle or my cousin or my brother. You are trying to talk to them about them as a person, which is going straight to self. Because we come from a context that encompasses all—our self, our family and our community—it is possible for us to actually present and talk to you in the framework of something that has happened to my cousin as if it happened to me, because it has affected me. If you talk about overcrowding in housing, if so and so cuts their finger, everybody in that household knows about it and everybody in that household is affected by it, especially if that person that cuts their finger is the person that is cooking the dinner. The youngest one in that family may present to you and say, 'I'm hungry.' Why are you hungry? Because uncle cut their finger. No, that does not make sense. Did you get fed? No. Because we talk about outside. We present to you with all these sorts of issues. We need to get the message and the words out there that we can make change for our people. It comes back down to understanding the roles of everybody.

There is a diagram on page 7. When we talk about therapy and counselling there are actually a whole range of standards of ethics that they have to follow. They follow their own levels of training as well. We have now tried to overload the social workers, psychologists and psychiatrists and we are saying, 'Take your normal role and we will give you counselling skills.' All of a sudden our social workers and our health workers, and there are community development workers and community workers in here—Jonathon would be somewhere between a community development worker and a health worker. We actually build them up with the skills for counselling by saying, 'Here, go and do this model in counselling and then we will give you clients.' Use your social work background, your community development work background, your community worker background, add a bit of counselling to it and all of a sudden you are meant to go out there and work with our people. We are saying there is a level of training, a level of qualifications out there required for counselling.

I will give you a classic example. I know Jonathon and his wife personally. He came from the Northern Territory. He came to us and I tried to talk to Queensland Health about taking on a cadetship with him with that qualification. Queensland Health knocked it back flat, the reason being that they do not recognise it. Batchelor may be wonderful but the qualification is not recognised. He sits in this area here and he has no qualification. I had a phone call the other day from one of my member groups that is a medical service, and they were looking to try and bring some sort of payment from the government, like the rebate the doctors get from the government. They have a family unit there. They were talking to the government about getting some sort of rebate for each time this person counselled someone. They knocked it back; they were not qualified. That is what is happening in here all the time. We are not recognising that there is a whole industry out there that talks about therapy and counselling.

We need the social workers, psychologists and psychiatrists to have an understanding of what counselling is. We also need people to understand that it is a discipline itself. We are pouring all our money into psychology, psychiatry or social work. We need to say, 'Fine, do that, we need

that, there is a role for these people, but there is also a role there for therapy and counselling.' That needs to be identified and that needs to be addressed.

CHAIR—People who present to us complain about us using a very medical model in treating mental health and that we need more therapists and we need more talking. It is hard to see where the difference is.

Mr Williams—When they say they need more therapists, they only go halfway. We have people running around presenting models but they do not meet the standards. There is a whole industry based against these standards. A therapist would be able to work on two or three different counselling models when dealing with a group or an individual. One example is a person who has done social work with one model in counselling; they say that counselling skill that they have is suitable for all clients. It is not true. What may work for one person does not work for another. We are now actually endorsing lower levels of therapy. We need to take the people with those skills, skill them up to be therapists and counsellors and recognise them. That is the difference. We are quite happy to take people from out of their disciplines, give them these extra areas and move them into a new area. We have to stop that. We have to start recognising this area.

In your mental health documents you talk about psychology. The last report which I worked on in Canberra was the mental health for Indigenous people. I saw the word 'social workers' once in the documents and I saw the words 'psychiatrists' and 'psychologists' about twelve times in the document. Where was the therapy?

CHAIR—That is what a lot of people are asking us, but not just for Aboriginal services.

Mr Williams—We have people running services out there who have one unit or one model of counselling. Where does that leave that service if somebody tries to sue them? Where does it leave the government for allowing that service to pay these people at this rate, that can only afford these people that are unqualified in what they are doing?

We are moving towards a society where we understand that if you want to make a quick dollar you sue someone. No-one can deny that. Think of a situation where someone's sister went to see somebody at one of the AMSs or drug and alcohol service and that person then goes and does some self-harm or commits suicide after seeing that person. If I was a smart solicitor or smart lawyer I would go back to that organisation and say, 'What are your qualifications and standards?' Organisations out there have not got any. How much of a field day am I going to have as a solicitor with you? These people that we employ and are deemed capable of working with our people in these areas of therapy would not get a job in Relationships Australia or Lifeline, yet we are happy to endorse and keep funding organisations to keep these people employed. We need to be upskilling them to actually deem them suitable to be in those areas.

Senator MOORE—On that area, one of the big complaints that we are getting from a lot of community organisations is that they feel they are overregulated and that they have to respond and do too many reports and be way too accountable. How does that cross with what you were just saying? I know that in the past people with questionable qualifications have been setting up services, but I think both levels of government now have come in really hard. One of the arguments for all the accountabilities is to clean that up.

Mr Williams—I am speaking off the top of my head, so please do not take what I say as gospel. I envision that the government may have their good intentions and they may write it in paper, but it is not actually being implemented on the ground. When you talk about paperwork and reporting, my organisation has gone through that many changes from the department it is not funny, but at the end of the day I am still producing the same sort of product. It does not matter how we report it; I could complain until the cows come home about writing and filling out forms but at the end of the day I am still producing the same product. Yes, I can see that there is an issue about people doing all this extra paperwork and being bogged down. The flip side to that is, is that the person delivering the service or is that the person that is running the service? You have to put the responsibility where it belongs. That is a whole new area.

The other issue we have is that those running the services are not qualified to do it. I am not talking about our therapists—

CHAIR—What are you referring to, Mr Williams?

Mr Williams—CEOs, senior management of Aboriginal organisations. We have industries running out there. Some of my member groups have budgets of $5 million or $6 million. That is nothing to be sneezed at, yet the CEOs and the managers and the line supervisors are not qualified. How are we supposed to get this understanding about upskilling and getting the right qualifications in our work force when those that are actually running the work are not qualified or skilled enough to do their role in the first place? It is a whole another issue. When you talk about mental health issues, how are we supposed to be rolling out these when those that are actually doing the jobs are not doing the jobs properly in the first place? It is another issue. It is a fact that needs to be discussed. If you are going to be talking about our mental health abilities, you have to talk about the boards of management, not just our counsellors and our workers. Are those people on those boards actually qualified to be there? How do you ensure the standards are there? How do you ensure the ethics are there?

Senator HUMPHRIES—Do you think we should be training more Aboriginal people to be psychiatrists or psychologists? I suspect the answer to that question will be, no, keep the two models apart, they are not particularly compatible.

Mr Williams—Our model is also a scale to move up in your work force. We have people out there working at that community work level who are moving through; they are becoming social workers and health workers. Jonathon was a health worker at one time and now he works for mental health; he went and did his studies. These are areas that move through, so there is nothing stopping the therapist or the counsellor moving into psychology or psychiatry or a social worker doing the same thing.

We go straight from social work into psychology. We do not give much thought to that realm. We need to be more persistent and more consistent about the role of a therapist. How do we get that vocation around? That comes back to your models here. We then have the issue that it is okay to go and train more therapists but are we training them in the western world view, which is limited when it comes to our people? How do we get that message out? I am here to give you all headaches; these are the headaches I have to live with every day.

Senator HUMPHRIES—If there is one thing that government could do to help the work that you do in your organisation, what would it be?

Mr Williams—I would love to get an endorsement to have an Aboriginal first nations psychotherapy and family association. When we get the money to do that then we can actually start to bring the standards and ethics into place.

Senator HUMPHRIES—Do you mean an organisation that would train people in that area?

Mr Williams—We have been down to Melbourne and spoken to PACFA already—

Senator HUMPHRIES—What is PACFA?

Mr Williams—PACFA is the Psychotherapy and Counselling Federation of Australia. They are the governing body that counsellors align to. They set the standards for workers and their qualifications.

We are moving through this anyway so whether we get the money or not is another question. We are seeking outside funds. We want to actually have this association up and running so that we can then start to dictate what are the levels of ethics and standards required for people to work with our people. We need it. We need an association out there that you, as the government, can come to and say, 'What are the benchmarks?' We do not have any benchmarks; that is the problem.

We have people walking around and doing things, hold your wrist and flick it up a couple of times and talk to your spirit. They are out in our communities supposedly healing our people. We have others walking around with rocks, moon stars and fairy lights that are supposed to be healing out people. What are the ethics and what bounds them? Nothing. Yet they are getting away with it. Worse still, some of them are actually getting funded by the government to go out and do it.

Senator HUMPHRIES—You would create standards that are applicable across all different types of Aboriginal and Torres Strait Islander communities and settings?

Mr Williams—We are not talking about a job role; we are talking about a standard and ethic that gives a benchmark for the role of Aboriginal therapists and counsellors. If you want to call yourself an Aboriginal therapist or an Aboriginal counsellor, what stops you nowadays?

Senator HUMPHRIES—Nothing.

Mr Williams—That is right, there is nothing there. Can I go out and call myself a social worker?

Senator MOORE—Yes.

Mr Williams—You are supposed to say no. Ethically I could not. I could not call myself a social worker. I could not call myself a psychologist or a psychiatrist, but I can go out there and call myself a therapist and heal our people.

CHAIR—Funded by whom?

Mr Williams—The universities. Jonathon is doing a qualification and now he has found himself moving into this area. He has counselling skills, he is not a therapist or a counsellor. You need to be a therapist to deal with some of the cases with which he deals. When he was talking about his fishing competition, our organisation sponsored half of that. I can tell you personally about some of the cases he was talking to you about and they were coming back to talk to him, that some of them worked at that level. When you have people that like you and they start to disclose, you do not know what you are going to get. You have no idea. He is now going, 'How the hell do I deal with this?'

It is the same for our health workers. Our health workers burn out at a greater rate than probably any other vocation in Australia. I would like to see the statistics to deny that. High stress employment rates and turnover, I bet my bottom dollar that Aboriginal health workers are in the top three, if not the highest.

CHAIR—At the outset you talked about the fact that the qualifications from Batchelor were not being recognised and that this was a problem.

Mr Williams—They are not.

CHAIR—Does Mr Link not have Batchelor qualifications?

Mr Williams—In what?

CHAIR—I am not sure I get your point.

Mr Williams—My point is this. The studies that he did gave him skill in counselling but did not make him a therapist. The work that he is doing requires him to be a therapist.

CHAIR—Should he not have been employed or should his training have made him a therapist? Where do we go?

Mr Williams—If you have a look at the scale, he is about a community development/health worker. He needs to upskill and become a counsellor or a social worker. If he went to work for Relationships Australia, chances are he would not get a job.

CHAIR—Why are we in this position? Is it because he is not willing to do the extra training? Is it because there are not enough fully trained people to fill those positions? What is the problem?

Mr Williams—Several aspects. One is that we have never recognised therapy or counselling as an industry itself. We have looked for the shortcuts. Get somebody, give them skill and then slot them into that job.

CHAIR—Batchelor does not have an appropriate course?

Mr Williams—No.

CHAIR—Does any college?

Mr Williams—Some do. If you make contact with PACFA, they can give you a list of organisations that deliver training that is at that standard. Each state has their own family therapy association.

CHAIR—Are they appropriate for Aboriginal people and for Aboriginal application?

Mr Williams—They set the standards. Being appropriate is another thing because that is about your western model.

CHAIR—You are telling the committee that there need to be culturally appropriate services for people. Why does Batchelor not provide this service? If the only thing you can get at Batchelor is something that is inadequate and you have to go to a western model, in your view, then why is it that Batchelor does not provide that Aboriginal model?

Mr Williams—Because it has no real employment outcome. It is not just Batchelor; we have people working in community management coming from some of the universities in Western Australia. Where is the alignment in this? We have people out there spending $14,000 on HECS fees to have a piece of paper that means nothing. It is so true. Jonathon is doing a role that if I was a solicitor and he did something wrong and somebody did something silly, he would be in a lot of trouble. You would turn around to him and say, 'What are your qualifications to do this job?' The Royal Flying Doctors and the AMSs would be in a lot of trouble because we are taking the shortcut. We are not recognising this industry. We are not aligning our industry to any sort of standard or ethic. If the standard was there, that university course that Jonathon did would have to meet that. It does not. The one in Sydney, Office of Aboriginal and Torres Strait Islander Affairs, OATSIA, paid that program close to $1.1 million to get that qualification up and running in mental health. It takes on very much a clinical view, but once again it is not recognised by any associations.

CHAIR—Why is it so?

Mr Williams—To me it is because we have come up with a culture where we have so much disparity out there that we are trying to come up with solutions.

CHAIR—Are we not just trying to get Aboriginal people into the service? Is that not the main reason why people are being put in underqualified?

Mr Williams—For about thirty years we have been trying to get Aboriginal people into qualifications, into higher education, getting them into feeder programs. It is time that we started looking at the qualifications that are being delivered and ask where they fit in society.

CHAIR—What if that means that no Aboriginal people can reach or do reach those qualifications for a whole range of reasons, for example, they are not willing to move from their home communities. We all know the reasons why Aboriginal people have had difficulty getting into tertiary education. If we do what you are suggesting and rule out these kinds of jobs that Jonathon does on the basis of their training being not quite adequate enough, where does that leave the system?

Mr Williams—We need to start enhancing their roles and getting their roles set to a standard. We need to stop playing games with these qualifications. We are building up people with false hopes. Jonathon was crushed when he came to me. I knew the person in the work force development unit in Queensland Health and I called him on his personal mobile and I said, 'I've got Jonathon here and I want him to go into your cadetship program.' We lined it up with mental health here, everything was set up, but the head office in Brisbane knocked it back because they did not recognise the qualification. Yet he is now working in this area.

CHAIR—They did not recognise this is a qualification for further training?

Mr Williams—It is not a qualification that they recognise to do those job roles.

CHAIR—In state health?

Mr Williams—Yes. If he wanted to be a nurse, social worker, psychologist or psychiatrist, he would have been in there like Flynn, but because he was doing this qualification that talks about Aboriginal mental health there was no alignment to it, there were no standards in it, and Queensland Health knocked it back.

CHAIR—What did they knock back?

Mr Williams—They knocked back his qualification.

CHAIR—To do what?

Mr Williams—When he came from the Northern Territory to Cairns, we tried to get him in to do the cadetship program to save him the HECS fees and get the government to pay for it. The reason they knocked it back was that they did not recognise the qualification.

CHAIR—What qualifications would you need to get into this cadetship?

Mr Williams—You need to be a psychologist, psychiatrist, nurse or doctor.

CHAIR—To be a cadet?

Mr Williams—Yes, in the cadetship program. If you go to the website you will see it when you talk about cadetships in Queensland Health. They have a list of what you can do.

Senator MOORE—That is a postgraduate position. They do not recognise the Batchelor degree in mental health as a prerequisite for the cadet program.

Mr Williams—Which is sad because Jonathon spent a lot of money and he is working in industry. I overheard him talk about their wanting to upskill people in the communities. The question has to be asked: what are you training these people to be in the communities? Are you giving them one unit of counselling and telling them they are now qualified to be a family therapist in the community?

CHAIR—That is what we say to GPs: give them six hours training and they are part of the better mental health outcomes program.

Mr Williams—That is exactly right, but are they? If they did stuff up and somebody were smart enough to cotton on to it, where would that GP stand?

CHAIR—Ideally Batchelor should change what it does and the qualifications it gives?

Mr Williams—Let us stop calling it Batchelor. It is actually a universal problem; it is not just within Batchelor. I can name four or five universities that are doing qualifications specifically for Aboriginal people that are not recognised.

CHAIR—Are you arguing for total mainstreaming—no particular Indigenous courses that are somehow lesser than others?

Mr Williams—I would love to. We have to have qualifications that are equal. We can still have the Aboriginal component to it; we can still argue for the Aboriginal focus on it. I would love to see these sorts of models being implemented and taught in the universities. The problem is that the qualifications that people are coming out with are not being recognised by industry.

CHAIR—I understand that. In order to make them accreditable across the board, people need to be at university for longer? Is it a problem with the trainers, the professors, the people who give them the skills? What needs to happen?

Mr Williams—The government needs to stop funding organisations that put qualifications out there that are not meeting industry standards. The universities, TAFEs and private providers are being funded to roll out these things. It is a whole of industry issue. We need to start benchmarking or aligning the qualifications to a standard and an award. I can do psychiatry or social work, finish my university studies today, walk out tomorrow and I am aligned to an award because there is an industry for it. When Jonathon finished his qualification there was nothing for him.

CHAIR—He has a job with the Royal Flying Doctor Service and doing useful work, is he not?

Mr Williams—He is. I do not deny him that.

CHAIR—He is being paid a lesser wage than you would expect?

Mr Williams—So are health workers. If he were a qualified therapist doing the work that he is doing, travelling to the communities and counselling in four communities, how much do you think he would be on?

CHAIR—How much extra would he have to train for? How many more years?

Mr Williams—Knowing Jonathon personally, he would probably only need to do about four units.

CHAIR—Which is what—one year or two years?

Mr Williams—I am not familiar with other areas. I am a manager.

CHAIR—Roughly.

Mr Williams—I was actually talking about myself as well before. I do not exclude myself from these issues. I would be looking for him to be dealing with therapy models because there is a lot more than one model out there. An important one that we always miss is how he heals himself. There should be a unit in every qualification, whether it is TAFE, university or private sector, that talks about how I handle my own personal health and how I identify my own issues.

I know a horrendous story of a women's shelter where the actual manager had an axe put in her head by her husband. She never healed. What sort of service is she projecting onto her clients when they come in and have been beaten? Is she fair? I cannot answer this and I do not think anyone else could, bar the person. We need to start looking at how we heal within ourselves. We do not do this. The qualification that Jonathon did did not do that.

We need to look at how we heal ourselves, the different models in therapy and the different roles of industry. How do social workers, psychiatrists and psychologists fit into it? We are getting an industry where people like Jonathon are treated as second class only because they do not have the same language or skill as the social workers, psychiatrists or psychologists. We do not have that level of language. We develop it but as soon as we walk out with these qualifications, we do not have it.

CHAIR—What you are advocating seems to me to be quite sensible for non-Indigenous people as well.

Mr Williams—I do not want to go there.

Senator MOORE—I think what you are saying has already been recognised, certainly in the area of Aboriginal health workers. That has been through the PHCAP system. They have been trying to standardise those qualifications so that people have something that is comparable. The particular issue you were raising about therapy, that area is being considered by somebody from Victoria whose name I cannot remember because of the proliferation of people self-identifying as counsellors and therapists. Your issue was particularly in the way that this can be exposed and manipulated in Aboriginal communities. Is that right?

Mr Williams—Yes. It is being covered up and being endorsed by the government funding models. Our organisation is putting through a group to be family therapists, and I am one of them.

Senator MOORE—Using the pre-established benchmarks of the national body?

Mr Williams—Yes.

Senator MOORE—Are you going to get that establishment for the existing body and then through that process try and get the acknowledgement of a particular Aboriginal Indigenous area?

Mr Williams—Yes. Nyrell is a therapist so she can join this association. She is going to be our patron to have the association up and running because you have to have that qualification and level. You cannot just walk in there and say, 'Let us open up this association.' It will not work.

In order to do that we also need to build our industry. We are now working on a strategy to include more Aboriginal people to be therapists that meet that benchmark, those standards and ethics. Then they become the members of it and from there we will roll it out nationally. We could talk about international strategies if you want to go there.

Senator HUMPHRIES—Would people working in this area accept the need for the kind of system you were talking about where standards are being set?

Mr Williams—Once they understand it, yes. A lot of people will take it as a threat if they do not understand it. They could get the impression that they are trying to set up the standards so now they are trying to take away our job. Or, 'I am not qualified. If I go with this, I am going to be out of a job next week.' It is not about that. We are trying to get these people that are doing these jobs to do the recognised qualifications and bring them up to a standard. It is as simple as that—let us bring them up to a standard. I am trying present to you here the arguments for it: we do not recognise counselling because we go to social work, psychiatry or psychology. Health workers are the same thing.

I went to the national training council for the health workers' training package in Sydney. I gave them a headache. They are not talking about ethics and standards; they are talking about this model here. Let us just upskill the health worker and call them social emotional wellbeing workers or counsellors. Health workers are overloaded as it is. Now we give them two units in counselling and they are a counsellor? Come on!

CHAIR—I think there are parallels still with the non-Indigenous sector. There are plenty of people learning counselling in a 12 month part-time course somewhere.

Mr Williams—There is but I do not want to talk about that. I will tell you a secret: that is your issue. That is not my headache, that is your headache.

CHAIR—We both have the same headaches.

Mr Williams—I just get a different headache from a different point of view. All in all, what I am trying to say to you is that the Western models that we learn from are limited when it comes to the Aboriginal self. You are not taken into the full realm of self. We did this over a couple of days, so we can go into it in great detail if you wish. When we go out there, we talk to people and say, 'These are your limitations. When you are dealing with an Aboriginal person you need to take these into consideration.' We talk about Aboriginal narrative, communication styles, the relationship between the family and community, holistic communities and definitions.

In this paperwork we talk about a definition for Aboriginal cultural service, what is a culturally appropriate service. You will not find that anywhere else. We also talk about the words 'transcultural practice'—that is about competency. That is what we talked about before: how do you take somebody from the Western world view and then bring them into a context that is competent for Aboriginal self? The program is there. We are doing it now. We just did an introduction with the department of communities.

CHAIR—Thank you very much. That was really useful. I hope our questioning was not too difficult.

Mr Williams—No. Once I got over my nerves it that was fine. I hope it helps. Our people are suffering and we need to make change. Two hundred years has not helped it. We need to take a different view.

CHAIR—Understood. We will take a short break for afternoon tea. You are welcome to join us.

Proceedings suspended from 3.04 pm to 3.21 pm

BRIDGE, Dr Simon, Private capacity

CHAIR—Dr Bridge, thank you for appearing. Do you have any comments to make on the capacity in which you appear?

Dr Bridge—I am a general practitioner in private practice. I am here as a private practitioner.

CHAIR—The committee has your submission which it has numbered number 500. You have presented us with the pamphlet that you refer to in your submission. Is it the wish of the committee that this be taken as a further aspect of the submission? As there is no objection, it is so ordered. Are there any other changes or additions you want to make to the document at this stage?

Dr Bridge—No, the document stands.

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

Dr Bridge—As I was not sure of the scope of the inquiry, I have picked up four issues that I have been running with over the years—going back some 20 years. The immediate one is the pamphlet. That was developed because it seemed to me that in the multi-strategy approach that we have to suicide prevention—where we try and empower communities to get communities better connected, where we try and encourage people to be more aware of potential warning signs and where we try and bring in legislation to reduce the means of suicide—the one gap that we seem to have is actual resources for people who either have suicidal thoughts or potentially might; in other words, high risk groups. There is nothing around that is simple, cheap and available. That is why I produced the pamphlet.

The pamphlet seems to have filled in a gap because it has been very popular and has been taken up by a lot of practitioners around the country. What I have found most difficult is engaging the main players in this area, in either acknowledging me, like writing back, or supporting it. I am thinking of players like beyondblue and Lifeline. Probably of particular interest here is the government agency AussieNet. They do not respond and have given me no support for this so far. It has been very much driven by front-line practitioners.

Just lately the Australian Divisions of General Practice has become more keen to be involved and supportive. Given that the chairperson, Dr Rob Walters, is on the national suicide prevention committee, he seems to be particularly keen to push it in a couple of areas. One is the general practice and physician area. We are looking at attaching the pamphlet to one of the GP magazines in a possible mail-out. It would go to 34,000 GPs and physicians, if we can meet the $9,000 cost to do that.

The other area is to have the pamphlet become much more of a player in mental health services, providing information for patients going into the service. We know the suicide rates are, unfortunately, very high. In Queensland they are three times higher than the suicide rates of those in prison—this is whilst you are in care. Once you leave, the rate is 100 times higher in the first month and 10 times higher at the end of the first year. In something like 40 per cent of

deaths people have had contact with a mental health service in the previous year. We know that this area is very high risk and my sense is that we do not really do much to address that. Something like this, which is simple information to give to patients on discharge, could have quite an effect.

The emphasis so far has been on carers, families and practitioners picking up signs, but unfortunately, especially in the adolescent and young area, we know that, because impulsivity is such a factor, quite often there are no signs. In my time in Indigenous mental health I would frequently have parents coming to me and saying, 'We had no idea; there was nothing to show us.' There is some life event, a teenager catastrophises, has an idea that life is never going to get better again, you add to that alcohol or cannabis and you have a problem—when people have no idea what to do with suicidal thoughts.

My feeling is that we need to move, much as we have with other issues that we think that teenagers need to know as they grow up, such as sex education. We need to have people coming through to get the information so the community has it in case they have a problem down the track. Through the Australian Divisions of General Practice we are also looking at the MindMatters Plus program, which is a combination of getting it into the curriculum of national education services and to GPs.

The advantage of the pamphlet is that it can be used both as a clinical tool and as an adjunct to the other preventative tools that we are using at the moment. I have not discovered anything like it overseas either. There are booklets on depression et cetera, but they do not lend themselves to preventative tools because they are just too expensive. The same goes in Australia. SANE Australia has one but it costs about $7 or $8 a booklet. The MindMatters program is an excellent one—the idea of giving kids more knowledge as they come through.

I see a lot of people in their late twenties, thirties and forties dealing with issues that arose in childhood which really mucked up their lives and which led them to self-harm, drug addiction et cetera. These are often to do with childhood abuse of one sort of another which were never addressed during their teenage years. We have come in far too late and missed the opportunity. Providing information so they can normalise and learn what it is like to go through that process and be aware of the sorts of behaviours that are likely to happen stops people feeling they are a bit freakish or odd or strange. It starts to let them see that this is what happens and that you can do something about it.

This is not an area that MindMatters has gone near. It would take some time to start talking around and looking at the best ways of approaching that information. It is the same with early psychosis. We know there is a two-year gap between time of onset of symptoms and diagnosis, so we are missing the boat by two years. There is a very good, simple pamphlet from the States that is used in schools to give kids an idea of what sort of behaviour might start to ring warning bells. It is something that could be included in the MindMatters curriculum.

I have worked in Africa. I have an interest in the developing world and a special interest in mental health. We have known for some time that the outcomes are better in developing countries than in the Western world, the industrial world. Despite knowing that, we do not spend much time researching that or wondering why. We still tend to spend all our time looking to the States or Europe for answers, which is strange because they have the worst outcomes, despite

spending a fortune on the problem. The sorts of things that we think are linked include the involvement of the community and the availability of work, such as part-time and unskilled in the fields. This is necessary because there is no welfare system and it has less stigma. The odd thing is that when you get a system like this that works better you have a greater sense of optimism. I think the outcomes have been so crummy in the West because when you get diagnosed with a serious mental illness you get a big dose of pessimism. We know that has quite an impact on outcome.

A lot of people are now saying that the outcome with things like schizophrenia is probably much more determined by the culture that it occurs in and how much support et cetera that you get, rather than the actual illness itself. In Africa, you can look at the way the community treats epilepsy and what sense they make of that. They can make it negative, like you are in touch with the devil. They can make it positive, like you are in touch with the spirits and are to be honoured. That impacts on the behaviour of the person enormously. With the former, you get people behaving almost like a schizophrenic where they become socially odd and isolated, even though we know that epilepsy has nothing to do with mental health. The same applies to leprosy between India and Africa. Again, we know that leprosy does not affect mental health but the reaction of the community does.

With things like outcome in schizophrenia, the question is raised: how much is due to the illness and how much is due to the way we respond to it? One of the things that distinguishes the way in which developing countries deal with mental illness is that there are not any resources. There are 70 million people in Ethiopia and 10 psychiatrists and a hospital of 300 beds. Clearly everyone gets treated in their community and are not in contact with the mental health service. They do not clump people together; people are treated within the extended family context where they are surrounded by people behaving normally.

This is a message that we need to constantly think about when we try to produce recovery programs and rehabilitation programs. Where possible we need to access community services, TAFE colleges or whatever it may be, rather than have a little group of people who have schizophrenia together. The rehabilitation and recovery program that we are setting up in Cairns has that as a strong thought behind it, recognising that sometimes groups are fine and good but sometimes they are not the way to challenge certain unfortunate behavioural patterns.

That makes me also a strong advocate for the involvement of general practitioners in mental health. I see it as part of normalising their lifestyle so that their lifestyle is based around the community and not around mental health services. The other advantage is that you are largely dealt with, for instance in my practice, by receptionists who do not have a mental health background and just treat people like Joe Bloggs. We have much higher expectations of behaviour. The patients that come and see me know that we cannot tolerate people being disruptive or being unpleasant to the front desk staff, so they are not. They might well be when they go down to the mental health service but they are not in my practice.

I think we have a very untapped resource in general practice. It has not been tapped partly because the financial return is not there. That is a major reason why GPs will not be involved. Secondly, they are not trained all that well so they are not that confident. Thirdly, at the moment the better outcomes in mental health program is really run by psychologists and psychiatrists; it is not run by GPs. I think we have to move on from psychologists and psychiatrists who work in

a different context with a different time frame and a different setting telling us GPs what works in general practice. Otherwise we will just not get other GPs coming in because the constraints have never been properly addressed.

Because I also have bipolar disorder, I am starting another career as a consumer rep. I suppose I am partly doing that because I have been concerned for a long time that our consumer reps have tended to be people who have had a pretty serious illness. Because they have had chronic disability, were mostly unemployed and then often they have a career as a consumer representative, it perpetuates a fairly biased view of mental illness in the community. Unfortunately, because of social stigma, we have a whole group of people who have mental illness and work and do not want it disclosed for good reason. You lose either your job or your business, whatever it might be. I can think of three people who hold down very good jobs who have schizophrenia. I would love them to talk more about the fact that they have it, but of course they will not because of their concern about what it might lead to.

That is a major part of it but it is not only that. When we have consumer representatives on committees, committees are usually mainly staffed by people who are on salaries. The meetings are held during the day and the people who turn up are on salaries, so they are being paid. The only people who are not paid and expected for some reason to be there out of the goodness of their heart are the consumer reps. If you want to have people with clout, with knowledge and something to contribute to the committee as well, such as professional people, it is very hard to get them. They have to leave their work in the middle of the day and have no income. I see a lot of advantages in involving a broader spectrum: (a) they are an excellent resource that comes into play; and (b) the community begins to understand that good outcomes are highly possible. To do that we need to think about when we hold meetings and have funding to cover costs. I think it is a path that is worth going down.

That leads into the whole approach of how you try and portray mental health. When I started out about 20 years ago, we had mental health days. Always the emphasis was on: if only we could get the community to understand how bad the problem of mental health was and what impact it had, they would respond by supporting it more financially. There would always be horrendous stories. To me it did nothing—the community already thought that was the usual outcome and—I think there was a sense of: we do give funding and it does not seem to make much difference so we will just do what we are doing.

Other parts of medicine took a totally different approach. For example, there was the asthma campaign where people like Rodney Marsh said, 'I'm the vice-captain of the Australian cricket team and I have asthma.' This is a totally different thing; you are actually giving people an idea that the outcome should be good and, if it is not, why is it not and why is there not more funding? That seems to be starting to happen a bit more in mental health. Certainly the direction we need to go down is to publicise the success stories.

I mentioned in my notes a book that has come out. The research was funded by beyondblue. It comes from Melbourne and was looking at 100 people with bipolar disorder and how they were getting on with their lives, what sort of strategies they were using to do it. That is the stuff we need to hear more of. That is the stuff that I tend to throw towards my patients and say, 'Read this and let us lift the expectations of where we can go.' It links in with things like media campaigns. From my understanding, New Zealand has been pretty heavy on this scene and has

spent a lot of money trying to change public perception. It has succeeded in doing that. Again, I think it is a track we really should go down as well. There are a lot of other issues I could talk about.

CHAIR—You have tossed quite a few very contentious ones into the ring, as it were. I can see why the leaflet would be very effective, but have you been able to measure in a real sense its ability to keep people from suiciding?

Dr Bridge—No, I have not had the resource to do that. It would not be easy to do. Suicide research is not easy because it is so multifactorial. It is very hard to say that if you suddenly drop the rate that it is due to this one factor. You can do that with international research where you conglomerate a whole stack of information. The book of Griffith University Professor Diego De Leo has a lot of international studies trying to work out what does make an impact. It would not be easy to do. It also raises the issue that you need a control group. You need a mob that are saying, 'I'm about to suicide,' and you say, 'Fine, I'm going to give you the pamphlet.' That is not easy to do either.

However, as far as qualitative research is concerned—getting comments back from people—I have got a lot of that, especially from practitioners. There is a woman called Leonore Hansens, who is the suicide prevention officer for mental health in the Northern Territory, and unbeknown to me she has been photostatting it for about four or five years and using it all through the Indigenous communities. When I bumped into her at a conference she had a bag full of them. She has also been using them in the Darwin high school Indigenous group. She swears by them and says that they have saved lives. I do not how much weight we can put on that, apart from her impression. I have written to the professor of psychiatry at JCU is to see if there is a master's student who would be interested in doing some sort of qualitative research, because people do ask me what proof I have.

CHAIR—Based on the submissions that we have received from parents and carers, the reaction to a son or daughter threatening to suicide is often to rush them to the nearest hospital and get them medicated and if they are on medication that will be all right. Would this be quite useful to parents as well, I would have thought.

Dr Bridge—Yes. The sort of people who have requested it are people from mental health services, drug and alcohol services, and certainly schools, and interestingly the sexual health clinic here bought several thousand of them. I thought: what is the connection? They said they have a lot of people who express suicidal ideation there too. The response is surprising. When I did the radio thing I got a phone call from the ABC the next day saying they had been deluged with questions about how they could access it. They put a direct link between their transcript page and my web site so they would not have to answer all the calls. So it is surprising.

CHAIR—I heard it and found it compelling. I want to ask you about your point on early intervention about childhood experience being the root of most problems that come later in life. What do you think about the way in which we deal with notifications of child abuse and neglect that do not appear to be followed up? This is a huge issue in my home state of Victoria and I know that it is in New South Wales and elsewhere. Obligatory notification by people like yourself and teachers and others means that we have thousands of children so notified where

nothing much else seems to happen. Can you comment on that? Is it your experience up here as well?

Dr Bridge—When I first came here—and that was me leaving mental health for a while and coming up to work in Aboriginal health—I was the only practitioner here and we had 10,000 people in Cairns and 3,000 in Mareeba for me to look after. I really got a sense very quickly that so much of what was walking through the door as a medical problem was actually problems with a very strong social side to them, and we were a very medical-looking practice. There were no trained Indigenous people to do much about that.

They had a weekly meeting with the department of families about cases of abuse that had been referred through. My sense was that it really was a waste of time, that the agenda for the department was: how do we get people off the list. There were no places to refer to and there were no services that were going to be helpful. So I stopped going to this as it was a waste of time, and with my wife—who is a social worker and family therapist—helped set up a social health program for Wuchopperen, which is the local Indigenous community controlled service. It now employs about 20 counsellors et cetera. We set up training programs.

Again, the number of people who will also work with perpetrators is very small. Part of my background is doing that. Quite often there is no service for someone who has been charged, except perhaps going to jail. This is obviously dealing at the impact area, the clinical area, where something has been going on for some time. Again, we need to look at other issues—the way men behave, the male role—as prevention.

I think the comment in early intervention with schools is that quite often it is not the case that somebody is going to suddenly declare: 'All of this has been happening to me,' or 'This did happen to me.' That is too outing and too big a risk. My feeling is it can be done in a more general sense, not only for people who have been the victim but for the population to start to understand what happens to people who have this sort of problem. We know that something like 80 per cent of women who have had a serious psychiatric illness have had a background of sexual abuse. They are very high figures. They are figures where you are actually looking for people who have not rather than people who have. We know it is the same sort of deal, 80 per cent, for people with personality disorder.

Unfortunately, my experience in mental health is that this is not attended to because there is an idea that, if you do, it might trigger another relapse. That has not been my experience. When I say to women who have had a diagnosis of schizophrenia and there is a suggestion they have been abused, what seems to have happened is that (a) they got abused through no fault of their own and (b) they got an outcome which is quite common: they started developing behaviours such as avoidance behaviour, being hard on themselves or self-blame, and also loss of self-confidence, self-esteem and trust so that they got increased anxiety. There are all those sorts of patterns, but then quite a percentage do go on to get voices and other phenomena. So that was a natural outcome of that abuse. But that is a very different story to what they have been told, which has been that they have been abused and then, double whammy, became mad.

Just putting it in that different context makes a huge difference for a lot of women. Then we can say: 'Okay, this has happened, it has been normalised and there are certain behaviours that you have adopted as a kid which have been quite good survival tactics. A kid has no power so a

kid learns to keep their head down or be in fantasy land or whatever, but these sort of behaviours do not work so well as an adult. As an adult, avoiding things or using alcohol to deal with things, or whatever, just does not work out.' We then talk about how we swing the behaviour around so that, as we do that, we are leaving the victim role behind and moving to a future where that has been put in the past because their behaviour is becoming different. That is what I said before—that is the sort of stuff that I am doing in their late twenties and thirties but that should have been done back in the teens before the habits set in.

CHAIR—How do you know all of this? Is this what you learnt at GP school?

Dr Bridge—You learn nothing of this in GP school. I have a niece who is doing her first stint of a general practice registrar job and she rings me up and says two things. One is that the seniors in the practice are a bit concerned that she is not going fast enough. That is a common thing, for young GPs to have trouble picking up the pace when they have come from a hospital setting. The other thing she says is: 'I have all these women coming in with these problems that I have absolutely no skills for dealing with. I picked up communication skills in my training and that was about it.'

I said, 'Okay, I have been doing this for 20-something years and I have been thinking about may be putting something on paper about the approaches I have learnt that work in the context of short consultations in general patience, often where patients do not come back all that often. So I will write you some letters called "Dear Kate", about the models that I have learnt that work, and we will just see where it goes. Maybe if it comes together we will produce a book for medical students or for GP trainees.'

I have spoken about this to Graham Martin, who is a professor of child and adolescent psychiatry and has been very involved in suicide stuff and set up AussieNet and MindMatters. Professor Martin was based in Adelaide and is now the Director of Child and Adolescent Psychiatry at the University of Queensland. I spoke to him a month ago at a conference. We talked about this and he was saying much the same, that there is still really no training for GPs coming through. Unfortunately, there is also a model called CBT, cognitive behavioural therapy, which is pushed by psychiatrists because it is a very easy model to evaluate because it is to do with filling in forms and ticking boxes and you can calculate sums. That is one of the things that is being pushed as the way to go for general practice in Australia.

My own sense is that it is not a great model for general practice for a number of reasons. It is very narrow; it does not take into account gender, race, socioeconomic status or where you are coming from. Also, it is meant to be quite a rigid program of 12 or 16 sessions and no-one gets to three or four, let alone 16, so you always have a sense that people have never completed the course. As I mentioned before, this is part of the problem, when people who are not general practitioners are trying to tell general practitioners how they should do this. We need to have more representation on those decision making practices. For instance, when I apply to get recognition of prior training as a family therapist that is not allowed; that is one of those things that is not included. Really, the only thing included is CBT. So I did CBT so I could qualify and then continued to do my own stuff.

CHAIR—So you would be confident that the majority of GPs would, like you, learn on the job, as it were. Is this stuff able to be taught at undergraduate level or in your training for a GP?

Dr Bridge—I think it is. I think we could do much more. I think we have to face the facts that for most GPs, partly for financial reasons but also maybe as a matter of interest or whatever, this is not necessarily their cup of tea. They basically would be looking for people to refer on to. They would not feel at ease. In no way do I think that suddenly the whole of general practice is going to take on mental health issues. But I do think there are people who would if (a) they were better trained and more confident and (b) there was more remuneration for their time.

In my practice I get a rough idea of what people earn around me and it would be something like $300 a day more than me because I spend time with patients and I use mental health item numbers. These are better than they were, but I still have to wear the fact that I do not earn as much by doing this; there is a price to pay. For example, when you work in this area you are often working with other people with the patients, you are often part of a team, and so you need to speak to them. There is an item number called 'case conferencing' but to get it you have to be speaking to two other people involved in that person's service. That is rare, and I do not think I ever want to speak to two people at once. I just want to speak to the psychiatrist perhaps or maybe the psychiatric nurse who might be involved. When I do that I can not claim anything. So someone who has set this up has just never worked in general practice and does not understand how these things work. If we can attend to that sort of thing so that people are then properly recompensed for their time, I think we would encourage more people to do it.

Senator HUMPHRIES—I was particularly struck by part of your submission where you mentioned that it is because the public are so accepting of poor outcomes due to their biased contact with mental health that they have a perception that putting in more funds is a waste of time. I think that perception does not just extend to the general public, it also very much influences the way governments fund mental health. Congratulations for putting your finger on that point. This pamphlet looks like a very useful document. Your name is on the back of it. Where would I find this if I was wandering around?

Dr Bridge—The web site is on the front page there. If you go to the web site you can download it from there.

Senator HUMPHRIES—Where would I find the physical version of the pamphlet?

Dr Bridge—From me. People contact me and ask me to supply it. I am not interested in sending out one to every Tom, Dick and Harry, which is one of the reasons why you can download it. Organisations or general practices might order 25 or 50, or a bigger organisation will order 500 or whatever it might be, and then I mail it out. I take one day a week off to work on this stuff. It is just like a home based thing, and that is largely because none of the key organisations put up their hand and said, 'Let's run with this,' so I just did it myself.

Senator HUMPHRIES—Have you contacted authorities like the Queensland health department or the federal department to see if they would be interested in picking this up and putting it out more widely?

Dr Bridge—I certainly tried to. With the federal department it would probably be through AussieNet, because they have a suicide prevention officer. It just so happens I have written and phoned and you just get no reply. It is difficult coming at it as a private practitioner; if I was coming from an organisation perhaps it would be a bit easier. Having the ADGP, through Rob

Walters, finally want to take it up has opened up doors a lot more. Beyondblue are now talking about putting it on their web site when previously they would not reply to anything. Lifeline are starting to do things.

There is a magazine called *Australian Doctor* that goes to every GP once a week; it is a glossy magazine. It has a section in it called 'Patient information', which is an A4 section which GPs can cut out and photostat. It goes out to GPs on a Friday and today's has got the pamphlet made into an A4 page as a patient information sheet. So, provided the GPs do not just chuck it in the rubbish bin, because they get so much information, that will be good because GPs have not been an easy group to penetrate, especially if you ask them to pay for anything. The drug companies have set up a culture where you do not pay for anything, so it makes it hard to compete.

Senator HUMPHRIES—We have heard how, through things like Better Outcomes in Mental Health, doctors have been given access to training regimes to give them an edge on these sorts of things. We have also heard about the difficulty in keeping across so many different issues. I assume you would be very atypical of doctors' awareness of mental health issues. Are we expecting too much from GPs for them to really understand these issues well enough? Should we be expecting there should be more specialisation, even within the area of GPs, with respect to things like this?

Dr Bridge—There are two things. One is that you need something that any GP can pick up on. When you become a GP you have an expectation that you will have to know something about the heart and you will have to know a bit about surgery; that there are certain things that you need to know and you might not learn them overnight either—you are going to have to put a bit of time into learning them. I think we need to do the same with counselling skills and therapy skills: you have to have an idea that if you are going to be a general practitioner you need to have skills in this area and that they will not just happen overnight. I do see it more as an art, a craft, rather than a recipe, which is what CBT tends to be. It is one of the reasons they push it—they think it is easier to learn because you just learn to do this, this, this and this. I think that is undermining the skill factor a bit. Again, you have to excite people that this is fun and this is good to do, rather than to shame them with the 'you should be doing more' type of approach. The reason I do it is because I enjoy the outcomes. Often you are seeing people who a lot of people have given up on, and when they change they think it is Christmas, so you get a lot back for it.

I think there is a group in general practice who do have a particular interest, who do courses and want to up-skill. Some will go on to do that full-time—they will just do counselling. That is a rarity. I did that for five years. So there is this range. I suspect that the time to do it is when they are training; that is when they are the sponge, when they want to hear from people who have been there and done that. It is much harder to do once GPs have locked themselves into a way of being. So I think the emphasis should be very much on that early time, either as medical students or in training as GPs, and physicians too, for that matter.

Senator HUMPHRIES—I was interested to hear you talk about your own personal journey with mental illness. We heard yesterday in Brisbane from Christina Wong, who has been much in the media with an issue of her mental illness. Would you hazard a guess as to what sort of numbers of doctors in Queensland are dealing with those sorts of mental health issues personally?

Dr Bridge—I would not have any idea because they are so guarded. Doctors are so concerned about people finding out and what impact that will have on their professional standing or their standing with patients. So I would not have any idea at all, except that we know that suicide rates amongst female doctors in the UK is extremely high. We have always known that anaesthetists and dentists have been up there, but they are now telling us female GPs in UK are not doing well.

It would not surprise me if a fair percentage have at times had some sort of depression or burnout type of thing and been very stuck as to who they can talk to about that. And that obviously gets worse the smaller the town gets. I have seen all the psychiatrists in Cairns at one time or another. It is odd because I see them at one stage to discuss patients as a fellow professional and then the next minute I am being treated by them. I had to learn to be on both sides of the fence.

What is quite interesting for me—and I pick and choose when I do this—is that I often self-disclose with patients. Patients say, 'Oh, no, I don't want to go on those pills.' I have been on most pills so I can tell them personally what they are all like. I say, 'Well, this one is not that bad—I have been on that one.' They say, 'Beg your pardon?' So we have a yarn about the fact that I have this problem but I am still being a doctor and that you can manage it that way. That does seem to have quite an impact in recovery, which is why I use it. I have got a bit more comfortable in doing it. I am more comfortable because I know I am an okay sort of guy so I have got nothing to be embarrassed about and this has just happened.

I suppose the funny thing for me in some ways is that most of my psychiatric patients have not been through what I have been through. I have had three courses of ECT and I have been taken to the Royal Melbourne in the back of a divvy van and I have been tied to beds by the arms and legs. So I have been there and done that. I suppose in some ways we are all part of the same club. It is a club you do not want to be a member, but it is a club that you can move out of too—you can put it behind you and get on with life. That is the message. We have to start looking at this thing a bit like diabetes or asthma: it is something you manage to stop it screwing up your life.

Senator HUMPHRIES—What is your opinion of the state of psychiatry in Australia today?

Dr Bridge—That is a tricky one. I worked for seven years in Wangaratta so I was working for Beechworth and it was very hard to attract psychiatrists to Beechworth. Personally I think that is why we did a lot of the good things that we did, because we were not constrained by mainstream psychiatry. That really was how it worked out. I did meet some very funny people who were psychiatrists.

The young people I meet who are doing training in psychiatry now I think are okay people, like Joe Bloggs. Prior to that I have met some very odd people and I often wonder what it is like for the patient who goes along and there is this person. That is one thing. The other thing is that, during my seven years working in Victorian mental health as a medical officer, every September there was an option to apply to do the training course. There were probably three reasons you did it: one was the pay; the other was the power, because you were working in a system that is so hierarchical that you would have a lot more clout as a psychiatrist; and the other was the prestige, I suppose. I did not do it because, firstly, I just could not connect with the way they saw

the world and their negative view of it and their negative view of outcomes. That was a major problem. The second thing that worried me was that when you did your training there was actually no training in counselling or therapy. You obviously had to do a psychodynamic long case during your course, but otherwise you did that sort of training when you had graduated. That concerned me because people might go and do it or they might not; they might set themselves up in private practice. I am not convinced they have all that flash skills in therapy.

Even in the psychiatrists that I have seen personally I do not recognise great counselling skills. My background has been more connecting with social workers and psychologists, especially in the family therapy scene. I think there they do work hard on developing their craft, and learning and training in that, whereas I think the psychiatrists tend to not do that and that is probably one of the reasons they favour the recipe type CBT approach. But, as I said, I am quite impressed by the young ones coming through here in Cairns. There are good kids coming through.

Senator MOORE—We have heard a lot of evidence about the lack of trained professionals anywhere outside of capital cities. I know there are a few psychiatrists in Cairns and I know there are a few in Townsville. Are there enough?

Dr Bridge—No. You have two systems, the public and private. Private, we have one full time and one part time in Cairns and one full time in Atherton. I use the one in Atherton because I know his approach more. Occasionally, when it is needed that we have some sort of report from a psychiatrist to get certain things happening or to authorise certain drugs—

Senator MOORE—There is actually a psychiatrist in Atherton?

Dr Bridge—Yes. He was based in Cairns and worked for mental health and he used to cover the cape. He is now living in Atherton. They just have to drive a bit further—it takes about an hour.

Senator MOORE—A lifestyle choice?

Dr Bridge—Yes, a much easier place to get to. So that is a huge dearth. It does not fuss me so much, because I do my own stuff and I am confident to do that, but for most GPs who want or need to access a psychiatrist that is hopeless. It is the same with the mental health services, although they actually have more now than they have had before, including a child psychiatrist, who I think he is only committing for a year at this stage.

Senator MOORE—That is relatively recently, and as a result of outrage, I think.

Dr Bridge—Yes. Before that they were spending a fortune by recruiting from the States. It was costing them an absolute packet. They have got numbers there but they are small. That is one thing. But, even if you only have that number, one of the major problems is that the services here are still based around a reactive process, where you are responding to emergencies all the time and your mental health unit is full all the time and you are chasing your tail. There has not been any great effort to try and look at early intervention or look at prevention or even at cultivating a better connection with general practice resources so that it takes the load off you a bit. There just does not seem to be the planning of how, even with smaller numbers, we could have a bigger impact.

Senator MOORE—We have heard evidence also about the better outcomes program that Senator Humphries referred to. It is an interest of mine to hear evidence about exactly how it operates. Have you actually done the six hours of specialised training?

Dr Bridge—I have done more than that. I have done 20 hours of CBT.

Senator MOORE—I think you are the first person who has given evidence that they have done the two components.

Dr Bridge—Yes, I have done my time.

Senator MOORE—Would you care to give any comment on the program? You said that it would be better to have a more cooperative approach, but the better outcomes program was hailed as the first time that the industry was effectively extending into general practice and trying to respond to the needs of the community. We heard the assessment from the Australian Divisions of General Practice that it was being picked up more; that it had started slowly and they hoped it was going to get better. Their assessment was that it was a considerable chunk of time given by GPs to be involved. Given that background, as someone who has done both bits, do you have some opinion of that?

Dr Bridge—The carrot is that you have to do it to access certain item numbers which give you a better return for time spent with a patient. That is why I did it. I did it for two reasons: one is that I am obviously not a fan of CBT. Where I felt awkward about it was I had never trained in it. I thought, 'If I am going to bag it, I should know what I am bagging. I should know exactly what it is and do the training.' That was the other reason I did it, because I can now happily bag it. Mind you, I do use bits out of CBT having done the course which I probably did not before. There are a couple of ways of working that I have picked up from there. I do not do the whole shebang because it does not suit my style, but I learned a little bit from that.

People were taught a way of working, but again if you are actually doing it the way that it was taught, you would take far more time than any GP is going to put in, especially someone who is not that interested. Secondly, it was meant to be part of a 12 or 16 part intervention. One of the GPs around here is very keen on mental health and does a lot of CBT. I have talked to him about it and he said to me, 'Look, I just never see them after the third or fourth session.' I kept thinking that was a bit of a burden, to think that with everyone you start with you have a sense they never got there.

The other models that I am talking about are things like narrative therapy, which is very big with the paramedical mobs, the psychologists and social workers. Solution focused therapy, which is from the States, is also very big in the general counselling scene. These are models that offer a lot to general practice partly because they are empowering, so the language is empowering. You do not actually have to sort out all the problems if you empower someone because they then go and sort them out themselves. You do not produce so much dependency. If they do not come back it does not matter so much because usually you have started a ripple effect that will go on. I usually leave a fair bit of time between sessions because I need to let what we have talked about have some impact and then come back and run with it more and emphasise it more.

These are ways where, in a short space of time, you can start to reorientate the focus on strengths, on capacity and competency, not problems. The problem with medicine is that it is based around problems; that is the style of medicine. You go to someone with a problem and we have learnt how to ask questions about it, how to categorise it, how to offer treatment for a problem. If I say to one of my GP trainees, 'Can you go and do a competency history on that person, on that single mother?' they look at me and say, 'What is that?' For me, talking to that mother in a way that gives her a greater sense of her own strengths and her own competency, which she usually does not have because she is very good at putting herself down and being aware of her failings, is going to have a much bigger impact than being problem orientated.

Senator MOORE—Are all those models covered in the 20 hours of training?

Dr Bridge—None of them. If you apply and say, 'I am trained in narrative therapy,' which I am—I am trained in family therapy over two years, and my two years was once a week, one day a week. They wrote back and said, 'No, we disregard that.' It is actually stated that family therapy will be not considered; instead you do 20 hours of CBT, that will do us.

Senator MOORE—The whole focus is CBT?

Dr Bridge—Twenty hours of CBT is worth two years of family therapy, narrative therapy and solution focused therapy. I think, hang on, who is running this? Who is saying that? It is the psychiatrists, it is the Hickies, Ian Hickie, who have got that sort of influence and say, 'This is what is in the literature.' It is in the literature because medicine is based around quantitative research, not qualitative. We are talking about craft which is much less a medical science approach and much more into quality of life changes and therefore qualitative research. Medicine has to take this up because that is what we are talking about. We have to move away from its fixation on quantitative stuff.

Senator MOORE—Did many people in this region access the GP training that was offered?

Dr Bridge—Yes, it was quite good. We have only run one that has done the whole two, which we did over a couple of weekends. There were more people from the FNQ region than actually from Cairns. They were quite interested. It does not surprise me because the further you go out the harder it is to find someone to send people to, you have to have the skills yourself.

I have just written to the executive of the Australian College of Rural and Remote Medicine, ACCRM; you have GPs, you have the RACGP and you have ACRRM. There are two committees that do the bare outcomes. One is the one that makes all the decisions and the other is one where people apply personal circumstances stuff and they interpret the decisions that come down from the top. Up the top, ACRRM has no representation, so there is no rural representation at the decision-making level. When I said, 'I am interested in having a part,' they said, 'We can only put you in the second committee.' Of course I said that that would be a waste of my time. My submission was that ACRRM have got to do something about getting some say-so in the decision making for rural people doing counselling or just general practice.

Senator MOORE—There has been a lot of interest from the rural communities in this committee inquiry. They have put in a lot of submissions on the reason you have given.

CHAIR—Thank you very much for the work you are doing and for making a submission. It has been terrific.

Dr Bridge—Thank you for your time.

[4.20 pm]

ELLIS, Ms Gaynor Anne, Coordinator, Mental Health Resource Service, Centacare Cairns

O'DONOVAN, Mr Ross James, Chairperson, Cairns Consumer and Carer Advisory Group

CHAIR—I now welcome to the table representatives of Mental Health Resource Service and Cairns Consumer Advisory Group. The committee has received your submissions, which it has numbered 65 for the Mental Health Resource Service and 152. Are there any changes you wish to make to that document at this stage?

Mr O'Donovan—I do not think so. There was a later two-page covering submission that I have done in the last week. I am not sure whether that original submission is the original from a couple of months ago.

Ms Ellis—We were asked to submit a two- to three-page thing for today and I am not sure whether that refers to this submission.

Mr O'Donovan—The latter one is relevant to what I want to address.

CHAIR—The one headed 'To whom it may concern'? I am advised that we have all that you have submitted. Can I ask each of you to make a brief opening statement and then we will go to questions.

Ms Ellis—The Mental Health Resource Service is a program based within a non-government organisation, Centacare Cairns, which is the welfare and counselling arm of the Catholic diocese of Cairns. On a national level Centacare Cairns is a member of Catholic Welfare Australia. However, each Centacare organisation is quite autonomous and operates as an autonomous locally governed organisation. Our organisation was established in January 2001 and is funded through three-yearly funding from the mental health community organisations funding program administered by state-wide health and community services at Queensland Health.

We currently have a service agreement that specifies our services as counselling, peer support, family support, community awareness and education. In 2004-05 we have provided individual or family counselling and support on 614 occasions and provided group programs to 840 participants. A further 522 people attended various community awareness and education programs such as workshops, talks and other community events. We have been initially funded since 2001 for $71,000 per annum, which increased to $75,000 in our first three years. We have been notified that our funding will increase to $115,000 this year. Part of that increase came in the last funding round and we were able to employ an additional half-time worker, so there are now 1.5 workers in the service.

We operate five days per week within business hours and our catchment area is the Cairns and Innisfail health districts, with a population of 175,000. People from other parts of the Far North region and other parts of Queensland and Australia also contact our service for support and

information. As coordinator, I am a person who has lived the experience of mental illness. I am also a qualified social worker and hold a master's degree in mental health.

I want to address the terms of reference (a), (c), (d), (i) and (l), initially terms of reference (a), (c) and (d). According to the National Mental Health Strategy, outcome 7 is national agreement on the broad levels and mix of services necessary to align current and future supply and demand for mental health care across the lifespan. Together with outcome 15, increased support and recognition of the role of non-government organisations, both of these have not translated into change at the community level in Queensland. We support the calls by the Queensland Alliance for significant increased investment in non-government, community owned and managed mental health services, resulting in 30 per cent of the total mental health budget in Queensland being allocated to non-government organisations within 10 years.

The Far Northern region, which is from Cardwell to the Torres Strait and west to the Gulf of Carpentaria, accounts for 7 per cent of the state's population. If the highly specialised remote area life promotion programs are removed from the equation, the area receives only 2 per cent of the state government health budget for non-government mental health organisations. Cairns is recognised as one of the fastest growing areas of the state, yet funding levels have not substantially changed in this region for the past five years. Additionally, the tendering process which Queensland Health undertook to determine funding for the 2004-07 funding period was ill-conceived and divisive.

The experience has been that NGOs have been locked into service delivery models that do not reflect their actual practice. The basis for the department developing these was a highly structured but restricted survey which all NGOs were required to complete prior to the tendering process and which most found to be inappropriate. This was the only consultation ever undertaken with the NGO sector regarding our service delivery across Queensland. No consultation was undertaken with consumers and carers accessing our services. The tendering process pitched region against region, city against city and in some cases agency against agency, with some organisations holding unsubstantiated views that large organisations such as those with religious affiliations were somehow taking over. Cynically we can view this as departmental divide and rule. What appears to be missing is transparency in decision-making and genuine consultation across the state, particularly consultation that brings all parties to the table: NGOs, clinical services, consumers and carers.

CHAIR—We do have that statement in front of us. It is not necessary for you to go through every last word unless there is something in particular you want to emphasise.

Ms Ellis—I would like to go through terms of reference (e), the provision of supported accommodation. Any accommodation is severely restricted in the city of Cairns; we are undergoing rapid change. The current emphasis by the federal government on the provision of rent assistance rather than expansion of public housing stock creates further likelihood of discrimination against mental health consumers, who then must compete on the private rental market for expensive housing stock. Currently in Cairns 55 units of public housing are planned for next year but these only replace accommodation that has been sold off in urban renewal.

Lack of affordable housing is an issue across many communities in Australia, not just our own. However, disadvantage is probably more acutely felt here because of the nature of the area,

which is one of high growth, and the impact of the growing tourist market. It is more profitable to the private sector to operate high turnover backpacker or overnight accommodation than to provide long-term accommodation. The current wait for public housing is five to six years and the only community housing available to people with mental health issues has long waiting lists also. If we are serious about providing whole of government care to people with mental health issues then a range of housing options is needed and a national housing strategy would direct the states on this matter.

I have made mention in the submission about recovery oriented practice under which our service operates. We operate an extremely cost-effective service and the skilling-up of consumers to support other consumers through their recovery is central to our approach. We intend to expand this work by introducing recovery training for carers as well. At this point in time this approach appears to be operating successfully but obviously needs to be assessed over time.

The NGO sector is the ideal sector from which consumer developed and consumer organised recovery programs and peer support can take place. Whether through consumer run organisations that are independent incorporated bodies or through non-incorporated consumer run organisations that are auspiced to acquire funding through already incorporated NGOs, through to NGOs like mine that employ staff with the lived experience of mental illness, I do not believe that the form this takes matters. What matters is that these services are supported by government and adequately funded.

The midterm review of the second National Mental Health Strategy outlined the need for the non-government sector to be adequately funded but the third National Mental Health Strategy did not produce any changes in this regard.

The nature of our funding cycles is also disruptive to the provision of programs and support over the long term. Being tied to three-year cycles with a new tendering process each three years creates difficulties in planning when our future funding base is uncertain. While some departments roll over the funding of a percentage of their funded organisations that are meeting performance standards, in Queensland that is not the case.

Terms of reference (l): NGOs have a great deal of value in terms of the fact that they are not bureaucracies and they do not see people as illnesses separate to all their other issues and strengths. We approach the person holistically and look to resolve a whole range of social issues, not just manage people's symptoms. This is the value of the NGO providing support. NGOs do not close files on people who are accessing other community or public services, yet often the process of a public mental health service referring an individual to an NGO means they will not continue to receive any services from mental health teams.

Current media campaigns direct people into the medical model of services, yet anecdotally we hear from consumers that mental health service staff no longer have the time to spend with them, that maintenance and clinical review are the mainstay of service provision and follow-up is often infrequent. A properly funded and supported NGO sector would go a long way towards filling those gaps.

Mr O'Donovan—I am a consumer that has been in psychiatric hospitals in New South Wales, Victoria and Queensland over the last 20 years. I feel I have a broad experience in how services have changed over the last 20 years. The main part of the submission that I wanted to address was looking at the consumer advisory group system that currently exists in Queensland, where we have district consumer advisory groups.

As a consumer, for me becoming involved in the Cairns Consumer Advisory Group has probably given me one of the most real and empowering opportunities to participate in my own mental health by being able to sit on committees within Queensland Health, and to have input into the development and the writing of policies and procedures. I have been able to own my role much more and as a representative of consumers in how we can partner with Queensland Health and mental health staff.

The main thrust of my submission is that the funding of local consumer advisory groups in Queensland is basically ad hoc. There is no organised way where districts fund advisory groups. It is dependent on the manager of the mental health service where you are. If you have a manager that believes in consumer participation, they may fund it. There are no funds that are earmarked towards consumer participation.

In the submission I have referred to what gives consumer advisory groups their strength. That is outcome 25 of the third National Mental Health Plan, where it talks about strengthening quality and consumer and carer participation to increased levels of full and meaningful consumer, family and carer participation in policy and in service planning, delivery and evaluation at all levels with evidence of improvement in quality. That is also underpinned by the national standards: standard 3 talks about consumer participation.

In my mind and experience, without a local consumer advisory group which is set up specifically to partner with your health district, you cannot really have meaningful consumer and carer participation, because you do not have a place where consumers and carers can meet and then actually engage with the service and take on those roles. I want to see a much more coordinated and consistent funding of consumer advisory groups across Queensland at least. I am not fully aware to what degree local consumer advisory groups exist in the other states. I know in my experience in helping rebuild the Cairns consumer advisory group that it can be really valuable and you can actually have a meaningful system that meets the third National Mental Health Plan, the national standards. You can participate, as we do in Cairns, in the development of policies and procedures.

We are participating in in-service staff trainings, assisting positions such as the service development coordinator and other project officers in changing the attitudes and shifting the views of staff. Staff may not have heard of consumer participation when they did their training. Consequently, psychiatric nurses working within the system may not really understand what consumer participation means. By having this consumer advisory group in Cairns we are actually able to address those attitudinal changes that need to happen, along with those other members within the system. My big concern is that if you do not actually have a proper system that allows consumer advisory groups to exist, you never actually meet the standards in the third National Mental Health Plan of having meaningful participation.

Another direction is that some health districts choose to employ a consumer consultant where one or two people will work part-time and basically satisfy the consultation process required by that service. The problem with consumer consultants is that they are not a committee, they are only representative of themselves unless they are linked to a consumer advisory group. Consumers are a diverse group from the full cross-section of the community with different socioeconomic backgrounds and ethnic backgrounds, so to have a single person satisfy all of those requirements of consumer participation can only be tokenistic. I cannot see how consumer participation can happen unless you have an actual committee structure that can recruit from that broader range.

I would like to repeat the major issues in my submission. The major issues include inconsistent consumer and carer representation at the district and state level, inconsistent funding for CAGs across the state, and ad hoc linkages between CAGs and other consumer groups across the state. Due to the above and inadequate funding levels, there are unrealistic expectations of function in CAGs to provide the consumer and carer view in a meaningful way. Therefore, often tokenistic views are recorded as comprehensive and representative.

The incredible amount of voluntary hours required to adequately participate often is undervalued and underappreciated by mental health executives and service managers. There is a need to train consumer and carer representatives to adequately fulfil their role, which includes remuneration.

Due to the lack of any state coordination, local CAGs have to constantly reinvent the wheel when confronting across-district recurrent concerns such as the development of remuneration policies, staff in-service training and wellness policies. There is often a lack of understanding by mental health service personnel of the role and function of CAGs.

Concerning the directives on consumer participation from both the national standards and the third National Mental Health Strategy, even though the national standards have been in existence for eight years, there really is a very minimal understanding by Queensland Health and mental health staff of the role of consumer and carer participation in the service. I have come across so few that understand the quality cycle of which we are a part. If the accreditation survey process is not understood by staff, you will never really fulfil the role that we supposedly have enshrined in those standards and in the third National Mental Health Plan.

I would like to leave one document with you that came out of the Mental Health Council national consumer carer forum this year. It is *Consumer and Carer Participation Policy: A framework for the mental health sector*. Within that, there is a lot of guidelines for a service that has not developed consumer participation or is in the process of developing that. It is, like the national standards, another really good reference.

There are good policies at state and federal level but the problem is that those things do not get implemented at a local district level. That is because at the local district level the manager can decide whether or not they pursue these good policies. They are not actually directives from Brisbane or Canberra, they are only guidelines or recommendations. If you have a manager that has been around for 20 years, it takes say 20 years to become a manager of a service, 20 years ago consumer participation was not something they would have come to understand. Now unless some senior people have recently been turned on and believe in consumer participation, it will

not happen in that district. I am wanting to use the good policies that are being established at senior levels to actually get the funding and allow the consumers and carers in a local area to actually pursue these good recommendations. That is the completion of my submission.

I am referring very much to terms of reference (a) in your terms of reference, which is about the National Mental Health Strategy and the responsibility for policy and funding between all levels of government. I am very much concerned that the national standards on consumer participation and consumer participation in the third National Mental Health Plan are not being practically implemented across all districts in Queensland and therefore Australia.

CHAIR—Are you both willing to go a little after five o'clock? We started half an hour late with you. If you are happy to continue then that is what we will do.

Senator HUMPHRIES—I was reading in your submission, Ms Ellis, about the problem with the NGOs competing with each other in the tendering process. You said that the experience has been that NGOs have been locked into service delivery models that do not reflect their actual practice. What do you mean by that?

Ms Ellis—There were a number of models put up when the initial tendering process was called. The nature of one of those changed completely between the initial tender being called and the final drafting of the performance framework with which we now have to report back.

Senator HUMPHRIES—Is it a performance framework rather than a model of actual delivery of services?

Ms Ellis—The performance framework is part of our service agreement where we are required to show that we have met our strategies for various objectives within our services.

The largest gap was in the area of what is mainly called psychosocial rehabilitation. There was no category under which organisations could apply for funding when in fact they did a lot of that kind of work. Everyone's services had to fit them into either counselling, peer support, family support, community awareness and education, and development of the mental health sector, which largely applied to the larger peak bodies in the state that might undertake training with the NGOs. There was another odd category called case management support which nobody seemed to know exactly what that did, including some of the people in the corporate office of Queensland Health.

A lot of services were operating basically psychosocial rehabilitation type programs which might involve developing social skills, connecting people to their communities, inclusive type programs. These were just not allowed for anywhere. We were told if we were doing that to put it under case management support. It was a very ad hoc process.

The Alliance has in fact raised a lot of these issues with Queensland Health. After the tendering process was complete, nearly all funded organisations gave feedback to the Queensland Alliance, which is the peak body in Queensland, to feed that back to Queensland Health. There were a number of complaints about the way that the models had been developed.

Counselling was also mentioned as non-clinical counselling and people asked what that meant. Generally the answer came back, 'We don't know.' It has now been decided that if you have a degree you can do clinical counselling and if you do not have a degree you are a non-clinical counsellor. That seems a very strange way of breaking down those differences.

Senator HUMPHRIES—The outcome has been that you have got NGOs out there who have dressed up their services complying with these models but in fact they do something different to what the models talk about. Is that how it works?

Ms Ellis—People have been trying to fit what they are doing into the model, or they might be doing a lot of work that they simply have to leave out of their performance framework. We are not funded in my job to do any kind of community development or community coordination committees, yet I am constantly being asked to sit on various committees that might be broadly based community committees, which might involve a whole number of different service providers, government and non-government. They might be very specific to the mental health service. Those types of activities I can not record anywhere; they are literally not part of my job. It is a very strange way in which most of these things are divided up and I think that whole system needs to be overhauled.

Senator HUMPHRIES—You mentioned that there was a divide and rule approach being taken and that led to 'unsubstantiated views that large organisations such as those with religious affiliations were somehow taking over'. We had evidence this morning from the Mental Illness Fellowship that suggested that when the organisations operating on a national basis came in, they tended to make specialist services more generic. That is, what started out as a mental health respite service would suddenly become a general respite service. Is there any foundation to that kind of concern?

Ms Ellis—Not that I am aware of. I am vice-president of the Queensland Alliance so I am aware of what happens across the state. Eight out of 55 organisations that are funded are part of national organisations. Like mine, those have a very specific focus on mental health. I do not see anybody unless they have a mental health issue themselves or they are the family or supportive people of somebody with a mental health issue, or they may be a service provider who is working with somebody with a mental health issue who needs some support or information in that role.

As far as I am aware, in Queensland all the national organisations—which are basically the church organisations, Anglicare, Centacare, the Baptist Church has one funded program in Brisbane—have not expanded since the last funding round. There were eight continuing to be funded in 2000 and there are still only eight funded in Queensland. That is not happening.

It has been a fear expressed to me by other organisations that somehow the large ones, particularly the churches, are taking over. That possibly may be happening in other welfare programs across the country. For example with employment, groups like the Salvation Army have come into the Job Network. In mental health in Queensland, I do not think that is the case.

Senator HUMPHRIES—I was interested in your account of the case study of this person you have called Brad getting out of prison and starting to spiral out of control, not having services and being caught at the last minute before going back into the cycle of reoffending. In that

particular construct, what would change in an ideal world? What particular service would have been available for him that was not?

Ms Ellis—The week before last, the people at the top of the department of corrective services were here doing a consultation in Cairns. A number of organisations were there. I think everyone in that room mentioned the need for some kind of halfway house for people coming out of prison. Often it was too difficult for people to cope, often they return to situations where, even if the referrals had been made to mental health services, they perhaps did not follow through with those and maybe fell into difficult circumstance fairly soon after release.

With that consultation, again there was no chance for that feedback to go anywhere. We were basically presented with a set of nice departmental PowerPoint presentations on how the budget was going to be divvied up. There was no way of the community getting its point in or its point being recognised about what was needed locally.

Senator MOORE—It was not a consultation?

Ms Ellis—No. They very rarely are, unfortunately. I might say I am terribly cynical, but often it is just one-way information flow from bureaucracies to local communities. The needs of local communities are not being picked up. I do not know whether they are picked up in other ways and means but I start to wonder whether departments ever use things like social indicators. Often it does not seem that they do. Those processes are not made apparent to people and to communities as to how decisions are made as to what services will be funded in a particular area. That is very true in mental health.

Senator HUMPHRIES—A question to Mr O'Donovan about the consultation mechanisms with consumers in Queensland. Dr Bridge was giving evidence about this issue and suggested that it is very important to get the consumer view but he said we tend to have the more serious illnesses represented on those consumer consultation bodies and not the less serious ones. The consequence was that the picture that policy makers and even the community gets of mental illness is that it is really difficult, it is intractable, it rarely presents real recovery and that kind of negativism about it. He said we should engineer a situation where people with milder mental illnesses appear more often on those consumer type bodies. What is your reaction to that suggestion?

Mr O'Donovan—I was on the state ministerial advisory committee, Queensland Consumer Advisory Group, QCAG, before its demise a year ago. When I got on that they advertised the position across the CAGs that they knew to exist and other organisations in Queensland, so it was open to anyone to apply. Then it was standard procedure; you put in your CV and you were not interviewed but through a panel decisions were made about who would go on. They tried to make sure that they had people from as broad a range as possible.

I really do not believe that there is a focus on trying to have people that are more unwell. I think that is a little bit ridiculous. If you are unwell, often you do not have the self-esteem or the self-belief to put yourself up to be in a representative role in the first place. Running a consumer advisory group as the chair as I have been in the last three years, it is extremely difficult to get people that want to be a consumer or carer representative. That is partly because it is a voluntary gig.

Most of the committee representation on the Cairns Consumer Advisory Group is drawn from the seven major members of our management committee, although we do receive broader nominations. We have clocked up 1,000 hours in the last three months. Of those 1,000 hours, 920 of them were voluntary. If you are a consumer that is reasonably well, you are trying to get a job or you have a job. If you are a consumer that is very unwell, often you are too unwell to get a job. One of the greatest difficulties to overcome that I have noticed with consumers who have joined our management committee is not so much the symptoms of their illness but the debilitation of low self-esteem and not believing in their right to participate. There is a lot of coaching and mentoring that has to be done to get that person believing that their point of view is valid, that they have the right to sit on a committee with professionals from Queensland Health and that they will be listened to and appreciated.

I think there are much broader reasons why it is hard to get consumer participation, and it might partly be because it is hard in any organisation in the community, in all areas of society, to get people to sit on a committee voluntarily, whether it is your P&C or your fishing club. I do not believe in Dr Bridge's view that there is a particular focus. When you have a committee and you want consumer representation on it, you will take whoever puts their hand up because often there are very few people putting their hands up.

CHAIR—Do they have meetings during the day, which would mean that people in employment could not go to them?

Mr O'Donovan—It depends on the organisation. The Cairns Consumer Advisory Group sits on four major committees and then there are working parties. They all meet in working hours because that is when Queensland Health is operating their committee business. Clauses in a recent remuneration procedure that are about to be passed provide for possible remuneration when there is loss of pay, apart from the flat rate that we have established for other people. But if, say, Dr Bridge were to join one of those committees, he would be compensated for any loss of pay in his day job. But that would be negotiated on a case by case basis with the manager.

Once again, how much the manager of the service is prepared to pay depends on how much they value consumer participation. We struggle every year to get our service agreement reallocated. We get a budget of $13½ thousand a year plus some sitting fees for some of these committees. We would have to do a lot of paperwork in order to get an increase of $400 from the $12 million a year budget on which mental health is run. Some managers do not like funding consumer participation but they have to have us participating.

If there were quarantined budgets for consumer participation for each health district, it would be a matter of saying, 'Okay, here's your set budget and it will be there next year.' There would be a chance of being flexible with that money and creating incentives for consumers and carers, whether they are on the disability pension like me or whether they work, like Dr Bridge. Maybe you would be able to have some financial incentives which would encourage more top end, functional level consumers to participate.

When I put in a quarterly report showing that I have done 1,000 hours along with my seven colleagues, and I am questioned about an application for a $400 increase in our budget over 12 months, I am outraged. We have just done 920 voluntary hours in the previous 12 weeks. Other than consumers and carers, no-one else is sitting on the committee with me in a voluntary

capacity. I believe in consumer and carer participation, but I have to bite my tongue when I note that inequity in remuneration and in appreciation of what we are actually doing, having regard to the huge voluntary capacity. Dr Bridge is a full-time working doctor. He will not want to be on a committee for nothing. He will not do the voluntary hours. It is not in his interests; he is a businessman.

Senator MOORE—Mr O'Donovan, in your submission you talk about the fact that at the state level the advisory group is not currently active. Can you give us some information on that because it seems to be a core matter. If it is in the plan that you are supposed to have consumer advisory groups, you are leaving to the discretion of individual regional directors what they are going to do at the local level, but at the state umbrella level, if it is not being used effectively, that could be a poor message. Were you on that state one?

Mr O'Donovan—Yes, I was.

Senator MOORE—Can you give us an idea about how, why, what next? I did not know that until I read your submission.

Mr O'Donovan—I got onto QCAG in November 2002. In September 2003 the mental health unit strategic planning division made a decision that they wanted to review the structure of QCAG. They were concerned that we were going outside our brief of being a ministerial advisory committee. We were getting calls from other departments like Centrelink, Disability Services, the police department, the department of housing, and calling on members of the Queensland Health advisory committee to give them advice in areas that affected mental health issues. The department of health wanted to rein us in.

Senator MOORE—Did they actually say that? Were they overt with you that that was the reason, or is this just something you know because you know the system?

Mr O'Donovan—No, they were clear that they did not want us to go outside.

Senator MOORE—They were clear on that bit?

Mr O'Donovan—They were concerned that we were going broader than our terms of reference. In 2003 they formed an interim group. There were 12 full members of the advisory group plus six proxies or deputies. Out of that pool of 18 people, nine of us applied and went onto an interim group that would go from November 2003 until June 2004.

Senator MOORE—To the end of that financial year?

Mr O'Donovan—Yes, to the end of that financial year. Our job was to review the terms of reference and put up a proposal for a reworked model for the advisory group which would then be considered.

Senator MOORE—That was 12 months ago?

Mr O'Donovan—Yes. We did that. Out of the eight meetings that we were to have in that interim group period, there were actually only five meetings due to cancellations by Queensland

Health on two occasions and on a third occasion it was postponed due to the state election. At the end of that period we did not actually complete our proposal. There was the classic whiteboard scenario—models were placed on a whiteboard. After we got feedback, we had been told that two models had been put up and that we evidently were authors of at least one of those models. What I heard through questioning was that one of the two models that was debated and placed on the whiteboard was a preferred idea of a senior mental health corporate strategic planning person. He wrote that up as a model that we were authorising. That was then supposed to go to the director of mental health—

Senator MOORE—It was a ministerial advisory group so it may well have gone to the minister.

Mr O'Donovan—Eventually it should have. Between June last year and now, in the last 14 months, we received one letter in November last year saying that processes were still unfolding. I then made phone calls in January and February asking, 'What is happening?' In February I received another letter stating that the proposal would come out soon. There has been no other formal communication from the mental health unit since then. I have heard through the alliance that there has been some movement on a model but, as far as I know, none of the interim group members have seen paperwork showing what that model is. So we are just waiting. Unfortunately, because this process has taken so long, those of us that were on the interim group, and those of us that were on QCAG prior to that, in some ways feel that we have been cut out of the loop regarding what is actually going on with our state advisory system. None of us really know what is going on.

Senator MOORE—We will follow up on that. We heard a lot of evidence in Melbourne from consumer advocates in that area, and they were very concerned about a range of things. They were particularly concerned that they felt that consumer involvement was now expected but, in effect, token. Whilst in the framework plans and in various working groups it was always expected, as a result of various processes, that it was a given that there would be a consumer voice in the area of mental health, their concern was that, although expected, it was now token. Do you have any comments on that?

Mr O'Donovan—What we have achieved in Cairns has been achieved in probably a dozen health districts across Queensland where there is real consumer and carer participation through these advisory groups. If you do not have a system like the consumer advisory group at the local district level, a funded body so that there is a contact point like an office where you can receive and send information and emails, and which has computers and telephones—the basics of what is required for any organisation—you cannot attract consumers and carers into the consumer participation system. Whether it is at the top level of state advisory committees or at the federal level, such as with the National Consumer and Carer Forum, if it is not funded at a district level it will be tokenistic.

An individual who is in the know regarding the mental health system, who is reasonably articulate, has some skills and maybe worked previously as a social worker or a nurse, will be picked off and seen as the representative consumer, but may not necessarily have a constituency to whom they refer back. Whether it be a support group like a bipolar support group or a local CAG or ARAFMI or whatever, they will just be individuals being picked off, and that will be seen as satisfying the requirements of the national standards.

Senator MOORE—You mentioned earlier in your evidence your concern about that one single voice.

Mr O'Donovan—There are some really good guidelines in this to show local district services how to set up a consumer participation system. Even though it is extremely difficult to recruit consumers and carers to do the work of a CAG, I believe in the principles of the CAG and that if they are operating well and are supported by the service with adequate training and funding, they really can meet the requirements of real, meaningful representation and participation. Without the local district committee bases, I cannot honestly see how you can do it. I do not know how they operate in other states. I do not know whether they have the local CAG system that we still have in Queensland.

Senator MOORE—It varies across the states.

Mr O'Donovan—That is why I think there needs to be a national directive, maybe coordinated to some degree by the National Consumer and Carer Forum. If they want consumer and carer participation, I think it should be paid for. There should be this recognition that it is a national standard and there is a quality cycle. I have learnt, having sat on the quality improvement committee in Cairns—I have also been accepted for training to be an assessor to do the accreditation surveys—that quality is a really important part of how a service is operating. If there is a safety or security issue, you would not hold back on spending the funds in fixing a problem that was threatening safety and security issues in a service. Because consumer and carer participation is part of the quality agenda within mental health service delivery, that should also be equally respected and therefore equally funded so that it can be a real and sustainable activity.

Senator MOORE—Ms Ellis, is this something that the alliance is taking up with the government—the issue of a consumer voice?

Ms Ellis—It is but, again, it has been frustratingly slow. I am a member of the partnerships forum which meets every second month with the senior bureaucrats in mental health, and the people are constantly changing. You might meet with a group of three people one month and the next month two of those people will have changed and they will be in acting positions. Continuity is absolutely hopeless.

Senator MOORE—Are those meetings held in Brisbane?

Ms Ellis—Yes, they are

Mr O'Donovan—That probably explains why we have not had any communication: there is no-one there who knew it was about time to send another letter out, because they have moved on.

Senator MOORE—Has this been worse recently? There are issues in Health at the moment, as we know. Is this slowness a long-term problem you have had? We are having difficulty talking with Health in Queensland at the moment.

Ms Ellis—I think generally that has often been an issue.

Senator MOORE—It is a long-term one?

Ms Ellis—I think it has a lot to do with the structure of bureaucracy in Queensland and its historical background.

Senator MOORE—We have heard there is a feeling of a general lack of professional services in this field in the whole country. We have heard a fair bit of evidence that particularly regional areas are ill-serviced generally in mental health areas. Queensland is particularly decentralised and we have always had a record of having services spread across the state. Would you care to give a comment from both your perspectives on the resourcing of mental health in regional Queensland, particularly in the far north.

My other question relates to the issue of Indigenous services. We have had a couple of Indigenous services come and see us today. I am interested, having regard to the mainstream service that you operate, Ms Ellis, in what your role is with the Indigenous community. Mr O'Donovan, from your point of view as a consumer and a consumer advocate, what is the interaction with Indigenous consumers and their role in the consumer voice.

Ms Ellis—From our point of view we tend to operate quite separately from the Indigenous services because we are not an Indigenous organisation.

Senator MOORE—Is there a cross-over of Indigenous clients?

Ms Ellis—We certainly do see Indigenous clients, although the majority of people would access places like Wuchopperen, which you have heard from today. There is also an Indigenous mental health team based with the government mental health services. There is a little bit of cross-over but not a lot. We are also fairly confined in that we do not go up the cape or anywhere where there is a large Indigenous—

Senator MOORE—Are you just Cairns and Innisfail?

Ms Ellis—Just Cairns and Innisfail health districts. I would love to work more closely with Indigenous organisations but even just the process of going out, sitting down and talking with people and saying, 'What can we do together?' is almost impossible when you have a whole heap of other demands on your time as well.

Senator MOORE—You mentioned earlier the problems with what is funded in your position and what is not funded. Would working with other agencies in the field come under any of the headings?

Ms Ellis—It would, as long as it improves our service delivery. It is never that broader thing of developing community services within the community.

Senator MOORE—What services are available in the area of mental health in North Queensland?

Ms Ellis—I think I mentioned that a little in my submission. We have seven per cent of the population—

Senator MOORE—Except for those specialised programs, is it two per cent of the funding?

Ms Ellis—That is right. If you took those out, they are very highly specialised programs and they operate in very small communities of between 1,000 and 3½ thousand people. In terms of our funding, they are funded at the same level that we are, but it does skew the whole picture of how well funded the far north region is. This is one of the difficulties we have had in lobbying with government. They will come back and say, 'Oh, but the northern zone has this much.' They will not mention the fact that most of those services are either located in Townsville or in other parts of the northern zone, which goes right down to Sarina, or that they are those very highly specialised programs which might only work within very small communities. In terms of the far north region, the Mental Health Resource Service in Cairns has 1.5 staff, there is an organisation on the Tablelands which has 0.5 staff and another organisation on the Northern Tablelands has a worker who works one day a week. That is all.

Senator MOORE—Where do the Tablelands and the Northern Tablelands cross over?

Ms Ellis—It is a departmental thing. The Northern Tablelands is regarded more as the Mareeba area. The Southern Tablelands is around Ravenshoe and Millaa Millaa.

Senator MOORE—Mr O'Donovan, do you have any comments on those issues—the Indigenous voice or the general services available?

Mr O'Donovan—CAGs are developing our own mutual support teams. I constantly ring Townsville and have good connections with Bundaberg. Recently, Charters Towers rang me and said, 'We're trying to re-establish the CAG, we need some help to be able to make a case to our manager to get a budget.'

Senator MOORE—There is a history in Charters Towers in this area.

Mr O'Donovan—Yes. I am about to send out our service agreement, our vision statement, our aims and an outline of our structure. CAGs are trying to help each other as much as we can—those of us that get to know each other. The chair of the Prince Charles CAG was recently up here on a bike trip and we had a chat about what issues are facing her CAG. They were similar to some of our issues. We are starting to create these informal links. Originally, a lot of the CAGs were relying on QCAG to be an umbrella organisation to try to support and resource each of the local CAGs, but that was actually outside the terms of reference of the ministerial advisory committee.

One of the things that the department did not want us to do as a state advisory committee was to help local district CAGs. Having regard to the names—the Cairns Consumer Advisory Group and the Queensland Consumer Advisory Group—you would think there is a link but in the terms of reference there is not a link. We started to create that link anyway, so anybody that was sitting on the Queensland Consumer Advisory Group was starting to try to help these other small district groups survive. Without that we do need some sort of peak body that can be used as a resource.

Cairns CAG is developing some really good policies and procedures at the moment which have been developed by having access to Townsville, Princess Alexandra and Bundaberg

procedures. We have used them to create our draft. Our draft is in a developed form. Our remuneration procedure is a very good procedure. That is something that should be available to every CAG or every health district in the state. If it has been done well and it is working, rather than have someone else reinvent the wheel, we should have a central location where all these good systems can be placed. Charters Towers could ring that place and say, 'I need copies of procedures on these areas and we will adapt them for the local need.' We need an organisation to have that role to help sustain CAGs.

Senator MOORE—Like a secretariat?

Mr O'Donovan—Yes. We have a very strong relationship with Innisfail and Atherton. Unfortunately, the Innisfail health district and the Atherton health district currently do not have a budget available or are not prioritising a budget for those groups. Those groups that want to become CAGs again cannot become a CAG until they can argue a budget. If you do not have a budget, you do not have an office. If you do not have an office, you cannot start organising. So there is the same problem again.

With respect to Indigenous representation through Cairns, the Cairns CAG holds a free monthly barbecue which attracts between 35 and 45 consumers and carers every month. We have been doing that for three years. That is one of the first points of contact that consumers and carers have with the CAG, either coming out of the woodwork or at first hospitalisation stage or having moved to Cairns from another area. That is a nice informal way to get to know us in the CAG and maybe show that they want to be a part of what we do. That barbecue is our development of a sense of community. A lot of Indigenous consumers do attend that. That is the main contact I have with Indigenous consumers. A representative from Wuchopperen attends some meetings. He has mental health consumers on his case load.

The Indigenous mental health coordinator has been developing an Indigenous mental health workers forum and also an Indigenous consumer and carer forum, although they have not been implemented yet. I know it is something that is on her books. The workers forum has held a few meetings but I do not think the Indigenous consumer and carer forum has had any meetings yet. It is something that they are trying to address.

Senator MOORE—Is it like an Indigenous CAG?

Mr O'Donovan—If not a CAG, an advisory committee. If there were Indigenous consumers or carers that wanted to become involved in CAG, it is an open organisation and that is possible. Once again, you probably need some sort of funded system through Wuchopperen or something, whereby Indigenous consumers and carers could come forward. QCAG, and particularly the people in the mental health unit in Brisbane, were concerned about representation from Cape York and the Torres Strait in their systems. Once again, there have been no solutions as to how to address that.

Senator MOORE—Does the funding for your barbecue come out of your $13½ thousand?

Mr O'Donovan—The service agreement, yes.

Senator MOORE—That is part of your ongoing activities?

Mr O'Donovan—Yes, we call it a peer support program. At the barbecues we have a talk for half an hour about things such as programs that are coming up. We will have guest speakers. Recently, we had the zone coordinator for the outcomes initiative do a presentation on mental health inventories. It is a place where other NGOs can also access a large number of consumers and carers at one time. It is serving more than just the peer support function.

Senator MOORE—We have heard evidence that one of the stressors on families and people who identify as having a mental illness is interacting with Centrelink, work, going in and out of places. Does the carer group provide assistance regarding who to speak to in Centrelink if you are having a problem, who to speak to in housing if you are having an issue about housing—that kind of active support?

Mr O'Donovan—We could informally but we do not really take on individual cases and concerns. I would usually refer them back to the mental health resource service. If there is a rights issue we would refer on to Rights in Action. If someone has an individual issue with something that has happened to them, we are not trained to do those things so we would rather refer on to other agencies.

Senator MOORE—You would be a referral point that they would feel confident to come to and then you would be able to say, 'You should go and see so and so'?

Mr O'Donovan—Yes. We do not follow up individual cases. Our main role as an advisory group is systemic rather than individual. It is also about being a voluntary organisation. I think you need some skills to deal with people when they have issues like that and that is why we should refer on.

ACTING CHAIR (Senator Humphries)—Thank you for your evidence this afternoon. It has been very useful. I thank all of the witnesses who have appeared before us today. I thank the staff of the committee and Hansard for their support over the course of this week. I declare this hearing adjourned.

Subcommittee adjourned at 5.19 pm