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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH

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

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

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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Committee met at 9.03 am**DEVLIN, Ms Jennifer, Solicitor, Northern Territory Legal Aid Commission****CLISBY, Ms Judy, Manager, Community Visitor Program**

CHAIR—Welcome. This is the 11th hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March 2005. Witnesses are reminded of the notes they have received relating to parliamentary privilege and the protection of official witnesses; further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public but, under the Senate's resolutions, witnesses have the right to request to be heard in a private or in-camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

You have lodged a joint submission with the committee, which we have numbered 348. Are there any amendments or additions you wish to make at this stage to that document?

Ms Clisby—There are and I have already discussed those with the secretariat. I have tidied up the submission and made changes to one of the points, after having discussion with the people involved.

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

Ms Devlin—Thank you very much for the opportunity to speak with you this morning. As you would be aware from the written document, I work at legal aid. There we provide a duty lawyer service for the Mental Health Review Tribunal, representing people who are the subjects of involuntary orders. Judy Clisby works with the Community Visitor Program, which is charged with inquiry functions, complaint functions and visiting duties in relation to the approved treatment facilities and agencies that are established under the act. Both Judy and I will introduce this session this morning. Judy will deal with a number of issues and I might hand over to her to go through those.

Ms Clisby—The submission covers the range of terms of reference, but we did leave out (l), (m) and (n). I will talk briefly about issues that I have come across, particularly as a community visitor. The first issue is that of the lack of Aboriginal interpreter services. There is an Aboriginal interpreter service in the Northern Territory, but it is difficult to access; in particular, for Indigenous Territorians coming into in-patient facilities after hours, it is almost impossible—and it is at this time obviously that it is most necessary.

We have talked of the need for Aboriginal mental health workers to be trained and to be located in remote communities. We have talked of the need for integrated care across sectors and between various aspects of the health sector. We have talked, in particular, about the need for mental health services to work very closely with drug and alcohol services. There is a lack of clinical rehabilitation services in the Northern Territory—in particular, for people who have such chronic symptoms and are so unwell that they need very intensive input, those who perhaps in

other jurisdictions could stay for long times in hospital. They are maintained in acute facilities in the Northern Territory and, if they still need to stay in hospital, they may be transferred interstate. When you talk about the least restrictive alternative, that is a real issue.

There is also a need for improved vocational rehabilitation. There is some funding for that in the Northern Territory, but perhaps there are no workshop type facilities available. There is some supported accommodation but nowhere near enough. So, when people are being discharged from hospital, many are discharged to hostels or going straight back to the 'long grass'—as they call it in Darwin. Another issue is that people with comorbid conditions of drug dependence, acquired brain injury—perhaps from petrol sniffing—or behavioural disorders are spending inappropriate times in hospital because there are not the necessary services in the community to deal with them. Another issue we raise briefly is early intervention for people with psychosis—early psychosis intervention. Again that is a function of our being a small jurisdiction and trying to provide an array of services for a small population base, but it means that those services just are not available.

Ms Devlin—The remaining issues that are addressed in our submission relate to the fact that, firstly, there is no diversion program currently available in the Territory for people with mental illness. That means that people are placed in jail along with other offenders, as there is no separate psychiatric facility available to those persons at the current time. Another issue that concerns us is that, because of the severe shortage of safe and secure housing for people with mental health issues and the lack of vocational rehabilitation support, there is an overrepresentation of people in the prisons, particularly as mandatory sentencing exists in the Northern Territory for a range of different offences from repeat breaches of restraining orders to some sexual offences and so on.

The last issue that we raise in our submission is the lack of choice of transport that is available to people who are required to enter treatment facilities. Despite the fact that section 10B of the Mental Health and Related Services Act stipulates that police transport should be used as a last resort, it is in fact the norm in the Territory. Those are the main issues that we treat in our submission. We would be very happy to answer any questions that you might have about those.

CHAIR—Thank you very much. There is one point in your submission I would like to ask you about. It may be that you are not able to expand much further than your submission. You say that a carer had been lobbying you for some time about orthomolecular medicine, an alternative to the medical model of treatment for schizophrenia. This is not an issue that the committee has heard much evidence about so far. I wonder if you could comment on that. It has also been suggested in some other submissions that there may be an Indigenous perspective on schizophrenia and on dealing with it in a traditional way. Are you able to enlighten the committee on those two issues?

Ms Devlin—I will answer in relation to the orthomolecular medicine issue. That was the mother of a client of mine who was very concerned about the lack of alternative treatment options available for her son. Obviously, I do not have a medical background; it is not an area that I know very much about, but, when I was assisting her with approaching medical staff at the hospital to see whether the treatment that she wanted for her son was a possibility, she was told that the resources were not available to even explore that option with her. She had done quite a lot of research into the issue and was convinced that that was the way to go. I do not know a lot

about it, but I understand that it involves administering a large amount of vitamins—for example, vitamin B or something like that—to the person who has schizophrenia. That has been found by some researchers to be an effective way of treating that illness, apparently.

Ms Clisby—The other issue was about services specifically for Indigenous Australians. The first issue to talk about with relation to that is the need for Aboriginal mental health workers. One of the reasons is that they are much more able to provide a culturally safe service. I am not an expert on this; I have only been in the Territory for a short period of time, but the sorts of things that people talk about are working with *ngangkari*s, who are medicine people for Aboriginal people, and an acceptance of the fact that some of the symptoms that we would normally describe as symptoms of psychosis—for example, hearing voices—may in fact be a cultural phenomenon rather than a sign of illness. There needs to be culturally appropriate assessment of people who are Indigenous Australians.

CHAIR—Are there people in the Northern Territory who are doing that? If so, who are they?

Ms Clisby—I have to be very careful that I am not making gross statements about this. I am aware of some people who are brilliant at what they do and who are very good at taking into account Indigenous issues, but I think there are not the resources to provide the range of services that are needed to make it appropriate. There have been a number of papers written by a psychiatrist who came up here on placement about how to culturally assess an Indigenous person. But, for example, the outcome measures tools are only tested against and valid for white Australians, not for Indigenous Australians. There are those sorts of issues that need to be addressed. The people who work in mental health have the AIMHI project, which I talked about earlier. That is doing some dynamic stuff, and they are researching while they are doing their project as to how to work most appropriately with Indigenous Territorians. There is some stuff happening. I guess, in an ideal world, there would be more.

Senator HUMPHRIES—You talk in your submission about the problem of the way that mental illness is defined in the Mental Health and Related Services Act in the Northern Territory. You say:

... the narrowness of the definition effectively works against people with personality disorders for whom there is no other intervention available in the Northern Territory.

You go on to say that mental disturbance can be dealt with—I assume that means when a person is behaving very strangely and needs to be restrained for their safety or the safety of other people—

Ms Clisby—That is right.

Senator HUMPHRIES—but that there is no ‘specific and specialist intervention’ for their underlying behaviour. What is the solution to that problem, in your opinion? Should we define the concept of mental illness differently in the act? If we did that, would there be a problem, in your opinion, with the way in which psychiatry interacts with people, because they have different definitions of what constitutes mental illness?

Ms Clisby—Personality disorders are what we were referring to in the submission. They are actually an Axis II diagnosis under the diagnostic statistics manual. In other jurisdictions, they are not excluded from treatment. In fact, the National Mental Health Strategy specifically says that there are groups of people who should not be excluded from treatment. So that is one of my issues. There are programs interstate that work specifically with people with personality disorders. They are expensive and they need to be intensive, but these are the people who use up the resources of the system, because they are the people who are demanding services. If the service is not delivered appropriately then in fact—and this is generally held knowledge—the behaviour is likely to become more demanding and more expensive to the service. So, for example, in Victoria, there is a program called Spectrum which works specifically with people with borderline personality disorder. In South Australia, where I am from, they had particular interventions aimed at this group of people. There is some counselling: a dialectical behaviour therapy. The evidence is that that is the most effective way of working with people with borderline personality disorders in particular. Because personality disorder is excluded from the act, there is just nothing like those services available in the Territory.

Senator HUMPHRIES—You talk also about the case managers, and you mention that the team based in Darwin, where they have approximately 380 to 400 consumers that they deal with, has a case load of on average between 30 and 40 consumers. You say that that is too much, and I am sure it is. Do you know how that compares with case loads run by teams elsewhere in Australia? Do you have any idea?

Ms Clisby—I hope it is all right if I talk about South Australia, because my background is as a mental health worker in South Australia. I worked in a mobile assertive care team. In most jurisdictions, you have a range of services available. You would have perhaps a team that has a high-level case load of people who are less intensive and require less input. Then, for people who are chronically unwell and require intensive input, you would have an assertive case management model, which has a case load of between 10 and 15. That is internationally recognised as the optimum form of case management.

Senator HUMPHRIES—What are the case loads like in outlying parts of the Northern Territory? In Darwin presumably 30 or 40 consumers would not be too hard to manage if you were not too far away from them, but when they are scattered—do you have any idea what the evidence is?

Ms Clisby—I believe the case loads are smaller in other parts of the Territory. I think they are in the 20s in Alice Springs. But the other issue for Alice Springs, for example, is that they are also covering the area down to the South Australian border. They even cover some of the Pitjantjatjara lands as well.

Senator HUMPHRIES—In South Australia?

Ms Clisby—Yes. And I think they have some joint project going with a psychiatrist from South Australia. But they are covering huge areas. So, for example, at Tennant Creek, which I visited a couple of weeks ago, they have a relatively small case load, but their area is the size of Victoria, so they need to visit out-stations. So you are offsetting the number of people that you are working with against the absolute size or remoteness of the area you are working with.

Senator HUMPHRIES—You say that there are plans for step down facilities in Darwin and Alice Springs. Do you know where those plans stand at the moment?

Ms Clisby—I understand that the funding for both has gone to non-government organisations. They have both employed staff and it looks like the referrals are just about to begin. I am aware of one person that they are working with in Alice Springs. I spoke to the manager at the step-down facility in Darwin yesterday and they have not yet received a referral, but it is happening as we speak.

Senator MOORE—You raise a lot of issues and have very few recommendations—which is understandable, I suppose—but have you read the Northern Territory government's submission?

Ms Clisby—No.

Senator MOORE—I ask because in their submission they talk about the things they have done, and it is always difficult to try and balance things when you hear issues being raised and then you see a government submission later. On that point, how do people talk about these issues in the Northern Territory, because geographically it is large but in terms of numbers and organisations it is relatively small? How do you feed through the range of issues that you have identified in your submission to the government agencies?

Ms Clisby—That is the role of the community visitor program, to a large extent. We have panels that go and visit the approved treatment facilities and the approved treatment agencies in the Northern Territory. On the basis of that they make recommendations. They are fed through to the director of mental health services and we report annually to parliament. It has really only been happening over the last 12 months, so we have yet to see how effective that process will be.

Senator MOORE—It seems, according to the Northern Territory government's submission, that everything has happened in the last 12 months. I am not quite sure what happened before then but, if you read their submission, it is like there has just been this recent acknowledgment. Is that a fair enough comment?

Ms Clisby—I would say that was a fair enough comment. I did not work in mental health services prior to 12 months ago, but I am aware there has been a lot of activity going on in the last 12 months.

Senator MOORE—So you are also just 12 months?

Ms Clisby—Yes. I have been in the Territory longer than that but I am aware that there have been huge changes over the last 12 months.

Senator MOORE—Specifically on the question you raised earlier about personality disorders, in the Northern Territory government submission it states that there has been a recent review of the whole act. Was the issue you raised about the extension of definition brought up in that review?

Ms Clisby—I certainly did not raise it because we only commented on the community visitor section of the act. I was not part of the process before that, so I do not know but I do not believe it was raised.

Senator MOORE—We will raise that with the government, but from your submission it just seems to be such a core issue.

Ms Clisby—It is a core issue for me.

Senator MOORE—They have just done a review of the whole legislation. It would seem that would be the place to raise that.

Senator TROETH—Earlier in your remarks you mentioned the need for supported accommodation versus its availability. Can you give us some idea of the proportion of that. What is the need for it and what is the availability?

Ms Clisby—I know there are 10 beds in Darwin available for people with mental illness. Five of those beds are for patients needing intensive rehabilitation. There are another five beds where patients receive four hours of care a day. There needs to be a range of supported accommodation options, from group type facilities to, perhaps, independent living with intensive, non-clinical intervention at home. I do not know the numbers. I have a social work student with me at the moment and she has a project that is actually going to be looking at just that so we can come up with some figures and estimations of exactly what is needed. But I am very aware that it is very difficult to get appropriate accommodation.

Senator TROETH—I take it that those beds are occupied all the time, both intensive and four-hour?

Ms Clisby—Yes. I raise the issue of a young person, for example, with a comorbid acquired brain injury having to live with family who just are not coping. That is because of her behaviour, safety issues in the home and other family members perhaps being assaulted at times. But there are absolutely no alternatives available.

Ms Devlin—On that point, I was speaking with one of the criminal lawyers at legal aid just this morning and she was telling me about a case that she had recently. She was seeking bail for the person she represented, who had been in remand for a number of months at the jail. A range of different places which provide accommodation were called and they all said either ‘He’s too mad for us’ or ‘He’s not mad enough,’ so each of those representatives were asked to come in and give evidence. The magistrate ended up having to release that person, not being able to send them anywhere. In the end it was decided that they should be released into the community with no support, as opposed to continuing to spend months and months in the jail.

Senator TROETH—With the clients who need to go interstate for further treatment or whatever, who pays for that?

Ms Clisby—That is an interesting question, because I am aware of a case in Alice Springs in which I think for one of the people who went interstate it was paid for by mental health services of the Northern Territory. I recently raised the issue of another person elsewhere in the Northern

Territory who has spent most of the last 12 months in hospital and whose family are looking at him receiving treatment elsewhere. I raised that with the manager of the service and that was the issue that was raised: 'There's treatment available here, so why should we pay for it?' But in that case I think the family would be prepared to.

Senator TROETH—Yes. Quite apart from the treatment point of view, from where you are geographically, air fares both for the patient and for any family members would pose a huge problem.

Ms Clisby—Yes.

Senator TROETH—With police transport, what other alternatives are available, and have there been any steps taken to prevent what amounts to discrimination against mental health patients?

Ms Devlin—As far as we are aware, it is only the police transport that is used. People are never transported in ambulances, for example, as they might be in other jurisdictions.

Senator TROETH—Why is that, do you think?

Ms Clisby—It may well be culture. It may well be that there are not enough ambulances. It requires a change in the way people think about a problem in order to change practice.

Senator TROETH—How many ambulances would there be here in Darwin, for example?

Ms Clisby—I do not know, but driving to work over the last week there have been signs on the highway saying there are only three ambulances in Darwin.

Senator TROETH—Four.

Ms Clisby—Four, is it?

Senator TROETH—Senator Scullion is telling me there are four. That is not a huge number, I must say.

Ms Clisby—That may well be the issue.

Senator TROETH—Yes, and there have not been any steps taken to change that as far as you know?

Ms Devlin—Not that we are aware of.

Senator TROETH—The other question I wanted to ask is about the Aboriginal mental health workers, who have been mentioned in your submission and other submissions. What is the acceptance by GPs and agencies in the field of the Aboriginal mental health workers? Are they accepted as colleagues and treated as such?

Ms Clisby—I am aware that Sandy McConachy is going to be giving evidence later on today and I think she would be far more qualified to answer than that I would.

Senator TROETH—Okay. You do not have any comment on that, Ms Devlin?

Ms Devlin—I do not represent Aboriginal people as part of the work that I do, so I do not feel I would be in a position to comment either.

Senator WEBBER—I was talking the other day to the woman who runs the visitor program in Western Australia, which is where I am from, and the major issue she raised was about the rights of the mentally ill and the preservation of their rights. Is protecting their rights a concern that your program has, or is the Northern Territory better than my home state?

Ms Clisby—I think the piece of legislation that we have in the Northern Territory is a really good piece of legislation in that it is very careful and it is written very much along the lines of the model mental health legislation which came about as part of the National Mental Health Strategy. It focuses very much on the least restrictive alternatives. In the Northern Territory, people who are involuntarily detained are all reviewed within a week. In terms of the legislation and people's rights, the culture is about the protection of rights. There are some issues at the moment that relate more to societal beliefs about the protection of people with mental illnesses, to demands that people not be allowed to leave hospital and to issues about people absconding. I am concerned that at some stage this may mean that our system becomes more restrictive, but I think that is a general comment rather than one particularly related to the Northern Territory.

Senator WEBBER—Are mental health practitioners well educated in the rights of the mentally ill?

Ms Clisby—I believe so; yes.

Ms Devlin—I would say 'not always', and partly that is because there is such a high turnover in staff in the Northern Territory. A complaint that is often made is that the people we are able to attract to the Territory lack experience. My experience of working with the medical members of the profession is that some of the members are very well versed in the legislative requirements and the need to uphold the rights of their patients, whereas some other members of the profession have not had that same education. There are some positive steps that have been taken. We have had some very positive discussions recently, particularly with Dr Rob Parker, who I understand is going to be speaking this afternoon. We are talking along the lines of having regular meetings between our officers and the doctors who make the applications for patients who come before the tribunal. We are hoping that those types of forums will provide an opportunity for doctors to be better informed about what rights are safeguarded by the legislation we have here.

Senator WEBBER—Is having that forum a new initiative?

Ms Devlin—We have done it previously on an ad hoc basis but, because of that rapid turnover issue, people who have attended might leave, and the new staff have not had the opportunity to have those discussions. We are hoping that with a more regular meeting structure that information will now stay here.

Senator WEBBER—I also have the dubious honour of coming from the only other place that has mandatory sentencing—in fact, we got it before you did. Could you expand on your comments about the impact that mandatory sentencing has on those with mental illness?

Ms Devlin—I probably cannot expand on them very much. I do not work in the criminal legal section of the Legal Aid Commission but, as I have said in the submission, the information that I have from my colleagues is that, because mandatory sentencing does exist for a number of different offences, it means that a large proportion of people have been subject to spending much longer periods of time in jail than they might otherwise have if their mental illness could have been taken into account in those circumstances.

Senator WEBBER—Would you be aware of whether it has any specific impact on young people? I know that that is a concern in Western Australia because young people are subjected to mandatory sentencing—

Ms Devlin—No, I do not know specifically in relation to young people. But one example that I raised in this submission is one that I had some contact with, of a person who had breached a restraining order. It was quite questionable whether he even understood the terms of that restraining order but, because the legislation states that subsequent breaches of it mean that you must spend time in jail, he was forced to do that, even though there are no psychiatric facilities there. There is a forensic mental health service available to persons such as him, in the jail, but there is no separate psychiatric facility.

Senator SCULLION—Perhaps one of you could take this question on notice. This group of people is overrepresented in the prison system—and I am speaking generally of those people suffering from mental health problems rather than Indigenous people. What level of service is there to deal with the everyday management of those people who—and these are sometimes acute cases—present with mental illness within the prison system? We talked about the integrated access that we have elsewhere under, I think, the Australian Integrated Mental Health Initiative, where often instead of the person going to jail we can have primary care delivery for them under the responsibility of a GP. Could you make some comments about that? It never seems to be much an option here because of the nature of resources, but I would like some comments generally on the level of amenity that is provided within the prison system to people who present with mental health issues.

Ms Devlin—I do not have the statistics or any of that sort of information to provide you with. As I said earlier, I understand that there is a forensic mental health service which operates in the prison. Some care is available, but it is our view that that is not the ideal place for people to receive that care and that often people with severe mental health issues are placed in high-security settings that they do not necessarily need to be in. They are put in there often for their own protection, because of the abuse that they are subject to in the jail system by being a person with mental health problems.

The defence of ‘mental impairment’ does exist under the Criminal Code Act. I understand that that is a relatively new section. Apparently it is having some positive effect because it does require the care of people who are in the jail system to be monitored by the courts. It requires forensic mental health services to provide reports in a way that they did not have to previously. There is an annual review under that mechanism.

As I said, I do not have the statistics. But, as I say in the submission, while that defence exists it is rarely used because, rightly or wrongly, the information I am given by the criminal lawyers—those from legal aid at any rate—is that the perception is that there is a lack of resources available for people in prison and that they would not be doing well by their clients to be pleading that defence. Maybe Rob Parker would be better able to answer those questions later on this afternoon about exactly what level of service is provided in the jail.

Ms Clisby—If a person becomes acutely unwell while they are in prison they are taken to the secure facility, which is part of the inpatient facility. They are accompanied by two prison guards at all times while they are there. We had the ludicrous situation a few weeks ago where we had three forensic clients and six guards in quite a small space. The forensic team does work within the prison. The prison medical system also works. There is a system, but there are issues sometimes about coordination within the system. The real issue is about people being placed in the high-security settings. There are no pre-release programs from there, so people can be released from a high-security setting straight onto the street. That is a major issue.

Senator SCULLION—This is perhaps a question for you, Judy. Comorbidity presentation is a difficult enough circumstance at the best of times without some of the language barriers that are necessarily encountered. When you travel to the communities, what opportunities do you think exist for an extension of our interpreter service so that people actually have jobs in some of these communities to interpret full time for people? Do you think that there is the capacity within some of these communities for people to be recruited for that?

Ms Clisby—I have not actually travelled to a community, so I cannot speak for them.

Senator SCULLION—What about your experience in South Australia?

Ms Clisby—I recently had a meeting with someone from the Larrakia nation who believed that there was capacity and there just needed to be the ability. He was of the opinion that he could supply a dozen Aboriginal interpreters and was looking for expansion of the CDEP funding, for example, in order to do that. It is those sorts of mechanisms that could be put in place throughout the Territory.

Senator SCULLION—Do you encounter some difficulties in finding somebody when somebody presents with obvious language difficulties? Generally, can you find someone? Is there a wide enough spread across the language groups?

Ms Clisby—Again, that is not something I have had a problem with because it is not something I personally have had to address. Some of the comments in our submission come from the community visitors' panels from when they visit the approved treatment facilities. In Alice Springs in particular the medical member also works for the Aboriginal Congress so he is aware of the issues across services. Issues such as lack of access to Aboriginal interpreters exist across all of the systems. I do not know how to access them. Whether there are the people with the skills available, I cannot say.

Senator SCULLION—My last question relates to refugees that come to the Northern Territory. You indicate in your submission that generally the counselling services available are

not up to scratch or are underfunded. Does this take into consideration the trauma and torture capacity within the migrant resource process that is currently run by—

Ms Devlin—The Melaleuca Refugee Centre is the only body which has the tender for the torture and trauma counselling. It used to be called the Torture and Trauma Survivors Centre, I think, and it is now called the Melaleuca Refugee Centre. It is the only body that has that funding, and its comment to us was that it feels it is grossly insufficient for the number of problems brought to it and that it is not able to deal with them.

CHAIR—The next witnesses argue that there should be a strengthening of the Community Visitor Program in correction facilities to monitor the use of detention and seclusion. Do you visit prisons?

Ms Clisby—No.

CHAIR—Is this a problem from your perspective?

Ms Clisby—Detention seclusion only occurs in the approved treatment facilities, I believe.

CHAIR—What happens if the beds are full in the inpatient services and someone has an acute episode?

Ms Clisby—They just keep filling them up. People have slept on mattresses on the floor.

CHAIR—So there are no people physically or chemically restrained in the present system?

Ms Clisby—Not that I am aware of. One of the issues for the Community Visitor Program is that we are still applying for funding to enable us to be able to continue. At this stage we have funding until November.

CHAIR—Where does your funding come from?

Ms Clisby—It is local Northern Territory funding.

Senator MOORE—Is it under mental health?

Ms Clisby—No, it is not.

Senator MOORE—Community services—

Ms Clisby—I guess so, yes. It has to be separate from mental health. We are actually located within the Department of Justice but I do not feel comfortable talking about this here—I am sorry.

CHAIR—So you visit people who are in prisons, not in hospitals—is that true?

Ms Clisby—No, we visit people in approved treatment facilities—the hospitals. The act is not clear about whether or not the prison system is an approved treatment facility so we have not visited the prisons although there is a community visitor scheme, a separate one, that does visit the prison. Our panel has visited the forensic team because they are part of the approved treatment agency in the Northern Territory.

CHAIR—As a visitor into the hospital system, are you in a position to assess the culture of the organisation—whether people are being treated with respect when they come in; whether restraint is kept to a minimum, both physical and chemical? Is that your role?

Ms Clisby—Yes, it is our role. We visit. One of my roles is to look at seclusion registers at the hospital. I would be very keen to see how the numbers of seclusions in the Northern Territory benchmark against the national average.

CHAIR—Because you suspect that they are higher?

Ms Clisby—I suspect that they are higher. I would also like to be able to have a look at the figures that actually demonstrate the number of seclusions against what is happening within the ward at particular times. When the ward is very full I would imagine that you would be much more likely to have people secluded. There are times when there are people who are held inappropriately in the mental health facility because there is nowhere else. These are people with severe behavioural disturbance rather than a psychosis. This goes to the issue about community accommodation being available and when that happens those people have been secluded for long periods of time. Sometimes that is about managing. There are really no gradations within the approved treatment facility. People go from being in an open ward to being in what was once a forensic facility. For example, most of the wards I have seen elsewhere have an open ward and a closed ward and if people require high security they would go elsewhere. Here you have open and you have high security. In that sense, because there are not those gradations, the number of seclusions is probably higher than there would be elsewhere.

CHAIR—‘Seclusion’ suggests someone is by themselves in a room which—

Ms Clisby—They are locked in a room.

CHAIR—How you can have this situation where you have people sleeping on the floor all over the place and overcrowding? You are still talking in terms of people being by themselves.

Ms Clisby—Yes, because they have seclusion rooms.

CHAIR—In Victoria, the rule for seclusion was that the person must be seen by a psychiatric nurse at least every 15 minutes and a supervising medical specialist of some sort every four hours. Are there rules like that here and are they adhered to?

Ms Clisby—They are generally observed every 15 minutes. That is something that happens. There is a rule with regard to there being a four-hour review. That is occasionally not adhered to but it is getting better. That is part of the stuff that we are working with mental health services on. I think that, on the whole, seclusions are managed appropriately in the Northern Territory as

far as they are able to do so and that any issues about that are resolvable. The issues around seclusion are more about what happens when the facility is overfull.

CHAIR—I now ask a perhaps awkward question. Does this insecurity with regard to your funding allow you to be truly independent? Are you able to tell this committee, for a start, of what may be of concern to you?

Ms Clisby—My difficulties with talking to the committee about these issues are that I did not raise them in our submission and that they are matters, at the moment, for negotiation between our program and mental health services. That is why I do not feel comfortable. It is not a matter of having issues about independence.

Senator MOORE—I would like to clarify something, because this works slightly differently everywhere. Your job is to review and see what is going on. People can come to you with a complaint and say, ‘We think this is going wrong here,’ or you have a regular process. Is your only act then to report back to the department and the minister? Is that all you can do?

Ms Clisby—I have very good relations with the staff in the facilities and the agencies and with their managers. There is a Top End mental health service and a Central Australia mental health service.

Senator MOORE—You are cut in half, are you not, in the Northern Territory?

Ms Clisby—Yes.

Senator MOORE—Is it from Darwin to Katherine?

Ms Clisby—To Katherine and then downwards, yes.

Senator MOORE—Then Alice?

Ms Clisby—Yes. I can contact the managers at any time. I have their phone numbers and they are really accessible. If there has been an issue—and occasionally something will come up—that has required instant action, it has been easy to make a phone call and have it happen. That relationship is really useful.

Senator MOORE—But the process to ensure that it is enshrined in good behaviour is then to go back to the minister and report on what you have seen.

Ms Clisby—Yes, it is to write an annual report. That is how most community visitor programs operate: through their annual report.

Senator MOORE—And the expectation is that the minister then puts that the parliament so that it is open.

Ms Clisby—Yes.

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

[9.48 am]

BROWN, Ms Dawn Patricia, Member, Northern Territory Mental Health Coalition

CARTER, Ms Kirsty Jean, Spokesperson, Northern Territory Mental Health Coalition

GREEN, Mrs Joy Ann, Member, Northern Territory Mental Health Coalition

JAMES, Mrs Julie Ann, Member, Northern Territory Mental Health Coalition

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

Mrs Green—I am a member of the coalition and a carer.

Ms Brown—I am a member of the coalition and a consumer representative.

CHAIR—You have lodged with the committee a submission, which we have numbered 409. Are there any amendments or additions you want to make to that document at this stage?

Mrs Green—No.

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

Ms Carter—This is very brief. We just want to put our submission into some kind of context for you. The submission outlines the role of the coalition. The coalition is fairly new. We have had a part-time person employed as a project worker with the coalition for the last year. The purpose of that role has been to develop the model of the coalition, the purpose of the coalition, among other things. The submission was based on information that we had taken from various sources. It was prepared by an external consultant, obviously with comment from the coalition. It really represents carer community perspectives, so in that sense it is not heavily evidence based in terms of statistics and that sort of information; it reflects the views of carers, consumers and service providers in the non-government sector. It also reflects the views of these organisations and individuals in Alice Springs and Darwin. We represent Darwin services, so possibly our capacity to comment on what is happening in Alice might be a little bit limited.

CHAIR—I will ask you first of all about the question of funding. You say that ‘over the past few years the federal government has funded some very innovative and effective “pilot projects”’, but lack of ongoing funding is a problem. Could you perhaps expand on that? What programs did work? Have they now finished? Have you made representation to the federal government about them? Are you able to tell the committee more about this?

Ms Carter—There is an obvious one that leaps to my mind. My membership on the coalition is from the Top End Association for Mental Health. We are probably the biggest non-government provider in Darwin. One project that we have recently finished is a family support project that was designed to provide support to families where a parent has a mental illness. It was a three-

year project. It finished in June this year, and there is no ongoing funding from that at all. We are currently preparing a project report about that, and we are hoping that, as a result of that, we will be able to approach both the NT government and perhaps the Australian government to re-fund, based on the evidence in that report. But it was a project, and it does not have any ongoing longevity, which is a bit disappointing because it went very well.

Mrs James—I am a member of the coalition, but I am also the field worker for GROW in the Northern Territory. A number of our people were accessing that service that TEAM Health was offering. For a number of our people who were accessing it, it was a really wonderful thing and it was really great support. They certainly lost out when suddenly that support that they had had was longer available. That has a dramatic effect on their ability to cope.

CHAIR—What was the level of funding provided?

Ms Carter—Sorry, I have only been in this role for a year, and the project is a bit longer than that. I think it was around 330 over the life of the project, so that was over a three-year period. That basically provided one worker, with some part-time support on top of that.

CHAIR—I was interested in your remarks about the ‘fallacy’—to quote your submission—‘that Aboriginal “culture” somehow replaces psychological make-up and the mistaken belief that Aboriginal clients do not experience the same levels of grief, anxiety, sense of hopelessness’ and so on. I invite you to expand on that. Are you speaking from the point of view that the services take this attitude, or is there something else which spells out what your complaint suggests?

Ms Carter—I think that probably reflects the concerns of the service in Alice Springs. The mental health association in Alice Springs works a great deal with remote communities and with Aboriginal people. Unless anyone else has anything to add, I am fairly sure that—

CHAIR—Ms Brown, you look as though you are about to speak.

Ms Brown—I think it is a misconception held by many health workers and professional people—if I may say that—because of the cultural differences between Aboriginal people and non-Aboriginal people. A lot of the time there is the confused thought that Aboriginal people do not get depressed as we do or they do not suffer mental illnesses as we do—which of course is nonsense. They do suffer mental illness. I think that misconception is held by many health workers.

CHAIR—When you say ‘health workers’, do you mean GPs and nurses?

Ms Brown—Yes; some policy makers too, as far as I know. I know as a consumer it is difficult trying to be involved in getting information across to Aboriginal people. It is a totally different—I accept that—and it is very big role. What Aboriginal organisations are doing now is absolutely fantastic. They have had to work very hard to get to where they are today because of certain misconceptions that are held in the community and in the general population. That is how I perceive it.

Senator HUMPHRIES—Can I clarify how the coalition is made up. What proportions of the coalition are of carers, consumers and service providers—roughly?

Ms Carter—There is a bit of debate about what is a carer organisation, a consumer organisation and a service provider. If I miss something, my colleagues will probably have to add to what I say. Currently we are in the process of determining membership and who are legitimate members. At the moment all our organisations are members. GROW provides a support service to people with mental illness. Top End Association for Mental Health, TEAM Health, provides a whole range of services for people, from accommodation and outreach to training and services. There is ARAFMI, the Association of Relatives and Friends of the Mentally Ill, which I suppose pretty much says it all. It is a support service to relatives and friends of people with mental illness and also provides ‘Pete’s place’ as a drop-in centre for people with mental illness.

Senator HUMPHRIES—I was really getting at whether the organisation is more representative of professional providers—if I can put it in those terms—of services or more consumer and carer based.

Ms Carter—Carer and consumer, definitely.

Senator HUMPHRIES—It is more the latter?

Ms Carter—Yes.

Mrs James—If you look at the make-up of this group here today, Dawn can talk on the top-end consumer group, which is run by consumers and is all about consumers. I do not know whether you know much about GROW, but it is a consumer organisation, which at all levels has very active involvement by our members. We have a very strong consumer base; having come from that base, I am a consumer myself. Joy is from ARAFMI, which is carer based. When we come together to sit and discuss issues, we bring with us not only our concerns but also the concerns of the people we interact with in our positions and we represent the base consumer/carers view.

Senator HUMPHRIES—That leads me to ask about the ideal way in which we should provide services. Let us fantasise for a moment that a lot of money is spilling around the system which enables you to provide much better prevention and early intervention services. In a place like the Northern Territory, are early intervention services, step-down facilities, rehabilitation services and all those sorts of things best delivered by a Territory-wide organisation—obviously dividing them between Aboriginal and non-Aboriginal client groups and so on—or would they be delivered better by a range of separate services around the Territory that specialise in those areas? What is the best outcome?

Ms Brown—I am a great believer in the saying that the community needs to look after its own. I am also a great believer that so many of the services can be provided by non-government organisations—not all services, obviously. I think we need to work very closely with government departments to make sure that all aspects are looked after, hopefully starting with early intervention and prevention. I think a lot of work is needed in that area, and a lot of the consumer and carer groups can have a larger input in that because we deal more with people out in the street and we do offer some services. For a lot of the other processes that people go through when they are ill, from the time they go into the services to the time they come out, I am a great believer that the community and non-government organisations can have a greater input

there also. I think in many instances they can have a better outcome than if we just leave them as government services.

Senator HUMPHRIES—So non-government based services and area- or client-specific services, not generalised services with compartments that deal with those things?

Ms Brown—Yes.

Senator HUMPHRIES—You mention in your submission that you feel the monitoring of most non-government services in many instances is disproportionate to the level of funding. Can you explain what you mean by that?

Mrs James—I was not involved in that discussion, but as a non-government service that has to report back on it, we have a reasonable size, I suppose, and I guess, proportionate to others, probably a fairly low amount of funding, but we are very answerable on what we do with that money and where it goes. It requires us sending in two reports a year to answer for that and to show that it is working and that what we are doing is actually beneficial. In an organisation the size of ours, where you have one full-time worker and one part-time worker, that can be quite a drain on our time and our ability to go out and do things. At times I think, for some of us smaller organisations, it is quite a drain on the level of monitoring we do to keep enabling us to get our funding from year to year.

Senator HUMPHRIES—So fewer reports or less information in each report is ideal, do you think?

Mrs James—I would probably say one report a year would be fine; that would be nice and take a bit of time off. I must admit we have been very lucky up here in that we have a very good working relationship with our funding people. Part of what we have been able to do in recent times is amend our service agreements so the types of stats I would be keeping in our GROW centre are the same types of stats I would require for my national report to the annual GROW report. There are just a couple of areas that I have to keep stats on here for our funding body, but mostly we are able to keep stats that are applicable to both our funding body and our national body. Some do take a lot of time but, again, whilst those stats take time to keep they are also valuable to have and government is able to look at us and see what it is that we are doing.

I think it is unfortunate that our written service report does not necessarily show whether it works. It is all a matter of just numbers of people and stats. The actual outcomes for our people are not necessarily represented. The only way we are able to do that in a written form to our funding people is by way of our annual questionnaire, which asks people: have you learned, has it benefited you or has it not? But the stats of how many people walk through our door, how many brochures I give out, how many talks I give or how many people I give information about do not necessarily reflect the work that we do.

Senator WEBBER—Before I comment on a couple of things in your submission, you said in your remarks that this seems to be the land of the pilot program. Could you expand on that? I am sure they are not all federally funded. I am sure the Territory government also does some of that. Does anyone talk to you about the fact that they are looking at ongoing funding, or are you just

told it is three years and that is it—so we create a demand for the service, we provide it for three years and then we walk away?

Ms Carter—My comments earlier probably did not reflect the discussions that I have had with the NT government about how we might continue some of these projects. For example, there is the family support project. I have talked to the department here about some ongoing money for postnatal depression support, and that will come out of that project plus other evidence. The discussions are definitely there; whether the money is there is another matter. I have certainly talked with the family and community services director here about how we might continue that.

Senator WEBBER—But do those discussions commence before the pilot program funding ends, or does it end and then we start talking about what we are going to do afterwards, so there is a big lag?

Ms Carter—Sorry, I cannot comment too much on how things were done before my time, but I certainly began those discussions last year while the family support project was moving to completion.

Senator WEBBER—Does anyone else want to comment?

Mrs James—From my perspective in GROW, we have not necessarily looked into pilot type ones because as a national organisation we are bound by what we can and cannot do, but we certainly have looked towards funding for expanding from just in Darwin, which is where we are based, into more regional areas. We are currently in a position of waiting to hear final news on possible premises in Katherine, which will be great. We will have a drop-in centre, which GROW also offers. We have a drop-in centre here in Darwin. We want to do that in Katherine as well and have a field worker. There is a real push from Alice Springs for us to get a worker down there, but that has not happened yet.

Senator WEBBER—You mention in your submission:

Mental health clients usually frequent low cost accommodation and there is the added need to provide adequate mental health training to low cost accommodation providers ...

How would you envisage that that happen? Do you have an idea in mind? I think it is a good idea.

Ms Carter—I suppose there are various ways that could be done. There is a package—I cannot remember the title of it, but it is basically mental health first aid—and maybe that sort of thing would be appropriate. However, somebody needs to deliver it, and that all costs money and that sort of stuff. A one-off project funded by the NT government was working with building up a skills base in SAAP services—Supported Accommodation Assistance Program services. That went very well and we did a lot of educating amongst those services, and that was great, but that project has finished and has not been refunded, so it stops there. At TEAM Health we try various ways to identify that kind of need and maybe develop some training programs with TEMHS, but it all takes time and, added to our existing load, it is very demanding.

Senator WEBBER—On the issue of comorbidity, I know that in some places in Victoria we were given evidence about their trialling, doing a lot more coordination and holistic treatment of people with dual diagnoses. Has there been a pilot program that does that in the Territory, or do we still just stick to silos of treatment and bounce people back and forth between them?

Ms Carter—From the point of view of TEAM Health that has been a major issue. Probably 99 per cent of our clients have drug or alcohol problems, and there are all sorts of complexities around that. I cannot give you the history, but I do not know whether a project looking at how we might better coordinate our services has been in place.

Mrs Green—I can answer that one. In the over 20 years I have been involved with mental health, no, there has not. The alcohol people do not want them because they are mentally ill, and the mentally ill do not want them because they drink—so, no, there has been nothing.

Senator WEBBER—It is a common problem.

Mrs Green—Yes, and, as you say, it is a hard one.

Ms Carter—At the moment TEAM Health are looking at our assessment processes and how we do that stuff. From our point of view, I have just decided it is essential—we cannot provide service to people if we do not know what these issues are and if they do not have that kind of support from somebody who is an expert in that area, and that is not us. So we are saying that that issue needs to be identified when a client is referred. Most of our clients are referred through government services. That issue needs to be identified and a strategy for managing that issue needs to be part of the plan when the client comes in. We have not seen whether that position makes any difference yet, but that would be the view I would take.

Senator SCULLION—I note in your submission that you quoted the Northern Territory legislation as not allowing young adults; it is almost like it is prohibited by law for people under 18 to get sick. I am quite sure there is no mischief in that. They are perhaps trying to separate the demographics so they can be dealt with better. I am not really sure what the intent was. It is clear that the first time we realise there is a problem, somebody has taken their life. We know that is the case all too often in the Territory. What can be done about catering for that particular demographic? We have been to other places in Australia and, in particular, I was delighted to see some of the work that is being done at ORYGEN in Victoria and the assistance of the adolescents themselves. In your experience, what sorts of things can be done to assist that demographic in getting access to some services?

Mrs James—I speak here about adolescents who were having problems. I am thinking of one particular case where a student at a school was identified as possibly needing intervention from mental health services. It was picked up reasonably early. Information was sent to the mental health services. It kind of missed the intake meeting, and when it finally did hit it was not necessarily seen to be that serious. There was no follow-up. Parents heard nothing of it and it wasn't until this particular student absconded from school with the intent to commit suicide that intervention started to take place. We hear so much about early intervention and prevention, but often the intervention only happens when it gets to crisis point. My general knowledge from talking to parents and people who come through our services is that a lot of the schools are very keen to keep an eye out and watch their kids and identify it early but it is a matter of whether it is

able to be followed up. I do not know that that necessarily reflects badly on the department; it is just that the department has more of a focus on dealing with things when they get to crisis, rather than dealing with things in the earlier stages.

Ms Brown—Young people can go to mental health services, or parents can take them to mental health services, and they will be turned away because of the decision that it is not important or it is not something they deal with. For instance, a child who lost both their parents was grieving pretty much and there were no facilities at mental health services for that, and the child was referred somewhere else. A lot of people will not carry it any further. They say, ‘Oh, well, we will have to deal with this ourselves, because we might have to wait weeks for some kind of appointment.’ I find that very disturbing because we are dealing with young children, under 15 or 16. So many things happen and the child can go from just being grieving to having suicidal thoughts. If that help is not there and they have to go somewhere else or somewhere else or somewhere else, then it is not going to happen. I find that a big drawback here in the Territory. It is very difficult because it is not clear as to who they take, what child they will accept to see and what the problem is. I find that very disappointing and very heart wrenching.

Mrs Green—Recently a 12-year-old was having major panic attacks. He could not go to school. His mother needs to work full time. I recommended that she go to the Tamarind Centre, ring up and make an appointment to see somebody. She then had to go back to her doctor to get a referral and could not get an appointment for three weeks. She needed this referral to take her child there. In the meantime this 12-year-old suffered, for three weeks. To me this was completely unnecessary.

This happens all the time. Again, she nearly gave up. I said: ‘No, don’t you give up. You go back, you get that referral and you take him there.’ But she said, ‘I’ve done this, I’ve been there, I’ve done this and done that.’ This child has now been suffering for over two years. I nagged her and said: ‘You have got to do this. Don’t give up; that’s not the answer. You have got to be in there. If you are not in there, you can’t complain down the track when something happens to him.’ So he is finally there, but we are talking about two years, really.

Ms Carter—In terms of the Tamarind, that may reflect the unwillingness to stigmatise children when they are very young and put a label on them when they are young.

Mrs Green—Yes, I agree with that. But, also, I do not think that is an appropriate place for that child to be. They should not go into adult facilities. There should be somewhere nice and friendly, with a garden and a play area, not a room at the Tamarind that used to be—I do not know what you would call it, but it is the day centre. It is not very nice anyway. And it is totally inappropriate for children

Senator SCULLION—In terms of the level of amenity that Mrs Green was speaking about, you talk in your submission about a need for a stronger watchdog. You talk about strengthening the community visiting service to address particular difficulties in detention and seclusion. From that, am I to assume that you believe that the standards in that area are in fact not being adhered to? If that is the case, could you give me an example?

Mrs Green—Do you mean in the hospital?

Senator SCULLION—Wherever they are: whether it is in a hospital or not. You talk about detention, imprisonment—

Mrs Green—Recently I know they were talking about locking down the wards. I think that is totally inappropriate. I can think of a much better way. There is a front door, and you could go through there. I realise there have been some changes: there is a reception area there. I do not know how good it is; the feedback I have is that it is not that good. But I cannot see why there cannot just be a desk with a nice, friendly receptionist there inquiring when you come in: ‘Good day, who are you here to see?’ They would get that person you have come to visit to come down to reception, and there would be a room where you can have an interview. There is another area in there that we used to call the ‘goldfish bowl’: all the nurses used to be sitting there. I believe they are now out of it—I would like to see that myself. You would have to go and knock on the glass and hope somebody would listen to you. I really do not believe in locking doors and locking people in. They are not prisoners. They should be allowed to come and go. They just need someone there to monitor who is coming and going in a friendly manner. There was two-way glass put there. I believe that has been moved but, again, I am not sure about that. You go into Cowdy and it is like walking into a prison facility.

Senator SCULLION—When you spoke about strengthening the role of the community visiting service, was that just in relation to the hospitals or to the prisons as well?

Mrs Green—I do not know about the prisons; I have not for a long time. I have a relative who was in there, and it was a totally inappropriate place to be. The thing he did that was wrong was because of a mental illness. Prison is not the answer.

Ms Carter—A colleague here has just informed me that this was an Alice Springs issue rather than a Darwin issue. It does raise one thing, and maybe the other panel members here will confirm this: carers tend to feel that there is a lack of transparency around decision making for clients in the hospital and a lack of communication between staff and carers. They are very complex issues to negotiate when a client is ill, so perhaps decision making around seclusion and the reasons that happens are not as transparent as they could be.

Mrs Green—It has been said, even in the Burdekin report, that carers should be included in the treatment. They know their relative or friend better than anybody. It is still not happening—they are not consulted. This year I was involved in stuff that I have not been involved in for years and years because the whole system broke down. My son ended up in hospital for the first time in 10 years. It was nobody’s fault but the system’s. They do not consult. You go to them with the person or the client, or whatever you call them, who says, ‘I want my relatives involved in what is happening to me,’ and you still do not get consulted. You put it in writing and say: ‘This is my phone number. Ring me. We will do anything we can to help.’

Senator SCULLION—Do you complain about those things?

Mrs Green—Do I complain about those things! I am complaining bitterly at the moment because my son is on to his second social worker in six weeks and he is in a very fragile state.

Senator SCULLION—So you go to them and say, ‘This is not good enough.’

Mrs Green—I do not see why they have to have the turnover of social workers like they do. I am sure people out there want a job a bit longer than six weeks. I think three months is the maximum lately. It is the same with the outreach workers. It is nonsense. It is not saving money. If you give them that care continually, you will keep them out of the hospitals. I do not know how much it costs to keep a person in hospital these days, but I am sure a social worker or an outreach worker would not cost as much. There are not enough of them. Some of them have 45 clients. No wonder they cannot ring the carers and say, ‘Your son is really ill.’ It is nonsense. If you talk to any carer or consumer and put them in there with your decisions, they would have it all fixed and you would not be spending half the money that you are spending.

Senator MOORE—How does your association consult with the government? We have the Northern Territory’s submission here, which talks about the things that they are doing. Your organisation is an accredited organisation that represents carers, consumers and organisations. What is the linkage between the department, the government and your group?

Ms Carter—Because we are so new we have not formalised regular meeting structures or anything like that yet. We have met with the new minister. We had a government election recently up here, and there is a new minister, so we have met with her. We have not set out a clear meeting structure or method of communication yet. As individual organisations we meet, but we have not set that out. For example, this is our first Senate submission. This is the first formal thing that we have done.

Senator MOORE—It would surprise me if any of the issues that you have raised here are brand new.

Mrs James—They are not brand new.

Senator MOORE—They are all from experience, knowledge and concern.

Mrs Green—In 20 years, how many times do you need to be told what we want? We keep going to the forums and keep giving the information, because if you do not nothing would happen. And good things do happen. I am sounding very negative, I know, but good things have happened.

Senator MOORE—There are so many issues. The statement that you make here about people providing information, giving stats and experiences and then having no idea where to go is obviously a cry from the heart over a long time. What is the solution to that? You have the expertise and people are involved, as a whole segment of your submission mentioned. What do you think should happen?

Mrs Green—They should listen to us and do it and not do another report. They can just pick up one that we did 20 years ago and use that. They spend so much money on having these reports. As you said, the story has not changed. I do not know why they are just not doing it.

Ms Carter—TEMHS, Top End Mental Health Services—the government mental health services—are looking at this issue at the moment. They have a meeting to which they invite the coalition, I believe, and individual services as well, but that meeting itself is problematic. It is up

and running, and it meets every three months now. I would love to tell you what the meeting's acronym—CPISM—stands for, but I cannot remember. Can anyone help me?

Mrs James—Collaborative planning and service improvement meeting, or something like that.

Ms Carter—It is a TEMHS meeting. At least part of its purpose is to improve services. One of the ways it does that is to involve carers and consumers.

Mrs Green—That is a positive.

Ms Carter—If you ask them, they would say that they do listen, but I think there is a lot of pressure on them too. It is difficult to listen in practice when you have 40 clients on your caseload. It is a numbers game: if we have 40 there is only so much listening we can do. To feed it back should be something we can do fairly easily but we tend to forget that; we just take the information, put it in a report and that is it. We all do that, I think.

Mrs James—I have been involved both as a consumer rep and with GROW since 1993. One of the things I have noticed, particularly over the last few years, is that the opportunity for us to have that type of input and to speak to a lot of these things has actually lessened. When I was first involved up here, members—consumers and carers—were represented on any committees or reviews that were happening. At one stage they did a review of the set-up of the Top End Association for Mental Health. They changed from a north team to a south team and then to all the different teams. There was very constructive consumer and carer participation in that.

A recent example is the changes to the Cowdy ward. At no time were we asked about that or informed about it until it was happening. It was the same for the carers. Once upon a time we would have been involved in that type of thing. It would have been: we really need to look at changing this unit and we need to look at the guidelines, and what input can the consumers and carers have in that? That is one thing that certainly has changed. I have certainly seen a change in my time. The level of involvement we have had has slowly fallen. There is still quite a level in some areas. People have quite a lot of input at, say, the national level, but when we get down to the nitty-gritty of the local stuff it appears we are left out.

Mrs Green—When they opened that hospital we were very involved. We made major changes to it. We had a couple of security stations taken out.

Ms Carter—I guess the changes at Cowdy ward were a result of the community visitors. I suppose they would think carers were feeding into that. Maybe there needs to be a step in between so community visitors make the recommendations and then it goes to carers and consumers for their input.

Senator MOORE—Was the Cowdy ward incident this year—2005?

Ms Carter—Yes.

Senator TROETH—Where do you receive the funding for your coalition? Is it through the separate organisations?

Ms Carter—The Department of Health and Community Services, Northern Territory.

Senator TROETH—I probably know the answer to this: is the funding sufficient to maintain the scope of your work?

Ms Carter—We have not really established the scope of our work! We are running a mental health week out of it, which is great. We have employed a worker. It is not recurrent so it will finish this year. Obviously, that is not going to be sufficient.

Mrs James—The other challenge is that we all work in non-government type organisations, and Joy is a member of a board. A great deal of our time is needed to be actively involved in the coalition but that takes us away from our jobs, in which we are already pretty well stretched, too.

Senator TROETH—That is always the dilemma when you are a volunteer. What are you hearing from the people you talk to about the skill levels of GPs in the Territory in dealing with mental health issues? For instance, I was interested in your anecdote about the person not being able to get in to see the GP to get a referral for three weeks.

Mrs Green—He was a children's doctor so she had to wait for him because he was away. It is not the person she rang at the Tamarind Centre. I know that; as you say, they have rules to follow. She just said it would probably be quicker if she got a referral. Yet my feedback was—I cannot mention names—to just ring up and he will be seen. It got stopped there by someone who picked up the phone and said, 'No, you would be better with a referral.' It does come down to individuals. I know if it had been another person they would have just said, 'Right, we'll get him in tomorrow.'

Senator TROETH—We have heard that the Better Outcomes in Mental Health program, which has been aimed at skilling GPs, has been a very good initiative, but the rate of take-up by GPs apparently has been limited.

Ms Brown—To my knowledge, from some information I received the other day, I think there are three GPs in Darwin who are prepared to take on psychiatric patients. I am very fortunate in that I have my own GP and she has agreed to take me on—she does not take very many on, so she is not one of those three—but I believe there are either three or four in the Darwin area who will take on psychiatric patients. I know members who have gone to doctors and there is no time. It costs money and it takes a lot of time for doctors to consult with their patients, or the other way around, and there are so few doctors up here who will bulk-bill too. It is extremely difficult for a consumer to be able to see a good doctor who will look after their mental conditions.

Senator TROETH—And what about the number of specialists? Apart from GPs who will deal with psychiatric patients, are the other GPs prepared to refer patients on to specialists?

Ms Brown—I think some of them do, yes.

Senator TROETH—How many practising psychiatrists or psychologists would there be in Darwin?

Ms Brown—I cannot answer that, sorry.

Mrs James—We have one psychiatrist who bulk-bills. There are only one or two others who are in private practice. There are probably quite a few psychologists, but you have got to have private health cover to be able to access those people.

Ms Carter—There was a GP clinic running out of the Tamarind Centre for some time, which was very well used, I believe. That was a good service. I heard feedback through the ranks of TEAM Health that that was good.

Mrs James—We are very lucky at GROW. The one psychiatrist who actually does bulk-bill is a very great supporter of our organisation. We get quite a few referrals and we have had some pretty great results as well. It is great to have that type of support coming through. One of the things that is sometimes difficult is getting out information on what our service is about. Getting that information out to GPs can be quite a challenge in itself.

Ms Carter—I want to refer back to your question about whether the funding is sufficient for the coalition. We were not sure whether it was ongoing; we have since been informed that it is ongoing, so that is good.

Senator TROETH—Good.

Senator WEBBER—That is a quick result!

Ms Carter—Yes, from the back of the room.

CHAIR—Thank you very much for your submission and for appearing before us today. It has been very useful.

Proceedings suspended from 10.32 am to 10.49 am

AH CHEE, Ms Donna, Deputy Director, Central Australian Aboriginal Congress

BOFFA, Dr John, Public Health Medical Officer, Central Australian Aboriginal Congress

CHAIR—I welcome representatives of the Central Australian Aboriginal Congress. I would also like to thank you for coming all of this way to appear before us today. You have lodged with the committee a submission, which we have numbered 486. Are there any amendments or additions that you wish to make to that document at this stage?

Ms Ah Chee—No.

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

Ms Ah Chee—Congress is an Aboriginal community controlled comprehensive primary health care service. It is situated in Alice Springs. We employ 11.5 GPs as well as GP registrars, 15 Aboriginal health workers and 14 nurses. We provide more than 40,000 consultations each year to over 8,000 clients. Our service includes a multidisciplinary social health team made up of a psychologist, five counsellors, an Aboriginal mental health worker, three youth workers and a specialist youth counsellor. We are also currently contracted to provide health services to two remote zones in Central Australia.

The ABS estimates the Aboriginal population of Alice Springs to be just under 5,700 people. Congress provides on average more than five services a year to each of these clients. This compares with an average of around three visits a year to a GP in RRMA 6 remote centres across Australia. We have achieved very high access rates through the combination of no payment at the point of service delivery, a transport service, culture and gender specific staffing programs and buildings and also a 1800 phone line. Most importantly, congress has been able to recruit and retain a full complement of health professionals. For example, our GPs have an average length of stay of more than seven years and a median of more than four.

Congress believes that Aboriginal people need to have good access to evidence based interventions that we know will improve their mental health and wellbeing. In order to achieve this, we need to do three things. First, we need to integrate mental health services into Aboriginal community controlled primary health care services. It will require a combination of grant funding plus Medicare in different mixes to achieve this outcome. Mental health specific grant funding for Aboriginal primary mental health care needs to be given to Aboriginal community controlled health services and not only to the state and territory government community mental health services. In Alice Springs currently, community mental health gets all of the Territory's health department mental health funds for primary care for the town. In spite of the much higher prevalence of mental health illness amongst Aboriginal people, they hardly access this service. So OATSIH, which is the Office for Aboriginal and Torres Strait Islander Health, has been forced into a situation where they have to fund primary mental health services with generic primary health care funding.

In addition, community mental health has had great difficulty in recruiting and retaining the necessary skilled work force. Medicare should be opened up to include a range of mental health

professionals under two conditions. Firstly, they should be trained and accredited to deliver CBT and other evidence based interventions for recognised conditions such as depression, including suicide and other self-harming behaviours; anxiety states; and psychotic illness. Secondly, they should be prepared to bulk-bill their clients in order to ensure that there is no financial barrier to access and that we do not exacerbate the two-tiered mental health system where you access better services, especially for psychiatry and psychology, if you can afford to pay. Many effective interventions can be more cost-effectively delivered by non-psychiatrists if access to Medicare is allowed. In addition, the extreme difficulty in recruiting and retaining psychiatrists in remote areas means that it is unacceptable to have them as the only Medicare funded mental health professionals. Although it could be argued that GPs can deliver these interventions and are much more cost effective, in our experience the GPs that are working at congress in remote Aboriginal health are far too busy to allocate the necessary time, even if they are adequately trained.

Secondly, we need to ensure that mental health professionals are trained to deliver evidence based care such as CBT for depression and anxiety, and family interventions for psychotic illnesses. This will require a system of accreditation which could then be linked to access to Medicare. If Medicare rebates were only accessible for mental health professionals who deliver treatments that are known to work, this would provide a powerful financial incentive to both reorient existing mental health services and ensure access to effective therapies.

Funding also needs to be made available to ensure that the current work force can be upskilled in these therapies. For example, congress are currently contracting Flinders University to come to Alice Springs and run their one-week intensive course in CBT for four of our existing mental health professionals. This cost will be absorbed from our core grant, and there will be a need for ongoing professional development in this area, which is also unfunded.

Lastly, the recruitment and retention of trained staff in remote areas is a major problem. Congress has addressed this issue by providing an interesting and challenging work environment, effective support as part of a multidisciplinary team and adequate levels of remuneration and working conditions. These three factors need to be applied more broadly. However, the maldistribution of the psychiatry work force needs to be further discussed. This requires geographic regulation of provider numbers, with work done in areas of need being used to give preferential access to sought-after city locations. In addition, there should be bonded places in psychiatry training, and GPs who have worked in areas of need should be given preferential access to psychiatry training. If Medicare is opened up to other mental health professionals then the granting of access to Medicare can also be regulated so that there is not a relative oversupply of mental health professionals in Sydney and Melbourne.

Senator HUMPHRIES—Thank you very much for those recommendations. They are quite useful in putting together a report. I want to touch on the question of funding for your organisation. You say that under the Commonwealth-state health agreements there is some expectation that funds that have been allocated to the state or territory government will pass down to organisations like your own. But you say that this has not happened to any significant extent in the Northern Territory. How much funding do you receive from the Commonwealth via the Northern Territory, and what would you like to see happen in future?

Ms Ah Chee—A majority of our funding is for our social and emotional wellbeing branch. Overall, we are predominantly funded by the Commonwealth. But our social and emotional wellbeing branch, which is where we employ our psychologist, five counsellors and an Aboriginal mental health worker, receives funding that eventuated as a result of the *Bringing them home* report. So that is Commonwealth funded as well. Sorry—the mental health worker is funded by the Department of Health and Community Services. So it is one position.

Senator MOORE—The Northern Territory department.

Ms Ah Chee—Yes.

Dr Boffa—So, in terms of the Commonwealth-state mental health funding, it is one position at congress. Out of a total budget of about \$8 million, it is one position. We see none of the mental health specific money that goes to the Commonwealth-state mental health agreements. The only money we are getting is direct funding from OATSIH, which is primary health care money; it is not mental health specific money. We do not see the mental health specific money. If we did not use OATSIH money to fund mental health professionals, Aboriginal people would not be accessing mental health care. They do not use the state mental health system, the community health system. They use the hospital, obviously. But in terms of primary mental health care we do not see that money.

The specific example we had in the submission was the national youth suicide prevention funding, which came with specific requirements in the contract on state and territory governments to look at outsourcing that funding to primary health care services such as ours. We were in the midst of a youth suicide crisis in 1995-96 and 1996-97 in the Alice, so we went to the Commonwealth specifically looking for money. They said, 'We've given all the money to the Territory. But there is this clause in the contract that says they should give it to you. Go and talk to them.' They did not give it to us.

Senator HUMPHRIES—Are they allocating it to other non-government organisations or are they simply not putting it down to the NGOs?

Dr Boffa—In Aboriginal health they are not. In non-Aboriginal health there is—

Ms Ah Chee—Community mental health centres.

Dr Boffa—the Mental Health Association. The only non-government organisation that exists is the Mental Health Association, and I understand that they might have a few positions. But Aboriginal people are not accessing that service either. They might have started to outsource some positions to that organisation, but we are not very familiar with what that organisation does.

Ms Ah Chee—And there is the point that we have made about access. Based on our patient data and the ABS data, we have very good access rates. Just about every Aboriginal person who lives in Alice Springs comes to congress. So in terms of providing a holistic service—and one of the questions earlier was about collaboration and care planning around the client having different practitioners involved—from our experience of providing service to Aboriginal people we think

that our model, a social health team based within a comprehensive primary health care service, is the best way to go.

Senator HUMPHRIES—We will ask the department about this when we see them this afternoon. You talk about the stigma that Aboriginal communities often exercise towards people that they call mad. Do you think that the stigma of the mentally ill is worse in Aboriginal communities? What can we do to reduce that stigma in Aboriginal communities specifically?

Ms Ah Chee—I do not know that there is necessarily the stigma so much now. There is an element of that, but, given the work that we have been doing out of our social health team in getting access to people who are suffering from mental illness or even our youth, in terms of our youth outreach team, one of the key messages that we have got from our team on the ground is that it does need to be a service that is not easily identified. So that is an important consideration that we need to be conscious of when patients are accessing our service.

Dr Boffa—I do not think it is worse. For instance, congress did a report years ago called *All that rama rama mob*.

Senator HUMPHRIES—What was that, sorry?

Ms Ah Chee—‘Rama rama’. It is an Aboriginal word.

Dr Boffa—There is a word in each language. The Warrumungu mob call it ‘warrunga’, which loosely translated means ‘mad’. ‘Rama rama’ is the word in the Centre. There are words in every language. There have always been people who are known to be very different, and Aboriginal people have accepted them for a long time very well. I do not think there is any greater stigma. I think there is an acceptance. Probably, if anything, I have tended to see more of an acceptance of these people than I have seen in mainstream culture. But then, when it comes to the problem of someone with severe mental illness, psychotic illness, without support services, that absolutely stretches a family’s ability to cope much more when people are living in poverty and do not have the sorts of support services that you would otherwise expect. In that sense, nothing to do with Aboriginality leads to the stress; the stresses are created because of lack of services.

Senator MOORE—There are so many questions, but I am going to concentrate on two. One is: have you seen the Northern Territory government submission?

Ms Ah Chee—No.

Dr Boffa—No, we have not.

Senator MOORE—The issue that they talk about with their suicide prevention process—because that was the issue that Gary pointed out and that is highlighted in your submission—is that they are putting more money into the Life Promotion Program. How does that work alongside the need that you have identified? Is there any particular issue such that there is just not an effective relationship between the NT government and your organisation?

Ms Ah Chee—I think that there is an effective relationship between congress and AMSANT, as our representative NT body, and the NT health department generally, overall. But I guess there

is a difference of opinion about where Life Promotion resources are best utilised. We would still argue that that money should be based within a social health team within a primary health care service, so that people are able to access the evidence based interventions that work. Do you want to add anything to that, John?

Dr Boffa—The key issue is that, if the resources are going to be used for service delivery, they should be within a primary health care service. If they are going to be used for coordination and advocacy—if that is the role—they can sit within the state government. But they have tried to play a centralised service delivery role from Alice Springs for the whole of Central Australia, and that just does not work.

There has been a lot of work done now collaboratively to look at strategic planning and what they can do. They are operating in an environment where there is a lack of services, so of course they try and play a service delivery role. But for a centralised resource like that it is difficult. I think that if they were going to play a community development role then they should again be in an Aboriginal organisation, not in the state system. They need to be working under Aboriginal direction to be effective. They have been trying to play a community development role, a service delivery role, a coordination role—and it is a smaller resource within a big problem.

That is only one small part of what we are focusing on. That was quite a few years ago, and it was in an era when those sorts of resources tended to come to the Territory government and you would end up with one or two positions in Alice Springs, Tennant Creek, Katherine, Darwin or Nhulunbuy. That was the model for everything—whether it was cervical screening, STI treatment or mental health, you would end up with two workers in each of the regional centres who were somehow supposed to deliver services to Aboriginal people in the regions. It does not work. We are now in the era of the Primary Health Care Access Program, which is putting comprehensive primary health care services in every zone to the tune of \$2,000 per person. So we are in an era where we can now meaningfully talk about integrating mental health into primary health care, because the primary health care resources have started to flow but the mental health resources are still sitting off to the side. They are not being integrated. There has been no movement. They are siloed. We have psychiatrists coming down to our service. We have a relationship at an operation level with the Territory health department but the problem—

Ms Ah Chee—It is the policy. There is a Northern Territory Aboriginal Social and Emotional Wellbeing Strategic Plan which we submitted as an attachment. That has been signed off at the Northern Territory Aboriginal health forum. That plan highlights the actual model. Now what we need is some commitment to the implementation of that model, which is really about a redistribution. It may not necessarily mean additional resources. All it could mean, to some extent, is a redistribution of the existing resources.

Senator MOORE—So there is actually some agreement to a changed model?

Ms Ah Chee—The department has signed off on the plan.

Senator MOORE—That did not come out in the submission.

Ms Ah Chee—Sorry. It has been signed off. The issue now is its implementation.

Senator MOORE—Does that mean there is a meaningful dialogue still happening?

Ms Ah Chee—Yes, there is.

Senator MOORE—Good. I have one more question that is a core one. One of the amazing things we keep hearing about is the lack of professionals and the lack of ability to attract professionals into areas. We have examples from all over the country of where people cannot get doctors let alone professionals. The story that you are telling from the congress is extraordinary in terms of the way you are able to attract people to work there. You made some suggestions in your comments, but what has to change so that that can be expanded so that people will feel that they can come and work in the areas and value that work—and you talked about bonded places, but it must be more than that?

Ms Ah Chee—I think there are three things which we have previously raised. It is interesting work. It is not just straight sick care for our GPs; they are involved in our community health programs. There are wide and varied components to their work. The remuneration was very important in terms of our ability to provide fringe benefits.

Senator MOORE—Do you pay better?

Ms Ah Chee—In terms of GP salaries we were competitive up until recently. Is that right?

Dr Boffa—Yes, we were. When Access Economics did the report in 2003, the average income of a male GP in Sydney, after all expenses, was \$130,000 a year. That was what they were earning before the insurance issue. We were matching that, but since the Medicare changes the average income of GPs in Sydney has gone up probably by \$30,000 and we are still paying \$130,000. So 50 per cent of our work force is overseas trained and 50 per cent is Australian trained. In recent years all of the recruits have been overseas trained except for the doctors we have got through the registrar training program which we run. Across the board, one of the key support issues that is not recognised is the multidisciplinary team. That is what we have.

In terms of bottom-up support factors—and we talk about how there needs to be top-down factors like bonded scholarships and geographic provider numbers—the bottom-up things are remuneration, a varying work environment and an autonomous work environment which you have to allow for. But then there is the support base of the multidisciplinary team, because it is not just GPs. We have had a psychologist for about eight years and social workers for over five years—

Ms Ah Chee—And a whole bunch of health workers.

Dr Boffa—So we have retained psychologists, social workers and counsellors as well and, in a multidisciplinary team environment, you start to feel like you are making a difference, it is all worth while and so people are more likely to stay.

Senator MOORE—Thank you. I think I will follow that up in another forum, because it goes across so many things.

CHAIR—Just to be clear on this model: it is not a fee-for-service model?

Ms Ah Chee—No.

CHAIR—All of your health workers are salaried, is that correct?

Ms Ah Chee—All our staff are salaried except, of course, the visiting psychiatrist, who is the department's employee. We have other visiting specialists who come as well.

Dr Boffa—We are grant plus fee for service, with GPs, which is the model we think should be extended. Aboriginal health is now a combination of grant plus fee for service for GPs. It is mixed-mode funding.

Ms Ah Chee—We bulk bill and we get grant money.

CHAIR—There is still no fee to the patient?

Ms Ah Chee—No.

Dr Boffa—That is right.

CHAIR—Medicare funding still flows for your GPs?

Ms Ah Chee—Yes, plus a grant.

Senator TROETH—You have mentioned in your submission that there is political pressure to criminalise and imprison those predominantly young males who have inhalant and drug induced psychosis. Where is that pressure coming from?

Dr Boffa—This is information that was fed to us by our counsellors and social and emotional wellbeing staff, who felt that there is a view that, in the absence of services, these people have to be put somewhere—and the jails end up being a place of last resort. There is a community expectation that people who are at the severe end of the spectrum, who may be considered to be dangerous to society—although that is often overrated, but there are people in that category—are going to be cared for by the state. In the absence of proper facilities, jail tends to be the place where they end up. I think the political pressure that is being talked about is partly that there is a community concern about this, and so—

Senator TROETH—It is community pressure more than political pressure?

Dr Boffa—Any government of the day is going to be looking to deal with this issue by getting these people out of the community, and when there are not appropriate services they end up in the jails.

Senator TROETH—I take it that that is not a policy that is adopted by the congress, given that you would have sufficient treatment options to look at that?

Dr Boffa—As we say in the submission, these people who need residential treatment, residential care and support accommodation are lacking that. We are reasonably resourced for outpatient care, individual patient care and group work, and we are heading down the path of

evidence based therapies and all that, but when it comes to people at the severe end of the spectrum, who need supported accommodation—particularly supported accommodation to avoid getting into situations where they are going to end up incarcerated—that is not something the congress does.

Senator TROETH—What would you do with a patient who presented and needed that sort of care?

Dr Boffa—We would refer them to the psychiatric care at the hospital, in the first instance, to be assessed. Then it would be determined from there. People in that situation can end up in jail, even after that referral is made, simply because the options for placement are not there for some of these people. They end up back at home and they end up reoffending. Then, before very long, jail becomes the option of last resort.

Senator TROETH—I wonder if you could comment on the training of Aboriginal mental health workers at the Batchelor institute and whether you consider that training to be successful.

Ms Ah Chee—We have not received that training. We really think that, in terms of mental health training, a prerequisite should be the Aboriginal health worker stream of training, and then, if you want to specialise in mental health, you can branch off into doing mental health, rather than having all these separate paraprofessional categories for Aboriginal people: Aboriginal health worker, Aboriginal mental health worker. We are really trying to bring it in and have the Aboriginal health workers, in terms of clinical skills, and then have them branch off into specialty areas like mental health. That is our position on Aboriginal mental health workers.

Senator TROETH—Of the Aboriginal mental health workers who are working in the field around Alice Springs, do you consider that they are sufficiently integrated with the other professional services that are available?

Ms Ah Chee—I can only comment on congress. That is where we do have an Aboriginal mental health worker, part of the social health team. But I am not familiar with what is happening elsewhere in terms of those positions, other than what is happening up here in the Top End.

Dr Boffa—There were only three. There is one at congress, one at Yuendumu, and one at Santa Teresa. The one at Yuendumu is not there anymore. I am not sure whether the person at Santa Teresa is still there. So there were never a lot. Our person works as part of the social health team. We call them an Aboriginal mental health worker, but they are not a registered health worker. They have had some training. You could call them a counsellor. Why create this category? The Aboriginal health worker profession itself is struggling to be viable. There is a registration process for that, but it is absolutely struggling to maintain its viability. To create another paraprofessional group, when we have just had to develop a career path for registered health workers—there are not enough Aboriginal mental health workers to create a new career path or a new profession. It was always going to be a dead-end street, which is our concern when the program got funded—where was it going to end up? Where are these people going to end up once they had a couple of years funding? With some training, who was going to employ them?

If we are talking about evidence based therapies, which Aboriginal people have a right to access, we need people who can do CBT, who know about interpersonal therapy, bibliotherapy. The treatments that work, work for Aboriginal people too. Too often you end up with untrained or certificate III level people, if you are lucky, out there as the only mental health professionals who have no idea about these sorts of evidence based therapies. Then someone says they have a service. That is the danger. That is what is happening. In a lot of remote communities you have someone called an Aboriginal mental health worker and every psychotic person, every patient who has complex, chronic diseases and complex mental health issues ends up being seen by someone who is maybe certificate III level. It is just wrong.

Ms Ah Chee—The national competency standards for Aboriginal health workers are currently being reviewed and they are considering where you can have mental health as a specialty, so I guess there is some progress towards not having a broad range of paraprofessionals but trying to bring it back in and branching out.

Dr Boffa—We have said there is a need for what we call community health workers. There is a need to have local people at a certificate II level who speak the language, who are from the community, and who provide a range of services. This is similar in many ways to what these Aboriginal mental health workers are—they are like the original Aboriginal mental health workers. The original Aboriginal mental health workers, before they required certificate III training, were local people who spoke the language. They did a basic skills on-the-job course and they were very useful as cultural brokers, as people of first contact. They knew the community. That is what these mental health workers are, but they are now called mental health workers, because that is what the funding was called. It is recreating the old. So we are calling them community health workers. In this path that Donna was just talking about you will have certificated II, III and IV. Registration will be certificate III level, but you will have certificate II level, which is below registration, where you will be able to get back to employing the local people from the community who speak the language who have not yet got the literacy level to get certificate III.

Ms Ah Chee—And may never get the literacy skills that are required to go on to certificate III and then be registered. So it is recognising the important contribution that they can make in their local community that assists with multidisciplinary care and being that conduit with health professionals.

Dr Boffa—And brokering access, but you have to have the other health professionals there.

Senator TROETH—Absolutely.

Dr Boffa—The trouble with calling them Aboriginal mental health workers is that people quickly fall into the trap of thinking they are it. That is not how it should be.

Senator TROETH—You mentioned you are getting some funding from the Bringing Them Home money. How long will that last? Is it ongoing?

Ms Ah Chee—It has just been refunded another four years, and that is the cycle.

Dr Boffa—That is pretty recurrent. Four years is what we call recurrent these days.

Senator WEBBER—I firstly wanted to return to your comments about opening up access to Medicare. You have come up with some innovative conditions on which we should place that. What health professionals would you open that up to? We have had lots of evidence that it should be psychologists. Would you take it further than that?

Ms Ah Chee—Social workers.

Dr Boffa—And even counsellors, if there is an accreditation process. For someone who calls themselves a counsellor at the moment, the registration process for counsellors is fairly loose. But if they had done accredited training and could demonstrate competencies for particular evidence based therapies, such as CBT, I would open up it to them too. You can have people other than psychologists and social workers. We have people who are employed as counsellors who have done certificate IV level or diploma courses. You can have people who have done different forms training who then go on and do further accredited training to be able to then say they can deliver CBT or they do know what family interventions are for psychotic patients and they know how to do that well. We would not limit it. It depends. There would have to be some thinking on it. Certainly there would be psychologists and social workers, but there would be others who could be included.

Senator WEBBER—As long as they met those other preconditions you were talking about?

Dr Boffa—Yes. It would be similar to the vocational registration system that is set up for GPs. For GPs there is a Medicare incentive to be vocationally registered. To maintain yourself on the register you have got to continually professionally develop. If you do not do that, you get less Medicare money. So there is a financial incentive to maintain your skills and to keep training, which there needs to be in this situation as well.

Senator WEBBER—You were discussing earlier, I think with Senator Troeth, inhalant induced psychosis and you were talking about starting to work towards some evidence based therapies. Can you expand on that? You may need to take this on notice and talk to your colleagues about what direction that is taking you in.

Dr Boffa—You mean inhaled solvent induced psychosis and evidence based therapies?

Senator WEBBER—Yes.

Dr Boffa—Do we talk about that in the submission?

Ms Ah Chee—No, I do not think we do—not for solvent inhalants. But we do talk specifically about CBT and other therapeutic modalities.

Dr Boffa—It is now clear from recent evidence that Menzies has published that, contrary to what people thought 10 years ago, brain-damaged petrol sniffers absolutely recover over time and they recover long term over time and they keep improving. People I was seeing 10 years ago who were wheelchair bound and in nursing homes are no longer wheelchair bound and no longer in nursing homes, even though everyone thought at the time they would never actually get over that. There is a need for slow stream rehabilitation of brain-damaged petrol sniffers. That does not exist, because people thought it would not work. Now it is clear it does work it is really

important to have that. But that is expensive. We would rather prevent it—Opal unleaded and all the other things we could talk about. Basically you get them off petrol within a few days. Alcohol induced psychosis is much more common. Petrol sniffers do not tend to get hallucinosis and psychosis in anything like the same levels. If they do, it is the same treatment.

Again, a service like ours is able to do all of that because we have the combination of general practitioners, counsellors and other people who can treat people in that situation—if they can be treated at home. But, of course, a lot of them need to be in either a hospital or supported accommodation for the initial part of the treatment. There is no residential treatment option at the moment for the petrol sniffers beyond the sobering-up shelters taking them for a few days. The alcohol rehabilitation organisation took one a couple of weeks ago, but you try to find a place for people like that who need residential treatment and is not there.

Senator WEBBER—Thank you; that is very useful. Finally, one of the other submissions recommends that, probably federally, a tri-border funding model be looked at, because Indigenous people in particular do not respect borders. I am from Western Australia and I know there is a lot of crossover between the two states. We need some tri-border funding so we look at treating Indigenous groups—mobs—rather than saying, ‘You live in Alice Springs at the moment so that is the only place you can get treatment.’ Does your organisation have much contact, say, with the mobs that are desert communities in Western Australia?

Ms Ah Chee—Yes, there is that tri-state movement between Western Australia, South Australia and the Northern Territory, and there would have to be some pretty good collaborative discussion happening between the states. We would certainly be supporting Alice Springs being seen as a regional centre—that some Aboriginal residents of Western Australian and the top of South Australia would come to Alice as a regional centre.

Senator WEBBER—Alice is closer for a lot of Indigenous communities in Australia than, say, Kalgoorlie is.

Dr Boffa—Yes. We see 2,000 visitors a year out of the over 8,000 that come. A significant number of them are from the AP lands. We see people from the Ngaanyatjarra communities in Alice as well. So there is a lot of movement to and fro. There need to be services, but we have been advocating that there need to be core primary health care services in every health zone. The Northern Territory is separated into 22 health zones. Every zone needs to have access to a core range of comprehensive primary health care services, then you can talk about visiting support services. In the mental health area we need to be clear about what is required on the ground and what can then be supported through visiting special services. That needs to be the mix that we get going.

Senator WEBBER—That is true.

Senator SCULLION—I have a slight advantage in that I have a fair knowledge of your organisation. It is second to none in its success in delivering primary health care. I think the principal reason for that, without a doubt, is the confidence with which Aboriginal people can access your service—it is like going and getting a bottle of milk; it is not a major traumatic language or cultural barrier at the front desk—and certainly because of the corporate success as well of passing on those responsibilities. I just want to clarify that you would prefer that we

would directly fund Central Australian Aboriginal Congress, perhaps indexed against your catchment—whatever zone in terms of population—and directly fund that potentially out of the Northern Territory's money that they give them directly.

Because you see so many people, obviously this is a great opportunity for an ongoing triage. There are 8,000 people you can actually try to identify in that triage process. You have indicated in your submission that you think you are quite successful at the secondary processes in terms of the presentation, but you think the primary issues with mental health are still that we need a lot more funding and that sort of stuff in there. How do you think you can use the opportunity of seeing so many people to increase the capacity to identify the early onset of those sorts of symptoms? I understand the comorbidity issue of how you differentiate some of those things. How do you think we could use that opportunity? You have thought about more funding. Can you tell me about some ideas you might have about how you would implement them?

Ms Ah Chee—It is not so much more funding but rather a redistribution of the existing mental health funding that comes from the Commonwealth to the state then, in the context of the Northern Territory, being given to an Aboriginal community controlled health organisation. In terms of our main clinic, it provides an opportunity for adult health checks, so we can do some preventive work in that context. Once an assessment is done by our GP, we then implement a care plan if we need to. That is where we get a multidisciplinary approach to the care of that person. I do not know if you want to add to that, John.

Dr Boffa—I do not know if you can see my computer screen—can you see that?

Senator SCULLION—Yes, I can.

Dr Boffa—On my screen are the screening rates for the last year at Central Australian Aboriginal Congress in the main clinic. What it shows is that 9.7 per cent of people had a full health check. A full health check includes the question about mental health. There is a question in that where you are asking people and trying to detect early whether they have anxiety problems, depression and so on. Sixty-one per cent of everyone over the age of 15 were screened for one or more chronic diseases, and sometimes that includes mental health. So we have got systems whereby all the health professionals who work in the clinic get fed back their screening rates. They get told for every person they saw over the age of 15 what percentage of those people they fully screened and what percentage they partly screened, and they compare themselves to the averages and medians of all the other health professionals in the organisation. We are trying to get that screening rate. Primary prevention will never happen with mental health specific money. It is going to happen through the general practice side of the mainstream—in our case, through our general clinic. That is where we have to make the most of the opportunity.

The challenge for us in this instance is not necessarily more funding, because this is well funded now through Medicare. The challenge is to reorientate and re-educate staff away from seeing a sick care opportunity towards making sure they see the preventive health care opportunity. That is an internal quality assurance system which is fed back to staff. Since we computerised the checklist, the doctors have gone from 10 per cent to 35 per cent screening rates. We are getting it up all the time. It is more a management and internal quality assurance issue than a funding issue for us. We are set up, because our GPs tend to see about six patients a session. Compare that to general practice where they are seeing four patients an hour; there are

no opportunities for a full health check in that. Because we have a grant plus Medicare, we are not driven by Medicare; we are buffered with the grant. People can go slower, and they have the time—

Ms Ah Chee—To provide the quality care.

Dr Boffa—and the space to do that preventive health care.

Senator SCULLION—I am not sure how many of your GPs have had access to programs for delivering better health outcomes, but with regard to upskilling, if we gave the money directly to you—which you currently do not have access to irrespective of the contractual arrangement; that is just not there; that is just not coming—would your tendency be to continue your program? Most of your GPs and health workers are not single skilled, they are not monospecific. They have quite a wide range. It seems to be a philosophy in your organisation to have a wide range of skills rather than focusing on one. Would you develop a mental health area as an embargoed area of your delivery, or would you maintain your program of simply upskilling everybody in the mental health area? What direction do you think you would take in a structural sense?

Ms Ah Chee—We have our social and emotional wellbeing branch which is focusing on mental health issues, but obviously in collaboration with our main clinic and our other allied health professionals. But there is a need to continually upskill our own staff. More recently, as we said, we have had Flinders University coming in and delivering a one-week course in CBT. There is a continual effort that needs to be made for ongoing in-service training, not just for a particular area of our organisation but more broadly.

Senator SCULLION—In view of the across-the-board lack of infrastructure for people to have somewhere specific to go, whether they are just post discharge or whatever it is, do you think there is the capacity to do something within your catchment to deal with that? Maybe a 10-bed respite centre that is fairly intense, rather than what is in the hospital at the moment—something that is not anywhere else.

Dr Boffa—Before I answer that one, I will comment on your other question. In the model we are pursuing, some of our GPs have been trained in CBT and know how to deliver it, but they do not have the time. A third of our patients wait more than an hour, and now cabinet has said that no-one is to wait more than an hour. The imperative on our clinical staff is to try and do a lot of other work to identify patients with mental health disorders early and then refer them to our social and emotional wellbeing centre. That is the model we want to pursue. We do not want to use GPs to do CBTs—a 10-week program an hour at a time. They do not have the time at the moment. Maybe in 20 years time, if the chronic disease reduces—

Senator SCULLION—So when that funding came across it went to fund that capacity within your emotional wellbeing centre so that everybody could come in and you could refer them.

Dr Boffa—Our social and emotional wellbeing centre, if you like, is the mirror image of community mental health. It is just not funded by the state. It is a duplicate of it, because Aboriginal people do not access community mental health and we have had to fund it out of core primary health care money, which is not the way it should be. The model we are trying to pursue is to refer patients—have them all coming through the clinic, screen everybody, pick up people

with mental health issues early and refer them. Then we know that they are getting evidence based treatment for the right problem. We need quality assurance systems that make sure that whole loop is working. That would work.

But in answer to your second question: there is an absolute need for supported accommodation for people who do not need to be in ward 1—who should not be in ward 1—but equally cannot be at home, and for people who need a period where in a supported accommodation house—

Senator SCULLION—Do you think congress could have a role in that?

Dr Boffa—Maybe not in running the service, but in providing visiting health professionals to people. We do not run supported accommodation services; that is not our core business.

Ms Ah Chee—But if it were to be predominantly for Aboriginal people then there would be an expectation that it was run by an Aboriginal community controlled organisation. Like John has said, we could collaborate in that instance and provide the health professionals that would be required to do the treatment in the residential areas.

Dr Boffa—We service the nursing homes.

Senator SCULLION—Part of the reason for my question was that I was thinking that if we were to say, ‘We would like to embargo some of this money—we’re not giving it to you; we’re going to give it directly to congress,’ the expectation would be that there will be a percentage of those people you are referring to who would have some specific requirement that is beyond the current role of congress. As you say, it is somewhere between the hospital and outside. It may be something you need to think about, anyway.

Dr Boffa—Just to be clear, we are not really talking about support and accommodation money; we are only talking about the community mental health funding, which funds psychologists, social workers, counsellors—exactly the people that we are employing in our social and emotional wellbeing centre. But we have had to fight to get money from the Commonwealth, which is money that could well be used for other aspects of primary health care service delivery, in lieu of not being able to access the mental health resources that are meant to provide mental health care for everybody.

Ms Ah Chee—The residential program is separate from the need for us to be accessing the Commonwealth-state money for the delivery of mental health services.

CHAIR—Dr Boffa, I wonder whether it is possible for you to either email or send us a print of the screen you have just shown the committee.

Dr Boffa—Yes, that is fine; not a problem.

CHAIR—The screening is presumably this project 710.

Dr Boffa—Yes, 710. We have been annual health checks since 1994.

CHAIR—Why is called 710?

Dr Boffa—That is the Medicare item number. Basically, that has helped to fund something that we have been doing for over 10 years. From the point of view of doing annual health checks, the system I have talked about has been in place for years but we have been trying to get the numbers focused on preventive health opportunities in the community. But 710 has been a welcome additional resource, which in many ways brings in more funding to put on more staff to make it even more possible.

CHAIR—Thank you very much for your presentation and your submission.

[11.39 am]

McCONACHY, Ms Sandy, Mental Health Program Manager, Top End Division of General Practice

SAMBONO, Mr Henry, Senior Adviser to Aboriginal Mental Health Program, Top End Division of General Practice

CHAIR—Good morning and thank you for coming. Could I ask you to make a brief opening statement and after that we will go to questions.

Ms McConachy—First of all, I would like to apologise for the program coordinator, Donna Mulholland, who could not be here today. The Top End division supports GPs, including the primary health care teams across the Top End. The division currently has about 160 GPs registered within its region.

Today I would like to speak on our Aboriginal mental health worker program. During the year 2000, all GPs within the Top End division were surveyed in relation to areas most in need of support. At the top of this list were issues relating to remote mental health. There were a number of other issues, of course, but mental health was certainly at the top of the list. It was identified as such because of the critical lack of allied health professionals available to support GPs and the primary health care team in remote communities in this work.

At best, the remote primary health care teams were struggling to address mental health issues; at worst, mental health issues were being ignored. The primary health teams struggled to understand whether individual behaviour was indeed mental illness or culturally related. Mental illness service delivery was often crisis driven and most generally treated by an air evacuation to Darwin. Air evacuations, at an average of between \$3,000 and \$4,000, are a huge cost to the community and have an equally high personal and social cost to the individual and their family.

The program managed by the Top End division aims to improve the overall health care of remote communities by providing that vital cultural and knowledge link between the primary health care team and the community, and also has the intention of improving service delivery for the individual and their family. This program is also obviously about improving satisfaction levels for GPs and the primary health care team, especially nurses, as this assists in the overall retention rates for GPs and nurses.

By 2002, the program was on the ground, and 11 individual Aboriginal mental health workers are today embedded in six remote communities. This program is unique in Australia in the fact that it is local Indigenous people providing local solutions to local problems. Apart from one individual in our program, Aboriginal mental health workers are chosen by their communities, employed by their communities and live in and are part of their communities. The primary health care teams within these communities have experienced significant drops in mental health issues, especially air evacuations. For example, in one location during 2003-04, five patients required air evacuation. In 2004-05, no air evacuations for mental health issues were required.

In 2003, the program was recognised for excellence by the MHS Conference as a finalist in the category for service partnerships and also as winner of the Australian divisions of general practice forum in the category of collaboration and integration. This program sits alongside the Territory government mental health program within the Top End with a joint vision to work ever closer over time. This is evidenced by the recent commitment by the Territory government to cover some of the loss of funding which will befall the program at the end of 2005.

The Top End division provides vital ongoing support role in the form of the program coordinator, Donna, who could not be here today, and obviously Henry as our senior cultural adviser. Support is provided by both Donna and Henry to the entire primary health care team, to the community councils and to the Aboriginal mental health workers who live within these communities. They provide ongoing support through phone and remote visits; they act as brokers on issues of dispute between various groups; they act as coordinators in areas such as education, prevention, promotion and early intervention events; and they also provide ongoing peer support.

Despite an ever-decreasing number of GPs in remote locations, many of the original mental health workers remain employed under this program, despite the enormous workload, providing a high level of stability for their communities and being invaluable role models to young people within their communities as well. Thank you.

CHAIR—Mr Sambono, did you wish to add anything?

Mr Sambono—I am not only a senior adviser but a senior man within my own people, which is the Djingili tribe, which sits near Newcastle Waters. My skin name is Djangala. My name is Balugarri. One of my main roles as the senior adviser was to go into communities. It was not only communities in the mid central area; it was also communities within Arnhem Land, Tiwi communities and communities in the Port Keats area. I went into the communities to make sure that the money that was coming from the Top End division was controlled by the community. That is the most important thing: that the community takes control of the program. We targeted places like the community council and any other Indigenous organisation that could take it on. We left the control to them and left them to look for an Indigenous person to employ. That was on the basis that they went to the Batchelor institute to do their training once they were employed. We focused on the relationship between the GP and the mental health worker, but there were communities that were also coming up with registered nurses and no GP—they just had a visiting GP. So we also had to look at that.

My main role was to make sure that there was a pure understanding that there was cultural intervention and acknowledgment within the mainstream treatment area. Things like traditional healers had to be acknowledged within the workplace and GPs and nurses had to acknowledge the need for cultural intervention. It was the main focus for me in going out there. So people were employed. Sometimes we only had funds to employ one person because that is all the funding that was given within those areas. Consequently gender differences sometimes had to be ignored. Within one community we had males and within another community we had females, and when it became an issue that there had to be both genders we had to split the position between the communities.

The Top End division program focuses on strong support. We go out there and make sure that there are visits made every couple of months. The program also focuses on training. If there were any issue of someone lacking expertise within the area of illnesses—they did not understand the signs and symptoms—certainly we would take that on and run a workshop on it. We would also make sure that there were meetings with the three areas that we signed a memorandum of understanding with—Batchelor, the Top End division and the Top End Mental Health Services—and I think that there was a fourth one, the Charles Darwin University. With that agreement there was access for the mental health workers to go into the clinical setting, record the issues that were coming up and work with the doctors and with the nurses. And now we have got allied professionals going out and making first port of calls to the mental health workers out in community.

The positions in the communities mean that there is very strong stability within the workplace. We now have workers there that have been there from the start of the program. It has always been that the council has first say. They are the ones that we go to. They are the ones that we talk to and we go with them on issues that do come up. We also go to the clinic and make sure that, if there is anything there that is an issue, we address it as adviser and supporter.

Top End division holds a GP forum to bring up with any GP or nurse any concerns that they want to discuss. I also hold workshops on cultural interventions and how you use mental health workers in the community, how you make sure that there is communication and no breakdown or barrier between Indigenous people and non-Indigenous people, and how to acknowledge mainstream intervention and treatment. Those are the sorts of things we address within the program.

Out of the whole area that we have targeted I think that only two communities have dropped out, because there were no GPs. Other than that we now have a strong, stable team of mental health workers out there. So the focus was to make sure that it was community based, community controlled, and the internal organisations within the community were the ones that had the say, and the position had to go by that. Thank you.

CHAIR—It sounds like a very effective and interesting model, but the funding runs out for it in December?

Ms McConachy—That is primarily the beyondblue component of it.

CHAIR—The Commonwealth funding component of it?

Ms McConachy—That is through the MAHS program, and that continues. We have got another three years of it, I think. That has continued and we are hoping that it will continue—at least that component of it. As I stated before, we are having some current talks with the Northern Territory government Mental health services and the Department of Health and Community Services, and they will be helping with some of that funding shortfall.

CHAIR—What sort of order of funding are we talking about? How much do you receive from beyondblue?

Ms McConachy—From beyondblue, to fund two communities for a two-year period, we received just on \$300,000. The Territory government is now going to provide \$188,000 to assist us to continue with the program.

CHAIR—Six remote communities is obviously only a small number in the Northern Territory. Why those six? Did they opt in? If so, how? What is happening to all the other remote communities? Is this to some extent a pilot program that will be rolled out everywhere if it is deemed successful? Where does it fit in the whole scheme of remote mental health services?

Ms McConachy—Primarily the MAHS funding comes through the divisions. As I stated before, we look to providing some form of allied health service support to GPs. The initial needs study was put out to all remote communities in the Top End. We had 15 responses from remote communities requesting that they have a mental health worker position placed in their community. Obviously there was only a small amount of funding so we had to choose by a number of factors, such as whether or not the remote community had a current GP, what sort of support would be available to the Aboriginal mental health worker if they were to be placed there—

CHAIR—So you could not do this without a GP being in that community. Is that what you are saying?

Ms McConachy—Initially that was where the program was. At that stage the division was very focused on GPs. In the last two or three years, divisions have moved outside of the focus of the GP and have looked at a primary health care team. So the remote nurses and anybody else within that clinic infrastructure are supported by the division. We support remote nurses, practice managers—anybody who is within that clinic team. In remote areas it is usually made up of a GP and/or the nursing staff—Aboriginal health workers.

At the beginning of the program we had resident GPs in each of those communities. Now we have one resident GP left in one of those initial six communities, primarily because the GPs have got to the stage of retirement and we have not been able to have anybody else move into that community. At the moment GPs will come in on a fly in, fly out basis and stay for certain amounts of time. Each of the communities is still serviced by the visiting mental health services, so psych nurses will come in on a regular basis. That provides the ongoing connection between our mental health workers and psych services to ensure that the people that psych services need to see are going to be at the clinic that day. It continues the connection between those two services.

CHAIR—And what happens to all the other remote communities?

Ms McConachy—We only have so much funding, so anybody else who needed an Aboriginal mental health worker would have to look to other sources of funding to see whether or not they could have somebody on the ground. They would possibly utilise the CDEP. There may be an opportunity to do some training through Batchelor.

CHAIR—I am trying to establish what size the sector is that you are dealing with and what the unmet need might be. What size, typically, are the communities that are in your group of six? How many people would be in each?

Ms McConachy—There would probably be anything between 600 and 3,000. Groote Eylandt would probably be the biggest because it has four communities within that area.

Mr Sambono—That is including the outstations. Where you have a base community you will still have about five or six outstations surrounding that area.

CHAIR—How many other remote communities of that size, 600 to 3,000, would there be who you do not provide this service for?

Ms McConachy—How many? There are 100 or 200.

CHAIR—Okay, so we can understand the scale.

Mr Sambono—At the moment the program is getting a lot of expressions of interest. They want an Indigenous mental health worker out there. At the moment our response is, 'We can only employ this many and if there is anything that comes up, certainly your area will be addressed.'

CHAIR—Are the six that you have got geographically close? Have you carved out a little part of the Northern Territory for this service, or are they spread around?

Mr Sambono—They are spread around. We had to close the boundary as far as Tennant Creek. We had two communities there, Borroloola and Lajamanu, and then the funding went to the Arnhem areas. It then went to the Tiwi Islands, which is nearer to the seaside, and we also focused on Port Keats. We looked at all areas and there were priorities in some of the communities. We actually got the data from the hospitals—Lajamanu was having a lot of calls and evacuations—to say that there was a lot of mental illness out there. Borroloola was the other one that we had to mainly focus on, because they were a long distance away and they were also having issues with evacuating people with psychiatric illnesses into the mainstream services.

That is the sort of thing that we were looking at: a vast area within the top end of the Northern Territory. At the moment, the only thing we can say is, 'No, we can't employ anyone out.' We have had communities and outstations contact us because they have found out that there was a mental health worker working in one of the main communities and they wanted one out within the area because they were having problems. We also have non-Indigenous people within the clinic ringing and asking, 'How do we get a person out in this area?'

CHAIR—So you could easily double the service you provide with sufficient funding and probably go to a greater extent than that.

Ms McConachy—Yes, easily.

CHAIR—Would it be possible for you to do that in a structural sense, or should there be separate bodies like you repeated around the Northern Territory to manage this service?

Ms McConachy—I suppose it really gets down to the model that people prefer to use or that is easier for them to use. We have a different model, in many respects, to Central Australia. We have a different model than the Top End Mental Health Services. I suppose it really just depends on the model that people want to work under, and obviously which is more cost effective.

CHAIR—It is fair to say one of the difficulties the committee is dealing with is understanding the enormous complexity and huge diversity of delivery of programs, and this is yet another model which is in the mix.

Senator HUMPHRIES—I have only got one issue to ask you about—that is, what seems to be the differences in the approaches in different places? You have talked about a well-integrated program with primary care with GPs. The previous witnesses from Central Australia talked about the lack of integration with primary care. It was a problem that they identified as being serious across a number of areas. Is there a difference between what goes on in northern and central NT? Or is there a problem in areas that you do not service of the same nature as what goes on in the NT—that is, a lack of integration between these sorts of services and primary care?

Ms McConachy—I really cannot speak for Central Australia; I can only speak for our small program that runs within the Top End Division of General Practice. Initially our program was primarily driven by GPs. It was very focused about what is it that the Top End Division of General Practice can provide for general practitioners out there in remote communities. That was very focused for them. Obviously, they needed to be supported more. That, of course, is a very important issue.

This program now, after being on the ground for 2½ to three years—we are going into our third year—is really focused on the community and what benefits it can have for the community, the general practitioner and the primary health care team. We are very lucky to have some experienced psych nurses to provide daily support in the remote communities where we have our mental health workers. It is a matter of looking at it across the board. We are one component of the mental health services that are delivered in the Top End. As I said before, we work closely with the visiting Top End Mental Health Service. In collaboration we have education events and workshops together. Our coordinator provides that vital, invaluable link between all the players by establishing long-term trust and credibility. She visits the communities and talks to elders, council presidents, members, her extended family, Aboriginal mental health workers, nurses and GPs. When she visits and when she phones in, she can establish whether or not any issues or problems are emerging or what things need to be addressed in those particular communities.

Senator HUMPHRIES—But these are only the communities that you operate in?

Ms McConachy—Yes.

Senator HUMPHRIES—Outside those communities, in the Top End are the problems the same as those we have been told about that happen in Central Australia?

Ms McConachy—Yes, definitely.

Senator MOORE—Has there been interest from other divisions in looking at the model that you have?

Ms McConachy—Yes, there has been a lot of interest. Again, we can provide information about what we do and how we do it, and then obviously it is up to them to see whether or not they could provide the same sort of thing.

Senator MOORE—Are you aware of any other divisions that have taken up the model? We have not heard of any, that is why I am asking the question.

Ms McConachy—No other divisions have, to my knowledge.

Senator SCULLION—Mr Sambono, in your opening remarks you talked about the difference in behaviour on presentation and the issue of whether it is a mental health issue or a cultural issue. You then went on to talk about acknowledgement of cultural intervention and how important that was. Could you expand on that for me? I would certainly like to have a better understanding of exactly what you are getting at there.

Mr Sambono—For example, we wanted acknowledgement given to traditional healers. When we look at mainstream intervention for the treatment of people who have some sort of psychiatric illness, cultural intervention is at a minimum. The focus was that, if the family wanted a traditional healer to come in, we wanted the clinical setting to acknowledge that and to make sure that it is part of the process of healing a person and getting a person well. It was not only acknowledgement but also the need for non-Indigenous health staff to understand the process of cultural intervention and to make sure that it was used within the clinical setting. It was a learning process for all health practitioners within remote communities. They understood that traditional healers were there, but they never ever used them within a clinical setting.

Senator SCULLION—So it is a sort of comfort zone. How does it work? Obviously there is a schism sometimes, and traditional healers feel a bit excluded from the process. Would traditional healers like to be involved at the early stage of intervention? How do they view the process?

Mr Sambono—The role of the mental health worker would turn around; they would make sure that there were continual visits by the traditional healer. It is not only traditional healers; it is spiritual healers also. You could also have people who come and make sure that the person is happy. The point is that it is acknowledged. The idea is that the Aboriginal mental health worker would make sure that that was documented at all times and that there was continuous support by any sort of traditional intervention within the community that was acknowledged by the patient himself or herself. The idea we are trying to get through to the clinical setting is to make sure that we address every problem. We should not only see it as mainstream intervention but also acknowledge the cultural issues that are in the communities and address them within the clinical area. Certainly, support was given. The division would keep an eye on that, record that and make sure that follow-ups were done with the mental health workers. Reports were going in all directions, including one from the mental health worker back to the coordinator. Also, we would address Sandy, as the manager, on any issue like that.

Senator SCULLION—I turn to the issue associated with the education of the health workers, particularly through Batchelor College. There has been some criticism, as there has been right across Australia at different institutions. Do you think there is a commonality of standard? Do you think that, when the Aboriginal health worker leaves that institution, there is a minimum standard and that you can have a high level of confidence they have actually achieved that standard? Or do you think there are some issues there we can improve on?

Ms McConachy—As part of the employment of the Aboriginal health workers within each of the communities, there is an expectation that they have a reasonable level of English literacy before undertaking the Batchelor course. They go directly into certificate III and then, as a few of ours have done now, they can go on to certificate IV in mental health non-clinical. Within our partnership agreement, there is an expectation that Batchelor will take on the people that the communities employ under our program and that ongoing support for those people actually exists. Our coordinator has the ability, and the rapport with Batchelor institute, to ensure that those people are going to classes and that they are getting enough education in certain areas. In other areas we ask Batchelor to look at different things we could possibly do or we bring in our own expertise if Batchelor cannot provide what we need for our staff. There is constant information and connection between all parties to ensure that things are actually happening on the ground. Without that constant coordination role of the coordinator, who is an Indigenous woman, the program might well fall apart because we are such a long way from the remote communities that we have links with. It is vital to have this program continue with that coordinating role.

Senator SCULLION—It has been put to the committee that it would be useful for the entry level to the mental health worker course to be the health worker course. You would go and do your health worker course with the intention, perhaps, of doing mental health or some other speciality. But certainly you would do that initially. What do you say to that suggestion?

Ms McConachy—I think there are lots of different ideas on that. I have my opinion, and I know Henry does as well. I am discussing that particular issue with our Aboriginal health workers. There are also differences of opinion as to whether some want to do the health worker course first and then specialise in mental health or whether they want to be stand-alone professionals in mental health. I think one of the issues for our mental health workers has been the provision of medication. As it stands at the moment, they are unable to have anything to do with medication, which therefore creates a slightly disjointed model of service delivery. They can do one bit, but they cannot do another bit. What is your opinion, Henry?

Mr Sambono—I have been a health worker since 1982 and I know health workers take on many positions. Add one more role on, like being a mental health worker, and you are putting big pressure straight onto the general health workers. General health workers are clinician workers. They have always been there, and within the last 20 years they have turned around and focused on the primary health care setting, on prevention. Personally, I am right against the mental health worker also being the general health worker. It is too confusing. As I have said, they take on too many roles, and I think that is where the stress factor is. I think that is why a lot of health workers are dropping out. I think the mental health worker position should be just one position that focuses on mental health.

Senator SCULLION—The context in which it was put to us today was that they should always be a mental health worker—that is what they are doing, that is what their work should be as a descriptor; they are just simply the journey there. Principally, I imagine, the issues are of presentation, of comorbidity and a general understanding of other things associated with clinical health. Obviously they have been referred and a wider knowledge of those matters may be important.

There are also, across the board, some assertions regarding the capacity at a certificate III level to deal with certain issues. I understand that people grow into that. That is a basic when you arrive on the job. Could you review that level? Are there other professional development courses that we can deliver for those mental health workers? Are there funding issues? Should we be providing those sorts of professional development courses specifically in mental health beyond the certificate III?

Ms McConachy—More onus needs to be put on training institutions to ensure that on-the-ground training is provided. It is all very well to have mental health workers come to Batchelor institute and sit in a classroom, but where they learn is where they live.

Senator SCULLION—The other sort of CBT—competency based training.

Mr Sambono—The division is preparing meetings with Batchelor institute. Certainly they are giving us information to say yes, they are competent with this unit and the other units. We would like them to be in the working environment as assessors and make sure that the mental health workers are competent within the work environment. That is our concern at the moment.

Senator SCULLION—That does not happen to a large degree at the moment.

Ms McConachy—That is correct.

Senator WEBBER—Following on from that, what is the acceptance like amongst other health professions? Obviously, your GPs accept the role of Aboriginal mental health workers. You say they want to be involved. Is there an acceptance of the legitimacy of their role amongst other mental health practitioners and are they included in the treatment plan?

Mr Sambono—They are, very slowly. It took a long process to have community based mental health workers within their own community. Certainly there were a lot of complications, but it is starting to improve. Like I said before, allied health professionals are now making the Indigenous mental health worker their first port of call. They are now having meetings on the telephone with the psychiatrists or psychologists, with the nurses and doctors. That is what we put the position out there for—to make sure that they were going to sit together and work together as a team. Now in some communities we have good communication and a good work environment within the clinical setting. We also have it with Indigenous people now coming to the mental health worker and the mental health worker processing whatever issue comes through with the clinic. It is working.

Senator WEBBER—So it is working at a community level.

Mr Sambono—Yes.

Senator WEBBER—It does not work, say, if someone from that community then ends up being admitted to the county ward. Is there an acceptance there by the professionals in that ward that, on discharge, they should come and talk to the Aboriginal mental health worker about looking after that person?

Mr Sambono—Yes, it is certainly happening. With the memorandum of understanding with the Top End Mental Health Services and Top End division, certainly we do have workshops here where we take the mental health workers to the Cowdry JRU. We set up issues of introducing them, making sure that they do know what community they are from, and if there is a client that goes into the mainstream services they communicate with the Aboriginal mental health worker within the community. So we see a strong support system when the patient goes back. We also have a system now set up where the Aboriginal mental health worker has certain things to do when the client comes out there and also the connection with the clinical staff.

Senator WEBBER—And that is a long-term beneficial arrangement.

Mr Sambono—Yes.

Senator WEBBER—So if other communities had an Aboriginal health worker that would—

Mr Sambono—Yes. Also, the mainstream mental health workers and psych nurses who go out all know now that the Top End division has workers out in the community. They have to go to them and address issues that have to do with whatever community they go to.

Senator WEBBER—Finally, in terms of the recruitment of people to become Aboriginal mental health workers, you have alluded to the fact you go out to talk to the communities and try to identify people. Is there much of a problem in attracting people and getting them involved? Are there any major obstacles?

Mr Sambono—Not really.

Senator WEBBER—So there is a lot of interest?

Mr Sambono—Yes. We wanted to make sure that we did not go out and pick the person. We wanted the community to have the control over picking them. We wanted the community to tell us the reason they picked a person. Some of those things might be the life experience that person has or because she is so senior within that community and knows how to address people. So we left it there. Certainly it was not only the Indigenous people but also the clinic. The clinic also had a say on their concerns or whether they wanted a person to be employed in a position. So it was not only with Indigenous people; it was also with non-Indigenous people within the communities.

Senator WEBBER—But once the community has picked that person, they are willing participants?

Mr Sambono—Yes. Our next process was to look at the job description and make sure that, within the first couple of months, we actually identified what they were doing in the community, what linkages they had in the community, what relationships they had and what sorts of meetings they should be going to to inform the community—that is, whether they should be going to the council or to the clinical meetings that they have out in the communities. Those are the sorts of things. There was one community—the Warlpiri community at Lajamanu—that was actually putting that person on the radio and saying what she does in the community. So health promotion

was there. Also, she was making her own people aware that she was there as a mental health worker.

Senator TROETH—So when the mental health workers are chosen or self-selected by the community and by you, do they then have a period of training or does the work at the Batchelor institute go on from there?

Mr Sambono—The agreement is that they start the course at certificate III, non-clinical, straight away. So certainly the clinic is aware that she or he is in training mode. As long as they know that, they will not be putting a lot of pressure on that person.

Ms McConachy—There would also be someone within the clinic, be it a GP or the nurse, who would agree to take on this person. A system would be set up where the Aboriginal mental health worker would come in and see that nurse every day or two or three times a week or whatever the process was. They would have time together to talk about clients, to know each other, to develop that rapport and knowledge base around the mental health issues and to work out how to work best together. Each worker is usually on some sort of three-month trial set-up.

CHAIR—From the outset, do they receive a full-time salary for this work?

Ms McConachy—The community council and clinic negotiate what hours they need this person to work. The three parties would sit down and look at what they needed to be doing and how many hours a week they would need to be working. If it is agreed that they would be working at a full-time rate, we provide the communities with a full-time salary, although up until now it has been less than what Territory mental health staff were getting as Aboriginal mental health workers. The funding that will come in from Territory Mental health services will bring those salaries up into line with Territory mental health workers.

CHAIR—So a certificate III Aboriginal mental health worker will be equivalent in payment to what other kind of worker?

Ms McConachy—When they have finished their level 3, they would be on an AO 4 level.

Senator MOORE—That is a fairly standard operational level in the Northern Territory.

CHAIR—Thank you very much for clarifying these arrangements. It is very useful for us to know how it works. Thank you for your submission and for coming in.

Ms McConachy—Thank you for inviting us.

[12.20 pm]

PARKER, Dr Robert Michaelis, Chair, Aboriginal and Torres Strait Islander Mental Health Committee, Royal Australian and New Zealand College of Psychiatrists

CHAIR—Welcome. Do you have anything to say in relation to the capacity in which you appear?

Dr Parker—I am appearing today in two capacities. My initial capacity is as Chair of the Aboriginal and Torres Strait Islander Mental Health Committee for the Royal Australian and New Zealand College of Psychiatrists, which is this presentation. I will later be joining the Northern Territory group to present Northern Territory issues in my role as an acting director of psychiatry.

CHAIR—You have lodged with the committee a submission which we have numbered 428. Are there any amendments or additions to that document?

Dr Parker—Yes. The submission that was sent by the college to you is an early copy. I have an updated copy with me. The important addition is a recent study from Western Australia which demonstrates the distress for members of the stolen generation. I have incorporated that into the revised addition. The college sent you an earlier edition, which did not have that revision in it.

CHAIR—Is it the wish of the committee that the revised edition be tabled? There being no objection, it is so ordered. I invite you to make a brief opening statement, after which we will go to questions.

Dr Parker—By way of introduction, this is almost a joint presentation today. One of the members of my committee is Pat Delaney, who as Pat Swan wrote the *Ways forward* document. I consulted with her about my presentation today and she wanted me to inform the committee about certain issues, so she will be a copresenter even though she is not here.

There is obviously a high burden of emotional distress and mental illness in the Aboriginal and Torres Strait Islander population in Australia. The statistics for that, or the bare bones of it, are in the adjunctive references I have given in the college presentation. The recent study from Western Australia appears to be one of the first studies that shows the effect of the stolen generation policy on Aboriginal people and the serious emotional effects as a result of the policy. It is a very important study in that respect.

An important issue that was not highlighted in the college submission was the very high rates of imprisonment for Aboriginal people in Australia. I discussed this with a senior forensic colleague from the college and he told me that there are no studies at the moment that show the real extent of mental illness in the Aboriginal prison population in Australia. We have a high number of Aboriginal people being imprisoned and there may be a significantly high amount of mental illness in this population. Further, Aboriginal and other prisoners with mental illness may be disadvantaged through their inability to obtain modern psychotropic medication because of its

prohibitive cost for prison medical services. This probably impacts on the state funding arrangements for health. Prisoners cannot access Medicare and therefore the PBS within prison.

There are high rates of substance abuse in the Aboriginal population. This appears to be impacting on the issue of mental illness in the population. The Trewin and Madden document from the Australian Bureau of Statistics appears to show that Aboriginal people have four times the rate of admission to hospital compared to the non-Aboriginal population as a result of substance abuse. That is a very high rate.

Pat wanted me to tell you that the Aboriginal and Torres Strait Islander community who control the health sector deal with a major burden of mental illness, family dysfunction and the consequences of sexual abuse in their local Aboriginal populations. However, this sector is poorly resourced from a variety of sources without long-term funding for most positions. An example is New South Wales where there are only seven state funded Aboriginal mental health positions for the whole of that state and the rest of the positions are brought up from a variety of funding sources which may not have continuation. People are employed for six months and then lose their jobs. They have to scabble around for money from different sources to keep people employed, which is a very unsatisfactory situation.

Pat also wanted me to make the point that there is no crisis resource generally available for disasters in Aboriginal communities. Again, quite often with Indigenous communities, there is either a small rural community where there are a lot of social networks and people know each other very well or, in the city, you have still got families that know each other. A single event, such as a motor vehicle accident which involves two or three people, may actually have a major psychological and emotional impact on that community. There does not appear to be an adequate crisis response. I think Pat was referring mainly to New South Wales and their ability to deal with community distress issues relating to a single incident like that.

One of the focuses of the college submission is that education is a very important issue for the cultural security of Aboriginal and Torres Strait Islander people with mental illness, and their appropriate treatment. Pat has made the point that the vast burden of emotional distress experienced by Aboriginal people may be best dealt with by their local community controlled health organisations through the social and emotional wellbeing action plan, although apparently this has not been released yet. OATSIH have stopped the release for some reason.

The funding of social and emotional wellbeing centres is an important priority, and mainstreaming may be a significant disadvantage for the mental health of Aboriginal and Torres Strait Islander clients. At one stage last year I actually made a direct appeal to Tony Abbott because I heard a rumour that the funding of OATSIH was going to be stopped and that most of the social and emotional wellbeing issues were going to be mainstreamed. I think that would be a significant disadvantage to Aboriginal mental health in terms of the loss of corporate knowledge and experience of Aboriginal mental health. I suppose there is a lack of tolerance for these issues in the broader bureaucracy.

One important education issue, and certainly the college has been very strong on this, is the wider education of the community about Aboriginal and Torres Strait Islander mental health issues—both the emotional distress and the specific mental health issues. To this aim, it looks like the college has managed to obtain some money from beyondblue to develop an Aboriginal

mental health web site, which will aim to educate both registrars of the college and the wider community about Aboriginal mental health matters. Basically anyone will be able to access the web site and hopefully gain knowledge of and experience in how to treat Aboriginal people with mental health issues.

I again want to highlight the local programs. I heard a lot of what Henry was saying about the value of Aboriginal mental health workers, but often the value of mental health programs relates to community resilience and the ability of a community to develop programs. I want to make a particular point about the success of such a program in the Northern Territory recently: the Tiwi Mental Health Program. I am not sure if the senators are aware but, in 2003, I think the Tiwi Islands had 10 suicides in a population of about 2,000 people, which must be one of the highest suicide rates in the world. There has been a very effective response from the Tiwi community, which has developed a very effective mental health program which has reduced that suicide rate. I think there was one suicide in 2004, and there may have been one or two this year. That is still far too many, but there have been some very effective programs in terms of leadership, the development of Aboriginal mental health workers as leaders in the community, crisis response and basic education in respect of life stress and substance abuse, which I think has had a major impact on the reduction in suicide numbers in that community. There could possibly be a role for suicide prevention programs elsewhere in Australia.

Senator HUMPHRIES—Thank you for that presentation. You have covered some of the issues regarding what needs to be done in the future in this area. I have to say, though, that the written submission that the college has made is a bit disappointing in that it does not actually touch on any of our terms of reference. You describe what is being done with respect to consultation and cooperation in your sector, but there is not much description of what needs to be done in terms of policy changes or, until you gave this oral presentation, in terms of improved service delivery in particular areas. That is particularly regrettable given that, in the course of this inquiry, psychiatry as a profession has had a huge battering. A lot of people talk about problems in psychiatry generally as being central to the problems we are facing in Australia with dealing with mental health. That is, perhaps, not an issue for you to have to deal with personally.

Can I ask you specifically about issues like the distribution of psychiatrists. I assume you have the same problem in the Northern Territory as we find in other parts of Australia, in that psychiatry is concentrated in the major cities, particularly the capital city, and private psychiatry is almost exclusively available only there. What is the nature of the problem here, and is the college, in particular, taking any steps to deal with this issue, either in terms of what it says to its members or what it is suggesting to government that it should do to change the policy that leads to this maldistribution?

Dr Parker—Again, I think the issue of why psychiatrists do not go bush is very complex. I have my own ideas on that. I suspect that the people who are attracted to psychiatry are people who like cities. They are the people who like wine, opera and whatever, which is why they do not like going away from cities. That is a personal view; I do not think it is a proven view.

Senator HUMPHRIES—We grant that you have frankness, at least!

Senator WEBBER—That is a more polite version of what I have been saying!

Dr Parker—It also has to be admitted that there are significant issues in attracting people to the profession currently. I understand there are almost 40 vacant consultant positions in public health in New South Wales. Half the training positions in New South Wales cannot be filled at present by registrars. So there are significant issues about actually attracting people to the profession to go and do the work later on. I suppose I speak in a different position now in my role as acting director. I have had a very fruitful relationship with my director, Bronwyn Hendry, in developing a number of positions. Since we started we have almost doubled the number of consultant psychiatrists in the Territory and there is an improved quality in psychiatric service available to Territorians generally. Certainly, I have been very keen to attract psychiatrists who have an interest in working in rural communities. I have one at the moment who we actually encouraged to come as a registrar and then a consultant to start a rural program here. There is another consultant who may be interested in coming across that Bronwyn and I are quite interested in trying to catch. It is a fairly subtle negotiation required to do that. As well as that, Bronwyn has been very active in developing the MSOA Program—attracting quality psychiatric services, mostly from South Australia. Psychiatrists come up here and then they go out and visit rural communities.

There has been a lot of goodwill on the part of the health bureaucracy to bring a number of psychiatrists to the Territory and to further develop resources for communities in terms of psychiatric input. However, it is going to be a continuing issue and it is going to get worse, because if half the training positions are not filled that means that in 10 years time there are going to be fewer consultants. The majority of those are going to want to stay in the city. It is a difficult job being in the public system. You often have very difficult, disturbed, violent people. There are all sorts of issues about pay and conditions for psychiatrists and, as the college has pointed out, we are way down in the pay rate for specialists compared to surgeons, physicians and everybody else. You often have to deal with different bureaucracies and management issues that make life very unproductive and make it not a very thankful task to work in the public system. You look at your colleagues working in private practice, who are often earning more, and they do not have all the issues of the public system to deal with. It is not surprising that quite a number of psychiatrists leave the public system to go out into private practice.

In New South Wales currently, because of the issues with bed stays, a registrar can see a patient and do an admission in half an hour and then spend four hours on the phone trying to get a bed for that patient. Given the reputation that goes with psychiatry about how in your first six months you are dealing with extremely violent and disturbed people and you do not get any sleep because you are trying to find a bed for them, it is not surprising we are not getting people in as trainees. There are a whole lot of issues that impact on the psychiatric work force. I think it is actually quite remarkable at the moment that the Territory is doing as well as it is; that we are actually attracting a range of qualified college fellows to come and work up here. I think that is a tribute to the current administration in the Territory.

Senator HUMPHRIES—I would ask you to pass back to the college the concern about the need to address some of the terms of reference. Perhaps you could pass back the message that I would like to have the college make a further submission to the committee to respond to a large number of the issues that have been raised about psychiatry in the course of this inquiry, not just here but all over Australia.

Senator WEBBER—I am from Western Australia, and we have significant challenges in attracting psychiatrists as well, so I want to follow on from what Senator Humphries was saying before I go to a specific point in your supplementary submission. We have one psychiatrist in Geraldton, and then there is nothing further north. Geraldton is a 4½-hour drive north of Perth. That psychiatrist was recruited from overseas. He is an Indian gentleman, widely accepted by the general community but not necessarily accepted by other mental health practitioners within that town, who are not very racially tolerant—but there you go. Were your recently attracted people locally trained, or were they overseas recruitments?

Dr Parker—Most of our current colleagues are fellows of the college and were locally trained. There are a whole lot of issues about what a psychiatrist does and models of psychiatry. The problem is also related to funding and MBS arrangements, in that you are paid to see a patient in a particular room. I suspect that the future role for psychiatry may be more of a consultation, where a psychiatrist is basically able to consult with a range of primary health professionals and give advice on the management of mental illness. That may be a more effective role for a psychiatrist in a rural area. They may need to see the occasional patient, but education and working with other primary care professionals may end up treating a lot more people more effectively than just seeing an individual patient in an individual room.

The other issue is that, yes, there are a lot of overseas trained people—I think a third of the psychiatrists proceeding to college examinations at the moment are specialists who have received their qualifications from overseas, most of those on the Indian subcontinent. The college is very aware of that and is now developing a program to improve the skills of that consultant group. It is looking at a specific assessment and training program and a special exam program for this group, because it recognises the important contribution of this group to the future of mental health in Australia.

One of our issues in regard to Aboriginal and Torres Strait Islander mental health, and one of the reasons we are developing this web site, is to increasingly upskill the profession generally in respect of Aboriginal and Torres Strait Islander mental health. So, with the education that basically every registrar is going through, in 20 years time every consultant psychiatrist will have had some input about Aboriginal and Torres Strait Islander mental health through their compulsory education. That education is also to improve the cultural awareness about Aboriginal and Torres Strait Islander issues amongst this overseas trained group. As part of their education process, they will have to do some sort of cultural competency training through the web site. Hopefully, that will improve their awareness and understanding of Aboriginal mental health issues. Yes, I agree that it is a significant work force maldistribution but, with fewer psychiatrists than there are jobs, the psychiatrists can basically pick and choose at the moment.

Senator WEBBER—You have given us your supplementary submission today. Is your submission actually on behalf of the Indigenous committee of the Royal Australian and New Zealand College of Psychiatrists?

Dr Parker—I do not know what happened with the college, but they got the heading wrong. It is actually the Aboriginal and Torres Strait Islander Mental Health Committee.

Senator WEBBER—Of the college?

Dr Parker—Yes. The college actually has two Indigenous committees: it has one for Australia, which is our committee, and one for New Zealand, which addresses Maori mental health issues. So it is important to identify the Australian one.

Senator WEBBER—Absolutely. So this submission is on behalf of that committee of the college. I was pleased by and interested in your remarks about the Western Australian survey that was done by the Telethon institute. I think they have done some fantastic work. For the benefit of other members of the committee, the survey is about the stolen generation. You go through the facts: they are more likely to live in households where there are problems related to alcohol abuse and gambling; they are more likely to have been arrested for an offence or to have had contact with Mental health services; children of members of the stolen generation have a much higher rate of emotional and behavioural difficulties, substance abuse et cetera than Aboriginal children whose parents were not members of the stolen generation. I am aware of the work that has been done in WA, and it was an extensive survey. Do you think those findings would hold for members of the stolen generation in the Northern Territory?

Dr Parker—I would suspect so, yes. The forced removal of children from families, particularly when they were placed in cruel institutions without any affection, would have had major emotional effects on people. It is not surprising that the people who have come out of those institutions (a) do not have any real model of family and (b) have a whole lot of emotional debris that they are trying to deal with. So it is not surprising that they themselves may have significant emotional mental health problems or substance abuse problems. Of course, the children who come from that environment would then be expected to also continue these issues. So I am not surprised at all, and I would expect that it would be a continuing issue, not just with the Western Australian members of the stolen generation. Any member of the stolen generation is more likely to have these issues.

Senator WEBBER—How likely is that to be an ongoing generational problem?

Dr Parker—I think that is highly likely. The crucial issue for wellbeing is the early family environment. If it is a well-functioning family environment, where you develop confidence and a sense of self-esteem, you tend to become a successful adult, because you continue those qualities through your adult life. When you have been brought up in a very difficult, disturbed environment, where there are a whole lot of issues, your ability to find yourself as a human being, to develop those confidence issues, is fairly low. That then leads to possible justice issues, mental health issues and substance abuse issues, all of which are fairly interrelated.

Senator WEBBER—Finally—and this is not necessarily about Indigenous issues, but I am sure it has a disproportionate impact on Indigenous people—we had some evidence from someone from legal aid, I think, saying that, as in every jurisdiction, there is a defence of mental illness when people present at court but, because of the lack of ability of the system to treat people who offer that defence at the moment, it is often not in their best interests to offer that as a defence, so people end up actually being committed for a crime and incarcerated when in fact they probably had a diminished capacity and should not have been committed if they had used that defence.

Dr Parker—Yes, that is likely.

Senator TROETH—I want to ask you about the practice of fly in, fly out visits by psychiatrists. Is that common in the Northern Territory—plus telepsychiatry?

Dr Parker—The fly in, fly out visits are part of the MSOAP funding. We have attracted a number of high-quality psychiatrists to come and pay regular visits to Aboriginal communities in the Top End. That is a common issue with the current MSOAP funding at the moment. Telepsychiatry is used occasionally, but probably not as frequently as it should be. Again it relates a lot to the technology. We spend \$20,000 or \$30,000 on a teleconferencing machine, and within about five years that almost becomes obsolete. The ability of services to continue to upgrade the resources is often very limited, and that may limit the use of teleconferencing.

Senator TROETH—Do you consider both of those practices to be effective—in the sense that they are better than nothing?

Dr Parker—I know the psychiatrists who have gone out to the Aboriginal communities. I have done an orientation with them. They come to see me before they go out. We discuss issues of Aboriginal mental health. The three psychiatrists I know of who are currently coming to the Territory are very high quality. They are senior psychiatrists with a lot of experience in mental health generally. Even though they visit on an irregular basis, they set up education programs. It is an issue where they probably educate while they are there. I suspect it is a significant benefit for the communities that they visit, for that reason.

Senator TROETH—My other question is this: do Indigenous people in urban areas present with different problems from those in remote areas? For instance, the committee is interested in the Aboriginal mental health worker possibility. Possibly we could look at getting that practice into urban areas as well as remote areas. What is your view of the problems of urban versus remote?

Dr Parker—The college has issued a statement that Aboriginal mental health workers should be an integral part of any team dealing with Aboriginal mental health, whether in the urban environment or in the rural communities. Again, I think that part of the whole issue of Aboriginal mental health workers is cultural security for people presenting with mental illness so that there is an understanding of the cultural and family factors behind it and an ability to negotiate with the person and their family about issues of mental illness and treatment. Certainly that is very important in the urban environment as much as in the rural environment.

I might quickly add something. I have mentioned the Aboriginal mental health worker. In respect to Senator Humphries, part of the whole issue about addressing the terms of reference is that there is such a massive distress with Aboriginal health in Australia. I could have spent pages in dealing with that, but I thought it was well described and not worth it. I felt that in my submission I had to look at things that the Senate might be actually able to do. I thought possibly education issues, but I think the Aboriginal health worker issue is a central issue that is going to have a major impact on the next 20 or 30 years of mental health issues in Aboriginal Australia.

Part of the whole problem at the moment is that it is a very poorly defined profession. In each state there are different levels of competency and different levels of training. There is no registration for Aboriginal mental health workers in Australia, which I think significantly limits recognition by other professionals about the important role they play. There are certainly some

very important projects going on in Australia at the moment with respect to VET competencies for Aboriginal mental health workers in establishing competencies and a further development of their role. There appears to be a very successful program in Queensland at the moment where they are trying to tie career progression into VET competencies for Aboriginal mental health workers to give people a career and a formal structure for their work. I think that this is a very important role the Commonwealth can play to try to tie these issues together and look at the role of Aboriginal mental health workers and to look at possible registration issues and the definition and competency issues to improve the recognition of this group.

CHAIR—On that point, Dr Parker, what was described earlier today as the process for appointing people through their communities sounds very sensible. But with such a process you are always going to get a very wide range of experiences and formal qualifications, if any. By saying that the position is ‘poorly defined’, do you actually really mean poorly trained? What difference would it make to have a registration system?

Dr Parker—Registration would allow for a level of competency.

CHAIR—But to say so suggests that there is at the present time too low a level of competency. Is that what you are saying?

Dr Parker—It depends on the different states. Competency and recognition vary from state to state. Probably some of the best people to do mental health work in Aboriginal communities are the older people, the people who have got recognition. Quite often they have very little formal education but they have got a heap of life experience and they have got a standing in the community which often allows them to deal with significant issues in their community. The problem is then whether they can get access to any position because they do not have the formal education. I know that that has been a significant issue in Queensland, where there has been a requirement that you must have degrees, diplomas or whatever. Aboriginal people have virtually got no chance to get into those positions because their ability to access formal education and to do three or four years of formal education and then go into a position is often extremely limited. That is why it is very welcome that they are trying to look at that now as a competency based issue with further education to enhance capacity. I suspect that a registration based issue tied to competencies and then education requirements would give more recognition. At the moment it is fairly diffused and poorly accepted and it depends on which state you go to.

CHAIR—Who defines what is competency in such an arrangement?

Dr Parker—I have given a couple of references here to a couple of projects looking at health related competencies. They are referenced at the back of our submission.

CHAIR—So you are confident that we could have a registration system without discounting those people without formal qualifications who might otherwise do very good work?

Dr Parker—That is correct. I suspect that one of the reasons the Tiwi system has worked so well is that a number of senior Tiwi men were recruited as health workers. They had a standing in the community which has been further enhanced by their role as health workers. I think that that is one of the reasons they have been so successful in trying to reduce distress and suicide in the community.

CHAIR—Do you have any criticisms to make about the payment arrangements—the salary level or—

Dr Parker—I think that it is terrible. Part of the problem is lack of formal recognition. Jobs are either too difficult to get or they are based on these limited funding arrangements where you get someone for six months and then you discharge them. I think that Tom Brideson from OATSIH described it as a ‘seasonal work’ phenomenon.

CHAIR—Six months?

Dr Parker—Six months to a year, then people lose their funding.

CHAIR—Why is that?

Dr Parker—The jobs are through funding grants and there are a few. A Commonwealth grant comes out for some initiative and someone grabs it and employs someone for 12 months and then the money finishes. The health workers on Tiwi are actually employed on CDEP, which is a community program to clean the roads and pick up the rubbish. These health workers, who were doing an important job, are paid minimal money on a community make-work program rather than actually being given a recognition and a value as professionals.

Senator ALLISON—So how should they be funded? Who should pay their salary and how do we make it recurrent?

Dr Parker—I suspect it is a combination of money from the states, so that you get a recognition of the profession. Certainly health workers are employed by the states. New South Wales employs seven of them, so there is obviously a recognition of a health worker standard there, as there is in Queensland. Also, if there are specific programs for mental health and there are health workers there and appropriate funding is given to employ health workers for that or if money is given and delivered generally through the divisions of general practice then that is actually on a continuing basis. The Commonwealth could actually provide a funding model where, if there are real health programs, they are set up with appropriate funding for staff at a certain recognised level.

Senator ALLISON—To your knowledge, is that discussion about the length of the term of the contract or the amount of money paid in salary also something that is put to the Aboriginal communities at the time someone is selected or co-opted to do this work?

Dr Parker—I can only reflect on the experience I had before I did medicine, when I did art and craft for many years. Money came and you grabbed whatever money was coming through. You did not question it too much because, in a general paucity of funding, if money came you grabbed it and you put someone in the job and you just hoped you could continue it. Unfortunately that is the situation. Because there is a multitude of different programs and you can grab a bit of money from this one and that one, you tend to grab it and let the future take care of itself.

Senator ALLISON—You worry about it later.

Dr Parker—Yes, rather than having ongoing funding commitments.

Senator MOORE—I want to clarify how your particular mental health committee—Indigenous health committee—works within the overall college. In your submission, you mentioned that there is a great deal of commitment and all that kind of thing—and how seriously you take all the issues—but I want to clarify how that operates within the overall college of psychiatrists.

Dr Parker—The committee is part of a college board called the Board of Professional and Community Relations, which is the main college board that interfaces between the community and the college. The board has two Indigenous committees: one for Australia and one for New Zealand. The chair of each committee sits on the board. The committee is therefore roughly half made up of Aboriginal consumer/mental health workers and half made up of psychiatrists who have an expertise interest in Aboriginal and Torres Strait Islander mental health.

CHAIR—They are not all psychiatrists?

Dr Parker—No.

Senator MOORE—Is that an unusual position?

Dr Parker—Pat Delaney is a member of a committee, as is Marsat Ketchell from the Torres Strait Islands. There are a couple of other people, off the top of my head: Dawn Fleming from up here, and Michelle Wilkes from Taree. All of them are Aboriginal mental health workers working in their own communities who have a very good personal understanding of the impact of mental illness and are also doing work in their own communities to enhance Indigenous mental health issues.

Senator MOORE—How many people are on that subcommittee?

Dr Parker—There are about nine or 10, so there are roughly half that are psychiatrists and half that are Aboriginal community members. We keep it very much 50 per cent so that the Aboriginal community members are not overpowered by the psychiatrist members. It is a consumer committee for that reason—so that they have equal representation and power within the committee.

Senator MOORE—And the various initiatives you have pointed out in your submission that are focused on Indigenous health are then fed through to the overall college with processes about what is happening in that field?

Dr Parker—The committee generates these issues and review them. It then goes up to the Board of Professional and Community Relations, which reviews it, and it then goes up to the college executive. An example of this is the statement on Aboriginal mental health workers. That came out of a conference that was held in Sydney in, I think, 2002, which was organised by Pat Delaney to look at the profession. The college statement came out of that. It then went to the committee for further review. It then went up to the board and the board then recommended it to college council as college policy.

Senator MOORE—One of the questions we asked one of your associates—and I forget which city that was in—was the number of people from different backgrounds who were qualified psychiatrists in Australia. We were asking whether there were any Indigenous people who were psychiatrists. That person did not know the answer. I am kind of hoping you do, in light of your background.

Dr Parker—Yes.

Senator MOORE—What is the answer to that?

Dr Parker—We have got one identified Aboriginal psychiatrist in Australia.

Senator MOORE—I thought that was going to be the answer: one.

Dr Parker—That is Associate Professor Helen Milroy from Western Australia. I know of two other people who are likely to become Aboriginal psychiatrists. There is a trainee in South Australia and there is Robyn Shields from Sydney, who is doing medicine at the moment. It is likely that she will go on and become a psychiatrist after that.

Senator MOORE—So that process is beginning to occur.

Dr Parker—Yes. One of the things we are very aware of is the distinct lack of Aboriginal psychiatrists in Australia compared to those on our New Zealand committee. There is quite a large number of Maori psychiatrists in New Zealand. Again I think that reflects the different history of New Zealand where you have the Treaty of Waitangi and the Maori population had an economic and political power that continued to enhance their ability to get into medicine in comparison to Australia, where the Aboriginal population had significant social and political disadvantage for many years.

CHAIR—Are there any scholarships available to Indigenous people who might want to move into psychiatry?

Dr Parker—I think the college gives a small amount of money to encourage registrars to do training in Aboriginal mental health. The Puggy Hunter award is given to Aboriginal people to do medicine. Robyn is a recipient of the Puggy Hunter award. That has enabled her to continue her medical studies.

CHAIR—Would it help if there was more funding available?

Dr Parker—Again, yes. I suspect there is an increasing number of Aboriginal people getting through to year 12. I suspect that would help offer the opportunity to go on and do medicine then do psychiatry. When I was at the University of Newcastle I helped set up the Aboriginal entry program into Newcastle, so I am very aware of the potential to enhance people's opportunity to do medicine.

CHAIR—Batchelor does not offer medicine, does it?

Dr Parker—No.

CHAIR—Should it?

Dr Parker—No. In fact I think it would be very difficult to set up a medical school totally within the Northern Territory at the moment. The Territory has a medical school at Royal Darwin Hospital that is contributed to by Flinders University from South Australia and James Cook University from Queensland. Senior medical students from those medical schools come up and do their clinical work here. A number of Aboriginal doctors have come through Darwin in recent years from those two medical schools.

CHAIR—Thanks very much, Dr Parker. That has been a really useful perspective for us. It is good to hear about what New Zealand is doing. I often think that New Zealand is dealing with its Indigenous issues in a much more holistic way than we are here.

Proceedings suspended from 1.00 pm to 1.42 pm

GRIEW, Mr Robert, Chief Executive Officer, Department of Health and Community Services, Northern Territory

HENDRY, Ms Bronwyn, Director, Mental Health, Department of Health and Community Services, Northern Territory

PARKER, Dr Robert Michaelis, Acting Director of Psychiatry, Top End Mental Health Services, Department of Health and Community Services, Northern Territory

RHODES, Ms Rose, Assistant Secretary Community Services, Department of Health and Community Services, Northern Territory

CHAIR—I welcome representatives from the Northern Territory government. You have lodged with the committee a submission which we have numbered 393. Are there any amendments or additions you wish to make to that document at this stage?

Mr Griew—No, thank you.

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

Mr Griew—First of all, I would like to thank the committee for the invitation to present to you today and to make a brief opening statement on behalf of the Department of Health and Community Services. I will begin by restating the commitment of the Northern Territory government and the Department of Health and Community Services to improving the mental health services system in the Northern Territory. This includes a wider range of mental health assessment, treatment, support and rehabilitation options for people with mental illness and their carers wherever they may reside across the Territory.

The Northern Territory government's commitment to mental health is evidenced by a significant increase in the mental health budget since 2003. The mental health budget in 2002-03 was \$18.8 million for our jurisdiction. Substantial amounts of new funding have increased this budget to \$28.8 million in 2005-06. This is an increase in the per capita expenditure on mental health in the Northern Territory from \$86 in 2002-03 to \$144 in 2005-06. This increased funding has primarily been allocated to community mental health services, which was our big deficit at that time. This has resulted in an expansion of specialist mental health services, including child and adolescent services, services to rural and remote communities, extended hours services and expansion of the subacute rehabilitation and disability support services that are provided by the non-government sector. A proportion of the funding has also been directed towards increased in-patient services and improved safety and quality in our public mental health services.

Although there has been a considerable increase in expenditure on mental health in the last three years, we recognise that there is still a long way to go before the mental health service system adequately meets the needs of consumers and carers in the Northern Territory. On 17 August this year, the new Minister for Community Services and Health, the Hon. Delia Lawrie MLA, made a statement in our Legislative Assembly reaffirming mental health as one of the key priorities of the Northern Territory government. To support this commitment, the government

has allocated an additional \$5.5 million over the next three years, starting this fiscal year. This additional funding will be used to establish 14 24-hour supported community beds, to increase services to correctional centres for people with mental illnesses, acquired brain injury and intellectual disability and to improve suicide prevention coordination and life promotion programs.

The Northern Territory government's submission to the Senate inquiry highlights some of the complexities and the high cost of delivering mental health services in the Territory. I will not reiterate these today; they are in our submission. In the time I have today, I would like to comment on how mental health services in the Territory could be greatly improved through increased collaboration between the Territory government and the Australian government. Although the Northern Territory government funding commitment for mental health has increased, the Australian government's allocation has changed very little in the last 13 years of the National Mental Health Strategy. The quantum of funds available is not sufficient to deliver the wide reform agenda expected under the National Mental Health Strategy.

The level of funding to the Territory for mental health through the Australian Health Care Agreement does not reflect the substantial burden of disease experienced in the Territory, particularly by our Indigenous communities, or the high cost of delivering services to a small population dispersed over a very large land mass. It certainly does not reflect the disproportionate cost of implementing reforms under the National Mental Health Strategy and the mental health plans in a small jurisdiction. Secondly, there are significant gaps in service delivery in the Territory, particularly in the areas of mental health promotion, prevention and early intervention and primary mental health care services.

These gaps are in large part due to Territorians' lack of access to the mental health funding provided to other Australians through Medicare and the Pharmaceutical Benefits Scheme. The Australian government's submission to this inquiry indicates:

The Medicare Benefits Schedule (Medicare) is a major part of the national health care infrastructure and enables high quality health care that is affordable and accessible to all Australians, including those with a mental illness.

While this scheme may meet the primary mental health needs of the population in most areas of Australia, I would like to draw the committee's attention to the average per capita MBS and PBS benefits paid in this jurisdiction compared with the national average.

The most recent comparative data for 2002-03, due to be published in the upcoming national mental health report, indicates that the MBS benefits paid per capita in 2002-03 for private psychiatric services was \$1.87 in the Northern Territory compared with the national average of \$9.92 per capita. This represents a difference of \$8.05 per capita, or \$1.6 million for the Northern Territory population. This disadvantage is further compounded when the benefits paid per capita for PBS funded pharmaceuticals, particularly psychotropic medications, are considered. The Northern Territory figure was \$9.81 per capita, compared with a national average of \$27.51. This represents a difference of \$17.70 per capita, which equates to \$3.5 million for a population of 200,000.

In 2003-04 the relative disadvantage experienced by the Northern Territory through PBS payments rose to \$3.8 million, and the trend is clearly upwards. This deficit is a direct

consequence of the very limited private sector: the private GPs and psychiatrists that provide services to mental health consumers in the Territory. The combined MBS and PBS disadvantage means the burden absorbed by the community and, to some extent, by public mental health services in the Northern Territory, is in the order of \$5 million per annum. This does not include the shortfall for Medicare rebates to GPs for primary mental health services which cannot be differentiated from the general pool of Medicare rebates. The total shortfall for Medicare rebates for GPs in the Territory is \$23 million. If the mental health component of this is conservatively estimated at \$2 million, the total shortfall in mental health services funding through our national primary health care funding systems is estimated to be \$7 million per annum or \$35 per capita. There are also no private psychiatric in-patient beds in the Northern Territory.

Similarly, the Australian government's Better Outcomes in Mental Health Care initiative, which is designed to facilitate and enhance mental health care through the primary health sector, works extremely well in jurisdictions with a healthy and competitive private sector work force, GPs and psychiatrists to provide mental health related services.

I understand that this morning our friends at the Central Australian Aboriginal Congress medical services made the point that, as a primary health care service, they are absorbing considerable effort in the mental health area and suggested that they should have access to a share of the Australian Health Care Agreement funding that we receive for mental health. You may want to ask us about this further. Although we sympathise a lot with their problem of absorbing a considerable amount of effort that would normally be absorbed through general GP and specialist psychiatric private services, we disagree that the appropriate source of that funding should come from the specialist funding provided through the Australian Health Care Agreement, which amounts to \$1.2 million a year and is primarily targeted at reforming specialist services. Congress are essentially picking up the same pressure that we pick up as the major provider of primary health care services. I make the point, without detracting from the pressure they feel, that the ideal environment would see mental health properly funded as a part of the primary health care sector, of which they are an important part in Central Australia.

In summary, the national model has had limited uptake in the Northern Territory due to a number of barriers, including the low number of GPs and the requirement for practices that access these items to be accredited. As a result, this jurisdiction has been disadvantaged by virtue of its small private psychiatry and general practice sectors and the limited capacity to attract professionals to expand these sectors and establish a presence in regional centres, especially in the more remote areas.

The lack of primary mental health services in the Territory impacts not only on the early detection of and intervention in mental health problems but also on the effective management of chronic disease in the primary health care sector and shared care arrangements with specialist mental health services. To address these gaps in service delivery, it is essential that we build on a range of innovative service models to meet the primary mental health needs of all Territorians. These include the establishment of integrated primary mental health programs in remote areas. Models of service delivery that consist of Aboriginal mental health workers and mental health clinicians working alongside GPs or medical officers and primary health clinicians have demonstrated their effectiveness in improving mental health outcomes for people living in these communities, including a reduction in suicides and in evacuations to acute specialist in-patient

units. These programs provide holistic, emotional and social wellbeing services that address mental health, substance misuse, family support and relationship issues.

The best example of this model of service delivery is the Tiwi Mental Health Program. A scaled-down but similar model, implemented by the Top End Division of General Practice, has also demonstrated improved outcomes in a number of remote communities. The introduction of the Tiwi model in other large communities in the Northern Territory would require investment of approximately \$300,000 per community, or the equivalent of \$150 per capita for a community of 2,000 people. The NT government would continue to provide specialist services to these communities through visiting mental health teams and psychiatrists and would expand the range of support and rehabilitation options available.

The lack of primary mental health services in urban and regional centres also needs to be addressed. This could be achieved through increasing the funding for allied health clinicians based in GP surgeries and in other primary health care services such as congress. These clinicians would support GPs to increase the quantum of mental health assessment and treatment services. Strategies that address the financial disincentives to GPs providing mental health services could also be considered.

In closing, I would like to say that, despite our relatively small population in the Territory, the high burden of disease and the complexities of delivering mental health services to our population are substantial challenges. The key funding indicators I outlined suggest that flexible funding approaches to the Territory by the national government are required if we are to build the capacity to provide services comparable to the rest of the country and foster the innovation necessary to address the unacceptable disadvantages experienced, especially by Aboriginal Territorians. I appreciate that this statement is longer than you would normally desire. In summary, I would stress the critical issue of a lack of primary care services and primary mental care services in the GP sector and the effect of that on both the general primary care services provided and our specialist services. This really is a cause for extreme strain on the health system in the Northern Territory.

CHAIR—Thank you, Mr Griew. I would like to ask you a little more about what you have just said about primary health care and access to Medicare. The congress model is an example of how Medicare can be tapped into from clinical surroundings. Whilst we might argue about allied health professionals being brought into that, I know in Victoria there is, for a whole range of historical reasons, a very well developed community health system which is primary care—a bit like as was described about congress. Will that new funding that you are allocating to mental health be utilised in this way? Why not set up clinics where doctors can be salaried, where you move away from the fee-for-service model to one where there is effectively bulk-billing and you effectively are working with Medicare money?

Mr Griew—Let me make a couple of general comments. I may also draw in other members of the department here to comment further. In general, in primary health care in the Northern Territory we have a model that probably exemplifies what you are talking about. We directly employ GPs as departmental district medical officers who work in multidisciplinary teams with nursing sisters and Aboriginal health workers—and, to the extent that we have them available, allied health workers. Those multidisciplinary teams work effectively under protocols developed for most of the conditions that they will see and those protocols are overseen by groups of

primary care clinicians in both the community and public sector. That model works very well for us. That multidisciplinary team model is also the model used in community based services such as the Aboriginal medical services. Congress, in talking to you about their multidisciplinary team model of primary health care, are actually describing a model that is now commonly accepted both in the public sector and in the community sector. We would argue that it is generally a better model of care than you will see in a lot of the private general practices, although the divisions work very hard to move down the same track.

The issue is whether the funding that the Northern Territory government is rolling out should be rolled out through those teams. Most of expenditure that we are responsible for is, of course, in the specialist mental health area. There are very big gaps in specialist mental health services that the government here has been trying to address. For example, the current initiative to develop residential places for people not requiring inpatient care addresses a complete gap in our system—that until we establish these beds, we are the only jurisdiction with no 24-hour supported care.

CHAIR—I think I understand that but, if your complaint is that you are not tapping into Medicare adequately and that there are not enough GPs functioning in the primary health care sector in the Northern Territory and you are missing out on \$7 million as a result of that, why would you not yourself set up clinics that could employ more GPs? What is the barrier to doing that?

Mr Griew—We do.

CHAIR—Presumably it is fairly cost effective if Medicare is funding the doctors' income?

Mr Griew—We should acknowledge here that the Australian government department of health has worked with us to make Medicare as flexible as it can be within its current parameters so that we are able to access Medicare billing in a greater range of areas than we were even a couple of years ago—for example, for GPs and sometimes Aboriginal health workers in remote areas. The problem is that there is an absolute lack of GPs who we can attract to work in the Territory, especially in remote areas of the Territory. As a result, it is often not GPs who are providing the primary service within the multidisciplinary team, and no-one but GPs, except in some exceptions, can access the Medicare payments. So you have a multidisciplinary team providing the care—a health worker or a nurse providing the care under a doctor's supervision—which may be the best, the most effective and the most pragmatic model but Medicare is built around GP service provision. That is the nub of the problem.

CHAIR—I understand that. I am sorry to press this, but it seems to me that you cannot on the one hand complain that Medicare is not coming in if you are not willing to set up the systems which would allow salaried GPs to operate. We have just heard from the congress about how stable their work force is under these arrangements; they are not having any difficulty attracting GPs or even other allied health workers to that arrangement. Have you tried to do this? Is there still a problem with recruiting GPs to that kind of model?

Mr Griew—We may be misunderstanding each other here. My answer to your question is that that is what we are trying to do. The federal department of health have helped us by making Medicare billing more accessible than it used to be. It used to be entirely inaccessible for our

services; they are now making it more accessible. The issue that we face—and congress does, too—is that we are willing to recruit GPs and then to at least get some partial reimbursement from Medicare. That is what we do.

Senator WEBBER—But there are restrictions under the Australian Health Care Agreement as to where you can access them, aren't there?

Mr Griew—Yes, and under the acts that cover the Medicare benefits. The primary one that inhibits congress, us and other Aboriginal medical services is that you cannot bill for the work of a multidisciplinary team. So if a nursing sister provides what is essentially general practice care, you cannot claim for it.

CHAIR—I understand that.

Mr Griew—And that same problem is faced by congress and us.

CHAIR—Of course; that is a given. If you make a case for not being able to tap in to Medicare for GPs, I think it is worth exploring whether that has been—

Mr Griew—And I would like to acknowledge and place on record the discussions we are having all the time with the federal Department of Health and Ageing, who are quite keen to see improvements in this area as well.

CHAIR—The increases in funding will raise the per capita spending, by the time you take into account the extra \$5.5 million over the next three years, to \$144.00 per capita or thereabouts a year. How does that compare with the national average or, say, Victoria?

Mr Griew—I think \$144.00 per capita is the figure for this year and, of that figure of \$5.5 million, a third of that would be included—that is my estimate—and then it will go up a bit.

CHAIR—Isn't that what I just did by saying \$144.00 per head plus the other amount which gives a total of about \$146.00 per head?

Mr Griew—Yes.

Ms Hendry—The most recent comparable figures across jurisdictions are contained in the 2005 mental health report. They actually refer to 2002-03 figures, which was the baseline that we started with, which was back at the \$86 mark. We are last in the rankings; we have that dubious distinction.

CHAIR—And now?

Ms Hendry—We do not know, except for information that we have gathered from sources, and partly from the transcripts of this inquiry, in terms of the information that jurisdictions have volunteered about their estimated per capita figure. Of the three estimates that we have managed to get from that process, we seem to be slightly above those three jurisdictions. But it really needs to be nationally validated through the process that happens with the national mental health report. Unfortunately, we will not have that information regarding this year's funding for another

couple of years. I would expect that we would have considerably improved in our rankings compared to the national average.

CHAIR—How do you determine what is enough? You also say in your submission that four per cent or thereabouts of your health budget is spent on mental health. How does that compare with the disease burden? How does it compare with the relative costs of delivering mental health services in remote areas, for instance? What do you say about that in policy terms? I should have read out the statement about not being required to answer regarding policy decisions.

Before we continue, I remind senators that, under the procedures for the protection of witnesses, officers of state government departments should not be asked for opinions on matters of policy. If necessary, they must be given the opportunity to refer those matters to the appropriate minister. I apologise for not doing that sooner. I am not really asking you for a policy comment but rather, given that you have got a forward plan of some sort, asking what the policy intent of that is. I am not asking you to give us reasons why; I am asking: what is the stated expectation in terms of both the proportion of health spending on mental health and the total quantum, if you like, on a per capita basis?

Mr Grieve—To answer a question about what is adequate in any area of health spending is extraordinarily difficult—

CHAIR—But that was not my question.

Mr Grieve—What proportion of our budget should we be spending on mental health? I guess the issue for me, in being responsible for this and other areas of health spending, is that, compared to the burden of disease in the Territory, there is unmet need. In any area where we increase particularly our primary health services—in mental health or in chronic disease or in infant health—the initial effect is that it brings forth previously unknown disease and so the burden on and referral to tertiary services goes up. That happens in mental health, as it does in other areas of illness.

I have been here for nearly three years. My strong sense is that there is a huge burden of mental illness in the community here, which has contours, causes and patterns which are quite different to what I am used to coming from the south of the country. It is a system that not that many years ago really had a very great deficit, particularly in the community mental health area, which led to and still leads to huge pressure on our acute inpatient services. So we have the challenge of modernising our mental health service and the challenge that you could characterise with the question: will a modern mental health service that would work in Perth, Adelaide or Sydney respond adequately to the particular patterns of mental health burden in the community up here? It is not just a matter of spending more money, which we will have to do; it is a matter of finding that balance—whether it is a greater share, it will certainly involve an increase in the mental health budget. There is also the challenge of finding interventions that will work at the community level and not just bring forth further burden into the tertiary system. We need to start to get more effective at early intervention and prevention.

Dr Parker—The Territory has probably got one of the most intelligent approaches to this issue. It has developed *Building healthier communities*, a policy document with a number of initiatives with respect to substance abuse, building families and mental illness issues—all of

which are connected, particularly in the more remote communities. It has also got a departmental structure where Rose, for example, is the secretary for children and family services, drug and alcohol, and mental health. So there is a very close coordination between the government arms that relate to important preventative measures for mental health.

In East Arnhem, I was part of a research group that identified that 60 per cent of adult men in the Miwatj area are smoking marijuana. That is a very large proportion. As a result, a certain proportion of those people will develop severe mental illness, and there will be other issues with respect to family function and money being spent on drugs that should be spent on food and dealing with family dysfunction et cetera. Therefore, any program to address these issues needs to be a multifocal program that looks at family issues and substance abuse and promotes and supports awareness of mental illness. There are particular challenges in the Territory for these sorts of issues, and the remoteness and the coordination of these issues are important. The Territory is trying to develop an approach that seems quite well set up to look at these issues, although there is obviously some way to go.

CHAIR—Is there a policy document that describes what the intention is?

Mr Griew—The framework that Dr Parker referred to is a document called *Building healthier communities*. He is absolutely right. It is fashioned in the face of exactly the sort of dilemma I was talking about.

CHAIR—Is that available on the web site?

Mr Griew—It is on the web or we can probably get a copy for members. It focuses very much on a prevention framework, precisely because otherwise, if we only focus on the burden of disease, it will be much harder to make the progress we need to make.

Senator HUMPHRIES—On hearing what you have had to say today about the effort that the NT is making in the area of mental health, I am more disturbed than I was before we started. In your submission you mention that the non-Aboriginal prevalence rate in the NT appears to be higher than the national average. From what Dr Parker has just said, there seems to be a very high incidence of comorbidity factors, particularly with Aboriginal people suffering mental illness. You have a high tendency to seek help—49 per cent versus a 38 per cent average across the country. It seems to me that all these factors combined bespeak a very significant problem in the Northern Territory.

I do not want to burst your bubble, but, given what we have been hearing about other states lifting their game on mental health across the board, I would speculate that the amounts you are spending in the next few budgets to improve your game are not going to lift you very far off the bottom of the league table. Don't you think there is a need to look at a different approach in the Northern Territory? All over Australia, including here today, we have heard evidence about the need for there to be more community based non-clinical responses to mental illness—things like community based outreach services, rehabilitation services based on NGOs and things like that. There appears to be a fairly fertile base for that, given some adequate support by government in the Territory. But there are many complaints in the submissions today about how inadequately those services are funded. What is your response to those criticisms by those organisations?

Mr Griew—Just to restate, a growth from \$18.8 million to \$28.8 million is a fairly substantial growth in expenditure, and most of that has been directed to community mental health services. And the proportion of the budget going to non-government services, as a result, has doubled, I think, in that period of time.

Ms Hendry—It has doubled, and the actual quantum of funds has tripled over that period.

Mr Griew—I would characterise the engagement with both community mental health and non-government service providers within community mental health as a feature of that period of funding growth. That is not to say there is not more to do. Absolutely. And the ratio of administrative costs as a proportion of total costs within government services here and non-government services in mental health is pretty much equivalent.

Senator HUMPHRIES—Can you give us actual figures on how much is now being spent on NGOs to deliver services as compared with—

Ms Hendry—Yes: \$2,300,000 has been allocated this year, give or take a few dollars. In 2002-03, about \$830,000 was spent on non-government services. One of the things that have been implemented is the intensive individual care packages for people either as an alternative to hospital or post discharge from hospital.

Senator HUMPHRIES—A step-down facility.

Ms Hendry—It is not actually facility based. The package is for people—individual packages for people in their own homes or other suitable accommodation. That is an innovative model in partnership with NGOs and public services. It has taken about nine months to develop and recruit staff and get the MOUs et cetera, but the service has just commenced. We have significantly increased the rehabilitation and outreach and disability support services available over the last year. And, as you heard people say this morning, we have expanded Grow to Katherine, expanded the drop-in centre and done a whole range of other initiatives with non-government organisations that are relatively small compared to the ones I mentioned before, which are a much larger investment.

In the coming year, when we develop the 14 residential intensively supported community beds, they will be managed by the non-government sector as well, with clinical in-reach by public specialist mental health services and on-call and after-hours services obviously provided to them by the public sector. They will manage those funds and those facilities.

The non-government sector have actually stated that for the most part we are going about as fast as they can go in terms of expansion. They have had to triple the amount of services they are providing over the last two years. Certainly, in a conversation I had recently with the Mental Health Association of Central Australia, who are by far our largest provider down there and, in fact, our largest provider over the state, they said that really they cannot cope with us saying, 'Can you do something extra?' They are at the point now where they can only expand at a certain rate. We do have to grow our non-government sector and also grow capacity in our mainstream non-government services, but that can only be done at a reasonable pace.

Senator HUMPHRIES—Conversely, bodies like the Central Australian Aboriginal Congress have said that they believe there is money cascading down from the Commonwealth that is not reaching them. You touched on that a little while ago, but I did not quite understand what you were saying about it. Can you explain what the rebuttal to their criticism is?

Mr Griew—The funding that we receive for mental health from the Commonwealth is through the Australian health care agreement. It is money that used to be tagged specifically for specialist service reform, and it is for specialist mental health services. The services that congress provide are essentially primary mental health services, very similar to the services that we are forced to provide as another primary health care provider. The point I was making is that I have a lot of sympathy with their point of view. They, like other primary health care providers, are picking up a large burden because of the absence of a private general practice centre. But, apart from the fact that the amount we get through the Australian health care agreement is relatively small—\$1.2 million—and would be inadequate to address that primary health care issue, it is for specialist services.

Senator HUMPHRIES—There are some other criticisms from other submitters that I want to put to you to respond to. One of them is from the Legal Aid Commission and Community Visitor Program, suggesting that the definition of mental illness in the NT is narrower than in other states and that that results in people with personality disorders being able to access some sort of crisis care support but no ongoing condition management type of funding. Is there a difference in your definition of mental illness and is their criticism well based?

Dr Parker—It comes down to what a personality disorder is. I have always thought of a personality disorder as an emotional vulnerability. People may have a personality trait, where they have an emotional response to issues that may be difficult for them, but a personality disorder as such is a significant level of disability related to that vulnerability which can actually interfere with their ability to maintain work, relationships and whatever. It is not appropriate to actually admit someone for a personality disorder per se because that is not usually a treatable situation. There may be particular facets of that which are very amenable to treatment. For example, someone with a personality disorder may have a substance abuse problem, may be depressed or may have a short-term crisis. It may be very important to actually focus the therapy on those particular issues to enable them to reduce the level of their disability. I suspect the Mental Health Act is therefore quite sensible to say that it should be used in a discriminatory way to address the treatable issues of personality as such, rather than just bringing someone in because they are disabled emotionally.

Senator HUMPHRIES—Others would argue, and have argued, that the range of problems as they manifest themselves in a person with an emotional vulnerability, as you put it, are quite serious. They can include suicidal tendencies and tendencies to want to be very damaging to their own personal interests or the interests of people around them. Although these conditions may not be treatable in the sense of some sort of recognised CBT type arrangement or chemical treatment, nonetheless the need for some kind of care for people with these conditions is very real and they ought to be caught by the mental health system, at least in order to provide them with care and protection until an episode of vulnerability is over.

Dr Parker—I cannot answer that in terms of legislation. I would suggest that there is an argument for that. But part of the problem with this emotional vulnerability is that quite often

people do not feel empowered to actually develop their lives. Bringing people into hospital for a long period really does not do anything for their situation. It may be more appropriate, for example, to appoint a short-term adult guardian to look after their interests in the community.

Senator HUMPHRIES—Or to be in a community based service of some kind that provides care out in the community?

Dr Parker—Yes. Admitting someone to hospital can quite often be counterproductive. Long hospitalisation actually takes away what elements of control a person does have in terms of self-esteem and the ability to develop issues. It can actually be made more disabling for them. So I quite agree. I am very sensitive to the issues of people with personality disorders and certainly I think it is very appropriate to develop some treatments for them. But bringing them into a protective environment for a long period I think would actually in many cases be counterproductive.

Mr Griew—One of the reasons this debate comes up is that there has been an alternative point of view which has been reluctant to let the definition of mental illness be too wide lest too many people get caught inappropriately into mental health services, particularly inpatient mental health services. Without making any comment on particular services here, the history of mental health services is not entirely without fault in terms of capturing people who should not be caught into mental health services. So, in part, the narrow definition has a positive side as well as having a danger in it. I think that is part of what Dr Parker is saying.

Senator HUMPHRIES—Do you think there is no difference between the definition that the Northern Territory uses for mental illness and those of other states? We have been told otherwise.

Dr Parker—I am unaware of the definitions of mental illness in other mental health acts. I cannot give an informed answer on that. I suppose the issue, though, is to look at the level of disability with mental illness. When I treat mental illness, the key issue is the disability. An example is schizophrenia. We have a number of patients who are severely disabled with the illness and who for various reasons have to spend long periods of time in inpatient services. It may be because they have substance abuse issues or personality issues or brain issues and they just cannot organise their lives appropriately. On the other hand, I have young people working in full-time occupations and going to university who have schizophrenia. They are on clozapine. It is a real pleasure for me to reorganise appointments to fit in with their work schedules. These people have basically full-time normal lives with the illness of schizophrenia and they are very productive members of the community.

The issue with the inpatient unit actually relates to the disability. You can have a mental illness, but there are people who are less disabled and people who are more disabled. The focus is therefore on looking at the disability as a result of the mental illness and what you can do to reduce that disability. That should be the focus of inpatient treatment. So, rather than defining a particular illness as a process of exclusion, it is probably more about looking at the level of disability related to illness and the ways that you can get that treated so as to get people back into some level of functioning.

Mr Griew—I will ask Ms Hendry to add something on the specific question of whether we are different in our definitions.

Ms Hendry—We based our legislation—it was developed relatively recently, in 1982, and is currently under review—on the model mental health legislation. In the review process that is happening, we asked all stakeholders and widely disseminated a discussion paper about the issue of whether we should change the definition of ‘mental illness’. There certainly were not any people who at that time suggested that we should. I am very happy to revisit that. We have not drafted the amendments and they have not been put before cabinet or the Legislative Assembly yet.

I would suggest that there is perhaps a little bit of confusion about where this definition is applied. The definition is generally applied for people who are considered to be appropriate for involuntary treatment in the inpatient unit. Somebody who has a personality disorder without an associated acute problem—that is, they have an ongoing issue without an exacerbation of their suicidal ideation, depression or other comorbid problems—would not be considered an appropriate person to place on an involuntary order in an inpatient unit. However, we certainly do not exclude people from our community mental health services.

What I would say is that we do not have the level of intense treatment for people with personality disorders such as Spectrum provides in Victoria because we do not have the funds nor the population nor the ability to recruit a whole specialist team for one particular disorder. That is one of the disadvantages we face through a whole range of services. When you only have a 200,000 population, then affording very subspecialty, very intensive and expensive services is quite difficult. So we have to come to some pragmatic arrangements about that.

Senator HUMPHRIES—Can I move on to some of the other criticisms, including the transport of mentally ill people in paddy wagons and police vehicles rather than ambulances. We are told it is inappropriate. It surely is?

Ms Hendry—That is a problem we experience. It is a problem for a variety of reasons. One of the amendments we will make to the mental health legislation is clarifying the powers of ambulance officers. Whilst it is relatively clear in the act, it has been interpreted by ambulance officers in a very narrow way. So they feel that they do not have powers that are actually outside of the vehicle. That is one of the problems we have. Plus we have a natural resistance by ambulance officers, as we do in other states, to transport mental health clients and particularly people who may be agitated or who they may feel present a risk to them.

Senator HUMPHRIES—I am sure the police are reluctant as well, though.

Ms Hendry—The police are reluctant. The other problem we do have is that, particularly outside the urban areas, there is often very few other choices. In a remote community that has one ambulance and that has a person on call who operates that ambulance, they will be very reluctant for that ambulance to leave that community to transport somebody with a mental health condition. So often in those circumstances—and you will find that in other remote areas of Australia as well, as I am sure you have heard—the police are really relied upon to do those transportations. I agree with you: we really need to improve the way we do both our air and our road transport of people with a mental health condition and we need to improve the support that

the specialist services provide to those agencies who do that transport. We will be endeavouring to do that.

Senator HUMPHRIES—The Mental Health Coalition has argued that there is too much emphasis on quitting grants—they are doing biannual reports on their expenditure but they should be annual. Is this a common complaint? Is it valid?

Ms Hendry—I was here this morning, so I will just explain that. They were really referring to predominantly Commonwealth grants. In the mental health program, we only have one grant that could be considered a pilot at the moment and that is the trial of the individual care packages outside of facilities. That is the first time in Australia that that has been done in that way. They are very happy to participate in this trial, but it is actually recurrent funding, so it is really more about altering the model than not providing ongoing funding.

Where we have a problem is with Australian government funding. We are quite often expected to refund something about which the Australian government has said, ‘Well, that’s three years and if it works then somebody else should pick it up.’ That is the situation we have faced many times, and many times we have picked it up. We have picked up the special projects for Aboriginal mental health workers and we have picked up the shortfall in the Tiwi Mental Health Program in the Top End Division—the general practice program you heard about this morning. Where we can pick it up and where it has been demonstrated to be effective, we do. But there is a problem with the way the Australian government chooses how to fund these projects, without adequate consultation and how they fit with the state mental health services, without adequate consideration about whether this program is deemed to be effective and how we will determine whether it is effective and then where the funding goes on from there. So it is a problem for us.

Mr Griew—I am sure all of that is a problem you have heard referred to before. It is about perennial issues that arise from funding pilots, especially when national funds come into pilots. It is possible that the group this morning you referred to was bringing up another perennial, which is that we do fund organisations and there are service agreements we attach to those and judgments have to be made about what the period of reporting will be. The general philosophy that we try to bring to that is that we will back off to longer term reporting when we feel secure that taxpayers’ funds are being used securely and that we have a system where we will know what is happening with the funding and what outcomes are being achieved. So we have tended to try to extend the periods, but that is not always possible. The philosophy is to leave third party providers—non-government organisations—the maximum room to determine how they do their business. But sometimes we get more interventionist than that and have to be cautious.

Ms Hendry—Certainly in mental health we do not have any programs currently running, apart from the one I outlined, that non-government organisations would not feel comfortable had recurrent funding attached to them. There may be renegotiations about exactly how that is delivered or what the target group is or whatever. There was a misunderstanding with the coalition in terms of their recurrent funding. We have actually increased their funding this year, and that is a one-year funding agreement, which is very short for us in mental health. However, it is very new and it gives the coalition an opportunity to decide how they want to take that forward. They are very happy with that arrangement. I think there was just a little misunderstanding over that.

Senator MOORE—You always have the issue of how community groups interface with government departments and also with the government. What is the program within your department and your subsection in particular with mental health as to how those voices heard and involved in decision making? I think that is a key issue. As I ask that question, I should just mention that there was evidence given this morning that some people have the view that their voices have become less heard. They gave a particular incident as an example. You were there when that was said. Could you just spell out how the people involved in this area are involved in the development of policy and also how you make sure that their views are heard so you do not find out about what is happening through submissions to Senate inquiries?

Mr Griew—At a high level there are two—

Senator MOORE—If you could go down through the levels.

Mr Griew—There are three ministerial advisory councils that cover the portfolio: a health advisory council, a disability advisory council and a Family and Community Services advisory council. They cover broad areas.

Senator MOORE—Are they appointed?

Mr Griew—They are ministerially appointed. They report to ministers. We have two ministers in our portfolio. Each of them receives direct input from those groups. I can assure you that they feel very free to express their views in full. They tend to operate at a level of policy and strategy, but they will also bring up particular issues. As well as that, three years ago we moved from a structure that had a service development division, which looked after contractual relationships in particular, to a more streamlined service structure. One of the things we were aware of when we made that change was that in moving from having a service development division we would have less of a focal point in the department for all non-government service providers to engage with.

Over the last three years we have had a number of approaches to how we will engage with the non-government sector. Within our central policy area we now have a unit which is responsible for community engagement. They have a specific focus on regions—so they have a Central Australia coordinator and a Top End coordinator—and on non-government liaison. That is an admission, I suppose, by the senior management of the department that this is something we constantly need to work on. Many of our service providers, especially in small communities like this, will interface with many of the programs. Congress, who have come up several times this morning, would be an example of a service that engages with us in health and welfare, and there are many others as well. Having a place they can go to to talk about the relationship in general is very important. So that is how the department works—plus the fact that, being a small jurisdiction, we all see each other too, so there is the ‘going down the shops’ kind of phenomenon as well. But Ms Hendry can talk about how in mental health there are also some specific structures.

Ms Hendry—As Mr Griew was stating, there is the NT Community Advisory Group, which is the ministerially appointed mental health group. That was one of the first established in Australia. There is a new carer and consumer participation framework that is in draft form that will go out for consultation very shortly. It is being developed and will be adopted statewide.

Where there was some criticism this morning was really about the service level in the practicalities of delivering services and some changes that had been made. The changes that were actually made to Cowdy ward, which was what was specifically referred to, were made for very urgent safety reasons. We had some incidents where people had left without medical authority and either there had been a significant adverse event or there was significant community concern. We had about five exits. Nobody had a clue if somebody had run off in an upset state, you did not have a clue which direction even to go looking for them.

We had an internal risk management review as well as an external one and made a decision that we needed to close all the entry-exit points except for one. That was made without consultation with consumers and carers. Unfortunately, it was a decision that really had to be made on safety grounds and our duty of care and the service we were providing. That has just been completed. It took quite a long time by the time we did plans and the building works and what not.

As to further modifications about how that will actually function and the famous goldfish bowl that they were referring to this morning, they certainly will be adequately consulted. That will commence from now. There is an in-patient task force set up to do that—to address a whole range of clinical practice and safety issues in the in-patient unit. There was a bit of a hiatus when there was a restructure of the Top End Mental Health Service in the consumer and carer input, and the committee structure and the management structure changed quite significantly. I think that has been a bit of a change for everyone but, as Kirsty from TEAM Health was saying this morning, that is actually getting back on track now.

As for my relationship with all the non-government service providers, I see them really regularly. I make sure that I am always accessible and that they can always get an appointment within the week or, if it is more urgent, certainly nearer than that. I think we have actually developed a very good relationship with the non-government sector and are very happy to negotiate reporting requirements beyond the absolute bare minimums that are required across the department and to negotiate service agreements and how services are delivered. I think it is a really positive thing that will continue to grow.

Senator MOORE—Did the media cover those five incidents at the hospital?

Ms Hendry—The media covers every incident in the Northern Territory.

Senator MOORE—I thought they might. But were all of those significant issues public?

Ms Hendry—Yes.

Senator MOORE—Is it possible and probable that issues to do with mental health could be discussed at all of those groups?

Mr Griew—Absolutely. The three that are referred to are kind of whole of portfolio.

Senator MOORE—Then they go to the specialists one?

Mr Griew—But mental health issues will come up at all of them, absolutely.

Senator TROETH—A couple of my questions have been answered. I do take the cautionary note in your submission that we should treat suicide statistics with care in relation to the rest of the national population, but obviously there is a massive increase in the rate of suicide in the Northern Territory among Indigenous people. What was your view on the reason for that?

Ms Hendry—If I could make an initial comment and then Dr Parker, who has been very involved in research in this area, can probably give you some more information. Suicide is generally considered, both in the Territory and everywhere else, to be not specifically a problem with mental illness, although that may be one of the contributing factors. There is a whole range of other factors that are really socioeconomic—employment, family conflict, substance misuse—that contribute to suicide. I think in the Territory it is unfortunate that that range of issues is very prevalent in the Indigenous community. I do not know that that adequately explains the marked increase over the last number of years. It certainly explains the present situation and the situation over the last few years. Rob might be able to give a more intelligent response as to why suicide in the Territory amongst our Indigenous population was very low about 10 years ago.

I do know from discussions with communities, though—and Aboriginal communities themselves have suggested this—that we need to take measures that give a strong message to people that suicide and suicide attempts, because they are very prevalent as well, are unacceptable. It has come to the point, I think, where communities—not only Indigenous communities but all communities—have developed a level of tolerance and acceptance of suicide that was not present 10 or more years ago. I think communities now have recognised that there need to be some negative sanctions as well as supports for people engaging in this type of behaviour. The Tiwi community, for instance, has developed a system where somebody who attempts suicide—and usually it is when those people are intoxicated in those instances—will be barred from the club for six months. So that is a negative community sanction. We obviously do not want punishment for people, and we do need support, and they do provide a lot of support for people who are depressed and/or suicidal. But quite often we also need to send a message that this is not the way to deal with problems.

Dr Parker—I would like to add a couple of important things. Firstly, with suicide in the Territory—and this may be reflected in national suicide figures—part of our problem is mental health literacy. I did a study of suicide in the Northern Territory, which was published a number of years ago. Over the eight years of the study, 60 per cent of people that committed suicide in the Top End of the Territory had apparently had no contact with a health professional prior to actually committing suicide. That seems to have continued in the current coroner's data. So I feel education is an important issue. Probably one of the most valuable people with respect to suicide prevention in the Territory at the moment is Maria Marriner, who is a teacher. She has been going out doing the MindMatters program in schools, to improve literacy. In the long term, I think that is probably going to be a really important program.

Suicide in Indigenous communities is a very complex issue. I suspect it relates to a generational effect. I suspect it is in some way similar to what happened in the north-west of Western Australia, where there was the introduction of substance abuse and a generation of kids who were raised in that environment are as adults now using substances and committing suicide. Also there is the widespread use of marijuana. I think that has significant mental health effects in respect of depression and psychosis and that may be a contributing factor. I know that certainly

there is that criminality element that is probably related to a number of suicides. I am aware of two suicides in Tiwi where people felt they were under threat of retribution. They owed money to gangs in the community or they thought there were going to be sanctions put upon them and they committed suicide out of fear of those sanctions.

The other factor is the actual meaning of suicide in small communities. One of the things I was aware of in my study was that a suicide in an urban centre is a very unfortunate event and has a particular meaning for the family and friends of the deceased, but it is a very anonymous event. In an Aboriginal community a suicide is a very public event and has a specific psychological meaning for the rest of the community. So when you have a disadvantaged community already, where people have got low self-esteem and substance abuse and lack of emotional resilience, it can then lead to further suicide. But the work that Bronwyn said they are doing involves actually trying to restructure cognition about suicide. I think that is one of the really valuable things that the Tiwi mental health people have been doing—trying to educate people about how to talk to each other and how to deal with stress, teaching them that suicide is no longer an option, that if you have a problem with your wife you actually go and talk to someone about it. As I say, I think Tiwi is almost leading the nation with some of the programs they have been doing.

Mr Griew—There is another program in the Tiwi islands focusing on young people. I do not know whether you have been informed about it. It is being run largely by a researcher at the Charles Darwin University working, through the school, with kids who are exhibiting out-of-control and self-harming tendencies. That is also really impressive. So, while on the one hand the story here is one of, as I put it, different textures and patterns and some reason for real concern, on the other hand there is also a level of innovation in the responses that you will see not just from within the health service but also from educators and from community members. As someone who has worked most of his career in the south of the country, I find that quite inspiring both for its interdisciplinary nature and for its level of innovation.

When I spoke before about the question of quantum, of how much we need, Rob was quite correct to add to what I was saying that the logic of our thinking here leads into a community development approach and working across government and with communities to try and interrupt the reproduction between generations of some of these patterns. So our emphasis on kids in the policy settings of the department and our emphasis on naming and tackling pretty firmly issues around substance abuse and the kind of work that Bronwyn and Rob have just been talking about of being prepared to go into communities and name issues around violence and so on are part of saying that we cannot just step back and deal with it in clinical health service terms but that we need to intervene in community terms as well.

I have been given two tables for the committee. These are the two documents I referred to earlier. One is called *Building healthier communities*, which is a five-year framework for health and community services generally and has focus areas on children, youth, families, Aboriginal health and substance abuse. So it has taken the kind of approach that we have been talking about. The other is a five-year framework focusing on Aboriginal health and families which, again, takes a life-course approach, which is essentially what we have been talking about. I am afraid they have come from somebody's personal store in their desk, so they are a bit 'used', but we commend them to you nonetheless. It shows that they do not just sit on the shelf.

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

Senator MOORE—Which five years?

Mr Griew—They were launched at the beginning of 2004, so they are for 2004 to 2009.

Senator WEBBER—While we are still on the cheery topic of suicide, it is still an issue in the north-west of Western Australia, but what has been marked there is the number of very young Indigenous people. In the Kimberley there has been a child aged eight or 10 who has committed suicide. Is there the same age profile in your Indigenous communities or are the early intervention programs that Mr Griew was talking about before starting to show some benefit?

Dr Parker—I could comment on the study I did, which was from 1991 to 1998. There was one 10-year-old child that committed suicide in a group of 180. It was a very unfortunate event. I am not sure of recent data with respect to young people. I am not aware of young people in the Territory committing suicide. There has been a phenomenon where young children have been strangling themselves in what may be almost an auto-erotic phenomenon, and some school based intervention is being tried on that. But it appears to be more of a thrill based intention rather than a suicidal intent as such.

Senator WEBBER—We have quite a serious problem with young people, which came out in the Gordon inquiry. Senator Humphries was talking before about the role of the police. They have a significant role in Western Australia too because our ambulance services outside most large centres is actually staffed by volunteers. I want to ask about the role of the air ambulance. Is your air ambulance service happy to accept transporting people with a mental illness? Ours is provided by the Royal Flying Doctor Service and we find that it is a significant issue to get them to accept someone from up north and to bring them down to Perth if they are in an agitated state.

Dr Parker—There are particular protocols here. We have an aeromedical retrieval service because a lot of our patients are rurally based. The health department runs an aeromedical retrieval service to bring anyone with an illness in to Darwin or—

Senator WEBBER—So you run your own service?

Dr Parker—In the Top End. I think Alice Springs is the Royal Flying Doctor Service.

Senator WEBBER—Therefore you have the protocols—

Dr Parker—If someone is actually agitated, what happens is that usually a doctor and nurse go out. People are usually placed on a gurney with a net for safety in transport, but there is no problem in actually bringing agitated people in.

Senator WEBBER—That is what the RFDS has offered can happen in the north-west of Western Australia in bringing them to Perth, but they still did not feel comfortable flying them down, which distressed me because it meant that that one person then had to spend three days in a police car.

Dr Parker—I suspect the issue with that is related to cultural continuity. We occasionally get rung up by someone from Kununurra saying, ‘This person’s psychotic. Will you accept them?’ While there may be significant cultural and family issues, given that the person has family in the Northern Territory, unfortunately the state mental health act stops at about Kununurra, so due to particular issues to do with the state mental health act they have to be actually taken to Perth, which is six hours away. The lack of continuity across borders of state mental health acts is another significant issue for us with the Pit lands, for example. I think there has been a recent agreement in respect of mental health acts and the Pit lands, but there is a significant problem if you have got someone who is acutely disturbed a kilometre over on the South Australian border and there is the question of applicability of looking after them in the Northern Territory.

Senator WEBBER—Whilst you give us a good chronology in your submission as to the increased funding and attention to services, obviously from the evidence we had earlier today the last 12 months have been particularly dynamic in the Territory in terms of mental health. I am wondering if any particular program or work that you do is addressing people with comorbidity. Victoria have trialled some dual diagnosis stuff. I was interested to hear what you were saying before about the role that Ms Rhodes has. She seems to encapsulate it a bit more. In other places there are silos of care and people bounce between them.

Ms Hendry—We have had some significant projects.

Ms Rhodes—The four programs fall under my responsibility. We have more than just the alcohol and other drugs program. We have family, youth and children’s services, and mental health as well as age and disability. In terms of directors working closely with other directors—because each of the areas has a director—the mental health director and the alcohol and other drugs director have already initiated some trial screening tools in the last 12 months and also some joint training. Staff actually commence with some of that training. To a degree, we also care for some of the children, under the guardianship of the minister, who require mental health intervention. That falls under our family and children’s services category. So the funding does not necessarily come only from the mental health program. Adults who have a disability as well as a mental health condition are cared for under the disability program as well. Recently the Volatile Substance Abuse Prevention Act came in. As a result of that, \$2 million from the alcohol and other drugs program have been channelled into providing treatment and rehabilitation services for people who are also affected. Some of them have a morbidity condition as well.

Senator SCULLION—I actually have a number of questions, but in the interests of time, if you do not mind, I will probably put those on notice and give you some time to consider them at your leisure. I do have one issue to put to you. We have pretty much discussed it and I want to get some closure of it. I am transparently asking the question in regard to the original congress question, as I am trying to get my head around the number of Indigenous people in Central Australia who access the congress out of habit and out of a feeling of very great comfort for the level of amenity that it provides. Could you explain to me roughly what demographic Indigenous people that access the Central Australian Mental Health Service represent? Do you think that demographic could be accommodated by perhaps shifting some of the funds that you would have received across to the congress rather than having that very confrontational situation of less from the Commonwealth and it being given directly to them? I know that terrifies all jurisdictions and I respect some of the deeper reasons why. So, in a more pragmatic sense, could you see some

sort of adjustment of that outside of some major changes to the health agreement actually occurring?

Mr Griew—I guess the question is about the profile of the two services as much as it is about the clients.

Senator SCULLION—And whether it is a matter of saying, ‘We’ll provide some extra assistance over here but we’re not taking that demographic here now; we reckon that they can best be handled there and we’ll provide further funding for that.’ I have no understanding about the Central Australian Mental Health Service and what level of amenity it provides.

Ms Hendry—I can take it on notice and provide a further breakdown for you.

Senator SCULLION—Yes, you can take that on notice.

Ms Hendry—I can tell you that Aboriginal people are over-represented in our community mental health sector. So the comments this morning about them not accessing services are not reflected in the statistics. They are accessing services at a much greater level than their level of population, which is 28 per cent.

Senator SCULLION—What I realised from this morning’s evidence was that if the congress had a greater capacity, particularly in the emotional and social wellbeing aspect, they could better cater for a lot of the people who are presenting, particularly in the primary triaging process, because they have 8,000 people going through.

Mr Griew—That is probably right, to some extent. The problem with that approach is that it will not sufficiently remove the pressure on the more acute specialist services.

Senator SCULLION—Your point is that the funding you are talking about, under the care agreement, is for specific services that you think, with respect, are beyond the ken of congress, having regard to the nature of the presentation.

Mr Griew—Yes. We are looking after people with a level of acute illness that will be hard to manage in anybody’s primary care setting—ours or someone else’s. Having said that, one of the structural problems in mental health in the Territory, in both Alice Springs and Darwin—it is quite obvious with those in-patient units—is that the in-patient units are congested, in part because we are still developing good community based services. Services like those of congress, our own primary care services or those provided by those GPs who do operate in this area are very important in that regard. So you are right: we need to take confrontation out of this and work together, because congress is an important part of this, as are a number of GPs who play a role in this area—it is just that we have fewer of them than we need for the population. We all feel the pressure.

The answer, unfortunately, is not to take funding out of the acute specialist service and put them into primary care. We need to build up the community care, and that will take some of the pressure off the acute services. The acute services, if you have the opportunity to see them, are really under a lot of pressure in both Central Australia and the Top End. There is no spare

capacity there. Down the track we might remove some of the excess pressure on them, but they have no—

Senator SCULLION—Going on from that, there is a specific demographic that you have identified in your submission—that is, people with mental health issues that are over-represented in our prison system. The judicial system has recognised that there is a mental health issue associated with that. You have also recognised that there is no real capacity within the prison system to deal with a forensic, post-judicial environment. Could you briefly tell me what you are doing about that. You have recognised in your submission that that is an issue. How are you going about dealing with that?

Mr Griew—We have a forensic mental health service. We also have capacity within our disability services. There is legislation in the jurisdiction that covers people who commit offences who are unfit to plead through reasons of intellectual disability, mental illness or for other reasons. Those people are managed either in prison, if that is necessary from a community safety point of view—this is putting it slightly crudely—or in the community. Our forensic mental health services provide services to those people in prison and to other prisoners with mental health needs and also to support those people when the Supreme Court judges that they can be appropriately managed in the community. That cannot happen until I sign various statutory instruments after detailed professional assessment. In the current year we have had the beginning of a three-year program to increase the resources for the forensic mental health team—this year by \$350,000; next year by \$500,000 and in the following year by \$700,000.

Senator SCULLION—Do you think that will include any provision for the separation of those patients from the mainstream inmates, which seems to be one of the critical tensions? They are in prison with mainstream prisoners, and a lot of those tensions exist. In a lot of places there is a capacity to separately house those individuals. Will that be catered to in those ongoing plans?

Mr Griew—There are two issues there. With extra professional staff visiting, one of the things they will be doing is training corrections staff. One of the things we have observed works well with those clients is having a continuity of corrections staff whom they get to know and who are trained by our staff. That has often proved to be very therapeutic for the inmate. There is a bit of a live question in discussion between us and corrections about whether and to what extent those particular prisoners need to be separated from the general population. Not in all cases is that the right answer, but in some cases it is. At the moment, it is on a bit of a case by case basis.

CHAIR—I would like to touch on a couple of issues that we have not broached today. One is about adolescents. One of the witnesses earlier this morning said that adolescents and children are not seen to be taken seriously—for instance, there is no follow-up, there is only intervention when suicide is threatened, they frequently get turned away, there are no facilities for them, they are referred elsewhere and people give up and do not bother trying to seek services after a period of time. Why is there no facility in the Northern Territory for children and adolescents?

Mr Griew—We have increased services, and that is one of the things we have referred to with the greater specialist staffing, in the child, youth and adolescent team.

CHAIR—That is over the last few months.

Mr Griew—I might ask Ms Hendry to give you some advice. The underlying question about why no specialist facility exists is that, in a small population in a rural area, as we essentially are, there is a critical mass issue about providing viable services. We instead have to put an emphasis on providing appropriate services, whether cultural, age or gender related or related to particular vulnerabilities, to people within mainstream services, which can involve the dedication of special staff, for example.

CHAIR—What would be the critical mass in terms of your population, and given the distribution of the population, for you to establish a child and even family unit within an in-patient facility?

Ms Hendry—At the moment, we have under-18 admissions at the rate of between one and two per week across the Territory.

CHAIR—This is into adult services, is it?

Mr Griew—Into in-patient services.

Ms Hendry—Yes.

Mr Griew—There is a bit of a misunderstanding.

Ms Hendry—They are predominantly adult.

Mr Griew—They are not legislatively adult, which is one of the misunderstandings in some of the material that has been presented to you. Of course any child or youth in those services needs special attention because they are primarily around adults, which is the issue. But there is no legislative prescription that they are adult.

CHAIR—No, I was not suggesting they are.

Mr Griew—It has been said this morning.

Ms Hendry—Yes, this morning somebody mentioned that. Those people are specialised on a one to one basis. Obviously one or two admissions per week does not constitute what you would need for staffing and establishing a facility.

CHAIR—These are under-18-year-olds down to what age?

Ms Hendry—Probably the lowest age would be 12. It is very unusual to get anybody younger than that. Occasionally, for a few hours or overnight, you might find somebody placed in a secure setting while some other arrangements are put in place. But we have a very short length of stay for anybody up to the age of 18; the average is about five days. We have very low admissions of people of a young age, because they get admitted to paediatric wards or local general hospitals with specialist child in-reach and adolescent in-reach from us. So we do not think it is appropriate to have those really young children in a specialist facility anyway; they

should be in a paediatric ward unless they need a level of care that they just cannot be contained in those wards.

We are having discussions with other departments like Family and Children's Services to try to develop some innovative models that can provide intensive support for children and adolescents with high needs but in an appropriate environment and in such a way that we can have a critical mass whereby we can develop an appropriate service. Where that would occur is still under discussion. But there are certainly plans to address that very high needs group—who are often common clients of ours and Family and Children's Services—in a different way from the way we are doing it now.

The anecdotes that you heard this morning are ones that probably were more prevalent prior to us expanding our child and adolescent community services, which we are expanding again this year as well. Whilst it is still not a big service, it is still a growing service and there will always be some unmet need in that area for many years to come. We certainly are improving in that way.

CHAIR—Is the chief psychiatrist or the principal psychiatrist the body who receives complaints? What is their purpose?

Ms Hendry—No, we do not have a separate—

Mr Griew—It is the Health Care Complaints Commissioner.

CHAIR—The chief psychiatrist in other states takes complaints, but he or she does not here?

Mr Griew—Only to the extent to which complaints happen within the service and are managed within this area.

Ms Hendry—But there is no separate office like in Western Australia, for instance, where they have a Chief Psychiatrist and a Director of Mental Health.

CHAIR—Going back to suicide for a moment, Dr Parker, can you let the committee know—maybe it is sending us a copy of your paper; I do know—the extent to which mandatory sentencing has been a factor in high suicide rates. Has the level of incarceration in the Territory reduced in recent times?

Dr Parker—Mandatory sentencing is no longer government policy. In fact, with the very unfortunate suicide of that young man a number of years ago, mandatory sentencing stopped.

CHAIR—Are there any prisoners in the system who were imprisoned two or three years ago—whenever it was policy—who remain there?

Dr Parker—No. Mandatory sentencing was stopped when the Labor government was elected here.

CHAIR—I realise that.

Dr Parker—People who were sentenced on a mandatory basis were usually sentenced for a fairly short period for fairly innocuous things. Part of the problem was that, for something that was fairly innocuous, such as throwing water onto a cash register, usually you would get locked up for only a week or up to a month. The government was then given quite a large amount of money from the Commonwealth, following the suicide of the young man in Don Dale, to develop diversionary programs in communities. The police, until recently, have been administering this in a very successful fashion. I think, unfortunately, that money has started to dry up. The money was also used for interpreter services. Be that as it may, the Territory does have a very high incarceration rate—I think we have almost double the number of prisons that Tasmania has at the moment, with pretty much half the population—so it has a very high rate of prisoners and a significant proportion of those would be Indigenous.

CHAIR—Incarceration rates have to be a factor in both mental illness and mental health and in subsequent suicide, surely?

Dr Parker—When you look at justice issues, my view is that the vulnerability to suicide is analogous to a number of branches on the same tree. Quite often, you have emotional deprivation and issues such as low self-esteem, substance abuse, mental illness and the likelihood of getting into prison are all various branches from that trunk. They are all vulnerability factors for the suicide.

Mr Griew—It can be hard to distinguish cause and effect here. There can be common causes—

CHAIR—What we do know is that prisons are not very good places for either rehabilitation or protection from mental illness, are they?

Dr Parker—That is correct.

CHAIR—I think the Legal Aid Commission said earlier that there were no diversion programs, but you say that there are? How would they get that wrong? They are the legal service.

Dr Parker—There used to be programs. Again, this is getting slightly outside my area, but there was a police superintendent who was actually directed to run the diversionary programs, and these were funded by the Commonwealth. I understand that the funding has recently started to dry up, so what was an effective diversionary program until a number of years ago may have stopped because of the lack of Commonwealth funding.

CHAIR—So when do you expect the diversionary programs to start to cut down the very high rates of incarceration?

Mr Griew—They may be reducing what might otherwise be a higher rate as well. The diversionary programs have worked reasonably well.

CHAIR—We really must go to the airport. Thank you very for your patience in waiting for us to come to you. Thanks for your submission. I think we have managed to put a couple of

questions on notice to you so if you can respond to those that would be good. We will send you the *Hansard* and a list of what we would like you to give us.

Committee adjourned at 3.10 pm