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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH
Thursday, 1 September 2005

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 9.08 am**SCOTT, Ms Michelle, Public Advocate, Office of the Public Advocate**

CHAIR (Senator Allison)—I welcome everybody to this 12th 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 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.

I welcome the Western Australian Public Advocate. The committee has your submission, which it has numbered 352. Are there any alterations or additions to that document at this stage?

Ms Scott—Not any alterations or additions but I would like to comment on some of the matters.

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

Ms Scott—I thought I would explain a little about my role and my involvement with people with mental illness. The Public Advocate is an independent statutory office holder established by government to protect and promote the rights of adults with a decision-making disability. That can be a mental illness, dementia, an acquired brain injury or an intellectual disability. My functions are primarily set out in section 97 of the Guardianship and Administration Act. They involve a number of critical issues. I conduct investigations to determine whether a guardian or an administrator might need to be appointed for a person with a decision-making disability. I can be appointed someone's guardian if the state administrative tribunal in WA determines that no-one else is suitable or willing to be appointed. I have a responsibility to conduct community education around guardianship and administration matters. I also have a role in working with business, the community and government in developing and promoting policies and programs that will protect and promote the rights of people with a decision-making disability.

Last year, I investigated about 679 matters. Approximately 14 per cent of the people I conducted investigations in relation to had a mental illness. If I include dementia in that, another 47 per cent of all the investigations involved a person with dementia. I am currently guardian for just over 200 Western Australians. About 14 per cent of those individuals have a mental illness and about 31 per cent of the new appointments to me as guardian in the last financial year involved a person with dementia. If we combine dementia with mental illness, it is a significant proportion of the workload.

By way of general comments, I suppose what I would like to say is that mental illness and issues surrounding mental illness are both complex and simple at the same time. There are significant issues for people with mental illness. From my perspective, it is not just a matter of what governments can do at the Commonwealth and state levels; it is also a community issue. It

involves community ownership and leadership at the community level. To summarise what I think the objectives of any mental health reform should be: (1), that we aim to create a more informed, supportive community around mental health issues; and, (2), that we have a substantial, integrated and comprehensive range of services for people who are affected by mental illness.

I want to draw the committee's attention to an article that appeared in the *West Australian* on 16 March this year. Some of you may have already seen this. It was a front-page article with the headline 'Naked walker is prime double murder suspect'. Like a number of organisations and individuals, I wrote to the *West Australian* expressing my concern about that article. The article relates to a tragic situation in country Western Australia where a mother and her child were killed. Among other things the article named a suspect—this was an adult son of the woman who was killed—and said that this person has a history of mental illness and was found by police wandering naked and incoherent in the busy street close to the family home and next to a school about lunchtime on Monday.

My purpose in raising this is to bring to the committee's attention the stigma that confronts someone who might experience a mental illness. Mental illness is something that affects us all. All of us have friends, colleagues and family members. With one in five in the population affected by mental illness, it is not something that occurs to other people; it is something that occurs to friends, colleagues, family members who we all have. I think the recent events in New South Wales with the former leader of the Liberal Party heighten that awareness. It happens to politicians and senior public servants. That is why I think it is a community responsibility. It is something which we all have a responsibility to do something about—institutions, organisations such as newspapers and business leaders. It was pleasing to hear Jeff Kennett speaking so strongly in the last few days on this issue. That was my first point. The other point relates to the need for a comprehensive range of services for people with mental illness. The current Western Australian Minister for Health, the Hon. Jim McGinty, said in August 2004 that there had been decades of neglect in funding for mental health services by successive governments. I think until the community sees this as an important priority, it will be hard for governments to see it as an important priority.

By way of concluding, because I know you want to ask me some questions, I thought I would reflect on some important developments at the state level. I see these as encouraging signs. Firstly, state government has allocated an additional \$173 million over the next three years. In August 2004 when the Minister for Health announced that additional funding, he indicated that the funding of mental health was a priority issue for the current government. I see that as encouraging. Secondly, two weeks ago the Attorney-General announced that he will develop a blueprint for the provision of mental health services for people in prison together with the Western Australian Minister for Justice. I think that is long overdue and I am pleased with that development.

There are two other developments in WA. You have probably already seen in some of the submissions from my colleagues that there is a real issue about people with complex needs across a range of government departments. For example, a person may have a mental illness but they also might have an acquired brain injury and they also might have an intellectual disability. The capacity for government agencies to work together is considerable. I developed a proposal, which went to the director-generals in WA, and they have established a mechanism now to look

at an improved case management system across government in relation to people with very complex needs.

The other and final development is in relation to people who are detained under the Criminal Law (Mentally Impaired Accused) Act in Western Australia. There are a very small group of those people who are found unfit to stand trial because of their capacity. It could be mental illness, it could be intellectual disability or a number of decision-making disabilities. They are a very small group of people, but a number of them are detained in prison because there is nowhere else for them to go in the community. They have been found unfit to stand trial, they do not have the capacity to stand trial and they are being detained in prison. Once again, at the director-generals group, a working party has now been established at that level to come up with a service model for that group of people. Those are the four things that I wanted to identify as positive developments.

CHAIR—Thank you. The committee was in Port Hedland yesterday. You do not identify any particular issues for remote areas but, nonetheless, do you represent those in the furthest reaches of the state?

Ms Scott—Yes.

CHAIR—What is your impression of the needs in those areas? Are they greater than in metropolitan areas?

Ms Scott—I would not be able to comment on the extent of it. What I can say is that I think there are real needs in regional and remote areas, particularly in relation to Aboriginal people. Something I have given a priority to in terms of my own work is establishing greater networks with Aboriginal communities around a range of issues. If I could give you one example, I have just undertaken some research in relation to elder abuse in Aboriginal communities. The reason I am raising that in this context is that Curtin University here in WA has done some research which has identified 75 per cent of those who reported abuse to the Curtin University study had a decision-making disability, most likely dementia. That is quite significant. Three-quarters of people who reported elder abuse had some form of decision-making disability, mental illness or dementia.

My experience with that project as we consulted throughout the state in remote and regional communities was that Aboriginal people themselves were talking about the lack of services for them. They were very concerned about the fragility of their communities to manage people who are in quite difficult circumstances. I referred earlier also to some people who were being held under the mentally impaired accused act. A significant proportion of the 30-odd people detained under this act are Aboriginal and they come from remote communities. One of the difficulties is how they can go back to their remote community with adequate community support, psychiatric support and community mental health support. So that is a real challenge, I think, in a geography like Western Australia.

CHAIR—We heard yesterday that the great distress is that some of these people are moved out of their communities and their families are not informed as to where they are going or what is likely to happen to them, and that the support is removed from those people once they are out of their community. Is that your experience as well?

Ms Scott—It is partly my experience. The other experience for me is that some Aboriginal communities are incredibly fragile and they need additional support and resources if they are to support that person in their own community. For example, I am guardian for a number of Aboriginal people and a lot of effort goes into trying to work with the individual family to support them back in their community. However, I think it is a significant challenge. It is not just about resources; it is about the fragility of the communities themselves.

Senator HUMPHRIES—You deal with intellectual disability as well as mental illness. It was put to me the other day by a person working in the area of intellectual disability in Canberra that there is actually a very large amount of mental illness among those with an intellectual disability but it is largely undiagnosed. Would you say that was true?

Ms Scott—I do not know if I could say there is a very large issue. There certainly is an issue. I think it is at the end where there are people with very challenging behaviours. I also think it goes to the question of: what is your primary diagnosis? This is the issue about how agencies serve a particular individual. You might be identified as mainly having an intellectual disability and the other aspect of mental illness goes unserved, if you like, and vice versa too. I think that there is a real need for agencies to work together to address that, rather than to gate keep and say, ‘This is only an intellectual disability and this is only mental illness.’ I think that that is really more the issue—how to ensure that you have a holistic approach with an individual.

Senator HUMPHRIES—I wanted to come to this question you raised about prisons and the number of mentally ill people in prisons. You have raised this issue, as have a great many other people who have made submissions to the committee. You talk about the need for alternative secure options that provide better for these people. There is a powerful body of evidence to suggest that we should do that.

But the devil’s advocate in me says it is likely that a secure facility for the mentally ill would end up looking not very different from a prison. It would have to be a secure facility and it would have to provide for a range of very problematic behaviours. There would be very difficult issues of management and that would lead to tensions that would make it a very unpleasant place to be. Obviously, the duration of a person’s stay there would often be quite long because people in that position would often have committed quite serious crimes and there would be a public expectation that they would not be released any time soon. Are we kidding ourselves to think that a secure facility for the forensically mentally ill would be an advance on the present situation?

Ms Scott—I would like to think it is an advance. A range of people with a mental illness are in prison and it is not always for serious offences; there are some very minor offences. People with a mental illness, like people with an intellectual disability, come to the attention of the police, and that contact repeats itself. I am guardian for a number of people who come into contact with the criminal justice system for very minor offences such as going down the railway line, being a public nuisance and for very minor assaults. The police arrest them for some minor difficulty. So it is not always for a serious offence. Some of the people are in prison, for which there is no alternative. So a full range of services needs to be provided. From a previous position I have held, I am also aware that in some situations a person with a mental illness, if treated, is not a future risk—and the risk is minimised. We have to look not just at the one model of a forensic facility. We already have a forensic facility here: the Frankland unit, which has a 30-bed

capacity, is located at Graylands. We are not talking about one facility; we are talking about a whole range of services. Some of my clients could be supported in the community if they had good services. They do not need to be in a forensic facility; they need a supported environment. The Aboriginal people I was talking about could live in their communities if there were adequate supports—if they had good medical supervision and those sorts of things.

Senator HUMPHRIES—For those with an identified mental illness who are sentenced to prison, would it not be better to build up the quality of mental health services in the existing prison system?

Ms Scott—Yes.

Senator HUMPHRIES—Even with the best will in the world, you may not separate the two classes of people, because their mental illness might wax and wane. So would that not be a better option?

Ms Scott—I do not know that it is a better option; I think it is part of the range of options. We need to improve mental health services in prisons for individuals who require it. Some of them can be managed in prisons, that is true. It is not a homogeneous group. You have to unpack the particular groups of individuals and design services around that. The problem is that, if we say they are all like that, we will fail in service provision. I keep reiterating the complex-needs approach. You are probably aware that the human services department in Victoria did extensive research. They identified 247 individuals who had very complex needs—an intellectual disability, a mental illness or some sort of disability—and found that 71 per cent of them were coming into contact with the justice system. Government is putting a lot of resources into those individuals. They end up in prison, they end up in an emergency department at a hospital or the police are constantly picking them up. Money is going into trying to manage those individuals, but the project found it was not effective. The thinking now is that you need to individually tailor services—you need to have more flexible, responsive services rather than treat everyone as part of a homogeneous group. I am alerting you to that as a way of saying that, as for prisoners with mental health problems, it will not be helpful and effective if we say: ‘They are all like this. We need a mental health facility or we can treat them all in prison.’ A range of things will need to be done, and I suspect that that will be more successful.

Senator HUMPHRIES—There is a problem you mentioned on the last page of your submission of voluntary patients effectively ending up being admitted without having consented to it. How does that come about?

Ms Scott—It is a small group of people, but it is a worrying group for me. Under the Mental Health Act, you can only be detained in an authorised hospital lawfully, in my view, if you are made involuntary under the act. I will give you a concrete example. There are a number of people who have an acquired brain injury and who are proving very challenging for people in the rehabilitation sector. As you probably know, people with acquired brain injury can have very challenging behaviours. In my view, some of those behaviours constitute a mental illness, because they have a disturbance of mood, thought or behaviour, and they are often treated with psychotropic medication to manage their behaviour. Due to the lack of services for those people, they end up going into a mental health facility in an authorised hospital. That person does not have the capacity to consent. In my view, they should be detained as an involuntary patient or

they should be in a specialist service that can provide for that, rather than being an involuntary patient.

There is a lack of these other services. Dementia is another good example where I do not think we have planned adequately for the ageing population. All of us have a direct interest in planning more effectively for that. So what we have seen—in the nineties, particularly—is a lack of specialist residential facilities for people with dementia who have very challenging behaviour. A number of those people are now in authorised hospitals. I think that most families are relieved that their family member is in a safe and secure place. However, it does not have to be an authorised mental health hospital. It could be a safe, secure residential facility in the aged care sector. When we do not plan well for an ageing population and for people with acquired brain injury, people end up in mental health facilities, where I do not believe it is appropriate for them to be. Does that clarify it?

Senator HUMPHRIES—Yes, it does.

CHAIR—Do those with acquired brain injury typically end up in aged care in Western Australia? It does happen in other states.

Ms Scott—They often do. In Western Australia we have a couple of specialist non-government, not-for-profit services that are being developed, but there is a huge need in Western Australia. The other thing that we have in Western Australia is the Disability Services Commission, which I mentioned in my submission. They have a particular funding option which is individually tailored. They also fund people who have acquired brain injury to live in the community with a range of support services. A not-for-profit group might manage them and have carers coming in and so forth to support them. But that group run under a lot of pressure too.

Senator MOORE—I was going to talk about the media, and I will get to that, but the last response you gave intrigued me, because another of the submissions talks about the division between the issue of disability services and the issue of mental health. That submission makes the claim that people with mental health issues are disadvantaged, because they do not have the option of taking up some of the services that are available under the disabilities process. Your office covers people who are caught up in all those areas. Could you comment on that? Your last comment tended to lead that way.

Ms Scott—I have said to mental health services consistently that it is a problem. If, as you were saying, you have an intellectual disability and a mental illness and you are successful in getting funding from the Disability Services Commission, it might not be enough. You might need additional funding. But mental health services do not have this individual funding option. They only run services. So there is a lack of integration. Service provision should be more seamless than that. That is why this complex needs project is important in looking at how we can start to develop services that respond more flexibly and develop more programmatic services that are more flexible.

The people with the complex needs project in Victoria have said to me on occasion that it is not that people are having complex needs; it is that the system is so complex—how do you access it? The public advocate often gets appointed because of those gaps—the lack of

integration and the lack of communication. That is why I am very pleased we have got this project up and running here in WA now.

Senator MOORE—I would like to have your comments on the role of the media, because you raised it in your opening statement. You talked about the role of your office in education across the community. One of our terms of reference is the issue of stigma. I have a view that the media has a huge role to play—but there are so many terms of reference. Could you give some comment, even to the extent of what happened when you wrote, in your capacity, to the major newspaper in the state raising your concerns about this issue? What happened then?

Ms Scott—I did write. Many, many people wrote. My letter was not published, and I suspect a number of other people's letters were not published either.

Senator MOORE—Did you get a response from the paper?

Ms Scott—No.

Senator WEBBER—It is the subject of a complaint to the Press Council though, isn't it?

Ms Scott—I am not sure.

Senator MOORE—In terms of your capacity, with your status as the independent government body, the newspaper did not bother to respond?

Ms Scott—It did not respond to me, no.

Senator MOORE—Just generally, for the record, do you have anything to add about the role of media in the area of mental illness and that kind of thing?

Ms Scott—It goes back to my opening comment. I think that all leaders in the community—institutions and organisations like the media, politicians and senior public servants like me—have a responsibility to try to educate the community in a positive way. It goes back to that issue of ownership and the fact that we are all affected. We all have someone in our lives. Everyone in here has someone that they know who is affected. It is not a 'them and us' situation. I think we should have a more sophisticated discussion than something like this, which is very stigmatising. They are very tragic circumstances for everybody affected—the direct family members and that small community. My concern is that it was gratuitous.

Senator MOORE—Is there any formal link in terms of education of journalists?

Ms Scott—I do not have statutory responsibility, but I take that opportunity any time I can.

Senator TROETH—I particularly wanted to ask you about accommodation options. Do you provide assistance? I am not implying that this is part of your role, but as the guardian of people who need assistance, does your office provide assistance in finding accommodation for those people?

Ms Scott—When I am appointed guardian for someone, I am appointed to make legal decisions in relation to the person. So I am a substitute decision maker. I do not actually provide any services. For example, if it was someone who had a mental illness, I would work very closely with the mental health services and ask them what options were available for this person, and then I would make a decision, as the guardian, as to which one I thought was in the person's best interest.

Senator TROETH—What happens in the extreme case that no accommodation is able to be found? What happens to that person?

Ms Scott—The experience in WA would take in a number of things. One is that people may stay in hospital longer if they are in an acute situation. I think there are some people who are having extended long stays in hospital because of the lack of suitable accommodation in the community.

One of the priorities that the government has announced with that \$173 million is some supported accommodation. There is basically a lack of step-down facilities and step-up facilities. To answer your question: we would find something. As I said in my submission, I am not saying that would necessarily be the ideal, but I would do everything to ensure that it was at some sort of appropriate level.

Senator TROETH—I guess that, apart from the people who are fortunate enough to be under your guardianship, there would be many others who simply have no support system and fend for themselves.

Ms Scott—I think that is true.

Senator TROETH—Obviously, with the state government providing money, that is a very welcome option. Do you have any views on the sort of accommodation that should be provided? You mentioned both step-up and step-down.

Ms Scott—From my vantage point and experience with the mental health sector over the years, even before my current position, what is really required is supported accommodation for people who have an ongoing mental illness and need ongoing support. They do not necessarily need to be in a hospital, but they need to be in some sort of supported, albeit congregate, care—so on a smaller scale than a hospital. In WA we have some quite good models in the disability sector, particularly for people with an intellectual disability. I think the mental health sector could learn a lot from them in terms of supported accommodation.

Senator WEBBER—In regard to the media, I was talking to Judyth Watson from the Council of Official Visitors and she tells me that the complaint about that article is being heard by the Press Council this week, I think—at the end of this week or next week. I think she has taken the complaint with someone from mental health.

Ms Scott—I did not know that.

Senator WEBBER—Hopefully that will go some way towards at least raising some awareness within the media as to the nasty outcomes of some of the things that they do.

Regarding services provided by disability versus mental illness and the people I have dealt with in Western Australia who suffer from both, there seems to be a lot of criticism about the lack of coordination of those two. People on this committee are probably tired of hearing me talk about having these silos of treatment and how we do not bring everyone together, so I am pleased to hear about the trial. That seems to be the most significant gap that I have heard of in WA. Is this trial particularly going to look at that?

Ms Scott—It is. It is a very significant development here in WA. It is the first time that the director-generals are saying that this is an issue, that this is something that needs attention. Senators are probably aware that there was a major inquiry in Western Australia in relation to Aboriginal children, the Gordon inquiry, which I think was important for Aboriginal children. One of the most significant findings was that there was a vulnerable group of young Aboriginal people who had had the intervention of a range of government agencies but that those agencies were not effective in supporting highly vulnerable people. I am saying that we have here another highly vulnerable group of people—adults with a decision-making disability. We need to ensure that the system is more responsive, more flexible and more integrated.

Senator WEBBER—One of the other issues that has been raised with me is the prevalence at the moment of people invoking the guardianship act as opposed to the Mental Health Act to get control over the lives of people who have a decision-making disability, because there is greater accountability with the Mental Health Act. Are you aware of those concerns?

Ms Scott—I am, and I share some of those concerns. I have had discussions with the chief psychiatrist and the director of mental health services. I have a view about the legislation—my legislation and the Mental Health Act—which is that, primarily, if someone has a mental illness and they meet the requirements under section 26 of the Mental Health Act to be an involuntary patient in an authorised hospital or to be treated under a community treatment order, then I think they should be treated under the Mental Health Act. Under the Mental Health Act, people have particular rights. They have a right of review with the Mental Health Review Board. It is an automatic right. It is a regular, ongoing review of their involuntary status under the Mental Health Act. They also have access to the Council of Official Visitors.

If they come under my act—and when I say ‘come under my act’ I mean in terms of me consenting to psychiatric treatment or consenting to them being admitted to a hospital—I think it undermines the integrity of the Mental Health Act and actually takes away people’s rights. I know that that is a bit of a complicated issue, but basically people have rights under the Mental Health Act that they will not necessarily have under my act.

Senator WEBBER—Can I return for a moment to the issue of the treatment of people with mental illness in prisons. Following on from what you were saying, we heard evidence in Darwin, where the situation is probably even worse in that—according to the people in legal aid—people do not avail themselves of the defence of their incapacity to make a decision, because there just is no treatment. So they end up being convicted of a crime that really they did not intentionally commit and because there is no other treatment they get slotted into prison. That is obviously a concern here as well, and also in terms of the lack of facilities. Again, someone raised with me that that is particularly the case with Indigenous people. Look at the high level of incarceration of Indigenous people and the incidence of mental illness. If you go to any prison there are lots of black faces but if you go down to Graylands there are not many, so

obviously we are locking them up, incarcerating them, rather than treating them. Can you expand on that a bit further?

Ms Scott—It is true that in WA 40 per cent of the adult prison population is Aboriginal. I do not have the figures in terms of their mental illness, but if the Department of Justice is saying that at least 30 per cent of the adult prison population has a mental illness, then the proportion of Aboriginal people with mental illness in prison has to be considerable. This goes to your earlier question about what do you do for people. That is another group that needs to be identified and specialist services and culturally appropriate services provided for that particular group of people.

In relation to the first issue you raised, we have, as I said, the Criminal Law (Mentally Impaired Defendants) Act 1996, which was reviewed by Professor D'Arcy Holman in 2003. I was a member of the government committee that prepared a response to the Minister for Health and the Attorney-General in relation to that review. One of the concerns about an act like that is that it was intended to protect people who did not have capacity. But one of the consequences is that you could be detained on a custody order indefinitely. So, often, lawyers advise people, 'Plead guilty, because you are going to serve a shorter period in custody than you otherwise would.' It is a good example of an act which had all the good intentions to capture a vulnerable group of people but, because of this indeterminate custody order, has not been able to do that. In the review, and in the government's response to that review, it has been recommended that there be set terms for custody, and that such a term should not be any longer than the maximum sentence for the alleged offence. It will be interesting to see if government endorses that.

Senator SCULLION—Thank you very much for your comprehensive submission. I found it very interesting. One of the recommendations that I am quite sure the committee will touch on is looking at whether or not we need some commonality of legislation between the Western Australian mental health act and Northern Territory legislation—some sort of commonality of approach, particularly with regard to the practical aspects of the transporting of patients. We have had evidence about the issues: for instance, a case where someone is in Kununurra and has close family ties to Darwin and where they are much closer to Darwin, and avoiding trauma in terms of the time of transportation—all those very practical issues. Of course, the Mental Health Act prevents that from happening, so they have to go to Perth rather than just across the border. You have brought up some other issues in terms of practical amendments or potential amendments to the act in Western Australia that may be beneficial. Do you think it would be worth while to recommend that we have some sort of national framework that is reflected at the level of states and territories and other jurisdictions?

Ms Scott—I was involved in the review of the Mental Health Act, which Professor Holman also undertook in 2003. It was a comprehensive review of the act. I suppose I would support a common framework. I think each state would probably still want to have its own legislation. One of the things we looked at was national principles—national standards in terms of the mental health legislation. We are seeing quite a lot of cross-border activity in the Northern Territory, South Australia and Western Australia in a number of areas. The disability ministers have just signed some agreement in relation to services, and that particularly affects Aboriginal people. There is a cross-border project in the justice system—you might be aware of that—where the transfer of people and how all that would be managed in the criminal justice system are being

looked at. That is a significant project. A lot more could be done in mental health to facilitate that.

One of the other things that we have recommended in the review of the mentally impaired accused act is more use of video conferencing so that people do not have to be brought from a remote community to Perth, which is what has to happen at the moment under the Mental Health Act. That is a particular difficulty for Aboriginal people in remote communities.

Senator SCULLION—I would like to explore further an issue that has been brought up by my colleagues, concerning the justice or otherwise of people who are currently being incarcerated. They have been found not fit to plead—in fact, they have not been convicted of any crime—and then find themselves in the general population of a prison. You are the public advocate. It is occurring on your watch. Is it lawful? And how does it happen?

Ms Scott—I think it is lawful.

Senator SCULLION—When you come through a court and you are not convicted, normally you wander out. What is the process whereby a person who is not convicted ends up in the back of a paddy wagon on their way to jail?

Ms Scott—As I was saying, the Criminal Law (Mentally Impaired Defendants) Act 1996 basically provides that, if a person is found unfit to stand trial, they can be detained. They can be detained in a number of places: a detention centre; a prison; an authorised hospital, which is under the Mental Health Act; and in Western Australia it could be a declared place.

Senator SCULLION—When the act says ‘prison’, is much attempt made to segregate a section of the prison for these people? I think the intent of the act is that they be held ‘somewhere secure’ to protect them from themselves, to protect them from the public and to protect the public from them—those sorts of things. In Western Australia, has any attempt been made to recognise that these people constitute a different demographic, that they are being held in a secure place and therefore should be held differently and with a different intention, that there is a different caretaker role and that different sorts of people should be looking after them? Has that been attempted in any practical sense?

Ms Scott—It is attempted in different ways, depending on the prison. I think that is why the Attorney-General has said that he wants to develop a blueprint. He is saying that he is not satisfied with the management of prisoners who have a mental illness in Western Australia. This is not a Western Australia-alone problem; it is a national issue of great concern. I have read in the *Australian* of the submissions that have been put to your inquiry and that a lot of other people have raised this issue as well. It is a national issue of concern. I am very pleased that it is getting some attention and focus. I am very pleased that the state government have said that it is a priority for them.

Senator SCULLION—This question is again on the issue of process. You have put to us that there are voluntary patients who have been given no valid consent to be inside psychiatric units. You have indicated that mental health practitioners seem to be reluctant to use the provisions of the Mental Health Act to that effect. Can you for a moment just think about duty of care. A policeman knows that his business involves detaining people and that he has to be very

cognisant of the law. One would have thought that a mental health practitioner, who is also in that business from time to time, would need to be aware of the provisions of the act. Clearly you have put to me that there are people who are not aware—although one would think that they would have to be. Again, what steps are you or someone taking to bring these people to task?

Ms Scott—I want to say two things. It is an issue of concern to me, but it is not all mental health practitioners, it is not all psychiatrists and it is not all mental health services. The WA Mental Health Act is relatively new—it is 1996 legislation—so, in terms of authorised mental health practitioners being as aware as they perhaps could be, I think there is scope for improvement there. I have raised it with the Chief Psychiatrist, I have raised it with the director of mental health services and I will continue to raise it. I also raise it, in relation to individuals who come to my attention, with the individual practitioner. I also participate in training programs operated through the Chief Psychiatrist's office. I think it is an ongoing training issue.

Senator SCULLION—The different approach is interesting. If this were a policeman, we would be taking the badge off him and putting his arse in jail. If he ignored his duty of care to that extent, we would be doing that because we as a community would be absolutely shocked by it. Do you think it would change the process if we took a harsher approach and started to say to people, 'Listen, you can't incarcerate people without actually going through these provisions. You may be reluctant to use them but that is the law and what you are doing is unlawful'? I understand the complexities and I sympathise very much with your office in particular and the many other offices who are equally responsible for this. It is a very difficult tension to negotiate. Everybody is trying with their best will to do this and people find themselves in very different circumstances before the law. Obviously there are different processes under which other people are brought to task on this. Do you think that your office has enough power or capacity to be able to ensure that we can make these changes? You can keep bringing it up with people—and they would be pretty comfortable with that, I would say—but do you think that you need to have other capacities?

Ms Scott—I am going to respond by saying I do not have direct responsibility for psychiatrists. The Chief Psychiatrist and the director of mental health services have direct responsibility, so I do not have that responsibility. It is something that I am concerned about though and I suppose it is something that your committee would be concerned about too. The civil detention of someone is a serious issue. That is why we have legal safeguards in the legislation and that is why we have the right to review, to the Mental Health Review Board, and that is why we have the Council of Official Visitors involved. Those safeguards have been built into the legislation. I do regard it as serious when someone is detained. In a previous life I was a member of the Mental Health Review Board and I took that responsibility very seriously in terms of whether a person's status should be confirmed or revoked. However, I do not have direct responsibility for those psychiatrists. I do have a general statutory responsibility for protecting and promoting the rights of people with decision-making disability. That is why I see it is a responsibility to take it up with the Chief Psychiatrist and the director of mental health services.

Senator SCULLION—Do you think they have enough power? No-one is suggesting that you are not taking your responsibility seriously. I was wondering about who then has the capacity and why they are not acting. Is it because they do not have sufficient powers under the act?

Ms Scott—To be honest, I really could not comment on that. That is probably something better directed to the Chief Psychiatrist.

Senator SCULLION—Thank you very much.

CHAIR—Thank you very much, Ms Scott, for your submission and for appearing before us today. That has been really useful.

[9.59 am]

HORTON, Dr Jillian, Private capacity

CHAIR—Welcome. You have lodged with the committee a submission which we have numbered 337. Are there any additions or alterations to that document at this stage?

Dr Horton—No. Madam Chair, I am appearing as a private clinical psychologist. I am not representing any organisation. I am representing myself.

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

Dr Horton—I will make a very brief opening statement. I start by thanking this committee for coming together and focusing on mental health and mental health services in this country, because I think that the state of mental health services is very poor and, from a number of the submissions that I have had a look at, I think there is fairly general agreement that there is a lot of work to be done. I think your task is very big, and I sincerely hope that it will not just lead to more documents and policy statements but that action will actually take place for community members on the ground that are needing the services that are not there.

We are in our third mental health plan now. Throughout all of these years, we have seen very little effect for people in the community who need mental health services. I think that is a very sad shame. I will be so bold to say that I think that the Better Outcomes in Mental Health initiative—which, as you know, is a federal initiative—is the biggest waste of mental health dollars that I have ever seen. I have made some comments about the reasons why I believe that in the submission that I have made.

The submission that I wrote was based on the people that I see in my clinical practice. They are people who do come in with a lot of life stresses, problems in relationships or problems with their children, people who feel depressed or anxious and people who are having serious difficulty in coping in their day-to-day lives. I am also aware that there are many people out there who cannot access private services and also cannot access public services. The public mental health service is becoming increasingly specialised at the extreme end of the spectrum, so there is a huge gap in the community. People who do not meet those criteria have very few places to go, or their only resort is to go to a GP and receive medication. In saying that, I have made some suggestions or recommendations at the beginning of my submission. I tried to make those as practical and as down to earth as possible. I am happy to take any questions that you might have.

CHAIR—Dr Horton, I will start by asking you to expand on the non-drug psychological therapies. In your view, to what extent are medications being used where that is not the preferred model of care, if you like, in terms of outcomes?

Dr Horton—I would say that they are being used extensively. There is enough research available now to show that the non-drug therapies—the psychological therapies—produce very good outcomes for people who have high-prevalence disorders such as depression and anxiety,

but we still do not see a shift away from the use of medications. I would be so bold as to say that pharmaceutical companies must be very happy that GPs are expanding into mental health. I think medication is still being used as the primary front-line level of care for people in the community. As I said, the research is there to show that the non-drug therapies are very effective. In the long term, they are more effective than medications, let alone the cost-effectiveness involved.

CHAIR—This committee has heard a lot of evidence to the effect that even those who are treated in hospitals in in-patient care receive very little by way of treatment per se other than what is normally described as stabilisation of medication. Is it also the case that people with psychotic acute mental illness benefit from psychological services, or could do? Does your work extend into the field of the acute end of the spectrum?

Dr Horton—It does not. I do not work with the acute end of the spectrum. I have worked in a public system in liaison psychiatry in New South Wales, but in my capacity now I do not work with the acute end of the spectrum. I am aware of literature in this field and I think there is very clear evidence to say that the psychosocial needs of people with mental illness, where you are talking about schizophrenia or bipolar disorder, is as real as for people who are not in that severe end of the spectrum. When they are in hospital, I suppose they are at an acute or crisis point. That is my understanding. They need to have that intensive care and stabilisation, which would no doubt include medication. When they leave that hospital though, there is nothing out there. I think Western Australia is even worse off than some of the other states. We have no community health centre type settings. I have mentioned that in my submission. At least in Victoria, they have a fairly extensive community health setting which embeds mental health services but, when people leave the acute setting here, they go into a hole. What happens is that they are left in the care of their families, which is increasingly difficult for family members, and then they are cycled back through. I cannot give any more comment than that because it is not my area of specialty but that is the information that I am aware of about the research in that field.

Senator HUMPHRIES—You begin your submission by saying:

There are statistics to show that funding levels into mental health services by the Australian Federal Government are amongst the lowest levels, in terms of percentage of National expenditure ... in comparison to other western democracies.

What is the source of that comment?

Dr Horton—It was taken from some of the policy documents. I will have to find that specific source for you but it was taken from some of the documents that I was reading about funding. I think I read that in one of the government documents.

Senator HUMPHRIES—I would be interested in finding out the source of that, because all the figures that I have seen are total national spending figures on mental health, not disaggregated by federal or state government. Most of the submissions today, for example, point the finger very directly at state governments as the area where services are falling down. Federal government spending, in fact, has risen quite dramatically in recent years. It is the state governments, it could be argued, that are not matching expenditure.

Dr Horton—You obviously have a lot more information about this than I do but my impression, from what I have read—and I will track the sources if you wish—is that the federal government is also very low in terms of the percentage of money that they put into mental health compared even to New Zealand. So I think both state and federal levels need to seriously consider the amount of funding they are putting into mental health.

CHAIR—It is worth mentioning, too, that most of the federal funding is for PBS.

Senator HUMPHRIES—I would be interested in the source of that statement, if you could provide it to us, please.

Dr Horton—Sure.

Senator HUMPHRIES—You refer throughout your submission to Medicare Plus. What do you mean by Medicare Plus?

Dr Horton—That is the new initiative that was put out fairly recently to bring allied health under the Medicare scheme.

Senator HUMPHRIES—Medicare Plus was a term applied to an initiative the federal government put forward in late 2003.

Dr Horton—That is it. That is the one I meant.

Senator HUMPHRIES—It was rejected by the Senate and has not proceeded as such. The scheme that is now in place is called Strengthening Medicare. That is what you are referring to, I assume.

Dr Horton—Okay.

Senator HUMPHRIES—You say in your submission that, in looking at the list of responsibilities of federal ministers, the federal health minister, Tony Abbott, does not list mental health in his portfolio responsibilities. The reason for that is that another minister of the federal government has nominal responsibility for mental health—that is, the Parliamentary Secretary to the Minister for Health and Ageing.

Dr Horton—Yes, I am aware of that. I suppose that is the issue that I raise there about the idea of a minister for mental health being nominal. The issue I want to raise is that mental health should not be placed in a nominal position—that is, it should have equal standing to the physical health portfolio or the health portfolio.

Senator HUMPHRIES—This is a minister within the portfolio.

Dr Horton—Yes, I know.

Senator HUMPHRIES—So a minister is responsible for mental health in this respect. Coming to the central tenet of your submission, where you say the emphasis should shift away from GPs and onto psychologists, it is an interesting viewpoint. But I am interested in where you

see GPs fitting within that model, exactly. I am looking at the diagram you have on page 17, for example. Where do GPs fit into that model that you have shown in that diagram.

Dr Horton—I tried to highlight there that, from a range of documents and policies that have been put out, there appears to be a lot of emphasis on GPs as being the central focus in primary mental health care. I believe that the central focus should be on the consumers or the people who are needing to access these services and then looking at what their needs are.

If there is a need for people to have access to non-drug psychological therapies, then I believe there is a need to look at the levels and degrees of training and the professional registration requirements, and to look to the profession that has thorough and focused training in that area. So, for non-drug psychological therapies, that is where I have highlighted the need to establish which group is most trained in that field. I believe that six years of training at university in the area of clinical and counselling psychology, to this date anyway, does provide the best training.

Senator HUMPHRIES—I understand that. My question was: in the model that you provided for us you mention various psychologists, psychiatrists, public health and mental services workers et cetera, but where do GPs actually fit in the diagram?

Dr Horton—I suppose they would fit outside of the circle and be a referral source.

Senator HUMPHRIES—Outside all of these circles?

Dr Horton—They would be a referral source. They would be participating members of that, but they would not have the central role they have had to date.

Senator HUMPHRIES—On the outer circle you have private mental health hospitals. Do GPs have an even lesser role to play in the provision of mental health than private mental health hospitals?

Dr Horton—What I am trying to say there is that GPs are very well trained in their medical roles, in their medical profession and in the treatment of medical health problems. My understanding is that people in the community are even finding it difficult to access GPs to get their medical needs met, so I cannot understand why the government would wish to burden GPs with a completely different health portfolio such as mental health when there are very clear alternatives available. The GPs are already struggling with their own practices and with meeting their patients' needs. That has been evidenced in a report that was written fairly recently on the mental health of GPs—I think I mentioned that in my submission. There are clear alternatives, so I find it very difficult to understand why those clear alternatives, which I think are better, are not being used more fully.

Senator HUMPHRIES—Since reading your submission I have had the chance to discuss what you suggest with both a psychologist and a psychiatrist working in Western Australia. They both accept that there should be a greater role for psychologists, but they also point out that most people's first interaction with the health system is through GPs.

Dr Horton—That is very true.

Senator HUMPHRIES—GPs play a central role in most other health services in the state—and, indeed, anywhere else in Australia. Also, people are less likely to go and see a person specifically for mental health type services because of the stigma associated with that. They are more likely to front their GP with a problem, which the GP can, with some training, identify as having a mental health dimension and then refer them to either specialist. Isn't that a good reason for retaining a program like Better Outcomes in Mental Health, which gives GPs the capacity to identify those problems in their patients?

Dr Horton—I have a couple of comments. If GPs were identifying mental health problems effectively and then referring patients to services—although there are very few services they can refer to—that would be a really positive step. For GPs to be trained more in the assessment and identification of mental health, to be able to make good referrals and to be able to deal with the issues of stigma would be a really good step forward.

Anything beyond that, I think, is not putting the money where it needs to be. That is where I would suggest that if it is a referral process it makes sense. But GPs taking on mental health services—actually doing psychological non-drug therapies—is, I think, a very ineffective way of going about it when there are alternatives. The Better Outcomes program has been running for nearly five years now, and there really has not been a lot of change on the ground. If that funding were redirected to better community services such as community health centres with embedded mental health services in the public sector, and if it were directed into allowing community members to get direct access—without any gatekeeping—to six-year-trained psychologists, then people would get better services.

GPs can continue to refer. It is a really unusual idea that, because GPs are the first point of contact for people that have depression or anxiety, they should therefore do the treatment. To me that is a huge step in an illogical way. GPs also do not do other treatments that surgeons do, for example. They make an assessment and a referral at that point.

Senator HUMPHRIES—They have to be trained, though, to make that referral, don't they? A person will not come through the door and say, 'I've got a mental illness, where can you direct me?'

Dr Horton—I agree.

Senator HUMPHRIES—They might come in and say, 'I'm feeling really tired and anxious, and my hair is falling out.'

Dr Horton—That is true.

Senator HUMPHRIES—They are likely to find other symptoms and then direct that person.

Dr Horton—Some people do. I certainly have people coming into my practice who say that they have been to their GP requesting a referral, even though they do not actually need a referral to see me. I have had many people come in to my practice saying that they have been to their GP, been given medication and they do not want to take it; they want to get some help. If it were just about GPs making referrals I think that would be really good, but it is not just about that in Better Outcomes. It is about bringing the pressure into the medical area to take on non-drug

psychological therapies. I do not think that is happening effectively because medication is still the frontline, and there are clear alternatives.

Senator WEBBER—I want to follow up on that because I am a bit perplexed about Better Outcomes, I must admit. Dr Horton, firstly, I would agree with your point that if you present to your GP and you have a heart condition, diabetes or, in my personal case, arthritis you are automatically referred to a specialist. I have rheumatoid arthritis and I am not treated for that by my GP anymore because there are specialists. Mental health is a speciality, isn't it?

Dr Horton—Yes. There is a dedicated training program of eight years for that.

Senator WEBBER—Therefore it would be a referral to a specialist who can treat that condition, which GPs are trained to do as far as I am aware.

Dr Horton—That is right.

Senator WEBBER—When the committee received evidence in Melbourne we were discussing the training of GPs with a number of academics, and no-one could tell me how much of a medical degree was devoted to mental health. They thought it might be a 10-week non-assessable block in a six-year degree in Melbourne, but no-one has been able to tell me. So you can come out as a GP having done no real training in mental health. You can then go to do Better Outcomes stage 1, which is six hours and which the Division of General Practice nationally tells me is a big chunk of time—too much time to expect GPs to have to undertake. Later on you can do 20 hours—

Dr Horton—And do psychological therapy.

Senator WEBBER—and do what you have taken six years to do.

Dr Horton—I think it is the most ridiculous thing I have ever heard. If there is some level of training in the medical undergraduate degree then I think that is a good thing. There needs to be some understanding of different professional groups, and to me that would be about helping them to understand the role of other specialists—for example, clinical psychologists—to understand their method of working but not to train them to do the work. That does not make much sense to me. Their specialty is in medicine, and they do that very well. That is the focus of their approach. There are other alternatives, and if that process referral system takes place that makes sense. Training for 20 hours borders on the dangerous and the unethical. I am absolutely surprised that the federal government is funding people through Medicare to do this therapy on the basis of that level of training.

Senator WEBBER—If I were to treat someone using CBT after my 20 hours of training, what would be an example of what could go wrong?

Dr Horton—At the very least, a person may not benefit at all from it, and then they might assume that the therapy is not effective. I have had people come to my practice and say, 'I've done CBT.' I ask, 'Where have you done it?' They say, 'I've done it with a GP.' And then I ask about how that was done or what has been done, and it is nowhere near what cognitive behaviour therapy is about. If it is done in a very superficial way it is like, 'Tell me how you're feeling.'

If it has very little impact it can be assumed that the treatment is not effective. This then leads to people needing to have multiple access to services, which surely increases the cost aspect, and drug therapies come in there as well. And I suppose people can go away still feeling very depressed and anxious, and that is a very poor outcome. Hopefully, people do not then go further down the track of despair, leading into more serious outcomes for them, but I think there is that potential. I think that when people go to a professional wanting a service and they walk away and they have not got it, or it does not have much impact, it can increase the amount of despair they experience.

Senator WEBBER—I am not sure whether you are originally from Western Australian or whether you have been here for long but one of the other things that I am sure members of this committee are sick of me carrying on about is the lack of access in regional and remote areas. Why is it, do you think, that I am more likely to find a psychologist happy to practice in regional and remote areas in Western Australia in particular? We were in Port Hedland and there is a private clinical psychologist there but not a psychiatrist. Is it because you guys are all around better and nicer and you care more?

Dr Horton—I would like to agree with that! I do not think I can comment on that. I do not know. I worked for nearly three years in the country in Tamworth in New South Wales after I graduated in 1986. That was in a community centre in the country. I find that these are wonderful ways to bring not only mental health services but other services into regional and remote areas or country areas, because you have a team of professionals who are going to support each other and you have a facility where people are not being isolated professionally. I would like to suggest that that sort of model could be very helpful if it were done for the regional and remote areas. But why a psychologist would be interested in going, I do not know.

Senator SCULLION—I was surprised to see at the front of your submission that you did not actually state that quite a few friends of yours are GPs. Perhaps it would have prefaced the tenor of your submission. This is almost an urban centric submission that does not take into consideration some of the issues. I am from the Northern Territory and we do not have the blessings of very many clinical psychologists. I wonder if you could help me with a couple of things. I do not think that the 20 hours training provided is to upskill GPs so that they are able to provide the same level of amenity as the professionals in that particular field, but it will provide them with a level of amenity to ask the right questions and even to make an assessment that the illness their client is suffering is a mental illness and not something else. So that is a level of amenity which I assumed the government are attempting to provide through this process.

Dr Horton—May I comment on that?

Senator SCULLION—Indeed.

Dr Horton—If that were the case, then there would be no need to open up Medicare for them to provide psychological therapy to their patients. They would refer on. That is, if it were just to help them to assess.

Senator SCULLION—Unfortunately, we do not have a six-year trained psychologist in Port Hedland but we have one who has done the four-year course. So she is probably not capable of a great deal of things but she is the only psychologist in Port Hedland. In fact we had not had any

psychologists in Port Hedland prior to that. So now, when somebody in Port Hedland presents to a GP, they are lucky enough to have somebody they can refer on to, but there are many places in regional Australia where there is no psychologist at all for anybody to refer on to. So it is a case of either travelling to Perth or notionally travelling to somewhere else to get access to a six-year trained psychologist, or someone at that level, or go without.

Certainly in the Northern Territory—that is the demographic I am talking about—they have absolutely no access at all to those things. So when the option is to go without or travel, the choice is generally to go without. The Central Australian Aboriginal Congress in Alice Springs delivers CBT through a range of processes and gets access through government funding. Without that service, which is not being delivered by clinical psychologists, there would be absolutely no access at all to therapeutic processes. What is the alternative—

CHAIR—Senator Scullion, as I recall it, there were two psychologists in Port Hedland; one is on leave at present but is coming back. So it is not the case that this was the only psychologist there.

Senator SCULLION—Whilst we were visiting Port Hedland, the only psychologist that was available was Michelle. The point is that she was not a clinical psychologist. Are you aware of whether the other person is a clinical psychologist?

CHAIR—Yes.

Senator SCULLION—That is good. Again, the issue in regional and remote Australia is that we do not have access to a wide range of clinical psychologists as you may do in Perth. Are your comments general ones or are they comments about an urban-centric environment? What do we do in areas where we do not have access to the level of amenities that we do in Perth?

Dr Horton—It is a very difficult situation; I agree with you. I suppose it is not one that will be easily dealt with. Yes, sometimes, for regional and remote areas, extra energy has to be put into getting the services up there. I am aware that in some areas they fly in people for a period of time to do servicing and then they fly them out again. Obviously that is quite an expensive approach but I am aware that that is done in some regional areas. That is an option.

You are right: there is a difference between the city central and the outer area. Clearly, there are other options in the city that may not be available in country areas. I suppose that requires a fair bit of thought about how you can attract people up to those country areas and we really need to have a look at what can be done along those lines, rather than jumping first into devolving the services and getting other people to do the services. It might be that some level of that will be required in extreme cases or in remote areas, where you do get people doing all sorts of things—sometimes vets act as GPs and all sorts of things. I think these are special and unique cases. It may be the case that people trained in certain skills can assist, but I would be concerned about the level of servicing that the people in that community receive. Because they are in regional and remote areas, it should not be the case that they get lesser services and no access. Thinking along those lines, I would prefer that the energy was expended on getting people there, rather than people in remote and rural areas getting poorer services.

Senator SCULLION—I still have some issues with how we can introduce some of the concepts into those areas, but thank you for your response. I note for the record that the clinical psychologist in Port Hedland is in fact employed by BHP and only services people in the one company in the town. The remaining townsfolk are serviced now, luckily, by Pauline. When she finishes working for BHP, she will be able to offer the first services for some time for the remainder of the community.

Dr Horton—That is quite an interesting concept in itself—if there are large companies in those areas, whether there could be some negotiation done for community benefit to provide services. They could be partners with government from a financial point of view.

Senator WEBBER—Especially having regard to the amount of money that BHP makes out of that town.

Dr Horton—Yes, that is correct.

CHAIR—You might also argue that it will be more attractive for psychologists to be in these areas if Medicare were available directly to them.

Senator MOORE—In your model and also in your submission you talk, as have many other submissions, about the concept of a multidisciplinary approach to service delivery. Can you give us some indication of how that would operate best? If you are looking at a consumer focused arrangement, which we have heard about, and your model focuses on that, the idea would be to have a multidisciplinary approach rather than this service versus that service. How effectively could a multidisciplinary approach operate to best provide services?

Dr Horton—I believe it could work very effectively. That has been my experience when I was working in country New South Wales. People could walk in off the street and ask to see the clinical psychologist, the speech therapist or the community nurse—

Senator MOORE—What kind of place were they walking into?

Dr Horton—What I am thinking about is a centre that has not only mental health but other services as well—speech therapists, dieticians and so on. If they are co-located in a building, they can cross-refer people. There is no gate keeping or need for a referral process. There is no triage system, where you might end up seeing someone or you might not. People in the community can go in and say, ‘I have this and I want to see this person.’ If the person they see is not the appropriate person, they can be redirected in the system.

I see that as a multidisciplinary team within one centre. But it would need to be well staffed. There is no point in having one psychologist or one speech therapist. As I have said to Dr Aaron Groves, the director of mental health services, there needs to be something like five adult clinical psychologists, three child and adolescent psychologists, three speech therapists, a social worker et cetera. It needs to be able to cater for all. If you have a range of those in community areas they can develop their model to deal with whatever the issues are in that community. If you are in a community that has a lot of elderly people, you can target preventive models and therapy services to that. If you are in a community that has a lot of young children and families, you can

target your staffing levels and services to that. Each of those centres can develop their prevention approaches and links into the community, based on the needs of their particular community.

Senator MOORE—How would the different professional streams cooperate in that kind of process?

Dr Horton—From my own experience, it would be through meetings, communications, team leaders and the usual management structures. I think it is doable, and that is the experience I have had. Especially in Western Australia, this is desperately needed. We have nothing along those lines at all here.

Senator MOORE—In our cancer inquiry, we had similar discussions about having a multidisciplinary approach. It was highly regarded but it was considered that there would have to be a change in the funding model to make that effective. Do you see this as similar? Would there need to be a change in the Medicare funding model to make this kind of team operational?

Dr Horton—Medicare is servicing the private sector. I am talking about people employed in the public sector in community health centres.

Senator MOORE—So you are envisaging a government clinic?

Dr Horton—That is correct. You can also bring in private people as consultants if you wish to, but that comment was aimed more at the public sector. The Medicare system, I think, is aimed more at the private sector. People need to have options and choices available to them.

Senator MOORE—We have heard considerable comment about the shortages of all professions in this area. You have been very clear in your submission about the need for highly skilled professional psychologists. What is the current state of the numbers—and people in training—for the kinds of qualifications you have recommended in your submission?

Dr Horton—I cannot comment clearly on that. I believe you have spoken with the APS, which is our representative body. They have probably given you some statistics.

Senator MOORE—They gave detailed evidence on that issue.

Dr Horton—My only further comment is that, from what I have read, the numbers are quite reasonable. If there is a workplace shortage, however, as there is in other professional areas, then I suggest it could be best dealt with by increasing training places in universities. I think that can also be done at a federal level by looking at subsidising or reducing HECS fees. If there is a need for a professional group—and this has been done with nursing and teaching—then something can be done to open up places and increase the number of academic positions to train more people and get them out into the system. I do not know if there are clear statistics on whether there is, in fact, a shortage.

CHAIR—Could you explain to the committee the importance of the extra two years to qualify as a clinical psychologist, as opposed to others kind of psychologists? What skills for dealing with mental illness does that provide to a psychologist?

Dr Horton—The extra two years is for a master's degree in, for example, clinical psychology or counselling psychology, and that is when most of the therapy skills are taught. For the vast majority of those two years, you are out on placements. You are treating people, you are strongly supervised in your field and you are taught about therapy skills. Up until that point, in the undergraduate program of up to four years, there is virtually zero training in therapy skills. So someone coming out of a four-year training program has very limited skills, if any, in psychological therapies.

After the six years of training, when you have gained those therapy training skills, you have two years of weekly supervision by a fully qualified clinical or counselling psychologist, or a psychologist in whatever your specialty area is. Those two years of supervision are there to finetune your therapy skills and to focus on wider issues of ethics, therapy practice and so forth. It is about finetuning and assisting. When you come out of the four-year training program, you also have to have two years of supervision. My argument is that that two years of supervision is about finetuning; it should not be about training therapy skills. I believe that therapy training is best in a standardised academic situation where there is assessment, examinations and presentations—where you have some level of assessment of the standard of training that is provided. Leaving it in community settings of various sorts with maybe limited focuses is perhaps not to the advantage of people in the community.

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

Proceedings suspended from 10.36 am to 10.48 am

BYRNE, Dr Simon, Private capacity

CHAIR—Welcome, Dr Byrne. You have lodged with the committee a submission which we have numbered 3. Are there any additions or alterations that you wish to make to the document?

Dr Byrne—No.

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

Dr Byrne—I thank you all for the opportunity to meet and discuss the issues. I have worked as a psychiatrist in Western Australia for 20 years, all of the time in the public sector, as well as doing a small amount of private practice. I have worked over the period of the national mental health plans. I have seen them evolve, I have participated in their implementation and I have seen some of the consequences. The issues that I want to put before the committee are about what I see as a deficit in the planning process, a failure to focus adequately on the need for hospital based long-term rehabilitation. This has been consistently left out of the planning and it continues to be left out of the planning.

This kind of hospital based, long-term rehabilitation can be effective and helpful, but you have to foster it to enable that to happen. I pointed out in my submission that we have a good idea of how many hospital beds we might need for this purpose. International research has consistently shown that we need about 10 beds of this type for every 100,000 or so of the population, which would be 200 for Western Australian or 2,000 for Australia. I can support this with recent Western Australian data. On 1 December, 2004 the Western Australian health department did what they called a snapshot, which was part of an Australia-wide data collection process looking at patients in hospital on any one day. On that day last year in Western Australia, out of 555 acute psychiatric beds, the clinicians estimated that 172 were occupied by patients needing long-term rehabilitation. So that is consistent with the 200 I am suggesting.

It is also important to recognise that this is not only about providing supported community accommodation. The solution people advocate and promote is that if only we had more supported community accommodation we would not need these places in hospital. This is grossly overemphasised. Of course we need supported community accommodation but, at any one time, we are likely to have up to 200 patients in hospital in WA who are going through a rehabilitation process. They can be admitted and discharged over a period of time. It might be a long period. It might be two or three years. Some might never be discharged. As they are discharged, the place should become available for a new person. But that is not what happens—over the last 10 years these kinds of facilities have been wound down and closed when people are placed in the community.

Since 1993, 2,300 long-stay beds have been closed across Australia, and it is still policy. In WA at the moment there is one 40-bed long-stay unit at Graylands Hospital. The health department's existing plan is to close this unit when 30 of the patients have been placed in specialised community accommodation. Then there will be no long-stay unit. There is no plan for the other 10 patients. Presumably, they will go to the acute wards. There are still up to 200 patients in acute wards now occupying beds. I know from personal experience and from my

knowledge of the literature that this kind of long-stay treatment can be effective. It conjures up images of psychiatric hospitals and all the grim fears that people have, but people also have to remember how severe some of the illnesses are and how severe some of the disability is.

I worked as the psychiatrist in the long-stay unit at Graylands 15 years ago. The treatment is complex. It involves comprehensive assessment. You very much need a multidisciplinary approach to treatment planning. People need medication, but they also need skills training and behaviour modification, which often has to be implemented over a fairly lengthy period. The training of people in basic care skills should be individualised and targeted towards helping the individual to cope in a realistic community placement option for that particular person. Over time, the patient can be trialled in community options and return to the long-stay unit as necessary. That is very important until stable community placement is achieved. The long-stay unit acts as a secure base from which the patient can be supported in their moves towards community living. This is infinitely better than patients being admitted repeatedly for relatively brief periods to acute wards, where they cannot get anything like this kind of long-term treatment planning. Just as bad, they may be placed in grossly unsuitable lodging houses, where they may enter a cycle of homelessness, petty crime and prison.

I have other experience which I am able to share with you. I was the superintendent at Heathcote Hospital during the last two years before its closure. I have personal experience of working to place long-stay patients in the community. I now work in a teaching hospital. I work every day in the emergency department trying to help acute and chronic patients access appropriate in-patient or community care.

I know that the committee has received a number of submissions about the problems in emergency departments too. But my main point, if I can mention it again, is that we need hospital based, long-stay beds. We have a good idea of how many we need. It is not an unachievable number of beds but it is a policy area that needs focus. I believe that, without doing this, we will continue to have acute beds blocked up.

CHAIR—You would be familiar with the arguments against this kind of approach—that this is really reinstitutionalising people. You do not see it that way. People who have long-stay care in hospitals do achieve better outcomes, in your view. Could you just expand a bit on what one can expect in a hospital setting, as opposed to community based care or even home based care with community support?

Dr Byrne—These are complex issues. We do live in an age in which there is a cultural prejudice against the notion of institutional care. That comes from a variety of sources, one of which, I think, is a very appropriate concern about what institutions can be like if they are neglected or if they are not properly fostered. Patients can receive neglectful or even harmful treatment if institutions do not run well. But I do not think that that should make us think that just because you put somebody in a boarding house in the community they are going to be treated well. I think this is a serious mistake. There is this notion that somehow patients with really severe disabilities are going to be better off anywhere other than in an institution.

The kind of work I have done over the years has involved intensive work with families and community services about really severe problems—young people often with schizophrenia or other severe mental illness. Families work really hard over long periods of time—years and

years—struggling to cope with a really unwell person who often has violent or offensive behaviour, which often causes the greatest problems. The family struggle and struggle and they fight to keep them out of hospital. I have seen them eventually give up. Their own capacity to cope is exceeded. But what alternative have they got? The patient goes in and out of acute wards and in between they go to the lodging house with the alcoholics and the down-and-outs because that is the only community place that will tolerate their behaviour.

I am not being dramatic here. The point I am making is that well-run, long-term institutional care with a proper focus on rehabilitation outcomes can be much better than so-called community care.

CHAIR—The committee has heard some fairly alarming evidence about in-patient services in mainstream hospitals with psych wards. We have heard a lot of evidence about very poor discriminatory stigmatising attitudes of health professionals, mostly in these kinds of places. It may be a truism but it sounds like a more wholesome thing to get people into the community. Do we need a whole scale change of the culture which is currently in institutions in hospitals or do you think mostly they are okay? What is the scale of the challenge in making institutions places that are truly rehabilitating facilities and that treat people with respect and dignity?

Dr Byrne—I think there are two aspects to the question you are putting to me. One is about mainstream units in acute hospitals. I think there are real problems with these units. I have worked in these units. The problem is that they are asked to provide all things of an in-patient mental health nature to all patients. There is no specialisation of environment, or there is very limited specialisation of environment. So regardless of the nature of the illness—like the middle-aged person with severe depression or the young person with mania or the other person with schizophrenia—they are all lumped together. That can make for a harsh environment. Also, there are often acute patients and chronic patients lumped together.

I know that is not the main point you are making, but I think it is one thing that contributes to the bad experience that people have of mainstream acute units. The point you are making about stigmatisation and negative attitudes, of health professionals in this instance, is a perennial problem. It has existed ever since I have worked in mental health. Overall it is probably a bit better now than 20 years ago, I would say. I do not think there have not been achievements in the last 20 years; there have been, but it is an issue which has to be addressed all of the time, day after day. It depends on training and leadership especially—I think these are the issues. I have seen wards and facilities go downhill and come up again, depending upon the calibre of the senior staff especially—what standards they are able to maintain and the expectations they set.

It is not only the senior staff; it also depends on fostering and maintaining the long-term staff. In the kind of area I am talking about, working with severely disabled patients, people who are good at this work do it because they care about it. They are earning a living and it is their job, but they actually have a relationship with the patients. Sometimes they have known them over many years. If you foster that kind of staff and give them encouragement for the work they do and a sense that they have a future—that it is going somewhere, that maybe there is an academic or research angle or even that it is something the government believes in—they will flourish. But if you tell them that they are earmarked for closure and that everything they are doing is a waste of time, people leave—they leach away. Anybody with any kind of career ambition goes somewhere else and you are left with people who have less ability.

Senator HUMPHRIES—What has the long-term trend been in acute hospital bed numbers for mental illness in Western Australia? The Western Australian government submission suggests that there has been a big shift in recent years from acute beds to community based beds. I wonder how that has come about. Have there been acute beds closed or transferred to the community sector? What is your impression?

Dr Byrne—I am not sure what they mean by acute beds to community based beds. As it has been throughout Australia, the trend over the last 20 years has been from stand-alone psychiatric hospital beds to psychiatric wards in general hospitals. Heathcote was a stand-alone psychiatric hospital of about 100 beds which closed in 1994. Twenty years ago Graylands probably had about 250 or 300 beds, off the top of my head, and now has 140.

Senator HUMPHRIES—What they say is that in 1992-93, for example, the ratio of in-patient to community expenditure was 76 per cent in-patient and 24 per cent community. In 2002-03 it was 49 per cent in-patient and 51 per cent community.

Dr Byrne—That is not beds; that is expenditure—services.

Senator HUMPHRIES—They also refer to beds and say that the percentage of psychiatrist beds in stand-alone hospitals as a percentage of total psychiatric in-patient beds was 70 per cent in 1992-93 and 38 per cent in 2002-03.

Dr Byrne—This is the shift which has happened everywhere in Australia from stand-alone psychiatric hospitals to psychiatric wards in general hospitals, which has had a lot of benefits. I am not advocating a large-scale return to psychiatric hospitals per se, but the policy debate has tended to assume that we can dispense with long-stay beds altogether. I think that there is a need for a relatively small but important number of these kinds of beds.

Senator HUMPHRIES—As I think the chair's questions were implying, the trend of evidence to us so far has been that we need to emphasise community based facilities. For example, the head of the School of Psychiatry at the University of New South Wales said that he thought there were enough acute beds in Australian hospitals at the moment. He said that we needed beds out in the community that would act as a filter against people ending up in those acute beds. He said that, unlike other illnesses like appendicitis or cancer, or whatever, often there is a build-up with mental illness where people are gradually getting worse and the unavailability of community based services for those people is what causes them to end up in the acute beds. You would reject that evidence? You would say that you cannot prevent people reaching that acute stage by providing comprehensive community based services?

Dr Byrne—No, I do not disagree with that at all. I think that is entirely true. I completely agree with that. Whether we have enough acute beds, I am not sure. Professor Andrews may well be right; I do not know. There is conflicting opinion about that, but perhaps that is right. We need acute beds and we certainly need community based care. But my point is that we also need a specialised focus on long-stay beds. It is not so much about the issue you are talking about of people getting community based treatment before they become so unwell that they need acute hospital care; it is more about the issue of people who actually have a chronic illness. It is not an issue of them developing an acute illness; they have an established chronic illness, which is often a lifetime illness.

It is not a good idea to keep readmitting people with chronic illness to acute wards because the community services cannot cope with them. I am not convinced that it is a matter of providing better community services or better supported accommodation in the community. Of course, we need those things as well. When people with severe chronic illness fail in the community, they fail because they assault people, behave offensively, grossly neglect themselves, are found homeless or because they are completely incapable of functioning in the community. It is not just a question of saying, 'We'll step up the home visits for some people'—they actually need a longer period of more intensive care.

Senator HUMPHRIES—Can you comment on the question of medication. As you would be aware, the biggest increase in spending in mental health in recent years has been by the Commonwealth in increasing the number of drugs and the availability of drugs through the PBS for mental illness. Many people have described this as being an unhealthy step in that there is too great an emphasis on medication. What is your view about the proper balance between medication and alternative therapies?

Dr Byrne—I can separate that into what I think are two separate areas. One is medication for psychotic illness. The new generation of so-called atypical antipsychotic medications are very expensive. They are a lot more expensive than chlorpromazine and thioridazine and so on that we used to use, but they are unequivocally better. Twenty years ago, there were two problems—at least two—in diagnosing schizophrenia in a young person. One was telling them, 'You've got this terrible illness that you may have for all of your life,' and the second was, 'There is medication for it, but it has horrible side-effects and you probably won't want to take it.' It is a lot better to be able to prescribe medications that do not have anything like the severe side-effects of the old ones. Even though the new medications are expensive, I think the expenditure is justified. Although the medication should never be the whole of the treatment for schizophrenia and bipolar disorders, it is a really important part of the treatment.

With respect to the other group, if I could put it that way—which is people with a broad group of anxiety and depressive disorders—in my opinion, there has been a very strong marketing push by the pharmaceutical companies for the SSRI antidepressants, and subsequent antidepressants, which are also not cheap. They are extremely widely prescribed, as the most appropriate or the simplest treatment.

Senator HUMPHRIES—They are too widely prescribed—is that what you are saying?

Dr Byrne—In the individual case probably one can always find a rationalisation for the prescription but arguably, yes, they are too widely prescribed.

Senator MOORE—I liked your term 'cultural prejudice' because in many of these discussions there tends to be a hope to find the right answer so that anyone who has a different view is obviously wrong. Regarding the proposal you put forward for having a clear option which is very limited, so you are not building enormous hospitals, how would you actually work that when every time there seems to be the provision of any service that involves a bed there is a long waiting list and there is a push from people that that is the way to go? If you set up an option as you have described, which has clear guidelines for the kinds of the service it is there for and so on, what would be the protection mechanism to ensure that it did not become a case of 'it's there so we'll send everybody there'?

Dr Byrne—I have experience of exactly what you are talking about. The key issue there is having a very clear idea of what the service is about and therefore having very clear criteria for the acceptance of patients for that service. The problem which follows from that is who will now work in such services. We also have a training gap because these kinds of services have been neglected and they were never glamorous. It was not the sort of thing people went into because they wanted a glamorous career. But because they have been neglected we even have a deficit of trainers who have the experience of working in this kind of way who can then train the next generation. I think we need to train people to take on these roles and then we need to have clear ideas on setting the criteria for entry. But that is achievable too. I think forensic mental health services have started to move in that direction; getting their act together in being clear about whom they will take on and whom they will not take on, because that is the crucial issue.

Senator MOORE—When you talk about a long-stay facility, what does that mean?

Dr Byrne—There are two or three issues there. One is that, because a lot of the treatment for people with severe disability does involve behaviour modification principles, in people who have cognitive or other mental impairment a time frame to achieve change in behaviour may be in the region of one, two or three years. That is for the people who are ‘trainable’, if you like. There are always going to be some people—and in my experience especially the people with head injury and mental illness are the ones who come into this category—whose capacity for being trained is so limited that it might not be achieved and so it is looking more like permanent stay. But they are the ones you need to be extremely careful about, of course. You want to be careful to try and avoid anybody becoming permanent stay if you can help it.

So in general, two or three years but also, as I was saying, with the capacity for readmission and top-up, people are placed eventually. This is the way we used to work at Graylands; people would be placed in a hostel or some other setting. The team involved in the long-stay unit were actively involved with the community placement. When it breaks down the patient comes back to the long-stay unit which they know, with staff that they know, and you pick up from where you were instead of them going onto the streets or into the emergency department or to some other place where there is nothing to pick up from.

Senator MOORE—Back into the cycle?

Dr Byrne—Yes.

Senator TROETH—I was interested in your reference to other studies on this issue that have occurred in Britain, the US and indeed Australia. Would you like to elaborate on findings or the outcomes of some of those research studies?

Dr Byrne—The methodology followed in those studies in a way is relatively simple. All that they do is count the number of people who have been in acute wards for more than a defined period of time—usually one year. It is quite remarkable to think that such a number of people have been in acute wards for more than one year. The way that things have evolved in Australia, and probably in other countries too, is that some of these patients are not in acute wards continuously for a year but, if you add up the amount of time that they are in acute wards over, say, a two-year period, they are in hospital for three-quarters of the time, and there is a push to

push people out inappropriately and then they come back. It is bad treatment, apart from anything else.

Senator TROETH—Do you consider that community care, as you have described it, has any benefit? If you were going to set up a model of community care for perhaps people who were able to have time out from hospital or people who should never have been in hospital in the first place, how would you structure that community care model?

Dr Byrne—Do you mean people with severe disabilities or people who do not have as severe illnesses?

Senator TROETH—People with illnesses that are not as severe. I am assuming there are some elements of community care which can cater for some areas of mental health.

Dr Byrne—Absolutely. I do not want to be misunderstood as if I am an opponent of community care. I am not at all. Twenty years ago—at the time of the Burdekin human rights commission report—the debate amongst psychiatrists and mental health professionals was hospital versus community; that is, community is better and hospital is worse. In light of the national mental health plans, that debate has, to some extent, settled on a concept of integrated care where hospital stays may or may not be part of somebody's treatment experience but that most treatments should be community based. I completely support that. That is what I do in the emergency department. I do that for every person who can possibly be treated in the community—both because of the shortage of hospital beds and because it is probably better for the person. I work with a private psychiatrist, community clinics and so on about trying to facilitate that. For the vast majority of patients that is going to be the best option. It is the small group for whom it is not that I am talking about.

Senator TROETH—You mentioned the absolute last resort option of seedy boarding houses. I do not think any of us would classify that as community care. In an ideal world, what sorts of elements would you incorporate into community care so that those persons who could be there were able to be effectively treated there? Are we talking about multipurpose community health centres or are we talking about more specialised treatment?

Dr Byrne—What is provided for a particular individual needs to be individualised according to the needs of the individual, but the components are community based mental health service with multidisciplinary staff—which exist in Western Australia—with the capacity for outreach services, mostly community nursing, where they can go to see people in private accommodation, hostels et cetera.

Some people will be able to stay with family if the family have appropriate support. Some people will be able to live independently if they have appropriate support. Some people, once they are stabilised and their illnesses are under much better control, will be able to maintain an independent existence as long as they have a safety net that picks them up. Some people actually need on-site staff in the accommodation simply because their coping skills are such that they can fall in a hole on a daily basis.

Senator TROETH—So a range of support measures are needed.

Dr Byrne—Yes.

Senator WEBBER—Thank you for taking the time to appear before the committee. There is a push towards greater institutionalisation and there is a push towards community care and I have probably fallen somewhere in the middle so far, but I am very ill informed. There is no doubt in my mind that there is a group of people who are acutely unwell. They need that treatment, but they also need to be put in a place where they cannot do harm to themselves or to the community. So we do need that acute level of care.

State governments make great play about the amount of extra money they are putting into health and into all sorts of things, but that seems to be more in the area of capital works than anything else. If we go down the line of providing those extra beds, do we actually have the staff we need? We can build shiny new things. We build shiny new police stations all the time, but it does not mean we have enough police officers to fill them. We can open up more beds down the road at Sir Charles Gairdner Hospital, but if we do not have enough nurses and doctors then they are just going to lie there. Do we have enough staff capacity in the system to go down that way, or what do we need to do to get more people like you in the system?

Dr Byrne—The answer to that is we probably do not have the staff. I think the biggest deficit is in psychiatric nursing. Somebody told me the other day that the average age of mental health nurses in Western Australia is 47 and rising. That is a profession that people are not entering, and comprehensively trained nurses are not generally attracted to doing that kind of work. We need to be pretty creative about that and think through what the care needs of people with mental illnesses are, and if it cannot be met through the traditional profession of psychiatric nursing we have to think about how else we are going to develop that kind of staff. I think psychiatrists, psychologists, social workers and occupational therapists can be attracted to doing this kind of work if it is seen as something which is valued and fostered. I do a lot of teaching, especially of young psychiatrists. Idealism is not dead—

Senator WEBBER—Good.

Dr Byrne—but you have to tell people: ‘If you would like to do this kind of work with really disabled people, we will encourage you. We will help to create academic pathways and research opportunities. We will see that if you develop a service it is not going to be in and out, with the threat of closure every year or two.’ That has been the reality over the last 20 years. Anybody who has some ability is going to say, ‘I would like to do that type of work, but there is no future in it.’ That has been a really severe problem.

Senator WEBBER—The other side of developing these places is developing the supported community accommodation. The state government has announced packages for Geraldton and goodness knows where. How do we cope with the community anxiety regarding where those facilities are located?

Dr Byrne—Do you mean the supported accommodation?

Senator WEBBER—Yes. That is the problem with Geraldton. The money is there, but they cannot find anywhere to build them because no-one wants these people living next door to them.

Dr Byrne—There are many issues there. I think the advertising campaign that the federal government ran a few years ago, which seems to have petered out more recently, was good. There were all those ads on TV about ‘Jillian has schizophrenia, and she can play in the band too,’ or whatever it was. I think they were great. Paradoxically, the gap in services that I am concerned about has something to do with community tolerance. If the most disabled people can have appropriate facilities in which they can be cared for and have rehabilitation, rather than being placed in a community, that has an impact on public perceptions. If the public perception is that the people who are being put in the accommodation, or for that matter are roaming the streets, are very scary and do alarming things, it is difficult for people to come to terms with.

Senator WEBBER—So, in a way, finding appropriate care for these people could help destigmatise the way we treat the mentally ill.

Dr Byrne—I think so. I spoke before about the severely disabled who are in long-term services. They can be trialled in the community but also brought back into the long-stay services. I think that helps with community tolerance too. Unfortunately, in many parts of Australia the acute services do not have room for people with chronic illness. Often their behaviour is not necessarily offensive or aggressive. They are in a grossly neglected state and they are brought to emergency departments usually, or some other place, and the acute services say, ‘Sorry, we don’t have the beds.’ I remember seeing something about St Vincent’s servicing Darlinghurst and how the hostels next door now keep a log of the calls they make to the mental health unit about patients who are in a grossly deteriorated state in their lodging houses. The hostels keep a record of whether the mental health unit returns their calls. This is terrible for public perceptions. If it seems that the mental health services are unable or unwilling to respond then the community feels abandoned, I suppose.

Senator SCULLION—From your submission, and perhaps some of your answers, you are obviously a fairly cautious and considered individual and you go to great pains to ensure that you are not putting one side against another. I want to get this clear in my mind. You appear to say, very rightly, that when we decided to go down the path of deinstitutionalising the treatment of mental illness, we probably went a little too far. I think that has been reflected in the wider community. There is a demographic caught up in that, which we read about in the newspapers and so on, that do not have the level of amenity to deal with this. I think that is what you are talking about.

Dr Byrne—Indeed.

Senator SCULLION—In your submission you talk a lot about wards. Thinking about wards inside a hospital, I have some difficulty seeing how we could deal with assaultive behaviour of schizophrenics in a hospital environment in the long term. You have indicated that the deterioration of the quality of a therapeutic environment in those areas would be difficult. We are talking about a new place potentially with a different level of amenity than those dark prison-like places that we moved out of. You are actually talking about a separate level of amenity rather than a hospital ward. Is this a concept of a new institution for these people, or are you saying that we can have this level of amenity in an existing hospital?

Dr Byrne—This is a very important issue which is well worth thinking through. One of the points I made in my submission was that I thought these kinds of facilities should be collocated with acute hospital services.

I find it difficult to get away from the model of the psychiatric hospital where there can be acute and chronic services side by side. We do have such acute wards in different parts of the country—for example in Perth we still have a residual Graylands hospital, much reduced from what it was. But in other parts of Western Australia and the country we have locked wards in general hospitals. These are facilities where people whose behaviour may be very disturbed—including violence and repeated self-harm—can get that intensive level of monitoring.

Before I came to this committee I spoke to the clinical director at Graylands. He did a quick check for me and estimated that they have about 25 long-term patients in the acute wards at Graylands now. The challenge is to have long-stay services for patients who are potentially violent or self-harming in such a way that you can work on their rehabilitation in an unlocked, open setting with the ready backup of a locked ward—and the staff and acute services—when things deteriorate. That was one of the strengths of the psychiatric hospitals—the fact that they had that backup on site. You cannot do that, I think, in a community-based rehabilitation ward. It is dangerous and it does not work; the person ends up back in the acute, locked ward.

Senator SCULLION—We have had evidence today that a large number of Western Australians who are currently incarcerated in prisons—for whatever reason—are actually sick. If the recommendations that we have heard today from the Attorney-General come to fruition and they make some attempts to move these people where they should be, to a place when they can be treated for their sickness, then the level of amenity that you are talking about will need to take cognisance of those people as well. Clearly, there is a level of safety that the community would demand in those circumstances. Can you see that level of amenity being encompassed in the sort of place that is collocated with a hospital? Those are the sorts of people you no doubt would have dealt with.

Dr Byrne—In parts of Australia like Perth or Adelaide there still are residual psychiatric hospitals like Graylands or Glenside—or, for that matter, in Sydney there is Callan Park, sort of hanging in the breeze. We should take advantage of that. We should get our heads past this cultural barrier that says psychiatric hospitals are bad, and use that as the ground from which to rebuild some of those services, but—and I stress—without there being an issue about reinstitutionalisation. It is actually about developing appropriate services.

Senator SCULLION—And treatment.

Dr Byrne—Yes.

Senator SCULLION—Thank you, doctor.

Dr Byrne—Thank you.

CHAIR—Could you respond to a question about what consumers think of this proposal. Do you get the sense that people understand that they are being bounced from one inadequate

service to another and that they are not getting long-term treatment? Or do they want to be as far away from a psych hospital as they possibly can?

Dr Byrne—Most people, including most people with psychotic illness, I think, quite wisely and appropriately, want to be as far away from hospital as they possibly can. There is nothing wrong with that and as long as they are coping and getting community treatment, I completely support them in that wish to have a normal life or something approaching a normal life. The relatively small group of people with a really severe disability have such impairment of their competence and decision-making that to ask them, ‘What do you want?’ or, ‘What service is going to meet your needs?’ are unfair questions. They are barely able to cope with daily life.

When I was involved in the closure of Heathcote we targeted the people who had had relatively long stays there. Although Heathcote never had any really long-stay wards, unlike Graylands, we had accumulated some patients who were in and out and in and out. They were the ones who were likely to need a lot of help to live in the community after Heathcote was closed. It was a time of mixed emotions. Sometimes it was exciting but sometimes it was tragic to work with these people who had the chance of living in a flat or living in some sort of setting in the community but then seeing them fail, seeing them getting into drug abuse or alcohol abuse. They were not able to provide for food or were found at large incontinent or with some other offensive behaviour. One fellow cut an artery in his neck in his flat and there was blood all over his walls.

I do not know if I am being clear here but the point I am making is that we must be able to say to some people, ‘What is going to happen in your life in the next couple of years is that you are going to be in the long-term rehab setting in a hospital. You don’t know where this is going to end up but we’re going to help you get somewhere better than where you are now.’ People do not take that message on board straightaway, but they do eventually. I am only advocating that we should say this to a small minority of people.

CHAIR—We are only talking about 200 for the whole of Western Australia, so they are presumably the people at the most extreme end of the spectrum. Thank you very much for the perspective, Dr Byrne. We have not had a submission of that sort so far, so it is very useful to us.

[11.38 am]

JONES, Ms Margaret Lynn, Consultant Clinical Psychologist representing North Metropolitan Area Health Service, Child and Adolescent Health Services on the Child and Adolescent Mental Health Services Advisory Committee

MARWICK, Mr Patrick John, Chairperson, Child and Adolescent Mental Health Services Advisory Committee

CHAIR—Channel 7 has asked to come in and take footage. Do you have any objection to that?

Mr Marwick—No.

CHAIR—I now welcome representatives from the Western Australian Child and Adolescent Mental Health Services Advisory Committee.

Mr Marwick—My occupation is program manager for the new initiative in WA called multisystemic therapy, MST, which is a program targeted towards young people with conduct and behavioural disorders.

CHAIR—You have lodged a submission with the committee which we have numbered 24. Do you want to make any amendments or additions to that document?

Mr Marwick—I have some summary comments.

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

Mr Marwick—The first thing to point out, which I have also made clear in the submission, is that the opinions provided are those of the Child and Adolescent Mental Health Services Advisory Committee—which largely represents the Western Australian public sector child and adolescent mental health service providers—and may not reflect the opinions of all clinicians within the sector and they certainly may not reflect the opinions of the state health department. I know that the committee has received submissions from the department, which will present its own views, and it is my understanding that we are not saying anything that is particularly contradicted by the department's views and that there is a fair degree of consistency.

The first comment to reiterate is that the prevalence of mental health disorders in infants, children and young people is estimated at between 14 and 18 per cent. That is from the National Health and Wellbeing Survey. The Western Australian contribution to those figures was from the child health study done in 1993, which did have some regions with slightly higher proportions than that.

Serious mental disorder affects between and three and seven per cent of all infants, children and young people. The current capacity in WA—certainly from the public sector point of view

and from my own experience as a clinical manager of child and adolescent services until recently—is just less than one per cent. So there is clearly a significant gap between the current capacity and the requirement in the population. That means that the current funding of child and adolescent mental health services in WA does not enable service delivery to comprehensively meet the national standards on mental health.

Greater investment is required in mental health services for infants, children, young people and their families. CAMHSAC would like to advocate that a minimum of 15 per cent of the mental health budget should be dedicated to infants, children and adolescent mental health services and that that should occur within a five-year period. We would like to see the proportion of funding reach 20 per cent by 2015, which would see the growth consistent with the WHO predictions of developments in morbidity and population. The proportion of the population in Western Australia—obviously there are some regional variations—of infants, children and young people up to the age of 18 is around 25 per cent. We are looking at something similar to that proportion in the longer term.

Infants, children and young people must be considered within their developmental context. The involvement of primary carers, which are usually parents but not always, and systems of care such as schools, which occupy a fairly major part in most children's and young people's lives, must be involved in the assessment and interventions provided to ameliorate mental disorder particularly in infants, children and adolescents.

Infants, children and young people must not be seen as small adults, thus requiring smaller amounts of investment. It is fairly clear that we do suffer from that kind of perception or that we can make that attribution at times to the current funding arrangements. I have commented at times that, from my observations, the per capita investment in mental health services of children in WA—this was some years ago so it has changed—was roughly in the mid-teens, at about \$16 per capita; the investment in adults was around \$45 per capita; and the investment in older people was around \$70 per capita. So we have a fairly consistent relationship between age and per capita investment.

Investment in a child is an investment in the future of that child, of the community and of the country. Children and young people have a right to participate in the planning, development and management of mental health services. Appropriate modellings are available for this. A fair bit of work has been done in many Australian states and we have had some attempts at engaging children and adolescents and their carers in appropriate infrastructure to represent their views. However, unfortunately at the moment there are no state-wide resources that are particularly dedicated to the engagement of children and adolescents as consumers. That is problematic. Resources must be provided to support the involvement of consumers and carers in meaningful partnerships with service providers and planners.

On the theme of partnerships, we need to see and have been working to promote a range of partnerships across government and non-government primary care and other secondary service providers. Investment must be made in the development and maintenance of these infrastructures which promote effective partnerships with consumers and carers. I note our partnerships with GPs. In the CAMH sector, GPs tend to be the referrers of about 35 per cent of children and adolescents who are seen within child and adolescent mental health services, with schools and school support services being the other large referral source.

In addition there are local government youth services, non-government youth services, welfare and justice services. As I have mentioned, multisystemic therapy is a research based service model that provides fairly clear evidence of the cost effectiveness of comprehensive investment in systems of care. So we are looking at assessments and interventions that target not only the child or the child's family but the ecological context of that child's life.

A commitment to research is required to support the development and implementation of evidence based practice within child and adolescent mental health services in WA. Currently, whilst we are fortunate to have the Institute of Child Health Research, we do not actually have any dedicated resource within the CAMHS sector to support research. Research is often carried out on the smell of an oily rag; people get hold of bits and pieces of money from clinical services as they are able to prioritise resource activities.

It is the view of the CAMHS Advisory Committee—and I do not think it is a particularly contentious view—that service development needs to be supported by the needs of the population and that research is fairly critical to getting access to population needs, as well as consultation with and input from consumers and carers which will promote the development of relevant and targeted services.

We need to develop and appropriately fund specifically targeted services for a range of special needs and disadvantaged groups—you will have heard of many of these previously—including infants, children of parents with a mental illness, young people with substance abuse problems, children in care, siblings of children with chronic illnesses, children exposed to family violence, Indigenous children and young people, and children and young people in detention.

CAMHSAC would also like to see specific attention paid to early intervention and prevention, including programs for infants and parents. There is a fair bit of research around that supports particular models to get involved in providing support and intervention services to infants and their carers.

Simon referred to the need to have a well-educated work force. As he indicated, and as was raised in the discussion, work force development is a fairly critical issue at the moment, particularly with some of the local strategy of funding increased FTE and the need to recruit. It is critical that we have a dedicated education program to provide services to children and adolescents. We cannot get by with the view that children are small adults and that a bit of education for an adult mental health service provider will do for kids, because of course it does not. In fact, the requirement is that clinicians working with children need additional training to be able to understand the specific developmental and contextual requirements of children and young people.

As we have noted, we need an agreed-upon research agenda. We need to develop and evaluate models of care, particularly those that include collaboration between a range of agencies and which deal with the ecology of the child, which includes partnerships and links with other service providers. It is important to improve the capacity of primary health care providers, in particular GPs, but I also emphasise the role of school support services, other welfare providers, youth workers et cetera. We do not currently have any dedicated GP liaison officers within the CAMHS sector. That is a critical need when it comes to capacity building within the primary sector.

There is a need for adequate outcome evaluation, which includes areas such as a coordinated state-wide approach to waitlist reduction, waitlist audits, treatment efficacy for specific disorders et cetera. There is a need, which I think was implied in some of Simon's comments, for the development of effective coordinated community based emergency or acute response capacity for children and adolescents—particularly for young people.

CAMHSAC would like to advocate for the development of a coordinated approach at both the state level—in the context of this committee—and the national level to develop a dedicated infant, child and young person's mental health action plan which would complement or be part of the National Mental Health Plan, with a dedicated state by state approach to implementation of the plan in a consistent manner, as I understand happens in other countries in the developed world.

We would like to advocate that a strategy for the development of an infant, child and young person's mental health action plan could occur through a national mental health summit, which would include key stakeholders from across the country. The summit may inform the development of a dedicated action plan, which I think would highlight and put on the agenda in a more significant way the needs of children and young people.

CHAIR—I refer to your comment about children and post traumatic stress disorder. It comes under our terms of reference (k), which deals with seclusion. You paint this fairly alarming picture:

Humane treatment often assists in reducing the impact of the traumatic experience of acute symptomatology and associated hospitalization. The current trend towards increasing levels of control and surveillance in response to agitation and arousal appears to be developing into a self sustaining spiral which is informing the development of an industry of control and insecurity.

Can you expand on that? What is happening in Western Australia with children and control?

Mr Marwick—I am not sure it is happening just in Western Australia. Perhaps it highlights more a risk and a possible development than the concrete situation on the ground at the moment. Certainly it is as a consequence of some of the adverse incidents that have occurred, largely in adult mental health sectors. There have been some investigations by Western Australia's WorkSafe agency, which is responsible for looking at the safety of staff and the general public within state government facilities, particularly over an incident at Swan Clinic in recent years. That approach developed some recommendations, which have generated quite a lot of discussion, concerning the appropriateness of the direct implementation of the recommendations without further consideration of their impact on the relationship with clients within Child and Adolescent Mental Health Services.

CHAIR—What are we talking about here?

Mr Marwick—The use of barriers in reception areas to prevent people getting access to the administrative and reception areas, the use of secure interview rooms, the use of barriers within cars. These have some application in adult services, but I think the outcome of the deliberations that have gone on has been to define it more specifically to particular circumstances and

facilities rather than there being a blanket approach which would run the risk of jeopardising the ability of clinicians to engage effectively with their clients.

CHAIR—Does such an environment affect children in a more serious way than it does adults?

Ms Jones—From a developmental perspective, adolescents, particularly those of middle adolescent age—15- to 18 years of age—are learning their self-control. They are learning how to manage their emotions. If you put them in an environment that assumes that they need to be as restricted as an adult—that you assume to have that kind of control, or the capacity for it, already—it can sometimes be quite a traumatising experience for them. It means that when you do try to help them to understand how to manage their emotions, you are hitting them with a bit of a double whammy.

One of the issues is that it is as much about the education of staff. Some points were made earlier about the training of staff in child and adolescent mental health facilities. It can be doubly difficult to get, for example, mental health nurses who have specific child and adolescent training. When there are safety issues, if they apply the same kinds of approaches that you would use with an adult it is quite difficult then for adolescents to not experience that as traumatic and controlling and to then move forward developmentally and gain some appropriate ways to deal with their environment.

CHAIR—This obviously has implications for children who are in immigration detention. Was your society involved in the issue in Western Australia? Did you go into detention centres?

Mr Marwick—No. We have never been directly involved. We have followed some of the literature.

Ms Jones—We have not been involved.

CHAIR—We will hear shortly from two groups about attention deficit disorder and arguments about the prescription or not of medication. Have you done any work in this area? Do you have research that might be of use to the committee in this respect? Is there something you would like us to hear?

Mr Marwick—I was recently involved in a working group that looked at attention disorders, made recommendations to the Office of Mental Health and considered the various reports that have been released in WA in recent years. Western Australia has a reputation, as I am sure you will hear from the speakers this afternoon, for having a fairly high prescription incidence with children. I do not think there is any doubt that some children end up receiving stimulant medication when they should not. By the same token, there are many children who have genuine attention problems which do respond well to the use of stimulant medication appropriately prescribed. Within the CAMHS sector we have tried to develop multidisciplinary approaches to the assessment and treatment.

CHAIR—I do not think that there is anybody disagreeing about the need for that.

Mr Marwick—No. There is a particular model that enables effective diagnosis. I think one of the issues is that you do occasionally have very busy specialists who diagnose on the basis of information presented by anxious or concerned parents and may run the risk of misdiagnosing and perhaps doing an incomplete assessment of the presentation. The multidisciplinary approach provides some protection against misdiagnosis.

Senator HUMPHRIES—There was something else in your submission which caught my eye. I am happy for you to explain it to me. You say:

Diversionary programmes often provide mental health services with a reluctant and disengaged client, making the provision of clinical services problematic.

I assume you are talking about children there.

Mr Marwick—Yes.

Senator HUMPHRIES—What sort of circumstance are you describing there?

Mr Marwick—The diversionary programs that come to mind are those that are sometimes engaged by justice services and school services, who may exclude a child from school, in the latter case, with the requirement that they attend some sort of service, so there is a coercive component to the service. Multisystemic therapy, on the other hand, is a model that emphasises engagement with the family rather than the use of coercion by other authorities as the way that you get results. The evidence from the multisystemic therapy experience over the last 20 years would suggest that, and certainly my advocacy would be for services to invest in engagement rather than in coercion.

Senator HUMPHRIES—So it is more about the means of entry to the program.

Mr Marwick—Yes. Which can in fact raise barriers to engagement by clinicians with young people and families.

Senator HUMPHRIES—You do not argue against diversionary programs, presumably.

Mr Marwick—No.

Senator HUMPHRIES—In your submission you talk about the need for specific services for adolescents and children. I am aware that in areas where they have psychiatric beds in hospitals they will attempt to separate children from adults. They are not always successful but they will try to do that. You are arguing to go rather further than that and create more specialised services for children and adolescents as much as possible. I think you make a very respectable case for that.

I am going to be a devil's advocate for a minute. In a state like Western Australia, where you have two million people living in an area the size of western Europe, you have to separate services by region. You cover the Kimberley and Perth, and obviously they are too far apart to provide common services to them. You break down the services again by separating Indigenous from non-Indigenous services, and it is obvious to separate psychiatric from non-psychiatric

services. You further divide what is left between adults, adolescents, children and maybe youth, and then there would be further divisions based on the nature of illnesses, such as separating trauma induced illnesses from chronic illnesses et cetera. Are we at a point where to divide to that level destroys economies of scale, prevents or inhibits cross-fertilisation of disciplines and, because they are so specialised, perhaps puts services physically too far away from family homes to be effective means of treating young people?

Ms Jones—It is possible to put services like that with other child and adolescent services. That then means that you have a kind of continuity of care. For example, on the Bentley campus, where there is an in-patient unit, there is also a transition unit and there is also a child and adolescent mental health service. That is a system where those services can work quite well together.

I am sure many people have already talked to you about the problem with putting adolescents regularly in adult psychiatric units. We would hope that it would not happen that a 14-year-old with signs of early psychosis or severe depression or who is self-harming to a significant effect would for the first time be placed in an adult unit. But at 16 it certainly could happen here that they were placed with an 82-year-old dementing person. We believe it is probably delaying the recovery of the younger people. It is often their first encounter with mental health services and they are likely to go on and have a few others over the following two to three years, at minimum.

So, yes, economies of scale are a problem, but on the other hand it is an investment that you are making in these people's mental health that will have long-term benefits for them. If we do not make it, it tends to be quite traumatising. Services going out to and receiving these people then have to do quite a lot of work around that which they would not otherwise expect to do, not only with the young person but also with their family, who have also been through a fairly traumatic experience with their son or daughter being in that kind of environment for a period of time.

Mr Marwick—The synergies come more from co-location with other child health services rather than adult mental health services.

Senator MOORE—When we were in Melbourne we had a chance to go and visit the ORYGEN group. Their approach was very much based on a multidisciplinary team and quite intensive action, child based, using consumers. There was discussion in their submission about how that model could be transported. They were talking about funding as well as goodwill. Is that the kind of model that you would be looking at, with a WA flavour?

Mr Marwick—Yes. To some extent the rudiments of that model exist in WA. The CAMHS sector is very much a multidisciplinary sector with a strong focus on targeting services towards the areas of need. ORYGEN came out of early psychosis work with Patrick McGorry and has developed as a specialist service covering the age range of young people that emerge with first episode psychosis. We have been utilising that model to some extent in mental health services in Australia for children, adolescents and adults. I would agree with that sort of targeted approach to specific disorders with specific populations that addresses the particular requirements of the age development status and brings together the research based evidence that promotes best assessment, best quality interventions and best engaging of families and consumers. The general principles of that model are ones that we would certainly endorse.

Ms Jones—And particularly the system of care principles. One thing that is so different about working with children and adolescents is that it is very labour intensive. You need a multidisciplinary team. You need to do a lot of work. Community based treatment is more expensive from that point of view. You are not relying on medication as much, but you are relying on quite a lot of service delivery. You are asking quite a lot of families too. It is quite important that they be very involved in the process.

The education department have tended to look less to other systems, I think, in their model. When you have a 14- or 15-year-old who goes into hospital for a couple of weeks and has been pretty unwell before that, you can imagine what has happened to their peer relationships in the school setting and their education and all of those sorts of things. The models that were developed around early psychosis—the specialised models—were not really concentrating on that kind of focus because the age range was older. So they did not really need to consider that kind of interface with the education sector, what it means for a young person in terms of the career path they take, how well they will be in the future and all of that kind of stuff. So, yes, there are the basic principles, but we would look to incorporate that and bring it further into a broader system of care across the departments too.

Senator MOORE—Your submission actually says that the sector is frustrated by poor coordination, fragmentation and little cohesion.

Mr Marwick—That is right. That refers to the point that was being made earlier about where the synergies occur. Child and adolescent mental health services are part of the mental health structure. To some extent that provides some restraints to the development of synergies across child health or across child and adolescent services more broadly. We would be looking at expanding into interrelationships with other child and adolescent services.

Senator SCULLION—In the interests of time I will ask one question, although this is very interesting and I could ask a number of questions. In regard to my colleague's earlier remarks about ORYGEN, one of the most notable experiences I had in speaking particularly to the consumers was hearing about the opportunity to use the consumers in the delivery of some of the services. They told me that nobody knew more about somebody in their demographic moving through the process than they did. They are actually being used in ORYGEN, as you know, not in service delivery but certainly in lobbying people like us. They do it extremely effectively. But I was speaking to the consumers and they were quite excited about the next step, which is being involved in service delivery. They are coming from a demographic that does not have a great deal of opportunity sometimes in employment. These people felt they could be used better in terms of actually delivering some of the services and having a job and those sorts of things. Through no fault of their own, they have suddenly fallen upon this experience. It is not particularly pleasant, but at least it can be used to some benefit. Do you think that is a reasonable expectation of some of these individuals? Do you think that can ever be the case? Do you think we can make that leap of faith?

Mr Marwick—That consumers could become service providers?

Senator SCULLION—Or should be encouraged to do so.

Mr Marwick—Indeed. It is clearly a question of the role they are playing as service providers. Certainly, I have been aware of and had some experience of a consumer advocacy program—the adult mental health consumers group in the south metropolitan area in WA—which was very successful in providing a voice for consumers to increase their capacity to act as advocates across the board. The issue I think we want to highlight is the need to actually resource children and adolescents as consumers and to develop some sort of infrastructure and relationships to enable them to have a voice in the planning and management, primarily as advocates. I do not know that we can see consumers providing clinical services per se. You obviously need a range of training and experience to do that. However, there is no reason why—

Senator SCULLION—I have to say that they strongly disagree with you.

Mr Marwick—Yes, indeed.

Senator SCULLION—They said that the people with all of these skills are the worst people you would talk to. That was the reason for my question.

Mr Marwick—That is a debate that can be had. I think there is some acknowledgment that clinicians do bring some particular knowledge and skills to the relationship.

Senator WEBBER—The state government has a much-heralded commitment to expanding its funding for mental health. There is some \$173 million. How much if any of that is going to CAMHS?

Mr Marwick—I do not know how much. Some of it certainly is.

Senator WEBBER—A little bit?

Mr Marwick—Yes. I would argue that it is not enough. We would argue that clearly—

Senator SCULLION—It is a ‘small adult’ amount?

Mr Marwick—That is right.

Senator WEBBER—Or an ‘infant’ amount?

Mr Marwick—An ‘infant’ amount, yes. What we would like to see is the funding being proportionate to the population.

Senator WEBBER—I am coming to that.

Mr Marwick—The morbidity is consistent across the age range.

Senator WEBBER—On that, the state government’s submission talks about where they are going to expand services for young people. It is all in the Perth metropolitan area.

Mr Marwick—Yes.

Senator WEBBER—It does not mention anything about young people outside Perth. If you go up to the Kimberley, obviously the overall population is younger. If we accept your proposition that the proportion of funding that should go to CAMHS is 20 per cent by 2015, how would we ensure that some of that actually got out of Perth? You are not going to have those synergies that you were talking about, with Bentley or whatever.

Ms Jones—A big issue there is going to be attracting the work force to go out there. There is work at the moment being done by child and adolescent mental health clinicians that work across the state. They have support via videoconference and they have access to a psychiatrist by videoconference for two sessions a week, so there are ways of doing that kind of stuff. In WA, videoconferencing is used a lot between the regional centres, and there is no reason that could not happen. The difficulty is far more in attracting well-trained staff to work in those areas.

Senator WEBBER—Do we have any idea? There is no point in saying, ‘Give us more money.’

Ms Jones—Yes. We proposed a few things: a training program and some kind of incentives for people to go to the country. High-level positions in the country, for example, might attract people. There are all sorts of things that could be done in this area that are not being done at the moment—for example, traineeships. There are ways that you could encourage people currently in professional training programs to go into placements in the country. We know that once they do things like that, such as GP training and experience, they are more likely to stay there. Those kinds of incentives have not really been tried for the CAMHS area.

Mr Marwick—I think there is a requirement for additional resources to provide a state-wide CAMHS coordinating function, which can provide some sort of oversight of where the dollars are going, where they end up and how they get used.

Senator WEBBER—My final question is about school support services. I live in Perth, but I am not originally from Western Australia; I did my education over in the east. I am surprised at the marked difference between the support provided to you over in the east, particularly going through high school, and that provided here. I refer to the employment of psychologists in high schools and what have you. There does not seem to be that kind of focus here.

Ms Jones—And it is not coordinated. To my knowledge, there is not a coordinated mental health strategy that involves all of the departments and that would allow that kind of thing to happen as well. We talked in our submission about the silo approach; people are operating in their silos, and often you do not know what is happening in the other departments anyway. That is just crying out for some way of addressing it in a properly resourced needs assessment manner.

Senator TROETH—My question is roughly along those lines: the existence or not of school counsellors. I take it that that is up to each school to determine.

Mr Marwick—The state education system is organised into regional districts, so we have Peel-Fremantle covering the south-west metropolitan corridor, and I think there is one in the north called the north-west metropolitan corridor. They provide the school support services to the schools within that catchment area. Whilst they exist, I know from talking and working quite

closely with some of the managers of those services that they are very stretched. There is a huge demand placed on them by schools, and they are often responding to crisis situations.

Ms Jones—A new mandate is more often to help the schools with a behavioural problem, rather than to help—

Senator TROETH—Yes, that is right. Quite often, in my experience, they would be teachers from the school with another element added on to their duties, rather than a specifically trained school counsellor.

Ms Jones—In Western Australia, it is a bit of a mixture in school support services. There are school psychologists who are specifically trained. There are one or two school social workers, and there are specialised teachers performing that kind of role. Also, pastoral care seems to be a large part of the role in many schools—

Senator TROETH—So it does depend on the region and the resources.

Mr Marwick—On the resources available.

CHAIR—Thank you. It was a very useful submission.

[12.15 pm]

BADCOCK, Dr Johanna, Committee member and Western Australian representative, Australasian Society for Psychiatric Research

JABLENSKY, Professor Assen, Member, Australasian Society for Psychiatric Research

MORGAN, Ms Vera, President, Australasian Society for Psychiatric Research

CHAIR—Welcome. You have lodged with the committee a submission which we have numbered 277. Are there any amendments or additions you want to make to that document at this stage?

Ms Morgan—There are no amendments. We have some materials that I will ask the secretariat to distribute, as we are speaking.

CHAIR—Could you go to an opening statement and then we will ask you questions.

Ms Morgan—I will start with a brief overview. I will ask Professor Jablensky to expand on the nature of and the burden associated with mental illness and to describe the potential impact of research on alleviating suffering and on reducing costs. My colleague Dr Jo Badcock will build on what Professor Jablensky says by describing the different targets of research and the need for a variety of research strategies to achieve those targets. I will present some unique research conducted in WA, since we are in a WA setting, and conclude with a statement about research infrastructure. We have a few handouts which I hope will make it easier for senators to follow our talk about research. There are three coloured diagrams which we will go through in order.

Before we go to the coloured handouts, we are addressing term of reference (n), with relation to mental health research. We are arguing that funding levels need to increase, that Commonwealth funding schemes must distinguish between high prevalence disorders, such as depression and anxiety, and low prevalence disorders such as schizophrenia and bipolar disorder; that they need to fund adequately and separately both arms of research; and that Commonwealth funding schemes need to build up a strong infrastructure of people and facilities to ensure that the best use is made of research funding. Professor Jablensky will talk to the first overhead.

Prof. Jablensky—I had the privilege to be a member of the working group which was established by the Prime Minister's science, engineering and innovation committee in 2003. As you are undoubtedly aware, it submitted a report to the Prime Minister on brain and mind disorders. That was followed by the establishment of a national task force to take up some of the recommendations of the report and develop the operational framework for their implementation. At the basis of all that was accumulating evidence from research, internationally as well as in Australia, that disorders of brain and mind, as we now term this group of conditions, constitutes the largest contributor to the level of disability in most industrialised societies. In Australia, they are undoubtedly No. 1 in terms of years of productive life lost and the burden of disease. The social and economic costs are enormous.

A major problem identified by the working group was dementia, which is age related. The most common cause of dementia is Alzheimer's disease. This problem is increasing because due to the ageing of the population the number of people affected by dementia at any point in time is growing. At present it is about 160,000 or 170,000. That number will probably double, or even treble, in the next 25 or 30 years.

The other major problem is disorders which have their onset relatively early, in late adolescence or early adulthood, like schizophrenia and bipolar disorder. We took a prevalence count several years ago. In Australia, about 40,000 people are affected with schizophrenia at any point in time. If you examine the evidence, the costs—not only the costs directly attributed to treatment but also the costs of lost productivity and lost opportunities for the affected person as well as for their families—amount to about \$6.6 million per annum for dementia and about \$1.9 million per annum for schizophrenia. These are just two disorders.

It was estimated that if we apply today the best evidence supported treatments and optimise our service provision we would probably be able to control or reduce the prevalence by something like 45 and 50 per cent, but more than 50 per cent of the burden of disease is not preventable or controllable with the means we have today. This is where research comes in. Australian research has been, in many respects, in the forefront of neuroscience research. Many innovations are the result of Australian effort. However, its relative support compared to support for other health conditions is very modest. At present the NHMRC's spending on project and program grants is about \$31 million per annum under the umbrella of 'mental health', with a very unequal distribution within that total according to the severity of the problem and the availability of the means to scientifically address that problem. This is where the need for more cross-disciplinary national and international collaboration comes in and where the role of the Australasian Society for Psychiatric Research—a voluntary association of researchers from several disciplines—will play an important part. Thank you.

Dr Badcock—I would like to pick up some of Assen's comments regarding the second handout. The National Practice Standards for the Mental Health Workforce call for the best possible outcomes for consumers. The quality of those outcomes depends heavily on evidence based research. In the case of a low prevalence disorder such as schizophrenia this may involve, for example, working out which of two new antipsychotic medications is more effective or whether combining psychological therapies with medication is better than medication alone. Applied research of that sort is obviously important, with immediate benefits for individual patients.

Unfortunately, our current treatments for mental illnesses are not 100 per cent effective. An exclusive focus on symptoms is probably inappropriate. Current research, including our own research here in Perth, shows that combining symptom evaluation with cognitive assessments of, for example, memory, attention, language functions and so forth, provides a much better description of patient problems and a better definition of those problems.

This level of research feeds back on treatment studies as well. So, for example, the cognitive difficulties that are now being identified provide new targets for the next generation of drug therapies that could be followed up. This level of translational research often requires a much longer time frame, however, to achieve its goals. But the yield is longer lasting benefits for patients.

Improved mental health assessment also increases the impact of neuroscience research, which is aimed at the biological and genetic causes of mental illnesses. But, again, this level of research often requires an extended time frame. In our own case at CCRN, much of our research is only beginning to come to fruition after a 10-year period. This is often the case with the low prevalence disorders in particular. However, whilst the first level of research occurs after a mental illness has already fully developed, the second and third layers of research provide opportunities for much earlier identification of illnesses. In particular, this allows us to begin to identify individuals who are at risk—so before the full symptom development has occurred—and therefore provides a focus for preventative solutions. It is important that funding policies recognise the different targets and outcomes of research and their interdependence and also the different modalities of research that are required to achieve these goals.

Ms Morgan—I will very briefly talk about the unique methodology for research that we have available to us in Western Australia, summarised in the handout here, which is research using links between multiple health and other registers to understand risk and protective factors in mental illness. I will not describe these in detail but I am happy to answer any questions about them, as are the other members of our team here. Briefly, the three projects that I describe here are peri-natal and developmental risk factors for the children of women with serious mental illness, the risk of offending associated with mental illness and the link between intellectual disability and mental illness. They are all research projects that we have the capacity to take on because we have the capacity to link between registers and work at depth, at a population level.

To conclude our overview, I want to talk about research infrastructure. It is very difficult to attract our best students or even any students into research careers. This is across the board. Grant funded positions are difficult, and research positions are intrinsically different from teaching positions in academia. Grant funded positions tend to lead to poorly articulated career paths, poor conditions of employment and no job security past the point of the grant. We need to build up a strong infrastructure, particularly in terms of people, if we are to achieve research excellence. This includes boosting the number of postdoctoral positions for newly completed PhD students and creating real positions in research that will form the basis of long-term careers.

Senator HUMPHRIES—I do not know if you have seen the Health Consumers Council of WA's submission to the inquiry. This is what they have to say about mental health research:

This research is costly and painfully slow at revealing meaningful insights into the operation of the brain in both well and mentally ill people. The prospect of any of this research yielding treatments for consumers in the near to medium term is limited.

They go on to say that an audit of the costs of the research should be carried out to see whether the real beneficiaries of the research are pharmaceutical companies and the researchers themselves. That is fairly unflattering stuff. What would you say in response to those criticisms?

Ms Morgan—I chair the research committee of the Mental Health Council of Australia, which has the strongest representation of consumer bodies in Australia. We hear that there to some extent. I think Dr Badcock covered that issue in part by describing the fact that there are different modalities and different targets. What is coming out in that statement is one target and one modality. The different modalities feed into one another, and pure research has a really important role to play. As researchers we also have an important role to play. Our role is to make

sure that consumers understand what we are doing and why we are doing it. In fact, one of my strategies on the Mental Health Council, as the Australasian Society for Psychiatric Research representative, is to have a research day next year for the representatives of consumer bodies on the council, to help bring into the arena what it is that the different arms of research are doing.

Senator HUMPHRIES—Do you think there is a way to go with explaining to consumers and other stakeholders in the mental health area what role research plays?

Ms Morgan—I think so. We have not done it very well in the past. The others may like to comment on that.

Prof. Jablensky—I respect very much the point of view of the consumer. I agree that the interface between the people who are actively involved in research and the consumers' needs need to be much improved. At the research centre, of which I am director and my colleagues are researchers, we have a research standing committee. On that standing committee we have two consumer representatives, so we have created such a link between our role in research and the community's or the consumers'. There is still a long way to go for this interaction and the more direct involvement of consumers. In defining the research priority, as well as in making the research process more accountable and transparent to the community, there is still much to be desired. I take that point.

Senator HUMPHRIES—I may give a bit of gratuitous advice. Very often what goes on with mainstream medical research is that there is a lot of trumpeting of successes, and breakthroughs are taken to the media and made a lot of. I make the suggestion that, if such things occur in psychiatric research, it would be beneficial in terms of selling the benefits of research that those sorts of things occur, as well. That is just a throwaway line from a professional self-promoter!

Ms Morgan—We have to work better with the media, do we?

Senator HUMPHRIES—Good luck to you on that score, as well. I have just one further question. In recommendation 4, you suggest:

That research funding may be contingent on the dissemination of the results.

I am surprised that that would be suggested, in that it implies that it does not happen at the moment. Surely there is a requirement on any funding body providing for research to have some kind of dissemination of results?

Ms Morgan—Within the current grant there is no specific requirement that results be disseminated. In future grant applications, people look back at the dissemination, but the dissemination is often in academic journals. What we are saying in this recommendation is that it needs to be broadly disseminated. Sometimes that includes going out and talking to consumer groups and Rotary groups. There is a whole range of people out there who are just not reading the academic journals. We should be able to report back to funding bodies in our annual reports.

Dr Badcock—That also includes dissemination to the other health professionals so that there is an interface between the researcher and the professionals.

Prof. Jablensky—It is important to know that the word ‘dissemination’ in this context is not restricted to scientific publications and journals, which are mandatory for any competitive grant funding, but applying to this broader interface with communities and other professions.

Senator MOORE—I have so many questions, but I will focus on one area. Ms Morgan, you mentioned the three particular research areas that you are involved in now. Each of those issues has been raised in evidence before our committee. Were those three research areas funded through NHMRC? I have not read the handout yet; the answer may be there.

Ms Morgan—It is not there. Two of them have been. The first one, women with severe mental illness and their children, has been funded by NHMRC, the Stanley Foundation in the United States and the March of Dimes Foundation in the United States. Professor Jablensky is the program director on that series of work.

Senator MOORE—It is a critical area.

Ms Morgan—Criminal offending and mental illness has been funded by the NHMRC and, more recently, the Criminology Research Council. Comorbid psychiatric morbidity and intellectual disability has a UWA grant for funding.

Senator MOORE—How long is the grant for each of those programs? Is it about two years?

Ms Morgan—The one for mothers with psychosis and children has been running since 1995. We have had continuing funding for that one.

Senator MOORE—So it is ongoing. You do not have to reapply?

Ms Morgan—We have been reapplying and getting funding.

Senator MOORE—Fabulous. What about the other two?

Ms Morgan—The criminal offending and mental illness has had two lots of funding over a period of about eight years, so we got some funding, had a break, and then got some more funding. The psychiatric morbidity and intellectual disability is just a recent one-year bucket of money.

Senator MOORE—In Melbourne we had evidence from a number of consumer groups, and one of the advocates who came forward is involved in research. She has come through the consumer network and is now studying at a very high level and is working on research. Her comments were about the difficulty of getting NHMRC funding for any of these areas. Is that something that your group has encountered, or have you been able to, because of the standing of your organisation, attract funding more easily?

Prof. Jablensky—The only way to attract NHMRC funding is to submit high-quality research applications which are backed by preliminary results, sound methodology and a reasonable track record of the investigators. We have, in a way, been lucky. The NHMRC clearly is interested in the kinds of research which potentially have implications for significant service provision improvements. In this particular study we have been following up the life histories of women

with severe mental disorders who have children, and now we are reconstructing the history of their children up to the age of 25, when they are at a high risk themselves of developing a mental disorder, and identifying risk factors. This is the kind of research for which we had relatively little difficulty getting both NHMRC and American funding. We had a major publication, which appeared earlier this year in the *American Journal of Psychiatry*, on the first phase of this research.

Senator TROETH—Is the concern that Australia, as a country, is not producing research excellence, or do we have budding or emerging researchers who then go to other countries to produce their research?

Prof. Jablensky—Unfortunately, yes, this is happening. Over the last 10 years in Western Australia, I had 11 PhD students who completed their PhD work. Of those 11, four left Australia for overseas after completing their theses. I am afraid that we are losing some of our brightest researchers because of what Vera Morgan said: the lack of a longer term structure of a research career for a young person in this field.

Senator TROETH—And when you submit applications for NHMRC funding, on average, what is the length of funding provided? Is it three or four or five years?

Prof. Jablensky—For a project grant, it is three years; for a program grant, it is five years. It has to be renewed. We have to spend a lot of time, about 25 per cent of all our time, writing applications.

Ms Morgan—Program grants are very hard to come by. Going back to what Senator Moore said, the cut-off level is very high in project grants, so there is a lot of good research that does not get funded because it is just not good enough. The bucket of money for research is limited.

Senator WEBBER—We heard some evidence earlier from Dr Simon Byrne. We were talking about the attraction and retention of mental health professionals. He was saying that he thought one of the problems in attracting people, particularly into psychiatry, was that whilst the world still had some idealists in it, we do not value them and we do not value their opportunity to do research and to encourage that. So not only does it have an impact on the way we treat people, but our lack of money in research has an impact on the overall availability of mental health professionals. Would you agree with that view?

Prof. Jablensky—Yes, I am very concerned about that point. We fail to attract sufficient high-quality researchers to the mental health field and the proportion of those who are successful in this field feel uncertain about their future careers and are looking for opportunities elsewhere.

Senator WEBBER—Should there be some kind of linkage in terms of the funding we grant, particularly in medical research, between the disease burden on society and the amount of money that we put into research? This committee has often heard that one in five people in our society will suffer some form of mental illness or mental distress. If you then had a correlation you would have to say, 'That is 20 per cent, so 20 per cent of funding for medical research should go into mental health.'

Prof. Jablensky—I do not think there is such a simple relationship. Certainly, there are many factors that have to be considered in this equation. One is: what is the state of knowledge in that field and is it a problem that is ripe for picking and solving? These opportunities are very unequally distributed in this vast area which we call mental health. But there are problems which are solvable and I think that, in so far as they also have practical implications for treatment or even prevention, they should clearly be a priority. I find it very difficult to advocate, let us say, a one to one relationship between the burden of the disease and the investment in the research.

Senator WEBBER—You mentioned in your opening remarks that Australia has had a significant international reputation. You sell yourself short: it is actually partly due to the work that people like you do that we have that significant international reputation. In terms of that, and my being from Western Australia, the committee has spent some time looking at the correlation between criminal offending and mental illness. I was wondering if I could get one of you to expand on that project.

Prof. Jablensky—This is a project which, as Vera Morgan mentioned, links two large databases—the database on mental health services and the users of services and the criminal offending database. This research is done in a way which guarantees full confidentiality so that the data we operate with is de-identified. We are interested in patterns rather than in, say, individual profiles. What we find at present is that there is a considerable overlap. People who are on the mental health database are more likely to also be on the criminal offending database and vice versa. There is, however, one fact which I think is probably underreported in the media and underestimated—that is, that the relative share of people with mental health problems in the overall burden of offending is very modest. The majority of offences are committed by people who are not on the register of mental health care. Unfortunately, there is some stigmatising in bad publicity of individual cases, but most instances of serious offending violent crime are committed by people with no mental illnesses—or no mental illnesses in the strict sense of that term.

Ms Morgan—What we are also finding is that when we look at the relationship in terms of contact with the mental health system and with the criminal justice system often these people come into contact with the criminal justice system first and the criminal justice system is acting as a gatekeeper and diverting these people into the mental health system. There are behaviours that bring them to the attention of the police first and then that brings them to the attention of mental health service providers.

Senator SCULLION—Given the very similar demographic environment that provides for the impact of people's mental health in the OECD countries, how do you ensure that the sort of research that you are doing is not duplicated in other places? Given the very small splash in the bucket, how do you ensure that you are not reinventing the wheel and that it is not happening somewhere else? I refer to your relationship with the American Psychiatric Society and those sorts of people who do a lot of research. How do you ensure that?

Prof. Jablensky—Research in the neurosciences and in psychiatry is now developing at a very rapid pace. With the modern means of communication we tend to know the majority of people and what they are doing so that very often we are in competition with one another, which I think is healthy and necessary for good research. So it is not a matter of simple duplication, although duplication is important, because sometimes a novel result needs to be replicated by

another group of researchers in order to be validated. This is what constitutes so-called evidence based medicine—results must be replicated without necessarily being duplicated. I think that each research group which has some success tends to identify an area in which it feels strong methodologically and has chances of success rather than scattering over too many areas and doing a little bit of everything.

Ms Morgan—I have two other points. The first point is that with Professor Jablensky's own team he has developed very important and strong collaborations with countries such as Indonesia, Africa, the UK, the US and Holland. These are strong research collaborations. That actually puts Australian research at the cutting edge, because it is working collaboratively with other teams. The second point is that we have international linkages with conference groups. In 2006 we will be having a schizophrenia conference here where we will be extending to the Asia-Pacific region and developing linkages with the international society.

CHAIR—Professor Jablensky, we are happy to excuse you if you need to go now.

Prof. Jablensky—Thank you. I apologise for it, but I have a commitment which I am unable to cancel.

CHAIR—I have a question about the chart. I think it was you, Professor, who presented this, but hopefully your colleagues can answer the question. I want to clarify what is meant by 'more than half of the burden of mental disorders cannot be averted by current knowledge'. By being averted, I presume you mean people being able to recover. Is it the same big chunk of a circle that we could relate to as being treatment which is not evidence based? Are the two comparable?

Prof. Jablensky—I think that is the yellow part of the pie.

CHAIR—Yes.

Prof. Jablensky—That is disease burden which cannot be averted in the sense that there is no evidence based preventive strategy or there is no effective treatment which will significantly reduce or eliminate the secondary consequences like disablement.

CHAIR—Do we know how much is spent by pharmaceutical companies on research funded by them in this country?

Ms Morgan—I do not know the answer to that. Certainly a lot of the research that happens in universities is not funded by the pharmaceutical companies. There are research programs conducted by them, and they are actually starting to work a bit with the Mental Health Council of Australia in supporting some research needs there.

CHAIR—Do you think that funding should be at arm's length from the research itself, given the obvious interests of pharmaceutical companies?

Ms Morgan—Very much so. When we publish in scientific journals there is an increasing onus on the authors of any scientific articles to identify any relationships they have with pharmaceutical companies.

CHAIR—But in determining what areas of research are covered, should that also be at arm's length? In other words, to what extent do pharmaceutical companies determine what kind of research is being conducted? Because that is a way of influencing an outcome, is it not?

Ms Morgan—That happens. I do not work with the pharmaceutical companies. I think Professor Jablensky would have been better able to answer that question. But I think there is potential for unrestricted funds from the pharmaceutical companies, and that gives the researcher a lot more scope to actually choose what happens with the money. It is where it is restricted and targeted that issues arise.

Dr Badcock—It is probably also important to point out that a lot of the research that is conducted by, say, the psychological community is not at all funded by the drug companies. Their funding is entirely separate from that.

CHAIR—As you would expect.

Dr Badcock—Yes.

Ms Morgan—Pharmacological research is just one modality, one target. A lot of the stuff that we are talking about—the linkage work and the work that happens at the Centre for Clinical Research in Neuropsychiatry—is not related to pharmacological treatments per se. They will have an impact on that, but they are not about pharmacological treatment. It is quite a specific area of research.

CHAIR—Thank you so much.

Ms Morgan—In the handouts, on the very last pages, there are some short-term, easily achievable recommendations that we want to put before the committee. They are there for you to consider in the fullness of time.

CHAIR—We very much like easy, achievable recommendations. Thank you.

Ms Morgan—We thought about the big things, but then we thought, 'What is possible?'

CHAIR—Thank you so much.

Proceedings suspended from 12.51 pm to 1.40 pm

FRANCES, Miss Katherine, Private capacity

NOTTAGE, Dr Cathy, Member, Attention Deficit Hyperactivity Disorder Team, Bentley Family Clinic

WHITELY, Mr Martin Paul, MLA, Chairperson, Drug Free Attention Deficit Support Inc.

SPENCER-FAWELL, Mrs Elizabeth Anne, Executive Officer and Consultant Accredited Practising Dietitian, Learning and Attentional Disorders Society of Western Australia

TONER, Mrs Michele Eva, President, Management Committee and Media and Government Spokesperson, Learning and Attentional Disorders Society of Western Australia

WHITING, Dr Kenneth Rowland, Chairman, Professional Advisory Committee, Learning and Attentional Disorders Society of Western Australia

MAYCOCK, Associate Professor Bruce, Associate Director, Western Australian Centre for Health Promotion Research

CHAIR—I welcome representatives and associates of the Drug Free Attention Deficit Support Inc. and representatives of the Learning and Attentional Disorders Society of Western Australia to today's hearing. Is there anything you want to add to the capacity in which you are appearing?

Miss Frances—I am the parent of a child formerly diagnosed and drugged for ADHD.

CHAIR—You have lodged with the committee submissions, which we have numbered 334 and 202, respectively. Are there any changes or additions to those documents at this stage?

Mrs Toner—We have an international consensus statement that we would like to table. It was developed by an international committee of clinicians for the treatment of ADHD.

CHAIR—Do you have sufficient copies for the committee?

Mrs Toner—Yes, we do.

CHAIR—Is it the wish of the committee that this document be tabled? There being no objection, it is so ordered. Are there any others?

Mr Whitely—I have a whole bunch of handouts here for the committee. I have produced individual copies.

CHAIR—We might do that one as well. What is that document?

Mr Whitely—It is a series of excerpts from documents. The first two pages are some notes I prepared on behalf of DFADS.

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

Prof. Maycock—I have a document which I produced only yesterday. Just to put this into context, I was asked to attend this hearing yesterday. Some of the information I will be presenting today, but, because of the numbers associated, I thought you may wish for a copy. But I only have one spare.

CHAIR—We will leave that with you for the time being. You may wish to leave that document with us at the end of the session. I invite each organisation to make a brief opening statement, after which we will go to questions. Can I have an indication from you as to who wishes to make brief opening statements?

Mr Whitely—I will open for DFADS.

Mrs Toner—I will speak for LADS.

Mr Whitely—Thank you for the opportunity to be here today. I will introduce the other members or associates of DFA DS if you like a little later. ADHD is a highly controversial subject for two basic reasons: the diagnosis is highly subjective and imprecise; and, secondly, the amphetamines used to treat ADHD have known severe side effects, unknown long-term effects and are frequently diverted for illicit use. In Western Australia ADHD is particularly controversial because WA prescription rates for psychostimulants are way above the national average and WA abuse rates of amphetamines, including methamphetamine and dexamphetamine together—so, speed and dexamphetamine, the prescribed form of amphetamine—are about twice the national average.

If you need evidence of the high prescription rates in Western Australia, page 17 of the document that I just gave you has a list of prescription rates by federal electorate. You will notice that, of the 150 federal electorates in 2003, the top 10 were all Western Australian. Page 21 gives you information by state by age, which again confirms that Western Australia is incredibly high for dexamphetamine. If you look at page 22, it talks about how that has been the case for a very long period of time. Page 23 includes both methylphenidate—Ritalin—and dexamphetamine so that you get the full picture of psychostimulants. Whichever of those documents you look at, you will see that, indisputably, Western Australia has very high rates of prescription of psychostimulants.

I said the diagnosis is subjective and imprecise. The diagnostic criteria outlined in DSM-IV—which I imagine you would be familiar with by now if you have been doing inquiries into mental health—state that there are no laboratory tests, neurological assessments or attentional assessments that have been established as diagnostics for ADHD. In fact, all the diagnostic criteria are behavioural. They are things like making careless mistakes, having difficulties sustaining attention, failing to finish school work or chores, having difficulty organising things, being easily distracted, fidgeting or squirming in your seat, being on the go as if driven by a motor, or talking excessively. They are all normal sorts of behaviours that we all display at

various times, but they are considered to be at such a level that they are dysfunctional—although, how you define ‘dysfunctional’ is entirely questionable. So it is open to subjective assessment and value judgements, and there is no clear definition of impairment.

In fact, this evidence of ADHD is used by clinicians to impute that the child has a biochemical imbalance in the brain, despite the lack of any evidence to support that. DFADS acknowledges that there are a whole range of conditions that could cause a child to be excessively active or excessively inattentive—things like having a poor diet; problems with vision, hearing, parenting or teaching; a history of physical, sexual or psychological abuse or trauma; sleep deprivation; toxins; even boredom. So a whole range of other things could contribute to a child behaving in those sorts of ways. This leads us to the fact that there is no short cut method for diagnosing ADHD or the other things that could be causing the behaviours. Accurate identification of a child’s real problems takes a very long period of time.

Unfortunately, the way the Medicare payments are structured, with paediatricians getting a fixed rate no matter how long the consultation takes, means that the more you diagnose, the more patients you see, the more money you make. In addition, paediatricians do not have the breadth of training that child psychiatrists have. Child psychiatrists and adult psychiatrists are paid on a per-time rate, so they get paid for longer consultations. Those two factors, along with the way that paediatricians have been trained in Western Australia, are contributing to the very high rates of prescription in Western Australia, added to the fact that we have a shortage of child psychiatrists in Western Australia.

As I said, dexamphetamine and Ritalin are the two drugs that are used. Until very recently, dexamphetamine was the only treatment that was subsidised by the PBS. Ritalin was added to the list on 1 August 2005. I was very disturbed to hear that because, on 30 June 2005, only a month prior to that, the US FDA issued a warning for Ritalin and methylphenidate products, saying:

The FDA has identified two possible safety concerns with the methylphenidate drug products: psychiatric adverse events and cardiovascular adverse events.

The psychiatric events listed include visual hallucinations, suicidal ideation, psychotic behaviour, as well as aggression or violent behaviour. Cardiovascular events listed include reports of hypertension, syncope, chest pain, prolonged QTc, arrhythmias and tachycardia. Dexamphetamine is no better. I would direct the committee to have a look at the additional information that I have put in the submission on pages 12 and 15 that highlight the known side effects of those two drugs.

As I said, Western Australia has a very high rate of abuse of amphetamines. In addition to the potential harm to the patient if they are incorrectly diagnosed, there is a problem with illicit diversion. WA’s rates of amphetamine abuse are about twice the national average. The statistics are provided on page 26 and I believe they are quite old. I understand Associate Professor Maycock has more recent data. I have also attached an article from Holyoake’s journal on the drug and alcohol treatment program. That highlights some of the anecdotal evidence, again on a daily basis.

To summarise the problem, Commonwealth funding of Medicare patients leads to a quick catch-all diagnosis of ADHD. ADHD lends itself to that sort of diagnosis. What we need is a system that gives a proper analysis of kids' real problems. PBS funding of dexamphetamine and now Ritalin results in problems for children who are incorrectly diagnosed and problems with diversion.

The solution, as DFADS sees it, is for the Commonwealth and the state governments to act cooperatively and to commit resources to programs like the program that is running out of Bentley. Dr Nottage is out at that program. Katherine Frances is the parent of a child who went through the program. It really took the time to find out the kids' individual circumstances and tailored the solutions to the problem. In the short term it may be slightly more expensive. However, extra resources will be available because there will be fewer subsidies for dexamphetamine and Ritalin. In the long term, accurate detection and appropriate treatment of kids' real problems will make thousands of Australian kids a lot healthier, a lot happier and a lot better educated.

Mrs Toner—ADHD is a neurobiological disorder and there are grave consequences if it is left untreated. However, it is important to know that many people with ADHD do access effective treatment and make a good success of their lives because of their ADHD, not in spite of it. It is thought to affect between three and nine per cent of the international childhood population. Up to 66 per cent of these children continue to have ADHD in adulthood and epidemiological studies in adults now tell us that the prevalence of adult ADHD is between three and five per cent.

Much has been said and written about stimulant medication prescription rates in Western Australia and we would welcome questions on this topic later. To cut a long story short, LADS enlisted the help of Dr Christine Sharp MLC to clarify the matter as we suspected that the health department and last year's parliamentary inquiry were engaging in some selective reporting to save face. The question was asked of the health minister in parliament and on 25 November he confirmed that the prescription rate for WA children—which is those under 18—is not 4.2 per cent as originally estimated, but 1.8 per cent. This is well in line with the national average. However, he also confirmed that the prescription rate for adults is 0.4 per cent. We know that that is four times the rate of New South Wales, so it would appear that the high prescription rate is happening in adults—which is not nearly as emotive and appealing as children.

Comorbidity, which is the coexistence of two or more disorders, is a common feature of ADHD. Psychiatric disorders comorbid with ADHD include oppositional defiant disorder, conduct disorder, mood disorders, anxiety disorders and substance abuse disorders. These comorbidities significantly affect the long-term outcomes of ADHD. Long-term studies have reported considerably poorer academic outcomes for children with ADHD than for others. Adolescents experience low self-esteem, poor peer relations and conflict with their parents. They are at risk of delinquency, smoking, substance abuse and academic failure. People with comorbid ADHD and depression are three times more likely to complete a suicide attempt.

According to scientific evidence, and LADS is an evidence based group, the most effective treatment for ADHD is a multimodal approach involving both pharmacological and non-pharmacological interventions, depending on each individual patient. However, families in Western Australia struggle to access many of these services, with waiting lists stretching out to

six months for those families who are deemed lucky enough to be eligible for them. Adults with ADHD, despite our higher diagnosis rate, are not even treated by psychiatrists in the public health system and have to access private psychiatrists, which is alarming because many of them cannot afford it and many of them have children with ADHD.

It is also worrying that young people are cut loose from the public health system at the age of 18—which is a very vulnerable time for young people, as we all know—and sent to access their own services in the private sector. Whilst the ADHD policy allows for young people to remain in paediatric facilities until the age of 25, this seldom happens in the public sector.

LADS, which does not receive any government funding but receives numerous referrals from government departments, supplies many non-medical aspects of ADHD support, including counselling, behaviour management workshops for parents, the Aussie Optimism program for children, workshops for adolescents, effective nutrition workshops and information sessions on things like central auditory processing, handwriting difficulties, depression and anxiety. One of our volunteers also conducts respite weekends for carers, some of which are partly funded by Carers WA.

We feel very strongly about this. Stimulant medication has been prescribed for children with ADHD symptoms since 1937. It is regarded as a safe medication by clinicians and has a huge amount of medical research behind it, and yet sensational reporting abounds. This is normally generated by the Church of Scientology in one guise or another and adopted by alternative support groups. Often these support groups advocate alternative methods for treating ADHD which have no scientific basis. They can be dangerous at worst and a shocking waste of money at least.

Dexamphetamine and Ritalin are both listed on the PBS. It is important to remember that dexamphetamine and Ritalin are short-acting medications which necessitate several doses throughout the day. There are two forms of sustained release methylphenidate now available in Australia as well as the new non-stimulant atomoxetine. These are not listed on the PBS and at about \$150 a month they are unaffordable to most people. We urge the Commonwealth government to include them on the PBS, as they are often a lot more effective in the control of symptoms and would effectively remove the black-market trade in dexamphetamine. It would also make it easier for teachers, who have the unfair responsibility of administering schedule 8 medications to their students.

CHAIR—I thought we might get the difficult question out of the way first, because my guess is that there is much more agreement amongst these two groups than there is disagreement. Neurobiological disorder—I think you said—or not? Mrs Toner, perhaps you could give the committee a bit more information about what studies can demonstrate that. Are there brain scans that show a difference in one group or another? On what do you base the claim that there is evidence? Then I will go to you, Mr Whitely, and ask why you think that this is about behaviour and factors other than those which could be described as neurobiological.

Mrs Toner—Certainly. I would like Dr Whiting, as the chair of our professional advisory board, to answer that question, if that is all right. He is a developmental and behavioural paediatrician. He is the Australian member of the Global ADHD Working Group, which was convened by Professor Helmut Remschmidt of Germany. He is the chair of the international

association of child and adolescent psychiatrists. He is also an honorary senior research fellow at the Centre for Attention and Related Disorders at the University of Western Australia and a clinical lecturer in the Faculty of Medicine and Dentistry at the University of Western Australia. So, as you can hear, he is far more qualified than I am.

Dr Whiting—There was a stumble there: I am not the chair of the international association of child and adolescent psychiatrists.

Mrs Toner—I am sorry.

Dr Whiting—The convener of the body on which you have a paper there was the chair of the international association of child and adolescent psychiatrists, and I was an invited member. There are many studies which would support the notion that ADHD is a neurobiological disorder. In studies involving high numbers of people, you can see changes in brain function by using various forms of brain scanning, such as isotope imaging, blood flow or functional MRI—magnetic resonance imaging. There are also various forms of electrical change within the brain which have been studied which may demonstrate changes in children with ADHD.

The other issues relate not just to brain scanning but to genetic or molecular biological type factors such as the receptors which the chemical that is thought to be a problem in ADHD works on: the D4 receptors. You can demonstrate, by attaching a radiolabelled substance to the dopamine transporter system, that there is a deficit in that dopamine transporter system. These studies do show differences between children with ADHD and the normal population, in numbers. They are not sufficiently finely developed, however, to act as diagnostic studies.

In terms of making any diagnosis in psychiatry—and I am sure that the members of this committee are aware of this, because you have listened to many people—I would be very interested to know which psychiatric disorders can be diagnosed by a blood test or by a brain scan and are not diagnosed by taking symptoms and looking at impairment.

Mr Whitely—Very briefly, Dr Whiting hit it on the head. The only diagnostic tool is behavioural. There are no tests that are diagnostic of ADHD. If you balance the behaviours, as I said, they are behaviours that we would all display at various times. So it is a highly subjective diagnosis. No parent is ever shown a brain scan and told, ‘This is what we use to diagnose ADHD.’ In fact, many are not told how the diagnosis occurs.

Dr Nottage—We certainly use DSM-IV and ICD-10 as a guide to make diagnoses for psychiatric disorders. Dr Whiting is right: we do not have specific tests which say, ‘Yes,’ or, ‘No, you have schizophrenia or bipolar affective disorder.’ My concern about what he was saying about looking at PET scans and MRIs is that he was comparing them to a normal population. The kids that we are seeing who are diagnosed with ADHD are not normal. These kids have major difficulties. They might have other difficulties that we often think are the primary diagnosis, such as anxiety disorders, post traumatic stress disorders and depression. Sometimes they have learning difficulties. We probably see it differently to the LADS group in that that is probably their primary diagnosis rather than ADHD being the primary diagnosis. Our experience, certainly with the ADHD team at Bentley, is that if we can treat the primary diagnosis then the sequelae, such as ADHD-like symptoms, can be resolved without the need for medication.

Mrs Toner—I would just like to say, Dr Nottage, that it is wrong to presume what LADS would treat primarily. We would recommend that every case be diagnosed on its own features. We are very aware of co-morbidities and of the fact that psychiatrists and developmental paediatricians, who are specialised in this area, are trained in differential diagnoses. It is no different from someone who presents with anxiety and something else. We just do not see the need for ADHD to be singled out as something different from another mental health disorder. I would ask you to please not comment on what LADS believes.

CHAIR—Could I suggest that you all address just the committee. That is probably the easiest thing to do rather than conduct another kind of dialogue.

Mrs Toner—Certainly.

Dr Nottage—And certainly I was not talking specifically about co-morbidity; I was talking about a primary diagnosis.

CHAIR—I understand. It was said by a Melbourne based psychiatrist—I think it was the head of psychiatry at the Royal Children's Hospital—that one of the problems with this whole area is that there is widespread overmedication and possibly undermedication in some groups, and that we are measuring symptoms, not impairment. Is there general agreement on that? Dr Whiting, do you have a view about this? Is it the case that paediatricians do not and cannot have the sort of knowledge that allows them to test when medication is appropriate and when it is not?

Dr Whiting—No, I do not think so. Paediatricians, particularly developmental paediatricians, are trained in measuring impairment. Basically, we are trained to measure impairment from day one onwards in people who have autism or other developmental disorders. There is no difficulty with the measurement of impairment as such.

However, what is impairment for one individual may not be impairment for another, depending on the circumstances in which they find themselves. Many of these conditions, whether it is anxiety or ADHD, are heavily influenced by, for instance, the kind of support that the child may get at home or the kind of support that may be available within the school. Impairment therefore has to be judged on an individual basis. I think there is no scale that at any time says, 'Everybody is impaired from this point onwards.' You have to judge it on an individual basis. You then pick particular markers that you think indicate that that individual is suffering significantly as a result of the difficulties they have. And that would be the same for all psychiatric diagnoses. Depression would be the same: you would have to judge the degree of impairment before commencing therapy, and that would very much determine which therapy you would be undertaking. So that is a clinical decision that you have to make based on your knowledge of the disorder.

For children with ADHD the things that we as paediatricians would usually look at are in three main areas. The first area is their academic progress, the second area is their social progress and the third area is their self-esteem and sense of wellbeing. Those are very important areas. There are other areas, but those are probably the three most important ones that we would look at initially in terms of impairment.

CHAIR—Did you want to comment on that question, Dr Nottage?

Dr Nottage—No. I think certainly you can have impairment from all sorts of different disorders. I am still quite concerned about that whole issue of whether it is really ADHD that we are seeing.

Dr Whiting—I think that generally, as you said, there would be a lot more agreement between the professionals at the table than disagreement. There have been studies which have looked at the difference between paediatricians making the diagnosis of ADHD and psychiatrists making the diagnosis of ADHD. I have great respect for my psychiatric colleagues and what I am about to say in no way demeans them. I think Dr Nottage will also agree with me. In general, you will find that paediatricians are not good at making mental state examinations and psychiatrists are not good at doing physical examinations.

CHAIR—What about psychologists in all of this? Presumably psychologists would inform your perspective, being an alternative to drug therapy. Is that fair to say?

Dr Nottage—I am part of the ADHD team at Bentley. I am not part of DFADS as such. I am here by invitation.

Mr Whitely—I am actually the only member of DFADS here. These people are here at my invitation.

CHAIR—I am just asking for your views about psychologists. We have heard about paediatricians and psychiatrists.

Dr Nottage—I work in a multidisciplinary team. As part of the team we have child psychiatrists, psychologists, social workers, a speech pathologist, an occupational therapist and a community mental health nurse. We really feel that it is very important that, when a child is assessed, we are all present during that assessment and we take a very holistic approach to that.

Mr Whitely—DFADS would argue that that is the approach that should be taken—a holistic, whole-of-child approach. You draw on the expertise that is needed to make an assessment of the whole child over a long period of time. Katherine might want to talk about her experience with her son Brandon at this point.

Miss Frances—Brandon was a very difficult child. He had a lot of problems with his hearing and behaviour problems. I took Brandon to a private paediatrician. He diagnosed Brandon with attention deficit disorder before he started school. Brandon also had to do speech therapy. After that, over a period of years he was put on a range of drugs, which included methylin, clonidine, dexamphetamine, Ritalin, risperidone and epilim. Brandon's behaviour seemed to get worse over the years. He did not get better. I searched for programs to help Brandon. Nothing made a difference.

In the end, I could not cope with this child who was screaming for three and four hours a day and beating me up. He was never at school. He was suspended all of the time. He was sick physically. He suffered night terrors. He sleep-walked. He did not eat. I thought that Brandon would be better off if I was dead and I handed him to welfare, because then they would have to do something. We ended up in Bentley. Brandon underwent a detox program to take him off the medications he was on. He was on dangerous levels of medication for a little boy. They looked at

what his needs and problems were and they worked with him. They made up a program to suit Brandon individually. Also, my other child and I entered the program. We did the program as outpatients.

I learnt how to deal with a child who had learning disabilities and other problems. They taught me how to do that because you cannot as a parent know how to deal with a child who is uniquely difference, like my son is, and you need to be taught how to discipline them. You do not discipline them like you do your other children. I did not know how to discipline this child. I did not know how to teach him. Bentley seemed to have a program that Brandon could understand, whereas he had not understood all the others, and he felt safe and secure there. I do not know exactly how they got through to Brandon. All I know is that part of Brandon's brain does not work like everybody else's, but they taught Brandon to access parts of his brain by going through the backdoor.

He has not been on medication for 18 months now, and things are fine. He used to be a child who was suspended from school every second and third day for violent behaviour. He used to be a child who beat his mother up daily. I have a report here that I requested from the school. It says that since he has been off medication my son is doing really well at school. He is behaving. He is living a life I did not think he could without medication. Medication was killing my son. Medication was causing him to have psychotic episodes.

There is another way to treat these children, and to treat them successfully. Brandon does have a disability, he does have a learning problem, but I have managed to get him into a high school that has taken that on board as well and has introduced a program off their own bat to help these children because they are falling through the system. If my child, who they thought would always be medicated, can survive and do better without medication then I think all children should be given the opportunity Brandon has been given. A system should be put in place like Bentley's for children when they first go into the system at four and five. Parents should not be feeling as though they have no options. Families should not be torn apart. While I believe there is a small percentage of children who do need medication, I believe there are more children who can survive and do better without medication.

I personally have not met one child that has done better on medication. There are other parents who did the program with me and we have become close and give each other support, but once our children finished the program we were sent back to the places that did this to our children in the first place. Our children have been thrown back into a system that only caters for children on medication. I now have nowhere to go with my child.

CHAIR—Are you referring to the school?

Miss Frances—I am referring to mental health services. When a child turns 12 at the unit they are not eligible because of funding and other things. I now have nowhere to go take my child, but my child still has a disability. The only place I can go to is where they only know how to treat children who are on medication. Their programs are not designed in the same way that the programs are at Bentley. My child understands the programs at Bentley. Somehow they have managed to get through to these kids. There is a higher success rate at Bentley with the children that go in there than at any other group.

Too often, people who make these decisions hear about all the good that these drugs do but nobody is seeing the truth and the ugly side of medication. Every neighbour in my street can tell you that they have seen me hold my child on the floor for three and four hours a day while he was hysterical—and this was on medication. But I have not had that anymore—not anymore. There needs to be more Bentley's. There needs to be more constructive help for children. There needs to be better services to help parents who have children with learning disabilities to learn how to parent these children, because they are different, and there needs to be more support in school.

CHAIR—Can you tell the committee a bit more about the Bentley centre?

Miss Frances—The families at work unit takes these children who have been diagnosed with ADHD.

CHAIR—This is a public service?

Mr Whitley—Yes.

Miss Frances—My child does not have ADHD, may I add. For eight years he had it and then, overnight, he did not. They take these children in and they detox them off their medication so they can find out who the real child is. Then they work with that and find out what their problem is—what their real problem is. Then they structure a program around that child to help that child educationally, socially and behaviourally. They go into the schools to help the schools and to teach the schools what they have found. They have a specific behaviour program that is so simple, but the children understand it and it actually works. It is not one that you would think of using in your own home.

I have another child that I have absolutely no problems with and I can discipline him in the way that any parent would discipline their child. But I cannot do that with Brandon. There needed to be a unique way to do it and somehow Bentley had the answers. They made a difference when nobody else did. They put the children on the program but they also bring the family in. It is not just the children who do the program; it is the whole family, and they do not just look at the child. It no longer becomes just the child's problem; it becomes the family's problem. We all have to work on things and we learn what our child in the unit is learning, how to interact with them, how to parent them and how to cater for their needs.

CHAIR—Providing that service for all of the children—and there are these amazing statistics about the numbers who are on medication at the present time—would be very expensive obviously

Miss Frances—I fully believe—and this is my honest opinion—that if I had been given Bentley when Brandon was four, I would not have gone through the years of hell and the government would not have been spending all that money on him. Brandon was on so much medication. The government must have been subsidising his medication at \$400 a month plus his psychiatric visits. When Brandon was four, if I had the information I knew when Brandon was 12, it would have made the world of difference. I contributed to the end result at the time because I did not know what to do with this little boy. Nobody does. The programs at CAMHS are good but they do not cater for this set of children.

Senator HUMPHRIES—I would like to get a fix on what the story is with the rate of medication of children in Western Australia for ADHD. The LADS submission refers to the fact that initially the Western Australian government suggested a rate of 4.2 per cent of Western Australian children being medicated. The minister subsequently changed that last year to 1.8 per cent. Was there an indication provided in information that there had been a revision of the estimates or that the earlier figures had been miscalculated? Can you give an idea why that figure changed?

Dr Whiting—Because of concern about medication prescription rates the Western Australia government introduced a new system of notification so that whenever a practitioner wishes to prescribe stimulant medication they need to notify the health department. Those figures of 1.8 per cent are based on that direct notification system. So it is a new system which started in August 2003.

Mrs Toner—Also, in respect of the previous estimate of 4.2 per cent, in the mental health policy it states that they assumed that 85 per cent of scripts written were written for children. They clearly stated that they estimated on that basis the prescription rate to be 4.2 per cent. New South Wales is the only other state that keeps very carefully audited figures and Western Australia just started doing that in August 2003. As a result of the first year of reporting, provisional figures were that it was 1.8 per cent in children and 0.4 per cent in adults. Now those figures are being audited and have been with the auditors since November last year. We are still waiting for clarification of those. That was reported in *Hansard* on 25 November.

Mr Whitely—With respect to the 4.3 per cent, there was not a proper stimulants notification system in place at the time and it was relying on estimates coming from federal figures. The 1.8 per cent was for a different age cohort. It was for zero to 17-year-olds—

Mrs Toner—Eighteen-year-olds.

Mr Whitely—Thank you for helping me. The other figure was for four to 17-year-olds, so obviously you are going to get a higher figure because there are not many who are diagnosed below four years of age. The other thing was that we had introduced a stimulants notification system in the interim, which I am proud to say I was one of the architects of. I think it had the effect of making clinicians more careful about how they diagnosed—and we did see a fall.

Nonetheless, Mrs Toner has brought suspicion on the West Australian produced figures. Have a look at page 17 of the document that I gave you, which gives you federal electorates. They are Commonwealth produced figures. You will see, as I said, that the top 10 federal electorates are all West Australian electorates. Do the numbers yourselves. We all know that the electorates have basically the same population. Have a look at page 20, which gives us the figures for 2002-03. It gives you a breakdown of dexamphetamine scripts for each state. You can see that in absolute terms, Western Australia is much higher than any other state, even New South Wales, given our population base. Again, they are Commonwealth government figures. Have a look at page 22, which gives us the figures for each state. You can see that whilst all states have been trending up, no-one has been running nearly as fast as Western Australia. Have a look at page 23, and it will show you that, if you bring Ritalin into the picture, Western Australia is about the same as every other state—it is almost identical—but it is way ahead in terms of dexamphetamine. It is on the PBS and represents the majority of scripts that were written. If it is

a matter of staking reputations on whether Western Australia is the highest prescriber, I am very happy to stake mine on that statement.

Mrs Toner—I was making the point that the four times prescription rate is occurring in the adult population; it is not occurring in the child population. My suggestion to the committee is to contact the chief pharmacist of Western Australia. They have just spent tens of thousands of dollars auditing these figures. I would request that you contact the chief pharmacist and the health department, and ascertain what the audited figures are. It is our belief that the four times prescription rate is happening in the adult population. We are concerned about that because there is no treatment for adults in the public health system.

Senator HUMPHRIES—I have not got the original figures, but in February this year there was a table in the *West Australian* that quoted the Health Insurance Commission. It suggested that there is a much higher rate of prescription of amphetamines in the age groups that we are talking about. In the 15- to 19 -year-old age group there were 16,000 scripts written in 2004 in WA, which is about the same as the scripts in New South Wales, Victoria and Queensland put together. Does that illustrate a problem to you? Do you think that those figures are accurate?

Mrs Toner—It is my understanding that the HIC figures need close examination and careful auditing because I think they report grams per head of population. It is dangerous to quote newspaper articles as sources of reliable information—not that newspaper articles are not, but they are not official figures. We have a newspaper article that says something different, also from the *West Australian*. That is why I would request that the committee contact the chief pharmacists and get the official figures from the horse's mouth. I believe that they are doing them, comparing them to other states and breaking them down into age groups. We have been waiting and waiting for the figures so that we could actually address them. As I said, they have been audited for a year now. We are concerned that perhaps they are going to be buried in some audit for a long time.

Senator HUMPHRIES—So you would say that you have seen no evidence that the rate of prescription of dexamphetamine in Western Australia is higher than anywhere else in the country?

Mrs Toner—I am saying that the figures that the chief pharmacist released provisionally and that the Minister for Health in Western Australia confirmed in *Hansard* show that stimulant prescriptions for children under the age of 18 are the same as the national average. But they are four times higher in adults. They said that it was 0.4 per cent in adults, but we know that it is 0.1 per cent. The chief pharmacist in New South Wales has released figures to say that it is 0.1 per cent of adults in New South Wales, yet the health minister in WA has said that it is 0.4 per cent in WA. We would like to get official figures. Since the government has spent so much of taxpayers' money auditing these figures and collecting them, we would really like them to be public knowledge now.

Mr Whitely—On that I agree. I should not break caucus confidentiality, but I was reminding my health minister the other day that I would like to see those figures as soon as possible. I take you back to page 21. It is indisputable—these are federal government figures—that the scripts are much higher across every age group. There has been an ageing—an upward movement in the demographic. That is in part because the spotlight has been on prescribing to children in Western

Australia. It has been a hot topic for a long time, and it has become less fashionable, if you like, to make the diagnosis. In a sense, the marketing of ADHD as a condition has moved towards the adult population. I will make one point, which perhaps Associate Professor Maycock could pick up on, that we have strong anecdotal and some numerical evidence of significant diversion of dexamphetamine. Not all the dexamphetamine is being used for therapeutic purposes; it is being abused. That is true of the adult population, and it is also true of some of the parents of children.

Mrs Toner—It is not useful quoting opinion and anecdotal evidence. The Drug and Alcohol Office, with which we work, has stated that there is no research into the black market use of dexamphetamine—that it is anecdotal evidence. There is nothing in peer review journals that investigates this. The government should be urged to investigate this scientifically so that we can stop all the speculation and the quoting of anecdotes and opinions, because we all have those. We look to the government to provide this information and to provide scientific information, and we would like to see it soon.

Prof. Maycock—I wholeheartedly agree with the suggestion that we need to improve the type of research we have been doing. There was an attempt to do this in 2002. Just prior to the school based survey going out, the dexamphetamine questions were removed. So there have been some attempts. We changed the most recent school based survey, which has been administered this year. We have included some questions that will give us some population estimates about what the kids are saying in relation to diversion.

Anecdotal evidence is not just an issue of hearsay. Anecdotal evidence that I am collecting is coming from, for example, police sources. It comes from sources which are not being reported. For example, we have had recent cases of significant diversion and fraudulent scripts, with one individual reported to have obtained 35,000 tablets. This is not an insignificant level of diversion. We have school based surveys going back to 2000 and 2002. We have 2002 data from school based surveys saying that 26 per cent of schoolgirls aged 17 have used non-prescribed dexamphetamines. So we have some good evidence already that dexamphetamines are well and truly entrenched within the illicit drug diversion market.

We have evidence from the states which shows that between 16 and 33 per cent of ADHD diagnosed children are approached by friends and peers to sell and supply. We do not have that evidence here because we have never asked the questions, so there are some significant gaps. But one of the reasons I was asked here today was that, in discussions with people in the field, we have put up some funding grants to try to obtain this data. We will obtain part of it at the end of this year because of the population based information that will come back. What we will not have is some of the gaps within the system. For me, this is not an issue about pointing fingers and saying, 'This is where you're contributing to this problem.' When a diagnosis is happening and when prescription is occurring or when fraudulent scripts are being honoured, then we start to get black markets being well established. We have done some preliminary research at Curtin University and in a number of the suburbs.

We ran recent focus groups with youth and found that amphetamines were highly socially acceptable—so dexamphetamines are a highly socially acceptable drug. It was costing youth only \$1 each time they wanted to purchase it. We did comparative parent surveys, or parent focus groups who were not aware of any of this information. One in three of a group of first-year university students had direct experience of people either selling or supplying. This refers to an

immediate friend or a family member. That was pretty significant. We are in agreement with LADS; we do not have enough information. That is actually quite criminal, given that we have had this on the table for such a long time and that Western Australia has been the leading amphetamine abusing state in Australia. I am not talking about dexamphetamines; I am talking about illicit methamphetamines.

Senator HUMPHRIES—Are you suggesting that we remove dexamphetamines from the PBS because of the illicit trade in them?

Mrs Toner—Is it true to say that there are other medications that people doctor shop for? There are barbiturates and antidepressants and, in fact, it is quite a common problem. A lot of those medications are decidedly more sinister than dexamphetamine. I think it is safe to say that the link between dexamphetamine diversion and amphetamine abuse is not established in the research; it is an interesting link but it is not an established link, and I would love more research to be done in that area. Liz, who is the executive officer at LADS, and I—as I was doing the job before her—get phone calls from people day in and day out who are on all types of medications for various reasons. We heard stories of people who doctor shop for various medications, and a lot of them are a lot more dangerous than dexamphetamine.

The Chair of Drug and Alcohol Office was quoted in the *West Australian* newspaper—I think it was last week—as saying that dexamphetamine diversion was not a source of serious harm to people. I am not saying that it is a good thing; I am saying that we need to know more about it. But, once again, I think the raving hysteria around dexamphetamine is unjustified, when we look at the other doctor shopping that happens. It should all be controlled and all be stopped.

Mrs Spencer-Fawell—Can I just make a comment regarding the shopping for other medications. A lot of people shop for other medications because they do not have access to treatment in the government sector. That is one reason that they go for other medications: they cannot get the medication that they may have been on originally as a child who went through the government system. When they are basically hurled out into the street at 18 with no ongoing treatment program, no referring doctor, no ongoing psychologist and no ongoing support for their families—either financial or emotional—they are then left to find other forms of treatment. If they are not getting treatment with their original stimulant or non-stimulant medication—remember, we do have non-stimulant medication now—these people are lost. We get those phone calls every day. I have statistical documentation of the calls we get, the help we provide and the referrals we make. One of the biggest complaints we get is that they cannot afford to go to a psychiatrist.

Senator WEBBER—Thank you. I will continue with that for a minute, but then I want to return to some other issues. Whilst we may have a conversation about whether it is anecdotal or not, from my life experience the easiest way to work out whether it is actually happening is whether the drug has a street value. From my conversations with the police force, dexies do have a street value—that is how they are referred to. People buy them and people take them because they alter their behaviour in a way they are looking for—whether it is to stay awake all night, whether it is to do whatever so they can go out partying or because it is a cheaper party drug than ecstasy or what have you. I think it would be fair to say that they do have a street value.

Mrs Toner, you were saying before that you are anxious to get hold of the information that the chief pharmacist has, and Mr Whitely says he is too. It is not my usual role as a member of the opposition to defend the federal bureaucracy, but I think that the Health Insurance Commission are a pretty reliable source of information, because they pay. They would know how many times they paid for that drug to be prescribed in Western Australia. Maybe the fraudulent use of scripts is actually part of our problem, which is why we are in the top 10 or 14, but I actually think that the HIC are reliable. Why would the chief pharmacist of Western Australia be better informed about what is happening than the HIC, which paid the money?

Dr Whiting—I think that is where our notification system will come in very useful. We have to account for the gap between the Western Australian notified figures and the HIC notified figures. I know from talking to colleagues in the HIC that they are extremely concerned about fraudulence in scripts. That appears to be their main concern. I think that that gap will probably give us some idea of where the diversion is occurring and how much diversion is occurring. The notification system here is the one where children are legally being prescribed dexamphetamine or Ritalin. Those figures will be accurate—there is no doubt about that—but they will be different from the HIC figures, and that difference is what we have to account for. I do not think we have anything in place at the moment that will account for that difference, but that is what we have to work on. I would agree with the researcher from Curtin on this.

The other issue, if I may answer your previous question, is that I do not think withdrawing the medication from use is going to be effective because it is a very good medication and it has helped lots of people. But there are other ways in which it can be made less available to the public. All these medications can be made less available to the public by supporting the use of long-acting medication, 12-hour type medication, which is administered at home only and therefore not taken to school or into public places. I do not know that we will ever get rid of the problem where adults—parents, as Mr Whitely has referred to—start covertly using medication. That is something which is remarkably difficult to monitor from a clinical point of view. But it would be helpful if the federal government, particularly, would support the use of longer acting medication for these children because the average parent is looking at about \$150 a month at the moment.

Mr Whitely—I will comment on that very briefly. I ask you to keep in mind, when you make decisions about whether things should be subsidised through the PBS, that a warning that came out from the US Food and Drug Administration had no impact upon the decision to put Ritalin on the PBS. The warning mainly related to concerns about adverse effects coming from Concerta, which is a long-acting form of methylphenidate. In the land of reality, I do not think taking them off the PBS is politically achievable, but perhaps it would be in an ideal world. However, we need to work collaboratively. I am not ducking the level of responsibility for state governments, but we need to work collaboratively to make sure that parents have somewhere else to go other than the medication, that parents have a place to go in the first instance and that we support Bentley's services. Even if they are not Rolls Royce services—and Bentley is an outstanding service—we can change the clinical culture of CAMH services.

In Victoria they have a far more holistic approach to the treatment of children. It is not a perfect service by any stretch of the imagination, but their rates of prescription are much lower even than those in New South Wales because of their clinical culture. They actually have a whole-of-child approach to services. We often get misrepresented, but what DFADS are asking

is that in the first line of treatment we actually identify kids' real problems and that medication is used as a last line of treatment and not, as it currently is, as a first line of treatment. We have a tragedy that happens to thousands of children.

Dr Nottage—I would like to add something about the use of medication. Our experience in the ADHD Team at Bentley is that we are seeing a lot of kids on polypharmacy and we have significant concerns about that. We see kids who are initially prescribed stimulant medication and then for whatever reason—they might have some side effects from the medication and develop sleep problems—they are put on another medication such as Clonidine. They then might be seen to have some anxiety symptoms or depression, and so another medication such as an antidepressant medication is added in. By the time we see them at our service—and we are seeing quite young kids; bear in mind that they have developing brains—they are on multiple medications. Certainly that is a concern of ours.

CHAIR—On that matter, is it the same paediatrician or GP who prescribes one after the other?

Dr Nottage—Generally. GPs cannot prescribe stimulant medication, so it tends to be a paediatrician. I think, as Dr Whiting said, some of it has to do with the fact that psychiatrists do very well in terms of mental state examination. That is our primary training. But perhaps other specialists do not have that training and families struggle to access child and adolescent psychiatrists in the community.

Mr Whitely—There is specific information on page 5 of the documentation I gave you that talks about who is doing this. It is preliminary data from the stimulus notification system, but it identifies that 57 per cent of ADHD notifications were from paediatricians.

CHAIR—It was more this polydrug prescription that I was interested in.

Mr Whitely—Sorry.

Dr Whiting—Can I address that? You could call it polypharmacy, which sounds terrible, or you could call it combined therapy, which sounds better. It does not really matter which term you use. I would like to draw your attention to the careful guidelines that have been prepared by the global working party on ADHD and the trigger points for the introduction of other medications if necessary. The majority of that party were child adolescent psychiatrists of significant standing throughout the world. There is a place for combining medications in some children, but not in all.

Miss Frances—Can I answer your question? Yes, it is the same people who do it. Most children with ADHD who I know of personally, and my child who was on medication, were on many medications. Brandon, when he was admitted to Bentley, was on risperidone, which is a heavy-duty tranquiliser. He was also on Ritalin and Epilim. All three drugs were used to compensate the reactions of the other drugs he was on. This is what was happening. He did not have the disorders; the disorders developed because of the drugs he was taking—he was given more drugs by the same doctor to counteract the drugs he had already taken.

Dr Nottage—That is not an uncommon experience.

Senator WEBBER—Can I continue to pursue the rate of prescription. Being the only member of the committee from Western Australia, and whilst I like to brag about WA having the lowest unemployment and the highest rate of economic growth and all the rest of it, in fact, Mr Whitely, you are wrong. On page 17 of your submission it says that Western Australia has got the top 14, and every federal electorate in Western Australia is contained within the top 30. I do not want to argue about whether they are prescribed to children or adults or what have you, because there is adult prescription as well. Apart from perhaps an extensive, fraudulent use of prescriptions—that is obviously something that should be of concern to the state government, and I am sure it is of concern to the HIC—what is so unique about Western Australia? Are we more fraudulent and less law abiding in the way we use these prescriptions? Are we harder to manage and therefore need to be medicated? My colleagues can be quiet about that! What is so unique about us?

Dr Whiting—From speaking to my colleagues interstate and throughout the world, I do not see anything unique about the way in which developmental medicine or paediatric medicine is practised in Western Australia compared to others. We have just finished drawing up guidelines for the Australian College of Paediatrics for the prescribing and diagnosing of ADHD and there is agreement across the board on how it should be done. So, professionally, we practise to the same standard because we all belong to the college and we have to follow their continuing medical education guidelines. So I cannot answer your question.

Senator WEBBER—It just stands out. It is bizarre.

Dr Whiting—I do not know just why it is unique to Western Australia over other states. I do think that accurate collection of data is very important, and we just embarked on that process in August 2003.

Senator WEBBER—So do we anticipate that this data will then change and we will drop down the list and, say, New South Wales will take its rightful place, as it is bigger?

Dr Whiting—I have been involved in this field for many years and I have been arguing—and I think the parliamentary inquiry has also argued—for the same process of data collection for all states in Australia. One of the biggest difficulties we have had is that the way they collect data in New South Wales differs from us and the way they collect data in Victoria differs from us. If we could have a uniform system of data collection for these medications, we would be able to make much more accurate comparisons.

Senator WEBBER—But these figures are collected by the Parliamentary Library from the HIC, so that would be a fairly uniform collection.

Mrs Toner—I think the bottom line is that in the past those prescriptions have been attributed to children, and paediatricians have been well and truly roasted for drugging children in WA, as have parents. What I have been trying to say all afternoon is that it seems as though the overprescription or the four times prescription rate is not happening because of paediatricians and there needs to be more investigation into it. I think it is unfair to ask consumers and professionals. It is a question that the government need to answer, because they have the resources to answer those questions.

Senator WEBBER—I understand that. That is why I prefaced my question by saying that I do not want to get into the definitional issue of whether it has gone to a child or an adult. If we just accept the raw data, it has gone somewhere. The top 14 federal electorates for the prescription of these drugs are in Western Australia, no matter what age cohort they have gone to. So there is obviously something happening in the Western Australian medical community that is different from New South Wales or Victoria or wherever in terms of that rate of prescription. I am not seeking to restrict it to children. We can put some of it down to fraudulent use. Maybe that fraudulent use is much larger than I thought. Mr Whitely, do you want to say something?

Mr Whitely—There was an inquiry done in 1996 looking at why Australian rates were different and why they were different across Western Australia, because we have hot spots in Western Australia. It concluded that it was most likely to be due to the diagnosing practices of the clinicians servicing those areas. I am interested to hear that LADS have changed their argument, because previously they used to argue that the reason that the diagnosis rates were so high in Western Australia was that we were better at spotting it. I would counter and say, 'I think it is because there has been a lot of enthusiasm for the diagnosis of ADHD.' I think the training that paediatricians have received at what was until recently Western Australia's only medical school has been very much along those lines. The Western Australian parliamentary inquiry took evidence to that effect when it went to Victoria, where they had a much more holistic, whole-of-child approach to the training of diagnosticians. So I think it is a medical cultural thing more than anything else.

Mrs Toner—But it is an opinion, once again.

Senator TROETH—I am happy for representatives of both groups to perhaps do us a couple of paragraphs on this, on notice. I was interested in the effects of ADHD on adults when considering their long-term recovery. Perhaps, Dr Whiting, you might provide the committee with some material on that. Is that possible?

Dr Whiting—Yes, it is. I can provide some material on that.

Senator TROETH—Also, are the treatment regimes similar or should they be different? Perhaps, Professor Maycock, you might take this on notice also. Were adult ADHD sufferers formerly children ADHD sufferers who failed to be diagnosed or to respond to treatment? I would be interested in that.

Prof. Maycock—That is not my area of expertise.

Senator TROETH—That is all right.

Dr Nottage—I am a child psychiatrist. I do not see adults, but I could certainly speak to my colleagues on that.

Senator TROETH—I would appreciate some information on that from your group.

Mr Whitely—The diagnostic criteria as set out in DSM-IV—and this is the gold standard—are that evidence of the behaviours has to be prevalent before age 7. So the diagnostic criteria as

they stand are completely inadequate for adults, because if you are diagnosing a 25-year-old you have to go back 18 years to figure out whether they were fidgeting on their seat 18 years ago.

Senator TROETH—That would be encapsulated in part of the question that I have asked. I would be interested in the information.

Dr Whiting—Mr Whitely is quite correct. You cannot relate DSM-IV to adults. The DSM-IV criteria apply until the age of 16 and no further. So to use them for adults would be incorrect.

Senator TROETH—I will be very interested in the information that you provide. Thank you.

Dr Nottage—Can I just say that it is a contentious area.

Senator TROETH—Yes, I know. That is why I would like your opinion and Dr Whiting's opinion.

Dr Nottage—I will give you some papers.

Senator TROETH—Thank you very much.

Senator SCULLION—Mr Whitely, perhaps you can help me with a couple of things here. I deal with a range of ADHD support groups in the Northern Territory. The issues that we are speaking about and the tension that exists today is not unique to Western Australia, I assure you. It is interesting that we do not have the same—part of the debate here was on non-compliance, not about medical health, I might add. That is an issue for the police substantially, and I know they do an excellent job in Western Australia. It appears there is a commonality between the groups. Nobody seems to reject outright the use of some of these drugs as part of a suite of medications, in some circumstances, and as part of a suite of tools that they approach that with.

You described the report from the Federal Drug Administration in the United States as saying things like they have aggressive violence behaviour and cardiovascular issues. It is really describing symptoms that should be of great concern to anybody. Whilst Ritalin was placed on the PBS in Australia after that date, I would have thought that had the US Drug Administration felt that it was a danger to the community, it would have withdrawn it in the United States. I am concerned about this, and perhaps you might be able to help me as to why both Ritalin and dexamphetamine have not been withdrawn from the marketplace here if they are so dangerous. Or are the circumstances you have described to me such an infinitesimal part of a challenge, as many drugs are, that they are a recognisable symptom in a very small percentage of cases and, therefore, have made that very considered judgment that there is a wider benefit to the community? I do not know that much about it, but you seem to be pretty well informed on it. Is that a reasonable assumption based on what you have told me?

Mr Whitely—There have been instances of drugs being withdrawn. Adderall, which I think is a brand name of dexamphetamine, was withdrawn in Canada because of 20 cardiovascular events. I think there were 20 deaths, but I can check that for you. There are approximately six million children who are mainly on Ritalin in the US. We do not operate in a political vacuum. It has become such a significant size that it is a snowball running down the hill now. It is impossible to stop, and it would be a very brave government that ever withdrew something that

was previously subsidised when six million families in the US have made the choice to put their children on it.

Senator SCULLION—While you are on that point: it is a political environment and we are both politicians. We recognise very clearly the views of people around us. I would have thought, as well, that there is another measure. Katherine had a particular set of circumstances—and thank you for bringing those here—where a whole series of things happened that did not suit and there was another type of remedial behaviour that did. One would have thought with that many people who seem to be happy with the behavioural changes and a whole range of aspects that they very cautiously provide these to their children. They are very concerned. They are aware of the controversy surrounding it, and yet they say, ‘We still choose to provide this process to our children.’ Why is it that we have not had the same wave of complaints from people—and clearly there are circumstances where this does fall through the hoops. I sympathise with Katherine about her circumstances, but it seems to be one of a whole range of people, people I know in the Northern Territory, who say that as part of the suite of treatments, this should continue to be provided.

Mr Whitely—The drugs are behaviour altering drugs. One of the things put up in support of the drugs is that they are the most effective. In terms of altering behaviour, getting an immediate effect, they are the most effective. Parents are told that they are safe, effective medications, which they frequently are, and they are told that they are to address a biochemical imbalance in the brain, which they frequently are told despite the act of any evidence, and they see their child’s behaviour improving at face value. Generally, if we take stimulants—they are called stimulants because they spark us up, they stimulate us—like methamphetamine, dexamphetamine and Ritalin orally and in low doses, they will make us more alert and more attentive. It seems to have the desired effect. Hence the claims that it is the most effective treatment that has currency with people. But the effect is often that the symptoms are masked. The underlying cause is not addressed and the symptoms are masked.

Intuitively, if you were starting with a clean slate—if you went back to a situation whereby you had the list of side effects of Ritalin and dexamphetamine, and you counterbalanced those with the paper criteria for diagnosing ADHD—you would say that there is an inherent lunacy in this approach. Why would you risk suicidal ideation against losing your toys and pencils? The point is made about other diagnoses—schizophrenia et cetera—not being based on blood tests et cetera. But we are talking about minimal behaviours here. We are talking about making careless mistakes, being reluctant to do your homework, being easily distracted, talking excessively, butting in. They are the diagnostic criteria. That is where, if you went back to day one, you could bring a degree of sanity to this debate.

Senator SCULLION—Since we are on the discussion of alternatives, do you think there is enough known about this? Some of it can be referred to as Scientology; I am not really sure what you are referring to. But a lot of the alternative processes have been the avoidance in diets of salicylates and amines and those sorts of things. There is a whole range of exercises and things that people have put to me.

Mr Whitely—I will be very brief. One of the criticisms that is made about groups like my own is that we sponsor some alternative solutions. You will see shows like *Today Tonight* that suggest sticking magnets on your kid’s head apparently addresses ADHD. Basically, you have a

fruitcake up against a psychiatrist or a paediatrician, and they dismiss that. Frankly, my message is that the drugs are portrayed as being a simple solution, and the real truth is that there is no simple solution to this problem. You have to find out what is causing the circumstances and match the treatment to the cause. That is what I suggest they do very well at Bentley.

CHAIR—We will have to move on. It is always a risk with such a big group of people that we will run over time. Senator Webber, you have a very brief question.

Senator WEBBER—Moving away from the issue of drugs, one of the other issues I want to explore is the use of ADHD as a descriptor. Claire and I have a colleague in the Senate that we often refer to as having ADHD because he is a bit more like what Mr Whitely was describing. Is it part of our problem that we use that as a catch-all phrase for behaviours that we find stressful and difficult to manage, and therefore does the treatment of legitimate ADHD get a bad reputation?

CHAIR—I will ask for just one person to answer that question—I am sorry I cannot invite everyone to—and to do it in about 30 seconds.

Dr Whiting—That is exactly the answer. You do have people's different perspectives of ADHD. We have just heard Mr Whitely's perspective that it is a condition where you lose your pencils and bits and pieces, whereas other people look at it as a very serious disorder. You are quite right that using that term loosely trivialises the condition enormously for people who have a significantly serious condition. I will provide Senator Troeth with the adverse circumstances that can happen for people who are left with untreated ADHD in adulthood.

CHAIR—If there is something else that you want to tell the committee, I invite you to let us know in writing. That way we can close this session. Thank you very much for presenting; it has been really useful to us. I am sure the argument will continue, but you have given us some good evidence today.

[2.59 pm]

DRAKE, Ms Maxine Elizabeth, Advocate, Health Consumers Council

CHAIR—Thank you for your patience. I apologise that we are so late in getting to you. You have lodged with the committee a submission which we have numbered 364. Do you wish to make any amendments or additions to that document at this stage?

Ms Drake—No.

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

Ms Drake—Thank you very much. I would like to say in my opening statement that mental health services provided essentially in the specialty area of psychiatry are the only specialty areas of treatment that can, in the process of providing the treatment, inflict abuses on individuals' human rights. I think this is a very significant issue that needs to be held in the forefront of the way we deal with mental health services and the way psychiatry is provided. Other areas of specialties in medicine might hurt the person—for example, through renal treatment, where a person is subjected to some physical pain—but there is never the potential abuse of people's individual human rights through the process of providing the treatment. Mental health services have a capacity to inflict iatrogenic harm. The human rights issue needs to be held at the forefront and monitored constantly over time. We can make enormous investments into the service provision in mental health, but unless we have parallel investment in the monitoring of human rights then there can be a normative swing away from protection of those human rights towards abuses of power and unnecessary iatrogenic harm that can stay with people for their lives and in fact encourage them to avoid seeking treatment.

The second comment I would like to make in introduction is that the National Mental Health Plan has had a central philosophy of the involvement of mental health consumers in the determination of the way that services are delivered. It is an interesting fact that mental health consumers enthusiastically embrace the opportunity to participate to reform services, even though at times those services cause them enormous harm. I would say that their willingness to embrace the opportunity to influence reform comes from the fact that they have the greatest investment in the reform of those services. They know they will have a continual need for those services and they see that there is enormous potential for improvement—perhaps in a way that you might not find a group of renal patients enthusiastically engaging with reform of the way their services are provided. The opportunities for consumer participation in health services reform have been diminishing over time as the strength of the national mental health plans has diminished. It is something we need to consider as a new way forward for reforming mental health services. Otherwise, I would like to answer any questions you might have.

Senator HUMPHRIES—You talk in your submission, Ms Drake, about the accountability in the mental health system for the use of seclusion. You say:

Accountability for the use of seclusion rests with the Office of the Chief Psychiatrist ...

I think you imply that there is some kind of review or reporting done to the Office of the Chief Psychiatrist, but you then say that there needs to be more accountability than that. How can you actually achieve that without compromising the privacy of the individuals concerned? For example, if you put out a report each year saying, 'Here are the cases where seclusion was used, against whom it was used and so on,' you would have more accountability but you would also compromise that privacy, wouldn't you? So how do you achieve that greater accountability?

Ms Drake—I am confident you could find a sophisticated way to monitor the use and misuse of seclusion without ever having to identify an individual. I think you could look at the use of seclusion in the dark hours—the hours between dinner and breakfast—when seclusion can be used by staff where there will not be anybody else on the wards who might see the use of that seclusion. You could break the issue up in a sophisticated way and study it without ever having to breach anybody's privacy. I think the issue for us in the community is that we are not even confident that there is any assessment process happening or that people are being brought to account for any misuse of seclusion. We would have to assume that where there is no scrutiny and accountability there is the potential for abuse. We would have to work on that as a fundamental, base assumption and move from there.

What I am aware of is that there have been no referrals—I suppose it would be to police or the Director of Public Prosecutions—from the Office of the Chief Psychiatrist or the mental health system for any breaches of the Mental Health Act in relation to seclusion. So it either means it is not happening—which would be spectacular—or it is happening but there is no rigorous approach to bringing it to attention. The issue for us is that if there are no determinations being made that the use of seclusion is either lawful or unlawful. If it is scrutinised and determined to be lawful, we can be happy with that. But, if it is scrutinised and found to be unlawful, then we would want to see that having some effect on how it is applied. Anybody followed by a police car looks at their speedo: automatically, you are brought to account for what you are doing on the road by the presence of a monitoring authority. If there is not that monitoring authority and it is not being made known to the public, then we can presume it is not happening or it is not happening perhaps with the rigour that we might need.

Senator HUMPHRIES—I do not think it is easy to construct a model that works very well. We will ask the Western Australian government later on today about what models there are at work in that system already. You might like to think about whether there is some mechanism that you could suggest as to how we can actually make that happen.

Ms Drake—It is such a closed, sealed, airtight system when it comes to the monitoring and scrutiny of mental health services. The community sector has so little opportunity. That is why we take these opportunities to fire a missile across the system. We are concerned about this; we have got no way of engaging to be informed.

Senator HUMPHRIES—I will ask just one more question, because we are running out of time. We have heard comments about consumers being excluded from the system and not being able to take part in influencing the treatment that they receive, either individually or collectively. I think you support that in your submission. I wonder what you think about the role of a living will type of arrangement, where people who recognised a mental illness in themselves could give instructions and there would be a system for those people to be made available to local emergency CAT teams, or whatever you call them in Western Australia.

Ms Drake—The development of that system is under way in Victoria by a woman named Merinda Epstein, and they are called advanced directives. They are recommended for people who are long-term participants in the mental health system. I do not know how well they would work for people who are new to the system. A lot of people actually have to go through a lot of pain and a lot of admissions and a lot of analysis of their own life experience to then know what it is they need. So advanced directives will certainly assist some people—generally the long-term survivors who have survived their illness and the system—and they can then give an informed view about what they need to have happen. But, yes, people would support advanced directives.

Senator HUMPHRIES—That is fine.

Senator WEBBER—We heard earlier today from the Public Advocate, and we are exploring the protection of people's rights. One of the issues that has been raised with me from other people in WA is the propensity of people within the mental health service to put people under the care of the Guardianship and Administration Act rather than the Mental Health Act because—and this was raised with me by someone from the Council of Official Visitors—basically you lose your rights under the guardianship act; someone else assumes them for you. Under the Mental Health Act you have a series of rights that are enshrined. Whether they are honoured or not is another matter. Is that something that your organisation would be aware of?

Ms Drake—Yes, we are aware of that. If a person moves out from under the Mental Health Act, they return to autonomy and control over their life and their life affairs. If they are under the Mental Health Act and the mental health staff are concerned and make an application and the person goes under the guardianship or administration systems, they lose autonomy and they lose control over their own affairs. What we see is perhaps a reflection on the in-patient social worker providers' lack of faith in community services. They think that a person is going to be discharged from hospital and they are going to languish and they are going to founder out in the community. So they make an application for an order. They are very ready to make applications for orders in certain areas. What it can mean for some people is that they are trapped under public administration for many years and they have no opportunity to escape from that. So that suggestion is something we support.

I could find six people today who are under the Public Trustee who do not want to be, but the difficulty for the community sector in assisting a person to make an application for any review of that is that in WA the two systems are separate. You cannot go to a guardianship board hearing and say, 'This person is capable of managing their own affairs.' They say: 'Well, prove it. They haven't managed their own affairs for the last six years.' How can we assist a person to prove it? What we need is a program like there is in the Public Trustee in Victoria, which is a return-to-independence program that enables a person to go through a systematic process to relearn or regain the skills for managing their own affairs and then to be brought out from underneath that system. So it is a big problem for mental health consumers.

Senator WEBBER—One of the other issues that has been raised with me is the length of time it takes our mental health service management to handle those initial formal complaints. I have a constituent from Clarkson who made a complaint about the treatment of relative over Christmas. She made a complaint in early 2005 and is still awaiting a response or even an acknowledgement from regional mental health services about that complaint. That is obviously

something I can pursue with the department. Is that a common thing? I could also refer her to you, because I know you are a very good advocate.

Ms Drake—You have to use my services to know that. I would have to say that I do not think that that is a big problem because people have access to the Office of the Chief Psychiatrist, they have access to the Office of Health Review or the Health Consumers' Council or various other avenues. If they have sat and waited for that complaint to be addressed, they have not taken it to the next stage of challenge, which is to then have somebody check why that has not happened. I would expect that person to call the Office of the Chief Psychiatrist or the health department.

Senator WEBBER—Would that be due to a lack of awareness on the part of consumers and carers that there are those stages?

Ms Drake—It would be likely that, yes.

Senator WEBBER—Thank you.

Senator SCULLION—I was speaking to the Public Advocate this morning and I was asking her why in her submission she confesses that sometimes there is no valid consent to the admission of patients by mental health practitioners and why they seem reluctant to use the provisions of the Mental Health Act to do that. I asked her: 'Who looks after the interests of these people? It's on your watch—what are you doing about it? Obviously this is unlawful. It is simply not going by the rules. Why is it happening?' There were some answers that are now on the record. Do you have anything to do with that in terms of trying to advocate for people obviously that have been incarcerated unlawfully or held in a way that is not unlawful? Do you get into that stuff?

Ms Drake—Are you talking about the prison system?

Senator SCULLION—No.

Ms Drake—This is the mental health system?

Senator SCULLION—This is actually into authorised psychiatric hospitals.

Ms Drake—What I was saying before about the difficulty of getting a determination about what is and is not unlawful is an issue that is probably separate from our experience. What we would do is challenge the system because the consumer thinks it is unlawful, the consumer feels that it is unjustified and that they are not in the system appropriately. Again, I think what can happen under the Mental Health Act is that behaviour that we would think of as abhorrent treatment of a mental health consumer can still be lawful. Segregation can still be lawful. We can argue until we are blue in the face that we think it is morally repugnant the way that it is done, but it can still be lawful. The administration of a so-called emergency medication when a person presents to a psychiatric hospital under police escort by four or five people without them having an opportunity to give consent and know what the implications are going to be we think should be unlawful, but it can actually fit, in the way that mental health services argue it, as a lawful act.

Senator SCULLION—I would certainly recommend you look at the *Hansard* of earlier today. What access do you get as an advocate to institutions or hospitals? Does somebody have a problem with you coming in? You get a phone call: ‘Look, I’ve been done over.’ You have given some great examples about how people are even more disempowered and made to feel more hopeless, which really does not aid their condition much. What access do you get? Do hospitals generally say, ‘Here she comes—smarten everything up,’ or do you have a pretty good working relationship and you get into those places?

Ms Drake—We only come in by the grace of the service allowing us to come in; we do not have any statutory authority. But I think services would acknowledge that they have a moral obligation to allow advocates in. If we conduct ourselves in such a way that hostility to allowing us to come in develops across the board from practitioners then we have absolutely failed in our role. So we readily have access. We will turn up for people’s appointments, and we do not generally have any difficulty with access, but we do not have any statutory authority to go there.

Senator SCULLION—Do you think you require some? Would you like some more?

Ms Drake—We have the Council of Official Visitors. There is an argument that their power should be extended to cover voluntary patients, because at the moment they can only see involuntary patients. Often they refer to us because they have somebody who is in a situation where they are feeling that they are ‘voluntary’ according to the forms but coercively voluntary, in that if they walk off the property they are going to be made involuntary.

Senator TROETH—You have advised in your submission that consumer participation was defunded in September 2003 by the state government. What arrangements were in place prior to the cessation of that funding, and how effective was it?

Ms Drake—The Health Consumers Council managed a little program for mental health consumers to train fellow mental health consumers to participate in committees and boards, to support them in doing that work, to foster the growth of consumer advisory groups in services and to run public speaking into education settings for trainee practitioners in the mental health area. So that is what we did. We had a small participation payments fund which paid consumers who were sitting on committees and boards. It was a small amount of money, but it was to dignify their involvement and make it possible for them to attend. The program ran really well. I think one 12½ hours a week position we advertised once got 250 requests for information and 56 applications. So there are mental health consumers throughout the suburbs who are interested in their mental health service experience as a criterion for employment being used to reform the mental health system. That is the project we had running. There was a cost-cutting activity at the time, and for some reason the project was cut. But it was well supported by mental health consumers and a fantastic vehicle for getting their participation and involvement.

Senator TROETH—So have you had further discussions about regaining the funding, or are there any moves to put it back in place again?

Ms Drake—Yes, we have.

Senator TROETH—Have they come to anything?

Ms Drake—We have had some fabulous letters, but they have not led to the outcome. We have had meetings with the minister to inform him that this is what we think is the issue. He has said that he has directed the mental health bureaucracy to reinstate this program. For some reason it has taken a long time for anything to move. There is still nothing substantive in place to replace that program, only concept papers at the moment. So it is not a good situation for consumers in Perth.

Senator TROETH—When you speak of ‘psychiatric emergency services’, do you have any specific models in mind?

Ms Drake—No. In a sense you could make it lowercase and just say ‘generic psychiatric emergency services’. Consumers say that if you ring the psychiatric emergency service and say, ‘I’m desperate,’ they might ask a few questions and say: ‘I’m sorry, you’re not desperate enough. You don’t qualify.’ That is the issue. You could expand it to some degree to allow early relapse prevention; the other area is transportation to psych facilities so that the police do not have to be used.

Senator TROETH—If it is a real emergency, they will transfer you to the police, I expect, and then they will arrive and take the person to the facility.

Ms Drake—The psych services would still need to be present with the police. Generally that is what would happen, but, if the psych services had the capacity to provide a transport service that did not involve flashing red, blue and white lights in the suburbs, that would be a good thing.

CHAIR—Thank you very much, Ms Drake.

Ms Drake—It is a pleasure.

CHAIR—It has been a very interesting submission and a useful perspective for the committee. Thank you for appearing, and my apologies for keeping you waiting so long.

[3.20 pm]

GROVES, Dr Aaron, Director, Office of Mental Health, Department of Health

TOWLER, Dr Simon, Executive Director, Health Policy and Clinical Reform, Department of Health

WYNN OWEN, Dr Peter, Acting Director, Office of Mental Health, Department of Health

CHAIR—Welcome. Does anyone have any comment to make on the capacity in which they appear?

Dr Towler—I have recently been appointed as the Executive Director for Health Policy and Clinical Reform for the state of Western Australia, and for 25 per cent of my time I am still a practising intensive care clinician.

CHAIR—You have lodged with the committee a submission which we have numbered 376. Are there any additions or alterations to that document at this stage?

Dr Towler—Not that I am aware of.

CHAIR—I remind senators that, under the Senate's procedures for the protection of witnesses, officers of state government departments should not be asked to give opinions on matters of policy. If necessary, they must be given the opportunity to refer those matters to the appropriate minister. I now invite you to make a brief opening statement, after which we will go to questions.

Dr Towler—On behalf of the Minister for Health, Mr Jim McGinty, I wish to thank you for the opportunity to give evidence before this committee. I have responsibility for mental health policy in Western Australia's state public health system. My two advisers who are here today are Dr Aaron Groves, the outgoing director of the office, and Dr Peter Wynn Owen, the incoming director of the office for the service.

As you are well aware, mental health is a major health issue in Western Australia. It is in fact one of the three priorities of the government, along with cancer and legislative reform. Currently, each year more than 32,000 Western Australians receive treatment in the public mental health services. Further, in the period between 1999 and 2004, service provision increased by more than 20 per cent.

During the past two decades governments from both sides of politics have underestimated the size of the problem faced by those with mental illness. The current state government has made a very major commitment to improving mental health services in Western Australia through our current mental health strategy for 2004-07. The focus of this strategy is on increasing access to appropriate in-patient services and, importantly, addressing the need for intermediate care treatment options and community support services.

The strategy is made up of five initiatives: the mental health emergency services; adult in-patient services; community health services, including services for adults and services for young people; importantly, supported community accommodation; and a very major focus on work force and safety issues—and there are some recent interesting events in Western Australia which have made that even more important.

The state government has allocated \$173.4 million to this mental health strategy for the next three years. In 2005-06, this will represent \$168 per person in the state, and it is estimated that upon completion of the strategy Western Australia will spend over nine per cent of its total health budget on mental health. While this is good news, there are considerable challenges for mental health services in WA, and I will highlight the major issues for this state.

Firstly, as members of the select committee will know from their visit to Port Hedland, service delivery in WA is complicated by the significant geographical spread and diversity of our state's population. In 2003, it was estimated that 23 per cent of the population lived in rural and remote WA. These people live in diverse situations, including mining communities, coastal fishing communities, isolated inland communities, the wheat belt, wine growing regions and substantial tourist areas with quite variable populations with each season. In some regions there are considerable difficulties in recruiting and retaining mental health staff—in fact, in retaining any health staff. This, in turn, limits the capacity to provide accessible, high-quality services to address the specialised needs of these communities.

We also have diverse communities of Aboriginal people. Sixty-six per cent of Aboriginal people live in remote and rural Western Australia and isolated areas of the state. The urgent need to provide a comprehensive range of mental health services has recently been demonstrated through the release of volume 2 of the Western Australian Aboriginal child health survey. Of the 23,000 Aboriginal children aged between four and 17 years, 24 per cent were assessed as being at high risk of clinically significant emotional or behavioural difficulties, which compares with 15 per cent for a similar non-Aboriginal population. The study concluded that there is a substantial unmet need for services to address this level of emotional and behavioural difficulties encountered by our Indigenous young people. As recognised in the Aboriginal mental health strategy developed by the state government, there is a need for better coordination of the mental health and social and wellbeing services provided through all elements of the state and Australian governments.

In WA we have been developing a non-government sector that provides a range of accommodation, psychosocial, recreation, respite and carer support services. The waiting lists for these services are considerable. Currently less than 10 per cent of the Western Australian Department of Health mental health budget is spent on the non-government mental health services. In order to reduce the demand for in-patient services, it is critical that the community mental health sector be expanded to support early intervention and provide long-term support that enhances relapse prevention and facilitates patient recovery.

In making the next comments about our workings with the Australian government, I would like to emphasise the current reform agenda in Western Australia. My new position is as the head of the Health Policy and Clinical Reform division, where we are seeking to establish health networks. Our mental health network is in fact our leading health network. We are seeking to partner with the community, consumers and our Australian government colleagues in improving

mental health services. However, we have some concerns about the way in which we work with the Australian government and how mental health services are funded. The current system is often limited by lack of consultation with states and territories about priorities, and expectations that the state will find funding to continue pilot and short-term projects established by the Australian government. There is an important need for better cooperation between the state and the Australian government when determining our funding priorities. Our recent experiences in Aboriginal health have shown that this can be highly effective.

The Australian government's major area of funding has been largely in the area of the Pharmaceutical Benefits Scheme, in terms of the additional money expended over the last three years. This is mostly accounted for by the escalating costs of newer antipsychotic and antidepressant medications, and it remains unclear whether or not this substantial increase in expenditure has indeed led to further services being provided or to improvements in outcomes for those people with mental illness.

We recognise in Western Australia that there is a significant unmet need in primary mental health care, which is at least primarily the responsibility of the Australian government, but an area in which we wish to share. While I have implemented a number of initiatives in primary care, we would like to see further funding directed to primary care in mental health. The 2002-03 report by the Australian Institute of Health and Welfare showed that, before recent initiatives were put in place, there were less mental health related GP encounters in 2003-04 than in 1998. General practitioners in the state regularly need the support of the specialist system. However, apart from the Northern Territory, WA has the lowest number of private psychiatrists per person in Australia. Compared with the national average of \$9.92 per capita, WA receives only \$4.99. This equates to over \$10 million of funding that is spent elsewhere on specialist psychiatric services, which is ultimately left to be picked up by the state of Western Australia and results in people having less access, particularly in a community setting, which is our current emphasis. Furthermore, per capita funding through the MBS going to private psychiatrists is less than it was in 1998.

The consequences for WA of an underdeveloped private system are that people with mental illness need to get their services from the state system and there is increasing demand upon services generally. This has two consequences. The private sector is not able to deal with the demand for mental health care and the result is an increased burden on all services, including state funded services. I believe there is also the additional imperative in relation to the educational role that is required of private psychiatry in support of services across the state. Primary care providers cannot be sourced from an underdeveloped private specialist system so, once again, the burden falls upon the community and the state generally.

To address this critical issue, the Australian government needs to reconsider the allocation of primary care funding and the need for shared care programs, in much the same way as we have done in Aboriginal health. One of the most significant blockages to mental health service delivery in WA is the size, age and skill mix of the mental health work force. Throughout the country this is a significant issue. The mental health work force is ageing, and processes to address adequate replacement have not been either developed or implemented. It is our view that this is an area where the Australian government should take the lead in ensuring that programs that renew, replenish and reskill the work force can be put in place. This should focus on a

greater breadth of mental health disability and recovery workers to ensure a sustainable work force to meet the nation's mental health needs.

Finally, we wish to draw to the attention of the senators the impact of mental illness in this country. While it was reported in the recent *National Mental Health Report 2004* that \$3.1 billion is spent on mental health care by the Australian government, states, territories and the private sector, the size of the financial burden on the country is less well reported. From the written submission of the Australian governments to your committee it is clear that, conservatively, in excess of \$3 billion is spent on welfare payments of one sort or another to people who are known to have mental illness. Furthermore, it has been estimated that as much as \$5 billion is lost through loss of productivity each year from undertreated mental illness in the workplace. Significant thought should be given to how programs can be implemented that support improvements in productivity and a reduction in reliance on welfare by adequately addressing the impact of disability arising from mental illness.

The Western Australian government have made a substantial commitment to mental health. This commitment will continue to substantially increase the number of Western Australians who receive specialist mental health services. We will welcome the possibility of developing a closer relationship with the Australian government in order to have a comprehensive system of providing services to the people of this state with mental illness. Again, I thank you for this opportunity to meet with you and look forward to our discussions.

CHAIR—Thank you, Dr Towler.

Senator HUMPHRIES—Where is the minister today?

Dr Towler—I am not sure where the minister is today, I am sorry.

Senator HUMPHRIES—It is not your fault, but I do note that this is—

Senator WEBBER—Senator Humphries, state parliament is sitting today.

Dr Towler—And the director-general is in the north-west today.

Senator HUMPHRIES—I just note that this is the sixth jurisdiction in a row in which we have not seen the minister.

Senator WEBBER—Perhaps if we had had the hearing at state parliament we would have been able to meet them.

Senator HUMPHRIES—I am sure they have all got a very good excuse for that fact. I also note that you record the amounts that are spent per head of population in Western Australia on mental health and you record that, as of 2002-03, more is spent in Western Australia on mental health than the national average. I commend you for that, but I also note that every jurisdiction bar one so far has also claimed to be spending above the national average. The exception is the Northern Territory, which has claimed it is about to get above the national average. Something strange is going on with these figures.

Dr Towler—As we stated in the submission, we expect to reach the position where nine per cent of the health budget is committed to mental health. That is, as far as we are aware, the highest level of commitment of any state in the country.

Senator HUMPHRIES—That is very commendable; I do commend you on those figures and I hope that is happening across the rest of Australia as well. Can I put to you some of the things that have been put to us by other witnesses, today and previously, on problems to do with mental health services in Western Australia. One example is the suggestion by the Public Advocate that there are no step-down facilities in Western Australia and that this is a serious unmet need, both in terms of subacute facilities for people who are recovering from serious episodes and in terms of housing options for people who need some kind of transition into the community. What is the government's plan for that?

Dr Towler—I considered bringing for you a full copy of the state mental health strategy. When the state looked at mental health services a number of years ago in putting the strategy in place, the major emphasis of the strategy was in fact on improving community services, and community accommodation is a major emphasis. I will ask Dr Groves, who has been the head of the office, to explain in detail what is being offered at the moment. There are initiatives in place and currently happening: we have building programs with the Department of Housing and Works which are specifically focused on those issues. Aaron will be able to give you some detail.

Dr Groves—I could probably speak for half an hour about the strategy, so I will just talk about the area you have asked about. The Public Advocate is correct: there is very little in the way of step-down accommodation in Western Australia. It is not true to say there is none. There is, in fact, a publicly funded mental health unit in Hampton Road in Fremantle which is an eight to 12 bed unit. We have had one for some time. But in comparison with other states, we certainly lag behind.

However, there are two aspects to what we have probably done very well in the state. The first is an independent living program, which has been well developed and has provided supported accommodation for about 590 people over the last 10 years, which we have continuously developed between the Department of Housing and Works and the Department of Health.

More recently we recognised there was a significant gap in the spectrum between people in independent living with disability support and in-patient care and just that one eight to 12 bed unit. So we decided to approach government about having a joint agreement between Housing and Works and Health to get the rest of that array met. What has been agreed to is the development of 47 intermediate care beds, of which 25 will be built in the southern suburbs of Perth, around Rockingham, and 22 in the north, ultimately in Joondalup. In the transition, until they are developed, they will probably be around the lower northern suburbs of Perth.

In addition to that we are planning to look at replacement type services for the licensed psychiatric hostel sector which, as is the case in most other states, is very variable in the quality of care that is provided and the fabric of the buildings. So the Department of Housing and Works has agreed to build what we call community supported residential units and 200 places will be built throughout the state. Hopefully this will help to provide supported accommodation to people as they move out of licensed psychiatric hostels.

Senator HUMPHRIES—When will those beds be built?

Dr Groves—They are in the process at the moment of the architects drawing up the plans. We are in discussion with Housing and Works as to how long it will take for them to be built. The land has been identified in all but one of the eight spots around the state where they will be built. Most of it is Health provided land. People may well be aware that the Western Australian housing industry is booming and it is very difficult for Housing and Works to get people to do the building at the rates that they were giving us earlier on in the strategy, which was around 52 weeks. It looks like it may take 60 to 70 weeks before those buildings are constructed. We are at the point now where construction is due to commence.

In addition to that, we also recognise that there are a group of people with very serious mental illness in this state who either have difficulty accessing the independent living program or are unlikely to live in short-term supported accommodation. We have looked at developing a model where people essentially have more of a SAAP service provided accommodation setting, but we make sure that the community clinical mental health services are provided for them. We are looking at doing that in Perth and Fremantle, partly because that is where most people with serious mental illness who are homeless in Western Australia tend to congregate. These people are often blacklisted for SAAP accommodation, usually because of the nature of their mental illness and comorbid drug and alcohol abuse. We are trying to make sure that we can move them along and get them into more long-term supported accommodation. Our strategy is about getting a spectrum of a range of options, rather than just one targeted approach. In essence, we plan to build around 467 spots over the next 2½ years.

Senator HUMPHRIES—That is very good.

Dr Groves—With \$42 million of capital money provided by the Department of Housing and Works.

Senator HUMPHRIES—I refer to the number of community beds which have already come on stream. At page 5 of your submission you have referred to the ratio of in-patient beds to presumably those community beds. You point out that 10 years ago 70 per cent of those beds were in-patient beds and a couple of years ago the figure was only 38 per cent. Presumably there is a much larger proportion in the community sector. But how have you achieved that? Has that been achieved by virtue of simply reducing the number of in-patient beds? Has there been a commensurate rise in the number of community beds? Can you say that in that 10-year period the total number of beds available to people who are mentally ill in Western Australia has remained constant or has increased?

Dr Groves—I would need to refer back to the submission and what we referred to. I believe that section was more to do with the change in the balance between in-patient and community funding—in-patient funding, clearly, as in beds; community funding is mostly in community provided services, rather than community beds.

Senator HUMPHRIES—There are two sections in the table here. One is on the percentage of in-patient and community expenditure; the other is on the percentage of beds in stand-alone hospitals—the percentage of totals of psychiatric in-patient beds.

Dr Groves—I will go through them. The first is the ratio of expenditure. In-patient expenditure has slowly increased in our state since the beginning of the National Mental Health Strategy. We have roughly the same number of beds per 100,000 as we did at the beginning of the strategy, so our bed numbers are essentially flat. Since the beginning of the National Mental Health Strategy we have had a major increase in the amount of community based mental health service delivery. So if you look at our state, since the beginning of the strategy growth in expenditure since 1992 is around 106 per cent in today's dollar terms. Nearly all of that has gone into expanding our community mental health program and keeping our in-patient program much the same. That is how the expenditure changes have happened.

The other ratio refers to the proportion in stand-alone psychiatric units for beds, as opposed to general or mainstream hospitals. What we have done in that regard is to close one of the two stand-alone psychiatric hospitals that we had at the beginning of the National Mental Health Strategy. We had a hospital called Heathcote Hospital, which was decommissioned in 1993-94 and was replaced by two new units in Fremantle and at Bentley. Since then, further in-patient beds that have been created in this state, whether they are metropolitan Perth or in the rural areas, have been in general hospitals; they have not been stand-alone units. During that time, the number of beds at Graylands Hospital has also decreased. It currently is at 245 beds or thereabouts, and we are looking at how, into the future, we will plan how the number of beds at Graylands becomes a viable number of beds whilst continuing with the National Mental Health Strategy to try to provide as many beds as possible in general hospital type settings.

Senator HUMPHRIES—Those Graylands beds would not be considered to be acute beds, would they?

Dr Groves—Yes, the vast majority of them are. There are currently 42 beds that are long-stay beds, which we would not consider to be acute; there are eight forensic beds on an open ward, which are also not acute; and there is one wing within the Frankland Unit, which is our forensic ward, which would also not be considered acute. All the rest are essentially acute. Dr Wynn Owen is the area executive director of north metro; he has overall operational responsibility for north metro, including Graylands. I will check to make sure that my figures are correct.

Dr Wynn Owen—That is right. There are 42 long-stay and rehabilitation, which are non-acute, and the eight forensic beds that you have mentioned within the acute hospital, which are non-acute, and 10 long-stay forensic beds in the Frankland Centre, a secure hospital.

Senator HUMPHRIES—I am looking at the submission that Dr Simon Byrne put in this morning, in which he suggested that, on a national or international ratio of beds per head of population, there should be 200 acute beds available at any one time in Western Australia. I think he implied that they were not there in Western Australia at the moment. Maybe I have misunderstood him.

CHAIR—I think the argument was that there be long-term psych beds, rather than acute.

Senator HUMPHRIES—Not long-term beds.

Dr Groves—I have read Dr Byrne's submission. We agree in part with what Dr Byrne is saying. There has been a longstanding trend to close long-stay beds and try to replace them with

more adequate models of care in the community. There is a perception that that has perhaps gone a bit too far as a policy initiative in Australia. We tend to agree that there is probably a need in our state for somewhere in the order of 100 long-stay beds and, as we move forward with restructuring our health service, we are looking at how to provide those beds.

The evidence that supports the fact that we do not have enough long-stay beds is that we have a long waiting list of people who are in our acute sector and have been there for months on end. Our long-stay ward was not really built for that type of purpose when it was originally constructed and is not an ideal situation for providing the best care for those people either. We are also looking at how we can provide better care for those particular people in the long-stay unit while recognising that there is an increasing need for long-stay care across the country.

Senator HUMPHRIES—Moving to consultation mechanisms with consumers, I direct you to the comments made by the Health Consumers Council about how they previously operated a program to assist in developing consumer involvement in mental health bodies and strategies in Western Australia. It is not so much that there are not opportunities to consult but their program was one that provided for the support of the development of consumer skills. Can you comment on the closure of that program in September 2003?

Dr Towler—There is no doubt that that program was withdrawn. There was a period of time last year when the minister found himself with a financial problem in Health, and along with a number of other initiatives that certainly had merit some things were stopped. I remind you that my new role in the health department is to underpin the development of clinical health networks. Through that process we are trying to embed into the way we manage and operate all health services an ongoing role not only for consumers but also for carers and non-government organisations. I have here with me, and I am more than happy to pass it on to the committee, the consumer participation plan which is being developed within the mental health network, which I have just signed off on to go to the acting director-general. We are planning to embed into our management structures and through the mental health network an ongoing and substantive role for health consumers which we think will go well beyond what was on offer before. Aaron may wish to make some further comments.

Dr Groves—I heard some of the evidence given by Ms Drake and I have also read the submission from the Health Consumers Council. It is correct that they had a very good program running up until 16 September 2003, at which point the funding for that was withdrawn from my budget, which specifically funded that program. As Simon mentioned, that was at a time when the health budget was in considerable difficulty and a number of worthwhile programs were defunded across the whole of Health. The flow-on from that was, from my perspective, a little different from how Ms Drake described it. There were several aspects to what we hoped the Health Consumers Council would provide with that project. She talked about the advocacy, training and representation roles, and so on. In addition to that there was a consumer participation payment of around \$40,000 per year. She made comment in her submission about the number of consumers that participated. Because it is actually state and national policy for consumers to participate we continued payment of consumers through my own corporate budget rather than going specifically through the organisation that previously had the funding.

We then, however, needed to pick up the pieces of trying to support part of the sector that is very vulnerable when it does not have the type of support that that program previously had. It is

fair to say that we have gone through a very inclusive process with consumers and carers during the last nine months. We have held a series of workshops investigating how we should provide a framework of participation that is much more comprehensive than what we had before. There has been unanimous agreement amongst the consumer movement in Western Australia with the plan that we put forward. The funding of that exists within my budget. As Simon mentioned, he has signed off on that. We had a workshop on 8 August this year and presented the work that had been developed over the nine months and all bar one of the consumers that were there said that they wholeheartedly agreed with the framework.

The component parts of the framework put us in a position where we would have as good a consumer representation framework as any other part of Australia. It has elements not only of advocacy and training but of information services, systemic as well as individual advocacy, and making sure that the participation in all elements of policy from a service planning level right up to state planning is in place. Western Australia has had what I would say is a poor tradition of employing consumer consultants within our work force compared with other states; however, there has been a substantial change to that in the last 12 months or so.

Three consumers have been employed within the South Metro Area Mental Health Service as part of a trial down there, which Maxine's organisation contract managed. It was interesting that she did not make reference to that either in her submission or in her evidence. However, we have also had a consumer who has been working in my office specifically to develop state policy in the direction of consumer participation. I also know that Dr Wynn Owen, within his own services, looked at how consumers can become more meaningfully involved in participation there. I hope that I can look back in a year or so and confidently say we have made a substantial move forward from where we currently sit nationally in respect of consumer participation, through the work we have done in the last nine months, and that there is funding there to put it in place.

Senator HUMPHRIES—That is good.

Dr Towler—It is a key element of the Reid plan, and it applies to all clinical services. Mental health is the leading clinical area at the moment in terms of putting a proposal through the system.

Dr Wynn Owen—Quite a few of the project plans that have been submitted around the mental health strategy for this new money now incorporate consumer payment and paid consumer participation and consumer consultancy, which is a big step forward for Western Australia.

Senator HUMPHRIES—The other criticism that was made by the Health Consumers Council, as you might be aware, is that they are not aware of any monitoring of the use of seclusion in psychiatric facilities in Western Australia. They are concerned that, if the Office of the Chief Psychiatrist collects information about the use of seclusion, he or she does not publish it or put it in any kind of publicly understandable form. Is there any monitoring of seclusion by the Office of the Chief Psychiatrist? Whether or not there is, should there be some kind of public document available to tell the public what is going on?

Dr Groves—The Chief Psychiatrist of Western Australia is Dr Rowan Davidson. He reports directly to the Director-General and the minister and not through me. I am aware, however, that it is a statutory obligation of the services to report to him incidents of seclusion and various forms of restraint and emergency psychiatric treatment and so on. He clearly collects that data. I know that he then uses it in terms of clinical governance reviews, going back to the services and pointing out to them differences in the rates of seclusion and restraint and ways of using that to try to minimise the use of seclusion and restraint. Peter may be able to speak more fully about how that actually plays out in principle.

I can make note, though, that other jurisdictions are much the same in that regard. There are few other jurisdictions that report rates of seclusion and restraint publicly, and that is a significant issue for us to address. You may not be aware that recently a group, which is called the Safety and Quality Partnership Group of the National Mental Health Working Group, released its safety priorities for mental health, one of which is to reduce the rates of seclusion and restraint and therefore, where possible, the adverse events related to that. That now is a national mental health safety priority. I believe that some of the strategies that will come out of that—and I think it will be important not only for states but for the Australian government to look at funding—will relate to how we start reporting rates of seclusion and restraint in in-patient settings. I think there is a very strong movement for adequately reporting that publicly so that there can be some comparisons around that. I know well that rates can vary by as much as ten-fold between various in-patient units and various practitioners not only in this state but in other states, and that is something that needs to be adequately addressed.

The group has looked at some of the evidence that has come from the United States. Several states in the United States have extremely low rates of seclusion and restraint, and they have specific training to ensure that their staff are well trained in how to reduce seclusion and restraint. I think that they are the sorts of programs that we need to look at introducing in Western Australia and, more importantly, nationally.

Senator HUMPHRIES—Just on the question that you raised in your opening remarks, Dr Towler, about the low rate of payments for psychiatric services in Western Australia, because of the low number of registered psychiatrists here per head of population: is that shortfall in payments to Western Australians a matter that you could or do take up through the Grants Commission process?

Dr Towler—I am not sure of the answer to that, to be honest; I have been in the role for four weeks. Aaron may be aware, but I really cannot answer the question at the moment.

Dr Groves—The simple answer is no, as far as I am aware.

Senator HUMPHRIES—You cannot or you do not?

Dr Groves—No, we have not. I do not know whether we can but I know we have not.

Senator HUMPHRIES—I make that as a suggestion you might take away.

Senator WEBBER—Thank you very much for your submission. I have to say—I guess because I am from WA—that I think it is a pretty good overview and summary of recent history

in terms of mental health and the priority the state government is giving it. It also points to the need for resources and a commitment to underlie the quality of services. However, given the mental health plan that you have outlined, there will be certain populations that will not get adequate services for quite some time, just through the fact that we have had neglect for a long time and now we are playing catch-up, as is the rest of Australia. What are we going to do as a stopgap in between times?

Dr Towler—There are a number of issues to that. I am not here to make excuses, but the importance behind what we are doing at the moment and the rate at which we are trying to move is to ensure that the resources that have been made available are put in place as quickly as possible. That is a critical element to the process, and we have recognised that it needs to be more than simply ‘metropolitan-centric’. At the same time that we are dealing with the issue of meeting the need, I have just put to the Director-General a new paper on cultural sensitivity and management of the Aboriginal population. We have identified the need and, as I mentioned in the submission, we have had a recent, second-stage review of mental health issues in relation to our Indigenous population, and that is our new focus. The other area which we are picking up on with substantial interest is the area of mental health in the areas of justice, an issue which we think also needs to be addressed fairly quickly.

As best we can, we are trying to put the resources where they can be. Mental health is not the only health discipline where the resources are falling short of the need. I believe that we are doing what we can in this process. The whole principle behind the development of the mental health network and working in partnership with the consumer, the carer and the NGO organisations is that the evidence is that you get much more mileage out of the services you have in place through that process because you do reduce admission rates and you improve community care. That means what you have in place will do more for you. That is one of the reasons that that is a priority and was emphasised through the Reid report in Western Australia.

The other issue is that putting in place psychiatric facilities in acute hospitals is improving the immediate care. In the emergency departments, we are putting in place roles such as psychiatric liaison which facilitate earlier discharge. So we are trying not only to put in more services but to maximise the efficiency of those services in dealing with more episodes of care and actually providing a better service overall.

Senator WEBBER—In the meantime, while we are evolving those services it seems to me there is often a divide between the view that the likes of you and I will have about the state of the delivery of mental health services and the consumer perception of that state. Because we can have this discussion, we can have some confidence about the forward direction, but they are not as involved. Do we have any strategies to address that gulf and to take them with us on this journey to a vastly improved mental health service?

Dr Groves—Simon has already touched on the issues of trying to change the different ways in which you provide service. There is also the issue of getting from where we are at the moment to where we need to get to in the future, given our work force, to change the type of work force we have. An important aspect of that is how we might look at having consumers much more actively involved in the provision of service, which is something that this country probably has not embraced as well as some other parts of the world. Alternative labour classes are an important aspect we need to look at, in particular the use of consumers and carers in our work force.

In respect of your comments about consumers' perception, I noted with some concern some of the comments in the Health Consumer Council's submission. They made a very strong point that their impression was that a lot of aspects of what they hear are not a lot different from 10 years ago. It is very difficult when a body that often advocates for people who have had poor experience of mental health care bases its view around that. What we actually lack in this country is any agreed mechanism to determine the consumer's perception of care; we do not actually measure that. Until we develop a mechanism by which we can measure their perception of care and adequately identify whether it has changed or does change, we will really find it very difficult to compare.

I know that my office gets numerous complaints, but they also get lots of compliments. An aspect that you often do not see is the numbers of compliments that come back from services. I think there is always a counterbalance to the aspect that you often hear in the media about care that has gone wrong or care that has clearly been very suboptimal. That is where care is much better than it used to be and where people's experience of care has been very good. What you do not see is active, open reporting, either in the media or through health services, of their compliments. So that is an aspect that I think there needs to be a balance around.

To answer your question about how we get by between now and the next couple of years when we get all the projects in place, we need to do two things. The first thing is to make sure that we can fulfil that commitment in terms of providing as quickly as possible the services that the funding is there for. The next issue is to very much engage with the consumers so that they understand what is happening and how we are changing the system, and to make sure that they have a very strong say in how we do that. An important element of that is that the network that we have established in mental health has two consumers who sit on the peak network body that will decide how services go forward. So they will have a very strong say, as will carers, in how we provide services differently.

Senator WEBBER—With the expansion of the mental health services, there are obviously some work force planning issues, and we have touched on some of them in terms of perhaps getting some Commonwealth involvement in it. To what degree is the state department undertaking some significant work force planning? Within that, is there an integrated, whole-of-government look at it? As you know, we were in Port Hedland and we had a very good and productive meeting with Dave Cutts—and congratulations on the great job the north-west mental health team are doing—but one of the issues he raised in respect of attraction and retention is actually education. Is there a dialogue between Health and other government agencies about the services we are providing to health professionals and their families?

Dr Groves—Most of those extra aspects of the quality of conditions of service are provided by Health, so, when he talks about education, there are those aspects that are educational for the children of people who work in services. That is a time-honoured difficulty. There is also that aspect of continuing education for professionals. In mental health there has been a tendency until more recently to see it as a second-order issue. Most of the area health services in Western Australia now have quite sizeable investments in mental health education for their staff.

We have recently, as part of the strategy, put an additional investment in the national practice standards for the mental health work force, which I am sure you would be aware of. Most states and territories have probably been on the back foot in terms of how they are going about

implementing that. We decided that would be a priority in Western Australia. We have funded and commenced five different projects that look at various aspects of how we provide education for the mental health sector in a consistent way. That was very much from the feedback we got from the sector about what their priorities were, like training in how to manage aggression. We very much picked on the high-order issues. Peter chairs the group that oversees all of that, so he might like to add to that.

Dr Wynn Owen—We have been trying, in a coordinated way, to approach the training and educative needs of our work force, reflecting on how important that is to retention of staff and how that will then impact on attraction of staff. The group that I particularly oversee is about work force and workplace safety as much as anything else. There are a whole range of other concerns which we have touched on, but that is within Health rather than multigovernment or all-of-government. However, we try to take an integrated approach to recruitment as well. We have created a work force pool. We have attempted to engage, through the Office of Mental Health, a single approach for all health services in Western Australia to attracting mental health staff, rather than each competing with the other. To date, that has been reasonably successful. We have had some 224 people register. Over the next three years we hope to recruit up to 425 staff to meet the needs of the strategy. That is a big ask. But we would expect that, with that number of people registering in the first six months, over the three years of the strategy we have a very good chance of meeting the work force demands. We also need to facilitate their retention within the work force through these sorts of programs.

Dr Groves—Senator Humphries mentioned other states increasing their funding to become above the national average. You can get the National Mental Health Report, which reports in a consistent way about funding. Western Australia has been the No. 1 funding per capita state for quite some time. The 2005 report that will come out shortly will still have us as No. 1. With the increase in funding we have just put in, we will remain No. 1; I am fairly confident of that. Having said that, there have been sizeable investments by other states—Victoria, in particular. That makes it very difficult for us as a state. It is not the blue sky every day here that is going to attract people to Western Australia. We need to take that into account. New Zealand is about to have a strategy to look at dealing with their work force. With most other states going to the UK—or even the UK coming here—it is a very competitive international market. Unless you are doing something to try to promote yourself, it is going to be difficult for our country to maintain our mental health work force.

Dr Wynn Owen—I think we have to see those overseas and interstate markets as a relatively short-term solution anyway.

Senator WEBBER—It is not a long-term work force plan.

Dr Wynn Owen—It is about what we grow within the state, how we look at the roles of those people and how we work with the educational establishments to develop the roles to fit the needs. We still have historical roles within our services, and our work force redesign is attempting to look at those roles again and give people clearer opportunities to do what needs to be done. That is again where the consumer participation comes in very importantly.

Senator WEBBER—I have specific WA things to discuss, which will come as no surprise seeing that I am from here. A couple of them are Indigenous issues. Why do we see a high

proportion of our Indigenous population incarcerated in prisons but we do not see as many in our mental health facilities? If you go straight from one facility to the other, you are struck by seeing a whole lot of black faces in jail but not so many in mental health facilities. Yet they have significant mental health problems. Are they not getting picked up by you first before they end up being incarcerated?

Dr Groves—I think your question has a very complex answer.

Senator WEBBER—I know it does.

Dr Groves—I think your concern about our rates of incarceration is for a different part of the Western Australian government to talk about. However, because the Senate has had submissions about it, you would be aware of the relationship between people in prison and their rates of mental illness—and I know the Public Advocate spoke about that this morning—and it is a concern to us that a lot of Aboriginal people end up in prison and also have mental illness. That is undoubtedly the case. However, the Aboriginal population is also overrepresented, in terms of their proportion of the population, in in-patient care as well, so I think you need to recognise that the issue is not just about our mental health services necessarily missing their mental illness and, as a consequence, them ending up in prison. There are other factors at play around that. That is not to say that our mental health services may not miss Aboriginal people who have mental illness. I think we know very well from the data in this country that 62 per cent of people with mental illness get no care whatsoever. So that is a very significant issue that has to come into play. You also need to compare high-prevalence disorders and low-prevalence disorders. In terms of the number of people who have psychotic illnesses and are Aboriginal, I think that a fair proportion of those people are well engaged in our mental health services, even if they might also coincidentally go to prison. The other concern, which is Aboriginal people who have drug and alcohol problems and depression and are in prison, is also a complex societal problem. I hope that adequately answers the question about that aspect of the relationship.

The other aspect is that of course there is a gradient of the proportion of the population who are Aboriginal across our state, and we have very few in-patient beds above 30 kilometres north of Perth, so that is a significant issue. For people who are Aboriginal and need in-patient care, particularly in the Kimberley, sending them to Perth is like sending us to China. It is a different culture. It is a different world. We have recently commenced a project—which I know you perhaps were not alerted to in Darwin—between the Northern Territory government's health and police departments and the Western Australian health and police departments, looking at the feasibility of transferring people from the Kimberley to Darwin if they need in-patient care. From our perspective, it is cheaper for them to go to Darwin. It is more culturally appropriate. In fact, we have good advice from the Northern Territory health department that we can get around the mental health legislation issues as well. I know that that evidence was not given to you, but I know that it is actually the case.

Senator WEBBER—It is good news.

Dr Groves—Currently, South Australia does take people across the border from the Pit lands. We have staff, for example, across the border between WA and the Northern Territory—communities like Wingellina, for example—where the mental health workers are very aware of the acts on either side of the border. Alice Springs staff know the Western Australian act, because

every now and then some of their clients may be on the Western Australian side of the border and they need to use our act. So that is the way in which we go around that. Ultimately, it would be better if those cross-jurisdictional type legislative problems were resolved. That is a complex issue that has been on the health agenda for at least 10 years.

Senator WEBBER—Also, in Port Hedland we had a discussion—and I have been struggling to remember—which I think was about the joint health partnership that is addressing Indigenous health. The signatories to that agreement were the Commonwealth, the state, ATSIC and WAACCHO. Two of those parties have fallen over, for various reasons, most of them understandable. The community up there seems to be struggling with the future direction and where we are going. Does the department have any view about where we are going? Is there any sign of any activity from anyone else?

Dr Towler—There is a good range of them. One of the other portfolios in my new division is the Office of Aboriginal Health, so why not?

Senator WEBBER—You're the expert!

Dr Towler—Not yet, but I will be! I did not bring Terry Murphy with me, so I apologise. This is an issue which is occupying our minds in particular. In Aboriginal health we have what I think is a very strong emerging relationship between the state and the Commonwealth in the way we support services. There is a very good example of the moment in the Balga district where a local provider has—shall we say—got into trouble. In fact, the state has just taken over to run the health services there. The dimensions of health services in those sorts of districts clearly go beyond health.

Within the state we have a cross-departmental committee looking at issues in common, and we met recently to look at some of these areas. We are building new relationships with the Aboriginal communities in a number of different ways and facilitating as much as possible the emergence of those administrative structures which are replacing ATSIC and the other administrative bodies which have had some difficulties. Balga is not a unique problem. There is one in the south-west at the moment where we have an administrative difficulty and there is one around Kalgoorlie. This is in fact core business in Aboriginal affairs management, and particularly in Aboriginal health.

It is very pleasing to me, when I go down to the Office of Aboriginal Health, to see a number of Aboriginal people involved in providing those services. We have built a structure in terms of our health contracts which has become more appropriate and we are now, as I said at the beginning, focusing on the cultural diversity issues in relation to dealing with the Aboriginal population. I think we can find a way forward. The partners to the arrangements are changing, but we have a long history of working with changing partners in the delivery of services in Aboriginal health. My impression from my short involvement is that it is moving forward in a fairly positive way.

Senator WEBBER—So when I go back there in October I will be able to tell them that something is going to happen?

Dr Towler—They will be seeing things happening, particularly around Balga. There is a very clear plan there that has been put in place. The director of the Office of Aboriginal Health and the director of the Country Health Service were in Balga only 10 days ago. The Service will be supported with the removal of the Mercy Hospital arrangement, and we are looking to build the Service into the future with Aboriginal input.

Senator WEBBER—I have some specific questions about Geraldton which I will ask you to take on notice, because they relate to an internal conflict in that town which will bore the rest of the committee rigid, no doubt. I gather there are plans to place some of the supported accommodation that we were talking about before in Geraldton, but during my visit there last week there seemed to be a bit of community anxiety about the placement in those places—who is going to live in them and goodness knows what. As these sites are selected does the department conduct any kind of community education? Does it talk to people about what is going on?

Dr Groves—It will be an important aspect of what we do. We have only just commenced that whole community consultation process. The most important thing they need to understand is that this is for people who already live in their community, and that it is about trying to provide something that is more appropriate for them rather than about them being disenfranchised and disadvantaged living in the community with no services around them. It is about trying to improve what we provide in a different way, not to all of a sudden uproot and move people. The one aspect of some of the submissions that I have spoken about before that I do agree with is the whole issue of stigmatisation of people with mental illness. By and large, that is still a large community problem which we have.

Senator WEBBER—Lastly, congratulations, Dr Groves, on your new appointment. Our loss is Senator Moore's home state's gain. Good luck in Queensland.

Dr Groves—Thank you very much.

Dr Towler—We are still trying to work out why he did it!

Senator WEBBER—It might be the effect of the attraction and retention!

Senator MOORE—You might go too, Dr Towler!

Senator TROETH—Yesterday in Port Hedland we heard quite a bit about the lack of psychiatric staff and the difficulty in attracting professionals. I note in your five key work force and safety initiatives that hopefully you are going to recruit 425 staff through a couple of measures. One of those is provision of incentives to practise in areas of greatest need, including rural and remote areas. What are those incentives likely to be?

Dr Towler—I can talk about some of the general ones. In terms of the whole provision of health service in the state there is an emerging program, particularly around housing and support for housing, in a lot of the rural areas. That has been identified by government and there is a substantial investment in it—I would have to go and look up exactly what it is. I think we have already heard in the information provided that the issues around the difficulty of supporting people working in a rural setting will never go away. There are the problems for families: the

issues around schooling and the other forms of support. Part of the process behind what we are trying to do with the clinical network is to look at the way in which the rural sector is going to be better supported by the metropolitan area. I do not think we have a detailed understanding of those programs at this stage, but it is an emphasis which we are trying to put across the system. This is no easy issue.

Senator TROETH—Yes, I understand that.

Dr Towler—In Western Australia, 25 per cent of people live away from the metropolitan area, but we do not have strings of community centres like those that exist along the coast of Queensland. When you try to put people into these roles, they are very isolated. We have been very dependent in a medical sense on doctors who are trained overseas who are unfamiliar with the local Western Australian situation and so it is even hard to build a small medical community or a clinical community around the medical practitioner because he may in fact be completely unfamiliar with the way the state operates. So this is a big challenge. I think we have a few things in our sights but I do not think we have got all the answers.

Senator TROETH—Yesterday we were very impressed with the way in which videoconferencing is obviously used—

Dr Towler—Very extensively.

Senator TROETH—and the amount of time that the health professionals around there are prepared to spend in their car travelling to various points and the way they support each other, but obviously having more professional feet on that ground is certainly the way to do it.

Dr Towler—That is the aim. The trick is to learn how to support them. The educational initiatives are important. We have recognised that in videoconferencing you have to teach people how to use it optimally.

Senator TROETH—That is true.

Dr Towler—And we are willing to do that. I recently gave a talk to RFTS members and we have representatives from seven locations across the state, and that is a routine tool in Western Australia now. So those are important, but you still need to provide people with the opportunity to come and work in the metropolitan area and you need better systems to teach them how to interdigitate with the facilities that are available, particularly with, as I said, this dependence on people actually who do not come up through the Western Australian health system.

Senator TROETH—We understand from a submission we had from Carers WA that the mental health clinic in Bunbury was closed last year, with little or no consultation; but I also note that you are going to be putting supported community residential units eventually in Bunbury, so can you give us an update of that situation?

Dr Groves—I can give you an update around the supported community residential units. I perhaps cannot around the issue of the closure of the clinic. There are 25 community supported residential unit beds planned for the south west. That currently is planned for 15 in Bunbury and 10 in Busselton. We have had significant difficulty trying to identify land in Busselton that will

allow us to build that community supported residential unit. However, we now understand that we have a prime piece of almost ocean-side land for that. The other 15 beds are planned for the old Bunbury hospital site. Again, they are both pieces of Health land that will be used and offered up for building that accommodation to support people.

Senator TROETH—So how will those accommodation units be supported?

Dr Groves—The plan is that we will put money out to tender to non-government organisations to provide the disability support. The clinical support will come from the local community mental health centre. So it is a partnership between the public funded government mental health services from a clinical perspective and the non-government providers. We have actually got quite a good highly regarded non-government provider of support down in the south west, which is a difficulty that we have in other parts of Western Australia.

Senator TROETH—In regard to the amount of interaction between the police department and the health department when it is necessary to transport patients who may be violent either to hospital or to another mental facility, I think we have understood from the police national body that police officers often feel that they are expected to do more than they should. On the other hand, with both patients and their families, they feel a certain public exposure in being transported by police officers and the associated public notice with that. So the police national body suggested that there should be memorandums of understanding between police departments and health departments. Is there one of those here, and could you give us an outline of what it entails?

Dr Groves—Yes. We have had one since 1999. It is quite extensive, and I would be more than happy to table it for your information.

Senator TROETH—Yes.

Dr Groves—It was something that we commenced reviewing about one year ago to update it. A number of the bodies and organisations that were party to signing it off have changed their names and structures since, so it has become a little bit antiquated in that way. However, we were also confronted by the circumstances that you may be aware of—the Mental Health Act 1996 in our state is about to be replaced. A review last year brought down some findings which the government has accepted. At the moment we are in the process of drafting the new legislation to come before parliament. That will change a number of elements of the relationship between the Police Service and health services. It seems not to be a good time to update a protocol which would need to be updated again probably within a year. However, there has been a longstanding and quite intensive relationship between senior parts of the Police Service and the Mental Health Services and we continue to work on the relationship with the Police Service.

As opposed to the submission that came from the Health Consumers Council, I think you need to understand that our act is very clear about how people are to be transferred when they are transferred under the act. We must use the police. That is just something that is simply in the legislation. We have multiple mechanisms for going about trying to minimise the way in which police are involved in that. There is clearly an understanding which hospitals and community staff have that police are only to be involved when they have to be involved. If there are ways in which people can be transferred without having the police then that is the first option you use. I

think you also need to understand that generally acute services have become much more acute as time has gone on. By that I mean that, when people come to care in an involuntary setting, they are much more likely to be very disturbed and the incidence of drug and alcohol use is high—

Senator TROETH—I understand that.

Dr Groves—so we often do need to have the police involved. We have a Psychiatric Emergency Team in Western Australia which has been in existence since 1989. In fact, Dr Wynn Owen has previously been a director of that service, as I have. So we are very familiar with the actual day-to-day operations of that unit. It is important that that unit tries wherever possible to assess people in the community and take them to hospital if they need to go to hospital without using the police. But, inevitably, police are involved. They are usually very much kept in the background.

The important aspect that we need to get right is safety for staff as well as safety for the community when we make those transfers. As opposed to the comments about the red and blue lights flashing, generally the police cars do not have lights on. In fact, they are usually unmarked police cars and often we even have plain-clothes police involved. The whole profile of having the police around involves an attempt to be as destigmatising as possible. From time to time you cannot do that because the imperatives of police operations are such that you will get a marked car as opposed to an unmarked car. That just happens from time to time.

As part of the review of the new act, the Police Service made the submission that we should look at alternative ways of third party transportation of people so that police would only be used when it had to be police rather than some other type of transport service. We have looked at some of the models that we have seen overseas and also in one part of New South Wales, where it has been contracted out. An organisation that is not the police actually makes those transfers under legislation. We need to make changes to our legislation to enable us to do that. That is something we have put up to our government to take into account, because it is important that we try to destigmatise that whole approach.

The current police commissioner in Western Australia has made it very clear that he wishes police to go back to their core roles in policing. That is not about providing escorts. They provide escorts for approximately 30 different classes of people, and mental health escorts is one. They are very keen to find a solution that works better. The thing that needs to be understood is that, when this act came into place, a considerable amount of funding shifted from Health to the police to recognise the fact that police were going to need to take on that role. So money just does not exist for Health to take over and do that. It is not just as simple as that it should always be picked up by mental health services. I suppose that gives you a bit of an overview.

Senator TROETH—Yes, it does. I assure you that my concern is just as much for the police as it is for any other parties in those arrangements, so I am pleased to know that there have been arrangements and that you will be updating those after the new legislation comes in.

Dr Towler—You may not be aware of the importance of the safety issues that face us in mental health provision at the state level.

Senator TROETH—I assure you I am. We have had several cases in my own state of Victoria.

Dr Towler—We have a very substantial duty of care.

Dr Groves—The other thing I forgot to say in my statement is that we have actually had quite a good education program, which mental health services have provided to the police service, around how to minimise their own risks when they are transporting people. We actively keep that going as well, so there is a good partnership in that regard.

Senator TROETH—That is good.

Dr Groves—Probably the biggest difficulty in our state is transfer by RFDS involving the police. There is a real difficulty in the transport.

Senator TROETH—Yes, we did hear about that.

Dr Towler—There was a comment in the papers from the health ministers council about patients being sedated for transfer, but amphetamine-intoxicated patients in the areas to the north-west are fundamentally unmanageable and have to be flown in an aeroplane. In my other world as an intensive care practitioner I have received those patients, and it is a challenging issue.

Senator TROETH—I am sure it is.

Dr Towler—There are no easy solutions.

Dr Wynn Owen—To underpin that, there are two key things. The Mental Health Act talks about using the least restrictive environment, which includes the least restrictive transport method. But that transport decision must be based on a good, high-quality clinical risk assessment that takes into account the patient, the staff and the community. And that is what we try to do in every case.

Senator SCULLION—I will make this as brief as I can. The sorts of issues that I am interested in are very similar to Western Australia's issues because the Territory has a very similar demographic. All our resources are in one place and we have a bloody big place to look after. I do not think your policies are any different. You are talking about increasing access for in-patients; about some of the work force issues, particularly in the regional areas; and about becoming less metrocentric. From visiting Port Hedland, and from being very familiar with my own country and knowing that area fairly well, some of the issues that we saw are the ones we have just discussed, including the issue of the RFDS. Unless people in mental health have a sudden degree in being an anaesthetist at the same time, they are going to face ongoing intensive care problems.

That being the case, we still do not seem to have addressed the issue. I am looking for some policy suggestions. You are not supposed to talk about policy, but be courageous! Just deal with it in a national sense, if you like. We really need to get a centre—literally, a building—or

something extra in places like Port Hedland to deal with those issues. There is going to have to be a long-term added sense of amenity if they are going to get the same degree of service.

Dr Towler, you started off by commenting on the roles of the Commonwealth and the state and taking a reasonable approach to that. Again, there are work force issues associated with this. There is no point having a building if you do not have anyone to deal with it. Dr Groves said that Perth is a wonderful place to be. Well, Nullagine is an absolute shit of a place to be. Having worked there, that is no slight on Nullagine; it just does not have the same services that Perth does. The difference between Perth and the catchment between Marble Bar, Nullagine and Port Hedland makes the catchment a very difficult place to recruit for. Potentially in your answer you could deal with some of those issues. Nationally, there is nothing new under the sun in those issues. You could talk about how we can resolve them and perhaps address the issue of where you think the state-Commonwealth partnership may go in trying to resolve those national questions.

Dr Towler—I will start with a few general comments and then I will ask Aaron to make some specific comments around where we are with mental health. The state of Western Australia has grasped the mantle in terms of how we manage and administer rural health services. Although it has caused a good deal of pain for the minister, we have recognised that having 36 disparate regional location based health boards is not actually leading to a sensible health system. That has been a difficult exercise.

Under Chris O'Farrell's leadership, we now have an emerging rural health sector which is genuinely trying to develop itself as a hub and spoke model where there is a clear focus on improving the nature of the facilities that are being provided. Although we have not really gone into the details of the health reform plan, there has been major investment in capital resources in the rural sector. For example, Geraldton hospital has just opened in the last two weeks. Part of that is about providing the appropriate infrastructure to support a region, which then facilitates how you develop a work force model and how you interdigitate that with a metropolitan health service. One of the key issues in the health reform area is that we build up partnerships between the metropolitan areas so that some of the power and grunt that we have in the metropolitan health system can support what is going on rurally.

Although the emphasis goes across the whole spectrum of health care, it also applies in principle particularly to the care of patients with acute psychiatric crises and underpins trying to provide a safe environment for their care. I think that is a very important initiative. Certainly in terms of what we are trying to do with Aboriginal health, having regard to the way we interdigitate that with health services, we are also looking for the same global control and a more sensible application of resources.

Dr Groves—We have had major concerns about how to move forward with providing more in-patient services outside metropolitan Perth without the work force. We have a viable unit in Albany and a viable unit in Kalgoorlie. We have struggled with Bunbury, as you have probably been informed. We do have, as part of the agreed planning process, to look at in-patient services in Broome. You would have got the clear impression, from speaking with Dr Cutts yesterday, that they have a viable service now in the Kimberley, with three psychiatrists who are all likely to be there for the long haul. Whilst that region probably needs more than three psychiatrists, that at least gives them the capacity to have an in-patient program.

That is hopefully where Western Australia goes next in terms of building an in-patient unit up there. Broome is a place to which you will attract people to come and work—not just seasonal work but long-term work. As you know, it is pretty unlike Nullagine. It is where I think we need to go next. The difficulty is with transport and the feasibility of going from the Pilbara to the Kimberley. There are not good flows. I think that in-patient unit would help to resolve the Kimberley issues which, in the short term, we would like to have resolved with Darwin. But even people from the east Kimberley might better flow to Darwin than to Broome.

The Pilbara presents a significant problem in terms of trying to plan where in-patient services would go and how you would attract somebody to go there and run that service. Interestingly, Geraldton has been able to attract and retain their psychiatrists for some time now, and that has been of benefit for that town and area because that was a major difficulty. I think we really need to do better in the Pilbara with key personnel before we can plan the establishment of an in-patient service there; otherwise, it just will not get used.

Dr Towler—The Pilbara is particularly challenging because with the current resurgent resource boom there will be another population surge in that area, and it will be largely a transient population—people moving around, flying in, flying out, not consistent. We know that there are some particular mental health issues with respect to those unstable populations. But it is a disparate population; it is not really based anywhere. Providing a quality service in that environment continues to pose a very great challenge.

Dr Groves—One of the common problems, of course, is that they often earn high amounts of income in short periods of time and usually spend it on alcohol or drugs, whether they are in the town, outside the town or come back. That is a very difficult service delivery type problem.

Dr Towler—There was a comment made earlier about the fact that traditionally we have been a little too centric on English-speaking Caucasian people. When you have small units with small groups of clinicians, it is extremely challenging to try to provide the extra layers, the cultural diversity and sensitivity in terms of the Indigenous population. We are trying to work out how to integrate that and provide an educational role.

One of the things that the mental health sector has achieved substantially in this state is to take a lead in educating non-mental-health clinicians in dealing with violent and difficult patients, and trying to upskill the general health work force in dealing with mental health problems when they present. I think that is starting to return benefits because our focus has shifted from keeping mental health separate to managing it as much as we can within the system.

Senator SCULLION—You seem to plan fairly carefully—and the long-term bed issue has been discussed. I refer to those individuals in prison who are there on the ‘not fit to plead’ demographic. They are clearly not fit to plead, they have not been convicted but they are currently in mainstream prisons in Western Australia—and this is reflected in other parts of Australia as well. I understand that your A-G is looking at some plan to deal with that because it is seen as being inappropriate. With respect to beds, do you have some contingency plan for that? In other words, they may well be appearing outside the prison system, in view of the fact that they are sick people who should not be in prison, and everybody accepts that—and not just those in Western Australia. How are you going to deal with that and was it incorporated in the figures cited previously?

Dr Groves—No, it was not incorporated in the previous figures. Our Attorney-General is also our Minister for Health and, therefore, this issue uniquely falls across both of his portfolios and both bits of legislation that he needs to manage. The report which he recently released made it clear that the model he wishes to take forward is one where those people who fall much more clearly into a forensic or prison population would have their health care needs met and managed by Health but the perimeter or custodial elements would be managed by prisons. It is about trying to create a facility that is much more health orientated than prison orientated.

Senator SCULLION—Would those health issues be delivered where they are now, in a prison environment? Are you are trying to change the prison environment rather than shift them into a health environment? Can you be more specific?

Dr Groves—The detail of that still needs to be resolved. It is a report that is a week old and we are currently working on that.

Senator SCULLION—Has it been released?

Dr Groves—Yes.

Senator SCULLION—It would be great if we could get access to it.

Dr Groves—We are more than happy to provide that.

Senator SCULLION—Thank you.

Dr Groves—The first time this issue was faced in Western Australia was with the construction of our first purpose-built forensic mental health unit. That was resolved by building it on the grounds of a hospital. The Graylands hospital had the construction of the Frankland unit. My view is that the same thing should happen with units where essentially somebody has never been convicted of any offence, because they have not even been to trial, because of a health issue. My understanding is that that is also the view of the minister.

Senator SCULLION—I just want to make it clear. The separation of the demographic is those people who have been convicted and have mental health issues are dealt with by Health in the prison system, and it is your intention for those people who have been seen as not fit to plea will be dealt with in specialist units outside of that?

Dr Groves—Yes.

CHAIR—How many beds will there be in the prison psych section?

Dr Groves—That is something that has not been determined; it is not clear in the report. We currently have 30 beds.

CHAIR—Is that at Graylands?

Dr Groves—Yes, in the Frankland Centre in Graylands. That is way under what our state need is. Our state forensic mental health services, which Peter operates, reach into the prisons at the

moment but, as you are aware, there is a huge demand within prisons for specialist mental health services.

CHAIR—What happens when you have 30 beds filled with acute patients? What do you do with the others?

Dr Groves—It depends on where they are coming from. The service we have is comprehensive. If they are coming from prisons and we cannot find a bed for them, it is about juggling the beds around, but they might have to be managed in the prison until a bed becomes available.

CHAIR—So you have secure units in the prison?

Dr Groves—We have crisis care units and we have an infirmary, but we do not have any beds within prisons that are staffed—

CHAIR—What is the crisis care unit? Is that a locked facility separate from the rest of the prison?

Dr Groves—It is a segregated, separate facility, yes.

CHAIR—And services are provided there, or not?

Dr Wynn Owen—The crisis care wings within our prisons are quite separate units. They are serviced by both the prison officers and the prison health staff. So they are employed by Justice, but they are designated health staff—both general and mental health trained health staff. Visiting specialists also come into those units. Those people could be there for a medical or a psychiatric problem but, once identified, they do have the option of going to those units, which are quite separate from the rest of the prison.

CHAIR—How many people can be accommodated in those units?

Dr Groves—I do not know.

Dr Wynn Owen—I am not sure of the total number.

Dr Groves—I want to clarify this. Prison health and custody are all managed by the Department of Justice; they are not managed by Health at all.

CHAIR—Yes, I understand that.

Dr Groves—It is only our specialist services that go in. It is psychiatrists and sometimes special psychologists who would go in. The rest of it is provided by Justice. It is different from what, for example, would be expected from the statement of forensic principles.

CHAIR—And your women's prison?

Dr Groves—Our women's prison has a muster of around 110 prisoners.

CHAIR—Is that 110 prisoners for the whole state?

Dr Groves—I might need to be corrected on that, but that is roughly right. I think that there are more prisoners than there are beds available in Bandyup, so there are significant crowding issues. There is a small wing that is for long-stay prisoners. There is one small part of the prison which provides sort of hospital care. I do not think that they have terribly much in the way of services that would be competent in managing mental health problems there.

CHAIR—There is no section at Graylands for women?

Dr Groves—Within Graylands, in the Frankland Centre, women can be admitted as well as men. It is a hospital.

CHAIR—I realise that, but you have a section there for forensic patients. I am asking you about whether there is a women-specific section.

Dr Groves—A separate ward in Greylands hospital, yes.

CHAIR—How many beds are there for women?

Dr Wynn Owen—Can I just make a comment. Graylands hospital campus contains an acute hospital and a stand-alone forensic hospital.

CHAIR—I realise that.

Dr Wynn Owen—There is no segregated unit within the forensic facility. But within the acute hospital there is a segregated female ward of 18 beds.

CHAIR—For forensic?

Dr Wynn Owen—No, that is the acute hospital.

CHAIR—What happens to the acutely ill female prisoners?

Dr Groves—They go to Frankland.

CHAIR—Where are they accommodated?

Dr Groves—In the 30-bed Frankland unit, which is mixed gender.

CHAIR—It is not segregated?

Dr Wynn Owen—No, they are on one of two 10-bed levels.

CHAIR—The beds can be male or female?

Dr Groves—That is right.

CHAIR—Is that a satisfactory situation?

Dr Groves—Yes, it is very well managed by the nursing staff in terms of the females not being vulnerable there compared to what happens in usual hospitals in mental health units that are not for prisoners, where people of different genders are often mixed. Graylands is in fact the only hospital we have in this state where we have a single-gender ward in the acute hospital—this is not prisoners; this is just usual people with mental illness.

CHAIR—I understand that 25 per cent of the prison population is formally diagnosed with mental illness in Western Australia. That was said by one submission to be a conservative figure. Do you have a more accurate one?

Dr Groves—That is pretty accurate. The figures we have are from taking the prison muster and doing a data linkage analysis with our mental health register. That is the longest standing mental health registry in the country and has been going since 1966. All people who have had access to mental health services at any point, both public and private, are on that register. We were able to do a database linkage and found that 25 per cent of prisoners at the time we did it, which was in 2001, were on the register. The issue to maybe clarify, though, is that at least half of those prisoners have high-prevalence illness. They have anxiety, depression and drug and alcohol use issues as opposed to psychosis. The point to press, though, is that the half that do have psychosis well and truly over-represents the level in the normal population. That is the group that really need specialist mental health services. If those with high-prevalence disorders were in the community the vast majority of the care would be provided by general practitioners or other people. They would not need to come into contact with specialist mental health services.

CHAIR—Do you have visiting GPs in prisons?

Dr Groves—Yes. The head of prison health is a GP. He has a number of GPs who run and provide services throughout the prisons.

CHAIR—What would be the percentage of prisoners who would be on medication at the present time for a mental illness or a disorder of some sort?

Dr Groves—I could not tell you. I do not know.

CHAIR—Is it possible to get that data?

Dr Groves—It might not be possible to get that data because we do not hold it.

Dr Wynn Owen—The minister of justice would have it.

Dr Groves—I can find out. I cannot say that they have it because I do not know their system of collections, but I can give you an answer. I cannot speak on behalf of another department; I do not know.

CHAIR—Is it also possible to get any data on the revolving door syndrome in terms of people with mental illness going back and back and back into prisons? Is that available? Has any work been done on the longitudinal studies of prisoners and prison populations? Are there differences between male and female, Indigenous and non-Indigenous?

Dr Groves—In terms of prisoners with mental illness or just prisoners in general?

CHAIR—No, prisoners with mental illness.

Dr Groves—We have some data. I do not think it is terribly robust data, unless Peter is aware of anything else that is being done. Again, I would be happy to provide you with whatever data I can find on that.

CHAIR—Thank you; that would be interesting. The Public Advocate says that the prisoners who are unfit to plead but who are put under the care of the jurisdiction of the Public Advocate lose certain protections. For instance, they lose the automatic review which would be available to those who are not under that system. Have you had a chance to look at the problem of the rights of those people to determine whether legislative change is necessary to fix the problem?

Dr Groves—At the same time as our Mental Health Act 1996 was reviewed we had a parallel process which was to review what was then called our Criminal Law (Mentally Impaired Defendants) Act. It is now called the Criminal Law (Mentally Impaired Accused) Act. This made a number of recommendations about strengthening the rights of people who are either on custody orders or have been sent for assessment. It also provided a number of recommendations in relation to those people who might be unfit to plead or unfit to stand trial—two different concepts but clearly very similar. These are in the process of being looked at by the Attorney-General who has carriage of that legislation. Whilst it is the same person, it is a different portfolio that looks at that. The chief psychiatrist headed a group which reviewed the recommendations and made recommendations to the Attorney-General. My understanding is that the recommendations that have been made through that review are likely to be incorporated into a redrafting of the legislation to help to protect those rights. The Public Advocate was one of the people who made strong submissions that were heard and incorporated in the review of that legislation.

CHAIR—The Public Advocate also raises the issue of voluntary patients in hospitals who have not signed a consent to the effect that they are voluntary and who also miss out on the regular review that would be available to involuntary patients, but they nonetheless receive the same services in seclusion.

Dr Groves—I do not think it would be legal under our act to seclude people who are voluntary patients. I am not quite sure of the point the Public Advocate was making.

CHAIR—You might look at the submission. She talks about—

Dr Groves—People who are voluntary patients have rights that are inherent on their not being covered by legislation.

CHAIR—She says that they are voluntary patients; they are not involuntary patients but they have not signed whatever document is required for them to be there.

Dr Groves—They have given implicit consent by agreeing to come in for treatment.

CHAIR—And there are no implications for not signing some document?

Dr Groves—I will happily look at that and provide you with an answer.

CHAIR—That would be useful; thank you. Evidence in submissions complains about the fact that people in WA are released from acute care after relatively short periods and end up in hostels and places where they are tipped out at 7.30 am and not allowed back in until later in the evening. What are the key initiatives in your strategy that will deal with that?

Dr Groves—Key initiative 4 is primarily focusing on trying to deal with that situation, although some aspects of key initiative 3, which is about expanding the number of community mental health staff, are also about trying to address that. Perhaps I should go back to what the root issue is here. The root issue has been the problem with our service model where people go into acute care and stay for short lengths of time—lengths of time vary in this state between about 11 and 21 days in in-patient care, which is roughly the national norm—and then we have difficulty finding adequate care for them in supported accommodation in the community. So our whole approach has been about looking at how we support that.

The specific example that you seem to be focusing on, of people being tipped out of their beds at 7.30 in the morning, probably centres around licensed psychiatric hostels. We license the infrastructure and pay for care packages from those hostels. However, they are essentially privately run businesses and we have difficulty in how we can regulate that.

CHAIR—Even though you license them?

Dr Groves—Indeed—but we license the infrastructure, not the care that is provided.

CHAIR—Do they receive any government funding?

Dr Groves—Yes, they do.

CHAIR—Why can't that be a condition of keeping the doors open, as it were?

Dr Groves—What we have just done is develop a purchasing framework for those licensed hostels which says, 'From now on, when we give you this funding it will be for you to provide this care, and if you don't then you won't get the funding.' Previously they had a very small level of care funding for which their requirements were very limited, and I think it is fair to say that the level of funding was very low. We have now increased that level of funding for care packages but said, 'Now we require you to document and show us a level of care, and if you don't, you get no funding.'

CHAIR—Will that have the effect of closing these services down?

Dr Groves—Part of the difficulty is that we have 588 licensed psychiatric hostel beds in our state and, at any one point in time, somewhere in the order of 540 people in hostel beds. If we closed them overnight—and we need to recognise that this is not a commercially profitable industry for the operators—we would have around 540 people with serious mental illness requiring in-patient care. So it has been about trying to get a slow process to reform the industry. The way we have done that is to look at how we build the community supported residential units, which have a much better fabric and for which there will be a better funding model with agreed preferred providers whom we know provide high-quality care, to start to replace that industry as it starts to diminish in size to what we think will be the good operators. There are some good operators within that industry. That is our contingency plan to try and manage a change.

CHAIR—Will some sort of staff training be part of that package?

Dr Groves—Yes.

CHAIR—There is an anomaly between the other submissions we have received and yours to do with the number of child and adolescent beds. Your submission says there are 28. There are three at Bentley, apparently. Can you tell the committee where the others are?

Dr Groves—No, there are 12 in the Bentley adolescent unit, not three.

CHAIR—Does the 12 include family members, or is it 12 children?

Dr Groves—I will go through them. There are 12 children in what is called the Bentley adolescent unit, which is an acute unit. There are eight children in the child residential unit, which is the adjacent in-patient unit to the Bentley adolescent unit.

CHAIR—The 12 children in acute are not in-patient?

Dr Groves—No. It is an acute in-patient unit but it is short stay and often involuntary under mental health legislation, so it tends to be adolescents and youth with early-onset psychosis. Then there are eight in-patient beds for a child residential unit. They are usually there for the length of the school term and taken in as a program. That is about doing work with highly behaviourally disturbed children within a family context model. In addition to that, there are eight beds at the Princess Margaret Hospital for Children, which generally deals with younger children for the state. That is how we get to 28 beds.

CHAIR—They are for mental health?

Dr Groves—Yes.

CHAIR—Young people in the 13- to 25-year-old range who are in adult facilities contrary to guidelines—is that going to be fixed with the new system?

Dr Groves—Not adequately. The long-term planning is for how we look at developing enough youth beds elsewhere, away from Bentley. The clinical services framework modelling, which looks at our in-patient needs for the next five years and then 10 and 15 years, makes

provisions for adequate numbers of in-patient beds for youth. The mental health strategy 2004-07 deals with the most acute demand issues at the moment. Our further planning does deal with the youth beds, but not the mental health strategy.

CHAIR—When would you expect specific youth beds for 16- to 18-year-olds to be available?

Dr Groves—We have specific youth beds already at Bentley. In terms of the expansion of those, some are planned for the Joondalup expansion in 2010. We are waiting for that clinical services framework to be signed off by government and agreed to, so I am not in a position to know.

CHAIR—Are you familiar with the ORYGEN service in Victoria?

Dr Groves—Yes, I know Professor McGorry and Alison Yung well.

CHAIR—Are there any plans to put in place a similar service in WA?

Dr Groves—I think it is fair to say that the ORYGEN service is extremely well funded and is a best-practice model throughout the country.

CHAIR—Does that rule it out for Western Australia?

Dr Groves—No, it does not at all, but Victoria is very fortunate to have had the resources to develop the service in that way. We have not done it in the way ORYGEN has been set up. Rather, we have looked at setting up early episode and first psychosis units in most of our acute adult programs. We have people in all of our services who understand the basic principles of early psychosis management and then we have certain people who specialise and take on caseloads of managing that. Peter, did you want to talk specifically about any aspects that you do in the north, just to give an example?

Dr Wynn Owen—Not really specific aspects, but we try and develop links between our child and adolescent mental health services and adult services to provide our early episode programs. We have also recently introduced two multisystemic therapy teams north and south of Perth under the mental health strategy, which focus on a wraparound model that provides services to these people in the community rather than managing them in an acute hospital.

CHAIR—What sort of percentage of the unmet need will the two teams cope with?

Dr Wynn Owen—That is a very good question. It is a very good start—in the absence of any teams—to actually have the two. I think that you are right, but it is a huge step for us.

Dr Groves—I am happy to answer that. When we did the planning around MST, we identified around 300 children who, at any point in time, have severe behavioural disturbances, a high likelihood of developing mental illness and are not adequately getting an array of care. We developed a proposal to have teams of six people using an MST model who would take on small caseloads but then hopefully work through—

CHAIR—What would you describe as small?

Dr Groves—They would be dealing with around 10 people at the maximum amount of time, in terms of an individual caseload. Depending on complexity, it could be as few as six children or adolescents within families that they would provide the services for. It is a highly intensive treatment approach for six months. The available evidence says that those people go on to be much lower users of mental health, justice and various other services.

What has essentially happened is that the Department of Justice took the initiative to develop three of those MST teams during the last financial year. They have done them more in the inner-city aspects of metropolitan Perth, whereas, because we have developed an MST approach as a cross-government approach, we decided to put our teams in the extreme parts of the north and south metro areas so that there is no overlap between where the Department of Justice MST teams and the Department of Health MST teams are.

So really, taking a cross-government approach, we have got five MST teams. They would look at probably dealing with around about 100 children per six months. So we would hope that within 18 months we would get through providing MST type services to those 300 children that were identified by the Department for Community Development, Department of Justice and the Department of Health as being those children having the highest need of MST type services, many of whom go on to have drug and alcohol problems and psychosis problems.

CHAIR—It costs you more further down the track.

Dr Groves—Absolutely

CHAIR—I have a couple of Port Hedland questions. I think the committee was a bit disturbed to hear about what happens in the Port Hedland hospital when someone presents with an acute illness. Depending on what day of the week this happens, they may be sedated for very long periods of time—in fact, anaesthetised for very long periods of time—at great risk to staff and themselves. Will the new hospital have a ward or even a bed that will allow a more secure environment for such people awaiting transportation elsewhere?

Dr Groves—I am unaware of what mental health in-patient services have been planned for that particular hospital, but I think it gets back to the comments from the other senator earlier that it is actually very difficult for us to provide in-patient care—mental health gazetted, if you like, authorised in-patient beds—outside of the metropolitan area. It would be preferable that, instead, we used the in-patient services within the hospital. That would be for any particular person rather than specific mental health services and would make sure we had sufficient staff within the hospital to provide care.

CHAIR—This is not just a staffing problem, as I understood it. I can understand your problems with getting staff up there; but these people are often right next door to women having babies, and people are exiting the place because they are so frightened of these circumstances. It would seem to be not impossible to have a more secure area, maybe even slightly removed from the main—

Dr Groves—A separated area.

CHAIR—Yes, a separated unit. I will leave that with you. It occurred to the committee as well that BHP, a very powerful and very wealthy corporation, might be contributing a little more than it currently does to community services, including mental health, given that some of their practices give rise to serious mental health problems, which you have already alluded to. Does the state government lean on BHP to do this and, if not, why not?

Senator MOORE—Develop effective working partnerships.

Dr Towler—We look forward to doing that.

CHAIR—The Port Hedland folk also point to Broome and say: ‘We would like the services Broome has. We are about the same size or bigger. How come we miss out and they get a centre?’ What they most want is a centre which can provide services, particularly for Indigenous people.

Dr Towler—In terms of the rural focus, they are a centre and they are getting a new hospital. Broome has been a major focus for a change of emphasis. If you look at Broome, they seem to have had substantial growth in services, but that has been a planned growth, because there has been a shift in emphasis from Derby being a principal health facility for that area of the Kimberley. In fact, Broome is now a major government centre. We have a clear focus on improving services at Port Hedland. I do not think those particular comments are exactly fair at the moment, given what Health is doing with the rural plan.

CHAIR—It is a pity we do not have a record in *Hansard* of the discussion we have had with carers, with Aboriginal women in particular—I think there was one male—who described the situation for their sons, it mostly seemed to be, and themselves in accessing services. We may be able to send you some notes if that is possible.

Dr Towler—We would be very pleased to receive them.

CHAIR—I found it profoundly disturbing. I would recommend that you spend some time with this group that we met with and hear them out.

Dr Groves—I spent a day in Alice Springs with the women from the NPY Women’s Council in September last year in relation to a couple of their sons who are currently in Graylands hospital. Even through the use of a translator, it was a very powerful message that they gave across about the concerns that they have. I do not think this is something that is exclusively about Port Hedland or the Pilbara. This is really about what happens in all parts of Australia for Indigenous people and their difficulties in accessing mental health care and support for them as carers. It is fair to say that there are significant steps that need to be taken to address that issue. I am quite aware of the nature of the problem.

CHAIR—Has there been a government response to the ADHD report which was conducted by the Legislative Assembly in October 2004?

Dr Groves—Yes, the government has responded—

CHAIR—Could you give the committee a copy of the response?

Dr Groves—Yes.

CHAIR—That would be useful. Have you received a response to your complaints about the HREOC report? Are you expecting them to respond?

Dr Groves—Yes, we certainly are. We are expecting them to release their report. I spent perhaps 90 minutes on the phone expressing my thoughts to John Mendoza, and I understand that he clearly took those on board. I will look with interest to see how that has been incorporated in their thoughts.

ACTING CHAIR (Senator Humphries)—I have a question which I will put on notice to you, but I have a question now to clarify something about the operation of the Criminal Law (Mentally Impaired Accused) Act. If a person is acquitted of a serious crime on the ground of mental incapacity, in what circumstances would they still end up in a prison in Western Australia?

Dr Groves—Probably in all circumstances they will end up with a custody order. That custody order would undoubtedly be to the Franklin centre in the first instance, because they are not seen as prisoners.

ACTING CHAIR—Is the Franklin centre part of Graylands?

Dr Groves—The Franklin centre is at Graylands Hospital. It is what we would consider to be a high-security hospital; the prison sector would consider it to be a medium-secure prison. From our perspective it is a hospital. It is entirely run by health and it sits on a hospital site. There have been some circumstances, though, where people have initially gone to the prison before they were able to go to the Franklin centre.

Senator MOORE—Dr Towler, I have a few questions, particularly on Aboriginal health, that I am going to put on notice.

Dr Towler—That is fine.

ACTING CHAIR—I thank the department for its appearance today and the other witnesses who are not here. I thank the Hansard staff and the people in the Commonwealth offices who have assisted us. I thank the committee staff particularly for their usual diligence throughout the week.

Committee adjourned at 5.13 pm