COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

FRIDAY, 7 OCTOBER 2005

CANBERRA

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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

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

Senators in attendance: Senators Allison, Humphries, Moore, Scullion 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.

WITNESSES

Committee met at 9.19 am

BUCKINGHAM, Mr William James, Consultant, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing

DAVIES, Mr Philip, Acting Secretary, Department of Health and Ageing

HORVATH, Professor John, Chief Medical Officer, Department of Health and Ageing

LEARMONTH, Mr David, First Assistant Secretary, Primary Care Division, Department of Health and Ageing

LYONS, Ms Margaret, First Assistant Secretary, Health Services Improvement Division, Department of Health and Ageing

PRIMROSE, Dr John, Medical Adviser, Pharmaceutical Benefits Branch, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting First Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing

WHITEFORD, Professor Harvey Alick, Mental Health Clinical Adviser, Department of Health and Ageing

CASEY, Mr Dermot, Assistant Secretary, Detention Health Services Strategy Branch, Department of Immigration and Multicultural and Indigenous Affairs

O'CONNELL, Ms Lyn, First Assistant Secretary, Detention Services Division, Department of Immigration and Multicultural and Indigenous Affairs

CHAIR (Senator Allison)—I call the committee to order. This is the 14th hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March this year. The purpose of today's hearing is to seek evidence from representatives of Commonwealth government departments and agencies, and I thank you for attending. I trust we can explore a number of issues that have arisen over the course of our inquiry so far. I would make the point that this a complex inquiry and issues continue to arise. There may be the need for us to follow up some issues with agencies after this hearing. If this is the case, we will forward questions to you in writing.

Witnesses are reminded of the notes they have received relating to parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public but, under the Senate's resolutions, witnesses have the right to request to be heard in private or in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

Before we commence I remind senators that under the Senate's procedures for the protection of witnesses, officers of Commonwealth government departments and agencies should not be asked for opinions on matters of policy. If necessary, they must be given the opportunity to refer those matters to the appropriate minister.

I now welcome representatives of the Department of Health and Ageing, together with representatives of the Department of Immigration and Multicultural and Indigenous Affairs. We note that the Australian government has lodged a whole-of-government submission to the inquiry, which we have numbered 476. Are there any alterations or additions to those documents?

Mr Learmonth—No.

CHAIR—I understand that the intention is for the Department of Health and Ageing to begin with an opening statement. If you could proceed to do that, then we will go to questions.

Mr Davies—Thanks for the opportunity to address the committee at the start of today's hearing which, as you have already pointed out, will involve various Australian government departments and agencies. I also need to apologise on behalf of Professor Horvath, the chief medical officer. He will be joining us later. He is just finishing his Walk to Work. Senators obviously either started earlier or walked quicker to be here. He will be with us shortly.

I hope that during the day members of the committee will be able to gain a clear understanding of the policies that guide the Australian government's involvement in mental health, as well as the programs and services that we fund in order to help support mental health consumers and lessen the impact of mental illness on individuals, families and the community.

The Australian government submission—as you pointed out, Madam Chair—brings together contributions from many of the departments that will be attending and answering your questions today. The Department of Health and Ageing, as well as providing material relevant to its own areas of responsibility, also took a coordination role in assembling the submission. It is my understanding that the committee will be calling on the representatives from each department in sequence to answer any questions and present evidence in areas relevant to their specific portfolio responsibilities. We understand from your secretariat that you would like to start that off with our colleagues from Immigration, so we will stand aside after these remarks and allow you to direct questions to them. We will, of course, remain present in the room.

As you are aware, Madam Chair, the Australian government and the state and territory governments have complementary roles in mental health care. State and territory governments are primarily responsible for the management and delivery of public specialised mental health services while the Australian government, as well as providing leadership on mental health issues of national significance, also subsidises the cost of primary mental health services, principally through the Medicare and Pharmaceutical Benefits schemes. The Australian government also subsidises private health insurance and directly funds a number of other initiatives which are detailed in the submission.

The National Mental Health Strategy, which came into being in 1992, is a fundamentally important document in this arena which defines the role of Australian, state and territory

governments in mental health. It lays the foundations for collaboration between jurisdictions and it establishes a basis for government and non-government organisations to work together in this field. But of course people affected by mental illness often need more than just health care and, as a result, they access a range of other Australian government programs and services in areas such as work force participation, income support, social and community services and housing assistance. You will have the opportunity to explore all of those areas through your questioning today.

In conclusion, since that strategy first came into being in 1992, our experiences clearly demonstrate that while reform has been possible, it has necessarily been incremental in nature and it has required ongoing commitment over a long period of time. It is very much still a work in progress. This inquiry is a timely opportunity to take stock of the achievement to date and to provide direction for future efforts. We very much look forward to working with you today. Thank you very much.

CHAIR—Professor Whiteford, Mr Casey or Ms O'Connell, do you wish to make some statements?

Ms O'Connell—No, Senator.

Mr Casey—No.

Prof. Whiteford—No thank you.

CHAIR—Perhaps I can start, Professor Whiteford, with the visit the committee made to Baxter last week, and ask you to describe for the committee the new environment that has been brought into Baxter and how you see it going. Perhaps give an outline of the changes that have been made in Baxter.

Prof. Whiteford—I will refer that question to Ms O'Connell. I can comment on the impact the change is likely to have on the residents but not the actual changes which are being implemented by the department.

Ms O'Connell—I would be happy to do that. Senator, could we do it in two parts: firstly, the health services changes, which I will ask Dermot to outline; and secondly, the infrastructure changes in Baxter.

Mr Casey—The major focus of the health services changes has been to introduce new skills, new procedures and new understandings about the potential for mental health concerns amongst the detainees. The first has been the introduction of mental health nurses as part of the health services team. Those nurses are now working in the health centre at Baxter. We have also introduced, on the advice of Professor Whiteford, some screening tools to help in the initial assessment when somebody arrives at the facility and, subsequently, at periodic times to check out whether in fact there are any concerns about their mental health. In doing that we have adopted the Health of the Nation Outcomes Scale, which is a well-known clinical rating tool that looks at people's symptoms, signs and behaviours associated with any mental health concerns.

We are introducing, as part of the initial health assessment, a self-questionnaire instrument which is called the K10. It is a 10-item questionnaire. The reason that we have adopted that is that it has been validated in a number of different cultural contexts and different languages, and that would be something that would complement the current health assessments that people arriving at Baxter have, as well as the current SASH screening instrument which is filled out by the detention officers when they are inducting someone into the facility.

By putting a much greater focus on not just the physical health assessments and physical wellbeing of detainees but also the mental health issues, we think that we can achieve two things: we can ensure that there is a much greater focus and thinking and much more positive attitudes towards people's psychosocial wellbeing and, at the same time, where we identify that somebody is experiencing mental health problems, then the current health service providers—the IHMS, International Health and Medical Services, the PSS, the psychologists organisation—are now working together. They have integrated their files. Where somebody is identified as having a specific mental health concern, there is a requirement to develop a mental health plan and all of the clinical staff are part of that management process. We have initiated, through GSL, a new position of team leader for one of the clinical staff who now has overall responsibility for coordinating mental health plans for detainees who are identified as having these concerns.

CHAIR—Mr Casey, is there a document that describes all of these changes, because there are a couple that you have not mentioned and the committee heard about when it was there. Is there a document, a report, a list of the changes?

Mr Casey—Yes. At the Immigration Detention Advisory Group meeting yesterday we tabled a paper which sets out our responses—the work that is being done in relation to chapter 6 of the Palmer report. I think that would be a good type of paper to table to this committee, and I would be happy to do that. It sets out how we are responding to each of the Palmer recommendations in relation to health and mental health concerns arising out of the inquiry into Cornelia Rau.

CHAIR—Thank you. Ms O'Connell, you will tell us about the infrastructure changes?

Ms O'Connell—Certainly—some of the infrastructure changes to the Baxter facility. These were announced on 19 September by the minister: firstly, some changes to the entrance and a new interim visitors centre established at the immigration detention facility; the introduction of a sporting oval at the Baxter facility; in line again with the Palmer recommendations, some changes to the accommodation areas so that they are more open to the outside, and that is coming in two stages—firstly, some immediate changes that are being put in place to open up and, secondly, we are seeking some advice about a greater opening up of the accommodation areas within the facility; and a review of some of the meaningful activities to link in with the work of health services for people who are in detention. They are some of the physical changes to the Baxter facility that have been announced and are being put in place.

CHAIR—Is there a similar new environment being laid out in other detention centres?

Ms O'Connell—Certainly we are reviewing them. The first priority is the Baxter facility, but there had already been some changes announced to other centres. We will be reviewing those changes to make sure that they are in line with the sorts of changes to the facilities that we would see in the future.

CHAIR—What is the time frame for that?

Ms O'Connell—Our expectation is that by the end of the calendar year we will have reviewed those facilities and made decisions about the types of changes. One example is for the Villawood centre. The government had already announced plans in the 2004-05 budget to significantly redevelop that facility. So that is in progress, in terms of the design aspects. We have undertaken to review the designs to ensure that they are in line with the sorts of recommendations that Palmer made.

CHAIR—The new and as yet uninhabited centre at Christmas Island?

Ms O'Connell—The Christmas Island facility is being developed. That was announced as a budget decision. I am sorry, I do not have the date—

CHAIR—No. I mean in terms of this new environment review.

Ms O'Connell—We will also review that to ensure that it is in line with the facilities we envisage having in the future. It is under construction at the moment.

CHAIR—Will that be done by the end of the year as well?

Ms O'Connell—The review will be, yes.

Senator HUMPHRIES—I have a question about the design of facilities like Baxter. At our visit, officers made the comment to me that, certainly from the point of view of dealing with people under stress or with mental illness, it would have been a better idea to have designed the facility along less institutional and more residential lines, I suppose. The suggestion was made that that would not only be a good idea from the point of view of those suffering from mental illness or severe stress but it would also be a good design innovation, had you been starting from scratch tomorrow from the point of view of accommodating and normalising people in that environment.

That is a bit of wishful thinking, obviously, but would it be true to say that that sentiment would be reflected in the thinking of the department? In other words, if a new facility were being established tomorrow, would it be more likely to follow that design impulse, rather than to reflect the need for security with the emphasis on it being escape proof? As an example, it was not possible to see the mountains around Baxter from any of the yards that we saw. Would those types of considerations be taken into account, as they have been in more contemporary mental health facilities like Thomas Embling Hospital?

Ms O'Connell—Certainly from the design perspective we are taking on board those kinds of design concepts. In addition to that, we already have in place the residential housing project at Port Augusta and the project currently under development, and nearing completion, at Villawood. Those residential housing projects are housing type accommodation with a different security regime around them, and I think now we have a greater range of options available for accommodating people who are to be detained from potentially residence determination to the residential housing project to a facility such as Baxter or Villawood.

You mentioned the current accommodation within Baxter and the inability to be able to view outside. We have a measure in place to break down some of the corners of the current accommodation compounds and to put in some courtyards so that it is possible to view outside. That will be done before the end of this calendar year. The long-term view is to look at the overall design and to be able to open up the compound. It is about taking on board the spirit of the Palmer recommendations to be able to view outside and to provide a better and more suitable environment.

I mentioned that we are reviewing all of our current plans for the infrastructure of specific centres, in terms of the ability to be able to view outside, the suitability of it, and to be able to provide a range of solutions to better meet people's needs.

CHAIR—Did you want to add something from the health side?

Mr Casey—Yes, thank you. I do have a copy of this paper called a discussion paper—'Mental health strategy, Palmer recommendations', and I can tender that to the committee.

CHAIR—That is so ordered, thank you.

Mr Casey—In relation to what Ms O'Connell has been saying, I have some pictures of what has just been verbally described. They are in the car.

CHAIR—They are in your car?

Mr Casey—They would show you the architects' design to open up the corners as a first stage in giving people the visual capacity outside of the enclosure.

Ms O'Connell—We have them here for you. It probably was better that I got them than rather than try to describe them.

Senator HUMPHRIES—We might table those.

Ms O'Connell—I will table them, if I can.

CHAIR—Yes. The committee will not object to those being tabled, so if you could hand them to the secretariat that would be good.

Ms O'Connell—Okay. We have the current view and also the proposed view—the courtyard aspects so that you can see outside.

Senator HUMPHRIES—That it is good. This is obviously converting a building which has been designed essentially as a prison. If we were to recommence this project at some other place or in some other way, it would be a very different kind of concept to the one that is currently evident at Villawood or Baxter or places like that.

Ms O'Connell—It would, yes. There would still be a need for some high-security components in the facility, but it is about having a greater range of options to accommodate people and to better meet their needs.

Senator HUMPHRIES—You talked about the review that you had undertaken to improve mental health services at facilities run by the department. Finn J in the Federal Court called for a review of mental health services in immigration detention facilities. Do you think what you have done to date satisfies that call or is there an expectation that something more was required by Finn J?

Mr Casey—The review that has been called for will look at the whole relationship. One of the issues that people have been concerned about is the way in which health services are delivered through the current arrangements, and I think that is something that we will have to think about, as the department has instigated a review of the whole arrangement for how the government purchases services for detention. One of the issues that we will want to look at is: is the model of health services delivery the one that should ideally be there? I cannot say that there is any decision, because the review that has been announced is now being undertaken, I understand, by Mr Roach, who has been appointed to do that.

In terms of the immediacy, though, of ensuring that people with mental health problems are responded to appropriately, I think that the measures that have been put in place in the short period of time that I have been with the department and the relationships that are in the process of being re-established with, for example, the South Australian health department—we are having further discussions with them. We have started to ensure that the people who are providing, say, health services at Glenside are in touch with and get to know the people who are providing health services at Baxter. The next phase of that development is to get the health staff who are looking after detainees in Adelaide, take them up to Baxter and run some training workshops there with them and the staff at Baxter.

We have invited South Australian Health to have one of their mental health nurses from the local Port Augusta community join the clinical review team in Baxter so that they can start to identify where there are concerns about somebody who might subsequently need some care in a South Australian health facility and so that they can get to know these people. In the past—and I think that this was what Finn J commented on—communication between health staff at Baxter and health staff in Adelaide was inadequate. We are very much focusing on that.

In relation to what Ms O'Connell was saying about the development in other centres, we want to work it out and get it right at Baxter and then the same sorts of principles in terms of mental health staff, better case coordination and better clinical management would flow into all of the other centres. The plan is—and the funding that was announced yesterday will help to support this—to ensure that we have a much better coordinated health care approach right across the facilities, but we are starting with Baxter.

Senator HUMPHRIES—This is a perhaps a difficult question to answer, because clearly the level of need for mental health services for people in a facility like Baxter is greater than it is for the average citizen in Australia, but would you say that the standard and quantity of services available for mental illness in detention centres are on a par with or greater or lesser than those available in the general Australian community?

Prof. Whiteford—They are less than for people in the general Australian community. What we have in Baxter is an at-risk population and you need to manage the population as such. The changes which have been introduced, and continue to be introduced, require everybody going

into Baxter to be screened, with the three instruments that Mr Casey mentioned, and then to be rescreened at their own request, at the identification of any of the professionals or advocates or at 90 days at a minimum.

You continue to screen the population to ensure that the emergence of any significant mental health problems is picked up early and referred to a multidisciplinary team. That team consists of psychology-mental health nursing, a general practitioner and a visiting psychiatrist. The level of that expertise is being greatly escalated but is not yet at the level that you might see in a community mental health service, where you would have, especially, additional psychiatric services. Part of the reason for that is the isolation of Baxter from major population centres.

That proactive management of screening and rescreening the population and managing actively anybody who has an identifiable mental illness on a multidisciplinary plan, which is agreed by all parties, is a great improvement over what was there before, but the simple fact of the isolation of Baxter makes it difficult to recruit mental health clinicians to the area.

Senator HUMPHRIES—Are you saying therefore that the services are on par with what would be available in other isolated communities in Australia?

Prof. Whiteford—Yes.

Senator HUMPHRIES—In terms of accessibility of other attention for mental health problems, subject to the availability of professional staff, do you feel that the department, with that escalation you refer to, has adequately provided for the basic mental health needs of people in those facilities?

Prof. Whiteford—What I described and what has been described by Mr Casey is on a par with what we would see in other isolated areas in Australia. There is a sustained effort to use telepsychiatry and other more innovative technologies, which are quite applicable to mental health care, to increase the specialist medical expertise which we need there. Given where Baxter is located, it is difficult to see how we can get more staff in there when, as I am sure this committee has heard, mainstream mental health services struggle to get mental health nurses and psychiatrists in much less isolated settings.

Senator HUMPHRIES—Thank you.

Senator MOORE—Ms O'Connell, there is a lot of effort being put into Baxter, but your answer to a previous question was that you were reviewing the services across all areas. Are there only two detention centres in Australia and one on Christmas Island?

Ms O'Connell—No.

Senator MOORE—That is what I want to get on record—where they are and whether these services are going to be available across the board.

Ms O'Connell—Firstly, in relation to the locations, there are immigration detention centres at Baxter in South Australia, at Maribyrnong in Melbourne, in Perth and at Villawood in Sydney. The Christmas Island facility is currently being built, so it is not yet available.

Senator MOORE—The review that you talked about earlier in terms of overall health services, and looking at mental health within that, is focusing on services across all those centres?

Ms O'Connell—It certainly will. The first focus is on Baxter and I think, as my colleagues said, we have put in a major change project. The mental health services were not up to scratch. We are now about making them up to scratch. We have put in a significant number of changes to date and there are more immediately being implemented, and then the intention is to make sure the equivalent services are available throughout all of our immigration detention centres, and that will be subject to review.

Senator MOORE—The other question I have on that particular point is to do with the process that normally occurs. For someone who is found to be in some form of breach, it is that the local police tend to be involved and they go through the state systems, wherever they are. I am from Queensland and, in terms of the process, if someone is found to be breaching a visa or whatever in Townsville, they are usually picked up in Townsville and put into some kind of correctional process within state government. What are going to be the guidelines under the immigration process for people who are going to be in state government authorities pending transfer to one of your facilities? Is there going to be the kind of pre-testing, the kinds of concerns, that kind of early intervention for someone who is picked up at Charters Towers?

Ms O'Connell—Yes. Firstly, there is a need for an immigration detention facility in Queensland in order to be able to appropriately accommodate those people.

Senator MOORE—There are a lot of questions about that, Ms O'Connell.

Ms O'Connell—Secondly, in terms of their care it certainly is our intention to make health services and things available to them. Obviously it will be relevant to where they are located and where they are held at present and also how quickly it is identified as an immigration issue versus detaining people for non-immigration reasons.

Senator MOORE—One of the things that has come out in this whole process has been the issue of early intervention—that the sooner someone is appropriately diagnosed, the better—and one of the things that I have been talking about for a long time with people in the state system is that there seems to be quite a gap sometimes between when someone has the opportunity to go through the kinds of testing Mr Casey has identified is going to be imposed in Baxter and when they can receive treatment. I am still uncomfortable about the kind of situation in a state where people are caught up in some kind of a process—for instance, when they are going through orchards and they gather a whole lot of people who may well be overstaying or inappropriately in the country. That responsibility is normally with the state government, so they are held in a state prison, and that came out in the Cornelia Rau matter, with that significant gap when the treatment was part of the state system before she came into the federal system. Does Immigration have a role, then, at the very start when someone is actually caught and goes into the immigration system, of ensuring that they get the kind of support Mr Casey spelt out: the interview, the discussion about their health, the focus on their mental health condition, and that kind of immediacy that I think everyone has said is needed?

Mr Casey—I think you have raised a very important issue. When people are identified by a compliance officer as being in breach of their visa, of course, most will not be taken into detention. They can be given a bridging visa whilst they regularise their position, to allow them to, for example, leave the country under their own steam. Most people who are detained for being unlawful noncitizens are not in fact placed in detention. If somebody is being held, though, whilst those decisions are being determined, if they are awaiting, say, transportation to a detention centre if they are to be detained, then I think you raise an interesting issue.

One of the things that Mr Palmer recommended is that we really need to get a better connection with our state colleagues. We have, through our colleagues in Health, written in order to try and take, particularly, some of the recommendations he made about clinical assertiveness and liaison with the states, and put them on the agenda for the National Mental Health Working Group, where we can start to pick up on some of those issues and start to think through those. Where somebody is in state custody whilst they are awaiting transfer to federal detention, what are some of the implications and issues?

We do know that the police also have training and, I think, have become much more aware of and sensitive to and positive about people in the community who have mental health problems, because the police deal with this a lot of the time.

Senator MOORE—Very much, yes.

Mr Casey—We should not assume that the police do not know what they are doing, but when thinking about people who are in the process of being or have been identified with mental health problems, we need to get better liaison and to work more closely. That is one of the things that we are taking on board and we have started to schedule discussions with state governments through the National Mental Health Working Group. I think we have put it on the agenda for November.

Senator MOORE—It is on the agenda?

Mr Casey—It is on the agenda. We have written and asked for it to go on the agenda of the next meeting so that we can start to have these discussions with our state colleagues.

CHAIR—Mr Casey, do you think it is time we dropped the title ‘unlawful noncitizen’?

Mr Casey—You are asking me for an opinion on something that is in the law. That is the term used in the Migration Act.

CHAIR—Professor Whiteford, let me ask you, as a psychiatrist. You are trying to change attitudes in our detention centres. Is it helpful to be still calling people unlawful noncitizens?

Prof. Whiteford—Is it helpful to their mental health?

CHAIR—Correct.

Prof. Whiteford—I think if the term is perceived by the individual to be pejorative, they might take offence to it. I do not think it would cause mental illness but it would be perceived by some people to be an offensive term.

Senator SCULLION—Professor Whiteford, when I got onto this committee I thought it was going to be about mental health and, fundamentally, my impact has been more about human rights, and I can assure you I am not normally seeking out human rights committees. Throughout the evidence there seemed to be a common theme. It is very interesting, from a DIMIA perspective, that we have had this focus on a number of individuals and the horrific circumstances and how we have lost duty of care, but I would make the point that the only reason that they are notable is that they were somehow unlawful, and I think those circumstances happen every day in Australia. The reason they happen every day is that those people that are interacting with them simply do not have the knowledge that they should about triaging basic mental health symptoms when they meet with them.

So much of the evidence has pointed to the issue of people now presenting to police, nurses, doctors. We have heard that doctors have processes to ensure that—even at the GP level—they can take specialist short courses to assist them in understanding some basic principles. Whilst I take on board Mr Casey's comment that they are getting better at it, clearly there is the issue of comorbidity. For instance, comments like, 'Oh, he's off his trolley'—is that a mental health diagnosis or is that somebody who is a drug addict or an alcoholic? Clearly, the capacity for individuals to identify cases of comorbidity and that they should be treated as such is something that we really need to change in a cultural sense.

You talked about the interaction between the states and the Commonwealth on these matters. What is your view? We have just gone through this microcosm of DIMIA and we have looked very carefully at a handful of people, effectively, in comparison with the Australian population, and discussed what we have to do about them. There is a huge focus on that now. There must be some learning from that, whether it be about the sort of delivery we need to get to GSL, about DIMIA generally. From that learning, what do you think we can do about some recommendations to upskill those people who are going to be presented with potentially comorbid individuals?

Prof. Whiteford—Comorbidity is a particularly difficult issue but certainly there are, from my perspective, some levels of national standards which need to be applied to the delivery of mental health care. There are existing, and about to be revised, national mental health service standards which describe the structures that have to be in place in a service operationally. Secondly, there are—already signed off by health ministers—national practice standards, which identify the attitudes, knowledge and skills required by all mental health professionals, and these are in the process of being implemented.

The way in which those clinicians with those attitudes, knowledge and skill treat major mental disorders, including comorbidity, should be identified in evidence based clinical practice standards which deal with how you diagnose and treat depression, psychosis, eating disorders, substance abuse or comorbidity. That is sometimes criticised as an inflexible cookbook approach but certainly an evidence based approach is better than one which is not based on evidence.

The roll-out of those sorts of upskillings across the Australian mental health work force is a challenge, financially and organisationally, but it is happening and it does have to happen. The area of comorbidity is particularly difficult because operationally those two services tend to be separated at a service delivery point. There tends to be a substance abuse or alcohol and drug service, and a mental health service. We need to revisit the way in which we organise those services, and the clinicians who work in them, to ensure that the individual patient or consumer is not disenfranchised by the operational separation of those services.

Senator SCULLION—You talk about the mental health work force. I understand the context of your answer but I was trying to get a handle on how we deal with those people who are not traditionally seen as part of that force. That is the police officers and the nurses and that is where the presentation of comorbidity is often the first tranche. That is where there are some of the human rights issues: 'I need to talk to someone.' 'No drama, mate. We'll just shackle you to the bed for a while and we'll see how you cope with that, and we'll get round to you in a few hours because we've got more important things to triage here'—those sorts of things. How are we going to use those fundamental educational tools, that I am pretty convinced are well developed within the mental health task force, and transfer them to those other people who, through choice or otherwise, have to be seen to be a part of the mental health task force?

Prof. Whiteford—General practitioners in primary care, nurses in accident and emergency departments et cetera, need knowledge and skill as well. Largely that is a matter for undergraduate medical, nursing, psychology and social work education, as well as ongoing professional development of those professions. It is important, in any ongoing professional development program of any health professional, that mental health is a significant and important component of that, given that most clinicians will come into contact with patients with mental health problems or mental disorders during their working career.

Senator SCULLION—I have one other question. I am not sure who should answer this. It relates principally to Indigenous health workers and the process of delivering Indigenous health care, particularly in remote communities. We seem to have a process where we—

CHAIR—Mr Scullion, I will just remind you this is the Department of Immigration and Multicultural and Indigenous Affairs but we may not have Indigenous Affairs—

Senator SCULLION—If you think I should direct it to someone else, I am happy to. I am not sure which aspects of the department are represented here. I tried to find out from my colleagues whether it was Baxter focused.

CHAIR—DOHA will be able to help us.

Senator SCULLION—Thank you. Then I will not ask it yet.

CHAIR—Senator Webber.

Senator WEBBER—Thank you. Unfortunately I was not part of the committee's visit to Baxter. I want to return to the issues that Senator Humphries was raising about the possibilities of designing these centres more appropriately, and the impact that can have on people's mental health. Has the department taken on board those comments about looking at the development of

the Christmas Island centre? Christmas Island has a very identifiable population and, as it is an island, you cannot escape unless you can get access to a boat. Apart from the fact that there are some people that you do need to keep in a very secure setting for their own safety, as well as the safety of the rest of the community, do we need to have a traditionally designed detention centre there? Or should it just be identifiable accommodation for those who are being detained?

Ms O'Connell—The Christmas Island facility is under construction. The advice I have to date is that the design of the facility is much more in keeping with the post-Palmer recommendations in terms of the nature of the facility, accepting that it is on an island. It was not built as a high-security facility. Having said that, we are still committed to reviewing those designs to ensure that, if there are some changes that need to be made to make it a better, more appropriate facility, we will be in a position to do that.

You mentioned an arrangement of having identified accommodation. There is a question about the overall accommodation on Christmas Island. Naturally that would be limited. In that sense we need to have some designated accommodation; some facility; some means of providing services to the people who might be accommodated there. Hence the approach of building a facility to do that.

Senator WEBBER—I wonder if I can get a bit more information from you about what it is going to be like. As I said, unfortunately I missed out on visiting Baxter but, having looked at the photos that you have shown me, congratulations on giving people windows so they can see out but it still looks like a very repressive institution—just looking at that sketch. What kind of assurance can you give me that Christmas Island is not going to look like that?

Ms O'Connell—Can I take that on notice and get back to you?

Senator WEBBER—If we are in the process of building it, we must have some idea of what it is going to look like.

Ms O'Connell—We do but I do not. I commenced with the department four weeks ago. I have not yet seen—

Senator WEBBER—I am sorry.

Ms O'Connell—That is all right. I have not yet seen Christmas Island. I will be going there in two weeks, the week after next. As part of that I am reviewing the current plans.

Senator WEBBER—Professor Whiteford, we were talking about the way we now see the population in a detention centre as being basically an at-risk population. That has not always been the approach that we have taken, has it? That is part of the changes.

Prof. Whiteford—That is part of the changes I recommended to the department of immigration.

Senator WEBBER—They didn't automatically go through that assessment process?

Prof. Whiteford—No. That was not in place.

Senator WEBBER—They go through the assessment. Then, as I understand it, if someone has a severe episode, such as people in rural and remote Western Australia, there is the facility to remove them; to take them out of the detention centre for appropriate treatment in Adelaide, for example. What impact does it then have on their ongoing mental wellbeing when, after they have had that treatment, they are returned to Baxter Detention Centre?

Prof. Whiteford—It depends on the extent to which the environment of Baxter was a contributing factor to the development of their mental disorder.

Senator WEBBER—But sensory deprivation in an institution like Baxter does have an impact on mental wellbeing.

Prof. Whiteford—It certainly can. Is your question what clinical factors should be taken into account when returning to Baxter the person who had been treated outside of Baxter?

Senator WEBBER—Yes.

Prof. Whiteford—If the person had a mental disorder in Baxter, was transferred out of Baxter and treated for that mental disorder and it improved—as I would hope it would—and the clinical view was that the returning of that person to Baxter would aggravate or cause a relapse in the person's mental disorder, the person should be returned to an environment other than Baxter, commensurate with any security issues which need to be taken into account. I would be, and have been, supportive of there being a range of options available to the clinicians so that they could have discussions with department of immigration staff about the placement of individuals where their clinical progress, including the potential risk of relapse, would be a significant factor in the decision on where that person would be placed.

Senator WEBBER—Do we have the capacity to return them to an environment other than Baxter?

Mr Casey—Yes, we do.

Ms O'Connell—We have a greater range of options now. Health consideration has not weighed enough in determining the location. We are now saying that there will be greater weight given to the health considerations. There will still be the security considerations but we now have a range of options, including return to Baxter in the improved facility and the potential of using the residential housing project. A lot of that is reliant on what sort of health related services the person would need and also the potential for residence determination, if that is suitable. There is now a greater range of options for us to use in assessing what is the best placement for that particular individual.

Senator WEBBER—Earlier on I think you raised with us the difficulties of attraction and retention of mental health professionals in regional and remote locations and that that has had an impact on the services that have been available to Baxter. It certainly has an impact throughout my state and, I know, in the Northern Territory as well. Surely there is going to be exactly the same problem, except worse, on Christmas Island. What arrangements do we have in place to ensure that, right from the get-go, we have this increasing emphasis on people's physical and mental wellbeing and that we provide appropriate professional assistance and early intervention?

Mr Casey—The short the answer to that is that in our discussions with GSL and its subcontractors we have identified that, if there are people placed on Christmas Island when the facility is finished, we would have to ensure that the same sorts of services are brought in. As you say, I do not think there are a lot of spare psychiatric nurses kicking around on the island. We would have to fly them in.

Senator WEBBER—There are none spare in Perth, let alone kicking around on Christmas Island.

Mr Casey—Some of the staff go into Baxter on rotation. They work in mental health facilities in the cities and then go in. The committee spoke to some of them when they were there, and it is a logistics issue.

Senator WEBBER—Absolutely.

Mr Casey—In the end, we have to fly them in.

Senator WEBBER—The problem that has been raised by a lot of the professional bodies about providing adequate mental health services to these people is the chosen locations of the detention centres. In a way, to continually choose to locate them in such remote places is making it really difficult to look after their mental wellbeing. We are either making it increasingly expensive for the department or we are accepting that there is risk that we are not going to look after them.

Mr Casey—It is also difficult getting staff to work in, say, corrections facilities. When it comes to choice, sometimes institutional settings—and it could be psychiatric hospitals—are not where a lot of mental health nurses or other professionals will want to go to work. It is an issue, but it is not—

Senator WEBBER—That is also an issue I have been critical of.

Mr Casey—It is something we are aware of.

Senator WEBBER—Could we feel reassured that when Christmas Island eventually opens, assuming there are people that it has to start to take in, early assessment and care for their mental wellbeing will be available as they are there?

Ms O'Connell—Yes.

Senator WEBBER—We are not going to put them in there and then try and organise to fly people in?

Mr Casey—No.

Ms O'Connell—No.

Senator WEBBER—We will be doing the stuff that Professor Whiteford talks about in terms of that initial assessment—

Ms O'Connell—Correct, but we would need to bring people in, I think, in order to do that initial assessment, should we use the centre, and then it will be a question of the individual—

Senator WEBBER—But we are not going to leave them there for six months and then do it?

Mr Casey—No, because—

Ms O'Connell—No, because our current plan—

Senator WEBBER—it seems to me that would create a problem.

Mr Casey—In line with the current discussions, we will have these assessments done within three days of somebody being admitted. If it is identified that somebody has more risk factors or concerns, then it is done within 24 hours, and there are mechanisms for assessing people much earlier. For example, I heard on the news that a number of illegal fishermen had been detained off our coast. Whilst we would still provide the same sorts of screening and processes for those people, the clinical team might have a different view about their priority in terms of a mental health assessment as opposed to somebody who may have been in detention for two or three years, and is better known, and is just being transferred from another centre to Baxter, where you would have identified that they may be of concern.

We still ensure that people get the same sorts of screening, but I think what we are trying to do is ensure that there is sensible prioritisation, so that we are not all just running around to tick a box. We are doing it sensibly, and we have had these discussions with the clinical staff in terms of the operational procedures.

Senator WEBBER—Three days is a pretty tight turnaround for Christmas Island. It is not the most accessible place in the world.

Mr Casey—If Christmas Island is operational, we will fly staff out there who will live there. Like people who go to work at Baxter on six weeks rotation, they will live in the local community and then they may return to another situation. We would not just fly them in for the day. They would go there to live.

Senator WEBBER—That is all I have, but I would like to thank you for your openness, given the difficulties that you have all faced in recent times. Thank you for coming along.

Ms O'Connell—Thank you.

CHAIR—I have had a chance now to look at the discussion paper and I have a couple of questions. It picks up on recommendations 6.2 through to 6.14. What happened to the other Palmer recommendations?

Mr Casey—Have you got a copy there?

Ms O'Connell—I have it here.

Mr Casey—I think 6.1—

Ms O'Connell—That is the whole chapter 6.

Mr Casey—Yes. It was about the missing persons, and that was something which—

CHAIR—This is about Baxter only?

Mr Casey—This comes from Palmer.

CHAIR—Sorry?

Mr Casey—It comes from the recommendations.

CHAIR—Yes, I realise that.

Ms O'Connell—The only recommendations that are picked up there are health related recommendations.

CHAIR—Health related?

Mr Casey—Yes.

Ms O'Connell—Not the full set of Palmer recommendations or the full set of chapter 6. It is largely chapter 6 but it is the health recommendations.

CHAIR—Anything to do with health in Palmer is here? Is that what you are saying?

Mr Casey—Mental health, yes.

CHAIR—The document does not spell out the number of staff that will be employed at a particular point in time. The committee when it was there met with two psychologists and two psych nurses who were there then. Is there a schedule of the number of such staff who will be there at any point in time and is there a relationship between the number of staff and the number of detainees in the centre at any particular point in time?

Mr Casey—At this stage, we think the staffing at Baxter—and I think at the moment there are about 140 to 160—is probably right, but it is fair to say that we are teasing that out. If there were a larger number of detainees, then I think that we would have to look at increasing the number of staff, just in terms of the modelling, but I do not think that we have a formula worked out for what that might be.

CHAIR—What is this modelling?

Mr Casey—If you had a larger number of people at Baxter, the actual screening time, the health checks and stuff like that might require—

CHAIR—That I understand, but who determines how many psych nurses there should be and how many psychologists there should be?

Mr Casey—The staffing at Baxter has been agreed with GSL based on a submission from them that we considered to be a reasonable response.

CHAIR—When Baxter fills up to 1,000 people again, you will wait for GSL to give you a submission about how many psych nurses there will be?

Ms O'Connell—No. It is something that we will be actively monitoring and, if we see that there is a need for greater services, we will do something about it.

CHAIR—Who determines this and on what basis? Professor Whiteford, are you involved in this? Are you giving advice about what the ratio ought to be and what the mix of expertise ought to be there?

Prof. Whiteford—Yes, I am. The standard that has to be maintained is that every individual who goes in has to be screened with 24 hours with the SASH and the K10 and within three days with the HoNOS, or earlier if they are positive on the SASH or the K10. Anyone with a mental disorder has to be treated according to the standards which I identified earlier and every individual has to be rescreened within 90 days, or earlier if there is cause for concern. Whatever staffing is needed to achieve that is the staffing that is needed to achieve it, so that as the population fluctuates the staffing will need to change.

Rather than set a number of staff, I would say that that is the clinical standard that has to be maintained and we have to employ enough staff to do that. When we were there meeting with the nurses and the psychologists, we asked them how they were managing the case load. If they are becoming overwhelmed, that needs to be identified and additional staff have to be provided.

CHAIR—What is the mechanism for identifying that?

Mr Casey—Every two to three weeks there is a health services delivery meeting, which involves DIMIA, GSL, IHMS and PSS. We meet on a two- to three-week basis, where we design and consider a number of issues. There are regular meetings now between the four agencies who are involved in providing health care, and these are the sorts of issues that would come up through those health services meetings.

CHAIR—At those meetings it is discovered that we cannot assess people within 24 hours, we cannot do the other outcomes that you have spelt out as being important. GSL says, 'Well, we're having trouble finding psychologists and psych nurses. We can't do anything about that.' What is the next step?

Mr Casey—I think the next step is that we have to, as a group of people representing the agencies, try and find the solution. If they say they cannot recruit, then maybe we have to look at other recruiting mechanisms. It may have an impact on the number of people who could be safely accommodated in one of those facilities, if we cannot staff it, in the same way as not having detention services officers there. I cannot give you an answer that, 'We've worked out an operational plan.' We have put mechanisms in place to improve the communication, the dialogue and the shared responsibility for ensuring that people get looked after properly.

CHAIR—The problem, it seems to me, is that we do not quite know what the process is to achieve it. How open and accountable is this? How will we know as parliamentarians, as the general public, that this new environment did not just fall in a heap because you could not get the psychologists or psych nurses?

Mr Casey—That is a good question. I do not know how at this stage, but I would like to go away and think about how we can make sure that there is an open and transparent process for reassuring people that this is happening.

CHAIR—Sorry, Mr Casey. I was not looking for reassurance.

Mr Casey—No.

CHAIR—We are looking for a process that can lead to some scrutiny.

Mr Casey—Yes—that there is a mechanism. That may be that we put in a reporting process that says, 'Here is the current staffing complement in relation to these services at these facilities.'

CHAIR—Then we come back to staffing and ratio and other means of assessing it, other than what you have described.

Ms O'Connell—We do not have an absolute process in place to do that at this stage.

CHAIR—But you expect to have one?

Ms O'Connell—We will. We do have an Immigration staff member who is the centre manager at Baxter on a day to day basis who we also expect to be part of a monitoring and alert mechanism, if there are issues in terms of staffing and whether we are meeting our commitments. But we take on board that we need an improved reporting regime and an improved process to be sure that it does not lapse or fall into decay. We accept that.

CHAIR—I would like to move to the question of screening and assessment. Professor Whiteford, are there any conditions, or characteristics of a detainee, that might lead you to suggest that incarceration would be a dangerous environment, regardless of recreation—the new hockey field and whatever else? Have you looked at the range of presentations that are likely to be made? I am thinking particularly of post-traumatic stress disorder. Are there any circumstances or procedures where that assessment says, 'This person definitely should not come into this place'?

Prof. Whiteford—A person would be inside the place by the time that information became available.

CHAIR—Correct. But within 24 hours, you have done an assessment on them. Right?

Prof. Whiteford—You would have done an assessment.

CHAIR—They have only just arrived.

Prof. Whiteford—You have done an assessment. That may need to go to the multidisciplinary team which may come to the view that the longer this person is detained in the detention centre the worse their condition is going to get. At present that information goes to the health services management committee, which then makes a recommendation about that person's placement outside of Baxter, if Baxter is the case in point. I have been recommending to the department that we have a proactive way of managing someone whose mental health is deteriorating, which includes early intervention to deal with the deterioration prior to the person needing psychiatric hospitalisation.

It seems to me that in the past people would only be removed from the facility if they had reached the point where they needed psychiatric hospitalisation and I would hope in the future that, while that still may be the case from time to time, we could intervene earlier than that and get either increased treatment, a greater range of flexibility of environmental options at Baxter, or placement in an alternative facility other than Baxter, if that had significant clinical outcomes for the individual.

CHAIR—This is your recommendation. Mr Casey, where has that recommendation gone?

Mr Casey—The recommendation in relation to taking the advice of the team is part of the process now.

CHAIR—No, the advice that Professor Whiteford has just provided.

Mr Casey—If it be contraindicated to their health that they should remain in detention?

CHAIR—Correct.

Mr Casey—That would come to the department in the case management process. The department would then have to take that advice on board in terms of considering whether that person should remain in that facility.

CHAIR—What extra information does the department bring to bear on the subject? If the team has provided you with clinical advice, what else would you take on board by way of information?

Mr Casey—I suppose the other major area of consideration would be whether there were any issues in relation to security concerns in the community. That might be a counterweight to the advice from the clinical team in terms of their remaining in a detention facility as opposed to other factors. That, for me, would be the only other issue that would be countervailing.

CHAIR—Is there a process to do this?

Mr Casey—Yes, there is a process to do that.

CHAIR—Has it happened yet?

Mr Casey—It comes into case coordination?

Ms O'Connell—It does come into case coordination.

CHAIR—Has it happened?

Mr Casey—Yes.

CHAIR—What was the outcome?

Mr Casey—I was in South Australia last week, the week before, talking to the staff at Glenside. They advised us that they thought there were a number of patients who were no longer required to be in an acute facility. We invited them to provide their clinical recommendations to us and we are awaiting those. They were going to be provided either this week or last week. We spoke to Professor James: 'Tell us what you think should be the next step in terms of their care.'

CHAIR—But they are still in Glenside?

Mr Casey—They are still in Glenside. We have not received a recommendation.

CHAIR—Professor Whiteford is talking about something quite different. He is saying that, before someone needs hospitalisation, there is an argument for them to be out of an environment like Baxter.

Mr Casey—That would go to the case coordination person.

CHAIR—But it has not happened yet?

Mr Casey—I have not seen a recommendation about somebody who has been admitted to a detention centre and there is an immediate recommendation that they should not be there.

CHAIR—But there is a process in place that would accommodate that?

Mr Casey—Yes.

CHAIR—We have just accessed the Palmer inquiry recommendations. Recommendation 4.12 says:

The Inquiry recommends that DIMIA consider constructing a flexible 'intermediate facility' at Baxter to enable more appropriate accommodation to be provided to detainees who cannot be allowed to remain in an open compound—

et cetera. What happened to that recommendation?

Ms O'Connell—That is part of the review that we are looking at for the overall design of Baxter to open up some parts of the compound accommodation more generally, but to provide different types of accommodation within Baxter. We expect to have those designs completed before the end of the calendar year.

CHAIR—Why doesn't it appear in the discussion paper?

Ms O'Connell—The discussion paper was about mental health.

Mr Casey—That was only about the mental health stuff.

CHAIR—This recommendation is not about mental health?

Mr Casey—I think it is about the suitability of the environment—broadly. But it is not considered as part of the recommendations that really went to how we deal with mental health referrals.

CHAIR—Professor Whiteford, do you think it would be a positive move for the people you have described? As someone who could intervene in their possible illnesses, is this the answer you had in mind: a separate compound at Baxter where they might go?

Prof. Whiteford—A separate compound at Baxter would be part of the range of options. I think the range of options needs to include community residential housing in Port Augusta. Some of them need to be outside the walls of Baxter, physically. That greater range of flexibility, which is part of the environmental changes that are being introduced, is significantly helpful to a clinical team where the environment is contributing to the person's mental illness. The recommendations on that discussion sheet dealt more with somebody who had a mental disorder. Making the environment less of a cause of the mental disorder should be there for everybody's wellbeing, because even where it is not going to cause a mental health disorder, helping people live in an environment which is less stressful is good for everybody's mental health.

CHAIR—Indeed. Can I just go back to the staff for a moment. Professor Whiteford, you indicated the difficulty of getting people to work at Baxter. We spoke with the psychologists and the psych nurses, one of whom was there for six weeks because she works at St Vincent's, I think it was, in Melbourne. How difficult is it—and I am sure you are going to say it is very difficult, but what do we do to overcome this—to get continuity of care? Obviously, if you have psychologists you cannot have someone coming in for a six-week period and then going off, and then someone completely new coming in. Particularly with long-stay detainees, surely there has to be, for any reasonable level of care, continuity?

Prof. Whiteford—That is true. The number of long-stay detainees in Baxter appears to be diminishing rapidly, which I think means that people who are there for extended periods of time do need continuity. You need fewer staff to provide that, and there is one psychologist, whom you met, who is there full time. The detainees that are there for shorter periods of time will be able to be managed by staff on contracts.

Whilst it is desirable to have staff who are there in the longer term, there is a value in having some of the staff rotate through. One of the things that happens in institutions is that bad practices arise amongst clinicians who become captured by the environment. I think one of the nursing staff that you met, Senator, came from one of the major teaching hospitals in Melbourne and having that person there on a six-, eight- or 12-week rotation, coming from a major teaching hospital and acute psych centre in Melbourne, bringing her skills and her outside influence and then leaving and going back—having some people like that in the team—is good for the culture of a place like Baxter.

CHAIR—Ideally you would like to see—

Prof. Whiteford—A mix.

CHAIR—some permanence there, but this flow of new blood.

Prof. Whiteford—Yes, because a lot of the stays there are much shorter now and would be more than adequately accommodated within an eight- or 12-week rotation of staff, but also because of the cross-fertilisation and the value, the opening up, that the service brings.

CHAIR—The other thing missing from this discussion paper is any action on the practice of seclusion of people within Baxter. Can you explain why this is? Are the rules changing with regard to exclusion? I think the committee was told, for instance, that it was a standard practice—up until this new environment—for anyone who was misbehaving a la the Rau case that they were, for a minimum period of six weeks, put into Red One compound, which includes a level of seclusion, and that there are similar rules that apply to the management unit. What is the new environment with regard to seclusion?

Prof. Whiteford—One of the reasons that I was strongly recommending that a discrete process be put in place for determining whether someone had a mental illness, and a threshold for that diagnosis using internationally accepted criteria, was that once the diagnosis was made that the person had a mental illness they then had to have a management plan which was signed off by the psychiatrist and was implemented by the mental health staff. If that person's management of their mental illness requires seclusion, they should not be in Baxter. They should be gone. If the behaviour of an individual is inappropriate in Baxter and it is not due to their mental disorder but needs to be managed within the facility, that is when the management unit might be used. It is an issue for Mr Casey and Ms O'Connell. But that unit would not be for the treatment of their mental illness.

CHAIR—Where is this written? Where is the plan? Where is the procedure to make sure that people with mental illness are not thrown into Red One?

Mr Casey—In the current operational procedures for Baxter, which actually set out the criteria for the use of the management unit. It specifically excludes—and I think the manager at Baxter made this comment during the visit—anyone being placed in the management unit because they are ill. The manager is the one who makes the decisions about who goes into the management unit.

CHAIR—Can you provide the committee with the document that spells it out?

Mr Casey—The operating procedures, yes.

Ms O'Connell—The operating procedures have been updated and that is the means by which it is stated. Yes, we can provide that.

CHAIR—Have you also updated the web site, the Emergency Demand Management Policy and Procedures series titled 'Restraint and seclusion in health units'?

Ms O'Connell—You mentioned that is on our web site?

CHAIR—Yes.

Ms O'Connell—We will need to check that that is updated.

CHAIR—All right. Can I go now to the role of the Ombudsman. One of the recommendations in parliament, I think, was for an Immigration Ombudsman and now we have got one. But in South Australia, the Ombudsman offered the view that the state Ombudsman should have access to detention centres. Can you give us an update on where the Immigration Ombudsman's establishment and operation is up to and why it was that the decision was made to not go down the state Ombudsman's path.

Ms O'Connell—I believe the Ombudsman is appearing here today, or a representative.

CHAIR—Not today, at another time. But it would be useful to have your perspective on the role within the new environment, as it is called.

Ms O'Connell—Certainly. I have been briefed. In fact, we met the other day with the Ombudsman and, yes, they have established the Immigration Ombudsman's role and function and they are in the process of, basically, staffing that. I think their current plans are to have that fully operational by Christmas. In terms of the difference between the state Ombudsman and the Commonwealth Ombudsman, I am sorry, Senator, I was of the understanding that it was a role specifically designed for the Commonwealth Ombudsman in terms of the Immigration Ombudsman function and that they have adopted that and are implementing that.

CHAIR—At no stage was there discussion about whether the state Ombudsman should be able to go into detention centres and represent those there?

Ms O'Connell—I have not had any discussion about or consideration of that. It has always been assumed to be, to me, the role of the Commonwealth Ombudsman and I would have to talk with the Ombudsman to understand the difference.

CHAIR—We will ask this question of the Ombudsman, but what is the problem with the Commonwealth Ombudsman not going into detention centres in the past and why is there a necessity for an Immigration Ombudsman?

Ms O'Connell—The Commonwealth Ombudsman was allowed into detention centres before and did review cases and all of those things. The emphasis in the parliament is to create a specific Immigration Ombudsman with increased powers and increased focus on immigration.

CHAIR—I am interested in the suite of activities that were demonstrated to us: bushwalking and shopping and a new hockey field and so on. What informs the decision to go down that path? It seems sensible to me for people to have activities while they are incarcerated, but what is the knowledge about, particularly, long-term detainees? I understand what you are saying about there being fewer long-term detainees there, but the detainees we spoke with were very—'unenthusiastic' is not quite the right word, but they kind of thought this was meaningless and pointless and that they still had to come back into the centre and face the gates and face being

locked up again, and some of them shrugged and said, 'Why would you bother?' Is it enough to just stick up hockey fields and take people out occasionally? What informs that policy that we now have?

Prof. Whiteford—My recommendation with respect to the environmental changes was to normalise the environment as much as possible, having regard to the security issues, and so the activities which were recommended and have been put in place are attempting to do that. I think sometimes the person's individual situation might disempower them to the point where they do not even want to engage in those activities, but where the activities can be normalised, having regard to the quite heterogeneous population in a place like Baxter, the more the better. I think that bringing in people from the outside who are not seen to be GSL staff or whatever, and encouraging those people to work with the detainees, to get the detainees going on outings so that they physically go outside Baxter as much as possible, over time should improve their mental wellbeing.

CHAIR—Do you think this disinterest might be an historical leftover?

Prof. Whiteford—This is a relatively new set of arrangements and it might take some time for all of the detainees to take advantage of it. There may be some who will not take advantage of it but it certainly should be offered.

CHAIR—Mr Casey, just finally, in your discussion paper you said the MOU with the South Australian health department was to be formalised by the end of September. We are now into October. Where is it?

Mr Casey—I am waiting for the South Australian government to confirm that they have accepted the MOU that we have drafted. They informally advised me that they would accept it but they were waiting for it to go through their crown solicitors before they could give a final sign-off.

CHAIR—What were the sticking points in the debate with them?

Mr Casey—Dare I say that wherever there is a document that has to go through our respective legal fraternities, sometimes people make observations that we say may not support the policy. We wanted a document that was about the Commonwealth and South Australian Health working cooperatively together. That is the document that I believe we have achieved.

CHAIR—It does not sound very cooperative when it took 18 months to deliver.

Mr Casey—With all of these documents, governments like to put them through their legal departments. Sometimes that takes time. Seven or 10 days ago we sent to them what we thought was the final draft. We are waiting for them to confirm that that is acceptable. Then we will move to formalise it through signature.

CHAIR—Do you have a new expected date of formalisation?

Mr Casey—All I can say is that we have been pursuing it and I did ask, pursuant to coming here this morning, for an update. Nothing has come back. I did actually anticipate your question

and did ask for somebody to contact them and ask them when we would get their formal response.

CHAIR—Send a pigeon across!

Mr Casey—I hope it will be in the next week or 10 days that we should be able to finalise that.

CHAIR—Right, thank you. Mr Casey, I wonder if it would be possible for you to stay around—in case you were thinking of going—given your background with the national mental health plans.

Mr Casey—I would be very happy to do that.

CHAIR—That would be good. Thank you very much for coming today. Anything we forgot to ask you, we will, with your indulgence, put on notice. Thank you for appearing and giving us that extra information.

Proceedings suspended from 10.42 am to 11.01 am

HORVATH, Professor John, Chief Medical Officer, Department of Health and Ageing

LEARMONTH, Mr David, First Assistant Secretary, Primary Care Division, Department of Health and Ageing

McGLEW, Mr Paul John, Acting Assistant Secretary, General Practice Programs Branch, Primary Care Division, Department of Health and Ageing

SAVAGE, Ms Joy, Assistant Secretary, Health Strategies, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

SMYTH, Mr Nathan, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing

CHAIR—I welcome back to the table departmental officials, who are now accompanied by Medicare Australia. Is it your intention, Mr Davies, to have an opening statement for—

Mr Davies—I think one is enough, Senator. I would not inflict another on you.

CHAIR—We will go straight to questions then. Senator Moore, would you like to kick off?

Senator MOORE—Mr Davies, I believe that people in your organisation would have been following the transcripts. I would hope that was the case, but I wanted to get that on record. I want to ask a couple of questions about some of the things that people have raised across the country, one of which is the issue of the focus and the priority of mental health in the overall Australian health system. There have been various comments made that, whilst there are national programs, there is some concern that, on the list of national priorities, mental health is not as highly regarded as it ought to be. We have had evidence to suggest that there should be identified ministers, identified departments and that whole building up for the priorities of mental health.

In terms of structure—and I know that we have a range of people here from the organisation, and I have seen your flow charts—when someone mentions the issue of mental health in Australia, where do they go to in the department? We have in front of us six officers who have various responsibilities within a Commonwealth agency. I want to know exactly how it works in terms of the process in relation to the issue of mental health in the Australian government now.

Mr Davies—I will start, but I am sure my colleagues will want to add to what I have to say. In terms of the focus and priority, I believe the evidence speaks for itself. There is evidence presented in the Australian government submission dating back to 1992 when the first strategy was launched. That has been updated on a regular four-yearly cycle since that time. It has the backing of all Australian governments, through their health ministers. It has attracted significant funding and, as I think the submission makes clear with a number of citations, it is a document and an approach which is looked upon very favourably by many other governments and jurisdictions around the world.

The answer to the question, 'Is there sufficient focus on priority?' is that mental health is recognised by all Australian governments as a very important component of the health care system and, indeed, as I said in the introductory remarks, is an issue that extends beyond the health system. Insofar as it is the responsibility of the health portfolio, mental health is up there very prominently with all our other areas of involvement and interest. In terms of where you go to ask about mental health—

Senator MOORE—Who has the accountability in the department?

Mr Davies—We have a mental health branch, which is within the Health Services Improvement Division, which is Mr Smyth's branch. I think he will give you a quick summary of what the branch encompasses.

Senator MOORE—That is a branch within a division?

Mr Smyth—That is right.

Senator MOORE—It is your branch within your division—

Ms Lyons—That is right.

Senator MOORE—within your department?

Mr Davies—Yes.

Senator MOORE—The title of your branch again?

Mr Smyth—It is the Health Priorities and Suicide Prevention Branch.

Senator MOORE—Where do I get mental health out of that title?

Mr Smyth—It is a health priority area.

Senator MOORE—That's it!

Mr Smyth—That is correct.

Senator MOORE—So health priorities and suicide.

Mr Smyth—And suicide prevention.

Senator MOORE—What other health priorities do you look at?

Mr Smyth—Diabetes, cardiovascular disease, asthma, arthritis, musculoskeletal conditions and injury prevention are the national health priorities, including mental health.

Senator MOORE—Down below you, who has the title 'mental health'.

Mr Smyth—I have four directors that sit within—

Senator MOORE—This is what I am trying to—

Mr Smyth—my branch that are responsible for mental health and suicide prevention.

Senator MOORE—And suicide prevention has its own little box?

Mr Smyth—Is its own separate section within the branch. That is correct.

Senator MOORE—What are the key titles of the four directors?

Mr Smyth—Their key titles are 'promotion and prevention', 'suicide prevention'—

Senator MOORE—As well as the other one, or is that—

Mr Smyth—No, that is separate as well. It is newly separated. 'Mental health strategies' and 'quality and effectiveness'.

Senator MOORE—They link back to the National Mental Health Plan?

Mr Smyth—That is correct.

Senator MOORE—That is how the link operates.

Mr Smyth—I also take along observers to the National Mental Health Working Group and I sit on the National Mental Health Working Group.

Senator MOORE—It is your position that sits on those working groups?

Mr Smyth—That is correct.

Senator MOORE—Where does the national medical officer fit, Professor Horvath?

Prof. Horvath—Primarily, due to its importance in the chronic disease strategy, in the area of national health priorities. I chair NHPAC, the National Health Priority Action Council, which reports to AHMAC. There was an agreement at that level that mental health needed to be right across all the priorities, so it actually sits within each of the current health priority areas and plays a very major role in the chronic disease strategy which will go to health ministers in November.

It is a strategy that has been developed now over 18 months, with enormous consumer input, stakeholder input and professional input. I am very much looking forward to this becoming a public document, because I think it is one of the best documents governments—states and territories—have done, and really sets the footprint for the management of all chronic disease, not taking mental health or any one of them out, because of the recognition of the huge comorbidity it is across. Somebody who has a stroke and has got diabetes and hypertension has a

very significant risk of developing depression, for example, six months down the road. To tease them out, it was agreed by all the contributors to the national chronic disease strategy that that would not be wise.

That is my major role at present. My other role is that I am the Commonwealth's representative on the beyondblue board. As you know, that is a very big investment by the Commonwealth and, mainly, the Victorian government. I have been the Commonwealth's nominee to that board since I became Commonwealth Chief Medical Officer. From time to time I provide resources—not so much provide advice, because that is outside my area of skill—of where we can gain additional advice when we need it.

Senator MOORE—Another issue is in terms of the general comments about coordination, because at every level there is a perception of fragmentation of service and a need for coordination. Your answers have indicated that, within this department, you are looking at that coordination. How is the coordination then between the department and government? There has been a demand from the public that mental health have a high political priority and that advice and so on—the linkage between the department and government—is of a high profile and there is that immediacy of response.

Who in the structure is accountable for the advice to government? I understand, with the division of the responsibilities with the minister and junior minister, that mental health and those issues are with the senior minister—with Minister Abbott—as opposed to Minister Ley, the parliamentary secretary. Is that right? We refer to them as junior ministers in terms of the process. Is it with Minister Abbott rather than Parliamentary Secretary Ley?

Mr Davies—The parliamentary secretary is Christopher Pyne.

Senator MOORE—Christopher Pyne?

Mr Davies—Yes. Minister Abbott has asked Minister Pyne to take carriage of mental health issues.

Senator MOORE—There has been a suggestion that we follow a model that has been promoted in New Zealand in terms of having commissions and a profile of that nature. Is that something that the department has considered?

Mr Davies—I think it would be fair to say that the relevant officers keep abreast of developments, both clinical and organisational, in other jurisdictions, but in terms of the idea of a commission, given the nature of our system it would have to be a commission that had the backing of all governments.

Senator MOORE—Because of the COAG process, yes.

Mr Davies—Yes. And that is not something that has yet been identified as an issue that ministers seem to want to move on in the Australian context.

Senator MOORE—I know there are other questions, but I have a particular issue because of my experience with the cancer inquiry. Through that process we talked a lot about clinical

practice guidelines and the way that they are developed and how they are then seen as a public focus for various conditions, and they have been rolled out in a number of areas—in the cancer area, the cardiovascular area, and diabetes I think. What about the processes within your portfolio in mental health and, in particular, with the issue of depression? There has been a lot of interest in having that kind of structure within the area of treatment for depression. Is there an intention to have clinical practice guidelines there? I do not know to whom to look. Professor Whiteford, are you answering that one, or is Mr Smyth?

Mr Smyth—I will answer. At the moment there are the National Standards for Mental Health Services. They were established in 1996.

Senator MOORE—Yes, very early in the process.

Mr Smyth—Very early in the process. There are 23 principles that are contained in those. There are also practice standards that are currently being implemented across all jurisdictions through the National Mental Health Working Group, and the first set, the national mental health standards, are under review because we feel that certainly, 10 years after they were first drafted, it is timely—given the pace at which change and reform are occurring in the mental health system—that they be revisited. They will be revisited over the next 18 months.

Senator MOORE—And the particular area of depression as a chronic illness?

Mr Smyth—The particular area of depression is taken in the context of the overall mental health sector. It is separated out, certainly, through the national depression initiative, beyondblue, which we as a federal government have funded since 2000, and we have just announced funding for another four years for that. In many respects, the Better Outcomes in Mental Health Care program is dealing with a lot of the depression related issues of people that take the time to visit their general practitioner as well, so some of the more high-prevalence disorders such as depression and anxiety are serviced, in many respects, by the federal government through the primary health care system and our interaction through divisions of general practice.

CHAIR—Does that mean there won't be clinical guidelines established?

Prof. Whiteford—There are guidelines. They have been developed for about five or six conditions. They are publicly available on the Royal Australian and New Zealand College of Psychiatrists web site. They are for depression, bipolar disorder, attempted suicide, schizophrenia, anorexia nervosa, anxiety disorder.

CHAIR—Would a GP commonly have those guidelines?

Prof. Whiteford—Certainly they are the ones that are what we call evidence based medicine, so they are the best practice guidelines from the literature about how you would treat those various disorders. Within the structure that I outlined earlier, the service standards describe the structure of a mental health service. Within that, the clinicians who work in the system have practice standards that they have to meet, which are about their attitudes, knowledge and skills, and when they treat a patient they would use the clinical practice guidelines for the diagnosis and the treatment of a particular condition. That is the way it would fit together.

CHAIR—But when does it get to GPs?

Prof. Whiteford—Those guidelines are best practice treatment written for mental health professionals. For general practice, the primary mental health care guidelines for the treatment of depression at primary care level would have to be consistent with those standards, although we would not always expect that a GP would have available the multidisciplinary team options that would be available in a specialised mental health setting.

CHAIR—They are coming for GPs or they are not?

Prof. Whiteford—I do not know the answer to that.

CHAIR—Mr Smyth?

Mr Smyth—The standards that are currently used by general practitioners include the training that they have undertaken through the Better Outcomes program, through level 1 and potentially level 2 training if GPs so wish to do, and there is also the General Practice Mental Health Standards Collaboration that looks at the standards for mental health related disorders for general practitioners.

CHAIR—So the answer is 'no'?

Mr Smyth—There are standards in place.

CHAIR—No, the clinical guidelines is what you were asked about.

Mr Smyth—I would have to take that on notice, I am sorry, Senator.

Senator MOORE—This is in terms of tracing through. We had highly publicised clinical guidelines for other key priority conditions in the country and we are trying to trace through, because there was an expectation—and I think Professor Whiteford talked about the things that were available—that there would be a package with the same kind of promotion and general accessibility across the whole of the community that had that a focus on depression.

Mr Smyth—A focus on depression?

Senator MOORE—I think that what you have said is that there are a range of things available but they are not quite at the same standard as what we have for diabetes or cancer.

Mr Davies—Guidelines come from a variety of sources.

Senator MOORE—Absolutely. Where did the ones on cancer come from? Maybe we will put it on notice so that we can have it really clearly seen. Promoted through the cancer inquiry was the value of having this particular product and that everybody in the network—consumers, practitioners—could refer to those guidelines and that it was the expectation of government that there would be such a product for other key conditions, and I know there is one on diabetes because we have asked questions at estimates, and I know there is one on cardiovascular disease. I am trying to find out if there is a similar product for the area of mental health. I know that the

issue of depression was given prominence when the government accepted it as a priority after there was so much public pressure and public tragedy. Is there an expectation to have such a product? If not, I think it would be useful for us to have something to have a look at that linked together the answers that you have given us, because Mr Smyth linked the various things that you have got, how they work and how they differ from the one on diabetes, for instance.

Mr Davies—I think it would be useful if we offered, as we have, to come back to you with a sort of mud map of what standards and guidelines are out there, what their status is, what level of endorsement they have.

Senator MOORE—That would be very useful. Can I have a comparison?

Senator WEBBER—Depression versus cancer versus diabetes.

Mr Davies—We could do that, yes.

Senator MOORE—It would be useful and also it would respond to the process.

Mr Davies—Yes, but I think we should just draw attention to one point that Mr Smyth did make. To access the Better Outcomes in Mental Health Care program and the Medicare benefits that that allows access to, the GP does have to undergo a formal course of training.

CHAIR—The vast majority of GPs have not done that training. What is there for them in terms of the clinical guidelines? That is the question. And is the department going to do something about it?

Mr Davies—Yes, we will come to that in—

Senator MOORE—I know that Senator Allison will ask lots of questions about Better Outcomes, so I will hold my thunder on that one. The other general point—and I am sure other senators will have questions on this as well—is that there has been a great deal of evidence across the community about the value of multidisciplinary teams and about the range of treatment options that are available for people in the community once they have had some form of diagnosis and are seeking help. We have had a lot of evidence that there is concern about the lack of Medicare coverage for psychologists, the lack of Medicare coverage for other kinds of therapists that are available that have different forms of qualification. I doubt whether we have had any public hearing where there has not been evidence of that kind. Could we have some comment from the department? The value of the Medicare payments in the treatment of mental health was a key point in the government statement. I am sure you are aware of these comments from the community about the Medicare limitations. Can we have some comment from the department about what research has been done?

Mr Smyth—Sorry, Senator, in relation to just general accessibility for such as the Better Outcomes program or multidisciplinary care in terms of chronic disease management?

Senator MOORE—Across the board in terms of mental health options. It has been put to us that certainly there are limitations with work force demands. I am sure people will raise the lack of skilled practitioners across the board everywhere in the country, in particular outside capital

cities. The current Medicare arrangements, by and large, preclude access to Medicare payments if you are being treated in an extended way by a psychologist. There are caps to the amount of visits you can have. If the person is not a psychologist but is another form of practitioner, there is no Medicare coverage. Also, the people who have not accessed Better Outcomes have limited availability to have longer sessions. The current Medicare plan limits treatment options for people who identify with mental illness.

Mr Davies—If I could deal with the broader issue before we go into the detail of the program, historically Medicare has provided subsidies for services delivered by doctors. What we have seen in the last two or three years is a broadening of that access to subsidies for services delivered by practice nurses in specific circumstances and, subsequent to that, services delivered by allied health professionals for and on behalf of a doctor. What we are seeing is a response to the issue that you are raising of broadening that access, but we are moving from a system that for many years has been the exclusive preserve of the medical profession. You can see in that a recognition of the value of multidisciplinary care and that applies just as much to mental illness as it does to a variety of other chronic conditions.

CHAIR—Mr Davies, psychologists have always been involved in mental health issues. It is just a question of whether they are under Medicare or not.

Mr Davies—Correct. What I am saying is Medicare is now extending its coverage to provide subsidy for those services which formerly were not subsidised.

CHAIR—But to suggest that the doctors were the only ones treating—

Mr Davies—No, they were only ones getting Medicare funding for doing that.

Senator MOORE—I have one more point before other people come in. There are lots of questions to your area. Your governmental response gave detailed costings of the amount of funding that the government has put into the treatment of mental health. There were considerable costings in the Medicare subsidy area. In terms of the issues we raised of concerns about access to allied professionals—in particular psychologists but others as well—has the issue of what that would cost been considered by the department? Have you looked at the way that Medicare, in particular, but also the general input of funding into the area of mental health has been rising in terms of the possible impact and how much more money would be required if you were to extend Medicare coverage? Has that been something that has been considered and costed by the department in terms of what that would do to the budget?

Mr Davies—I am not aware that that costing has been sought.

Senator MOORE—It hasn't been a demand that has come up through the various consultative processes? People want to have psychologists able to provide services at a larger level, particularly for the private—

Mr Learmonth—Where the emphasis has been, with the introduction of the new allied health items, has been on take-up of the existing measurements. Psychologists and mental health workers are covered and have been since July last year under that Allied Health Initiative. They provided some 23,000 services in the last 12 months under the allied health components.

Senator MOORE—The capped components.

Senator WEBBER—Is that the six visits?

Mr Learmonth—Five allied health visits. It includes psychologists. It also includes mental health workers such as OTs, social workers, mental health nurses and Aboriginal health workers. The focus of the debate has been on take-up, which has led to the creation of the new chronic disease management items, for example. This has made it easier for GPs to get through the gateway to the allied health items. Whilst it is very early days, since the new items have come in we have seen uptake in team care arrangements, which is the precursor to allied health. That seems to be working in improving uptake.

Some of the other debate has been about the structure of the rebates in relation to how services are provided for; for example, something like psychology versus physiotherapy and the amount of time that is taken and the rebates which are available. Where that structure might go in the future is a matter that is being considered.

Senator MOORE—So there is a start.

Mr Learmonth—Absolutely. There has been quite a lot of discussion about what alternative structures there might be or what directions you might take them in to better facilitate the use of those parts of the allied health community currently funded. The current construct serves quite well for most of them but there are some that you might structure differently to improve uptake and utilisation, for example, where some professions tend to spend more time than others. That is very much a matter under consideration.

Senator MOORE—This is my last question on this point. Is there any way, through the current processes of assessment that you have—and it would be particularly in your area, Mr Learmonth—of looking at where demand has not been met by the existing services? You codify how many people have taken up the allied health services and you divide that between chronic illnesses but we have had overwhelming evidence to this committee about the demand for alternative support through mental health issues. Is there any way in the current system to get any kind of quantifiable data about whether it is enough? Someone is seeking visits to a psychologist and is able to access them through the current gateway that has been opened. How do you find out whether there is an overwhelming demand for more?

Mr Learmonth—It is not an easy question to answer.

Senator MOORE—No, it is not.

Mr Learmonth—If you look at the broad picture, which is one of less uptake than had been estimated, you might suggest that there is not the demand that you estimated or imagined there would be. Equally, that picture is confounded by whether or not the structure is particularly amenable to utilisation. There is no clear picture. There is no clear inference you can draw from the data that we have, and I am not aware of any particular studies that go towards identifying the unmet demand. Certainly the overall picture for us and the issues that we are grappling with are insufficient uptake, rather than overwhelming demand.

Senator MOORE—Maybe it is the way the questions are asked.

Mr Davies—There is an important additional point to make here. Your line of questioning is focused entirely on the private provision of services funded by Medicare.

Senator MOORE—Yes, when people have to seek the services themselves.

Mr Davies—There is a whole other side to this, in that there are large volumes of allied health services of all manner delivered through the public system under the state and territory umbrella. What you are seeing here is just part of the bigger picture in terms of access to those services.

Senator MOORE—But it is what we see in your submission under the Medicare box.

Mr Davies—Sure.

CHAIR—Senator Scullion has an interest in Indigenous issues in particular.

Senator SCULLION—Thank you, Madam Chair. Before I get some very clear answers from Ms Savage, I would like to put a general question to Mr Davies on the Better Outcomes in Mental Health initiative for GPs. Across the board this has been welcomed. It is a great initiative. Unfortunately, as the chair alluded to a little earlier, we have had very little take-up; some 12 per cent. There has been some criticism about the level 1 and the level 2, six hours and 20 hours. Really is this a help? I hope those issues are being looked at. Perhaps you want to make a comment on that. My specific question is, can this sort of initiative, with provision of something like a 20-hour course, whether you are a policeman or making sure it is part of somebody's training—we know the people who are going to be front line. There is no confusion about that. We know that it is an increasing aspect of the training of a general nurse. Has there been much thought about how we can introduce into that front line, that we know is outside of the standard mental health work force, something along the lines of this initiative. Have you put much thought to that?

Mr Davies—I might have to defer to Mr Smyth on that one. As to your first more general point, the Better Outcomes program was developed in its initial form through extensive consultation with professionals and experts in the field. We have seen how it has gone and it has been modified as we have gone through. I think your observation is right. It has been very successful but where there are elements of curate's egg about it, we are trying to maintain the successful components and address those elements that have been holding us back. Nathan can give you details of that and probably also talk about initiatives to raise more general awareness of front-line workers on mental health issues.

Mr Smyth—We are looking internally, after receiving advice from the Better Outcomes Implementation Advisory Group. There was a workshop recently held in Adelaide in August about increasing the accessibility and making the red tape for programs such as this easier to navigate through. Those issues are certainly under consideration by the department. What we have noticed over the course of the National Mental Health Strategy is that our promotion activities and destigmatisation activities have been highly successful. That has created more of a demand for our mental health services across the board. We are also seeing evidence of that through the public hospital system.

We have a number of awareness and education campaigns that we deliver through the divisions of general practice. We are looking at issues around the mental health work force for nurses and other allied health care professionals. It is something that we look at on an ongoing basis to ensure that we are delivering appropriate services, where they are the Commonwealth's responsibility, or funding of appropriate services into the community. We are looking at a number of pilot activities as well where there might be some restrictions placed around the current Better Outcomes program and how we might look at some alternative arrangements for particularly rural and remote communities to get access to allied health care professionals in those regions.

Senator SCULLION—Thank you.

Prof. Horvath—Could I just extend that a little bit, Senator. I interpret the end of your question as how are we getting out into the broader community. In terms of education, from medical school through postgraduate medical councils and colleges, this is very much on the agenda. Medical school curricula for a long time had difficulty with where to appropriately put training in behavioural sciences and psychiatry. Clinical schools are looking at this. More importantly, the committee of medical board presidents has recently been looking at some core curricula for all medical colleges. Strangely enough, even the surgeons are talking about some core skills in basic psychiatry—or call it behavioural science.

These are on the agenda and, similarly, for those first two years of internship or PGY1 and PGY2, discussions are being had on some core teaching of primary mental health, so they are certainly on the medical education curricula.

Senator SCULLION—I appreciate that. Perhaps you may be able to take on notice, Mr Davies, that again with this siloisation, that answer the professor just gave me is appropriate to his specific field. It is the kind of answer that I would be very grateful to receive in terms of the medical and nursing field—that we are adjusting curricula. What is happening? What have we adopted? Have we got a similar sort of process? How is it being funded? And like it or not, the police are a fundamental part of the front line and perhaps we should have called the police to appear before us as a separate entity.

In terms of responsibility about a curriculum across the board, which is fundamentally about understanding mental health, perhaps you could take on notice about how we could have a look at that and how you are approaching it in a holistic sense, rather than siloisation.

Mr Davies—Part 3 of the submission goes to some of that education and community awareness. On top of the police I would add another very important group of what you might call first responders, and that is schoolteachers. You will see there has been a quite significant investment in raising their skills and awareness in this area.

Senator SCULLION—Thank you. I will briefly ask questions in regard to Aboriginal and Torres Strait Islander health. This committee has spoken to a number of people in Indigenous communities, as well as visited some Indigenous health centres. The way it seems to be funded is astonishing. In some places the principal funding may be Bringing Them Home, which comes from the stolen generation. That is their source of primary health care for mental health. There is

the Link-Up money and while Aboriginal primary health care services are funded by OATSIH, that is generally it.

I have gone to a community and said, 'What you are doing?' Somebody will tell me, 'I'm studying to be a mental health worker and so are my two colleagues.' I go there again: 'How's it going?' 'Well, I've studied. We finished it. There's no money. That program finished, so I'm just sitting down. People come and see me if they're a bit sick from time to time. I don't get paid. There's nothing in the infrastructure.' That is a function of the very short periods of time that we seem to fund these programs. It is very hard to find a program for mental health and Indigenous Australians that is funded for more than three years. It is difficult enough to get health workers out there, without them knowing that they are into a program that is only going to last three years. Could you just tell me how you think this method of funding is going and are you reviewing it? What are we doing about that?

Ms Savage—Thanks, Senator. I was quite interested in your remarks. Most of the funding to Aboriginal community controlled health services, and indeed other health services that provide primary health care services inclusive of social and emotional wellbeing and mental health services to predominantly Aboriginal and Torres Strait Islander people, are largely funded on an ongoing basis through the Office for Aboriginal and Torres Strait Islander Health. The overall funding may come from specific titled programs but, by and large, we have one contract with numerous schedules so as to ensure accountability and reporting. That is seen as a package of funding that we provide for both primary health care services and a range of ancillary and integrated services, such as mental health. Indeed, Bringing Them Home, Link-Up and some of our mental health service specific funding has largely been ongoing.

Senator SCULLION—How can you say 'ongoing'? It has to be reapplied for. Notionally it is ongoing but it is normally two-year funding, then what you have got to do is reapply, and we will give you all the assurances but it does not give the same level of confidence as recurrent funding. It is actually determined on the program that, as you would be aware, the funding has to be reapplied for. Whilst you may say this is ongoing, those programs are not ongoing. They are programs that require usually an application from time to time. That is the evidence that I have been given.

Ms Savage—Right. We do not have an annual submission process for services that are in receipt of the sort of funding and programs that I have mentioned. I can only assume that some of those comments have really come from where we might have one-off initiatives and innovative and creative programs that encourage linkages between a range of organisations and so forth. Yes, in those instances they would certainly be time limited and applications would apply.

I feel fairly confident in saying that that would not be the main game for most services but I am certainly happy to look at that. We have an approach that really is about providing as much certainty about the funding levels—subject, obviously, to compliance, accountability and reporting—and that that funding flows through to ensure the ongoing nature of the service and, indeed, provides some security for staff. That is the approach that we take.

Senator SCULLION—Perhaps you could provide the committee, on notice, a schedule of those programs that provide mental health funding to Indigenous communities and clinics, and the period of time under which they are reapplied for and the sustainability of those funds.

Ms Savage—Most certainly.

Senator WEBBER—Ms Lyons, I would like to go back to the discussion that Senator Moore was having. Unlike Senator Moore, I am not as aware of your organisational structure within the department. How many branches come under you and what are their names?

Ms Lyons—I have a number of branches in my division: health priorities and suicide prevention, which Mr Smyth heads up; electronic health policy; rural health services; work force; safety and quality council. I think that is it.

Senator WEBBER—There is health priorities and suicide prevention and under that I think you said there were about four or five categories.

Mr Smyth—There are four specific areas that relate to mental health and suicide prevention within my branch.

Senator WEBBER—Symbolically, when you look at an organisational chart, it tells you something about the priority that an organisation places on an issue. If I look at that very superficially, it seems to me that mental health is a little less important, say, than the electronic stuff or rural health or what have you, because I have to go to a branch and then I have to look under that branch, so it is a subcategory underneath that.

Ms Lyons—I do not believe that to be the case at all. It is a health priority.

Senator WEBBER—If I go to, say, a state Department of Health, it is a division, there is a chief psychiatrist, it is all identifiable and I do not have to go from a departmental secretary to the next layer down, to the next layer down, to the next layer down. I can go to the secretary of the department, straight to the chief psychiatrist, to the head of mental health.

Ms Lyons—And I think that is a reflection of the different roles and responsibilities between the Australian government and the state and territory governments, because state and territory governments are responsible for service delivery.

Senator WEBBER—Absolutely.

Ms Lyons—Clearly, that would be a critical part of their health departments, as it is a critical part of ours.

Mr Davies—I noticed a slightly puzzled look when Ms Lyons was describing the areas of responsibility that came within her division, which I admit do appear to be quite wide ranging. The rationale behind that, I think, is actually significant in terms of the question you are asking, which is all of those issues have in common the fact that they apply across the whole portfolio. Mr Learmonth is responsible for primary care. We have other colleagues here who are

responsible for acute care, public health, Aboriginal and Torres Strait Islander health. All of those areas rely on the work force.

All of those areas have issues in terms of electronic health, safety and quality. As Professor Horvath said a few minutes ago, they all have to be cognisant of mental health issues and best practice in mental health. In a sense, although the Health Services Improvement Division looks like sort of a vertical silo within the department, you could almost tip it on its side and say it has a presence across the whole department.

Senator WEBBER—How do I feel reassured about that when, in addition to that, the committee gets evidence about the increasing prevalence of mental health difficulties that our community faces? We have heard evidence that up to one in five people in our community at any one time are suffering from some kind of mental health challenge, shall we say. That can be up to 20 per cent of our community, yet to look at a Commonwealth key responsibility I have to go a long way. Maybe if I did actually know the chart, I would be a lot clearer on where the priority is.

Mr Smyth—Perhaps we could provide you with a lower level breakdown of the area.

Senator WEBBER—That would be good. One of the sections in your submission is about the financing of mental health services, and I notice you have given us a nice chart for the year 2001-02, with what percentage the Commonwealth spends and what percentage the states and territories spend. To get a more accurate perception of 2003-04, because you have given us some precise data and then you have given us some expenditure over five years, I have had to try and add that up for myself while I have been sitting here, so I could have the maths wrong. I am more likely to be close to it than my friend Senator Moore here, because she apparently does not like adding up. She particularly does not like fractions. You have given us the figure for PBS of $591 million.

Mr Davies—Before you go on, give us the page.

Senator WEBBER—Page 11. Your chart for 2001-02 was on page 9. On page 10 your table 3 gives me Medicare benefit schedules in terms of expenditure for 2003-04 and on page 11 you give us what you are going to spend on the PBS. If I take the $591 million and I add to that the $201 million and the $175 million from page 10 and I go back to page 9 and I look at some of the other issues you talk about—the $331 million provided to the states and territories from 2003-08 for public sector mental health reform, the $66 million and what have you—and I add all of that up, I come up with less money for 2003-04 than you have for 2001-02.

I must admit, because I am new to this and the figures are new, where you have said you are spending it over five years, I have just allocated it evenly across the five years because I do not know any different. I come up with a figure that is less and I come up with the fact that well over 50 per cent of your expenditure is on PBS. If you were not subsidising drugs, which is a very legitimate thing—and I am not having a go at that—there is not a huge expenditure commitment from the Commonwealth on mental health strategies.

Mr Davies—We have a numbers expert.

Senator WEBBER—Excellent! He can correct my maths.

Mr Davies—He can do fractions as well.

Senator WEBBER—Well, we're cooking with gas! I warn you that I have to leave in 10 minutes to get a plane to Perth.

Mr Buckingham—I am an independent consultant who has worked with the department extensively throughout the period of the strategy in monitoring things like money and structural change. I have also worked with every state government as a consultant. My background is as a clinical psychologist who has been in the system for 32 years.

Senator WEBBER—Excellent!

Mr Buckingham—I am here by invitation today—not representing the department, because I cannot do that—to assist with any of these sorts of matters that you—

Senator WEBBER—Numbers.

Mr Buckingham—Numbers and dollars and so forth. I will not try and replicate your methodology, because I need a computer to do my maths—

Senator WEBBER—Yours will be a lot more sophisticated than mine.

Mr Buckingham—but I can assure you that the 2003-04 data has not gone down.

Senator WEBBER—It hasn't?

Mr Buckingham—That data has only recently been submitted by the department for the Report on Government Services which, as you know, is an annual report. The ROGS report has, for the last six years, taken a particular interest in mental health and provides a mental health chapter. It wants to get in first before the national mental health report has gone through the extensive validation that is required to get that right. The 2003-04 data, for example, has only come in from the states in the last six weeks. It takes six months to put it through the mill.

The Report on Government Services wants that data to get out there on the streets as soon as possible. The department has just coordinated its preparation of the material to the ROGS people, the Productivity Commission secretariat, I think the week before last, and it showed that the figures continued to go up at the sorts of rates that have been present across the period of the strategy. It would be silly for me to try and replicate your methodology. It is possible that all components that are counted have not been laid out there. They would not have been available when the Senate submission was prepared. It is around $1.2 billion in 2003-04.

Senator WEBBER—I am short then.

Mr Buckingham—$1.2 billion and a bit.

CHAIR—Perhaps Mr Buckingham would be helped if—

Senator WEBBER—Could you take that on notice, because in 2001-02 it was $1.1 billion. It is not a significant increase.

Mr Buckingham—The material that has been given to the ROGS report has been prepared. It is with the department as to whether it would want to handle that. The ROGS report comes out in January.

Senator WEBBER—If we could perhaps have as close as possible the 2003-04 version of this, I will try and work it out. You are obviously spending money that you have not accounted for in your submission, if it adds up to more than what I have. But $1.2 billion is not a big increase from $1.1 billion from 2001-02.

Mr Davies—Certainly tables 3 and 4 do not tell the whole story of what is in figure 1.

Senator WEBBER—No. Then there is this stuff here.

Mr Davies—There are some balancing numbers that need to come into play.

Senator WEBBER—That is right.

Mr Davies—The Productivity Commission tend to be quite rigorous with their embargoes but, subject to that, we will see what we can get for you, Senator.

Senator WEBBER—If we can have a look at that, that would be good. I will then check that against what I have come up with.

Mr Davies—In terms of like with like.

Senator WEBBER—I will probably come back to you. I do have a lot of questions but, like Senator Moore, I am trusting Senator Allison to pursue the issue of better outcomes because I will not have time to stay for that. Ms Lyons, this probably comes back to one of your other sections. One of the issues that certainly the Western Australian Department of Health raised—and we can have the usual jurisdictional fight about what is a Commonwealth responsibility, what is a state responsibility—was the capacity for Commonwealth leadership on the issue of work force planning and our capacity not only to attract and retain current professions but to get professionals that are qualified and registered and not working in the sector any more to come back into the sector to help alleviate the pressure; also to plan for anticipated mental health needs because I do not think it is going away. It seems to be increasing. I would like your views on that.

We were talking to DIMIA earlier. Now I would like DOHA's views on how we can ensure that we attract and retain the best possible people to service not just regional and remote places such as those that Senator Scullion and I represent but Christmas Island and Baxter and what have you. All the professional bodies tell me it is easier to provide a good service to people located within capital cities, and I know it is a very big issue.

Ms Lyons—I was just about to say that you have touched on a very big issue. It is an issue that clearly is at the very front of mind of every government in Australia, because the Council of

Australian Governments has commissioned the Productivity Commission to undertake a study into the whole medical work force in Australia, insofar as there are areas where there are shortages, and has asked the Productivity Commission to consider how we might move forward in terms of the medical work force. I am sure you are aware that only last week the Productivity Commission issued its draft discussion paper with some proposals attached to it. In that regard, we would certainly be guided by whatever comes out of the Productivity Commission report. When a body as expert as it is looks at the issue of the medical work force, it is important to take cognisance of what they find.

In terms of mental health itself, it falls within the broad medical work force, as you would appreciate. There are a number of programs that the Australian government has undertaken over the years to try and attract and retain the medical work force in rural and remote regions of Australia. If you wanted some detail on that, my colleague Mr Lennon is here who could provide you with some further detail on that.

Senator WEBBER—That would be good. Perhaps before he does that, I would like to get some comments from you about whether you think there is a need for more national coordination and national leadership. One of the many problems we have at the moment is that every state health department is poaching from one another. I know that my state recruits from Victoria and New South Wales. Senator Moore's state of Queensland has just stolen half of our mental health staff in Western Australia, as far as I can work out; certainly our former director of mental health—and I am not saying that they do not have a need in Queensland. Every state government also independently tries to attract people from overseas. There does seem to be a lack of a coordinated approach to work force planning and the provision of services for mental health in Australia.

Mr Davies—The phenomenon of poaching—

Senator WEBBER—Perhaps an unfortunate but political term.

Mr Davies—Yes. Short of actually restricting individuals' rights to better themselves by moving around the country—

Senator MOORE—To Queensland.

Mr Davies—in a situation of shortage—and I think Ms Lyons has acknowledged that there are some areas where we do have shortages—you are in a seller's market.

Senator WEBBER—But it is a very piecemeal approach, isn't it?

Mr Davies—No. The work force planning is carried out nationally under the auspices of the health ministers council. It is an area that has, dare I say, the passionate interest and involvement of all jurisdictions, all ministers, and the Australian Medical Work Force Advisory Committee and its equivalent committee that looks at other health professions. They are groups that speak with a lot of authority on these matters. The simple fact is that, given the lead time for training doctors and other health professionals, the government has put a lot of money in the last few years to increasing medical school places, but it will be a long time before they come through the system.

There are a number of very thought-provoking ideas in the Productivity Commission report going to the question—which I think is more the question of the day—'It is all very well to feed more people through the training system, but what can we do in the shorter term to improve access to services?' It will be very interesting to see how that plays out.

Prof. Horvath—Unfortunately, to make things even more difficult, Australia, along with everybody else internationally, has been caught in the same paradigm. Not only are we poaching between states; the poaching is going internationally.

Senator WEBBER—Absolutely.

Prof. Horvath—The difficulty here is that we have been caught with an ageing population with an increasing series of needs, not only in mental health but in all sorts of other health issues. At the same time, the work force participation rate is falling. There is good data from AMWAC from a national study, showing the work force participation rate is dropping considerably. It is an international poaching problem, as well as a state problem.

Senator WEBBER—The anticipated training is one issue, but it is also the case that we do have professionals that are not practising; they are pursuing something else. There is obviously something about immediate attraction or attention that we need to look at in terms of getting them back into the field. The committee has had evidence about that. Perhaps that is something that you could comment on. I am also anxious to hear from Mr Lennon before I run to the airport.

Mr Lennon—In terms of what is happening around health work force issues generally, there is a lot happening in terms of trying to increase the number of health professionals being trained. In answer to your question about particular problems for rural areas, there are a lot of programs that are directed at trying to get more of the available work force into rural areas. On the issue of health professionals being trained, to take doctors first, the government has created, I think, five new medical schools since 2000, and there are another three on the drawing board. That means that the number of doctors graduating will increase from around 1,300 at the moment to 2,100 by 2011. That is a 60 per cent increase. There are a lot more doctors coming through the system.

It is a similar sort of story with other health professionals. For example, the Minister for Education, Science and Training announced an increase of 5,000 in the number of places for nurses up to the period 2008.

There have also been about another 3,500 new places created over that same period for other health professionals. The first part of the answer to the question is that there is an awful lot of additional investment happening at a Commonwealth government level around the education and training of health professionals. Some of this will take time to work its way through the system. We are now looking at a situation where we have shortages—for example, of doctors—that will be largely alleviated but not for another seven to 10 years, when they are fully trained.

That is the point on general education and training. Around what we are doing for rural areas, where we have particular problems—and I will content myself with talking about doctors to start with—the government has a range of programs in place which have been successful in increasing the number of doctors who are being attracted to and retained in rural areas. These

range across the continuum from short-term strategies to longer term strategies. Short-term strategies involve, for example, financial incentives for general practitioners beyond the normal fee-for-service income to operate in rural areas and also regulatory policies involving directing overseas-trained doctors to areas of work force shortage, which have predominantly been in rural areas.

Senator WEBBER—Which is the way most country towns in Western Australia have a GP.

Mr Lennon—Those have been successful. To quote one statistic, the overall increase in doctor numbers in full-time equivalent terms over the period 1995-96 to, I think, 2003-04 in rural areas was about 21 per cent compared with an increase in urban areas of about half a per cent over that period. So a lot more GPs are going to be attracted out to rural and remote areas, where their services are needed most.

On top of these shorter term policies, there are also longer term policies being put in place around trying to train more doctors in rural and remote areas—through, for example, the establishment of a network of rural clinical skills there. We now bond about 20 per cent of our doctors to work in areas of work force shortage on completion of their training, including rural areas. We also have a positive bias in the system in terms of medical selection for universities for students from rural backgrounds. All that adds up to a fairly comprehensive strategy.

Senator WEBBER—You mentioned nurses. Yes, we are going to train a lot more nurses, but that is one profession where I absolutely know we have a whole lot more of them out there than are actually working in the system. Do we have anything in place to, in the immediate term, try to bring them back? What measures do we have in place to train an increased number of mental health nurses, because there is a chronic shortage of them. If you look at their demographic, we are saying at the moment that we are going to give them greater access to our mental health facilities, because that is the way we are going to cover for the shortage of psychiatrists and what have you. Their average age is pretty high, so that is a very stopgap measure and I do not think it is going to last that much longer.

The other issue, which probably goes back to what Senator Moore was saying, is that we have another group of people in abundance but not working very effectively in the system, and that is psychologists. Perhaps one of the reasons we are not getting them back into the system and they are working in the corporate sector or what have you is their lack of access to Medicare, and perhaps that is an initiative that involves attraction and retention.

Mr Lennon—Yes, that is a problem.

Senator WEBBER—What's the plan to fix it?

Mr Lennon—The major employers of nurses by far is the acute care sector, which is the responsibility of the public hospital system, which is the responsibility of the state governments. What we are talking about here essentially in terms of retention are issues like terms and conditions of employment, working conditions et cetera. If you are going to effectively address that problem, you have to address issues like terms and conditions of employment. That is not an area which the Commonwealth can directly impact on, because it is not a direct employer of nurses. The major direct employer of nurses is the acute care sector.

Senator WEBBER—Yes, but does the Commonwealth have any plans to increase training of mental health nurses?

Mr Lennon—Moving on to your question about mental health nurses, I think where the Commonwealth is coming from in the first instance is to put a lot more funded nursing places generally out into the higher education sector. I recognise that mental health nursing is an area of particular need, and that is something that will need to be kept under close scrutiny.

Senator WEBBER—But there is no identifiable plan or—

Mr Lennon—I am not aware of any specific plan around that area at this point in time that I could make publicly available. You will appreciate that the actual funding mechanism for higher education for all health workers, including nurses and mental health workers, is the responsibility of the Department of Education, Science and Training. They may well be able to offer some additional information on that.

Senator WEBBER—I am sorry to do this to you, but I have a plane in half an hour so I have to run.

CHAIR—Thank you, Senator Webber. I would like to go back to the first term of reference for the committee, which is the National Mental Health Strategy and the subsequent plans that have been developed for it. I think it is fair to say that the most consistent criticism the committee has had of the whole service has been the failure of the plans or the strategy itself in setting health targets and goals. Is it possible to get some comment about why that has not been possible so far. Can we look forward to the goals being set in future plans? What is the status of National Mental Health Plan No. 3 in this respect? Presumably, you have also read the submissions and will have understood this as a criticism and have some response to it. Mr Davies, do you want to start?

Mr Davies—Yes, I will kick off and then I think Professor Whiteford is probably far better able to go into the detail. The strategy, as I said earlier on, first came into being in 1992. It has evolved with the five-yearly cycle and it has been subjected to review. From my reading, the reviews were generally positive in terms of what the strategy was achieving.

CHAIR—That was not my question, though.

Mr Davies—Sorry, I thought that was the first part of your question. In terms of the performance measurement, that is an area of current significant activity, where we are developing some quite sophisticated measures of the outcomes that are achieved by mental health services. To say that that is an area that is now neglected is probably to fail to recognise some very significant achievements.

CHAIR—Perhaps you can be more precise about the process you are going through and what we can expect by way of outcomes from that process. Are you working towards a document which will indicate precise goals and targets?

Mr Davies—I will defer to my colleagues, who are closer to the coalface on that one, I think.

Prof. Whiteford—The goals and targets are of two types. One is population goals and targets, where you are reducing the rate of suicide or trying to reduce the prevalence of conditions like depression or schizophrenia. We had them in the mid-nineties and they failed abysmally, because there are no data sources routinely collected for population-level goals and targets. The only one that is collected is suicide rates.

The goals and targets considered in the National Mental Health Strategy were around how much money you spent on mental health, how many beds you had in which place, how many community staff you had and those sorts of goals and targets. There were no national targets set for those because each state started at a very different point.

Therefore, each state had its own goals and targets. They were not national goals and targets. Queensland, for example, had a very different mix of services to Victoria. Having the same target for service mix for both those states would have been unachievable from the first five years and would not have meant anything. What has happened as each national mental health report has come out is states have measured their progress against themselves over time, as well as against each other. That is my brief comment on the national targets.

CHAIR—Because we did not have the data, the goals—and for a number of other reasons you just said the goals did not mean much—a third plan? Are we not getting closer to being able to develop those goals now? Are the same circumstances applying now as they did back in 1992 when the first one came out?

Prof. Whiteford—The data we have now is greatly improved from what we had in 1992. In 1992 we did not know how much money was spent on mental health in Australia. We can do an awful lot better now. What has happened over the 15 years that the national mental health policy has been implemented with three plans is a move from counting inputs in dollars to counting the number of beds to trying to get an idea of what benefits are flowing to people being treated. It is a move to outputs or outcome measurements by putting in place routine outcome measures and other ways of measuring output and quality.

The health ministers have recognised that the current policy and the three plans which are implementing it do need to be updated. We can do a lot better. It was agreed earlier this year by health ministers that Australia would have a new national mental health policy. The steering committee to oversee the development of that policy is being put together as we speak. I think that will take on board issues around how we can hold services more accountable for reaching good performance, given our current data sets which are more sophisticated than they were 15 years ago.

CHAIR—How does this new policy sit with the National Mental Health Strategy?

Prof. Whiteford—The National Mental Health Strategy is the 1992 policy plus its implementation over three five-year plans aligned with the Australian Health Care Agreement and the national statement of rights and responsibilities, so we have really been implementing a 1992 policy. What the health ministers have now said is that we will have a new policy and an implementation of that new policy, taking into account everything that has changed and everything we can do better since 1992, including issues such as performance targets.

CHAIR—I understand how the strategy is feeding into the new policy process, and that is welcome, but will we then have another Mental Health Strategy mark 2, with plans 1 through to whatever?

Prof. Whiteford—Yes, I suspect we will.

CHAIR—The current plan goes until 2008.

Prof. Whiteford—It does.

CHAIR—Do we wait until 2008 before the next plan comes, or will there be one that comes earlier than that time?

Prof. Whiteford—As I understand it from health ministers, we will have a new policy. The first implementation of that will have to be aligned with the next set of health care agreements. We have the current plan, which is signed off by all states and territories and the Commonwealth government and which is being implemented. Any changes in the current cycle would have to be made to the existing arrangements. The new strategy will not start until the next cycle of the health care agreements. That is the way in which the arrangements were put in place for the Commonwealth to fund the states.

CHAIR—We cannot expect any addressing of this criticism that the whole strategy is limited by the lack of coherent health targets and goals? Until 2008 the current arrangement will remain with respect to those goals.

Prof. Whiteford—Government can make decisions about refinements, as they do, during the life of the current health care agreements and during the life of the current plan. Refinements can be made all the time. My comment was to say that certainly issues about performance targets will be taken into account in the new policy and plan which is being developed. There are changes all the time to the way in which services are being rolled out.

Mr Buckingham—May I add one small thing to what Professor Whiteford has said? I have also read the transcripts with a lot of interest. While I understand that people have put forward concerns about targets, it is much more about the input targets: how many staff, how many dollars; things that people want to be able to use in judging whether they have a decent service or not. Am I reading that correctly?

CHAIR—Not entirely, but certainly those questions have been asked.

Mr Buckingham—Okay, but that is what twigged for me. All I wanted to add was that if you put the question of targets into the international domain, there are no world targets. Australia cannot just reach for things such as spending levels or staffing levels. They vary hugely across the world. If there was a gold platter for us to go and take targets, it would be there. These things often become ferociously local because they have to respond to local needs. As Professor Whiteford was saying, that is where things were a decade ago.

A very recent development in the last year has been much more commitment by states to look at the performance of their services, to move away from talking about dollars and to look at what

comes out of the service system. Just last year they agreed through the national working group process to adopt first-generation performance indicators that actually provide windows into service delivery, such as how many people get seen in the first week after leaving hospital; how many people are seen by crisis teams before they go into hospital. Those would never have been considered 10 years ago as being legitimate things to pool. I can say this because I represented Victoria on the other side of the table, responsible for Victoria's planning a department for mental health. It would not have had a bar of pooling and contributing data to the Commonwealth government on those sorts of matters. The states are now coming to the table wanting to participate in that. It is an evolutionary process. You set the indicator; you do not say how far you have to get up to it, but that is where it is going. People have agreed on 13 core indicators that give windows, for the first time, into how services are going to perform. That is where things are going to move.

CHAIR—That is a very positive indication but we do have such things, as we heard this morning, as detention and how someone is to be seen within 24 hours of being brought into a detention centre, and so on. What are the difficult targets to set? The ones about service that border on efficiencies are straightforward, but what are the ones which we need to tackle as a country to improve mental health services? Are you able to tell the committee what your difficulties are in identifying them and spelling them out and achieving them?

Mr Davies—If I could comment, just to share the workload here: as has been pointed out, we are moving from a situation where we counted inputs. We counted numbers of doctors, beds, nurses, whatever. The purpose of a mental health service is not to employ nurses and doctors. The purpose of a mental health service is to make life better for people with mental illness.

CHAIR—I appreciate that, Mr Davies, but the evidence we have been receiving is that it has been inadequate.

Mr Davies—As you were just hearing, it is only relatively recently that we have got the wherewithal on a uniform basis across the nation to start asking the questions that really matter, rather than these poor proxies.

CHAIR—Indeed.

Mr Davies—The indicators that we are looking at for the new plan cover such areas as access to services, continuity of service and appropriateness of service. Those are the sorts of things that we will be measuring. They are fairly abstract concepts, so clearly developing measures is not as simple as just counting numbers of heads but we have made remarkable progress. It sets us on a very good path for the future.

CHAIR—And that will be spelt out in the new policy?

Mr Davies—Yes. I certainly hope so.

CHAIR—Can I just ask you about an example of what comes back and back and back to the committee. It is the revolving door syndrome. We had evidence, and it sounds implausible but I am pretty sure that the figure is right, that the average number of people with serious mental illness who present and are admitted to a general hospital, usually through the accident and

emergency department, is 65 times a year, which means that people are coming back more than once a week. I may be a bit wrong on that figure. Nonetheless, there is plenty of evidence that we have received that the revolving door syndrome is alive and well. Is that a goal that can be set and targets established for it?

Prof. Whiteford—Yes, it is. It is still one of the indicators. The extent to which that is happening and inappropriate readmissions are occurring is a sign of a system under a lot of stress and failing to ensure adequate care out of hospital, often; failing to ensure the continuity of care that people need so that they are maintained in the community. Where the pressure is on, the service retreats to the hospital more. It is dealing with multiple admissions and perhaps issues such as rehabilitation. Certainly this is the evidence, I know, that has been presented by some people to the committee and I would agree with it: that rehabilitation, recovery programs, after-care programs, have been less of a priority because people have been concentrating on all the admissions coming through. But, of course, unless you can adequately look after the people in the community there will be more relapses, which you then have to deal with in your acute service. Continuity of care is a key issue. Inappropriate readmissions are an indicator of failure in the system.

Mr Buckingham—Two of the 13 indicators that I mentioned are specifically concerned with unplanned rapid returns to hospital. One of them is the proportion of people who leave hospital who return in an unplanned way within 28 days. That is within clinical control and largely indicative of a clinical failure as opposed to, say, readmission sometime in this lifetime, which usually reflects a recurrent illness. Indicator 1 therefore monitors it. Indicator 2 looks at what we are doing to actually prevent it, so it is looking at the time of first appointment in the community after you leave hospital, on the basis of world best practice knowledge. Hospitalisation itself is a traumatic process for individuals.

CHAIR—Indeed.

Mr Buckingham—Going home requires very prompt proactive care. If people do not turn up for their first appointment, you go and find them. One of the indicators is how long it takes between the discharge date and the first appointment.

CHAIR—Have you provided to us in your submission those 13 indicators you mention?

Mr Buckingham—I believe the document itself was part of the department's submissions. It is a document that is in the public domain now, on the national key performance indicator framework for mental health.

CHAIR—And it is in our submission.

Mr Buckingham—I believe it was presented as a supplementary paper. It is prepared and published by the department. It is in the public domain.

Mr Davies—It is not attached. I think it is reference 33: Performance Indicator Drafting Group.

CHAIR—The status of that list of indicators is that this is feeding into the policy that is being worked on at the present time. Is that right?

Prof. Whiteford—Yes, that is correct, but the changes in the current plan are occurring now. They are being agreed by states. Most of that work has been funded by the Commonwealth government and all states and territories are adopting those indicators now, during the life of the current plan, as part of the quality and effectiveness theme of the third National Mental Health Plan.

CHAIR—At what point will we see some reporting on those indicators?

Mr Buckingham—My best guess is in probably two, possibly three, years. That is a best guess on the basis of people putting in the systems to collect those, putting in the systems to begin to nationally report them. Probably about two states could do it now. The issue is whether they will go it alone. One of those states, by the way—Victoria—uses these indicators and presents them back now to its agencies. It is doing this to try and get some knowledge about what the indicators actually mean so that it can start setting targets. The indicators are not put out, I believe, onto any public site, but they are ready to go. New South Wales is working hard at it. Whether those states are prepared to publish by themselves without a one-in, all-in effort we are not sure yet. A national committee has been established to move this forward.

CHAIR—What is the name of the national committee?

Mr Buckingham—The National Mental Health Performance Committee. It is a committee that sits underneath the Mental Health Working Group. Consumer and care representatives sit on that committee, because they are very concerned about developing indicators that show their picture, and so they are there to help us develop indicators that we have not yet put in place to do with their perceptions and experiences of care. That group is there to drive this forward and the states and territories are largely represented on that committee. The department, to get it going, to try and pump this system, is establishing next year a series of benchmarking forums. They are providing funding to something like 28 to 30 agencies around the country to volunteer, as they see fit, to participate in a sharing of information and learning about what it means in practice. Those benchmarking forums have only just recently been agreed as trialling for the indicators—largely to advance them, to move them forward as fast as possible. They commence in March of next year.

CHAIR—Mr Buckingham and Professor Whiteford, you are authors of a paper that said the pace and extent of change has not been enough. Is what you are doing now enough?

Prof. Whiteford—Nothing is ever enough. The majority of people with mental illness in Australia do not receive any treatment at all, so we have a long way to go, and there are many experiences that consumers have in services which is far from satisfactory. We certainly do not walk away from that. I think the system is substantially better than it was in 1992 and, having returned to Australia from the World Bank and seen the systems in many other countries of the world, Australia has a lot to hold its head up about, but there are certainly many examples of where the system is not working, so we just have to keep going. We have a long way to go.

Trying to understand how to make the system better by performance measures is one important thing, but getting the resources on the ground to treat the people who have not been treated, to ensure that the quality of care is appropriate, is a big challenge for Australia, and we have not risen and met that challenge yet. I am proud of the Australian system and I think one of the reasons that I was recruited to the World Bank was because Australia was recognised as having a credible national system, but, as the evidence before this committee shows, we still have a long way to go to get mental health to the level that we would expect for other health conditions.

Senator MOORE—The work that you are describing is being done in Mr Smyth's branch. Is that right?

Mr Smyth—That is correct.

Senator MOORE—In which bit?

Mr Smyth—It is in the quality and effectiveness section.

Senator MOORE—You are developing those standards within the quality and effectiveness?

Mr Smyth—And we are working with the National Mental Health Working Group. It is in collaboration with the National Mental Health Working Group, so it is across all jurisdictions.

Mr Davies—And I have now a copy of the performance indicator report.

CHAIR—Is it the wish of the committee that that be tabled?

Mr Davies—It can indeed.

CHAIR—Thank you.

Prof. Horvath—Senator, these sorts of performance indicators is where we are going with the Chronic Disease Strategy also, because what pertains here pertains to all chronic diseases. Readmissions and the sorts of things we have been talking about for the last 10 minutes are the same markers—if you do not manage heart failure properly, for instance, they will bounce back—and I do not know the sorts of figures that are bandied around for the rest of chronic disease, but they are equally startling. Chronic heart failure that is not managed appropriately has a large number of readmissions. The strategy is looking at those links: when you leave hospital with any of the chronic diseases or multiples, how can you actually make those links with the community practitioner and all the other services to try and avoid unnecessary readmissions? There is an integration across that whole area, so the branch mental health currently sits in is very logical place for it to sit. It might not appear so at first.

Senator MOORE—Yes, I am hoping to be convinced.

Prof. Horvath—Yes, I think it is the right place. Whether the headlights are enough I do not know, but it is the right place to sit; otherwise, it will be out there on its own again.

CHAIR—Another indicator that is commonly raised is the dollars and, whilst we might spend them more effectively, it is the case that the dollars that end up in mental health are not, as a proportion of the disease burden, as the phrase goes, proportionate. Is there a comment to make both on the Commonwealth and the state contribution to mental health services in terms of its sufficiency?

Mr Davies—I am not sure you were arguing this, but to argue that the spending should be proportionate to the burden of disease is not a safe line of argument to pursue, because obviously the costs of treating different types of conditions vary. Just because something is 10 per cent of our burden of disease, to argue we should spend 10 per cent of our health budget on it is not really a logical line of argument.

CHAIR—What is the argument? What is the line of establishing what the level of spending is for particular burdens of disease?

Mr Davies—Spending in health care and the allocation of resources between different conditions is essentially a social, political, societal decision. In terms of the services we fund, as the Australian government, all that Medicare spending, the PBS spending, is ultimately determined by people's propensity to seek out services and doctors' propensity to prescribe. There is no cap on the total MBS or PBS budget, nor is there an allocation of that as between mental health and other services. It is very much demand driven for the Australian government funding. In terms of the state and territory government funding, obviously we have no control, nor would it be appropriate for us to seek to have any control, over how state governments allocate their health budgets. They are accountable to their own electorate as to how they do that.

CHAIR—Do you agree with that, Professor Whiteford, that the negotiation through the National Mental Health Strategy with the states should not broach this question of how much is being spent? If there is such a failure to make progress on mental health issues and, as you point out, such a large number of people who receive no service, is expenditure not a factor that the Commonwealth takes up with the states?

Prof. Whiteford—I lived through the time of quarantining the inputs, when we did quarantine them under the health care agreements, or the Medicare agreements as they were. That was a mixed blessing; quarantining becomes a cap as well as a floor. The reason that was done was to try and ensure that the dollars followed the patients into the community when some hospital beds were still being closed. It might have been okay for that, but I think, rather than trying to set financial input targets, I would much more try and set how many people were treated and their outcomes, so that it was looking at a patient level outcome mix and a performance mix, rather than a financial mix. There are many examples of more money going into a dysfunctional and ineffective, inefficient system that does not produce good outcomes.

We would all like to see an increase in the amount of dollars going to the treatment of mental illness but, as Mr Davies said, that is largely determined by patients coming forward for treatment; how many services are available for them. Some of the reasons that people do not come forward for treatment, according to the ABS survey, are around issues such as stigma and discrimination, as well as mental health illiteracy, so I think we have to tackle those sorts of issues—and we have. There is some evidence that more people are now coming forward for

treatment because of that. If they come forward for treatment, under the uncapped MBS and PBS schedules they will be treated.

CHAIR—The Mental Health Council has estimated that $1.1 billion more a year over the next 10 years is necessary. What was the Commonwealth's response to that assessment? Are there any plans to look at it in a serious way?

Mr Smyth—Senator, where did that figure appear from? Where was that?

CHAIR—The Mental Health Council of Australia's submission.

Mr Smyth—We are obviously constantly reviewing the amount of expenditure in mental health care.

CHAIR—You missed that one.

Mr Smyth—There have been a number of organisations and bodies who have been advocating for greater funding for mental health, as there are for other health priority areas. That is a matter that we have to take on board in the budget context. In many respects, sums like that become political decisions as well.

Mr Davies—As Professor Whiteford said, whether it was half that amount or double that amount, we should not just talk about the dollars. We should be very concerned about how those dollars are spent. I am sure their submission has some very constructive suggestions as to where those dollars should go. But I think we need to move the debate on from talking about quanta of money to talking about services and outcomes from those services.

CHAIR—Indeed. They say what is needed is leadership, accountability, governance and investment in research and innovation. I do not think that they are suggesting throwing money at a system without those precautions in place.

Mr Davies—That is good to hear.

CHAIR—Another core issue is that the money that is thrown at the system has gone to the acute end of the spectrum. This committee was in Shepparton only a couple of weeks ago. We were told and in fact shown and had a very good discussion about what seemed to me to be a very straightforward approach but is highly innovative—that is, the state area mental health service had done a collaboration with an accommodation service, a non-government organisation, and solved what comes up time and time again—supported accommodation for people coming out of mental health facilities. Is this not an area that the Commonwealth could grasp and see replicated elsewhere, given the Commonwealth's role in housing and supported accommodation?

Mr Davies—Of the parties you have described in that model, one side obviously is the state mental health services.

CHAIR—Isn't that why we have a National Mental Health Strategy that involves the states? Why is it that the Commonwealth cannot pick up on ideas like this and deliver them through that strategy?

Mr Davies—I am sure that there are very good ways within the strategy and all the other fora in this sector to share those positive experiences. The Commonwealth does come to the table there on the housing side, which is more the area of our colleagues from Family and Community Services. I am sure, if they are aware of that initiative, they will be happy to talk about it.

CHAIR—We will ask them. I am hoping this discussion is about leadership and about the Commonwealth and its role in leadership. Professor Whiteford, is this an area that you and Mr Buckingham have focused on?

Prof. Whiteford—One of the real challenges for people with psychiatric disabilities living in the community is how they are linked to the range of Commonwealth and state, public and private, non-government services which they may need to have good quality of life, of which only one small wedge turns out to be mental health. There are their links to their GP and their physical health, housing, disability support, and on we go. One response to that, Senator, would be to think about some national model of case management for the identified individuals for whom that linkage is critical. That is not everybody, but it is a significant majority of, I think, the consumers who are now inadequately supported in the community: a mechanism by which we support them being linked into those services, of which housing turns out to be only one. I think that is where the difficulty is. If you have a PhD in social work, you could probably find your way around all the services.

CHAIR—I did not go into all of the details of these. There are two programs, and part of it is to link them with all of those people, and it has been done effectively under current arrangements.

Prof. Whiteford—Yes. There are several other examples around Australia where locally it is being done well. I think that taking those models that work and making it national would be something that could be taken up under the National Mental Health Strategy, as it has been for other areas of mental health service delivery, where we have taken national service standards or legislative reform and made them national. It is possible to do that. It requires the goodwill of the states and territories and departments other than Health, but I believe that is important.

Mr Buckingham—Within the beds that more or less replaced the functions of the old longer term hospitals, most of the development up to 2002 was occurring in Victoria. Queensland are only starting to now develop similar beds. The way I read the states—and I go around and work with them—is that it is now being picked up by other states, 10 years after Victoria. The senator from Western Australia is not here, but they are building new arrangements with the non-government sector.

I know that you have had evidence in regard to the HASI program in New South Wales. That involves a large investment. My view is that there is a general acknowledgment that this is an area where development was too slow in regard to housing and accommodation and that people are now starting to invest in that through a spectrum of services. It is not as if everybody needs a staffed bed. They may need something like the HASI program or they may need non-

government type of support. Sometimes they need beds in the community which are staffed 24 hours a day by mental health nurses. I have been watching this closely for 10 years, from a monitoring perspective, and I am starting to see hopeful signs occurring other than in the south-east quadrant of Australia.

CHAIR—To what extent does the National Mental Health Strategy drive that?

Mr Buckingham—From the Commonwealth's point of view, all it can do is report. Every year in its national report it says, 'Hey, we are not developing this as fast as we should.' It says things like, 'For every four long-term beds that have been closed, there has only been one residential bed opened.'

CHAIR—Should we rename it 'a report' then? It is not a strategy at all.

Mr Buckingham—It cannot put its hands on the levers and change the clocks or whatever. It does this through a complicated process. When I entered this, someone said to me, 'Change is really long term but the first 25 years is the hardest.' Counting my bureaucratic period—the time I stopped treating patients—I am into my 15th year, so I am thinking, 'They were right.' It should have happened yesterday, last year, last decade. I am reading that it is starting to happen now. My personal view is that the role of the Australian government, in reporting on this stuff, is putting it up-front every year and keeping it there so people can look at it. Organisations like the Mental Health Council of Australia can rightly take that information, because it is trustworthy, and go out and advocate—bring these things forward to people—so that there is proper action.

Prof. Whiteford—Mr Buckingham is talking mainly about the report there. I think there are things which are agreed on by all states and territories, and signed up to, and for which often the Commonwealth government provides funding under the National Mental Health Strategy. All states agree to go away and do it and then the reports measure whether or not they do it. I think it is getting those things right that is important, because they are the high national priorities. The performance measures are an example of that. Getting everyone accredited against national service standards is another example of that.

Where the system is failing now is around the continuum of care, where there are crisis points in that continuum. One response to that, which I was suggesting a minute ago, would be around a national case management model. That may not be the right way to go but it is the sort of thing which could be tackled under a national mental health strategy. I think we should be looking at the examples such as you mentioned and saying, 'If that's really working in Shepparton, is there any reason why it couldn't work in central Sydney or in rural Western Australia?' If it can, or if it could be modified to do that, we should take it on board nationally and drive it. Then the national report should measure and report publicly on how each state and territory is going in introducing that model of care which their minister has signed up to.

CHAIR—Indeed. I am aware that the program is for us to finish this session at 12.45. I have more questions and so do my colleagues. With your indulgence, we will take a break now but come back to this department. Is there anybody for whom that is a problem?

Mr Davies—It is not a problem, but we have a great panoply of people here.

CHAIR—I understand that.

Mr Davies—If you could narrow it down to some specific programs or areas, it might enable some officers to go back to the department.

CHAIR—I do not think we do not want to ask anybody about anything. It is just that we need to expand this session a little longer.

Mr Davies—You want to keep all avenues of inquiry open?

CHAIR—Yes, I am afraid so.

Mr Davies—Having said that then, presumably we are breaking for an hour?

CHAIR—Do you need an hour?

Mr Davies—No.

CHAIR—Then I am sure we could manage with three-quarters of an hour.

Mr Davies—Could you guesstimate from 1.30 how long you will need, just so people can make arrangements.

CHAIR—I think some of us have time frame problems that mean we cannot go much beyond the current timing, so we will have to finish at the allotted time.

Mr Davies—My agenda has a whole list of other departments as well.

CHAIR—It is my guess that we need less time than was allocated for the other agencies than this agency, but I am afraid we cannot predict that precisely. We are fewer in number this afternoon, so that they make a difference. My guess is that we will be able to move through those more quickly. If we are not able to do that, we may even have to ask you to come back at some stage.

Mr Davies—On behalf of people from other departments, do you still want them here available as well?

CHAIR—Yes.

Proceedings suspended from 12.48 pm to 1.34 pm

ADDISON, Ms Linda, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing

PRIMROSE, Dr John, Medical Adviser, Pharmaceutical Benefits Branch, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting First Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing

MOULD, Dr Janet, General Manager, Program Review Division, Medicare Australia

CHAIR—Welcome. Senator Humphries?

Senator HUMPHRIES—Thank you, Chair. I want to start with some questions about medication, the PBS and its involvement in dealing with mental illness. I note in the submission the reference to an increase in spending of about 128 per cent since 1992 by the Commonwealth government. That point, when it has been cited, has been criticised by some of the witnesses before us on the basis that that increase in expenditure has been very largely through increases in the PBS. I was wondering if you wanted to react to the question of whether increasing so substantially your spending through the PBS has necessarily been the best policy—whether we have, because of the availability of extra spending in that area through the Commonwealth government as opposed to perhaps more spending on therapies at other levels, overemphasised the medication option and whether there should be a strategy in some way to minimise or to see alternatives to medication in this area.

Mr Davies—I think you are going to some fairly detailed issues of clinical practice there, so yet again I am going to have to defer to one of our clinicians. An observation, though, from the bureaucrat perspective is that, of course, from the Commonwealth's point of view, this is not a zero-sum game. It is not as if, by spending more on pharmaceuticals, we are taking money away from another area. As I explained before the lunch break, the MBS and the PBS are both fundamentally demand driven. We are not spending on pharmaceuticals at the expense of other forms of intervention within the overall Commonwealth area of responsibility.

I think it is also fair, from my reading of the situation, to say that there are many things in the mental health arena that we can now address to some degree through medication which 13 years ago we could not. It is at that point that I hand you over to Professor Whiteford again.

Prof. Whiteford—The first line of treatment should be non-pharmacological for the majority of mental disorders. For common mental disorders—depression, anxiety—the first line of treatment should be non-pharmacological. The problem we have had there, from my perspective, has been the skill base of the primary care clinicians—general practitioners—and primary care nurses to provide effective psychological intervention, such as cognitive behaviour therapy, and I think a lot of the work that has been done under the Better Outcomes in Mental Health initiative has been to upskill and encourage greater skills at a primary health care level.

I think the apparent imbalance has been about the ability to provide a prescription for a pharmaceutical agent and the time that takes versus the training and the support that primary care clinicians have had in the past to provide effective psychological interventions, which take a lot longer than it takes to write a prescription.

Senator HUMPHRIES—In saying that the first line of treatment for the majority of conditions ought to be non-pharmacological, are you saying that that is actually what we achieve at the moment in Australian policy with respect to mental health?

Prof. Whiteford—The majority of people with anxiety and depression do not see a health professional at all. Of those that do, 75 per cent of them see their GP and I would think that a large percentage of those would get a prescription for a pharmacological agent. What I would be hoping is that they also get psychological treatments—counselling, cognitive behaviour therapy—and I think increasingly they are. Some are getting prescriptions instead of non-pharmacological treatments, and I think non-pharmacological treatment is a practice that we will have to continue to work to encourage.

CHAIR—Isn't that a problem with our Better Outcomes in Mental Health program, in that they tend to be prescribed pharmacological products and then go off to do the cognitive behavioural therapy or whatever else?

Prof. Whiteford—I do not think there is anything under the Better Outcomes program which requires the prescription of pharmacological—

CHAIR—In practice, that is what happens.

Prof. Whiteford—That is more about the way doctors get trained in medical schools, I am afraid, than the Better Outcomes in Mental Health program. Unfortunately, we have trained doctors to prescribe medications more than we have trained them to provide psychological treatments for mental health problems.

CHAIR—What does the training do in respect of this question?

Prof. Whiteford—It provides knowledge and skills for non-pharmacological interventions. A general practitioner, for example, would receive training to do focused psychological interventions, which for many mental disorders should substitute the pharmacological treatments. Then pharmacological treatments become what you use if the focused psychological interventions fail.

CHAIR—Does the data we have for those doctors who take part in the Better Outcomes program show us that there is less of a propensity for prescribing?

Prof. Whiteford—I do not know the answer to that. I have not seen an analysis of the data that way.

Senator HUMPHRIES—Are there any stats on the common forms of treatment by GPs of mental illness, as in CBT versus drugs versus referrals, for example? Do we have figures of that kind?

Prof. Whiteford—The data on what GPs are using to treat mental disorders?

Senator HUMPHRIES—Yes.

Prof. Whiteford—The only data I know of that reflects that is the BEACH data, which is a very small sample of general practitioners. I would defer to one of my colleagues who might know more about that dataset than me.

CHAIR—We don't fund BEACH any more, do we?

Mr Davies—We do, Senator. We just fund it on a different basis to that on which we used to fund it. In terms of the data that it produces in this particular area, we would probably have to run a special query to find that. We would have to interrogate the database to find that.

Senator HUMPHRIES—It would be useful, I think, if it is possible to put all that down without too much time taken in doing so, to know what the response of GPs is to mental illness. We have heard this is the front line for the majority of people. Perhaps it should not be but it is, and having information about just what they are doing to respond to mental illness would be useful.

Mr Learmonth—My guess is that it would be very hard to pick up any sort of relationship because you are looking at a comparator not against their normal population or people they would otherwise see, but that specific group, who might well be presenting for the first time. Whilst it might be possible from the data to get an idea of what the prescribing habits are in relation to those people, it is getting a comparator to make a judgment, and I am not sure it would be possible.

Senator HUMPHRIES—Are you saying that the data held by the department would not be able to do that now or that you would not be able to obtain that data if you were, say, to survey doctors on that subject?

Mr Learmonth—I dare say it might be possible one way or another to come up with that data from one source or another, whether it is something that we hold or, more likely, a survey. My only question would be what you would do with it. If the question is, 'Does their training and the provision of non-pharmacological strategies have an impact on their prescribing?' you need a comparator that is relevant to the group of people that you are measuring the current consumption on.

Senator HUMPHRIES—It would be useful to know, I would think, whether Australian doctors are preferring non-pharmacological treatments over pharmacological ones, and we apparently do not even have that information, do we? We know how much is being prescribed overall but we could not say with accuracy what the responses to particular mental illnesses are by doctors in terms of what is happening in their surgeries.

Mr Davies—None of the routine statistics that are held by Medicare Australia would give us the full picture of services delivered by GPs for people with mental health problems, simply because they are not separately identified as a claim for a level B consultation. Clearly we can pick out those that are charged to the Better Outcomes program. I am not sure we could even

necessarily link prescribing to those particular services. Rather than going to mainstream claims data, I think you would only be able to explore this area through the use of special surveys. That is something we could look at in terms of whether you can ask those questions of BEACH or any of the other GP activity surveys.

I think Mr Learmonth's point is, in a sense, what is your control. We could look at the mix of interventions for patients who present with mental health problems, but to actually then say whether that is different according to the GP's background would be more difficult. The overall picture in terms of the mix of services—

Senator HUMPHRIES—It would be better to have this information in any case, irrespective of whether there is no control sample to put against it.

Mr Davies—Yes.

Senator HUMPHRIES—The absence of that information is a matter of concern to me. I think the overwhelming majority of those mental illnesses being treated and dealt with each year in Australia is happening in GPs surgeries, but we do not know exactly what they are doing.

Mr Davies—There are a number of surveys and data collections that do look at GP activity at a level of detail that Medicare Australia does not have. The question is could we, short of commissioning a special study, extract that information from any of those databases? GPRN, I am told, is one of the other—

Senator HUMPHRIES—Anything you could extract would be useful.

Mr Davies—We will certainly have a look.

Senator HUMPHRIES—I am interested in seeing that. It would be interesting to have medium- to long-term surveys of doctors if there were funds available for that kind of work by the department or somebody else. Can I just go down one level, with this question of medication, to the specific question of the prescribing of Ritalin in WA. I do not know if you have seen the evidence that the committee received about that particular issue and the apparent extensive overprescribing or prescribing much above the national average—put it that way—in that state for ADHD type conditions. If anyone has seen that evidence, do you have a response to it? Do you have a view about what it suggests is going on in Western Australia?

Prof. Horvath—Senator, thank you. This has been an issue that has come to the department on a number of occasions. We sought advice from Professor Jill Sewell from the Centre for Community Child Health in Melbourne University. She is also the former president of the College of Paediatrics and now the president of the College of Physicians. This is an area of quite considerable expertise and it is an area of concern. She and others in the field are of the view that this is not in fact an overprescribing. In Australia, due to some concerns about prescribing in general practice, it used to be only from specialist paediatricians and there were all sorts of restrictions around it. Perhaps we can take on notice the dates when those changed.

This is a very appropriate form of medication for children with ADHD and the view of that group of experts is that there is not overprescribing in the community. In fact, by some

international standards there may be underprescribing because of concerns of general practitioners of media and other interest in the whole area. We have been reasonably reassured that the issue of Ritalin is not a matter of overprescribing or inappropriate prescribing.

Senator HUMPHRIES—Are you saying that they might be underprescribing by international standards in Western Australia?

Prof. Horvath—No, I am not talking about Western Australia particularly; I am talking about nationally as a whole.

Senator HUMPHRIES—Is that advice on a record that we could see?

Prof. Horvath—I will just have to seek some bureaucratic help here, Senator. It is a letter from Professor Sewell to me, which then was a part of policy advice to our minister. I think we need to check with Professor Sewell.

Senator HUMPHRIES—Sure.

Prof. Horvath—I suspect she will be quite happy about it.

Senator HUMPHRIES—Whatever you could provide would be good. There might not in this case but in other cases be practices by GPs in prescribing which are excessive by international standards, for argument's sake. We have processes in this country to test the efficacy of particular drugs and treatment regimes. It was pointed out to us that in Western Australia there is no agency which functions to overview that level of prescribing of particular medications across the board. Obviously, if an individual is prescribing to an excessive level, there is some activity within PBS schemes to deal with that. Where you have a pattern of overprescribing across a community, there is no mechanism for dealing with that. You suggested to me that the Ritalin issue is not the concern that it appears to be. Would you say there is a need for an assessment of that problem across the board in the Australian community, obviously not just in respect to mental health but generally speaking?

Prof. Horvath—Others of my colleagues can describe some of the extensive measures we are doing through the National Prescribing Service and others. Dr Primrose might be able to give you chapter and verse. The Commonwealth in fact is doing a lot. There are also within the states, under their various state acts in relation to prescribing, a number of monitoring mechanisms. Most of those are around different schedules of drugs but there are a number of avenues for looking at these issues, as well as a large amount of educational material. A lot of it has been tested. Now I will hand over to Dr Primrose.

Dr Primrose—The National Prescribing Service has been funded by the government for some years now to provide advice to doctors about prescribing and also provide advice regarding medicines to allied health professionals. The NPS tries to promote rational prescribing by operating on the four principles of rational drug use. The first is judicious use of medicines. As Professor Whiteford was saying, not all patients with mental illness need to have drug therapy. Judicious use applies to deciding whether to use drug therapy or not. Then there is appropriate selection of the medicine for the patient, according to the features of their illness. Then there is safe use of the medication in terms of appropriate dosage, avoidance of co-prescribing of drugs

that can adversely interact and so on. Then there is efficacious use to ensure that the goals of treatment are met.

With drugs for mental illness specifically we would expect that the caring practitioner is not only prescribing drug therapy but using other forms of therapy like psychological therapy and doing whatever he or she can to promote the patient's social network as well to maximise the effectiveness of treatment. Obviously this is where the team approach to mental illness care comes in. The National Prescribing Service does provide feedback to doctors in terms of their prescribing by classes of drugs, obviously not just drugs for mental illness but drugs across the board. The doctor can benchmark his or her prescribing against his or her peers.

The other organisation that obviously has a role in this is Medicare Australia, which Dr Mould is here to represent. That would be particularly looking at unwise overprescribing. Perhaps I should ask her to comment on that.

Dr Mould—We are tasked generally with considering, reviewing, monitoring, detecting, compliance, Medicare and PBS. Can I approach the answer in two ways: we have a regular review of servicing by doctors, which involves quarterly reviews at which we identify anomalies of practice or outliers outside practice, either in servicing under Medicare or in prescribing.

We also have an annual program of targeted analysis on specific areas of interest. We adopt a number of methodologies which, first of all, can simply be about education to prescribers about the correct use of the PBS—and we are only talking about the PBS here. We can then use targeted feedback to prescribers that we identify as perhaps being outside the norm, to provide feedback again about their level of prescribing on the PBS and remind them of their obligations under the PBS.

We seek advice in the course of doing that from the appropriate specialty or craft group who are considered to be leaders within that area, and include that advice to the prescriber. Where we have what we would call significant concerns—in other words, where a doctor has been identified as being significantly outside the norm—we would contact them individually.

Senator HUMPHRIES—I am not really so interested in individual doctors who might overprescribe, although that is a problem that you obviously have to deal with. I am more interested in what the landscape of prescription practices looks like, compared with international practice. Do we prescribe particularly mental health medications in the same way as other nations do; do we prescribe more or do we prescribe less? Do we have any data that would answer those questions?

Dr Mould—I would have to refer you to my colleagues in Health on that, Senator, simply because we are particularly focused on monitoring prescribing under the PBS in Australia.

Prof. Whiteford—I do not have any international comparative data on that.

Senator HUMPHRIES—When you say you do not have any, do you mean that there is none available or that you are not aware of any?

Prof. Whiteford—I am not aware of any.

Senator HUMPHRIES—I might ask the department to be so kind as to see if there is such data and put it in front of us. It is fairly central to the issues that we are looking at in this inquiry. Information like that would be useful.

Mr Davies—We will see what we can get. Again, I will put a bit of a caveat around it, because you are looking at health systems where there are varying degrees of financial barrier to accessing pharmaceuticals.

Senator HUMPHRIES—Yes.

Mr Davies—That is a bit of noise that would be in that data. But it certainly is an interesting thing to explore and we will see what we can find for you.

Senator HUMPHRIES—Thank you. I want to move from medication to the Better Outcomes in Mental Health strategy and look at the extent of take-up of that training program among doctors. Clearly there are benefits in having access to such training but there is only a limited number of doctors who have taken it up. What is the view of the department about the extent of gaps or unevenness in treatment for people with mental illness across the country because there is both inconsistency of training for doctors in this area—we have heard ample evidence about that—and the lack of take-up of Better Outcomes type programs? What does it say about the extent of capacity amongst GPs to deal with these problems?

Mr Smyth—From the available evidence, we have found so far that the Better Outcomes program has been highly successful. It has made a very positive impact on people with a mental disorder. Approximately one-quarter of GPs are currently level-1 or level-2 trained in the program and those figures are continuing to rise. We understand from our discussions with the Better Outcomes Implementation Advisory Group that they perceive there are still some problems with regard to that take-up. As I mentioned earlier, at the Adelaide workshop we took a significant amount of advice on some of the barriers to take-up from the group. They are now under consideration within the department.

Senator HUMPHRIES—What sorts of barriers are we talking about?

Mr Smyth—Some of the barriers raised were around the cap that is currently placed on the focus psychological strategies, which is $10,050, and equates across a 12-month period to 67 three-step mental health processes. Another area was access to training for GPs to become accredited under the program. Some of the other areas were related to access to psychologists as the component work force for the Better Outcomes to be able to refer patients to.

CHAIR—What has been put in terms of that access? What arguments were being suggested to you by way of change?

Mr Smyth—It related to the number of psychologists that were in urban areas as opposed to those that were in rural and remote areas. Therefore, there were some difficulties in accessing some of those services.

Mr Davies—If I could add another factor which I think is sometimes overlooked: ultimately it is the propensity of the individual GPs to participate. We can offer incentives, but GPs are by no

means a homogenous population and some will choose not to engage in this sort of training and this sort of service delivery.

Senator HUMPHRIES—Or have the time to commit to that process.

Mr Davies—The time and the willingness are probably the two requirements, yes. We can offer the service, but if they choose not to avail themselves of it, we are fairly limited in our ability to press them.

Senator HUMPHRIES—This leads to the argument that has been put to us—that others should have access to Medicare provider capacity with respect to psychology and so forth; to access that kind of service. What is the department's reaction to that?

Mr Davies—I think that is the issue we explored this morning. We have expanded psychologists' access to rebates in a particular way at the moment. It is an area where there are arguments on both sides—for and against—and it is for the government to keep the situation under review and move in whichever way it deems appropriate.

Senator HUMPHRIES—I have a Medicare question. It was put to us in Victoria that there would be a better range of outcomes for people who are prisoners in state prisons if they were able to access the Medicare system through local health practitioners. This was not, I suppose, a particular comment that applied so much to mental illness; I do not imagine that there would be many people, particularly in regional and rural areas, who would be able to help in that respect. Do you have a reaction to that particular proposal—in other words, people in prison should be able to access a provider of a service; presumably, the provider would be willing to come to them, in much the same way as anybody else?

Mr Davies—Samantha obviously will elaborate. Fundamentally, I think it is deemed to be part of the state's responsibility to provide prison services; they provide health care for the people who are within their confines. Is that correct?

Ms Robertson—That is correct. Section 19 of the Health Insurance Act has provision within it, and says that Medicare benefits are not payable where a service is rendered under an arrangement with a state. Correctional facilities and the medical services that are provided to people within those facilities would be regarded as being under an arrangement with a state.

Senator HUMPHRIES—It is a division of responsibility issue.

Ms Robertson—Yes.

Senator SCULLION—I have a question on the Medicare benefits issue in a general sense. In Western Australia at Port Hedland, for example, one of the issues that confronts many people in those remote areas is the capacity of the staff to have a clear enough understanding of the way the process works to ensure that they have all the paperwork up to date to enable the face to face meetings that they have with clinicians and whoever else to be effective.

We can cite places like congress in Alice Springs. They just have it right. They have, over my time, gone from three and four doctors to 12 full-time doctors. They have psychologists and they

are considering going to an even larger extent. That is all on the back of having a system that can effectively access Medicare benefits. How do you think we might go about ensuring that that level of amenity is spread? It is obviously just attitude, training and a better understanding of the system. How do you think we can ensure that that system and that that access to those sorts of things are spread to other areas?

Mr Davies—In the case of the AMS—the Aboriginal Medical Service—their funding is not just through the MBS.

Senator SCULLION—Indeed.

Mr Davies—My impression—and maybe my colleagues from OATSIH will confirm this—is that they have a level of organisational capacity in terms of support staff which probably makes it easier for them to maximise or optimise their access to MBS services. An awful lot of one- and two-GP practices are still struggling with the idea of having a practice manager to take some of the administrative workload. In that sense, I think the AMS is probably ahead of the game.

Probably the more significant barrier to accessing MBS—and it is one that the department and our colleagues in Medicare Australia are tackling actively—is the numbers of Aboriginals and Torres Strait Islanders who do not have Medicare cards. There has been a significant push in the last couple of years to improve uptake of Medicare cards amongst those communities.

Senator SCULLION—Congress holds duplicate Medicare cards for everybody in that area, so that makes a vast difference to them.

Mr Davies—Medicare Australia have excellent Indigenous liaison officers, who are very active in promoting and encouraging people to obtain Medicare cards. I think a lot of AMS and other Aboriginal health service providers are equally very vigorous in promoting the fact that you have to have a Medicare card to access Medicare benefits. To the extent that there is a barrier, I would put it more in the case of not registering for Medicare but I would also convey quite a positive message that we are addressing that issue.

Senator SCULLION—Thank you.

CHAIR—In relation to the Better Outcomes program, it could be argued that the least well trained GPs are providing the most mental health services, by virtue of the fact that you only get to refer patients to someone who is a specialist if you have done the training. Was the decision to go down that path one of containment of this program or is there a clinical reason why a GP is in a better position to refer, having done that training, than otherwise? It seems to me that we have a lot of people being treated by GPs who have no training and no planning in place for taking this to the broader group.

Mr Smyth—24,000 consumers have been treated under the Better Outcomes program.

CHAIR—Out of how many?

Mr Smyth—That is the number of people that have actually come through the door. There is obviously still the option for GPs to refer to psychiatrists, as you would refer to any other specialist, if the GP deems that necessary.

CHAIR—Mr Smyth, you would know as well as I do that anyone can go to a psychologist without a referral. The point is that it is Medicare funded.

Mr Smyth—There has also been expansion as a result of the red tape review to embark on the chronic disease management items for Medicare, and that enables GPs who have not conducted the Better Outcomes training to refer patients to psychology services.

CHAIR—How many of those have taken that psychology—

Mr Smyth—I would have to refer to my colleagues in the GP programs.

Mr Learmonth—There were about 23,000 mental health consultations under the allied health initiative last year.

Mr Davies—Just to be clear, who were those consultations with?

Mr Learmonth—Psychologists.

CHAIR—In relation to my question about the clinical evidence that gives rise to going down this path, I do not know, Professor Whiteford, if you can contribute to that.

Prof. Whiteford—You could take the position, Senator, that you took; that the GPs who have less interest in mental health—do not bother to do the training—should be the ones who get better access to the psychologists who have the skills. I think the view that has prevailed is that we want to encourage all GPs to upskill and the quality of the referral to the psychologist is greater than the knowledge base of the GP. It may well be the case that that, therefore, has assisted with the constraint issue.

I have sympathy with your view that the patients of GPs who are not interested in mental health should in some way get support if they have mental health problems. As Mr Davies said, there are some GPs who will not ever be interested in mental health. It is not their area and they do not like it particularly, but they may well have patients with those issues. I do not think this strategy necessarily helps them as much as those GPs who are more interested in mental health, so we needed to broaden the strategy as we work it through.

CHAIR—Did the review that was conducted a short time ago investigate those questions?

Mr Smyth—In terms of the lapsing program review?

CHAIR—Yes.

Mr Smyth—I am not really in a position to talk about what the review did and did not do. That is budget-in-confidence.

CHAIR—Is there to be a decision made about when that review will be released?

Mr Davies—Those lapsing program reviews are carried out within the budget context, so they are subject to the normal budget confidentiality.

CHAIR—After the budget, is it likely that that review will be made available publicly?

Mr Davies—I am not sure they even become available then.

CHAIR—Mr Learmonth, I think you were talking about the $63 million underspend a little earlier.

Mr Learmonth—I was not, but I am able to, Senator.

CHAIR—Is there a budget for that which is equal to the underspend? Is the government going to achieve the original target of funding for better outcomes in mental health?

Mr Learmonth—I am sorry, I am not sure which underspend you are aiming at here. There are a couple of things it could be. One is in the mental health service incentive payments, part of the forward estimates, which we used to fund the new chronic disease items. There is the allied health measure.

CHAIR—The service incentive payment and the MBS component of Better Outcomes in Mental Health Care program were underspent against their estimates for those components by about $63 million. Do you agree with that?

Mr Learmonth—$63 million does not strike a bell.

CHAIR—Over the first four years.

Mr Learmonth—No, it was about $50 million.

CHAIR—Then my question is about the $50 million. With the chronic disease management MBS items, are you saying that they will pick up this underspend or is it the red tape outcome?

Mr Learmonth—There was, going back over the history of the mental health service incentive payments as part of the Better Outcomes program, an underspend against what we had anticipated the level of expenditure to be, without the capacity for particular precision in that process. Some of that projected underspend going forward—so there has been a ceiling left—has been transferred to the MBS to create the new chronic disease management items.

CHAIR—Which are not all mental health?

Mr Learmonth—No, which are about disease management—the GP and team care arrangement care planning—which will include mental health. By definition, we expect the amount of that transfer to be totally taken up in terms of utilisation of that item. The early figures are that it is going extremely successfully—better than we had imagined. It is early days, but the early figures are extremely positive.

CHAIR—Is it possible from those figures to determine how much money has come out of mental health into those more general areas as a result of the changes?

Mr Learmonth—It is certainly possible to quantify how much money has come out the mental health forward estimates, and I am being precise there because it has not come out of services. It was never being used for services because it was not being drawn down on.

CHAIR—No. I realise that.

Mr Learmonth—The amount we can quantify was $85.4 million over four years that has come out of the forward estimates for the mental health SIPs and gone into the chronic disease management items.

Prof. Horvath—Just to expand that a little bit, that was done with a lot of discussion with all our advisers around the Chronic Disease Strategy and after extensive discussions with people like Professor Hickie, because of the need to reinforce that mental health issues come right through the chronic disease strategies.

CHAIR—You are not justifying this on that basis, are you?

Prof. Horvath—No. It is just one of the inputs. That was one of the issues around funding the chronic disease items, because mental health is such an important component of the entire chronic disease spectrum.

CHAIR—Why didn't we quarantine the mental health aspect of the chronic diseases program? Why didn't this money just fund that bit of it? What are the other programs? Diabetes and—

Mr Davies—But I think the point that Professor Horvath made this morning was that in all of those chronic diseases there is a legitimate mental health component.

CHAIR—There is?

Mr Davies—Or there can be a mental health component within the care and treatment delivered to the individual.

CHAIR—Could you just go through the list again?

Prof. Horvath—Cancer, heart disease, strokes. They are the major chronic disease burden.

CHAIR—They all have a mental health component?

Prof. Horvath—There is a very large mental health component to all of them.

CHAIR—There were a number of submissions that said to the committee that they predicted, and they in fact told you that they predicted, there would be an underspend in this area because of the cap. Why was that advice not taken at the time?

Mr Learmonth—The underspend has got almost nothing to do with the cap.

CHAIR—Can you explain that?

Mr Learmonth—The cap affected some 17 doctors out of over 4,000 who are trained, and it accounts for about, I think, half a per cent. Straight utilisation is the issue. The cap is simply not relevant. It is not material.

Mr Davies—The constraint is the number of doctors who are participating, not the number of services that a participating doctor delivers.

CHAIR—Of those doctors who are participating, are there figures on the average participation rate? Do we know how many, for instance, would use the program more than five times in a week?

Mr Learmonth—We have got a curve that shows the number of practitioners and their utilisation, yes.

CHAIR—It is about understanding the behaviour, I suppose?

Mr Learmonth—Yes, certainly.

CHAIR—Mr Davies, you mentioned the BEACH program. The government, I know now, commissions on a project by project basis. Has it had any thoughts about referring these issues to BEACH for study?

Mr Davies—If there were questions we wanted to answer or explore—and I think Senator Humphries has already highlighted one possible avenue—we would look at the variety of possible information sources, of which BEACH is one, and we would arrange to commission or purchase the research or the data that we need to explore that particular issue. We do not just fund research in the abstract. We commission research to take us—

CHAIR—That is what I asked you. Would you commission research into this area—the whole Better Outcomes in Mental Health? You have already demonstrated that there are lots of gaps in our knowledge about behaviour and about practices with regard to prescribing and so forth. It seems to me to be an area ripe in questions that might be answered by a survey of GPs.

Mr Davies—I think, as Mr Learmonth has just explained, there is quite a lot of data we get just from the routine claiming. If it came to a point where we needed to know more about the underlying causes—

CHAIR—It hasn't come to that point?

Mr Davies—It has not come to that point yet, to my knowledge. I could be wrong.

Mr Learmonth—We know part of the reason for the underspend and we have addressed the most significant reason, which was the difficulty in using the three-step process, the three separate consultations. It has been collapsed to two.

CHAIR—Under chronic disease management, the new arrangements are, as I understand it, that there is a $45 rebate for one or two sessions with a psychologist, yet to some extent what this semi-replaces is a program where there were six to 12 sessions at around $100 each.

Mr Learmonth—Sorry, Senator. It is five sessions at $44.95.

CHAIR—For chronic disease management for psychologists?

Mr Learmonth—It's five allied health, $44.95. A psychologist or any other type of allied health provider.

CHAIR—There is not the option of going to another set of sessions, as there is under Better Outcomes?

Mr Learmonth—Not under that particular Medicare allied health provision, no. It is five per calendar year.

CHAIR—Have you done any work on the implications of that? Is that working? Is five enough? If it was deemed that six was necessary under Better Outcomes and that 12 was likely to be necessary, why is it that five was adequate, and what can you tell us about what is happening on the ground?

Mr Learmonth—Again, the issue is not so much whether it is meeting the demand. It is that the take-up is not at the level of the five. The average utilisation is 3.6 visits out of five, so people are not actually, by and large, using the capacity the system has currently got to access allied health.

CHAIR—This is under Better Outcomes or under the chronic disease?

Mr Learmonth—This is under chronic disease management, allied health.

CHAIR—That is interesting.

Mr Learmonth—It is something we are looking at very closely, certainly. It is something that is attracting ongoing scrutiny and thought from us about why that is so and what we might do to improve the take-up. There have been a number of administrative matters we have cleaned up around it to try and make it as easy to use as possible, and the trend is clearly up on both the level of utilisation of allied health—there is a slow and steady trend upwards—and on the gateway activities of the care planning. Those figures are up quite substantially. We have not really reached a stable state yet on these things and they are still growing exponentially.

CHAIR—Is it worth the committee having access to those figures, the breakdown of each of the programs within chronic disease management?

Mr Learmonth—Of the allied health services used? Yes. I think it probably would not have changed since the last table we provided. Yes, we can provide that data, certainly.

CHAIR—Can I ask about the special task force that was set up to develop a strategy for the mental health work force. What has happened to that task force and that strategy since that time?

Mr Smyth—Sorry, Senator, is that the task force that has been set up under the National Mental Health Working Group as a subcommittee of that group?

CHAIR—Yes.

Mr Smyth—That was set up in July. The first meeting was held last month. That committee is chaired by Dr Ruth Vine, who is the director of mental health in Victoria.

CHAIR—And there is a program of work for the committee?

Mr Smyth—There is a program of work being developed and the committee will report back to the National Mental Health Working Group at the next meeting, which is going to be held in November.

CHAIR—Can you explain why it took so long to set up a committee to do this work, given that the shortage of mental health workers has been around for quite a lot longer than since July?

Mr Smyth—The short answer is that there are, I think, nine committees under the National Mental Health Working Group, there has been a lot of work conducted through that group on quality standards and that has had priority over getting some of the standards and data analysis ready. I have a list of the committees here.

CHAIR—Are they all the same people on the committees?

Mr Smyth—No, they are not.

CHAIR—Why couldn't this committee have been set up at the same time as the others?

Mr Smyth—As I said, I am unaware. I am only new to the committee. I have been three months in the job and have been to only one committee meeting so far, so I do not have the history, the background, on how it was conducted prior to that.

CHAIR—Can you help with that, Mr Davies?

Mr Davies—I would not jump to a conclusion, Senator. I am sure you would agree that the establishment of a committee is not a symbol of an issue becoming live. Mr Lennon this morning talked about a whole raft of initiatives that have been put in place in recent years to improve the mental health work force. The fact that it was only seen fit to establish a committee a few months ago should not be taken to imply that no-one had done anything about this before the committee was set up.

CHAIR—There must have been some reason for setting up the committee.

Mr Smyth—A lot of work had been done at the jurisdictional level with regard to work force. This committee was considered timely to pull all of that together and take a national perspective.

Mr Learmonth—Senator, you asked a question about the number of allied health services that have been utilised per patient. My colleague gave 3.6, which was correct for the Better Outcomes. For the chronic disease allied health initiative, which I think was the focus of your question, it is 2.96.

CHAIR—Any further questions?

Senator MOORE—I have one question about private health insurance. Ms Addison, we had a bit of a discussion about this at Senate estimates. There have a number of submissions that have referred to concerns about private health insurance and portability; in particular, concerns about possible discrimination against people with mental health conditions and their treatment by a range of private health insurers. For the record, can you let us know what role your organisation plays in looking at the kinds of services that are provided. I believe there is a review going on of portability of health insurance. Where is that at? I am sure you have looked at the submissions as well and this issue has come up a number of times.

Ms Addison—The branch has a role of looking at private health insurance policy, as well as the regulation of private health insurance. The requirements for health funds to cover psychiatric care as part of the product offering is a requirement that is set out in the National Health Act. We have a role as the regulator of the industry in ensuring that they comply with their obligations with respect to what they cover in the products that they offer.

To the extent that there have been concerns about portability, for the record those concerns arose following a dispute between a health fund and a hospital in late 2003. Primarily the concerns subsequently arose when one health fund imposed what was called a benefit limitation period in relation to psychiatric services for members transferring to them. What had happened as a consequence of that dispute was large numbers of members transferred from the fund that was in dispute into other health funds. This particular health fund, Australian Unity, felt it was financially at risk and took steps to put a benefit limitation period in for 12 months for people who were immediately transferring into the fund and were the people associated with that particular contract dispute.

Since that time there have been ongoing discussions at an industry level to resolve the concerns related to portability. Portability, as provided under the National Health Act, is about people being able to transfer to a comparable product without having to re-serve waiting periods. There is a school of thought that says that benefit limitation periods are waiting periods. Certainly the Private Health Insurance Ombudsman believes they are. The imposition of a benefit limitation period was seen as the imposition of a further waiting period, which people were concerned about.

The minister asked the industry to have consultations. There were some areas where they were able to agree but there were a number of areas where they were unable to agree. As a consequence of that, and subsequent to the last time we spoke on this issue, the minister agreed to the circulation of what we call a condition of registration. The condition of registration is a mechanism by which we can put conditions on health funds for what they are required to do as part of their product offering. This particular condition of registration that went out for consultation, as it is a legislative process, would in effect ban benefit limitation periods being imposed on transferring members.

We have been through the consultation process with respect to the condition of registration. We have analysed and considered all the submissions that were received and have recently provided advice to the minister on the condition for him to consider, with some expectation that if he is satisfied he will then formalise the condition of registration. Due to the number of submissions we received—and some of them, as you would expect, came in a little later than our deadline—we had suggested that there would be a start date of 1 November, which would be when health funds would have to notify members of the change in the condition. That has not been possible to meet because of the time frame between getting the submissions and providing the advice to the minister. The time frame for when the condition will commence and when notifications will be required to go to members will be a reasonable one and will be set once the minister makes his views known in terms of his preferences, having regard to all of the submissions we received.

Senator MOORE—That first bit that you described previously has now been concluded?

Ms Addison—Yes.

Senator MOORE—The advice is with the minister?

Ms Addison—Yes.

Senator MOORE—Is that the only area of discrimination against people with mental illness that has been brought to your attention?

Ms Addison—Yes, Senator.

Senator MOORE—I just want to have that on record. I have one more question and it is a general one. I do not know who will field this. It is to do with consumer consultation. A number of the submissions talked about the role of consumers and talked about the fact that the plans have specified that there needed to be consumer voice at all levels of decision making. There was a degree of dissatisfaction across the board with the importance of consumer voice and exactly how relevant it was, as opposed to a token acceptance that they had to be there because that is what the plan said.

There were specific issues about privacy. I do not know who has the jurisdiction to determine, within the field of mental health, the role of privacy for consumers, particularly carers. We had many submissions about carers who had active roles with people with mental illness. Across the board, as always, in all government agencies those carers could not have access to information, be it through Centrelink or doctors or institutions. As you said at the beginning of the evidence, Mr Davies, your department tends to take the coordination in this area. Where do we turn for answers to that one?

Mr Davies—To start at the highest level, the National Mental Health Plan 2003-2008 includes an undertaking by all government to:

Strengthen mechanisms to facilitate the genuine participation of consumers, families and carers in decision-making at all levels.

I believe that undertaking is taken seriously and is enacted and reflected in a number of actions. The consumers and carers are represented on the National Mental Health Working Group and on many, if not all, of its subcommittees. It is my view that their input is taken seriously and afforded the weight that it deserves to be given in those deliberations.

Mr Smyth—It is one of the fundamental principles that we adopt in terms of seeking consumer and carer participation. We have entered into a new funding agreement with the Mental Health Consumers Network for a three-year period to ensure their sustainability and to make sure that they train or grow appropriate people to be able to commit to sitting on a number of our committees. We have very active participation of that group and the Mental Health Council of Australia we also fund at the national mental health working group level. We do take it very seriously. We also fund it through our CSSS program as well.

Senator MOORE—The issue of whether consumers feel as though their input is valued, is that one you have heard?

Prof. Whiteford—Yes, we have heard that a lot, Senator. At the start of the strategy in 1992, it was said that about 17 per cent of mental health services in Australia had formal care and consumer participation. The latest data is that that is over 60 per cent now. The question has been, though, just the fact that you have a consumer or carer at the table does not mean they are actively engaged. It could be tokenistic, because that is what the strategy says you have to do. What we are trying to do now is get a better understanding of the roles of consumers and consumer consultants in services, for example, and identify this in the national mental health report. I will ask Mr Buckingham to comment on how we will actually ask the services to report on that, so we have a better idea of not just consumers and carers present but how they are actually engaged in it.

Senator MOORE—That is a core point; how are they engaged.

Mr Buckingham—The strong advice that the consumer carer consultants who work with us on preparing the data collections with the states is that the most valued mechanism is to have paid consumer and carer consultants on the ground who make connection with their fellow consumers and advocate for their needs, who are involved in complaint reviews and so forth. We began asking that two years ago as part of a formal annual reporting requirement from the states and territories. The consumers and carers did not have much faith in the numbers that came in; they felt that individuals were saying they had a paid consumer carer consultant because they paid a bus fare or they might have paid a parking fee or something.

Senator MOORE—The definition of ‘payment’.

Mr Buckingham—Yes. This is about real jobs. We subsequently modified the definition in conjunction with the carer and consumer consultants. Any organisation of the 250 organisations that exist out there in the public sector, any one of them that claims they have a paid consumer and carer consultant are now asked to say the salary and wage payments in summary and the equivalent full-time staff that are on the ground. Those data are now coming in and will be processed for the next national report to give it a bit more quantification to see what is really out there. Is that—

Senator MOORE—Yes, it is core.

Mr Buckingham—Yes.

Senator MOORE—The next report should be one where we can actually look at exactly where it started and then be able to assess from then on.

Mr Buckingham—There is a related development, if I can just take one second or so. There is also a move amongst the states and the territories led by the Commonwealth to develop a national standard for the measurement of their experiences of the service delivery system; core consumer or perceptions of care. I think New South Wales in their submission talked about their MH-CoPES and their MH-CaPES projects. It is rolling that sort of work out nationally so you can in the end put a number to look at where the states are going, by way of how they are responding to issues to do with whether consumers and carers are treated with respect, whether they believe they are heard, whether they believe they are participating in care plans.

This will take several years to get off the ground, but it is one of the indicators. It is not in the 13. It is put as first cab off the rank for the next generation of indicators; that by the end of this plan the states and territories have agreed on a standard set of measures. It will mean a survey regularly. A standard set of measures will be reported publicly by way of how they are responding to consumer and carer perceptions, and what it is like to be on the other end.

Senator MOORE—The expectation, Professor Whiteford, is that that would be picked up in the new plan and strategy?

Prof. Whiteford—Absolutely. What we would have then would be a clinician rated measure of how the clinician thinks the patient or consumer is going, and the consumer also saying how they think they are going. Some of the analysis of the early data which is coming in is starting to look now at the difference between those. Sometimes the clinician says the patient is going great and the patient says, 'I think this is going terribly,' and sometimes it is the other way around, and trying to understand, therefore, what those indicators mean. That work has already started.

Senator MOORE—That is very positive. To whom should I refer the privacy aspect question, Mr Davies?

Mr Davies—It is another of the multiple responsibilities of the Health Services Improvement Division.

Ms Lyons—Privacy is an issue in relation to patients and carers. There is a balance between a patient's rights and the fact that sometimes patients are at a point where they need a carer to understand what their particular care plan is. If a patient consents to a carer having their medical information, that is allowable. The Privacy Commission has recently done a review of the private sector aspects of the Privacy Act. One of the outcomes of that was she believed there is appropriate provision for patients within the limits of the Privacy Act, but provided consent is given by the patient.

Prof. Whiteford—Can I just add something to that from a clinical perspective. My colleagues have sometimes hidden behind patient confidentiality as a way of not communicating with the

carers of the patient. One thing we would be encouraging would be for psychiatrists and mental health professionals to talk to consumers, and encourage them to perhaps engage the carers more in the ongoing management of their conditions rather than because they are busy, just hide behind this privacy. It is a real thing and patient confidentiality is of course important, but sometimes that has been traded off in an inappropriate way which has not been good for the consumer because without the carer and the family involvement, the outcomes are not as good. Sometimes it requires the doctor or the mental health professional to be assertive and work it through with the consumer to try and engage the family better.

CHAIR—That is certainly the evidence we have been receiving.

Senator HUMPHRIES—Some of the advocates and organisations in the area of mental illness have been suggesting to us that Australia needs a mental health commission a la the New Zealand model that would report on and put pressure on areas where national targets in mental health were not being met. Are they right?

Mr Davies—We briefly covered this one this morning, Senator. You might have been out of the room.

Senator HUMPHRIES—I was.

Mr Davies—The answer I gave at that time was for such an office or such an organisation to be effective, it would have to be an initiative that came from all of the governments, given the shared responsibilities in the area of mental health. I am certainly not aware of any pressure coming through the health minister's council for such a role to be established.

Senator HUMPHRIES—Perhaps it is a question of opinion, but would there be advantages in such a model in your opinion?

Mr Davies—It is a question of opinion; you said it yourself.

CHAIR—There are a few other questions we would like to put to you about what the Commonwealth is doing and some updates on things like comorbidity and so on, but we should stop here so that we get to the next program. Thank you very much for appearing.

Mr Davies—Thank you very much.

[2.46 pm]

BOZIC, Ms Suzanne, Director, Carers Policy and Program Section, Disability and Care Branch, Department of Family and Community Services

WESTON, Ms Michelle, Section Manager, Disability Policy, Department of Family and Community Services

WOOD, Ms Ellen, Section Manager, Homelessness Policy and Assistance, Housing Support Branch, Department of Family and Community Services

SANDISON, Mr Barry, Acting Group Manager, Working Age Policy, Department of Employment and Workplace Relations

DRAYTON, Ms Moya, National Manager, Disabilities Services Branch, Centrelink

HOGG, Ms Carolyn, Deputy Chief Executive Officer, Centrelink

SPERLING, Ms Perry, First Assistant Secretary, Service Delivery Policy and Strategy, Department of Human Services

McALPINE, Ms Patricia, National Manager ProfessionalPractice, CRS Australia

STEVENSON, Ms Cheryl, Branch Head, Service Quality and Support Group, Child Support Agency

CHAIR—I now welcome representatives from the Department of Family and Community Services, Employment and Workplace Relations and Department of Human Services, together with Centrelink. Is there anyone amongst you who wishes to make an opening statement, or should we go straight to questions?

Mr Sandison—Straight to questions.

CHAIR—I apologise for keeping you sitting around for most of the day but, as you will understand, we have lots of questions to ask. Senator Humphries, would you like to start?

Senator HUMPHRIES—I would like to ask the representatives from DEWR about the impact of the welfare work changes on people with mental illness. The work test is for a certain number of hours per week. Is it 15 hours?

Mr Sandison—The intent is to reduce it to 15 hours, Senator, from 30.

Senator HUMPHRIES—There are many people with mental illness who would in a particular week be quite capable of working for 15 hours and in other weeks would not be able to work for any hours.

Mr Sandison—Yes.

Senator HUMPHRIES—The flexibility of the system to be able to ensure that those people are not inappropriately excluded from access to a disability support pension, or whatever they might be on—even breached and refused access to benefits at all—is very serious. What flexibility has been built into the Welfare to Work package to ensure that mentally ill people particularly do not fall through that net?

Mr Sandison—One of the intents is to make sure that it is not just looking at a one-week period for the 15 hours. We would be looking more in the line of 26 weeks of 15 hours. When we did our consultations before budget earlier this year, there was a very strong push from the Mental Health Council and the consumer groups to ensure that we take account of flexibilities for them. Another issue would be that if they do move onto a payment where they are looking for work—and not move onto the pension—they can also take into account temporary incapacities. There are still exemptions available if they are required to look for work.

You mentioned breaching. That is one of the issues that we would be looking at through the suspension process. Breaching would be changed, so that it is actually a suspension model. The issue there is to support the engagement of the person, rather than push for penalties. If they do end up looking for work and have a requirement to look for work, on that basis it would be, 'Can they continuously look for it?' If there are problems, they can then get that exception.

Senator HUMPHRIES—Looking at the 26-week period first, are you saying that a person would be asked to indicate whether they would be capable of working an average of 15 hours at any stage during a 26-week period?

Mr Sandison—That is basically the intent, yes. We still have to work through the legislative drafting which is going through now, and also the guidelines. That will interpret it to help advise Centrelink and the assessors in their decision-making processes.

Senator HUMPHRIES—I realise there is drafting to be done, so it is hard to be specific. But if I fronted up and said, 'Look, on an average month I may go for three weeks, but there will be one week every month when I'll be off my trolley and I can't work,' how would a person like me be treated in that system?

Mr Sandison—We are trying to look at people who have chronic conditions. If they are at the psychosis end—and, again, I can only say in all probability—they would probably be the people that would move onto the pension. The people that might have a bout of depression that might last a week or two weeks, we have to look at whether we are deeming it to be an average or a period of 15 hours per week across the 26 weeks. We recognise that there will be people that will need a week off, just as there are people in the work force now: people who have depression need a week or two weeks off from work. We are trying to get that balance, but it is still a work first policy.

Senator HUMPHRIES—How are those things assessed? Are they done on the basis of interview with the affected person or is there a capacity to take evidence from medical practitioners and psychiatrists—people like that—in assessing the person's capacity to work?

Mr Sandison—When somebody comes into Centrelink and applies for a disability pension—which we would treat as probably one of the normal routes in—they would be referred to a comprehensive work capacity assessment, which might involve more than one person. The assessing organisation would arrange for the assessment, and they would have to go through a series of processes because there are other eligibility criteria as well—primarily the impairment tables and an assessment of the person's capacity to work. The person would probably bring with them at least a GP's paperwork, but might also bring specialist work. Assessors can also ask for additional specialist advice in making their determinations.

Senator HUMPHRIES—When you said bring in a GP, you meant bring a GP—

Mr Sandison—Bring in a GP report or an assessment or a comment from the GP. That would be the same for the temporary incapacities as well.

Senator HUMPHRIES—A problem obviously arises if a person's mental illness is undiagnosed. Will there be safeguards in this process to pick up such people?

Mr Sandison—There are a range of safeguards that are in place. At the starting point when a person is applying for the disability pension, we would probably expect them to come in with a request for a certain illness or ailment that they have. If other things manifest themselves as they are going through the interview process, then that would be taken up by the assessor. If it is deemed as not being significant enough but people might be sent to a disability service or rehabilitation service, those services might then decide that there are significant other issues that need to be taken into account and can ask for a reconsideration of the assessment. If it is six months down the track—so they have been denied a pension, they are in a service—they can ask for a full assessment to be done again. We realise that a lot of individuals do not want to declare all the issues, be that with Centrelink, with an assessing organisation, or with a service provider. Some things will come out later down the track. We have a number of processes in place for reassessments or reconsiderations.

Senator HUMPHRIES—Will the assessors be given any training or guidelines with respect to identification of mental illnesses, or potential mental dysfunction, in the course of their interviews or assessments?

Mr Sandison—The operation of the assessors is a function of the Department of Human Services. I do not know how far you want to go, Perry. I am happy to make some comment.

Ms Sperling—It is certainly still under development, but we will be consulting with peak bodies in the development of guidelines. That does include key stakeholder groups who have expertise in mental health conditions, because they are an important group of clients who we expect will be coming through for assessment.

Senator HUMPHRIES—I am reassured by that. I hope that is what ends up happening on the ground. We are told that Australia, by comparison with other OECD countries, has a much lower rate of participation in the work force of people with mental illness than average. Is that your understanding of what those figures show? Is there a particular reason why Australia would have that experience?

Mr Sandison—I am going to start stretching expertise levels fairly quickly, Senator, on the mental health side. We have over 700,000 on the disability support pension, of which about a quarter of them have mental illnesses. Our participation rate on DSP is about 10 per cent where they have declared earnings. If we compare that to the parenting side, where it is 30 or 35 per cent, it is down when compared to OECD. It is a low number and it is a significant number on the disability pension as well.

CHAIR—How do you explain that?

Mr Sandison—There are probably a range of issues. Access to the pension in some countries can be seen to be easier, but it is very hard to compare like with like. Every country has a different grading of what they would consider a disability or an incapacity, so you cannot just say that ours is exactly the same as even New Zealand's, where there are a lot of comparisons. We have a lot of people that are on income support payments that do not require them to look for work, and that has been one of the drivers of the policy changes. Just now the participation rates—it comes into the effective marginal tax rates, the incentives to move off payment or into another payment. All have implications as well, as has been discussed, and some of the changes were made within the Welfare to Work policies.

Senator HUMPHRIES—Are there existing programs to educate employers in relation to issues associated with employing mentally ill people? If not, are there programs that are being built into the advent of this Welfare to Work package?

Mr Sandison—From the employment side—the direct education of employers—it is limited. Disability Open Employment Services, which provides services for people with disabilities who are capable of looking for work, whether it is with ongoing support or independent work status, has that expertise and works with employers to identify and understand what they might need to support a person who they seek to place in a job. The same applies to CRS Australia on the rehabilitation side, where they engage with employers. The personal support program, which I think is about 46 per cent of the program, is for people with mental health problems, again where they seek employment for people, engage with employers and work with them to understand the issues that these people are facing.

Senator HUMPHRIES—Did you say that 46 per cent of the personal support program is directed at people with mental illness?

Mr Sandison—46 per cent of the people that are participants in the PSP have a mental health problem, yes. It could be that that is along with other health issues. I think we have discussed PSP and JPET, very similarly, about the support for the program. It is very hard to quantify whether that is the lead issue for them or whether it is homelessness or drug and alcohol issues or whatever.

In the budget this year we had $1 million for mental health. That is $750,000 this year and $250,000 next year. One of our targets is to achieve the link between health and employment. You had your health discussion this morning and we will have our discussion now. We would like to see stronger links between the two. We want some tools that will go toward what is called the Job Accommodation Network. That is an American web site. We will build an Australian version that provides support for businesses and people with disabilities to seek employment,

and mental health will be a key target in that. This money was to build tools—I cannot go into detail on them, but they include a mental health first aid kit, the MoodGYM, links to beyondblue, SANE Australia, the Mental Health Council and so on—that are internet based, to make sure that we are doing more to assist employers to take people who have mental illnesses.

Again, our biggest issue is disclosure. If a person does not want the employer told, even if they have told the service provider, it is extremely difficult to work with an employer and help guide them or train them and support them or the workmates who the person will be working with. That is probably one of our biggest barriers.

Senator HUMPHRIES—If a person is on a Newstart program and they have disclosed to the department that they have a mental illness, is it possible for the department or the service provider dealing with that particular client to not pass that information on to a potential employer?

Mr Sandison—There are some major limitations about what the provider should or could do in terms of providing that information to anybody else. Currently, as we are working through some of the more detailed policy, the department is engaged with the Privacy Commissioner to look at the transfer of information. The important triangle is not so much the department but the service providers, the assessors, who will be operating with human services and Centrelink. One of the biggest issues we have had is that people can tell each of those different organisations a different story.

What we need, to make sure we give the best continuum of care as they move through the different steps, is one understanding of what the person is facing and, as new information comes to hand—normally by disclosure as they get to know a service provider—everybody is aware of the issues they are facing. As far as them going and telling the employer, primarily that would still come back to trying to convince the individual that this will help them in the workplace and engage in and be supported in the workplace. Privacy rules will still apply in terms of what can be passed on to an employer.

Senator HUMPHRIES—So it is possible for a person to disclose to the department what their mental illness is, or to the provider, but they have no obligation to disclose that to an employer?

Mr Sandison—That is right. From the other side of things, we have a discussion area with employer groups about what the requirements are in relation to the government's policy changes around assisting people with disabilities and what the disclosure rules are in relation to workers compensation, occ health and safety and other things. There are two sides to trying to work through all of the issues with that.

Senator HUMPHRIES—You are not suggesting that that capacity not to disclose will change as part of this process?

Mr Sandison—I think the advice would be what comes back from the Privacy Commissioner, and I do not have that information.

Senator HUMPHRIES—I wanted to ask a question about the Commonwealth-State Housing Agreement. The committee has had lots of evidence about the acute need of mentally ill people for housing and the lack of available options for them. We have also heard, I think, that there is some component of the agreement that deals with issues of this kind. Is there an expectation that this issue is going to receive more attention in the future or is it a matter that is regarded as being satisfactorily dealt with at the moment and is not likely to attract any new work in the context of the agreement?

Ms Wood—The new agreement includes a new guiding principle which is designed to ensure that housing services are linked with a broad range of support services for people with special and complex needs. We are asking states to move beyond the provision of housing and also provide support to keep people in housing. That is being measured in bilateral agreements.

Senator HUMPHRIES—When you say 'keep people in housing'—

Ms Wood—Some people need support to maintain their tenancies. You can give them a house but they cannot manage their affairs. They need support, so we are asking the states to step up to that responsibility as well.

Senator HUMPHRIES—Is that done by asking the states to develop policies that will appropriately identify and support people, say, in this category of mental illness—

Ms Wood—Yes.

Senator HUMPHRIES—or does the Commonwealth have a role there in suggesting or even dictating what sorts of targets will be set for that category of need within the housing sector?

Ms Wood—The Commonwealth has negotiated bilateral agreements with each of the states, in which each state has the opportunity to develop its own local responses to meet those sorts of requirements.

Senator HUMPHRIES—They are therefore quite different from state to state—

Ms Wood—They can be.

Senator HUMPHRIES—Are there any figures kept on how well those sorts of needs in the area of mental illness are addressed from state to state?

Ms Wood—I am not aware of mental illness being singled out as an issue.

Senator HUMPHRIES—Thank you.

CHAIR—Senator Moore?

Senator MOORE—Do you have community consultation mechanisms that involve consumers? I know most of you do have them, so I want to find out what they are and whether consumers—in this case, mental health consumers and carers—have roles in advising on policy and advising on service delivery. I know that only Centrelink and some delivery elements of the

Department of Human Services have face to face contact all the time, but you can see what the question is. I would like on record from each of you what consumer involvement you have in your public policy.

Ms Hogg—In this arena, we have two major consultative groups. We have a large consultative forum on the general issue of participation, which represents people with disabilities, welfare rights, sole parents et cetera—probably about 20 organisations. We also have a separate consultation process or consultative group for people with disabilities.

Ms Drayton—We have a disability reference group in Centrelink. We met a few weeks ago. The membership of that group includes people from the Mental Health Council, it includes parents of children with intellectual disabilities, people with acquired brain injury—a whole spectrum of people with disabilities—and that is used not to inform the development of policy but to help us improve our service delivery to meet the needs of those particular groups. What we find is that people often want to spend their time talking about policy, and we would endeavour to feed the views back to the policy departments and work with them to try and input their views into the policy departments, but the focus is really the service delivery and how we can improve that.

Ms Hogg—They, for instance, help us to develop our training material for our staff.

Senator MOORE—That is the second group, Ms Hogg?

Ms Hogg—Yes. In terms of how we train staff in Centrelink, we have quite a significant program for disability awareness. The community and consultation groups work with us to develop that training and, in fact, come in and help us deliver it. We deliver parts of that training to other providers outside of Centrelink as well so that there is a consistent approach to the awareness-raising of the issues that people, particularly people with disabilities, face.

Ms Sperling—In terms of the core department, the Department of Human Services, you would be aware that we are a relatively new department. We are dependent on each of our agencies having ongoing consultative forums. Centrelink has just described theirs. We have colleagues here from CRS and the Child Support Agency, and I will run through some of those issues in a minute. But we also, as a core department, conduct consultation on an issue by issue basis. For example, as we were saying before, we have responsibility for rolling out the program of comprehensive work capacity assessments as part of the Welfare to Work reforms and we have consulted with peak bodies and stakeholder groups, including consumer groups and specific mental health representative peak bodies in the initial consultations, and will be, as I said before, in the development of relevant service delivery guidelines. In terms of the Child Support Agency, again I am advised that there are ongoing consultative forums, including parent groups, and ACOSS representatives, but no specific disability representatives on those groups.

Ms McAlpine—Again, like in Centrelink, CRS Australia's focus is on increasing and improving the quality of our services to our consumers, so our focus is during program. We have focus groups at the end of program. We have questionnaires. We have 26-week surveys after the customers have left our program, again seeking feedback on the continued improvements to their lives since they have commenced work. That focus tends to be the way we monitor our improvement, rather than an advisory group per se.

Senator MOORE—CRS has that customer focused, needs based concentration.

Ms McAlpine—Yes.

Senator MOORE—In relation to the Child Support Agency, I know it has not been a core submission but, around the edges, the issue of families and family break-up has come up a lot, and—in terms of the agency, which has such a big service delivery focus—I am interested in issues to do with mental health and where they fit in your planning.

Ms Stevenson—Yes, you are quite right, mental health does figure a lot in family breakdown, and we are acutely aware of it. Some time ago we worked collaboratively with the Department of Health and Ageing on getting some funding for a pilot program which was to enable us to link clients directly with a telephone based counselling service, and we are continuing to provide that service to any of our parents who express a high degree of distress or indicate any risk of self-harm in conversations with our service officers. We do see it as a major issue for our parents and one that we attempt to address as best we can.

Senator MOORE—And the department has continued to fund that after the end of the pilot?

Ms Stevenson—Yes.

Senator MOORE—When did the pilot start, Ms Stevenson?

Ms Stevenson—I do not know if I have got that.

Senator MOORE—Take it on notice.

Ms Stevenson—All right.

Senator MOORE—If we could get some information about that specific service, that would be very useful.

Ms Stevenson—The pilot started in 2003. I think we did include part of it in our submission.

Senator MOORE—That would be good. We had some dot points that we just did not process. DEWR?

Mr Sandison—Senator, the department has a disability advisory group and, because it is the broad base of all disabilities, a lot of the focus for us is the providers, but we also have the CEO of AFDO—Australian Federation of Disability Organisations—and the Mental Health Council represented on that. That meets every couple of months, and it is to provide advice and get updates from us in terms of referral rates and the operations of some of the services conducted by the department.

In relation to Welfare to Work and the changes, while it was not a specific reference group, we did a consultation process in each state. Ministers attended four of those and that was by invitation but really through the disability advisory groups or councils in each of the states, so we used them and the federation as the key links for us and then we have ongoing discussion

with ACOSS and Welfare Rights, again in a sort of more generic way across the range of things, but specifically over the last three months we have probably met about three or four times with them on disability-specific issues. Again, mental health issues clearly come up, particularly the sorts of issues Senator Humphries raised, but that is as part of the total discussion around disability issues.

Senator MOORE—And FACS?

Ms Bozic—We have a number of consumer consultation processes in the department. I am going to cover some of them and then I will pass on to Michelle Weston, who will brief you on some of the others. We have two ministerial bodies who advise the minister on policy issues: the National Family Carers Voice and the National Disability Advisory Council. Both of these bodies comprise community representatives, people with disabilities, and carers, and they advise our minister on various policy issues and work very closely with our minister on developing policy.

Ms Weston—The department also has a program. We fund 22 peak bodies as part of an ongoing conduit between the minister and policy development in the community. Some of those are national peaks, such as ACOSS and ACROD and Volunteering Australia, for example. We also fund a group of disability peaks, which are basically our consumer focus body, and, as I think Mr Sandison mentioned, the Australian Federation of Disability Organisations, which is the premier peak for that group of people. In addition to that, there are other groups, like Community Housing. I cannot think of them all at the moment, but we are happy to provide the full list.

Senator MOORE—Thank you.

Ms Weston—They are basically employed in most of the consultations that the department undertakes. They cover the community services sector, disabilities, children, families, and most of the groups in our portfolio. We also meet with the National Welfare Rights Network twice a year. They come and meet with senior representatives of the department and discuss their issues.

Senator MOORE—Across all of your agencies there is the awareness of consumer participation, and particularly from this group. That is fair?

Ms Weston—Yes.

Senator MOORE— I want to go particularly to Centrelink, with a little bit of FACS, on two issues that have come out in consultation. One is service delivery, and I know that Ms Hogg and Ms Drayton have said you have your group that lets you know about service delivery, but I think that at most of our public hearings there have been comments about how some clients or customers with mental illness feel isolated from the system.

They feel as though their needs are not met. They feel as though they do not fit the system. One of the specific allegations was to do with the carers payment about which we have heard considerable discussion in the community. They talked about policy guidelines which I know comes through FACS, but the particular issue that came up was the view that the program was

not particularly friendly for carers of people with mental illness. The focus of the form, the focus of the interview, the focus of the process, was on people with other forms of disability.

Carers of people who have a wide range of mental illness were not welcomed by the system. In fact, they often did not claim because they felt isolated. I refer you to the evidence from South Australia if you are following the actual words. The carers payment, carers allowance, role of carers, has been a very strong theme through this inquiry. I would like to hear specifically from Centrelink about that statement and also from FACS, whether you have any issues about policy and whether there has been this issue raised.

Ms Drayton—I will start, if that is all right. On the service delivery side of that, we have specialists we would use to try and help people come to grips with whatever it is they need from Centrelink. That would include disability officers, social workers and psychologists who are trained specially to try and help those people who do not fit neatly into some of the boxes that people like to put them in. With the carer payment—I think we might have mentioned this in the Centrelink submission—we have been doing quite a bit of work around particularly young carers who are caring for parents who have mental illnesses. We are trying to get an understanding of what their needs are and focus our service delivery around that. In the carer's instance in particular, we have probably spent more time working out how we deal with the actual person with the disability rather than the carer. We have done a lot of out-servicing arrangements, a lot of visits to hostels, to prisons, to hospitals, to try and focus our service delivery around the needs of the person who actually has the problem. We are now turning to what we need to do to support the carers as well. They would have access to the specialist services that Centrelink has, as well as the links to community. One of the roles we play, and an important role, is linking people to other services in the community and from other government organisations. We are trying to strengthen those referral programs. I am not sure, Carolyn, if there was anything else you wanted to add.

Ms Hogg—No.

Senator MOORE—Were you aware of that issue that came up—

Ms Hogg—Only through the submission. I read that through the issues that were identified through the secretariat.

Senator MOORE—FACS: some terms of policy?

Ms Bozic—I do not think I could add anything from a policy perspective. Eligibility for carer allowance and carer payment is based on an assessment of the care needs of the person requiring care. This is done through the adult disability assessment tool. The tool has a number of questions. It has a questionnaire the carer fills in and also a medical professional. The person is then assessed on that form. The actual form does have a mix of questions, so we have questions relating to the physical needs of the person as well as psychological and emotional needs. It does try to cover conditions such as mental illness, as well as physical disabilities. We are aware through our ministerials that people with mental illness have had problems with the actual forms.

CHAIR—Those who are in denial about their mental illness, for instance?

Ms Bozic—No. People who have felt there were not sufficient questions regarding mental illness in the actual form to test eligibility. We are aware of the problem. We are currently in the process of reviewing the adult disability assessment tool and mental illness is one of the issues we will be looking at in that review, and the extent to which mental illness is adequately covered in the actual assessment form. We hope the review will be finalised early next year.

Senator MOORE—I have one last question, Chair, and once again it is to everyone. I could talk for hours, but I am not going to. This is to do particularly with the privacy aspects. This is coming again from the carer's perspective. We have heard it from practitioners and from people with illness themselves. There is no common theme to this; how each of your agencies deal with clients who have identified their mental illness. It is very difficult to handle people who are in denial, because they are not telling you, but if a client has a mental illness their capacity is affected.

They have a caring arrangement that is either a partner or a family member. That person has significant care responsibilities. How do the departments handle the privacy aspects, about communication that relate to the person who has the disability when it is the caring person who is involved with trying to sort payments, trying to sort disappearance, trying to sort if a person is in hospital and cannot be reached but their payments may be ceased either through child support or through a parent, a father who has gone, or through particularly Centrelink? How do you deal with that very difficult privacy aspect?

Ms Stevenson—In the Child Support Agency the legislation allows for a representative to be appointed and many people take advantage of having someone act in that role for them in relation to the agency. That would cover some of those situations you refer to.

Senator MOORE—You require a signed document from that person to allow that?

Ms Stevenson—Yes.

Ms Hogg—Centrelink is same. We call them a nominee. Basically if there are any signs or any issues we think the actual individual with the disability will have a problem either in understanding or accessing in any way, we would press for a nominee to look after the circumstances of that individual. Again, we require signage.

Senator MOORE—So the person has to give you that authority?

Ms Drayton—Senator, in addition to that, we would send letters to the nominee as well as to the customer then, so that the nominee can assist in following up and making sure if there are issues that need to be followed up they are aware of them. It is a protection as well.

Senator MOORE—Correspondence to someone who has authorised a nominee would go to both persons. DEWR?

Ms Drayton—Yes.

Ms Hogg—Yes.

Mr Sandison—Senator, a lot of our stuff gets picked up through Centrelink in terms of the decision-making process around income support. CRS Australia are our service provider for rehabilitation and then it is through our provider networks. Under the contracts the focus is on the individual. If a person has circumstances which the provider might have to deal with, they might involve others, but again only through privacy and having looked at privacy restrictions. The only other issue comes up in terms of participation agreements that individuals have to enter into and there is the requirement that the participation agreement has to be reasonable in the first place. If Centrelink are looking into suspension or currently a breach, again it is the reasonableness of the expectation on the individual and part of that would be their capacity to understand what it is you are asking. I would assume in those circumstances if there was a doubt about capacity to understand, there might also be consideration of what payment they should be on. It would get us back into that loop of what is the status of the individual and their circumstances.

Senator SCULLION—I have a couple for DEWR first. When you are actually making an assessment in relation to a workplace and you are going to make an assessment of somebody about how they are particularly suited or otherwise to a particular workplace, I am very curious about how you assess people on, in one case, a mild disability. A serious disability is against a different benchmark perhaps than another environment. That disability may not be as profound because of a different environment. I am very curious to know how you go about that. It must be a very difficult area.

Mr Sandison—You probably cross a range of different things. There is the policy element, Senator, from DEWR where the assessment process is not about an individual workplace. Our policy is about the person's capacity to work and getting above a 15-hour target, along with other eligibility criteria. That is the intent for the legislation that will be brought forward. Tied with that will also be about the individual's capacity to work in the open labour market and without ongoing support. Some of those key elements where you talk about chronic conditions: the people may well stay on the disability support pension and get access to cap places either through rehabilitation or open employment services.

Then there is the assessment process decision making, but also the providers that actually make decisions about a specific workplace and the ability of the individual to work in that particular work environment and how they might best support them to move into that workplace. Our other providers are not here, but perhaps Pat from CRS Australia can give a specific example of looking at a particular work environment.

Ms McAlpine—Yes, 29 per cent of our clients each year have a mental health condition as their primary disability. I would estimate, if we count secondary disability, that we would probably be talking in the region of 50 per cent. It is something that we are confident in working with. We approach working with people with disabilities of all types by looking at the individual basis of the client needs, so that we are identifying what their specific barriers are, what their strengths are. We focus on ability and tend to look at ways to minimise the barriers to participation. We do a lot of job matching. We look for the triggers, the indicators of success, and we build on those indicators.

Our organisation uses allied health professionals, multidisciplinary teams, to do comprehensive assessments of that client's particular circumstances. We have a very in-depth

knowledge of the labour market, so that we look at all the different issues that are going to impact on that individual. We then offer post-placement support for up to 13 weeks to make sure that we deal with issues as they arise and work with the employers and the consumer to help them put in support strategies, and also educate them for the longer term to help them identify triggers to make sure that the job match works.

Senator SCULLION—I have a supplementary question on the same area. It is a slightly more complex issue, but again work placement and comorbidity and those issues: how do you address those issues and what success have you had in trying to ensure that those people get a work placement? They are, in my mind, notionally the most complex in terms of episodic, as well as the comorbidity issues.

Ms McAlpine—Are you talking about clients with drug and alcohol as well as mental illness?

Senator SCULLION—Indeed, yes.

Ms McAlpine—We have recently conducted some research on that internally, and looked at best practice across the world; trying to take some of the learning from that research. We have found that the important thing of setting up a successful work placement for those clients is that we do try and help them with disclosure; that we set up good support mechanisms, both in the workplace and in the community. The issue of stigma is an issue that we have talked about several times today. That is an issue that can take some effort in helping that person to disclose their information. An indicator of success is being able to set up those good supports within the workplace and community. It is not always easy.

Senator SCULLION—That leads into my next question about some of the housing issues and how you deal with those, given that in the public housing sector often there is close proximity. We talk about the privacy issues and sometimes, if it is discovered perhaps that somebody has a mental illness, they may be taunted and things like that. Some people are not particularly kind. That is an environment that is not particularly conducive to somebody with a mental health challenge at the time. The private rental market is not only expensive, but because of the episodic nature of mental illness it is very hard to maintain an income that will support private rental. What alternatives have you thought of? There is community housing. What are the alternatives? I trust that the government is continuing to look at innovative and new ways of meeting these challenges.

Ms Wood—Housing is state government delivered. Our mechanism is the extra conditions put into the Commonwealth-State Housing Agreement that I referred to earlier: for us to put in special procedures to support clients who otherwise may have difficulty maintaining housing and to negotiate with each state on an individual level to allow them to develop their own responses and to give them flexibility to develop models that suit their particular circumstances.

Senator SCULLION—The homeless and the notion that homelessness of course is particularly dysfunctional—if we do not have a house, we do not have any of those things—and yet we still have to go and try to chase all these different various areas—Centrelink; it does not matter what it is. It always seems that you have to go somewhere and find these things. It was put to us by the Council of Homeless Services that the homeless assistance services and the SAAP process should be perhaps amalgamated to a one stop shop for homeless people. They

should not have to navigate their way around the remainder of the public institutions. We thought that was a reasonable suggestion: a one stop shop for those sorts of people would be very useful.

Ms Wood—Joined-up service delivery is certainly the way homelessness is going. We are trying to encourage services. SAAP is one possible place, but only one-fifth of homeless people access SAAP. SAAP beds down about 20,000 people per day and there are around 100,000 homeless people. SAAP is one good place. Another thing is that contact with SAAP is normally short. It is a crisis program. You are already in pretty serious trouble when you get there and most people stay less than five days. The new SAAP agreement will reform the program and try to get to people earlier—before they lose their housing—and provide assistance, and also to extend support after they leave SAAP so that they are supported over a longer period of time.

People need complex packages of services and they do not deal well with complex packages. We have been supporting an initiative in Victoria called YP[4], which is targeted at the homeless young job seekers. We are trying to give them all of the services that they would normally be accessing under one case manager and delivering all of the services. One of the biggest barriers is privacy. You cannot share information. Another barrier is that the different systems do not talk to each other: IT does not talk to each other, so DEWR's system does not talk to Centrelink's system. There are those sorts of issues. If you try to deliver a number of programs through one case manager, each program's funding has to be kept separate and delivered separately. There are all sorts of barriers. FACS is now convening an IDC to start to work through some of those barriers to make joined-up service delivery more of a reality for the homeless and people who have complex needs.

Ms Sperling—Within that context, I think it would probably be useful to hear from our colleagues in Centrelink who are undertaking a range of innovative outreach services specifically for homeless people.

Ms Drayton—I was going to mention the one that, I think, Ellen has referred to.

Ms Hogg—We have been doing some work in Victoria with the Hanover Group.

CHAIR—Is that the YP[4]?

Ms Hogg—Yes. If one of the Centrelink people identifies that there may be potentially, or there is a homelessness issue, especially for young people, we start working together and really very carefully manage that customer through all the issues and all the contacts and services that potentially that person can access over a period of time. We look at them very closely over that period to make sure that their situation does not deteriorate and they end up being in a situation where, because of the rigour of the system, they can end up getting breached and without money at all.

From my recollection, this has been particularly successful. But it does have to be a concentrated effort over a period of time. You cannot just do it with one contact; you have to keep in touch very closely with a range of providers. But it certainly is a very good model. Once the person comes through Centrelink for the income support process, there is an active case

management of that person. It is really in the early intervention and recognition by Centrelink that there is a potential problem. There is some data available on that, if you would like to—

Senator SCULLION—Potentially, there is a genesis happening now of the recognition that if you triage early enough—this is just the matter of homelessness?

Ms Hogg—It is homelessness which is often brought about because of dependency issues and/or undisclosed issues of health generally.

Senator SCULLION—A lot seems to be riding, Ms Wood, on SAAP. I know we have had a lot of comments from the NGOs who provide services to state and territory governments in their contract. They say that this is a large unmet need and it is pretty much underfunded; I think that was across the board. You mentioned that there was a review happening. What do you think the outcome of that review is going to be? I do not want you to predicate the outcome of the review, but do you think that there is much scope for establishing out of that review that there is in fact an unmet need, rather than just anecdotally?

Ms Wood—We know that there is an unmet need. We do not have good measures of it, because the same client may go to several services, if they cannot get a service. A new SAAP agreement has just been signed with the states. It will have an extra $350 million in it, an extra $100 million from the Commonwealth—SAAP 5 as it is now.

Senator SCULLION—Between the states and the federal government from time to time there is a bit of tension and that can be difficult to negotiate. What are your feelings? Are there any principal issues about this delivery service and the interaction between the federal government in terms of particularly the SAAP program?

Ms Wood—The new agreement has three priority areas. Firstly, as I said before, it will encourage services to help people earlier, before they lose their housing, so they do not become homeless. Secondly, it will get them stabilised earlier and the books will not be closed on them as soon as they exit SAAP, so they will be provided with assistance for a longer period. Serious problems are not fixed in five days, which is how long most people stay for. Thirdly, it will deliver more service linkages so that it can deliver more complex packages. They are the principles driving the new SAAP. There is an innovation and investment fund, which will benchmark best practice in respect of those and then drive that through the entire program. There are 1,300 different SAAP services and they offer quite different models.

Senator SCULLION—Thank you.

CHAIR—Could I ask DEWR to respond to what I thought was a really good presentation to the committee in Cairns from Ms O'Toole of Advance Employment Inc. She talked about their agency being capped at 78, in terms of the number of people they can assist, and the agency having a waiting list of 25 to 30 people at any point in time. I would be interested in your view of this particular agency and what was provided to us by way of evidence. Can you explain why it is that that cap is necessary, why that agency should not be properly funded and why all the people on the waiting list should not receive that service?

Mr Sandison—Firstly, I am not specifically aware of that service.

CHAIR—Generally speaking. You are in Far North Queensland: are you going to have a cap on your service and does it matter how many people are on the waiting list?

Mr Sandison—The program is across the board. It is a capped program, so government budget decisions are made about the number of places that are available in the program. Under Welfare to Work, the program will be uncapped for those people in that new 15- to 30-hour work capacity category, being people with a partial capacity. They will have a participation requirement. Because they have a participation requirement, they will be given access to uncapped places. In part, there will be a change to that service along with others.

People with a disability who, under the proposed new rules, are required to look for work will get access to places. It will be the same for rehabilitation because the same issue applies: at present there are caps on the number of rehabilitation places available also. It is across the board. The personal support program operates under the same process of a capped number of places and also with waiting lists.

CHAIR—Perhaps you could give us a fairly detailed response as to what I imagine would be the typical case here. It might assist the committee to know how hard we are trying to get people with mental illness into the work force. I would ask you to look at the *Hansard*.

Mr Sandison—What sort of information would you like?

CHAIR—You probably need to read it.

Mr Sandison—From the report, okay.

CHAIR—There is a lot of complicated commentary about the funding formula and so forth. It would be helpful for the committee to have your response to a current case study.

Mr Sandison—No problem.

CHAIR—A trial was conducted by DEWR of early intervention and referral through, I think, 12 Centrelink offices that involved 2,000 disability support pension recipients. What was discovered at that trial? What implications came out of it?

Mr Sandison—This is looking at a new comprehensive assessment process. The pilot started early this year and involved a range of people not only applying for disability support but also coming in for an incapacity exemption, so they would be Newstart recipients. It was provided through not only a number of Centrelink offices but also CRS Australia and APM. APM is Advanced Personnel Management—I knew that one of the acronyms would get me.

The findings were twofold. There was far better engagement through having a comprehensive assessment, so more effort was being made in assessing all the issues that a person was facing and then engaging that person and looking for them to volunteer to attend a voluntary activity with one of our services. The outcomes are still being written up and a report is due within the next two or three weeks.

CHAIR—How many people with a mental illness were part of that trial?

Mr Sandison—I do not have the data. It was whoever came through the door, whether they were applying for DSP or looking for an incapacity exemption. It was not channelled at all.

CHAIR—Perhaps you can take on notice a question about how many in the trial had mental illness; what that tells you about them compared with others; if they were not in the trial—and I think we have some evidence to suggest that they were not—why they were not; and whether you will do a trial on people with mental illness to see whether there is a difference.

Mr Sandison—Yes. There certainly was no exclusion.

CHAIR—I understand that.

Mr Sandison—We will find out whether or not there is evidence there.

CHAIR—You have said that the supported accommodation agreement was signed in just the last few days.

Ms Wood—Yes.

CHAIR—In the end, how much did you extract out of the states?

Ms Wood—$350 million extra.

CHAIR—I thought $100 million of that was from the Commonwealth.

Ms Wood—$100 million is from the Commonwealth, yes.

CHAIR—So it would be—

Ms Wood—$250 million.

CHAIR—What is the agreement with the states with regard to what that money will be used for?

Ms Wood—Most of it will go into the services, with some being quarantined for an innovation and investment fund to drive reform, as recommended by the evaluation.

CHAIR—Will it go anywhere near addressing what the Commonwealth's submission says is the highest level of unmet need in the provision of SAAP services—that is, for people with mental illness? Is there anything in there about mental illness?

Ms Wood—There is stuff in there about people with high and complex needs and better services linkages to meet their needs. As I have said, we do not have strong measures of unmet needs, so it is very difficult to say. Extra money went into the last agreement, but we still did not see a drop-off in the measures of need. Our evaluation recommended this strategic change and approach, so that is what is happening.

CHAIR—In what way is it strategically different?

Ms Wood—Early intervention, pre-crisis intervention, longer term support and better service delivery to people with high and complex needs.

CHAIR—Where does that happen?

Ms Wood—That will happen under the new agreement. That is the sector reform to be driven over the five years of the agreement.

CHAIR—But the Commonwealth is not doing that; this is an undertaking by the states.

Ms Wood—Yes, the states deliver SAAP; the Commonwealth does not deliver.

CHAIR—Catholic Welfare told the committee that funding they have for services for people with mental illness was cobbled together from about eight different sources; this is to provide accommodation. Have you looked at what is going on on the ground with supported accommodation? This business of getting a bit from here and there seems to us to be a very inefficient way of providing services.

Ms Wood—It is the YP^4 trial and the attempt to bring service delivery together in a more coordinated way. As I have said, there are quite significant barriers, but the work is under way. Yes, we are aware of that. If they are getting funding from eight sources, that is quite a small number. Some are administering 40 programs and every one has to have a separate contract, separate finances, a separate audit report and separate data requirements.

CHAIR—It sounds like a nightmare.

Ms Wood—Yes. We recognise it as difficult and we are trying to deal with it.

Senator MOORE—We have heard about the YP^4 trial and will be given more information on that, which is good. Is it a trial or a pilot? You would have heard of the amount of evidence given to this committee about the fear and loathing that the word 'pilot' is met with in the community. Everybody gives money for certain things and then the money runs out and the programs stop. The evidence we have been given is that so often, when the federal and state combined moneys stop, very few organisations can maintain what they have. How do you see the YP^4 trial from that perspective?

Ms Wood—It is a trial.

Senator MOORE—What does that mean, particularly in terms of ongoing activity?

Ms Wood—It is largely using money that is already in the system. The only extra money is the evaluation. These kids are already accessing JPET, Job Network, Centrelink payments and housing services. They are trying to put all the money into one bucket and deliver services in a coordinated way rather than having the kids go here for their health service, there for their Job Network and there for their housing and whatever. They are saying that, if we get all these services delivered in a coordinated way, we will get a better outcome. The National

Homelessness Strategy has funded the evaluation—it is quite a robust evaluation—to see whether it does get better outcomes.

Senator MOORE—So there is not the fear about it being another pilot.

Ms Wood—No. People with mental health problems already will be accessing a number of programs serially and, at the same time, it is getting better outcomes by coordinating service delivery.

CHAIR—To what extent do you work in association with the Mental Health Strategy, generally speaking?

Ms Wood—For SAAP, an IDC was convened and a mental health working group formed. We sit on the housing and homelessness task force and the complex needs group. At state levels, SAAP workers get some training in mental health. So there is coordination at various levels.

CHAIR—Have you had brought to your attention the program that the committee visited in Shepparton, Victoria, a couple of weeks ago? The state government mental health unit is working with a non-government organisation to provide accommodation, with enormous success; they are providing services, The national mental health alliance—I think it is—has scraped money probably from a range of sources to put this together. Are you evaluating that program as well?

Ms Wood—That one has not been brought to my attention, no.

CHAIR—There are two programs within the one. One is a kind of a step down from acute care.

Ms Wood—Yes. The Pioneer Clubhouse in Queensland has various programs too, some of which have accommodation.

CHAIR—Again it might be useful for us to send you some material on this.

Ms Wood—Thank you.

CHAIR—We did not take Hansard with us, so we cannot give you the Hansard. It was yet another really good idea and good program that was brought to our attention, but we did not get the sense that the experience in that program was likely to be replicated elsewhere.

Ms Wood—A lot of great initiatives are going on. One of the challenges is to disseminate the—

CHAIR—How do you take up that challenge?

Ms Wood—The National Homelessness Strategy this time is going to fund communications activities. Organisations can apply for a small grant, say, to run a forum—

CHAIR—Sorry, to run a forum?

Ms Wood—a forum—if they want to bring a number of service providers together. SAAP is also looking at the development of a knowledge management strategy on how you capture the experience of service providers and what they have learned and disseminate that to the sector, because it is a very diverse sector.

CHAIR—How do you do that through forums?

Ms Wood—They are working that out at the moment. They have just commissioned work on that. There is research, which is one way. But the day-to-day knowledge of the service providers is very hard to capture, especially in a big sector like SAAP where there are 1300 services.

CHAIR—Why don't you put something on the web site?

Ms Wood—We do put stuff on the web site and that is one way to get it out. We find that services want to network locally, but they do not have the funding to do it.

Senator MOORE—That particular funding for communications is new, isn't it?

Ms Wood—Yes. We advertise and will be calling for submissions shortly.

Senator MOORE—We have not had that in previous years that I am aware of.

Ms Wood—We funded some communications activities under the last strategy, but we did not have it as a separate identified stream, which we will have this time. We have recognised that we do a lot of work on building knowledge bases but very little about disseminating the knowledge.

CHAIR—This was touched on earlier and you said that the Commonwealth's role is to provide rent assistance and supported accommodation. Has any serious work been done in the department on the appropriateness of the rent assistance program for people with a mental illness? Do you acknowledge that there may be a difference regarding the needs of that group and how well they sit with the rent assistance approach?

Ms Wood—Essentially, rent assistance is a subsidy for private rent and so is really part of an income support stream.

CHAIR—I understand that.

Ms Wood—In that sense, it is part of their income support payment.

CHAIR—That is understood, but a lot of people have pointed out that the nature of mental illness means that keeping up the rent is very difficult; there needs to be much more assistance and it might be provided in another kind of way.

Ms Wood—We have Centrepay, which Centrelink might like to talk about.

CHAIR—Centrepay?

Ms Drayton—I would pick up on something else first, if I could. In relation to homelessness, mental illness and rent assistance, we find that a lot of people do not so much fit the traditional definition of 'homeless' but might be moving very often in short periods of time, not accessing rent assistance and not paying formal rent. So an issue of ours is in trying to make sure that people get their full entitlements. To help that happen, we have tried to train staff in identifying triggers to help them understand that this person could have a homelessness issue and might need some kind of special help or attention with their compliance activities or entitlements. Triggers we have identified are if they have moved several times within a six-week period, their address is changing or we have return correspondence—all the usual sorts of things. We recognise that for some people, particularly people with a mental health issue, stable accommodation is often very difficult to achieve.

CHAIR—But are you referring just to their entitlements, their disability support pension?

Ms Drayton—And rent assistance, yes.

CHAIR—So you can give them rent assistance if they are transient.

Ms Drayton—If they are not sure about what they need to be telling us. Sometimes they do not claim what they are entitled to. They do not get their full entitlement because they are not aware of what they need to tell Centrelink. We would proactively try to help people who we know need extra assistance. Homeless people or those who are moving often and for whom we are getting lots of return mail are a trigger group; they are people who need extra assistance.

CHAIR—Is extra assistance available for the person who comes in and says, 'Tonight, I might be staying at the hostel, but tomorrow night I am going to bed down with a mate of mine and after that I usually spend a week in the park,' or that sort of thing?

Ms Drayton—By 'extra assistance' I do not mean financial.

CHAIR—What do you mean?

Ms Drayton—I mean assistance like a social worker or a psychologist helping them to stabilise their accommodation and to work out whether they should be getting rent assistance and whether they are getting the right kind of income support payment. I think I was probably talking about something different from what you were talking about.

CHAIR—That person does not get rent assistance, unless they stabilise.

Ms Wood—If they want it, they have to have a liability, which they obviously do not get if they are sleeping in a car.

Ms Drayton—They have to be paying.

CHAIR—If they are at a hostel for one night and a shelter for another night, if their typical pattern is three or four places of abode in a week for which they may not be paying, they are not entitled to rent assistance of any sort.

Ms Wood—No. They have to be paying a minimum amount of rent and be able to produce a receipt. To help them meet a rent commitment, if they do have one, they can opt to have their rent paid directly from their payment through the Centrepay system and other essentials can be handled in the same way. That helps people who have difficulty budgeting.

CHAIR—What is the experience, through Centrelink and SAAP, of people who seem to pay very high amounts of money sometimes for a tiny room as some form of accommodation, which seems hard to justify? Can you give the committee a picture of what is going on out there? Are people being ripped off? Is the sort of accommodation on offer to people who can get that rooming house kind of—

Ms Wood—It is not a matter that the Commonwealth has direct involvement in because tenancy regulations are a state matter.

CHAIR—So the Commonwealth is not interested in the issue.

Ms Wood—We do not have the powers.

CHAIR—I know that you do not have the powers, but surely it is a matter that can render people homeless and, therefore, dependent on your SAAP services. I would have thought that at least you would raise it with the states in your negotiations with them.

Ms Wood—If we had sufficient evidence, it could be raised through various—

CHAIR—But it has not been.

Ms Wood—I am not aware of it having been raised. Work is done from time to time on boarding houses, caravan parks—that sort of issue—and tenants' rights regarding charges. That receives consideration and has been subject to various studies.

CHAIR—Do you have a role in providing accommodation for people who come out of prison?

Ms Wood—Prisons again are a state responsibility. Centrelink sometimes will send community officers in to contact prisoners before they are released to ensure that they will receive payments as soon as they are released. That is subject, as I understand it, to the prison official's agreement. Some SAAP services also get pre-access to prisoners pre-release, but again that is subject to the jurisdiction's agreement to them going in.

CHAIR—Given the high numbers of people in prison—50 per cent I think of male prisoners have a mental disorder or illness of some sort—do you have a view about the suitability of the current system for that group of people?

Ms Wood—An awful lot of them are released and come into SAAP. We would certainly like to see the states working to better plan release and to release into stable accommodation.

CHAIR—I am sorry, you would certainly—

Ms Wood—To release them into stable accommodation and not into crisis accommodation, which is what happens.

CHAIR—So they are coming into shelters and SAAP accommodation.

Ms Wood—Yes.

CHAIR—Does this come up at your talks with the states?

Ms Wood—Once they are in SAAP, SAAP provides the very best service it can. I am not aware of it being a particular focus at the moment.

CHAIR—It was not raised at the negotiations that have just been completed?

Ms Wood—Not that I am aware of, no.

CHAIR—There are no further questions. If we think of any other questions, with your indulgence, we will put them on notice.

Committee adjourned at 3.57 pm