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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH

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

Senators in attendance: Senators Allison, Moore and Troeth

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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Committee met at 8.48 am

BRENT, Mr Ronald Ian, Deputy Commonwealth Ombudsman, Commonwealth Ombudsman

McMILLAN, Professor John Denison, Commonwealth Ombudsman, Commonwealth Ombudsman

MASRI, Mr George Michael, Director, Immigration Investigations Team, Commonwealth Ombudsman

CHAIR—Welcome. I declare open the 15th hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March 2005. Witnesses are reminded of the notes they have received relating to parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in private or in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera. I now invite you to make a brief opening statement, after which we will go to questions.

Prof. McMillan—Thank you. I will briefly outline the perspective that the Ombudsman's office can bring to the issues of mental health being addressed by this committee. The principal area in which mental health issues confront the Ombudsman is in the area of immigration detention. I must say that we do see mental health issues arising across all areas of our jurisdiction. Some of the people, for example, who come to the office complaining about matters concerning Centrelink or taxation occasionally display signs that raise mental health worries or concerns. But it is principally in the area of overlooking the Department of Immigration and Multicultural and Indigenous Affairs and receiving complaints from people in immigration detention centres that this issue arises. I will briefly outline the issues there.

Our concerns have been raised in successive annual reports. We have identified each year issues arising in detention centres as one of the issues that dominate in complaints against the department of immigration. I might say that we receive about 860 or 870 complaints each year about the department of immigration. Issues that are prominent in detention centres concern access to health care, both general and specialist, and to dental care as well. Our concerns, as I said, have been raised in annual reports and other discussions with the department of immigration. For example, in 2003 we forwarded a discussion paper to the department in which we raised some of the concerns we had arising from complaints and visits to detention centres. Those are matters that are familiar in public debate—for example, whether decisions on health care and mental health issues in detention centres were being made by appropriately qualified people; whether the mental distress of detainees was being properly diagnosed or was simply being accepted as a consequence of their indeterminate detention; and the waiting time that people experienced in accessing professional care and medication. Those issues were raised specifically in a submission that we discussed with the department in 2003. It is possible that some of those issues have been overtaken by subsequent developments.

The committee may be aware that the government has made a number of announcements following the publication of what I will call the Rau and Alvarez reports. The Ombudsman's office, as the committee may be aware, formally published the report on the Alvarez matter. It was a report of an inquiry undertaken by Mr Neil Comrie and finished in the Ombudsman's office. Both the Palmer and Alvarez reports raised a number of issues about the suitability of steps taken within the department of immigration when people who had been apprehended as suspected unlawful noncitizens presented with mental health worries. Some of the issues raised in both the Rau and Alvarez reports are whether departmental officers are properly trained to identify the signs of mental illness, whether there should be better records management on individuals who present with signs of mental illness so that a proper story can be presented to clinicians and whether clinicians should be more clinically assertive in trying to diagnose mental illness and so on. That is principally the position that the Ombudsman's office has been in until now.

A consequence of the Rau and Alvarez reports is that the government conferred a substantial new role upon the Ombudsman's office in relation to immigration matters. I will just mention briefly the aspects of that role that connect with the issues of mental health. Firstly, the office has a new role under statute of doing a periodic review of people who have been in detention for a period of two years. Our task is to prepare an assessment that goes to the minister on the suitability of the circumstances of a person's detention. We look at a range of criteria. One criterion we look at in particular is the mental health situation of a person. We have specifically asked for departmental documents on that issue. When we can we also interview the person in detention. As well, we have often met with their advocates or friends and we have made visits to detention centres.

In that role we have been focused on looking for some of the stress factors that are associated with long-term detention. A similar pattern arises in many cases of people who have been in detention for two years or more, showing signs of definite distress arising from the detention, from the indeterminate and uncertain nature of the period of detention, from the unpredictability of their circumstances—where hopes can be raised and dashed by litigation or other processes in which they are involved—and from the circumstances of confinement and their lack of control over access to specialist services. Our reports on those matters go to the minister and eventually are tabled in parliament.

As well, the Ombudsman's office was asked by the government to review the situation of 220 people about whom there is a question as to whether they were unlawfully detained. Each of these 220 cases concerned people who were either Australia citizens or a person with residence status in Australia and they were nevertheless taken into immigration detention for a period of time. We have done an initial profile of those cases and in at least 11 of the cases there is an issue as to whether the person's detention arose from mental health worries; for example, the departmental officer who detained a person was unable to ascertain at the time of detention that the person was an Australian citizen or a person with lawful residence status because of communication difficulties between the officer and the person.

Finally, as part of the new immigration changes in my office it has been proposed that the office should adopt the role of immigration ombudsman, and legislation to confer that specialist title on the office is presently before the parliament and the government has made a commitment of substantial extra funds for the office to discharge that function. One of the distinct programs

that we will undertake under that role of immigration ombudsman is to focus on health issues in detention centres. We will be undertaking a much more active program of visiting detention centres, of regularly monitoring conditions, of liaising with advocacy groups and of interviewing people who are in detention without necessarily receiving a complaint.

That is an outline of the perspective that the Ombudsman's office can bring to this particular issue.

CHAIR—Thank you. Do either of your colleagues wish to add to that opening statement? If not, I will go to the last point you made about the extra funds and the health focus. Do you expect to have expertise on staff in mental health issues and if so how will you do that? How many staff and how much money did you get, by the way?

Prof. McMillan—In total we will have about 47 staff working on various aspects of the new immigration ombudsman function and that will involve looking at detention health issues, detention conditions generally and compliance, and a general complaints handling function. There was a proposal put forward in the Palmer report on the Cornelia Rau matter to establish within the office of the Ombudsman a specialist unit. I think it was to be called an immigration detention health review commission that would have a very active role in setting the standards for immigration health. My office is not in favour of that proposal because we believe that the role of an ombudsman is not to be the primary standards setter or policymaker; it is an overview agency. We feel that our role is to oversight the standards that have been set for detention centres.

What we propose is that as part of the budget for the issue we will maintain a fund to enable us to access consultancy services, part-time services and the like where there is specialism in a mental health issue. The short answer to your question is that at this stage there is no member of the staff who has any special expertise in mental health, and there is no present proposal to appoint anybody with those credentials.

CHAIR—Why not?

Prof. McMillan—The emphasis generally in appointing staff to the office has been to get people with a generalist expertise who can conduct investigations across the area of government and that we access specialist services where they are required. I apprehend that there would be a difficulty—at most we could probably appoint one individual with specialist services in the mental health area. There is a real question as to whether that person would be fully occupied in the position and whether it would really be better for the office to use funds to access a variety of different opinions when needed. The issue that arises in detention centres is that they are dispersed around Australia and often we use people from different offices. We have eight offices around Australia. The deputy might want to add to that. He has been more in charge of the personnel management side of the office.

Mr Brent—Certainly the general practice of the office is not to try to develop a greater level of expertise in any field than that held by the department or agency responsible for the administration of that particular matter. I do not think it would be possible, let alone sensible to try to develop within our office greater mental health expertise than would exist particularly in the agencies contracted by the Department of Immigration and Multicultural and Indigenous

Affairs. Our job therefore is not to try to ‘out-expertise’ the agency that operates the system. It is in fact to review and analyse the services that have been provided. On occasions that will require getting specialist expertise but so that we can get the very specialist services that we need—not generalist skills in mental health matters—we will go to a specialist and contract those services.

CHAIR—In the case of Rau the expert, if you like, advice was given that there was no mental illness present but it became perfectly obvious to other detainees that this was not the case. In those circumstances, how would the new system work?

Mr Brent—It is not our job to then become the agency that will determine whether particular detainees need mental health services or not. Our job will be to determine whether the systems in place within the department, detention centres and service providers are adequate to identify whether mental health issues exist. Therefore, in a case like Rau our role would be similar to that undertaken in the Palmer report. However, given that we now have the resources to move more quickly and immediately and to monitor more consistently and regularly, we would identify issues sooner. Those issues would not be that we assess a particular detainee as requiring mental health services; it would rather be to look at the system and determine whether we are confident that the system will identify properly whether a detainee has mental health issues.

CHAIR—You did not have the resources to do that in the cases we have just talked about?

Mr Brent—No, I think the numbers speak for themselves.

CHAIR—Have you lacked the jurisdiction or the resources?

Mr Brent—We have had the jurisdiction—there is no doubt about our jurisdiction—but the numbers speak for themselves. We have a number of staff across the agency who deal with immigration matters; they have in the past and will in the future. However, in the past we have had only two specialists focusing on the department of immigration. We will now have in the vicinity of 47. That gives a sense of the scale of supervision that we will now be able to provide.

Senator TROETH—The committee visited Baxter detention centre, as I am sure you would be aware. There we heard of the difficulty of attracting health care professionals to such a remote area. Are you aware of any discrepancies in mental health professionals being available, say, for Baxter as compared to Villawood?

Mr Brent—Certainly there is a discrepancy in that the remoteness of Baxter creates an issue in providing any form of external support, including in physical and mental health. The focus for us is going to be very much on whether there are sufficient mechanisms in place to deal with that. That does not necessarily mean stationing high-level mental health expertise at Baxter; there are a number of ways in which that sort of expertise can be brought to bear. But we will need to be convinced that the systems in place are sufficient to identify with enough promptness detainees with mental health issues, and then the task is to find a system for managing those mental health issues. That may well involve moving people out of Baxter where there are concerns about mental health issues or it may involve bringing more expertise to Baxter. It is an issue, but it is one that I believe can be managed if focused on.

Prof. McMillan—Until now, our experience is best described as episodic—we have responded to individual complaints and have seen evidence and heard instances of all of the complaints that have been placed on the public record. Certainly, when we have visited remote detention centres it has been said to us that there is a distinct problem faced by people in those centres in accessing specialist care. On the other hand, it is sometimes said to us that that difficulty is simply illustrative of a difficulty that exists generally in the community in accessing specialist services. Until now, it has been difficult for us to penetrate beyond that level of episodic experience and complaints, but in the new, properly funded role we will be in a better condition, as Mr Brent has indicated, to draw comparisons between different detention centres and see whether a better result is possible.

Senator TROETH—Would you also give us your view of the follow-on between those patients who needed to be taken from Baxter to Glenside in Adelaide and any issues that have arisen from your scrutiny of that procedure? We were aware that some detention centre detainees needed to be transferred from Baxter to Glenside, but it did appear to us to perhaps be at the very last minute or long beyond the time that it was apparent that they needed further treatment. Do you have a view on that?

Prof. McMillan—I will make two points and see if either of my colleagues want to add anything, because they have had some experience in this as well. Firstly, the complaint was made to us that, when there was a need for a person to access specialist health services beyond the detention centre itself, an eleventh-hour decision has tended to be made. Secondly, in recent times we have seen a substantial change in the management of problems in detention centres. Over the last two or three months we have seen a sizeable number of people moved from Baxter to Glenside. For many of the long-term detainees that we have interviewed, interviews have been conducted at Glenside and we have seen a readiness, often before we have even visited, to deal with that. So whether or not a change in experience confirms an earlier complaint is speculative, but certainly there has been that change.

Senator TROETH—Yes, I must say, on our visit to Baxter I was impressed by the readiness and willingness of the authorities to make sure that those precautions were put in place before they were needed. Although I had only read of conditions before, I certainly thought that those conditions had improved.

Prof. McMillan—Yes. That is why, in my opening, I indicated that at the moment we draw a line between, for example, the experience that we have had in preparing a discussion paper for the department in 2003 and our present experience. Again, it will take some time to see whether the improvement is substantial and whether many of the earlier concerns we had are erased, but at the moment there does seem to be a substantial improvement.

Senator MOORE—Is the change in your role going to be extended beyond the regular review of long-term detainees? Is there going to be more to it than that?

Prof. McMillan—Yes. In the new role we will be focusing on about six different areas. There is this distinct statutory role of looking at long-term detainees and there is this other specialist role of looking at the 220 cases. Then, really under the umbrella of the immigration ombudsman, we will have a separate program looking at detention health, a separate program looking at other issues in detention centres, a separate program looking at compliance matters in the

department—compliance matters being the kinds of issues that arose initially in the Rau and Alvarez cases—and, sixthly, an enhancement of our existing complaint handling role in all areas of immigration.

Senator MOORE—So those enhanced roles will not be stimulated by complaint. You will not have to wait for complaints to act on that.

Prof. McMillan—No. The Ombudsman has, in a sense, two roles: to handle individual complaints and to conduct, on the initiative or own motion of the Ombudsman, an investigation. Our principal role until now has been an individual complaint handling role. In future I think the balance will swing more to activities that we initiate ourselves by way of visits to detention centres, by selected case studies of issues or by monitoring conditions over a period of time.

Senator MOORE—I am interested in how that role will differ to your role with a place like Centrelink or the Child Support Agency, because the Ombudsman's report of 12 months ago initiated a great deal of concern about Centrelink services and raised issues about clients who may have mental health issues and their ability to access that system. It was not the overall aspect of the report but it was certainly an aspect of the communication process. So, on government service delivery and the role of the Ombudsman, it would seem to me that mental health issues, as you said in your opening statement, cross a whole range of government services. There is a question of whether the kinds of things you are doing for immigration—quite rightly—could then be done for Centrelink, where I think issues have been identified, and child support, where we are getting more and more cases of people claiming that there are significant mental health issues being raised in Family Court processes—and you could go on and on with just about every one. I think I could make a case for just about every government department. How would the Ombudsman's role—the office of the Ombudsman, as opposed to you personally—work with other areas of government service delivery?

Prof. McMillan—We often say that the great strength of the Ombudsman's office is in dealing with all areas of government. It deals with them nationally through eight separate offices that we maintain. Problems arising in one area of government are often not unique to a particular topic or discipline but are often problems across government. Record-keeping problems in one area often have a distinct parallel with record-keeping problems in another. Similarly, many government agencies, particularly those with a service delivery function, deal with clients who present signs of mental distress or mental illness. We argue that it is better to place specialist functions, such as an Immigration ombudsman function in the office of the Commonwealth Ombudsman. We have other specialist functions as well, including a Taxation ombudsman and a Defence Force ombudsman, in a generalist office, because one draws from the other. We would now expect that the extra experience and insight into mental health issues that we will gain from the Immigration ombudsman role will be an experience that we can apply in other areas.

One final comment on that is that the areas where we particularly see it being applied are Centrelink and the Child Support Agency. Centrelink and the Child Support Agency are the two agencies about which we receive the largest number of complaints. Many of the clients, because of the circumstances of their lives, do present issues of mental distress. Sometimes they become special problems for our office because some of the people become persistent and obdurate complainants and their original complaint against a government agency is transformed into a

complaint against the Ombudsman's office. We have had occasion to even contact the police because of difficulties that we have faced in interviewing individual clients.

CHAIR—Now and again, Professor McMillan, we as parliamentarians receive some copies of those.

Prof. McMillan—Not everybody walks away happy.

Senator MOORE—I do not think they walk away happy from anywhere.

Prof. McMillan—We say that it is a distinct problem that now faces government: there is a culture of persistent complaint that is sometimes difficult to deal with. Studies are under way about how best to deal with persistent complainants. One of the issues that we are currently examining is whether we should have a more active program ourselves of trying to refer a complainant to an appropriate facility or professional for treatment. In the past we have simply dealt with each complaint as a complaint against government and, if we find that it is not substantiated, we dismiss it and try to close the file. But an issue that we are now confronting is whether we should be more actively managing the relationship with complainants and trying to identify signs of a problem, other than the one stated by the complainant, and taking appropriate professional action.

Senator MOORE—The Mental Health Council expressed a desire that the issue of mental health be on the agenda generally. One of their concerns, through a variety of work that they had done, was that for too long mental health had not been openly discussed and identified as an issue. I would like a comment from your office, in view of the evidence you have given, about whether the issue of mental health is a concern and is something that your office does take into account. Your evidence has indicated that it does but, just for the record, in terms of the work the Ombudsman's office does across so many areas of government service, is consideration given to the issues of mental health and community need?

Prof. McMillan—I preface my remarks once again by saying that our experience is episodic. It is gained by and large only from the individual complaints that come in our door. But it is firstly our experience that mental health issues arise commonly in different areas of government. Many people who are in contact with government find the relationship distressing for one reason or another. I think it is a feature of Commonwealth administration that many of the clients of Commonwealth programs have a continuing relationship with a government agency. A person is a taxpayer for life. A person may be a Centrelink benefit recipient for a long period of time. A person may be in a child support arrangement for a considerable period of time. A particular concern to us is that the relationship between a government agency and a person can easily become toxic—for whatever reason. Sometimes there is no fault on the part of the government agency but the relationship becomes toxic and that becomes a continuing and escalating difficulty in the relationship between the person and the government agency.

My second point is that government agencies are attuned to that problem. It is certainly our experience that, in the large client service agencies such as Centrelink, Taxation and Child Support, there is a keen appreciation of the difficulties that people are facing and the problems of mental stress in the community. Government agencies actively train their staff to deal with it and have active procedures for dealing with it. That said, individual complaints are a window on the

world. Reports on cases like the Rau and Alvarez cases and some of the individual complaint investigations we see indicate that, in the system of government, we can do better.

CHAIR—How far through the review of the 220 people who are suspected of being unlawfully detained are you?

Prof. McMillan—We have received basic information about all 220 people, and that has enabled us to draw up a profile, which we presented to another Senate committee this week and which became very public. We have a team of five people at the moment, headed by Neil Comrie, who prepared the Alvarez report, working through those cases. We have picked two groups of cases at the moment for priority study. One of those groups of cases is the 11 cases we have identified in which mental health was possibly a factor in a person's citizenship or residency status being identified after—

CHAIR—Where are those 11 cases now?

Prof. McMillan—We are working through each of them at the moment.

CHAIR—So they are still—

Prof. McMillan—I suppose it is probably fair to say that there will not be a report on any of those cases before, say, about January. That is not to say that there will be a report in January but—

CHAIR—Are these people still in detention?

Prof. McMillan—No. Our understanding is that none of the people involved in those 220 cases is currently in detention. I say 'our understanding' because circumstances sometimes change. We might find that a person was released from detention but, when we look at the case later, it is possible that a person has, for some unrelated reason, been returned. But our understanding is that in all 220 cases the individuals have been released from detention.

CHAIR—Are these people typically in in-patient care for mental illness or are they out in the community?

Prof. McMillan—Again I cannot speak for all 220—

CHAIR—No, I am asking about those in that group of 11.

Prof. McMillan—I know, for example, in one case we are looking at that, yes, the person is in in-patient care.

CHAIR—Only one.

Prof. McMillan—Yes. There is only one I am aware of, and that is our priority case at the moment. There could be others.

CHAIR—When you do the review of people who have been in detention for two years, what will be the process? If you find someone has been kept in detention for two years and there is a mental illness that you perceive is a result of that long-term detention, what is the process then? You report to the minister: can you make recommendations about that person being released into the community? How does that sit with the immigration process which will be going on—presumably an appeal of some sort against determinations? What exactly happens?

Prof. McMillan—The role of the Ombudsman is simply to conduct an investigation and make a report, with any supporting recommendations, to the government. Our principal focus in these matters is, firstly, whether there was a period of unlawful detention: that is whether, for all or any of the period a person was in detention, that detention was unlawful for the reason either that when the person was detained the criteria set by the Migration Act—that is, that an officer has a reasonable suspicion the person is an unlawful non-citizen—were not met or that at some subsequent time during the detention the person should have been released, earlier than they in fact were. So the first issue is whether there was a period of unlawful detention. A second prominent issue for us is the department's management of compliance and detention generally, as illustrated in these 220 cases. At the moment that will be the focus of our report, much as it was in both the Rau and Alvarez matters. It is possible our report could take up issues of compensation but those are usually taken up by separate processes. It is possible that our report could recommend the need for further studies on, for example, the capacity or professionalism of the department in dealing with mental health issues.

CHAIR—Is there any opportunity for people who might have been put in punitive confinement within detention centres to make complaints to you after the event on the basis that that is unlawful or does not fit with our National Mental Health Strategy? Is there some avenue through your body for complaint about people being put in management units for a minimum of six weeks when they are clearly very sick? Can you expand on your role there pre and post the changes?

Prof. McMillan—Yes, a person can make a complaint of that nature. I will see whether my colleagues have anything specific to add but my understanding is that we have conducted investigations of that kind in the past. In the new role we will probably be more active in looking at the situation of people who are in, say, management units or confined detention.

Mr Brent—I will make a short additional comment. There are two separate issues here. One is the 220 cases of detention that may not have been legal, required or appropriate. Within detention centres we have had numerous complaints about the use of management units or other special facilities and different forms of detention within the detention centre. That is something that we would anticipate continuing to get numerous complaints about, but it is also something that we will deliberately target in our own investigations into the management of detention centres, with the additional resources. It is an area of particular concern.

CHAIR—You did not quite answer my question. If you find that a complaint is justified about what I can only describe as punitive incidents, as opposed to services for people with serious mental illness, do you advise the government about compensation? Is compensation an option for people, as it was for Alvarez, and what is your role in that question?

Prof. McMillan—The Rau and Alvarez reports are probably good models for the approach that we would take—that is, that we will examine the facts and express an opinion on whether there has been unlawful detention. But the issue of compensation raises other issues as well—for example, about whether there has been negligence, about whether it comes within a recognised legal doctrine by which compensation should be paid, or, if not, whether it comes within the criteria of the scheme for compensation for defective departmental administration—the CDDA scheme. The CDDA scheme contains a criterion that says a recommendation by the Ombudsman for payment of compensation is a sufficient basis for administrative compensation under that scheme. So it is open to us to do that.

CHAIR—Can the Commonwealth appeal against that?

Prof. McMillan—No. The CDDA scheme is an executive scheme and so it is just a self-administered scheme. It is managed by the department of finance, although there are delegations to different agencies to make payments up to certain amounts. Decisions under the scheme are potentially—there is no right of appeal under that scheme.

CHAIR—By either party?

Prof. McMillan—By either party, no. The Ombudsman's office has an active role in relation to the CDDA scheme. Indeed, it was one of the proponents, many years ago, of the need for a scheme for administrative compensation. We become involved in a couple of ways. Firstly, we can make a recommendation for payment of compensation. That is exceptional, because we are aware that we often do not have the full suite of facts. We will often say to a person that if we think there is potentially a case for compensation, say in an immigration matter, we might look at it. We often say to the person that we recommend they put in a claim for compensation and they may want to get their own professional help or assistance and that they will need to deal with all of these issues. Secondly, we can accept a complaint about the way a department has handled something—whether it has rejected a claim or whether it has not paid enough or whether it has given proper reasons or not. That is the more usual role we play in compensation matters, reviewing a decision by a department.

Mr Brent—I would like to add one clarification: there is actually no need for there to be any appeal by an agency because our recommendations are not binding. Therefore, we can make a recommendation for a CDDA payment. If the agency chooses not to make that payment that is a decision that is open to that agency.

CHAIR—But this has not been put to the test so far?

Mr Brent—Yes, we have made recommendations in the past for payments.

CHAIR—And all those recommendations have been paid up?

Prof. McMillan—Yes. For example, the largest single payment made under the CDDA scheme was a compensation payment for \$7 million that stemmed directly from an Ombudsman investigation.

CHAIR—For a detainee?

Prof. McMillan—No, it was in relation to the Department of Agriculture, Fisheries and Forestry.

CHAIR—And have there been any successful claims made under immigration detention?

Prof. McMillan—I am not aware of any, but George, this is your area.

Mr Masri—I know that we are pursuing some possible compensation claims in relation to detention. But to answer your question in relation to the use of management units and strategies in detention centres and whether they are appropriate, especially for people with mental health issues, that is an issue that has come to our attention by way of individual complaints, but it is also an issue that we have addressed in a broader, systemic way—certainly over the past year or two.

CHAIR—So when did complaints start to be made? Were they prior to the Rau incident?

Mr Masri—Yes, we are talking about those who were detained legally, albeit for a long period, and who had a range of health issues, including mental health matters. We were concerned about the use of Red One as a punitive measure—and about other inappropriate measures, especially for those people who require other attention. As I said, we are dealing with these issues on an individual basis as well as on a broader systemic basis. Over the past year, for example, there have been significant improvements in the way in which the department and GSL have been addressing that issue.

CHAIR—Prior to Rau, how many complaints did your body receive about punitive detention arrangements?

Mr Masri—I do not have that figure.

CHAIR—Was it three, was it 300?

Prof. McMillan—We have a fairly good data system. We cannot always provide the statistic that has been asked for, but we can go back and see.

Mr Brent—I will give you a ballpark figure. There are tens of complaints per year—not 100 and not one or two.

Senator MOORE—On this issue?

Mr Brent—Specifically on the issue of the use of management units or similar facilities within detention centres.

CHAIR—At what point did you become concerned about the use of these management units within detention centres in relation to people with mental illness?

Mr Brent—It would not be an exaggeration to say we have been concerned about that issue for a number of years. I would describe the level of our concern over recent time as significant,

particularly in the context of, for instance, the use of Red One at Baxter, which we have been actively pursuing since before the Rau matter came to light.

CHAIR—Prior to Rau, on how many occasions did you bring your concern to the attention of the government? We could do pre Rau and post Rau—that would probably be more useful.

Mr Brent—That is a difficult question to answer because our concerns have been quite varied, depending on the facility, and because a lot of the concerns have arisen in individual cases. There have been individual concerns drawn to the attention of the service provider and the department over a number of years, and many of them have been responded to. Other concerns of a more systemic nature, such as those in relation to Red One, we have drawn to the attention of the department at various times over the course of the last 12 months or so. I should immediately say that the department has been very responsive. There have been new procedures and arrangements for the use of Red One in direct response to our concerns.

CHAIR—But you did not draw attention to those concerns prior to the recent 12-month period?

Mr Brent—We drew attention to concerns in individual matters. I am not aware of any broader systemic issues that have been raised—although I would say that, in a range of reports that we have produced in the past, the use of management units has arisen and has received comment and there have been modifications in the way those units have been used.

Prof. McMillan—Those were some of the matters we raised in a discussion paper that we presented to the department in September 2003. At about that time, we instituted the practice of giving a quarterly- or half-yearly report to the department on issues that have arisen in our general oversight of immigration matters, and issues about detention centres—and specifically management units—were raised from time to time. Part of the issue is that we report to and discuss matters with the department in a variety of ways—through annual reports, through quarterly- and sometimes half-yearly reports, through individual complaint reports and through occasional meetings and visits to detention centres.

CHAIR—So the government was aware for some time of your concerns about the use of Red One and other management units?

Prof. McMillan—Correct.

CHAIR—At the hearing we conducted in Adelaide, the South Australian Ombudsman said he would like to have had access to Baxter but because it was not his jurisdiction—it is Commonwealth—he was unable to do that. He felt that some of the problems there might have been headed off if he had had access. Does the Commonwealth Ombudsman have a view on that? Do you have a dialogue with the state ombudsmen's offices? To what extent do you communicate?

Prof. McMillan—We have excellent working relationships with all of the ombudsmen. I meet the other ombudsmen at least once a year and the deputy ombudsmen also have a meeting at least once a year. In fact, in South Australia the Commonwealth and State ombudsmen's offices are collocated. That said, we have distinct areas of jurisdiction. The Commonwealth

Ombudsman has jurisdiction in relation to Commonwealth agencies and the state ombudsman has jurisdiction in relation to state agencies.

It sometimes happens that an issue can cross those jurisdictional boundaries, and there is for that purpose a section in the Commonwealth Ombudsman Act that says we can undertake a joint investigation with a state ombudsman. It is possible, to take Baxter as an example, that a complaint could cross jurisdictional boundaries: it is a Commonwealth-managed facility but visited at times by state health professionals, and people from the centre also go to state schools and health centres and the like.

CHAIR—So you are saying that, if the state ombudsman had approached you, it might have been possible to arrange for him to have—

Prof. McMillan—a joint investigation of the specific issues. I am not aware that we did that.

CHAIR—But he did not do that?

Prof. McMillan—It rarely happens that we conduct joint investigations, but it is possible.

CHAIR—I am aware that you have to go, but I wonder whether it is possible to answer just one other question.

Prof. McMillan—By all means.

CHAIR—Could you give the committee your views about the effect of long-term detention on detainees with regard to mental illness—particularly that group of detainees who might come into detention with fairly traumatic experiences behind them?

Prof. McMillan—Our experience is often episodic and it relates to the individual complaints that have come our way, and we have been reliant to a large extent on the reports that we are provided by other health care professionals and by our own unprofessional observation of the way that people present. But, with those qualifications, it has to be said that particularly in our review of the long-term detention cases—a function that is in its early days—at least in most of the cases that we have been examining, where a person has been in detention for two years or more mental health issues have arisen. There are various factors that contribute to the signs of mental health distress that we see: the length of detention itself is an issue; the uncertain period of the person's detention is a contributing factor; their reaction to the stress and unpredictability of litigation and other review processes is an issue; their difficulty in obtaining easy access to specialist care in a centre is an issue; and the fear that they may be removed from Australia and that a tormented and difficult period of their life has left them in a worse position or seems to have achieved nothing is a distinct worry they raise with us in every case.

In many of the cases we have looked at where a person has been in detention for two years or more, the professional advice on file is that the length of the detention has an impact and that the best prospect for improvement would be release or at least a different form of detention—for example, under a community detention visa—or, in the most optimistic of cases, being given a permanent residency visa of one kind or another.

CHAIR—I am sorry, I have just been corrected—it was not the Ombudsman; it was the Public Advocate in South Australia who made that presentation. My mistake.

Prof. McMillan—I see. All right. We are not co-located then.

CHAIR—There are a couple of other issues I would have liked to have raised, but we realise you have to go.

Prof. McMillan—With the committee's indulgence, I could leave and my colleagues could remain and answer any other questions.

CHAIR—We are probably almost at the end anyway, so we will let you go. It would disrupt the rest of our program in any case. Thank you very much for coming today.

Prof. McMillan—Thank you for the opportunity to appear before the committee.

[9.45 am]

POWLAY, Mr John Frederick, Private Health Insurance Ombudsman

CHAIR—Welcome, Mr Powlay. Would you like to make a brief opening statement, after which we will go to questions?

Mr Powlay—Yes, I would. Annually, the Private Health Insurance Ombudsman deals with about 2,600 complaints about private health insurance matters. In examining our database I have been able to identify only 25 complaints relating to psychiatric treatment. I should say that we may well have had more complaints from people who have a mental illness or are having psychiatric treatment, but in many cases it is not necessary for us to know that to deal with the complaint. So the number of complaints involving psychiatric treatment is relatively small.

It is difficult to draw any compelling conclusions from any analysis of such a small number, but there are some interesting aspects. Twenty of the 25 complaints were from Victoria and 18 of the 25 complaints were parents complaining on behalf of their son or daughter. The range of issues about which we have received complaints includes restrictions on the level of benefit for psychiatric treatment, hospital contracting where the hospitals were psychiatric hospitals or the contracting issue involved payment for psychiatric treatment, the application of copayments where psychiatric programs occurred over a number of weeks and a small number about the billing practices of psychiatrists in private practice.

The main thing I want to comment on in my opening statement is in the area of restrictions on health insurance benefits for psychiatric treatment and particularly the issue of benefit limitation periods imposed by Australian Unity and the issue of portability—both of these issues figure prominently in submissions and evidence given to this committee. In relation to benefit limitation periods and restrictions generally, all health funds have one or more products that restrict benefits on psychiatry and psychiatric treatment—that is, they pay the minimum benefit amount. Under the health act, funds do have to pay at least the minimum benefit for psychiatric treatment on all their products. Most of the larger open membership funds have what are called benefit limitation periods.

Benefit limitation periods pay benefits for some specified treatments but the benefit is limited to the minimum for an initial period of membership—generally between one and three years. Benefit limitation periods are more common in Victoria, South Australia and Western Australia because originally they were designed by AXA, now BUPA health funds, which have a significant share of those markets. The treatments that are most commonly subject to benefit limitation periods are psychiatric treatment, rehabilitation, heart surgery, joint replacement, eye surgery, IVF and obstetrics.

Until April 2004 all funds, except the BUPA health funds, waived benefit limitation periods on transfer if the person already had the requisite period of membership with their previous fund. BUPA apply benefit limitation periods on all transfers, including people who transfer between products within their fund. In April 2004 Australian Unity introduced benefit limitation periods covering just psychiatric treatment and rehabilitation on all its products. They applied these

benefit limitation periods to all new joiners, including transfers from other funds. As I said, no other fund, other than BUPA and Australian Unity, applies these limitations on transfer. The distinguishing features of the Australian Unity arrangements are that they apply across the full product range for Australian Unity; most funds have at least one product that is not subject to these limitations. The Australian Unity arrangements relate to psych and rehab only across all their products. Most products will have variations in what is limited across the products.

In terms of portability and the background to this change, in August 2003 there was a significant contract dispute between the BUPA health funds and Healthscope hospital group. BUPA is the largest health fund in South Australia and Healthscope has significant major private hospitals in Adelaide. South Australia was the main focus for that dispute. BUPA is also a significant fund in Victoria—HBA. Healthscope has about 60 to 70 per cent of the Victorian private psychiatric beds. During the dispute, Healthscope aggressively promoted the idea that patients should transfer to other health funds. Medibank and Australian Unity were most significantly affected by this mass transfer of BUPA members. The estimate of the numbers transferring is around 50,000 health fund members. These funds initially indicated that they had refused to guarantee full portability for BUPA members transferring—that is, that they would not extend the benefit of their contracts with Healthscope to transferring BUPA members. But, following intervention from me and the department, both funds agreed to do so before the contract arrangements ceased.

Both Medibank and Australian Unity experienced substantial benefit payments from transferring BUPA members. Most of these members were transferring at the point at which they were having expensive hospital treatment. Most of these transfers occurred in South Australia and were not related to psychiatric or rehabilitation treatment. BUPA and Healthscope settled their dispute and established full contracts with the key Adelaide acute hospitals. But BUPA and Healthscope reached an agreement between them whereby BUPA would provide only minimum benefits for some rehab hospitals and all Victorian psych hospitals and there would be high out-of-pocket costs for BUPA members. I stress that this was not a situation where the fund and the hospital went out of contract; the fund and the hospital agreed between themselves that the payment the hospital would receive would be just above the minimum amount. So there was an incentive for BUPA members to transfer. Australian Unity decided to protect itself and its members against the additional cost of these transfers by implementing these benefit limitation periods on psych and rehab for all its products. The department decided not to recommend disallowance, in part because it had previously approved similar rules for BUPA.

Other funds became concerned about the cost implications of mass transfers in the context of contract disputes—and with the ability of hospitals in disputes to initiate these sorts of transfers. Since that time, there have been industry discussions on portability, with some funds—and, to some extent, the AHIA—pushing for a change to portability rules so that members transferring in these situations would not have access to the full contract benefits. To date, the discussions have not led to any significant agreement. Despite all of the rhetoric and arguments around portability, there is an effective portability regime operating in health insurance at the moment. I have seen no instances of hospitals denying people portability rights on transfer, even when there has been contract dispute.

The debate around portability within the industry is about whether the current liberal portability regime should change. I think it is important to stress that, because I think many of

the submissions could lead the committee to an incorrect conclusion that there is something wrong with the way that portability operates at present. No fund has broken ranks on portability, and no other fund has sought to adopt the AU approach of benefit limitation periods on psych people transferring. My assessment is that there has been no significant real impact on consumers as a result of the AU changes—other than the fact that the opportunity for them to join Australian Unity is not there. But, in most cases, consumers have between 12 and 15 other funds that they can transfer to without detriment, and most have taken that opportunity. The effect of the AU benefit limitation period has simply been to ensure that psychiatric members do not join or transfer to Australian Unity. They join other funds and in that way shift the cost from Australian Unity to other health funds.

CHAIR—Can I take it from your statement, Mr Powlay, that you are not making any recommendations to the committee with regard to changes to portability rules?

Mr Powlay—No, I am certainly not supportive of any recommendation that reduces or takes away the consumer's right to freely move between funds without undue detriment, even where there are changes of contract situation.

CHAIR—And you have no other recommendations for us?

Mr Powlay—Recommendations for the committee? No. My view in relation to the portability situation is that the legislation relating to portability does need to be amended to make it clear that it supports the current regime and current policy but, as I said, at present it has not been a problem other than being raised as a point of debate within the industry.

Senator MOORE—Just on that point, as you have said, the submissions we have had on this issue have been ones that have been raising concerns about the process. It seems that it is more that, if Australian Unity can do it, everybody can. Simplistically, that seems to be the view. My understanding, because we had a bit of this discussion at the last Senate estimates, is that that is right under the legislation.

Mr Powlay—That is right, but I would say that Australian Unity made this change in April 2004. In July 2004 the legislation took effect, giving health funds the opportunity to make such changes without any prior advice to the department or minister, and no fund has done anything since then. So I can see no indication at this stage that other funds are moving down that path.

Senator MOORE—But they could, and it seems to me, reading the submissions, that that is the fear. With all the other rhetoric that goes up, that is the fear.

Mr Powlay—I should also add—and the committee may be aware of this—that about a month ago the department circulated within the industry a proposed change to the conditions of registration of health funds which would effectively outlaw what Australian Unity has done in terms of applying the benefit limitation periods on transfer. My understanding is that that condition will go ahead fairly shortly.

Senator MOORE—Is your office involved in those discussions—as an expert—when the department puts something like that out to the fund? Because it is out there for consideration before moving forward with the legislation.

Mr Powlay—That is correct.

Senator MOORE—Is your office part of that process in terms of industry discussion?

Mr Powlay—Yes. I made a very, very detailed response. As you would expect, I was fully supportive of the thrust of what they were trying to do. I had some concerns about the draft of the condition and made some redrafting suggestions which, I understand, will be taken up.

Senator MOORE—Is that response to the process of consultation public?

Mr Powlay—It belongs to the department, so you would need to ask them.

Senator MOORE—We will follow up, particularly on the proposal that came out that said that this should change to preclude this from happening in future. You have made a formal response to them on that basis, and we might follow up on that.

Mr Powlay—I understand that they received responses from a number of different bodies and health funds.

Senator MOORE—That is our understanding as well. On the issue of the way people know about your services, you received a couple of thousand complaints about private health insurance matters. Twenty-five of those were about psychiatric matters and 18 of those were in Victoria. Is there anything the Victorian office does differently that would have contributed to that awareness factor?

CHAIR—Victorians!

Senator MOORE—I am surrounded by them.

Mr Powlay—There is some explanation in relation to psych. A significant chunk of complaints related to a dispute between HBA—one of the BUPA funds—and Pine Lodge, a hospital in Victoria, about its contract. The hospital wrote to all of its psych patients indicating that they were going to have to pay a substantial out-of-pocket cost. That resulted in a number of complaints to my office, largely because one person came to me and I was able to fix their problem. Word got around, so others came.

Senator MOORE—So it was stimulated by something as straightforward as finding they could use their office and then telling others?

Mr Powlay—Yes. I think the hospital gave advice of my office's arrangements. In general, though, last year we saw that Victorians were more likely to complain about their health insurance than any other state. That has not always been the case, and I am not sure why it should have been the case last year. I have not been able to get to the bottom of it. But these things do fluctuate year on year. In the year before, South Australians were much more likely to complain. My office certainly does nothing different from the other states in terms of its information and outreach program. By and large, people hear about my office when they receive a decision from health funds. The funds are required to advise them of the existence of my office and their rights to pursue the issue.

Senator MOORE—We heard evidence from the Ombudsman's office about the range of roles that that office takes on, and it is not just about consumer complaints. Do you have a research role in your office? If people had a particular issue within the area of private insurance, does your office have the capacity to look into it?

Mr Powlay—Yes. In addition to the individual complaint handling role, if I identify a systemic issue I can conduct an investigation into that issue. I can conduct investigations on my own initiative. Generally that would be as a result of representations made to me about a particular issue or on becoming aware of an issue, perhaps through media coverage. In addition to that, I do have an information role. I produce information products about people's rights and private health insurance and an annual report on the performance of health funds from a consumer perspective.

Senator MOORE—The reason I ask is that we have had evidence from all states through submissions and from some states in verbal evidence about people's concerns about the effectiveness of private health insurance for people with mental health conditions. There are a range of complaints: the portability issue that you talked about; concerns about coverage for things like psychologists' services, which are not covered by Medibank; the gaps through various private health providers; and the process of using private hospitals for psychiatric services and rehabilitation services in mental health processes. They have been common across all states. Have they come through your office? There are two kinds of generalisations. One is that a lot of people who suffer from mental health issues do not have the resources to pay for mental health insurance so they are closed out from the system all round. The second one is that, even if they have private health insurance, the kinds of services provided are at such cost in gaps and availability coverage that they cannot get the best service out of that.

Mr Powlay—I think your question was whether I have had that issue come to me.

Senator MOORE—Have you had that?

Mr Powlay—No, not outside the context of this inquiry.

Senator TROETH—The Australian government advised us that the National Health Act 1953 requires health funds to pay at least the Commonwealth determined default benefits, and I am sure you will know what I am talking about. Do you receive many complaints from people who feel that they are not given sufficient cost relief, given that mental illness is recurrent and often requires a long hospital stay?

Mr Powlay—Of the 25 complaints I referred to, I think there are about 10 that relate to that issue—from people who were not satisfied with the level of coverage they had, for various reasons. By and large, the bulk of complaints I receive are from people who are not satisfied that they got enough coverage from their private health insurance. So yes, it is an issue. You are right: the health act does require that funds pay at least the minimum for psych rehab and palliative care. That requirement is not there in relation to any other forms of treatment, so they can actually pay nothing for some forms of treatment. The issue of products that pay this minimum level of benefit is one that has been of concern to me and to my office for a long time.

I have particular concerns with psychiatric treatment being limited in this way and I am particularly concerned that many of the products that are developed by the funds and that target young people restrict psychiatric treatment. My concern is that it is very difficult for anyone to assess the risk of becoming mentally ill. A further concern is that in many cases the publicly provided options are not adequate. In some kinds of emergency treatment and so forth—or even, say, heart surgery—at least you know that there is the public system to fall back on. But in many cases with mental illness—particularly involving drug dependency—there is not the availability of treatment in the public system that people would like to see. That is part of the reason why people take out private health insurance. As I said, I am concerned about those products that target young people because the indications are that most of the complaints that I receive are about young people. Indeed, the complaints are made on their behalf by parents. In many cases the parents will be funding the private health insurance for the young person. So yes, I agree there are issues there.

CHAIR—On that point, could you just expand a bit on how private health insurance companies target young people? I do not often watch television, so I do not see the ads. Why do you think they do that?

Mr Powlay—The theory of private health insurance companies targeting young people particularly in their advertising is that young people are less of a risk in terms of expenditure—

CHAIR—Not from what we have heard.

Mr Powlay—With many of these products that target young people, the funds feel they have to be made cheaper and more affordable for young people and, in that way, more attractive. Younger people tend to be more interested in some of the ancillary and alternative therapy benefits, so the sorts of products that you see coming onto the market will offer reasonable benefits in relation to alternative therapies but only offer basic benefits in relation to most hospital treatments, including psych. One fund has recently started marketing a product exactly like that. It only provides hospital cover in the case of accidents or sporting injuries. For most things it provides only that minimum, restricted benefit, including for psych.

CHAIR—You said that people take on private health insurance because services are lacking in the public sector. Could you be more specific about what services are missing? Does your evidence come from complaints or have you investigated more broadly?

Mr Powlay—No. My evidence comes from discussions with people in the industry, rather than any firm—

CHAIR—Private health—

Mr Powlay—Private hospitals et cetera. I do not have hard evidence. But I have read through many of the committee's submissions which seem to support that contention. From what I have been told, there are particular issues around the treatment of substance dependency where often it is extremely difficult for people to get treatment in the public system. There are other priorities. That is one of the motivations for mentally ill people and their parents to look at private treatment.

CHAIR—So it is principally in-patient care or rehab?

Mr Powlay—In-patient care. Bear in mind that I deal with private health insurance matters, so I am predominantly dealing with in-patient care. It is also sometimes an issue that some of the programs offered by private hospitals involve an element of out-patient care and sometimes there can be disputes with funds or different attitudes taken by different funds as to how much of that program they will be prepared to fund.

CHAIR—You said a little earlier that the funds tend to determine what psychiatric services they provide. Is that a fair summation of your statement?

Mr Powlay—No. In general, in designing their policies the funds do not distinguish between what particular psychiatric services there are. They are required under the act to provide at least the minimum benefits for any in-patient psychiatric treatment, no matter what it is. However, sometimes in a contracting arrangement a hospital may propose that the fund pay for certain programs that may include both an in-hospital and an out-hospital element. In some cases, funds will agree to do this. Some funds will not.

There are some types of programs where specific legislative arrangements have been made to allow piloting of both in-hospital and out-hospital services. That model is the model that has been adopted by BUPA with Ramsay's hospitals in South Australia, where rather than fund the hospitals on an episodic basis they in effect provide a capital grant to the hospital for each of its members with psychiatric illness who are admitted. The hospital is then free to use that money as they decide is best, whether that is in-hospital care, out-hospital care, community based care, home care or whatever. It is an extremely flexible model, but it is one that requires some specific authorisation for the fund to become involved in.

Senator MOORE—Is that the only one like that?

Mr Powlay—That is the only one that I am aware of.

CHAIR—So the act should not be changed to more clearly define the in-patient services for psychiatric care to cover all products? Isn't that the requirement under the act?

Mr Powlay—It is a very difficult requirement to incorporate into the act. I think perhaps what could be looked at is whether there is scope for the level of the minimum benefit in relation to psychiatric treatment to be increased or to introduce a requirement that funds provide more than the minimum benefit. As I said, I do not think it is necessary to define psychiatric treatment in terms of what goes on inside the hospital, but there is an issue about the extent to which funds can provide a payment for out of hospital services. I think that issue has been raised with the committee by the health funds. The funds argue that those restraints that limit them to funding in hospital services should be removed and that that would allow them to fund more flexible programs in the manner that they have been able to do in South Australia.

CHAIR—One difficulty I can imagine for people with mental illness in dealing with their private health insurance company would be that they would not know prior to becoming sick what sort of services they would need in a hospital. I do not know whether private health insurance companies spell out in their agreement with people that they provide this service but

not that service in hospital for psychiatric care. Do they do that? Is this an issue you are concerned about?

Mr Powlay—I have been very critical of the health funds in terms of the quality of information that they provide when people join, particularly around these areas where there are restricted benefits. I have put the view that I think the funds need to specifically acknowledge when people are joining those areas that are subject to restricted benefits. Pretty well all of the complaints that I get from consumers when they have had a hospital episode and only been paid these restricted benefits consumers is that they did not understand that that was the limit of their coverage when they signed up.

CHAIR—Did they understand before they came into the in-patient facility?

Mr Powlay—In most cases, yes. But people tend not to be in the best decision making frame of mind immediately prior to treatment.

CHAIR—Thank you very much for coming to the committee today. It is much appreciated.

[10.18 am]

GRAINGER, Mr David L, Chair, Health Policy Development Strategic Committee, Medicines Australia

SHAW, Dr Brendan Antony, Senior Manager, Policy and Research, Medicines Australia

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

Mr Grainger—I am also the director of corporate affairs and health economics for Ely Lilly Pharmaceuticals.

CHAIR—You lodged with the committee a submission, which we numbered 389. Are there any amendments or additions you wish to make to that document at this stage?

Dr Shaw—Not at this time.

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

Dr Shaw—I want to thank the committee for the opportunity to appear today. By way of background, Medicines Australia represents Australia's research based pharmaceutical companies, who discover and develop new medicines. We have about 43 member companies, ranging from small Australian owned pharmaceutical companies to the Australian affiliates of some of the larger global pharmaceutical companies. In Australia the industry represents about 15,000 people, exports about \$3 billion a year, and spends—and this will change depending on how you define it—about \$520 million a year on R&D.

We welcome the opportunity to be here today. We are keen to contribute to the debate about medicines and health in Australia. One of the issues that we have been trying to highlight is the benefits of medicines for society. Often the debate about the Pharmaceutical Benefits Scheme, the ageing society and so forth is focused on the cost side of things, and that is important because we need a Pharmaceutical Benefits Scheme that is well-managed, but we are also keen to make sure that the debate includes a consideration of the benefits of medicines for the community more broadly. More evidence is emerging that medicines can help provide a range of benefits for society as well as for patients and their families. There are productivity benefits from participation in the work force—from helping people get back into the work force sooner—and there are cost offsets in other parts of the health system: for example, medicines for high cholesterol, stomach ulcers or asthma. Using those medicines can often help offset costs in other parts of the health system—in hospitals, nursing homes and so forth.

One area where we think those issues are evident is the mental health area. Our submission tries to highlight some of those issues—where medicines can help to prevent things like suicide, where they can allow people to live at home and in communities rather than in hospitals and where they can help in the productivity of workers by helping them to get back into the work force and participate in society. The MA submission itself was prepared by Medicine Australia's

Health Policy Development Strategic Committee, of which David is the Chair. He was also one of the key authors of the submission. I will hand over to David.

Mr Grainger—Thank you for the opportunity to appear today. I will very briefly build on what Brendan has said. It is clear that medications in the mental health area are a significant part of Pharmaceutical Benefits Scheme expenditure—in the order of over \$600 million in the areas of antidepressants and antipsychotics alone. We were keen through the submission to illustrate some of the benefits that are associated with those particular areas of expenditure and to highlight some of the directions we are going at the moment—in the quality use of medicines as well as in some synergistic things across all the stakeholders in the mental health sector—with regard to how to achieve better outcomes through the use of medicines and to further maximise that value to Australians in general.

I want to highlight two other aspects mentioned in the submission. One is the important synergy with other government programs, such as the Better Outcomes in Mental Health Care initiative, because very clearly the quality use of medicines is partly dependent on good educational activities around prescribers and consumers, as well as access to interventions other than pharmaceutical ones. We think the synergy that is now starting to build around all of those things is very important. Finally, I want to highlight the role that the industry is playing and can continue to play in collaborative research efforts in a wide range of aspects of mental health—well beyond the normal view that the industry supports clinical trials and new medications, which of course it does, and so on. There are a number of good examples now where there has been collaboration with industry on mental health related research, which goes beyond just the role of medications and ways of improving outcomes in general. Part of the reason for industry working on how to maximise the outcomes in general, not just working on how a particular drug works or what particular side effects there might be, is that it is obviously in our interests as well as in the interests of the society as a whole. Those are the key things that we think are important for the inquiry to consider.

CHAIR—On that last point, could you expand a bit on the way in which you can be at arm's length on those issues? We have heard about quite a lot of services and research that is being done through, for instance, ORYGEN Youth Health in Victoria. Some would say it is rather alarming that pharmaceutical companies are funding this kind of research and having a direct role in it. How do you ensure that you do not steer whatever the outcome of this research is towards the greater use of pharmaceuticals for your own benefit?

Mr Grainger—There are two points there. One is that, with respect to research that is very product related—in other words, the evaluation of new medications or the ongoing evaluation of existing medications and new indications—all of that occurs through very well regulated controls and mechanisms, ranging from ethics committees at sites where research takes place, and associated health services, through to international standards and guidelines around the conduct of clinical trials, processes of informed consent and all those sorts of things. So I think the trials, or the research that is related specifically to medications, is very well regulated and controlled.

The synergy that occurs around research, beyond just product or medication specific research, in part comes about because of a realisation on the part of the companies involved that achieving good outcomes in mental health is about much more than just medications. Therefore, there is

some interest—and obviously there is self-interest as well, from an industry point of view—in helping demonstrate those broader aspects of improving outcomes.

You mentioned the ORYGEN Centre and that is one good example of where research has occurred into the role of medications and early intervention in psychosis, for example. That is an example of where there is a specific medication component. There are other examples. One I can think of is where there is some industry funding assisting evaluation practices in vocational rehabilitation programs for people with serious mental illness. That research is nothing to do with the medication component; rather, it is looking at the value and effectiveness of different options of employment and vocational rehabilitation programs. You might ask, ‘Why would industry support that at all?’ I think, again, it comes back to the fact that industry is keen to see the end outcomes optimised because then the whole value of the interventions, of which pharmaceuticals are one, are seen in the best light. There are a range of things like that, extending from that level of rehabilitation type activity right back to biological research at the laboratory stages where industry does get involved. To answer your question, I think there is a very good framework of regulations and so on that protects that.

CHAIR—The committee has heard a lot of evidence to suggest that medications have improved enormously in recent years, particularly in treating high prevalence disorders. There is also a lot of evidence to indicate that there are still many people who are reluctant to take medication, because of the side effects. There are many who use drug and alcohol props because of those side effects. Can we expect some great progress over the next decade or so in overcoming some of those problems, and does Australia currently have world’s best practice, if you like, in pharmaceuticals, or is there a struggle to get some of those drugs onto the PBS?

Mr Grainger—There are three parts to that question. Unfortunately, I suspect that we will continue to see the sort of innovation that has occurred in this area in recent times continue—largely with periodic ‘breakthrough’ steps and then with a lot of incremental innovation. For example, very significant innovation and change went on to move from the older antipsychotic medications, which had a very large number of side effect problems, to what are called the atypical antipsychotics, the newer ones that have significantly fewer side effects—although they are still not without them altogether. That was quite a significant improvement. But after a significant improvement you then tend to get a period of incremental innovation where there are minor improvements. Those are good, but it is unlikely that we will see something that is going to dramatically change the concerns that people have about medications arising from either the stigma around the condition or concerns about side effects. Part of the response to that comes back to the quality use of medicine sorts of concepts—which are about trying to get people to better understand side effects, to manage their medications and to be well informed about risks and benefits. With respect to best practice, I assume you mean best practice in relation to access and to funding of pharmaceuticals?

CHAIR—Yes.

Mr Grainger—The short answer is yes, I think Australia does have the world’s best practice, with a system that provides relatively universal access and has a sound evidence base for making those decisions. Clearly, there are situations where delays occur in getting access to new medications at all. That is often because of the rigour of the process—or sometimes you will see a situation where a medication that is more broadly available to wider groups of patients in other

countries might be more heavily restricted in Australia. That particular situation can become important in the mental health area. Again, a good example is the antipsychotic medications, which under the Pharmaceutical Benefits Scheme are largely funded for schizophrenia and, more recently, for bipolar disorder and, in some cases, for conditions related to behavioural disturbances—and for dementia in the case of one particular product.

From time to time we get calls from psychiatrists who are concerned about access in a community setting to medications that may have been started in a hospital setting under a hospital's access and funding and are not covered for that particular indication under the Pharmaceutical Benefits Scheme. Those situations, I think, are not common, but they can be quite serious when they do occur. For example, severe psychotic depression is a condition that can be very much helped by antipsychotic medication, but it is outside the conditions for which such medications are funded under the PBS.

I know it has been suggested in some quarters that some sort of exceptional access, which would be based on a high degree of qualification and experience, would be another way of trying to solve those sorts of problems. Perhaps some sort of mechanism by which a register of specialists who are able to use some medications outside of the mainstream PBS listing is a possibility.

Dr Shaw—For the committee's information, the Productivity Commission recently released a report entitled *Impacts of advances in medical technology in Australia*. One of the chapters in that report had a quite comprehensive look at the current listing process and some of the issues that might have arisen in delays. They made some findings and recommendations in relation to the listing process for new medicines in Australia. As I say, that chapter looks particularly at pharmaceuticals and the listing process. That might be of use.

Senator TROETH—We have heard some views that over prescription of medicines is occurring. I would like to hear any evidence you have to challenge that view. Also, what role do you consider the pharmaceutical industry should play in encouraging responsible behaviour by the medical profession?

Mr Grainger—In answer to the first question, it probably requires one to look at the subsets of mental health as a whole. There is some evidence that antidepressants historically have been a first-line option for many general practitioners. In being so, it is probable—I do not think there is any good data to document it—that there is some usage in mild depression which would probably be quite adequately treated without medication. I think there is anecdotal support and a lot of expert support for that. It is very difficult to tease that out of PBS statistics, because that sort of information is not available. I think that happens far less commonly outside of that area, because, for example, for low-prevalence and more severe conditions the medication is usually considered appropriate.

In terms of what to do about that and whether there is a role for industry to take greater responsibility in prescribing, again I think there is increasing recognition of the concept of quality use of medicines, which is part of Australia's national medicines policy. That approach suggests that one should firstly ask: 'Is the medicine necessary?' If so, what type of medicine and what is the best one for the individual patient? So, on the one hand, industry's role is to develop and make medicines available with an appropriate range of evidence both of the risks

and benefits and then leave the prescribing decision to the individual practitioner and the individual patient interaction. On the other hand, I think there is an argument that the industry can and should do more around this quality use of medicines approach—provide better information about risks and benefits and better information about what sort of patient is the medicine right for. Increasingly, I think there is recognition within the industry that there is no downside to that for it, because you end up with more appropriate use of medicines, fewer side effect problems and better outcomes.

Senator Troeth—In your submission you have also advocated initiatives such as depressionNet and other web based consumer tools. You raised the question of sponsorship by the pharmaceutical industry for those sorts of initiatives. Are there any partnerships currently being considered by pharmaceutical companies to support those sorts of initiative, and how do companies address the problem that you mention—that is, the potential that such sponsorships will be seen as coming with strings attached?

Mr Grainger—There are a couple of factors there. One is that in general the industry—particularly the companies involved in this sector—share some very common goals with those sorts of organisations and groups about improving outcomes of patients with these conditions. Having done that, we get a great many approaches for funding from those sorts of organisations, because in general they are stretched and relatively poorly funded. There has been a good trend in the last few years towards far greater transparency around any sort of relationship and interaction like that.

A good example of that at the moment is the collaboration between seven pharmaceutical companies and the Mental Health Council of Australia. That came about a couple of years ago, because there had been one-off interactions over time with a couple of companies. With recognition of the fact that it is better to have these things well documented and transparent, this collaboration was put together with the seven companies and documented in an MOU, with some clear goals and objectives. Some of those are more specific to the pharmaceutical component and relate to increasing the quality use of medicine approach—finding ways to do that better. Equally, some of the funding through that partnership is going to things like stigma reduction and overall awareness of mental health in the community. The increasing view is that these things can be appropriately managed with a high level of transparency and documentation and by avoiding a focus purely on pharmaceutical related benefits.

Senator MOORE—This follows on from Senator Troeth's question about overprescribing. A quote on page 8 of your submission begins:

'Thus, even if some antidepressant prescribing is unnecessary or ineffective, ...

And it goes on to talk about that. My understanding of the quote is that, just by having these new drugs in the system, people are going to get better. Is that too simplistic? I have read it so many times. I actually put a big purple thing beside it when I was reading the submission.

Mr Grainger—That may be too simplistic. The paper by Wayne Hall and others argues that there is no doubt that awareness, recognition and diagnosis of depression over probably the last 10 years have increased. Some of that is certainly attributable to the activities of the pharmaceutical industry, as the newer antidepressants became available. The implication is that, apart from the effectiveness of the medications themselves—and, as we said, that is greater in

more severe conditions—the increased awareness, reduction in stigma and increased dialogue at a doctor-patient level have increased the effectiveness of the management of depression. Their data goes on to say that we are now starting to see a decline in suicide rates as a result. Other data supports this. Obviously, that is not totally cause and effect. It is a somewhat more complex interaction of those things that they are getting at.

Senator MOORE—Yes—it is just that that one sentence has kept leaping out at me. There are two things I want to follow up. One is that we have been hearing a lot about advisory groups. There seems to be a proliferation of advisory groups around mental health and health generally in Australia. We have evidence from a number of people about who is actually on them. Medicines Australia is on a couple. I know they are in several of the advisory groups for the PBS. Does the industry have a role in any of the other programs that are around?

Mr Grainger—No, and Brendan can help to clarify this as well. There are subcommittees to the Pharmaceutical Benefits Advisory Committee.

Senator MOORE—I can see the fit there.

Mr Grainger—There is industry representation on those subcommittees. Industry, of course, is not represented at the level of the PBAC itself. There is, from memory, no direct industry representation at the Therapeutic Goods Administration's ADEC. As I understand it, that operates very independently.

Dr Shaw—We have representatives on a couple of the subcommittees of the PBAC. We do not have any representatives on the PBAC itself.

Senator MOORE—I think we have heard evidence about that in other committees.

Dr Shaw—The representatives on the economic subcommittee and the drug utilisation subcommittee of the PBAC are non-voting members, so they are members but have no vote, and we have a representative at the PBPA, the Pharmaceutical Benefits Pricing Authority, as well.

Mr Grainger—That is correct. The other advisory group where industry is represented is on the PHARM committee, which is the ministerial advisory committee on the quality use of medicines. I can speak to that because I am one of two industry representatives. I should clarify: that committee is not a representative committee but is, rather, an expert committee, so there are two people with an industry background on that committee.

Senator MOORE—So you are unaware as to whether industry has any role at the various state advisory committees? Most of them have, in some way or another, some form of advisory committee around health issues.

Mr Grainger—I am not aware of that.

Dr Shaw—Not that I am aware of, no.

Senator MOORE—Your submission actually goes to great lengths to indicate the role of the industry in the overall process and to knock off a bit of the bad press. That is my, again

simplistic, interpretation of the submission. I am sure you have read a lot of the submissions we have received. In a lot of them, increased funding to the area of mental health being majorly taken by the PBS seems to be an issue. What do you say to that?

Mr Grainger—Very clearly the statistics support that quite a high proportion of the increase in Commonwealth funding over the last 10 years or so has been in the pharmaceutical area. I can make two comments. One is that perhaps it reflects a lack of funding in some of the other areas, which I am sure other people have also said. But more specifically around the pharmaceutical area, I think, as Brendan said at the outset, there is very good evidence for the cost effectiveness and cost offsets that occur as a result of some of the pharmaceutical expenditure. Nowhere is that more apparent than in the area of antipsychotics. There is data in the submission indicating that the total costs of management of someone with schizophrenia in the community runs at, in Australia, around the level of \$15,000 a year, and about 10 to 15 per cent of that cost is the medication. The far bigger part of that cost is the hospitalisation, when it becomes necessary, and other sorts of medical care. I guess our perspective is that the return on investment for that pharmaceutical component is very good. That has been why both at the PBAC level, where the cost effectiveness of individual medications is tested, and then at the cabinet level the question, 'Do we allow this to increase at the level that it has?' has been accepted.

Dr Shaw—The other point to add, and the Productivity Commission picked up on this, was that, as David has alluded to, any medicine that is listed on the PBS has to go through quite a rigorous cost-effectiveness process, which is not something you can say for the whole of the health system, I guess. It is quite a rigorous process before a medicine gets on the PBS, in terms of demonstrating its clinical effectiveness and its cost effectiveness, its value for money and so forth.

Senator MOORE—I cannot help asking this question because of the evidence we have received: in a number of states we have received specialised evidence about childhood behavioural issues and the linkage between the prescription of various medications and some assessment, particularly in Western Australia, that there has been an overuse of medication for that area. Probably one of the more dynamic pieces of evidence that the committee had was when a whole group of people who had different views on this issue were collocated and giving evidence. It would be fair to say that there was no agreement at the end of that. But, particularly in view of the fact that we have had specialised evidence on that issue, I think it would be useful if I asked for some comment from your body and also whether you have any papers you have released on this particular issue. Just for the record, can we have a comment about the situation of childhood to young adult behavioural issues and the use of medication in the treatment of that?

Mr Grainger—Firstly, I think there is increasing evidence from some of the large longitudinal child health studies such as the Otago study in New Zealand that mental health problems in the broader sense in childhood do lead to more serious problems in adulthood. I think that is becoming more and more accepted. From an industry point of view, I think the view is that the important factor here is sound diagnosis. If one looks at attention deficit and hyperactivity disorder, which is one of the more controversial aspects of this, there are good diagnostic criteria in existence. There are specialists in Australia both in the child psychiatry and paediatrics areas who adhere very strongly to those diagnostic criteria. So the industry's approach—there are a couple of old and well-established medication options in that area and

there is at least one newer one—is to research, register and market those products in relation to that diagnosis and all of the evidence being built around that.

Very clearly, what the Western Australian situation illustrates is that there is scope for people to fudge that diagnosis and have a broader interpretation than what I would call mainstream practitioners would. I think the industry view, as I said, is very much that diagnosis is very important and needs to be properly and appropriately done. But, when that is done, there is also good evidence that medication is beneficial in a number of ways, partly in specific and short-term symptomatic improvement of the various problems that a child might be experiencing. From some of the very large international studies there is the suggestion that, if you do those things well, you get longer term benefits for these children as well in terms of educational improvement, societal behaviour and all of those sorts of things. I think the focus has to be on accurate diagnosis in the first place.

CHAIR—Where new antidepressants come on the market and are very superior to the old ones, do the old ones come off?

Mr Grainger—No.

CHAIR—Why is that?

Mr Grainger—Normally they will wither in terms of use anyway because people will tend to replace the old with the new. Sometimes, as happens in many therapeutic areas, you will have groups of people who respond better to something that has been around for some time so you will often get a residual level of usage that continues because that happens to be the best thing for certain people. Normally companies do not take a product away when they bring a new one on. Certainly the use of that product diminishes over time.

CHAIR—The committee has had evidence—I am not sure who gave it to us—to the effect that those old antidepressants were in fact no better than placebos in studies that were done in other parts of the world. Are you aware of that?

Mr Grainger—There is quite a lot of debate from time to time about the effectiveness of not only old but also new antidepressants in relation to clinical trials and outcomes versus placebos. I think the body of literature—and there are meta-analyses of studies that demonstrate this—shows that antidepressants both old and new are more effective than placebos. The area where it becomes controversial at times is where trials are very short. Duration is probably one of the biggest factors. There is also recognition that, in treatment of depression, there is a large placebo effect. Many people do improve from being in the trial. That is not necessarily the same as taking nothing. The fact of being looked after in the trial will improve mild depression. Again, one has to look closely at the entry criteria for the people in the trial, ask if they were in the right group and examine the body of evidence.

CHAIR—I will try to dig it out, but presumably it was peer reviewed. But you are saying there are other studies that show otherwise.

Mr Grainger—Yes, I am saying that the consensus in the literature is that, properly done, the trials support the view of effectiveness.

CHAIR—To follow up on Senator Moore's question about children and ADHD, is it still the case that no clinical trials are done on medication for children?

Mr Grainger—No, that is not correct. A lot of people would argue that there are too few studies done of children, and there are lots of reasons for that in terms of the logistics as well as the medico-legal side, ethics and all those things associated with it. A lot of the critics say that there are too few studies done of children and medications in general, but for medications that are specifically for use in children, yes, trials are certainly done. In the case of ADHD medications, they are quite substantial.

CHAIR—You mentioned in your submission the government's Better Outcomes in Mental Health initiative and say it is:

... to be commended for its comprehensive approach to up-skilling GPs ...

We have heard conflicting evidence on the question of how upskilled GPs are, I think it is fair to say. Also, questions have been raised about whether, under this program, people are more or less likely to be medicated. It would appear that, where there is a referral to a psychologist, for instance, the practice is to medicate prior to the referral. Do you have any data on whether a GP who is not trained and therefore not able to be involved in Better Outcomes is more or less likely to prescribe medication? One of the interesting aspects of this program is that we pretty much have the least well-trained GPs doing the training as opposed to those who have had a minimal training period being able to refer to someone with expertise in counselling and so forth. My question is really about that data: do you have any and would you like to comment on that practice?

Mr Grainger—No, we do not have any data. I can understand the question, because, as you say, there is a certain paradox in how the program is targeted. The only comment that we would make from the industry point of view is that something often overlooked about the role of medication is that often it is the thing that helps people get to the point of being able to engage in the non-medication options. That is particularly the case, obviously, with severe illnesses—that almost goes without saying—but it is often the case in depression as well where the dysfunction at the acute stage when the person presents to a doctor in the first place can often be so acute that the desire, willingness and ability to participate in, say, cognitive behavioural therapy at that point are not there. Again, it needs to be patient specific in terms of the severity of the condition and all those sorts of things. There are occasions where the medication becomes an important first step, with the follow-on to other treatment as soon as possible and as soon as the person is more physically able to engage in that. I suspect that is part of the phenomena that you mentioned, but, no, we do not have any specific data on how prescribing might differ across the system.

CHAIR—Rather than medicating in the first instance, can you see a problem with the two health professionals—the psychologist and the GP—looking at each case in order to determine whether that is warranted?

Mr Grainger—No, not at all. I think that is probably an ideal scenario and, whilst it is not necessarily our role to comment, the feedback that we often get, as I am sure you have heard, is

about the lack of resources and the difficulty of getting those sorts of consultations to occur. In principle, I suspect that would be ideal.

CHAIR—Indeed, we have heard a great deal of evidence about ADHD and how medication should only ever be one aspect of assistance for such children, but those other bits are not really ever available or adequate in the way they ought to be.

Mr Grainger—We have certainly had the same thing expressed to us.

CHAIR—You would say the same?

Mr Grainger—Yes.

CHAIR—As there are no further questions, thank you very much for appearing today.

Proceedings suspended from 10.55 am to 11.11 am

[11.11 am]

CASTLES, Dr Carole, President, Australian College of Psychological Medicine

CHAIR—Welcome. You have lodged with the committee a submission which we have numbered 411. Are there any amendments or alterations you want to make to that document?

Dr Castles—No.

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

Dr Castles—The Australian College of Psychological Medicine felt that the opportunity to make a submission was fortuitous. We are an unusual group of people, I think, who spend some of our time trying to bridge some of the gaps in the provision of care for people with mental health disorders. We are medical but we are not psychiatrists. Many of us practise in a more psychological way and that gives us a different perspective from some of the other bodies that will speak to you. It also gives us an opportunity to give some indication of the spectrum of things that we may see and deal with and the inadequacies of our ability to enlist additional assistance or resources for some of those things.

CHAIR—Can you expand on the position of the college on the Better Outcomes in Mental Health Care initiative? This has been a fairly central issue to the committee and we would like your perspective on how well you think that works and what improvements you would like to see made to it. I am not sure how your membership is formulated, but are the people in medicine who are with your organisation part of that program?

Dr Castles—The majority of our members work in primary care. They would be considered by most people to be general practitioners with an interest in mental health. A smaller proportion of our practitioners are doctors but they practise wholly in mental care and not within a managing people's blood pressure and other issues type framework. They are providing mental health care alone.

CHAIR—As private practitioners or in community health centres or what?

Dr Castles—We have people working as career medical officers in the mental health system in some states. The majority of our members—85 per cent—work within private practice. We did a survey almost 12 months ago—so I am afraid my data is no newer than that—that said that 35 per cent of our members underwent the better outcomes training and registered. We have less than 20 per cent of our membership—less than two-thirds of the people who registered—who actually claim under Better Outcomes. There are a number of reasons for that. Bureaucracy and rigidity are perhaps two of them, and the red tape and the difficulties of some of the claims processes. They have been ironed out as time has gone on but it is not always an easy system to use.

The biggest limitation our members have is the requirement to be practising on that day within an accredited general practice. We have members who, for some very good reasons, are not

working within an accredited practice when they do their mental health work. Some actually choose to do their general practice in a normal practice and to go somewhere with more of an office environment to do their mental health work; they believe that facilitates the kind of work they do.

We have members who are working in university health centres, which are not accredited as general practices. In our submission we have an example of one member who does wholly mental health work. For half of his work he works out of an accredited general practice and for the other half he rents a room in an accredited practice, but the room is not accredited because it is thought to be part of the specialist centre. So he can only claim Better Outcomes rebates for half of the work that he does, because of that anomaly. It seems unusual to us that, having accredited a practitioner to be conversant with the requirements of Better Outcomes, you then have to accredit the room as well.

CHAIR—Is this because some of those unaccredited places would reasonably be run and conducted by state governments? Is that the argument the Commonwealth provides?

Dr Castles—The Commonwealth has not provided an argument as to why the accreditation requirement is included.

CHAIR—Are you confident that the current review of Better Outcomes in Mental Health Care will—

Dr Castles—We have made a submission to that review and hope that we will be heard. We are not the only organisation that finds that difficult.

CHAIR—Do you have any other suggestions to make about Better Outcomes?

Dr Castles—Better Outcomes is a nice starting place. It acknowledges a need for a continuum of professional care for people managing mental health issues, from primary care, through a multidisciplinary approach to some skill building on top of what skills a general practitioner might bring out of their undergraduate and college training, right through to psychiatry. Our perception has always been that one of the reasons the college exists is that, between general practice, and even people who had an interest, and psychiatry there was a very broad gap in terms of access to people with some additional mental health care training. There was a gap in access to people trained in the talking therapies. Better Outcomes goes some small way to try to bridge that gap, but unfortunately not far enough, we believe.

We grew as an organisation out of a group of medical practitioners who had an interest in mental health, most of whom had sought, in their own time and at their own expense, additional training in mental health to feel more competent in filling that gap. They came together in the college for collegiate support, to share training opportunities and to help upskill each other. But to the rest of the world most of us are general practitioners; we are not psychiatrists—and there is no middle ground.

CHAIR—Does your organisation provide training for your members?

Dr Castles—The organisation itself is small and does not provide training specifically for members. A significant proportion of Better Outcomes training around the countryside is done by people who happen to be members or fellows of our college. We otherwise pool training opportunity knowledge. I work with a lot of psychologists—perhaps more than most doctors would—so I hear about training opportunities in the psychology network as well. I have colleagues who work with more social workers than I do. So our members, albeit medical practitioners, often go along to training courses that are aimed at psychologists and other practitioners, in order to make themselves more aware and better prepared to deal with the spectrum of things that walk through their door.

CHAIR—So you are not critical of either the length or the content of training for GPs for the first stage or the second.

Dr Castles—That is the next step. Better Outcomes is a nice starting place. We have a concern that the range of therapies and orientations that are available to be trained in through Better Outcomes is very narrow. I understand the reasons why the evidence base is invoked. I think it is worthy of discussion some other time as to the weakness or the limitations of the evidence base. The limitations in the time make it very easy if you see somebody with a single, discrete mental health problem. But in primary care we do not see people with a single, discrete mental health problem. We do not see somebody who has depression and does not have anxiety or does not have the depression on top of a post traumatic stress disorder or does not have substance abuse on top of a personality dysfunction. That is the reality of life and that is human beings—they do not come through the door with a single mental health diagnosis.

The range and depth of training available through Better Outcomes has assisted many GPs to feel more competent to deal with a lot of the stuff they see, but it goes a very small way towards providing care for the wide range of mental health issues in this community.

In saying that, we have to remember we are talking about mental health, not just mental illness. We have a very strong orientation towards early intervention and preventive strategies. Because we work in primary care, many of us are dealing with teaching parents better behaviour management for children. We are involved in trying to help adolescents learn better coping skills—ones that do not involve drugs and alcohol—because they are our patients and when they walk through the door that is what they need of us. So we are looking at a spectrum of mental health care, not just the management of the tip of the iceberg—that is, of very disordered and distressed people who have severe diagnosable mental illnesses.

CHAIR—How many of your members specialise?

Dr Castles—We have around a third who work wholly in mental health.

CHAIR—How do they get by with the HIC and long consultations? They must be doing more than most.

Dr Castles—A significant proportion of them are no longer considered vocationally registered if they do not have an FRACGP and are not able to claim the vocational registration rebate for their patients, which exacerbates the difficulty of providing that care.

CHAIR—No; I was referring more to the need for long consultations. In dealing mostly or wholly with mental illness, presumably your members—

Dr Castles—They get investigated!

CHAIR—Precisely.

Dr Castles—They get investigated but they get through the investigation, as people come and see that they are providing a bona fide service. They are not overservicing. People look at the client population they are dealing with. We do not have anybody who has had ongoing difficulty with HIC.

CHAIR—That is good to hear.

Dr Castles—The difficulty does arise because some of our members have fellowship of the Royal Australian College of General Practitioners and are members of the vocational register, and others are non-fellowship vocationally registered, and there is some slight difference in the way the requirement to be predominantly in general practice is applied to those two groups. Several of our members are no longer on the vocational register because they were grandfathered in the old days—they do not have the fellowship—and are working wholly or predominantly in mental health; they have had their vocational registration withdrawn. I have two members who no longer practise medicine at all as a consequence of that.

CHAIR—Is that right?

Dr Castles—Their practices were no longer viable.

Senator TROETH—You have recommended a new item number for lengthy consultations.

Dr Castles—That comes down to numbers. It will always come down to numbers. When they are dealing with mental health issues, most of them require considerably more time, either to engage with the patient or to explain things, or to manage multidisciplinary stuff. For instance, I work with a lot of suicidal people, and fitting suicidal people into 15-minute consultations is quite difficult. It is the nature of the beast that mental health consultations will tend to be longer. If you are working within a framework of broad general practice, it is more financially viable for you to put a small proportion of that aside for long consultations and still be able to keep the business afloat. For those people who are working predominantly in mental health, the rebate per minute for long consultations is effectively very poor, and many of our members do those long consultations at significant financial detriment to themselves—given, particularly, that the population they deal with are those people least likely and least able to pay a differential gap.

Senator TROETH—Have you proposed that new item number before?

Dr Castles—We are in the process of trying to put together a more detailed submission with some more background to it. We have that perspective. The issue, obviously, before we try to make a formal move is to have the second and third levels of ‘what ifs’ behind it, and that is what we are working on the moment.

Senator TROETH—So you have not got any idea of what the reception might be?

Dr Castles—I would expect the reception, on the whole, to be poor—

Senator TROETH—Yes.

Dr Castles—because it is a demand-driven service on a cash-limited budget.

Senator TROETH—Yes.

Dr Castles—I have spoken with senior health officials who perceive that if we remunerated minute by minute the same, then all doctors would want to sit around and talk to their patients for an hour at a time, but there are a great many doctors who would rather not do that. It is draining work; it is not sitting around chatting to your patient for an hour.

Senator TROETH—I can appreciate that.

Dr Castles—That is also one of the obstacles. It is seen as potentially a bottomless bucket if you say to people that there is no disincentive to long consultations. I can see the point of view. I do not necessarily agree with it, but I perceive that would probably be the major obstacle to having a submission accepted.

Senator TROETH—You have also talked about the importance of early intervention and the fact that almost 50 per cent of people with mental health disorders are not recognised by their GP as having a psychological problem. Your college is working with Auseinet to develop programs and create education modules. Can you tell us more about the education programs. If doctors are failing to recognise mental health problems in their patients, in your belief is there something missing in the undergraduate training they receive?

Dr Castles—I think it is a systemic issue. There are time limitations. We have to remember that the majority of patients do not walk through the door and say, ‘Excuse me, doctor, I have a mental health problem.’ They present for other reasons. It may take quite a long time to recognise that there are underlying issues behind the other presentations of a patient. Addressing the failure to recognise the mental health disorders of 50 per cent of people requires that doctors be made more aware—but they have to be aware of so many things. Particularly in primary care and in general practice, not a quarter goes past without us being told by a specialist college that we are not very good at something and that we should all improve our education and our ability to pick up something else. There is only so much time in that framework. I think it could be improved. It will never be 100 per cent—that is the nature of human beings.

The other aspect that is not quantifiable is that not all general practitioners have an interest in mental health. They go into the profession for a wide range of reasons, the same as people go into any other profession. There are people who are comfortable dealing with emotional distress and there are people who are not comfortable dealing with the emotional distress of themselves and others. Doctors follow a personality distribution very similar to that of other groups. There are those people who, I would imagine, even if there were sparklers going off, might not see things and then other people who have an interest and a sensitivity to those things who are perhaps more likely to ask or to probe.

Senator TROETH—What about the education programs?

Dr Castles—Education programs are still in their infancy and not rolling out at the moment. In three states some of our practitioners are involved in postnatal care and assisting with behaviour management of infants. They are also closing the net with respect to identifying mothers who are not coping with the change in their role or with looking after many small children—or any of those other things—and trying to support them in terms of parenting skills. The other aspect is to try to identify people through things like postnatal groups, rather than through community identification. All up, we have about 12 practitioners in various places who are closely associated with schools, often in rural areas, where the medical practitioner knows the community well and is closely associated with the school. They are involved, again, in trying to recognise behavioural difficulties early or to recognise adolescents who are expressing distress or not functioning as well as they would hope at school and making resources available, particularly to small communities.

We accept that a very large proportion of adults with mental health problems could have had their path through life smoothed if things had been picked up earlier with not only some treatment but support for their family, some training in parenting skills and some backup respite for difficult situations and all those other things. We are looking at early recognition of the improvement in behavioural skills, because that flows on to the rest of the generation. When we are dealing with people with a diagnosable mental illness that we are treating ourselves, we always look at the implications for the remainder of their family and their children. Where we are seeing a patient of ours who is perhaps not coping well in the family environment, the challenge is to find another resource to bring in to help support that family in the hope that we will not get that vertical transmission of difficulty to the next generation.

Senator MOORE—What involvement has your college had in the Better Outcomes process with the range of advisory committees that the minister is surrounded by?

Dr Castles—We write letters and we make submissions.

Senator MOORE—So you are not involved in any of those things?

Dr Castles—No, we actually have a close association with one or two members, who we speak to. We are a very small and not a particularly visible organisation and one whose role and goals do not always coincide with some of those of some of our colleagues. We are still finding our feet. We do not consider ourselves in our infancy anymore, but we are still toddlers as organisations go.

Senator MOORE—The way the submission reads, you are the face of primary care who are interested in mental health. In all the propaganda we have about Better Outcomes and GPs, this is the group that I would have thought would have been involved. But you are just able to write letters and things; you have not been specially sought out to be involved and involved in feedback?

Dr Castles—Certainly not.

Senator MOORE—In reading the linkages with the different places it seems there is a linkage with South Australia. Is that just coincidence?

Dr Castles—The organisation was formed in New South Wales. The second major changeover in the executive coincidentally took three people out of the executive who were in Adelaide. We have a member of the executive who is a member of the University of Adelaide's Department of General Practice. A lot of work we have done in South Australia has been through that liaison with the South Australian Mental Health Education Initiative, which is supported through the University of Adelaide's Department of General Practice. That is one of those places where we actually had somebody in an organisation who could assist us with our goals.

Senator MOORE—That is the linkage—with the university and so on?

Dr Castles—Yes.

Senator MOORE—It is hard to pick one issue out of all the evidence we have, but there is one about the shortfall in the work force. It comes up all the time—there just are not enough people working in the area. As someone practising and interested in this area, have you or your organisation given any thought to what can be done to encourage more people to be GPs and more people to work in the area of mental health?

Dr Castles—We have talked about this extensively—

Senator MOORE—I thought you might have.

Dr Castles—and we look at it from two perspectives. One is to try to get more people in at the front end and the other is to try to slow the attrition at the other. It is not easy work to do. We are members of the professional peer support program that the RACPG is sponsoring and supporting in an attempt to improve self-care amongst doctors and perhaps to lower the degree of burnout. Burnout is a significant problem for people working in the mental health arena. The people who choose this work tend to have a very high level of dedication to their patients and to the issue and are often very passionate about it. As a consequence they sometimes overlook their own care. Every year we lose perhaps seven or eight fellows out of a small organisation like ours who have taken retirement early or have moved into a non-clinical aspect of medicine as a form of respite.

My undergraduate training was quite unusual—I graduated in a little boutique medical school in Western Australia, which was relatively young at the time and had a course in behavioural science in medicine from second year.

Senator MOORE—That is unusual.

Dr Castles—I think we were very unusual. My graduating year of 94 people has 11 psychiatrists these days. So I think we were an unusual little group of people.

Senator MOORE—That is relatively high, isn't it—over 10 per cent?

Dr Castles—It is very high. We ended up with the expected 40 GPs, but we ended up with 11 psychiatrists, which is unusual. So I cannot speak from experience. I had a good mental health grounding and perhaps a lot of my graduating peers felt the same and felt confident to go into that area. The difficulty arises out of there being so much to teach. We need to be better at identifying those people who have an interest early and fostering that interest. The undergraduate training still revolves strongly around psychiatry, which is tip-of-the-iceberg mental illness, predominantly, and I do not necessarily think that the spectrum of intervention possible to medical practitioners is appropriately represented. Psychiatry might be a scary prospect to a lot of people who would be more than interested in developing a particular interest in mental health in primary care.

I do not think we identify people well early enough. I think the demands upon undergraduate training are significant. The amount of mental health training people would get as a consequence of their FRACGP training is variable and, again, depends somewhat on interest. I am not the most appropriately qualified person to speak on that subject. People tend to follow their interests. I think we have to peak their interest a little earlier, particularly—and this is going to sound awful—with the predominance of women we have coming in the medical profession. All the statistics show that, of those people working in mental health in primary care, a strong predominance of women choose to work in interpersonal ways. I was speculating earlier that women may feel more comfortable dealing with distressed people, which is a nasty generalisation to make. It is one of those things whereby we need to peak interest early. This is about taking care of whole people, not individual illnesses, and that is very much the orientation we have as a college.

Senator MOORE—Does the medical school that you went to continue to have that dual stream of behavioural science and medicine linked?

Dr Castles—Not that I am aware of. That was very much fostered by the now professor, Bob Sanson-Fisher, who happened to be our senior lecturer in behavioural science at the time. But, as a second year medical student, I was taught active listening skills, reflection, self-management in the face of distressed people, how to manage angry relatives and a bunch of things that I took for granted. I found out after graduating that my peers from other colleges and other areas had not had that exposure in their training. I came away feeling comfortable with distressed people to a greater degree, and that facilitates the ability to pursue this as an interest.

Senator MOORE—That is very valuable.

CHAIR—What has happened to that boutique course?

Dr Castles—We joked about it being a boutique medical school because, when I first came to the eastern states, it was not looked upon favourably by some of the more ivy league medical schools. Sydney and Melbourne people told me it was a nice little boutique medical school but it would not last.

CHAIR—And did it last?

Dr Castles—It is still there. The medical faculty in Western Australia continues to flourish, but I do not have close enough contacts these days to know whether they still have such a wonderful orientation to mental health early in their training.

CHAIR—I am interested in your response to our terms of reference (e), which is about unmet need. You choose to respond to unmet need in family and social support services. You make very strong statements. You say:

The College believes there is no choice but to develop a co-ordinated approach to providing services dealing with social disadvantage and isolation ...

You go on to talk a lot about children and teaching parents to respond to children in a non-damaging way. Would you like to expand on that? Your recommendation from that is that the GPs should do more of this parenting skills work.

Dr Castles—I think GPs can do that. I see that not all GPs will want to do that work, but I still see a very strong role for GPs as a pivot and a case manager in a multidisciplinary approach. It is all very well for us to deal with what we might consider to be a very damaged parent and to see their behaviour causing difficulty at home in their children, but we are constantly frustrated at the inability to find anybody else to share the management of that family and to go into their own home and to mitigate against some of those difficulties. Whether the parent has a substance abuse problem or a personality dysfunction of their own or whether you have a parent living with post-traumatic stress disorder, all of those things are going to affect the environment in which young people are brought up.

The thing that strikes us on a daily basis is the extent to which the people we see come from those sections of the community least able to initiate contact with what facilities there are. They are least able to persevere, and you often have to be very persevering to try to get some kind of care. The bottom line is that the resources are just not out there. The public resources we have access to, be they social work, psychology or those things, are dramatically overburdened. If we pick something up early, we cannot pass it on to a system that is so overburdened it can only deal with the tip of the iceberg stuff. The frustration of being sent away and told to bring the problem back when it has got out of hand is the real tragedy here.

CHAIR—Is the problem with the model and it is just a question of resources, or would you like to suggest to the committee a way in which, as you describe it, GPs might be pivotal to another multidisciplinary group? What would that look like in an ideal world? How could the Commonwealth and state governments work together to achieve that?

Dr Castles—The first thing would be that we would not have the state and Commonwealth divide in the resourcing and funding which makes it so difficult to try to coordinate. The kinds of public resources we are trying to access tend to be state based resources out of public health clinics and university and hospital departments. I would be the first to accept that they will never have all the resources they need to deal with all the problems, but they are so poorly resourced. Their staff turn over fast because they burn out. They cannot possibly deal with the spectrum of mental health issues as we discussed and must, of necessity, deal with the most disordered and distressed people, who take up an inordinate amount of time. If we go back to the idea that 20 per cent of the clientele will take up more than 80 per cent of your time, that very much applies

to the people whom our current public resources are trying to deal with. Again, first steps are being taken with the ability to look at the enhanced primary care scenario with case conferencing and having a management plan, but that still presupposes that you have other people to be in the team. There is a willingness by a lot of practitioners to do that but there are no other people to be in the team.

CHAIR—Coming back to your comments about evidence based medicine, is there evidence that early intervention with parents can work? Or, by the time you become an adult and a parent, are you so set in your ways and preprogrammed, if you like, by your parents that almost nothing works?

Dr Castles—There is variable evidence, most of which is from overseas. Much of it comes from a field of study that looks at attachment theory—that is, the bond that occurs between primary carers and infants from a very early age. One of the primary roles of the bond between a carer and an infant is to teach the child emotional self-regulation. Most of do it instinctively with an infant. If they are getting overwrought, we wind them back down again; if they are completely flat then we will tickle them, and wind them up again. This is normal. We use our ability to express emotion in our faces and our voices and the way we deal with an infant to teach a child to self-regulate. We continue that through. The research shows us that the first 12 months—perhaps even the first six months—is vital in planting the neurological foundations for a child to be able to self-regulate. Children who experience significant stressors in the first three months of life have the threshold for their stress response mechanism, like a thermostat, reset—almost for the rest of their life. They often go from a day-to-day basis perfectly well but then, when challenged with something that causes them to decompensate or become distressed, their response will often be much, much greater than one would expect or they may respond to normal social stressors at a much lower threshold. There is some very good research that shows that. We are talking about early early intervention as well as recognising dysfunction and illness and mitigating them once they have been recognised, trying to prevent them from progressing.

CHAIR—Would you put ADHD in those dysfunctions?

Dr Castles—ADHD, we understand, has a very strong biological basis. This is a very philosophical issue—that is, the division between mind and brain. As we understand the neurology of the brain and how behaviour, mood and those other things are managed in the brain, more often we are starting to move where that divider is. The medical profession has a stronger understanding of that as a biological model and have a better understanding now of which parts of the brain do not function in the same way as they might in somebody else. In a lot of the community it is still a mind issue, which is one of personal identity and personal responsibility. I think that is sometimes where we end up with a bit of a mismatch in understanding.

My personal understanding of ADHD is it has a strong biological basis, but again you need to teach a child to self regulate—and these are very trying children to try and teach to self regulate; they require a lot of input over a long period of time. The research shows that behavioural management and behavioural modification in ADHD children is very efficient in terms of resources, but that is only because the medication is very expensive. So if you weigh up the cost of medication against the cost of behavioural intervention, they actually come out quite well. The problem is that it takes time and people to help with the behavioural intervention, and there

will always be a proportion of children whose behaviour needs to be reined back a little so that they can attend to and participate in the ongoing behavioural stuff. I do not see it as exclusively one or the other; there is a role for both. And there are some families better able to manage challenging behaviour in children because of their own resources than some other families.

CHAIR—It is complex, as you say.

Dr Castles—Yes; people are messy.

CHAIR—A further question on that subject: the head of psychiatry at the Royal Children's Hospital in Melbourne argues that many children are receiving medication for ADHD who do not need it because their level of impairment is not at a certain point and many others who have serious impairment are undermedicated, and that impairment is different from symptoms. Do you agree with that?

Dr Castles—I agree with the concept that impairment is different from symptoms. Symptoms you can ask about and have recounted; impairment is the degree to which life has become chaotic and non-functional. Some of the discrepancy will always occur because different people have a different tolerance for the dysfunction. An outsider might determine the level of impairment as being relatively little, but you can have a child who is in a family or in a classroom that does not have the ability to tolerate even that level of impairment. If that then breaks down the environment around them, then perhaps you are better managing that child at a lower level of impairment than you are trying to tell everybody that they should just be more patient or they should just have another teacher's assistant in the classroom or they should just teach all the other children not to be worried about being poked in the eye.

There is a lot of dispute about whether you can measure impairment objectively at all. It still comes down to whether or not the environment that supports that child can tolerate their behaviour and has the resources to manage it. There will always be environments that do not have those resources and the medication may produce a faster and smoother response in that environment where we all know we would perhaps prefer to use a different method.

CHAIR—I want to change tack a bit and ask you about the comorbid conditions or dual diagnosis, or whatever is the latest term, for drug and alcohol use in association with mental illness. How well equipped do you think GPs are to handle dual diagnosis? We have heard so far that there is a fair bit of rhetoric about the need for the two to be dealt with together and that GPs and others should not say, 'Come back when you've got rid of your drug problem or alcohol problem', and that there is a problem with the separation of psychiatry and drug and alcohol services in this country. Do you have a view on that? How well equipped do you think GPs are to deal with those issues?

Dr Castles—I come back to the perspective that we need to treat whole people and not individual disorders. You cannot divorce the two, and to tell somebody to come back when they are drug-free does not help people deal with the underlying reason why they may have taken up drugs in the first place. It is very hard sometimes to work out which came first, the mental disorder or the substance abuse, and a proportion of people who are substance abusers are self-medicating their anxiety or their depression or their distress in some other way. My perception is that general practitioners are not particularly comfortable in managing substance abuse and

alcohol abuse if they do not have additional training. The other aspect of that is to know where your backup is if you take on the management of drug and alcohol issues in a patient. I work in a fairly privileged environment at the moment and have a lot of backup in that respect, and I am not reluctant to make a diagnosis and get involved in the management of somebody because I have a lot of backup.

For instance I would guess the majority of GPs do not know a great deal about drug subculture—that is, where a substance abusing person may live and the environment of the world in which they live. It is not necessarily a comfortable situation when a person is going back to live in a squat and, perhaps, a lot of risk-taking behaviour. It is not always something that is easy to deal with. We come back to social disadvantage. It is all very well to try to manage and mitigate, but what else is there to support that in the background? We are bound to still miss people who are substance abusing. As I said, people do not come in and volunteer that information but, after a lot of treatment and a lot of relapses for their depression, it may become apparent that there is another issue.

Despite a lot of rhetoric, I do not think we have a handle on alcohol abuse within our community. There is still a lot of cultural tolerance of heavy drinking and, particularly amongst our young people, there is the escalating problem of binge drinking. Sometimes it is hard to intervene early because society often tolerates their behaviour. It is very hard for an individual to appreciate that there is something that needs changing when everybody around them is behaving in the same way. There are social impediments to trying to intervene. I can know what is best for somebody but that is not the right approach to take. The individual has to perceive that there is some value in engaging in treatment and ongoing management. People are messy.

CHAIR—We will see a bit of that messiness. We are going to the Gold Coast during schoolies week.

Dr Castles—And taking your mental health practitioners with you.

CHAIR—We have a few minutes, so I will ask you another question on the idea of dealing with the whole person—and, we hear you say, the whole family as well. Those people are either parents of people with a mental illness or children of people with a mental illness. We hear that practitioners often do not want to know about ‘significant others’ in a person’s life. They tend to very much look at that individual alone. Is that your experience? If someone comes to you with a significant mental illness, do you ask them whether they have children at home before they get put in hospital?

Dr Castles—Always.

CHAIR—What is your experience with others? Is this a criticism you have of services generally?

Dr Castles—I do not believe it is a systems issue. I think it comes down to the individual practitioner or whoever is providing the care. It is very much easier to see a problem with a line under it or a box around it. I work in mental health. I come from a different orientation than one that says that a person’s behaviour will often make sense in the context. I can be trying to change a behaviour in an individual that actually makes sense in the context of their difficult home or

their dysfunctional home. I am dealing with people who do not have a home to go to, which is the other side of seeing people as part of a system.

I and a lot of our college practitioners have training in family therapy. If you come from that background, you have much more systemic orientation. No man is an island. A great many people self-medicate because of conflict at home. If I send somebody home on medication that is going to impair their ability to act as a parent, I have to take that into account. If I want somebody to take time out to take care of themselves, I have to know whether or not there is somebody else to take care of children. If I know that somebody is a serious substance abuser, I have a very strong responsibility to know whether there are children in that house and the effect it is having on them.

The difficulty comes down to dealing with carers. Carers, particularly young carers, are put under an enormous amount of strain. Children and adolescents caring for an ill parent are quite invisible in our world. They come in with a problem, and it can be dealt with. You may or may not know—unless you make a point of asking—how things are at home. You might have to ask many times before somebody will tell you, but do not believe that human beings are islands. Their behaviour makes sense generally in the context of the other things that are happening in their lives and the other people who are in their lives. In the absence of other resources I have to rely heavily on families to either collect information for me or to report if things are not working or to support a person in their attempts to become well or to make changes in their lives. I have to see people as part of a system.

CHAIR—Our hearing with Commonwealth agencies a couple of weeks ago raised the question of standards and guidelines—I probably do not have the right title—that are used by GPs for particular circumstances and conditions. Do you have a view on the adequacy of them? Should more work be done by the Commonwealth in providing guidance to GPs in that way?

Dr Castles—I am having difficulty with the question without having an example of what kind of guidelines you are talking about.

CHAIR—I am talking about practice guidelines. The issue came up because there is one whole area where there are no practice guidelines at all. I forget what it was but, since you are presenting to the committee a slightly different approach, I wonder whether you have had a chance to look at practice guidelines and whether they might be a solution to looking at the person in the whole, and children and parents and so forth.

Dr Castles—My perception is that general practitioners are more likely to deal with whole people rather than isolated illnesses. I think it is inherent in the way primary care practitioners do business to see people as part of their environment. Practice guidelines can be very helpful in orientating those people for whom this is not their particular area of interest and in giving people a framework on which to do things. Most of us came through medical school with mnemonics, lists and outlines to help us manage an enormous knowledge base and put it into practice, so practice guidelines are part of how we do business.

Practice guidelines are a double-edged sword in that they are frequently seen by some other players in the field not as guidance at all but as rules. Practice guidelines have to be applied knowing an individual, their circumstance and the interplay of stresses upon them. As I said

before, you may medicate someone whose symptoms or impairment is not so bad because the environment cannot tolerate that. Does that contravene guidelines? Guidelines are guidance and as long as they are accepted as such by all the players in the field I think they are very valuable, particularly for orientating people and helping people who would not necessarily always choose to do this work.

CHAIR—But clinical guidelines might help overcome this problem of some GPs or psychiatrists—or some psychologists, for that matter—not asking, for instance, whether there are children at home when there is a substance abuse situation such as you just described. If you have time it would be useful to the committee if you would look at a couple of those clinical practice guidelines, to advise us where you think there might be opportunities or shortfalls. I understand the limitations you just described but, nonetheless, this may well be useful to the committee, by way of recommendation.

Dr Castles—I think we have to be very pithy about guidelines because there are potentially so many areas of practice that you could end up with a cookbook. Do you know what I mean? There is guidance for the management of rectal bleeding in people over 50; there is a clinical guideline for so many different things that it is becoming overwhelming to know where they all are. As various members of the community see them more as rules rather than guidance, it becomes harder to know whether or not you actually have to spend half your time reading them all to be up to date. They are a very useful tool; they will always be a useful tool for those people who want to use them. Nobody is ever going to know what all the practice guidelines out there are because there are a rapidly escalating number. I have a theory—this is a Castle's theory, it is nothing more serious than that—that, of all the doctors who are practising, perhaps about a third have an interest in mental health. Perhaps about a third do it because it is part of the job and for about a third, for whatever personal reasons or temperament or whatever else, it is not their orientation or their interest.

I think the greatest bang for your buck comes from trying to hook and help the group in between. There are highly motivated practitioners who probably sort these things out for themselves, there are people who will print off the guidelines and file them because it is not particularly their area of because it is something they are avoiding and there is a group of people in the middle with whom, if we can identify them, we can produce the greatest change and support them in feeling confident to do more of this work.

CHAIR—Thank you very much. That was most interesting. Thank you for your submission.

[12.00 pm]

ROWE, Dr Leanne, Councillor, Royal Australian College of General Practitioners

CHAIR—Welcome. Would you like to comment on the capacity in which you appear today?

Dr Rowe—I am on the national council of the Royal Australian College of General Practitioners and I am also the chair of the Victorian faculty of the RACGP. I have been a GP in rural practice in Victoria for over 20 years and I have a particular interest in young people's mental health and Aboriginal health. I have also been personally involved in education. I am on the council of Monash University and I have been a senior lecturer of medical students at the University of Melbourne. I have also worked as a medical educator with GP registrars.

CHAIR—You have provided the committee with a submission which we have numbered 311. Are there any alterations or provisions to the document?

Dr Rowe—No.

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

Dr Rowe—Firstly, I would like to thank the Senate committee for the opportunity to make this presentation today on behalf of the Royal Australian College of General Practitioners. We believe this inquiry into mental health in Australia is very important. The community values our general practitioners as important providers of mental health care. As you have heard, we play a significant role in the recognition and management of common mental health problems, and primary care is seen as one of the strength of this nation's current mental health system. GPs also play a crucial role in contributing to be destigmatisation of mental illness for consumers, carers and the community.

The Royal Australian College of General Practitioners is keen to assist in its role as a national leader in setting and maintaining standards for quality practice, education and research in Australian general practice. We have more than 11,600 financial members and manage the quality assurance and continuing professional development of nearly 22,000 general practitioners. We are accredited to do this by the Australian Medical Council. Over 3,000 of Australia's rural and remote GPs are financial members of our college and we have the largest membership of any medical college in Australia. General practice is the cornerstone of Australia's system of health care. Each year there are over 97 million services throughout Australia, or approximately 4.9 services per person.

The RACGP strongly supports evidence based policy development and we caution that any changes to mental health policy should be based on evidence that works in the context of the Australian health care system.

In relation to the provision of services to special needs groups, I would like to speak about the five main groups that require specific attention—Aboriginal and Torres Strait Islander people, refugees and asylum seekers, older people, Australians living in rural and remote areas and

young people and children under 18. Aboriginal and Torres Strait Islander people experience worse general health and mental health outcomes than non-Aboriginal and Torres Strait Islander people, and this is an area of core concern for the RACGP. The college urges the committee to give particular attention to ways in which programs can support culturally appropriate models of mental health care. I bring to your attention our new guide on preventative health assessment, including information on suicide prevention, which we have developed with the National Aboriginal Community Controlled Health Organisation.

Similarly, the RACGP has considerable concerns about access to mental health care for detainees, refugees and people seeking asylum in Australia. The college urges the committee to consider the provision of primary care within detention centres. It should conform to the RACGP's standards for general practice and the training and qualifications for staff in these centres should meet our standards. I bring to your attention our document on the standards for general practices.

CHAIR—Can I just to stop you there, Dr Rowe. Are you able to table those documents today?

Dr Rowe—Yes.

CHAIR—Is that the wish of the committee? There being no objection, it is so ordered. Thank you.

Dr Rowe—Dementia is a national health priority area. Psychogeriatric care, for both mental illness and dementia, requires collaborative multidisciplinary approaches which complement existing geriatric services. Many older Australians also experience multiple comorbidities and require a whole person approach to their health care management. This sort of approach may be offered through general practice. Many of the college's rural and remote fellows report that there are fewer options for care available in rural Australia for patients with sometimes severe mental illness who present to general practice. We urge the committee to give attention to alternative strategies, including telepsychiatry, to increase the access to specialist mental health services for all Australians living in rural and remote areas.

The college supports the establishment of a youth mental health foundation and we have submitted an expression of interest to establish and operate the new foundation. The college is keen to increase GP access to training on psychological therapies, particularly to reduce antidepressants prescribed to young people under 18. As you know, the prevalence of mental health disorders and problems among general practice patients is high.

As such, we must continue to promote quality and responsiveness by strengthening the capacity of general practice to fulfil this central role in our mental health care work force. The Bettering the Evaluation and Care of Health data reports that there were more than 10 million consultations sought with GPs for a mental health condition in 2002-03. Of these consultations, depression accounted for a third of the problems seen by GPs. Similarly, data from the national profile of mental health and wellbeing study indicated that approximately 20 per cent of the Australian population over the age of 18 met the criteria for a mental health problem or disorder. However, this data shows that only 38 per cent of these people sought help. And when they did seek help, approximately 75 per cent saw a GP in the first instance.

The recognition and management of mental health disorders are more likely to occur within longer GP consultations. However, the general practitioner consultation item structure encourages short consultations and discourages longer ones. This results in disincentives for GPs who treat patients with mental health problems. This seems to be particularly affecting people from disadvantaged areas in that, whilst they may have a significantly higher need for care, they are less likely to have longer consultations. Our college strongly urges the committee to investigate the financial structures that encourage longer consultations for patients as needed.

Research consistently demonstrates that even Australia's largest medical work force, our GPs, cannot currently accommodate the burgeoning requirements of managing mental illness in general practice. Strategies to ameliorate this are required, particularly in rural areas where there are still significant GP and specialist work force shortages. Our college proposes that the committee give strong consideration to ways that multidisciplinary practice based models of care that strengthen the roles, skills and capacity of all our members of general practice teams can be implemented.

Whilst general practice is the appropriate environment to provide service to a proportion of people, the complexity and difficulty of some mental health presentations often means that additional support, more intensive therapy or in-patient admission is required. Our college recommends that the committee consider establishing a time limited task force to undertake the review of the public mental health services and especially how to integrate these with private health services through general practice.

Our college applauds the success of the Better Outcomes in Mental Health Care initiative. I note that it has been raised in previous committee hearings and I am pleased to report that, since its introduction, approximately one in four GPs have received training, sourced and adjudicated through the General Practice Mental Health Standards Collaboration under the auspices of the RACGP. The General Practice Mental Health Standards Collaboration is now working with the RACGP to develop ongoing education and support for GPs already registered by the Better Outcomes in Mental Health Care initiative. As the organisation responsible for setting and maintaining the standards for high-quality general practice, and given the success of the General Practice Mental Health Standards Collaboration initiatives to date, the RACGP strongly advocates that we continue to host this important work of the collaboration.

Finally, until there is significant investment in general practice research, both in terms of the capacity and the development of skills, quality of general practice research will continue to be limited and the relative deficiency of published research will continue. The RACGP strongly urges the committee to consider ways in which GP research capacity, particularly with regard to mental health, can be expanded. Suggestions include funding university appointments in departments of general practice with specific focus on mental health; support for scholarships; grants; awards for GP research; career development through the RACGP Research Foundation; and funding to create additional general practice academic registrar positions that have a mental health focus. The issues that I have outlined today are covered in more detail in our submission and we look forward to working actively with you on the reform of the mental health system in Australia.

CHAIR—Thank you, Dr Rowe. Following our conversation with a previous witness, I invite you to expand on your recommendation to do with a national mental health summit on infant

child, adolescent and family mental health, to develop a dedicated infant child and adolescent mental health plan. I invite you to expand on the reasons why you think this is now necessary. You have singled out this group as being in need of such an initiative.

Dr Rowe—Clearly, this group has special and unmet needs. We are aware that mental health problems, particularly in adolescents, are increasing in prevalence and yet the capacity of services to respond to these needs is limited. That goes from primary care right through to young people and children who need tertiary care. We believe that there is a need for greater priority in this area. Since we made our submission, we have become aware that the tender for the Youth Mental Health Foundation has been released. We need to consider how much that foundation can deliver. The proposed task force and the mental health plan for children and young people under 18 may be able to be incorporated under the umbrella of that foundation. Clearly we have a Commonwealth mental health plan, but it gives very limited priority with regard to young people and children under 18.

CHAIR—So you would strongly recommend that the new plan, which we understand is currently being developed, includes much more than has been the case in the past for this group of people?

Dr Rowe—Yes, that is right.

CHAIR—I go to your recommendation on alcohol and drug co-morbidity. You say that education and training programs are needed to improve the knowledge and skill capacity of GPs in the prevention and management of co-morbidities. What is your understanding of the current level of knowledge in this area? It seems to us that not too many years ago people were refusing to treat either the mental illness or the alcohol or drug abuse, and there is general acceptance that we must treat both together. How knowledgeable are GPs in particular about doing that? Is it more about rhetoric than actual ability and practice?

Dr Rowe—GPs treat the whole person. I think there is a very high level of knowledge among GPs that it is important to treat both the mental illness and the substance abuse problems. Our college has been involved in training GPs in that regard. The blocks are when GPs try to refer such patients with co-morbidities to mental health services. They will often be denied access to services on the basis of their substance abuse or mental health problems. We see that the major block is with the services who support general practice, but there is a growing awareness of the need for services which encompass dual diagnosis. We are pleased with that, but there needs to be greater funding for those services and better access for people with dual diagnosis.

Senator TROETH—You have referred to the increasing workload of GPs, which I am sure we do not doubt, and the work force shortage of GPs. You say on page 10 of your submission, ‘Alternative practice-based models of care are required.’ You might like to explain that. Does that mean upskilling practice nurses? Would you support including psychologists as part of the practice team?

Dr Rowe—Definitely. In relation to mental health problems, we need to involve so many people in the practice team—practice nurses, psychologists, the local teacher at the school, the school welfare coordinator, the employment agencies or the accommodation agencies. There is a great need for GPs to work very closely with a whole range of other services. The Better

Outcomes in Mental Health Care initiative has allowed to some degree for that to occur. While we are pleased with the progress of that initiative, there are clearly some barriers to some GPs becoming involved in that.

Under that program you would be aware that GPs have better access to allied health professionals and psychiatric support—we have a telephone linkage to psychiatrists through that program—but at present only one in four GPs is eligible to access those other services. We would like to expand the program further. We understand there has been a massive underspend in that area, so it is important to understand the barriers involved. Many GPs who have undertaken the training—the level 1 mental health training, particularly—do not claim the Medicare item numbers. That is because there is too much red tape associated with those item numbers. There are specific rules to use them. For example, you need to provide three consultations. The last consultation needs to be between one and five months from the first. I can never remember what it is either! GPs are also juggling a range of other items for asthma, cervical screening, care planning, health assessments and so on. We are stifled by red tape already; this just adds to our burden of red tape.

The incentive payment after three consultations does not recognise the chronic nature of many mental illnesses; many GPs see patients many more than three times. There is no funding for the training under Better Outcomes in Mental Health Care. Either the GPs pay for it or it is sponsored by pharmaceutical companies. We have to look at these difficulties. We need greater access for GPs to the training, particularly the level 2 mental health training, which is at least 20 hours of mental health training. Many GPs in rural and remote areas particularly find it difficult to access that training. If we could increase the access of GPs to that training, it would also give GPs access to the level 2 Medicare item, which is a significant increase in the Medicare rebate.

Our college has also been advocating with the Australian Medical Association for many years for a seven-tier item structure which acknowledges the need to provide longer consultations for management of chronic disease in general, including chronic mental illness. We believe that it is important to overcome the disincentives to providing good quality care for people with chronic illness.

At the moment the accreditation processes for mental health training are separate from the RACGP quality assurance and continuing professional development program. In the future it would make good sense to roll these into one so that GPs do not have separate accreditation for mental health and all their other areas of education. It makes sense to roll these into the one QA and CPD program. Our college has a wonderful GP online learning program. Over 15,000 GPs have registered with our online learning. This provides a wonderful opportunity to increase the access of rural and remote GPs, particularly, to training.

Senator TROETH—Would you mind if we also tabled that document?

Dr Rowe—Sure; that is fine. I have heard you ask what could be done to encourage more GPs to become involved in mental health. I think GPs see mental health as an integral part of their work but they do have limitations because of the current work force shortage. The other issue with mental health is that there is still a stigma to mental illness in the community and often people present in crisis and want a quick fix. Often they want a prescription when they come in. If you look at those combined difficulties—a person in crisis and a GP with limited time—then

you can see the dilemma for many GPs in prescribing. This is particularly of concern for young people under 18. GPs do not prescribe to children. With the increasing prevalence of adolescent depression this is a major concern. GPs need better access to training on psychological therapies. Our college is currently running such training, which is very well attended by GPs and we would like to roll that out as a national program.

Senator TROETH—In rural and remote areas there will be the combined factors of the stigma in the local community of a patient presenting, the GP having to work over a wide range of skills to be all things to all people, geographical remoteness and the difficulty of the patient getting to a medical centre.

Dr Rowe—That is right. The issues of access to mental health services in rural areas should not be underestimated. There is good literature to say that the high suicide rate in rural areas is directly related to the lack of access to mental health services. I have just completed my doctorate of medicine on the evaluation of GP training for psychological therapies in adolescence. I found that GPs are very willing to implement that new training into their practice if the practice system supports them. That means peer support, access to other specialist services, better remuneration and the use of the increased incentives through the Better Outcomes in Mental Health Care initiative.

You mentioned guidelines. Currently, under the Better Outcomes in Mental Health Care initiative, all GPs who complete that accreditation will receive a wonderful kit of information on common mental health problems and have access to many great resources through the Internet. But guidelines are lacking. One area that requires attention is the psychological management of adolescent depression. Guidelines for the management of adolescent depression were written in 1997. Since that time there has been a considerable body of research that needs to be incorporated. We need to be aware of some of the dangers of prescribing selective serotonin reuptake inhibitors to the under-18 age group and the benefits of psychological therapies. We very much need new guidelines in that area. However, I think GPs in general feel that they do have access to good written material, particularly with the wonderful resources that are produced by the RACGP.

Senator MOORE—I am interested in some of the evidence you have given on chronic disease and mental health within that area. When talking to the department they always talk about chronic disease. It is very hard to get them to pull out and identify mental health in its own right. The evidence we have had from some of the advocates in the mental health area is that they want to see mental health given focus. As a result of years of what they see as lack of concern, they think the only way to get it into people's faces is to keep talking about mental health. My understanding from listening to the evidence from the department a couple of weeks ago is that they are much more keen on the whole medical structure and funding now going into this big bag of chronic illness, then within that you can pick what you want. That is a very big generalisation.

Dr Rowe—No, I understand.

Senator MOORE—But just in terms of the debate, I would like to get your views—and I apologise; I forgot to ask that question of the previous witness—on just where we are on that balancing at the moment of priorities and general practice.

Dr Rowe—It is an important tension to understand. I think it comes from the problems with the Commonwealth-state divide. They are problems for the whole health system but particularly for mental health. The whole health system requires reform to overcome those barriers between Commonwealth and state. In mental health there is a lack of funding, coordination and access.

You know about the need out there. You have heard many of the distressed reports. As GPs we see that distress on the ground every day and we see the problems with access to the mental health system. So I understand that tension and the desire of some to bring mental health out and to make it a priority. I can understand the reasoning behind that. However, by doing that, it then means that mental health is not integrated with the rest of the system. As GPs we look after the whole person—we do not divide the problems. Many people with a mental health problem will also have a physical health problem. It might be very much related.

For GPs it is important to be able to access appropriate services, whether they are Commonwealth or state funded. Our major concern is that services work together on the ground. As to how they are funded, if there was more integration between Commonwealth and state then perhaps GPs would not be so concerned about it. At the current time, we have a lack of coordination of services on the ground because the funding comes from so many levels. We should remember that GPs are also working across many of the social services—accommodation, employment and education services as well as mental health services—so we see that lack of coordination of funding in other areas as well.

My personal interest is in adolescent health. I set up a young people's health service in Geelong in Victoria. That was a service originally auspiced through the Geelong division of general practice. It was very much set up in response to need in the community and the need of young people. It responded to the voices of young people about what they needed. It is a wonderful model because GPs are colocated with youth workers, mental health services and drug and alcohol workers and have wonderful contacts with the local hospital, the schools and many other services I have just described.

For young people that is a very accessible service. It has had three external evaluations that have been very successful, but it has lost its funding time and time again, because its funding is short term and is sought from many different sources from many different levels of government. The amount of energy taken in writing proposals and ticking evaluations and so on is taking staff away from where they are needed.

Senator MOORE—Is that funded at both levels?

Dr Rowe—Both levels, yes.

Senator MOORE—Little bits funded by different bits?

Dr Rowe—Little bits on short-term project funding. I raise that example because I think it is a very good example of the effects of a fragmented system. However, through the hard work of staff on the ground, they have been able to overcome the barriers for young people who are very disadvantaged—many of them homeless, in contact with the juvenile justice system and a significant percentage of them Aboriginal. It is definitely a service that is reaching that need and

yet, after 10 years of operating and many external evaluations, it still does not have long-term funding. That is just one example.

Senator MOORE—And it is vulnerable because of that?

Dr Rowe—That is right.

Senator MOORE—Do the medical aspects of that model fit within the Medicare model?

Dr Rowe—Yes, GPs come in from the community and there is also multidisciplinary training where GPs receive training with other health professionals, which increases their ability to collaborate. They take the skills that they have learnt at the centre back to their traditional general practices, where they are able to implement many of those new skills and use the contacts they have made.

Senator MOORE—And be able to access Better Outcomes if the GPs had the training?

Dr Rowe—There is only one problem with that.

Senator MOORE—That is exactly what I was leading to. Is that model you describe accredited?

Dr Rowe—It is not accredited, no.

Senator MOORE—And therefore it cannot access this?

Dr Rowe—Most general practices are accredited, but this case is one example of where there should be some flexibility around accreditation.

Senator MOORE—In terms of the college's role in working with the department, because that seems to be the way it goes, what kinds of advisory groups is your college involved in in giving advice to the department and the minister so that things can develop?

Dr Rowe—It is involved in so many ways at so many levels, and we have many representatives from the RACGP, that perhaps I would need to take that on notice.

Senator MOORE—Would you take that on notice? I am interested to know where they all fit in—in particular, in Better Outcomes.

Dr Rowe—In relation to committees associated with the Better Outcomes program, we host the General Practice Mental Health Standards Collaboration. The members are representatives from our college, the Australian College of Rural and Remote Medicine, the Royal Australian and New Zealand College of Psychiatrists, the Mental Health Council of Australia and the Australian Psychological Society.

Senator MOORE—They are the standards group?

Dr Rowe—Yes. There are many other people who are very active in representing our college, so I will take that question on notice.

Senator MOORE—Thank you. It is just to see how it all links in, because when getting evidence from the department a couple of weeks ago it seemed that every segment had a form of advisory group, and how often they met, what role they had and who talked to whom I am still to find out, because they are all working towards the same goals.

Dr Rowe—Yes.

Senator MOORE—I wanted to ask the same question that I asked the previous witness about work force shortages. You identified it in your submission and everyone knows about it. In terms of the role of the college, where you are working with people who have made the choice at this stage, what kind of recommendations could the college make about ways to get more people into the work force?

Dr Rowe—We have made a detailed submission to the Productivity Commission.

Senator MOORE—Would it be better just to give that to us?

Dr Rowe—I think it might be, yes, because it is a very complex question that I cannot answer in a few minutes. I will forward our submission to the Productivity Commission to you.

Senator MOORE—That would be useful, because the work force issue is going to be overwhelming in the considerations of the committee.

Dr Rowe—That is right.

Senator MOORE—Do you see that there is a shortage?

Dr Rowe—Yes.

Senator MOORE—Everywhere?

Dr Rowe—Yes, in metropolitan and rural areas. It is particularly acute in rural and remote areas, but it is right across the board. We have major concerns about the lack of numbers of GPs and the tendency of GPs to be reducing their participation in the work force. Our college does a lot of work in supporting international medical graduates in training. We have just confirmed a major grant from the Commonwealth to roll out training on a national level to international medical graduates. That will be of great assistance. You would be aware that the fellowship of the RACGP is the gold standard for general practice. Under the training program in the journey towards the FRACGP there is a recommended curriculum on mental health. We are undergoing our curriculum review at the present, and there is a particular emphasis on the need to strengthen mental health within the training curriculum.

CHAIR—Is it possible, Dr Rowe, to give the committee a copy of the curriculum? Is there an outline of the curriculum that would let us understand how much training is done by GPs in mental health and what the changes you are proposing for a new upgraded curriculum?

Dr Rowe—Yes, I can forward what we have. I think the time frame for that curriculum review is the next six months—we will have our final report at that time.

CHAIR—It would be useful for us to know what you see as inadequate in the existing one.

Dr Rowe—I do believe that medical schools have made significant progress in this area. I think there is a very good awareness among medical schools of the need for communication training early in the medical curriculum. The previous presenter also alluded to the need for self-care. The RACGP is in the process of establishing a professional peer support program which will be rolled out in the next 12 months to support general practitioners and other medical practitioners across Australia. We will set up a framework for professional peer support groups, because we are aware that GPs are much more likely to become involved in mental health care of patients if they have peer support, the capacity for self-care, access to other specialists and so on. If the service system supports them then they are more likely to be involved.

Senator MOORE—My next question was about the protective processes within the system for medical practitioners who have been identified, or who self-identify, as having problems. We have had evidence from a couple who felt very abandoned by their own profession. There did not seem to be much support for them through their processes. We have had evidence from people who have had severe depression and psychiatric problems which affected their work. Then there is a whole other group, which has not come into this inquiry but which I have heard about from other places, who have addiction issues. It is very sensitive to have that in your workplace.

Dr Rowe—It is, but there is a groundswell of support, particularly in the last one to two years since our college has taken leadership in this area. We have undertaken a literature review of the last 30 years of issues to do with doctors' health. The findings are consistent in that medical practitioners have a high level of psychiatric disorder. We were disappointed, in reviewing that literature, that there has been a lack of follow-up of those studies. For example, I think it was nearly 10 years ago that a study in New South Wales showed that female medical practitioners had a suicide rate which was four to six times greater than the general population's. That study has not been followed up. To our knowledge there was not an intervention.

We are hoping with our new initiative to look at this area in an ongoing way. We will be able to provide interventions and we will follow up these sorts of results to make sure that the interventions we have implemented are working. It is early days, but we do have a groundswell of support. We have most of the other medical colleges supporting our initiative. We have the General Practice Representative Group—which comprises us, the AMA, the Australian Divisions of General Practice and the Rural Doctors Association of Australia—supporting the project. We have just developed a handbook on the self-care of medical practitioners, which will be distributed to every general practitioner in Australia and to every college so that they can then distribute it to their members. It is early days, but it is a significant project.

Senator MOORE—And that is imminent?

Dr Rowe—Yes.

CHAIR—Your submission has some strong comments to make about mental health services for detainees in immigration centres. Have you had an opportunity to look at the detail of the ‘new environment’, as it is described, for Baxter and elsewhere?

Dr Rowe—I have not, no. I would like to bring to your attention our journal; I would like to table a copy of it.

CHAIR—Indeed. Is it the wish of the committee that this copy of the journal entitled *Australian Family Physician* be accepted as evidence? There being no objection, it is so ordered.

Dr Rowe—This recent edition of our journal was on health inequalities and it has some wonderful articles on the GP care of refugees and asylum seekers. Our *Standards for General Practices*, which I have just given you, also sets out the standards of care that we expect in medical practices.

CHAIR—What difference would it make if entitlement to Medicare rebates were available to asylum seekers in detention centres?

Dr Rowe—They would have access to general practitioner care. At the moment, it is very much dependent on the goodwill of the GP involved, or the GP employed by that centre. That creates problems with that practitioner’s independence and with access to general practitioner care.

CHAIR—Are you suggesting that, if there were rebates available, detained asylum seekers could make appointments with their choice of GP?

Dr Rowe—That’s right.

CHAIR—So then that GP might come into the centre? You are suggesting that should be able to be done?

Dr Rowe—That is right. Our college hosts a network of GPs who have a particular interest in this area and who care for refugees and asylum seekers. They communicate via an email link-up. This suggestion is very much coming through from that group of very concerned GPs.

CHAIR—The government might argue that all you would get would be activist GPs who would be advocating for the release of the whole population on the basis of the mental health damage that might be being done. I have not heard the government saying that, by the way.

Senator TROETH—I want to say that we have not heard that.

CHAIR—And I am not suggesting that. I am just saying to you, as the devil’s advocate might say, ‘This would be the problem associated with that; how would you overcome that?’

Dr Rowe—Clearly there is a great need in these centres; take the Cornelia Rau case, for instance. There has been media attention on the retention of people. There are clearly major difficulties within these centres and we are very concerned about the effect of detention on the mental health of these people. Our GPs are very compassionate people, and are very concerned.

It is unfair to deny people access to GP care on the basis that you may have activist GPs and loose cannons going to the media. I do not think that is an argument which should prevent access of these very needy people to basic health care.

Senator TROETH—It has not been put on the record or said at any time that that would be the case.

Dr Rowe—No.

Senator TROETH—That has never been floated.

Dr Rowe—That is right. I think that there is a clear need. GPs want to respond to that need. A Medicare rebate for these people will increase the access of these very needy people to basic health care, including mental health care.

CHAIR—Why would the government not agree to that suggestion—or have you put it to them and they said no?

Dr Rowe—We have, and they are open to it.

CHAIR—They are open to it.

Dr Rowe—There has not been any formal announcement but, from my informal reports of the discussions of our president, Professor Michael Kidd, and the president of the AMA with Tony Abbott, he is very open to the idea.

CHAIR—This was a recent development?

Dr Rowe—Very recent. That was an informal discussion. It has not been confirmed, but I do not think there is much resistance to that suggestion. I think it is being taken on board.

CHAIR—Good. Thank you very much for your submission and for appearing before us.

Dr Rowe—It is a pleasure.

Proceedings suspended from 12.45 pm to 1.45 pm

[1.49 pm]

KIFT, Ms Dale Monica, Rank and File Member, Probation and Community Corrections Officers' Association Inc.

NORMAN, Mr Brian Bently, Foundation President, Immediate Past President and Spokesperson, Probation and Community Corrections Officers' Association Inc.

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

Ms Kift—I am also on the executive of the state organisation, the New South Wales Probation and Parole Officers' Association Inc.

Mr Norman—I was the president of the association at the time this paper was presented. I should also indicate that I am a current member of the executive of the New South Wales Probation and Parole Officers' Association, which is affiliated with PACCOA.

CHAIR—You have lodged with the committee a submission, which we have numbered 503. Do you wish to make any amendments or alterations to that document?

Ms Kift—Yes. There is one correction on page 7. At the last paragraph on the page, we have mentioned the 40-bed Mum Shirl unit at the Metropolitan Remand and Reception Centre. That needs to be changed to the 'Mental Health Assessment Unit at Mulawa Correctional Centre'. There is some confusion around that because the new assessment unit is often referred to as the 'Mum Shirl unit', which was the earlier building and the core of that treatment unit.

Senator Troeth—Is Mulawa in rural New South Wales?

Ms Kift—Here again we have an interesting juxtaposition. Mulawa is almost within the Metropolitan Remand and Reception Centre, which is a massive network of buildings.

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

Mr Norman—I would like to commence by indicating that PACCOA is an association of people who work within the fields known variously across the country as 'probation and parole' or 'community corrections'. We are not an industrial body. Our goals are simply to work towards the creation of a just, fair and decent society to ensure that victims are protected and to work towards the reintegration of people who have fallen, who have broken the law. The work of probation and parole officers—we will use the term commonly used in New South Wales to save referring to both—is essentially to build a bridge between the justice systems and the community. Probation and parole officers have to have a foot on both sides of the bank, as it were. The work is challenged by the fact that in each situation—person by person, case by case—the probation and parole officer has to make important decisions about that person, their needs and the opportunities for restoration to the community. Of course, the safety of the community is paramount.

I would like to raise some issues that were foreshadowed in the submission that have occurred and are occurring as we speak in New South Wales which we believe are going to be severely detrimental to the wellbeing of mentally ill people. Firstly, I would like to mention that a couple of weeks ago the Crimes (Administration of Sentences) Amendment Act 2004 was proclaimed. Within that legislation, it is now fact that people who have been refused parole by the Parole Board will not be able to apply for reconsideration for parole until a year has expired since the refusal. They will have to apply to be released to parole if they are to be considered. There is a provision for what will now be called the State Parole Authority to consider a person's release earlier than that year if a manifest injustice has been determined. If a person on parole has had their parole revoked, they will not be entitled to reapply for consideration for rerelease to parole for a year. At this stage, I am advised that there is no provision for the parole authority to take into account the issue of manifest injustice having occurred, although I am told that there may be an amendment.

Under the amendments the Commissioner for Corrective Services now has power to make representations to the Parole Board and will have power to suspend parole orders to have people brought back to custody. Our view and our concern is that this is going to fall very hard on those people who are mentally ill. It is going to fall hard on a lot of people, but for mentally ill people, with no-one necessarily there to advocate on their behalf, a lot will find themselves refused parole, they will have difficulties reapplying because of their mental illness, and if they are released they will be cast back into jail. Prior to these amendments, people were sometimes returned to custody because they were spiralling out of control, and it would buy some breathing space to try to get a new case plan going. Under these new amendments, it appears that this will not be the case, and they will be cast into jail for a year.

There is a restructure within the New South Wales Department of Corrective Services in progress at the moment which we believe will also significantly disadvantage people with mental illness. The Probation and Parole Service, which is also called the Community Offender Services and is a division of Corrective Services, is going to have its leadership removed shortly. There will be a new structure created in Corrective Services which will be a single operational structure covering the custodial and community based operations for the department. The concern of our members is that this will lead to the imposition of an ethos on community based work which is more aligned to a punitive surveillance approach to working with people.

As I mentioned before, the role of the probation and parole officer has always been to maintain balance and always to take the community's interest first. Our concern is that this is going to result in more chances for people to break down basically on parole or on probation. We fear it will lead to people's failure to engage and to work with us. Part of the problem for our people in New South Wales is that to date there has been no information released about this restructure which is imminent. There has been no process of consultation. In fact, our colleagues within the New South Wales Probation and Parole Officers Association have not been able even to secure a meeting with either the commissioner or successive ministers to discuss their proposals. It has all been done in secret. As far as I know, even the board of management of Corrective Services have not been briefed in relation to this.

What we do know from things that are being said and revealed is that there is the possibility of changes to recruitment standards. Our concern is that people may not have the skills to identify what is going on with people. Those skills will no longer be required. I think that is probably

enough other than to say that there have been assurances that all will be well and that this restructure is there really to pay more attention to community based operations. We have very severe concerns.

We note that the justice inquiry into the management of offenders in Western Australia has provisional recommendations made by New South Wales retired Justice Mahoney which suggest the creation of a department of corrective services in WA with separate deputy commissioners responsible for custodial and community. I understand that it is likely that a submission will be made to WA to ensure that, if that is to occur, sufficient robustness is built into the system to ensure that it is not possible for one division to envelop another. That is all I would like to say at this stage of the game. There are a number of issues that we would be very happy to elaborate on if you wish to raise them with us.

CHAIR—The committee has been quite interested in this issue of punishment being used in an attempt to control or modify the behaviour of people who are mentally ill. Are you in a position to give the committee a comparison between New South Wales and other states? If I can prompt you, we did visit the Thomas Embling forensic hospital in Melbourne, which appears to be seen as a best practice model. Does such a facility apply in New South Wales or other states? Do you know about it? What you think about that as an approach?

Ms Kift—There is an overarching strategy in New South Wales, but it is in its early stages of development. It will mean that mental health will have its major line of direction and governance in justice health. That augurs for a much better result than we have seen in the past. There has been a heavy investment in new forensic services. That is impressive and it has been noted in the *Not for service* report. I see there that New South Wales has been commended for making inroads there. The underlying problem—and it is very easy to commend positive gains, but when you weigh up what the negatives are, it is a drop in the ocean—is that we are looking at 63 per cent of the prison population being on short sentences of six months or less. Many of those people are there for minor offences that are related to mental health problems.

What we are very concerned about is that those figures are going to blow out. Under restructuring arrangements that are proposed for our department, the end result of the changes to the parole legislation—which will entrap many more people than before into a full sentence—is that many more people will be in jail. So far, the 63 per cent is highly unlikely to ever get proper mental health services while they are in there on those short sentences anyway. Then we will get a large number of people in jail for much longer periods who cannot really engage with the more positive aspects of the jail therapeutic programs anyway, simply because the underlying difficulties they are suffering under are not receiving proper treatment in the prisons.

In the early part of the submission, I drew attention to there being no inherent link between mental illness and crime; but there is a causal link between mental illness and incarceration. More and more as you look at this, it becomes a very prominent issue. It creates the conditions under which that person is more likely to go to jail and more likely to stay there for longer periods of time and more likely to offend. We see a great deal of that in our work at the city office in Sydney, where we both work. I feel that office affords us many opportunities to see exactly what the problems are that are faced by people with mental health problems who have little support, if any, in the community, and who are released from jail on a half payment from Centrelink. For the entire first month of their early release into the community, they have to exist

on one single Centrelink payment, which is given to them in two instalments; they currently have access to one—but not more than one—emergency payment. Under those conditions, it is hardly surprising that people frequently breach their parole, as I have pointed out in the report.

When the court directs that people should receive supervision in the community or identifies there should be a parole period, it implies that the person is sufficiently stable to be able to keep afloat in the community—to be able to cope with and gain from some form of parole supervision or community based sentencing. But, if that person has a mental health problem, plus, as is very often the case, an addiction problem, and the services are going in different directions—most of the time, they are mutually exclusive services—that person will be hard to understand, hard to diagnose, very difficult to treat and very difficult to refer.

We know there are prejudices against clients of ours who have presented with mental health issues, particularly when they have had a dual diagnosis. Services do not like to take on those people; they are not geared for that heavy need. These people stand to lose most from the current policies. In effect, that is discriminatory. This is what worries us greatly: it is discrimination, purely and simply.

Mr Norman—Perhaps I could illustrate that with some information I received only this morning about someone who came to our office, the subject of a presentence report to assist the court in sentencing. This person has been in the system for quite a long time, is quite suicidal and, with his mother—who herself is mentally ill—has been involved in a previous suicide pact attempt. The person was quite hysterical, drug affected and living in appalling conditions. A mental health team called and said, ‘Sorry, you’re a dual diagnosis. We can’t help you. Others are much more seriously ill than you and they take things seriously and don’t use.’ The person replied, ‘Well, if you could make my life more bearable, I wouldn’t use drugs.’ The team left and told the probation and parole officer who had called them, ‘Look, try to get him down to’—and they named a hostel, a totally unreliable place—‘If he turns up tomorrow unaffected, we might have a look at him; otherwise, he’s better off in prison.’ That person has since been arrested for assault and robbery.

The officer told me that she drew to their attention during the course of the interview that she believed he was psychotic. The mental health team said they did not believe that he was psychotic. She noted that he had been talking about being able to get the cockroaches in his room to march in file with male and female on either side. In her view, and she is a very skilled practitioner, he was psychotic. But he was turned away. This sort of thing is a daily occurrence, certainly in New South Wales. It is a very frequent occurrence in the areas in which we work.

Ms Kift—I would like to offer another example where a client was released on parole. He had been diagnosed as paranoid schizophrenic and had been on antipsychotics for quite some years. He had been responsible for a homicide, was eventually released and admitted to a psychiatric facility as an in-patient. The reaction there was, ‘We do not want him here.’ The psychiatric facility was in such a rush to offload this particular client for two reasons. The first reason was the potential for him to be violent—it was perfectly understandable why staff would feel threatened. The other reason was that he might be on their hands for a long time before they could find a suitable placement for him in perhaps a high-security psychiatric facility. Following were the most extraordinary discussions with staff. I would call it almost institutional insanity. I

remember attending a case management meeting at which there was an extraordinarily circular discussion about whether this young man had a mental illness.

This went on for about half an hour, among some rather learned psychiatrists. Their records on him as an in-patient at that hospital went back quite some years. He had had many admissions. He had been suicidal. They knew he had been incarcerated for a homicide. The writing was on the wall that this was someone that they were not going to allow to be on their hands for very long at all. They succeeded, and eventually he was released to a backpacker hostel at Bondi—the worst possible accommodation for someone who had a background of drug addiction and could easily get the drugs. He relapsed onto them while he was at the backpacker hostel. He was taken under the wing of a kindly hostel manager who had had experience as a carer and thought that he could get somewhere with this young man. He helped him considerably because this young chap needed 24-hour help, and he could not get that from probation and parole. Eventually he became highly delusional and very dangerous to the point where the crisis team was saying: ‘If something is not done, we anticipate a critical incident within 24 hours. Something must be done,’ and, of course, it was. But what a risk was posed to the community in that exercise! It is going through the motions. There is hypocrisy in this sort of exercise, a hypocrisy that we would like to see end. We would like to see the depth of the problem acknowledged instead of it becoming a festering problem that could create a tragedy for the community, a tragedy for him and an absolute nightmare for our service.

There are many similar cases to this. It was not long ago that one particular client could not get the kind of mental health care and neurological screening that he had been asking for many times, particularly neurological screening. There were signs that he had a brain injury. He eventually spun out of control while he was on parole, and made threats of taking hostages and mass killings. Certainly he had the skill, as he had been in the army in another country, and had knowledge of incendiary devices and weapons. He had been exposed to war trauma and was a great worry to us for some time. The Parole Board took very swift action to protect him and to protect the community. However, eventually he was in the community and not subject any longer to parole restrictions. In fact, he had become a problem on parole because he had developed a dependency on our service but was also a menace at the same time. An entire year later, after he menaced us to the point where we took out an interim AVO against him, he is still waiting for resolution of this matter and still waiting for a sense that our judicial system is actually going to organise some form of integrated neurological testing and psychiatric services for him. It is still going through the courts.

Mr Norman—One of the critical issues for us is that huge divide between the justice and the helping, the community side. There really is a need to build up those bridges there. There certainly is a need for forensic mental health services, which appear in a number of states and territories to be working fairly well. New South Wales and Tasmania are very slow to move in this area, with the lack of coordination of these services and the lack of forensic mental health services. We certainly support those recommendations from the *Not for service* paper about the bridging of the two disciplines. We would suggest also that somewhere in there a third arm needs to be the issue of justice, because very frequently people land in the justice system with orders that are justice based rather than health based.

The difficulty and the experience that we have is: ‘Not our problem; it’s a justice problem. Take them away: we don’t want to have anything to do with them.’ Part of the answer may be

mental health courts to actually deal with people in those situations, perhaps to bring people back who are on orders. Because our workers in the community are working mostly with people in the community, it is to get people who are mentally ill and who have a range of issues there managed. If it is necessary to bring them before a tribunal to ensure that they are properly assessed and properly managed, maybe that is the way to go. If the recommendation is that the federal Minister for Health and Ageing takes a lead role in the development of national standards, we would like to suggest that it be looked at that the Minister for Justice and Customs also have a role in trying to pull together correctional agencies into that process. If we are talking about community based operations, on the ground that could look like having mental health teams with probation and parole officers working alongside people who have justice based orders, trying to reach the best resolution for that particular person.

There are a number of examples of agencies co-working and they seem to work pretty well. Drug courts would be a case in question. They seem to work pretty well because people are able to bring the experience of different disciplines. Certainly in those areas there is a crying need for forensic mental health services and there is a crying need for ongoing assistance for that growing number of people who have co-morbidity issues. It is not just drug and alcohol issues but people with intellectual disabilities, people with alcohol related brain damage and a whole lot of other issues, and people with brain injuries who are often at peril in the criminal justice system for a whole range of reasons.

Ms Kift—On that note of the coordination of services and the integration of alcohol and drug services with mental health services, I have noted that in the *Not for service* report they made a very strong recommendation that the National Mental Health Plan that was recommended by the Burdekin report be combined with the National Mental Health Strategy, because there has to be some very strong and very compelling national movement to coordinate those services. They are not going to work without that. I feel that the national organisation of our officers could be instrumental in providing some sort of consultative body that could assist that process and work towards a national plan and maintain national quality standards of common case management plans. Because our officers have those backgrounds—they are social workers, counsellors, psychologists and drug and alcohol counsellors—they are ideally suited and trained to do that work.

We are very concerned that in New South Wales, where we have half the prison population of Australia—we have 9,000 people in the prison system—we have a strong law-and-order imperative. The number of inmates has increased by 50 per cent over the last 10 years. Now we are seeing initiatives and proposals that are bound to greatly increase those figures. That is a huge drain on the state budget. As was stated in that report, keeping someone in jail is 18 times the cost of maintaining their life in the community—establishing and building connections, assisting with employment and assisting them to maintain hope and a positive view of their life. They can be contributing members of the community where they are part of the community and welcomed by the community.

CHAIR—I might just stop you there so that my colleagues have a chance to ask you questions. If you could just keep the answers a little shorter, we will make sure we get to you the questions that need answering.

Senator TROETH—In comparison to what you have just said, you have mentioned the option of community based sentencing. Would you like to tell us briefly about that option, and do you think it is appropriate for offenders with mental illnesses?

Ms Kift—There is no doubt that currently, with the best of intentions, our community based option of supervision in the community is about the last resort of many of these people, particularly people who have existed in financial hardship or homelessness. We are their last resort, and that is writ large in our work. But we need more resources. We need a national vision to enable us to do our jobs properly, and we cannot at the moment. We are struggling with very few resources.

Mr Norman—There are many people who suffer from mental disorders which would not necessarily bring them under the direct control of a mental health act and who are deemed legally still to be responsible for their own behaviour but whose lives are chaotic and disordered in any way. They are inevitably going to fall within the justice system. The important thing is to be able to get them access to the resources necessary to assist them to deal with those disorders. I think that these are probably inevitable facts of life. For people who are mentally ill, as distinct from mentally disordered, I do not think there is a place for corrections to be involved.

Senator TROETH—That is right. Thank you.

Senator MOORE—I just want to have a little bit more on record about the Centrelink process that you were talking about, particularly in New South Wales, where you are doing the liaison plan with Centrelink. It is mentioned in the submission. My understanding is that nothing has changed—that the process Social Security was using 20 years ago to talk to prisoners before they were released, where people were just let out with their own resources and given a card to know where their nearest office would be, is still the unfortunate model. What is happening with the work you mentioned in your submission to make it a little bit better?

Ms Kift—Brian has been heavily involved in that.

Mr Norman—It has actually been handed back to Centrelink and the departments to work on. My understanding of the situation in New South Wales is that the issue of a service agreement between New South Wales Corrective Services and Centrelink is progressing slowly. Of course the half-payment is an issue for government ultimately to determine. In local areas things are happening already. Ms Kift and I now have a Centrelink officer who works out of our office one day a week. It is a model. It is certainly not around the place. It is extreme. These things move very slowly because you end up in huge bureaucracies. In New South Wales they are revising the existing service agreement they have with the institutions, so it is taking a long time. But my information is that it is progressing, albeit slowly. Part of the issue has been that Centrelink has recently reformed its own structure and set up a new national structure to better manage the process. So it is still, I think, getting its feet. This has happened only in the last couple of months, whereas previously the coordination was really being done on the cheap, as it were, by someone with a real interest and a passion in trying to pull things together. Centrelink has realised that some resources need to go into it. I am afraid I cannot answer much beyond that at this stage.

Senator MOORE—The other points you have made are in the submission.

CHAIR—Earlier you touched on the institutionalisation of people in prisons as opposed to asylums back in the old days and how this was a response to being tough on crime, to law and order issues. The quotes you gave us by former Premier Bob Carr about people with mental illness are decidedly alarming. Do you find that those sorts of attitudes to people with serious mental illness are through the system? Please tell us they are not shared by judges who deal with people on a day-to-day basis.

Mr Norman—I do not think they are, but I think there is enormous frustration at the level of the judiciary. I can think of a case that is not actually a mental health case but which I can use to illustrate the frustration of the judiciary. It is a case of a grandson of someone I know, who has an intellectual disability. He committed a fairly minor robbery—he took a car from someone but was entirely apologetic at the time. There was no major menace. He was held in custody without any form of intervention in the metropolitan reception and remand centre, which is a very scary place. He was held there on protection for a couple of months whilst efforts were made to find a suitable place to house this person and a suitable program. The judge was absolutely irate at the inability of the relevant department to find accommodation. The judges are very aware of it, but often their hands are tied. The general political discourse is: ‘We just don’t want to know. We just want people out of the way. If it means scooping them up and putting them back in again then so much the better.’ We look at the situation with police, who now visit parolees as soon as they are released and let them know, ‘We know who you are, we know where you are and, if you step out of line, we’re going to have you.’ This is quite common.

CHAIR—That adds to the anxiety and fear that these people are experiencing.

Mr Norman—Yes. If you put that to someone who is mentally ill, where do you go? The problem particularly in New South Wales is the uninformed and extremely reactionary media and the level of influence they have over policy making, and the fear that they seem to generate at political levels of being seen to be weak on crime.

CHAIR—Indeed.

Mr Norman—If you are mentally ill, then, sorry, you are collateral damage in this particular war.

CHAIR—You may be able to add to that—maybe not now—if you know of any studies, papers or references that might be of help to the committee, just to follow up on the recommendation you made just a moment ago about a mental health court system which might be part of a federal approach to law and justice. That is an interesting idea. If some work has been done, such as comparisons from overseas, the committee would be very interested in hearing about that.

Mr Norman—We would be happy to put those together for you.

Ms Kift—Absolutely.

Mr Norman—They are there. It is probably better if we give you proper detail on it than mislead you at this stage.

CHAIR—One or two other submissions have made that suggestion, but I am not sure that we have really explored it to the extent that we would need to in order to make a recommendation along those lines, so if you could assist us in that respect that would be useful.

Mr Norman—We would certainly be very happy to do that.

Ms Kift—When I looked at the *Not for service* comments on court diversion programs I saw that we are getting a version of reality that gives a false impression of ‘order’. It gives the impression that the criminal justice system is adapting well, but it is not. There is mention here that treatment orders that are enforceable by the courts are assisted by the community corrections, or community offender services in the case of New South Wales, and that such matters are simply referred back to court for an adequate informed response. This is often not happening. It does not happen because a lot of the clients disappear into the ether.

Suspension of supervision can quite frequently occur. If someone is not responsive to supervision or they are moving from house to house or are homeless, they are very hard to pin down and very hard to maintain contact with, and it is happening on such a scale that very often these people are just disappearing. The service will do its best to keep something in place for them, but these people are not automatically being referred back to the court. There are treatment orders, of course, where there is a proper legal framework and there is some form of cooperation between mental health teams and our service. It is far more likely that that will be followed through.

Senator MOORE—Is that in New South Wales?

Ms Kift—Yes.

Senator MOORE—Just in terms of the report, is that in response to the New South Wales comments?

Ms Kift—Yes, that is correct.

CHAIR—I would like to ask a quick question to finish off. Are there differences with gender? We know that there is a very high prevalence of illness amongst women in prison, but do they end up being homeless in quite the same way as male former prisoners do?

Ms Kift—No. Overwhelmingly, male prisoners are in those circumstances.

CHAIR—How do you account for that?

Ms Kift—The number of female inmates is so much lower.

CHAIR—I see. The overall number of male prisoners well and truly outweighs the number of women.

Ms Kift—Yes, absolutely.

CHAIR—I understand. That has been most interesting. In fact, it was a very powerful submission. Thank you for making it to us. If you can follow up on the question about the court, we would appreciate that. I am sorry to send you away with work to do, but it would assist us.

Ms Kift—We would be happy to.

Mr Norman—That is what we like to do. Thank you all very much for the opportunity to speak to you and to present on behalf of PACCOA.

Ms Kift—We very much appreciate it.

CHAIR—Thank you.

[2.35 pm]

McIVER, Mr Douglas Lindsay, Private capacity

McIVER, Mrs Janice Marin, Private capacity

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

Mr McIver—I have recovered from schizophrenia. I was diagnosed with schizophrenia, obsessive compulsive disorder and latent homophobia in 1972-73. For 10 years I was on medication. By way of background, I am an honorary life member of the Mental Health Foundation, where I provided services in looking after the supportive accommodation program. As well as that, I was involved in various other things related to mental health groups. I received the Australian Centenary Medal and I am a Paul Harris Fellow of Rotary.

Mrs McIver—I am Doug's wife and I was his carer for many years. I still am, I suppose, except that he is fully recovered. That is the point of our submission, that he went through a period when he was under medication, then went through an alternative program and is now, as far as we are concerned, fully recovered.

CHAIR—You have lodged with the committee a submission, which we numbered 317. You have provided the committee with a supplementary submission to that. Is it the wish of the committee that this be tabled? There being no objection, it is so ordered.

Mrs McIver—Incidentally, included in that is a list of my qualifications and background.

CHAIR—Thank you very much. I invite you to make an opening statement, after which we will go to questions. Do you both wish to speak?

Mr McIver—Yes, if we may. I will give an introduction and my wife is willing to answer questions. Incidentally, there is an alteration to page 9 of the submission. The second sentence of the top paragraph should read:

It is important that the Federal Commonwealth ensures that Principle 1 of the UN Resolution 98B not be compromised from their own perspective and certainly not from the consumer perspective.

Firstly, I would like to thank the committee for inviting Jan and me to appear before you to answer questions about my submission. Background information, as Jan has mentioned, is included in the handout material provided to you. We hope that our submission about the use of orthomolecular and environmental medicine for the management of my schizophrenia, and the additional material provided, will persuade you that some cases of schizophrenia are treatable with a complementary intervention strategy.

What are we asking of the committee? Firstly, that you recognise that current treatment options for the mentally ill are far from ideal. We believe that the intervention I applied, whether used with or without psychiatric drugs, could improve the quality of life for sufferers.

Secondly, that you consider the implications for patients, medical resources and government expenditure of using potentially more effective treatments—treatments that could enable some patients to re-enter the work force to become more productive members of society.

Thirdly, that you do whatever you can to encourage discussion with government representatives, medical practitioners and medical bodies to ensure more appropriate testing so that claims may be substantiated to the satisfaction of medical accrediting bodies.

Fourthly, that a recommendation be made for a substantial increase in funding for mental health research in order to prevent an ever-increasing burden of mental illness on our society. Fifthly, that you be aware of the 1991 UN resolution principle that states:

All persons have the right to the best available mental health care, which shall be part of the health and social care system.

What we did is outlined in the handout provided to you today. We used the medical principles of orthomolecular medicine, including nutrient supplementation. After many years of using them, I have observed no ill effects and many benefits, and we know these strategies have been used successfully for many years by some medical doctors. We applied an environmental medicine approach of removing certain foods and chemicals and applied desensitisation processes. We made dietary changes, including no wheat or dairy products and eating more fish. I used a lot more energy by exercising. I also practised yoga, meditation and had Chinese massage. My Christian faith has also been important.

I value Jan's support and I have trusted it. I have trusted her advice and her counsel, especially in encouraging me to control my mental state through the avoidance of chemicals and specific foods and taking other measures. This highlights the need for supervision in this intervention strategy. My decision to not continue with medication was an important factor in being invalided out of the Commonwealth Public Service in 1985 at the age of 45.

Relevant to our approach is the place of medical accrediting bodies in medical practice. The submission draws the attention of the committee to position statement 24 of the Royal Australian and New Zealand College of Psychiatrists. We feel that the statement is based on misleading information and may be impeding greater consideration of the role of nutritional and environmental medicine in the assessment and treatment of mental health matters. Can the committee see any means of resolving the issues contained in position statement 24? You might like to note attachment B to my submission.

We acknowledge the importance of efficacy in treatment but, if a treatment works, do we need to know how it works or why it works before we use it? Surely the important question is: does it work? Is a double-blind trial, as sought by the Royal Australian and New Zealand College of Psychiatrists, applicable to the type of equipment that we are advocating? We think not. We believe that it is in the government's own interest to direct that detailed studies be undertaken to

test the orthomolecular and environmental claims. If these claims can be confirmed, they have the potential to decrease the strain that mental illness is putting on our mental health services.

We strongly urge the select committee to recommend a massive increase in public funding for mental health research, and that at least some of that funding be applied to treatment beyond the conventional modes. Individual doctors are told not to use orthomolecular treatments and tests. They do not have the resources to undertake properly controlled clinical trials. Much of our present research is directed by the needs of the pharmaceutical industry. Who then can do the sort of research needed to prove efficacy to satisfy the medical accrediting bodies?

There are many shortfalls in the care of the mentally ill. If we can improve the degree of recovery of patients, with a wider range of treatment options, everyone gains. We believe that mental illness is not due to just one factor; it happens when a number of factors come together, so treatment must also involve a number of interventions. The magic bullet mentality of using medication has its limitations. We hope the committee may perceive the potential of what we have achieved and its relevance to the terms of reference. We think that the approaches we have used have the potential to reduce the anguish of individuals who suffer a mental illness and the heartbreak of their carers. If a successful outcome can occur in my case, why not for others? That is my opening statement.

Mrs McIver—We have worked on that together.

CHAIR—Thank you for that extra information, Mr McIver. You talked about psychiatrists' reaction and the call for a double blind trial: can you perhaps expand a bit on why you think that is inappropriate in these circumstances?

Mrs McIver—A double blind trial is suitable for testing drugs which have a very clear operation. Most drugs act as inhibitors. Inhibitors are a little bit like throwing a spanner in an engine to stop it from going; it does not particularly matter where it hits, as long as it hits a critical point it will stop. The approach that we took, particularly with additional nutrients, is like greasing an engine. If you do not grease all the moving parts, it is not going to work properly. When people use a double blind test for, say, one nutrient, they are forgetting that nutrients act as a team. If you have even one member of the team not fully functional, the team does not work properly. It is very difficult to cover all the necessary nutrients in a double blind study.

CHAIR—I imagine you cannot dramatically change a diet either in a double blind trial?

Mrs McIver—No, you cannot.

CHAIR—You cannot know if they are eating broccoli, wheat or whatever.

Mrs McIver—Exactly. You try to change a number of factors simultaneously and you cannot do that with a double blind strategy.

CHAIR—There are many GPs and other medical practitioners who use complementary supplements and treatments much more. To what extent have you found that this extends into the mental health area, or is it mostly in other areas related more, in a traditional sense, to diet, in particular, and supplements?

Mrs McIver—In 1983, Doug had been on medication for 10 years. The medication was effective in that he no longer had hallucinations. However, he was showing signs of what we thought were indications of tardive dyskinesia and we decided that, as his mental state was good, we would try phasing it out. He was on a relatively low dose. He was fine for about six months and then he started to get symptoms again and eventually he went into full-blown psychosis again. His original doctor was no longer alive, so we went to our general practitioner. At one stage, she wanted to hospitalise him and I said no. I felt we could manage without that. She referred him to a psychiatrist, Dr Merrifield. When we went to Dr Merrifield we explained that we wanted to use an alternative approach. He said categorically that it would not work, that Doug must go on to medication and that he would eventually need medication. So after three visits, Doug did not go back again. We basically worked on our own from then on without medical assistance. We were not totally without medical assistance—the GP was fairly helpful, although she was not totally convinced. We had some testing done as well.

Mr McIver—Chemical testing.

CHAIR—Was this GP persuaded by what happened with you? Did she become an advocate as a result of that?

Mr McIver—No, I would not say that. I think it is fair to say that in my representation to the Royal Australian and New Zealand College of Psychiatry about the progress that I made, they were very pleased to know what occurred in my situation. It is also fair to say that Professor David Copolov, who at the time was the director of the Mental Health Research Institute, was also pleased. He played a very important part in position statement 24 of the Royal College because he was the consultant to the Royal College general council on that. He is no longer with the Mental Health Research Institute.

CHAIR—You would presumably recommend that more money be put into this field?

Mrs McIver—That is one of the strong recommendations that we have. There should be research and it should look into the effects of nutrition in a much more comprehensive way. It is no good looking at one element; you have to look at the individual. One of the pieces of research we have studied is by Carl Pfeiffer and he maintains that there are about five biochemical types in schizophrenia. There is one, for example, that shows a high level of folate and another that shows a low level of folate. If you add folate to the ones that have a low level, you improve their mental state; if you add it to the ones with a high folate level, you can make it worse. So you cannot use one treatment across the board.

Mr McIver—You may be aware that in Queensland there is an embryonic centre which is looking at the issues in our paper. It is based a lot on the Carl Pfeiffer treatment model that was used in Chicago, Illinois. Dr William Walsh came to Australia on a lecture tour. Their approach has been to use supplementary nutrients, change of diet et cetera alongside the client's psychiatric medication. Of relevance to those who spoke earlier is the fact that they are working with a lot of people who have been in corrective institutions.

Mrs McIver—In particular, they are looking at mineral profiles. They have quite a database of mineral analyses and responses. William Walsh is coming here again in February next year.

Mr McIver—In earlier submissions and presentations there was discussion about children in adolescence and things like that. I should mention that Pfeiffer's book *Nutrition and Mental Illness* is referred to in the spring 1998 edition of *Open Minds Quarterly*. It says that in children the most common foods causing brain allergies are listed by Dr Carl Pfeiffer as milk, wheat, eggs, beef, corn, cane sugar and chocolate. A broader list of foods that have been found to cause food allergy or food sensitivity are cows milk, wheat, sometimes oats, barley, rye, rice, corn, eggs, peanuts, sometimes peas, soya beans, yeasts, moulds, chocolate, cola drinks, tea, tomatoes, shellfish, bananas, oranges, some other citrus, artificial colours and flavours, some other additives and foods containing salicylates. Less commonly, any food can, of course, cause adverse reactions.

CHAIR—You have pretty much described the diet of most children.

Mrs McIver—That is right. The implications of this approach are that, if we can prove beyond doubt by experimental data that convinces the medical scientific community that nutrition affects the brain—and we believe very strongly that it does—then the potential for prevention is huge. It is very significant for things like government funding of medical health resources and the correctional system.

Senator MOORE—The potential for proof is interesting. Establishing a proof based model is always difficult. You have excluded—

Mrs McIver—The double blind.

Senator MOORE—The one that the psychiatrists seems to be wedded to. Do you have another model of proof?

Mrs McIver—One of the problems is simply that most of the scientific work done asks the wrong questions in the first place. If you ask a silly question, you get a silly answer. I worked in research—not this type of research—at the ANU for 21 years. If I was trying to repeat somebody else's experiment and I got a different result, the first thing I had to do was ask: 'What did I do that was different?' One of the papers that the RANZCP has based some of its conclusions on is by Vaughan and McConaghy. Basically, they tested for two orthomolecular elements and expected to get a result—as I have already said, there are at least five biochemical types, according to Carl Pfeiffer. It does not work. You have to ask: 'If that didn't work, how come so many people have got a different result? What are they doing that is different?' You have to start with a properly framed question and, to do that, you need to make a lot of observations. That is my experiences as a researcher, anyway. You must observe people closely and have a really good look at what is working. If it is working, what are they doing that is making it working, and how is that different from where it is not working? And that is what is not been done.

Senator MOORE—So it is a form of clinical trial?

Mrs McIver—I think the first thing is to actually study one or two cases very thoroughly. The researcher Piaget worked on children. His initial research work, as far as I know, was done on his own two kids—on only two children. He worked out a whole theory based on two kids which, as far as I know, has stood up to scientific testing very well. That is what I am saying needs to be done in the case of things like schizophrenia. You have got to look at single cases

and you have got to look at them very thoroughly and say: 'What's been done here? Can we repeat that? Can we find the conditions that will actually give us a repeat result?' Because if you can, if you can repeat a result, then after a number of repeats it becomes a very valid statistical result.

Senator MOORE—So despite the fact that the board of psychiatrists have rejected this particular form of treatment and that on that basis, I am sure, it does not draw any Medicare support—

Mrs McIver—That is right.

Senator MOORE—or any kind of acceptance by any of the private health insurers either, there are still people who are practising this?

Mrs McIver—Yes.

Senator MOORE—In significant numbers?

Mrs McIver—World wide, they would be significant numbers. People who have a mental health problem can be pretty desperate. I am including in that things like ADHD—and there are a lot of people who will spend a lot of money to try and get an answer to that one.

Mr McIver—I think it is important, Senator Moore, in answer to your question, that when the royal college lays down its position statement 24 it is telling its fellows what it will accept and not accept. There is the well-known retired Sydney physician and psychiatrist Dr Chris Reading—

Senator MOORE—Whom you quote extensively in your supplementary submission.

Mr McIver—Yes, and in attachment B you will see the story there. But it is interesting that in June 1989 the Royal Australian and New Zealand College of Psychiatrists wrote to Dr Reading informing him that if he continued the present mode of practice then the executive officers would be inviting him to consider his position in relation to continuing his membership as a fellow of the college. There was a lot of lobbying and advocacy after four or five months of that. It is of interest to me in my representations to government that, for example, the Queensland ministry were not aware of that position being held by the royal college, of not allowing its fellows to practise orthomolecular treatment. It was believed that just because that position statement was in place that did not prevent psychiatrists, fellows of the college, from practising orthomolecular medicine. That was not the case.

Mrs McIver—But it is.

Senator MOORE—From your understanding, it is currently the case.

Mr McIver—I think it is an opportune time to highlight, when we talk about the intervention that I applied, that I came off medication because of a number of side effects, and there are a couple I am still following through and one is including the heart. But the thing that is of interest to me is that when we introduced allergy testing and single test challenging by using the pulse

test I was getting tremendous reactions from certain foods. It was just amazing to me. I was a bit of a doubter of what Jan was saying.

Mrs McIver—One of the things that was very convincing was that, fairly early in the piece, Doug went on five-day fast. I give full credit to him for having stuck to this five-day fast—the most I could ever do was three, but he kept to the five-day fast. At the beginning, before he started it, he was having hallucinations and other symptoms that we associated with the schizophrenia. By the end of the five-day fast he had no hallucinations, his mind was clear and I could converse with him far more easily than I had been able to for some time. He was normal—his mental state was normal. That was after five days of fasting. As we introduced foods we found that gradually some of the things came back in, but it was sufficient to convince us that there was a very real phenomenon here. I use the word ‘intolerance’ to foods rather than ‘allergy’, because I do not know if it is all immune mediated or not; some of it could be just purely toxic effects. That is not what is important. What is important is: does it have an effect on the function of the brain? Yes, foods can affect the functioning of the brain.

I know myself that, if I have some foods, I feel fuzzy-headed and my brain and memory do not function as well. Certainly, in the early days it affected Doug’s mental state. He can eat foods now that he could not eat then, because his whole biochemistry is geared up to handle them. When he was mentally ill, his biochemistry was pushed to its limit—he could not handle it. Now he can.

Mr McIver—The hallucinations are deplorable in this illness. The auditory and visual hallucinations are like commands; it is absolutely deplorable. Senator Moore asked a question about personal evidence. In this exercise book is the sort of record keeping that I was doing. I listed, for example, all the foods that I had and ticked them off day by day. Why? I had to make sure I was not repeating a food within five days, because there was a masked reaction. I found that if I had a certain food the effects could still be around for a couple of days, according to my pulse testing. So I tried to space it out over five days and not repeat foods too regularly. I also recorded which vitamins I was taking each day, which they were and so on.

That brings me back to the point I wanted to make earlier. When Royal College Position Statement 24 talks about orthomolecular psychiatry, it is much more than megavitamin therapy, which is what we applied. We looked at challenging individual foods and the responses and reactions to those foods. We decided to eliminate foods that we thought I was reacting to. One of the important indicators of that was my pulse. If I had a change of over 16 points in my pulse, it indicated that I was not reacting to that food well physiologically. I was also keeping a record of my moods. So I could eliminate foods I was reacting to, which meant introducing other foods. When we talk about getting certain nutrition, if you have some sensitivity to a particular food, you have to find the nutritional value of that food somewhere else. This is where supplementary nutrients also became important.

So I have been an advocate of using supplementary nutrients as well as watching my diet. I had to also minimise my exposure to toxic chemicals. The medical doctor gave me some good advice on that after several tests that he conducted in Sydney. That was not Dr Reading. I have never been a patient of Dr Reading, but I know of his work—I learned of his work only after I had come through my journey in about 1991 or 1992.

Senator MOORE—I am looking at your submission. Have you provided a definition of orthomolecular treatment?

Mrs McIver—One is given in Chris Reading's submission.

Mr McIver—In section B you will find a very good description and background. Some would simplify it. Linus Pauling, of course, defined orthomolecular psychiatry—

Mrs McIver—Orthomolecular meaning 'of the right molecule'.

Mr McIver—Of the right molecule, and getting all of these molecules together. Linus Pauling was a very important figure in this field.

Mrs McIver—Basically, the idea is to optimise the person's biochemistry. That will vary from one person to another. You have to look at what their biochemistry is to start with, because we are not all the same. We all look different externally, and internally there are differences as well. That is what genes are about.

Mr McIver—Linus Pauling was a PhD. In 1968 he defined orthomolecular psychiatry as:

The treatment of mental disease by the provision of the optimum molecular environment for the mind, especially the optimum concentrations of substances normally present in the body.

Mrs McIver—Something that a lot of people seem to forget is that every cell in our body—every organ, every part of us—is dependent for its functioning on the food that we eat. The mind is part of the body, so it too is dependent on the food we eat.

Mr McIver—There is something else that is valuable to your work. You must have been doing so much reading of all the submissions and hearings, but just to bring you into the picture with our own family, we had a daughter who was also diagnosed with schizophrenia. She got an illness which was unsuspected by everyone—she got cancer, and she died six months later. The point I would like to make, quite apart from the way she approached her medication and doctors, is this: when we talk about mental health we often think about depression or suicide we think about how a person may manage their mental illness, but we do not think about other factors of mental illness which may lead to death. Here is a lass who died of cancer who had been diagnosed with a mental illness; there may have been factors in that which led to her death.

Mrs McIver—We wonder whether the physical illness was simply a part of the whole condition and whether it may have been exacerbated by the medication that she was on for her mental state, because when we looked up some of the side-effects later on it said it was a possibility. She would not accept our approach because her doctors did not agree.

Mr McIver—As we all know, SANE is doing wonderful work with tobacco smoking. In my work with the supportive accommodation programs and other work I have done over the years in mental health communities, I have found there are a number of people who find smoking is very important to them; it gives them a lift and so on. They are aware, not even just from what is on the package, that it is a dangerous drug, but it is a legal drug.

Mrs McIver—And it may be a form of self-medication.

Mr McIver—It may be a self-medication that leads to cancer.

Mrs McIver—Particularly for people with schizophrenia. Incidentally, I mentioned Nicole rejecting our approach. She did eventually come home—she had left home—when she was ill. She went onto our approach and she was following it reasonably well, but she was still having hallucinations. The other problem, which turned out to be cancer—we did not realise it initially—was bothering her so much I said, ‘Let’s just try going off the medication for a while and see whether that makes any difference.’ And she did. Interestingly, a few days later she said, ‘Mum, I don’t have any more hallucinations.’

Mr McIver—We all ought to be considering the effects of foods on health. There have been questions recently about obesity. Maybe we need to take into account in our early intervention and prevention strategies the role of foods and chemicals and what that means to families in helping their kids and for kids helping themselves. We all know that it is difficult to get some kids to want to do A, B or C; some are very motivated and want to do A, B, C. But it could well be that the multidisciplinary approach in medical teams—with allergists, if you like, clinical ecologists, people who are concerned about toxic chemicals and foods, nutritionists and the like—are a very important part of the medical model that you may want to develop, given the concerns that are coming before you, not only about mental health, but also community concerns about cancer, obesity and a range of population health matters.

Mrs McIver—One thing that came up in a previous submission was the question of stress in the first three months of life. Some research papers suggest that stress of the mother when she is pregnant has an effect on the baby. I suggest the nutrition of the mother, even before conception, has an effect on the baby—not only on the physical aspects of the baby—we know that folic acid has an effect—but also on the mental state of the baby. Maybe one of the preventative areas that should be looked at is making sure that pregnant mothers, particularly the ones who come from backgrounds where they do not get adequate nutrition, are given much better care and training in nutrition.

Senator TROETH—Are you aware of any other individuals or groups in Australia who are using this approach?

Mr McIver—In Australia there is Dr Chris Reading, for example. I hope the committee might meet with him. He is retired now and he is a valuable source of information about his own practice, quite apart from what is in attachment B of our submission. He presented some evidence in 1989 of about 589 patients. He had used the methodology with both the issues about chemicals and nutrition. Internationally, it relates to the earlier question, and we are aware of the research that comes through. There are doctors also in Canada, the late doctor Abram Hoffer received an award from the Canberra Schizophrenia Fellowship. Many of the carers say, ‘If we take our kids off drugs how are we going to look after them with the approach that you and Jan have used?’ In Canada Hoffer was working with the Canadian Schizophrenia Foundation on the orthomolecular and environmental medicine approach. A lot of the things about our approach are a bit of a worry to the carers because they can see that having the magic bullet of medication is helpful and they ask, ‘How can we care for them with these other approaches unless an infrastructure is in place.’ That leaves you back in the catch-22 situation of the importance of

position statement 24 and other medical people, particularly a couple of the other medical accrediting bodies—not the Royal College of General Practitioners because many of their general practitioners are supportive of supplementary nutrients.

Mrs McIver—It raises the question of supervision. Doug did need a lot of supervision to keep him on the dietary aspects because one of the first indicators that he was having a reaction was, ‘Oh, it’s more than diet.’ That was one of the first things that told me, ‘Oh dear, okay, now we have to get past this.’ Sometimes when he had a reaction, quite often it would take five days before he fully recovered from it. You were asking about the work being done. There is a conference in February which will include—this is the one that William Walsh is coming across for—nutrients and mental state. There will be a number of presentations by a number of practitioners.

Senator MOORE—Does it have to be either/or?

Mrs McIver—No, it does not.

Senator MOORE—I think in the previous inquiry that I was on, which was the cancer inquiry which talked about other forms of treatment, the thing that scared the medical practitioners was the concept that it had to be either the full medical model or the alternative.

Mrs McIver—We would say definitely, no. You can use the two together.

Senator MOORE—Can you stay on the formal medication that would be prescribed by the medical practitioner and also work with another practitioner who understood this process? Can you use them in concert?

Mrs McIver—Yes. For people who are on medication that is working reasonably well, there is no reason they cannot use the nutritional factors to help them improve their response. For a lot of the people who are on medication it is terrible, it really is awful and it is not that great for the carers either. I think there is a lot of potential there to improve the general responsiveness. One of the things with Doug, for example, was trying to get him on to this system in the first place. A person who suffers from schizophrenia goes into denial: ‘There’s nothing wrong with me; I’m all right.’ But I was able to use it for him because he had sore muscles. His muscles were breaking down. I would say, ‘Look, do this with your diet and it might improve your muscle function,’ which was a good way to get him started in the early days and it did help.

CHAIR—Did you identify serious deficiencies in your diet, Mr McIver, prior to becoming sick? Can you look back and say that if your diet had been better back then you might have avoided illness?

Mr McIver—Briefly, if only I knew then what I know now. Before 1972-73, I had a lot of cow’s milk and a lot of wheat. I eliminated those. It took a lot of self-discipline and I was able to achieve it. It took a long while to settle down with the new diet, the new regime and all the things that Jan was encouraging me to do. I suppose I did not fully settle down until 1991. In that orthomolecular psychiatry position statement, the royal college highlights the McConachy study, and they only did it for five months. It needs much longer than five months.

Mrs McIver—And it needs to be much more thorough. I know from having talked to Doug's mum that, when he was a baby, she had difficulties with feeding him. He was fed on Nestles sweetened condensed milk, which was a very inadequate diet. I would not have a clue how much of an effect that had. When we went on this exclusion diet, we did it by trial and error. We did not really know what was going to work and what was not, so we trialled things. We used the pulse test a lot. He finished up on a high fish diet. There is research going on now that suggests that omega-3 fatty acids are vitally important to the brain's function. There is a suggestion that it affects bipolar and possibly schizophrenia. Of course, these omega-3 fatty acids come from fish, and he had a very high fish diet. He still has fish at every breakfast.

Mr McIver—One of the important research institutions is NISAD, the Neuroscience Institute of Schizophrenia and Allied Disorders, which is associated with the Garvan Institute of Biomedical Research. I understand from the research manager that there is not a great priority there on nutrition and dietary matters, yet one of the most important studies about the importance of fish oil came out of the neurobiology program of the Garvan institute. It is very disappointing that there is not as much coordination of results in the areas that we are talking about. If we knew that, we would be able to answer some of your questions. In our own case, we know what happened. We know what happened with our daughter. We know that we have some valuable experience to share with you.

Mrs McIver—Apparently some of the fish oil experiments have been a bit disappointing. I would say that that is because they have not put in all the supplementary nutrients that they need in order to get that to work.

Senator MOORE—Mr McIver, has the doctor who treated you in the 1970s and the 1980s accepted that you are now cured?

Mr McIver—I have not seen Dr Merrifield nor Dr Goldrick. Both of them said that I would land in hospital if I did not continue with my medication.

Senator MOORE—I take it that the answer is no.

Mrs McIver—The original doctor who diagnosed it has died.

Mr McIver—I do not think I was responsible for Dr Bob McDonald's death!

Senator MOORE—It is not in this submission!

Mr McIver—Bob was a very good man, and he helped me a lot. Bob was concerned about a number of things, and he was able to help me. He died in 1976. I asked for my records, and all the records had been destroyed. He prescribed Stelazine, Largactil and Cogentin. Cogentin is the medication that I am following up at the moment. It seems that a part of my heart is not operating as well as it should, and Cogentin is one of those things that does affect the heart.

CHAIR—Thank you very much for your submission and for coming all the way from Melbourne. We appreciate your doing that. It has been most interesting.

Mr McIver—Could I simply say thank you. I have something to say that might interest you. We have come a long way. I was a psychology student at Melbourne university in the 1960s. One of the ways I received income to help my work in psychology—I was also doing theology—was to do part-time work in the vocations. I worked at the Kew Mental Hospital. This is a very sad memory for me and it is one of the things that keeps me motivated to be well. People were bound in straps and were given handfuls of medication. They would go out of the ward and walk around in circles as though it were the mounting yard of the Flemington race course and the horses were getting ready for Melbourne Cup. That has encouraged me, as well as my wife in doing what she has done to help me, and I hope that our experience is a help to the committee.

CHAIR—Thank you very much.

Proceedings suspended from 3.19 pm to 3.30 pm

HICKIE, Professor Ian, Clinical Adviser, Mental Health Council of Australia

MENDOZA, Mr John, Chief Executive Officer, Mental Health Council of Australia

OZOLS, Mrs Ingrid, Executive Member, Mental Health Council of Australia

ROSENBERG, Mr Sebastian, Deputy Chief Executive Officer, Mental Health Council of Australia

WILSON, the Hon. Keith, Chair, Mental Health Council of Australia

CHAIR—Welcome. Thank you very much for appearing before the committee for a second time. We appreciate that. Do you have any comments to make on the capacity in which you appear?

Prof. Hickie—I am also the Executive Director of the Brain and Mind Research Institute at the University of Sydney.

CHAIR—We now invite you to make a brief statement, after which we will go to questions in the usual way.

Mr Wilson—I do not intend to make the statement, but I want to say on behalf of the council that we are very grateful to have a second opportunity to make a contribution to the inquiry. I would like to introduce Ingrid Ozols, who is a member of our executive and who was not here on the previous occasion.

Mrs Ozols—Thank you for the opportunity to present to you. Having read some of the *Hansard* transcripts, I have been considering what I could offer you that you have not heard before and that might help you in your deliberations. Many perspectives have been delivered echoing similar concerns and a variety of issues, so I thought long and hard about what I can bring that might prove useful to you. I came up with a story, a story of hope, an example of the human spirit, a story of someone who has had a mental illness and been able to manage life well even though there have often been times of adversity and grief. Mental illness has even provided an opportunity for vulnerability to become a strength.

That story is mine. I would not be here today doing the things that I do if I had not been touched with a mental illness since early childhood. In fact, I have had so much mental illness around me in my family that I know no differently. My grandparents were Latvian immigrants who came to Australia having suffered severe traumas in the Second World War. My grandparents suffered severe depression for many years. My mother, who is now deceased, also had bipolar disorder. My stepfather had an excessive alcohol problem to mask his own demons. But today I am finally learning how to use my vulnerabilities and channel what has at times been excruciating psychological and emotional pain into something that I hope is useful, passionate and gives me purpose and meaning. That something is belief in my heart that by undressing myself emotionally I may reach out to and help someone else and make a difference, so that they feel less isolated, less neglected, less hopeless, less ashamed and less guilty. Mental illnesses are

intense. They are a crisis of one's self that strikes at the soul, at one's very being. They impact on every dimension of a person's life.

During my life's journey, there have been occasions when my mind has been my captor. I have wanted to die and I have tried to do just that. Today I look back on my life, and I have it all: a 22-year marriage, a gorgeous eight-year-old daughter, I am studying my third degree, I run a successful corporate mental health education business, I sit on several boards and committees and I speak at many community functions and forums. Even though there are still occasions when I drop the ball of life and I am unwell, I have good family support and I have had great mental health care. I can say proudly that every chapter of my story grows more and more positive.

There is a mantra that runs in the veins of consumers and carers in this country: 'nothing about us without us'. The lived experience is a powerful measuring stick that can inform what works, what does not work, what can be improved and how. Consumer and carer participation is enshrined in the National Mental Health Strategy, but it has been slow in its uptake. The National Consumer and Carer Forum and the Australian Health Ministers Advisory Council National Mental Health Working Group are current examples of consumers and carers feeling as though they are tokens. It is in these groups and committees that they feel dismissed. They feel unsupported, devalued and directionless. I would like to share a quote with you from the *Not for service* report. A Western Australian chief psychiatrist states:

It's the patients who can best tell it "as it really is" and professionals need to develop the mechanisms and the skills to listen to patients with "authentic curiosity".

By walking in our shoes many valuable insights can be learnt and go towards enriching the mental health system, value adding to services. My hope is that one day consumer and carer participation will be a natural part of the mental, and hopefully even the general, health system; that it is legitimate; and that we are recognised as equal colleagues and experts in our own right.

We are more than capable of being colleagues around a board table, partners in service provision, service providers, drivers of change, policy makers, educators, facilitators and business operators. I would like to share with you an example of where I have been able to use some of these elements in my own professional life. As a human resources consultant in my previous career, I saw mental illness poorly dealt with in the workplace, and this prompted a career change. Tertiary studies and work experience did not prepare me for dealing with what was commonly faced—including obviously mental illness—in the workplace. I felt overwhelmed. I did not know what to do. Many talented people who wanted to work were either demoted, made redundant or managed out. Others who took time out for these health conditions would find accessing new employment opportunities difficult and explaining absences on their resumes very stressful.

Today, with my expertise from having lived with a mental illness and living with a mental illness, I have been commissioned by Telstra to be a consultant in helping them develop a national mental health workplace strategy. Telstra's mental health program includes several elements and tools. We have already conducted forums for the staff and their families around the country. There is an intranet site with information on mental health. There is a booklet titled *Mental health: creating a supportive workplace* which I would like to table; I have copies for

each of you. An interactive e-learning software tool called 'Mental health at work' has been developed and is now available to other businesses through my company, Mental Health Information Services. Recently, Telstra partnered with the Mental Health Council of Australia for Mental Health Week. A variety of teleconferences and seminars were conducted in each state. Academics, clinicians, the lived perspective from consumers and carers with different mental health issues and service providers came together to give messages of hope, help and support.

With Telstra, in essence, we have been trying to bring some heart back into business. We recognise that changing culture so that we are more empathetic in the workplace towards mental illnesses will take time. We know that it will take time to filter these messages through the ranks, so we are planning ongoing education, support and other tools to evolve continuously. The response to this initiative from Telstra staff has been overwhelming with hundreds of positive emails and phone calls.

Through the work of this committee, my hope is that our social conscience is awakened and that governments and community are moved to work together in constructive action. Healing and recovery is more likely in an environment of optimism and hope in an integrated, well-educated and supported mental health system and community.

I was fortunate enough to have the resources to access and be treated in the private health system. But every Australian should be able to choose and be able to access high-quality services and assistance whenever they need them, whether they be clinical or non-clinical, wherever or whenever they need them. I owe my sanity and my very life to my partner, my daughter and my medical health professional. They have helped me to take responsibility for my own wellbeing, supporting me when I have fallen and helping me to get back on my feet and walk proudly forward. It is through education, reaching out to one another and giving everyone a fair go that we can all make a difference to help the most vulnerable of us to live full and protective lives. Thank you.

CHAIR—Thank you so much. Perhaps I can begin by congratulating you on your report *Not for service*. To us, it is a very useful document. I have not quite read the whole thing yet, but I am sure I will eventually. Thank you for the effort that has gone into that and congratulations. Perhaps we can talk a bit about the aftermath of the release of that report. Suggestions were made, for instance, that the federal government should take over all health services or, variously, just mental health services. The committee will struggle with the question of structural change in order to deliver what I predict will be a better outcome for mental health services. I wonder whether you have had a chance to reflect on some of the evidence that has been brought before the committee in this respect as well as your own report and those suggestions. Do you think that such an arrangement might be useful, or should we be focusing more on how the two levels of government might work together? If I could get a response to that, it might be useful.

Mr Wilson—We have been able to get a pretty good assessment of the response to the report. It varies from the facile to that which is of more substance. Nobody ever took seriously the idea that the Commonwealth would take over mental health services, so that was a dampener to start with. However, since then, we have had a fairly spontaneous response from two state Premiers—the Queensland Premier and the New South Wales Premier—to the concept of a cooperative drive at leadership level between the states and the Commonwealth. That is very pleasing, because it has always been our contention that this needs not just the involvement and better

performance of health services—as you would be well aware, it is not only health services that impact on the prospects of people with mental illness in terms of their recovery and participation in the community—but also education services, prison services, justice departments and the police; it involves a whole range of government agencies. Some are federal agencies and some are state agencies.

The nexus is that it is only the leaders of government in Australia who have the capacity to make it happen at a federal level, a state level and between state and federal agencies—and there are plenty of examples to indicate the need for that. One of them is the implementation of the government's Welfare to Work reforms. While we all understand that the greatest ambition of most people with a mental illness is to get a job, we know that accessing that objective is extremely difficult. It will not be made any easier if people who are still working through their mental health problems are put under pressure to move from a pension into meaningful work—which is quite a stressful experience—without having backup health support for their mental health condition.

We believe in better access for the mentally ill to find real jobs, to have real homes and to develop better networks of friends as the three great essentials. They can only be achieved if the Prime Minister and the premiers provide important leadership and bring together different agencies from across the states and the federal government. We can already see signs that, with these responsibilities divided between departments like FACS, through Centrelink and DEWR at the Commonwealth level with no interaction with state health departments responsible for delivering mental health services, there is an immediately built-in dysfunction in ensuring that we give this the best shot on behalf of the people with these problems, who are conscientiously looking and who very much desire to be part of the work force.

It is not impossible but it needs to be given very strong leadership at the top level, so we are very pleased that the Prime Minister has indicated that he has already established a high-level interdepartmental committee in his office and that the premiers of New South Wales and Queensland have indicated their intention to cooperate with the Commonwealth. In fact, I understand that the New South Wales Premier has written to all his colleagues asking them to support a mental health summit for all premiers so that they will be in a position to make a common front approach to these issues when dealing with the indications from the Prime Minister that he is willing to work with the states. We see that leadership, which is now starting to show, to be one of the key breakthroughs flowing from the release of our report.

The other two great things that we emphasised in that report are the need for greater accountability and the need for greater investment. Further investment should be largely placed in the development of better community based services and better support services for people in the community and not, as the states have been doing in the past few years, investing the large proportion of due funding in more hospital beds, more hospitals and more secure facilities and using it to patch up facilities in emergency departments of hospitals. I think the Senate has already heard evidence to the effect that people are suffering great indignities and questionable restraint when being held in those situations.

We are heartened by the response so far. We are hoping that other premiers will come on board, but we believe that, if only two or three premiers are willing to work with the Commonwealth, they should go ahead. I am sure that the rest will be dragged into it in due

course, but it is important that they make a start and that that start is at that leadership level across the country.

CHAIR—Thank you.

Senator TROETH—We have heard some mixed views about the better outcomes in the mental health initiative from both doctors and consumers, so could I ask the council's view of the program? Should it be expanded? If so, in what way? Should it be completely revised and, if so, in what way?

Prof. Hickie—I will answer on behalf of the council. I have been involved in and chaired the evaluation committee of the Better Outcomes initiative for the Commonwealth. I have written and published on the issue and I would like to table the evaluation of the data that was available to us and published in the *Medical Journal of Australia* in 2004. I think those involved in the program and many of the major consumer and carer groups, psychologists, psychiatrists, GPs, and people from the Mental Health Council who participated in the formation of the program felt that it offered the best way of providing integrated medical and psychological care for those people who presented to general practice with common anxiety and depressive disorders.

At the time that the program was established there was limited funding, and the Commonwealth was budgeting for approximately 2,000 GPs and their patients to enter the program. Over 4,000 GPs eventually registered for the program, so it was twice the expectation. From the utilisation date of the moneys available for the GPs, it seems that approximately a thousand have used the program to some degree. Many more have entered into training and education. But predictable barriers to utilisation, which were suggested to the Commonwealth by the original committee for incentives in mental health, which I cochaired with Dr Julie Thompson, and the subsequent advisory group, were pointed out and we think have proved to be major barriers.

In terms of where the program has been most successful, it is important to say that those are the areas where there was the greatest access to working with allied health services, particularly psychologists. Where GPs and psychologists were able to work together is where you saw the greatest GP uptake of the program. The GPs wanted to work in partnership with the psychologists. The amount of money for allied health was one of the capped parts of the program, because there was a fixed amount of money—\$23 million over four years—and much of that particular component did not come into operation until the last two years, in the last financial year of the program. So the program did not start as a whole. It started in increments, and the bit that the GPs, the consumers and carers most valued—that is, the access to the additional allied health—was least available until the end.

We, in association with the Australian Psychological Society and others, have argued that increased investments in that program should largely be focused on expanding the access to the allied health services. We made submissions to the government before the last election and the last budget that that needed to be at least in the order of \$50 million additional per year. The government has made increased commitments in that area, but there remain problems with the utilisation, so I do not think the problem is between the professions. It is the system that one has to work through in order to access the issues. Also, the Commonwealth had rejected attempts to

publicise the program widely to the public, to make it better known, because it was afraid of overutilisation of the program.

I had been involved with my colleagues prior to the implementation of the program back in the late 1990s in looking at the situation in general practice—and I note that Senator Moore and others have looked at what data was available. We looked at the number of people in general practice. We looked at over 46,000 consultations in general practice and knew that the demand would be large and that the demand would be there, particularly for non-pharmacological treatments in addition to pharmacological treatments. We also knew that, if sufficient non-pharmacological treatments were provided, you would have less use of pharmacological treatments, particularly for less severe disorders. We showed, in association with training programs, that that is exactly what happens. If you provide services and if you provide training then people with less severe disorders are likely to receive more non-pharmacological treatments. So GPs rapidly alter their behaviour when faced with these disorders if they have alternatives available to them. Also, the better informed the public that they see and the more that they know, the more likely they are to request non-pharmacological treatments.

So our disappointment with the program has not been with the fundamental structure, which basically recognises psychologists and other allied health workers as mental health specialists supporting the GP work force, but with the availability and with other structural elements. The biggest disappointment from a GP point of view is what we see as the cap on the number of services. The Commonwealth rejects this as an issue, but what you want here is fundamental practice reorganisation, for GPs to alter the way they work. In fact, if you say there will be a limit to the number of people whom any individual or practice can service then you get a fundamental disincentive. So there has not been the degree of GP practice reorganisation that we would have hoped for, and certainly the principal issue from the GPs' point of view is less to do with the paperwork but more to do with the lack of access to allied health services. If they can work with others—specialist psychologists, specialist psychiatrists—they will do more of this work. They are reluctant to do it on their own and they are reluctant to do it where they have poor access to non-pharmacological treatments.

CHAIR—You seem to have enough copies of that for us. Is it your intention to table them, Professor Hickie?

Prof. Hickie—Yes.

CHAIR—While we are at it, Mrs Ozols, perhaps you would like to table those at this point. Is it the wish of the committee that those documents be tabled? It is so ordered.

Prof. Hickie—Also, Chair, Senator Moore asked previously about guidelines, which are an important issue. There were guidelines produced in 2002, through beyondblue, and published, so I was surprised that the Commonwealth was not aware in its submission and its representation that guidelines specifically for the treatment of depression in primary care had been produced and had been fed back into this process as well. So I would like to table those as well.

CHAIR—Thank you.

Senator TROETH—So I can take it from your comments that it is a valuable program but needs to be restructured?

Prof. Hickie—We think it needs significantly more money in, for the non-pharmacological end, and the structuring needs to facilitate access. I see in others that we do not necessarily agree with in some aspects—Professor Andrews and others—about the money investment. The issue is all about coverage. If you provide access people will use it. If the access is limited and you do not let people know it is there then its utilisation is likely to be less.

Senator TROETH—There was a public hearing a fortnight ago—and I must say I was not at it—when the committee did hear evidence from officials from the federal department of health. From evidence received it is clear that there are a number of intergovernmental steering groups and committees all involved in developing policy in mental health, and that involves all levels of government. Does the council have a view of evidence of achievement by all those groups? You would expect that there would be a high level of experience and commitment from the officials involved in those groups. Isn't that sufficient to improve the system as it now stands? If it is not, what else should we be doing at that level?

Mr Wilson—As chair of the council for the last three years I have automatically been a member of the National Mental Health Working Group, which is the group that works to AHMAC in relation to mental health policy and, in fact, is the group that is meant to monitor the National Mental Health Strategy and the National Mental Health Plan. That group meets three times a year. It brings together the directors of mental health services in each jurisdiction and, of course, brings in the Department of Health and Ageing as part of that array. Quite frankly, my personal assessment of having sat on that body for three years is that it has no authority, it has no teeth, it achieves nothing but the production of large reports, which are then referred to AHMAC and which then, usually, the states and territories see fit to ignore. It is all done by consensus, in that everything has to be levelled down to what the state directors are prepared to cop. So you never get any real leadership there; it is always one jurisdiction being sure that its independence to run its own race is preserved at all costs.

What we have is not plans that have clear accountability with them, that have clear outcomes to be achieved. We have plans of which the latest five-year plan, 2003-08, is a perfect example: it simply sets out general directions which you may or may not choose to adopt. So these reports are largely generalised, unspecific directions which you can choose to interpret or not at will. That system is not effective. That National Mental Health Working Group has not been capable of being a really proactive monitor of the effectiveness of our National Mental Health Strategy and national mental health plans—and we are well into the third one of those. So it has not done the task that it was meant to achieve and there is no other mechanism in Australia which can come anywhere near providing that system of national accountability, national reporting and a national impetus to achieve some national objectives and outcomes. We do not have that in Australia.

In New Zealand they do have a national, independent commission, which is empowered to deliver independent reports about progress on programs and objectives and a national agenda. The United States has the President's New Freedom Commission on Mental Health. It is interesting to note that the latest initiative from the federal department of drug and alcohol and mental health services in the US administration has been to deal with six states who are willing

to work with the federal government. They have received grants which are specifically tailored to changing the whole ethos of mental health services from one that has previously been very much focusing on acute care—hospital care—to one which now has a primary focus on rehabilitation and recovery as the prime objective of mental health care. If that can be done in United States, whose health care system is always seen to be so much inferior to our own, there is no reason that it cannot be done here. That is why the leadership, we hope, that will be given by the Prime Minister and the premiers is so important to achieve that.

We have a dearth of mechanisms with which to achieve what you have indicated was the initial way forward. We have no way forward which is coordinated and which has any sense of national cohesion. We are very much of the mind that the National Mental Health Working Group is no longer the mechanism that can fulfil that task. We have to look to a new mechanism which actually is driven by the leaders of the Australian governments.

Senator TROETH—Mr Mendoza, do you have something to add?

Mr Mendoza—Yes, thank you. There is no IDC as such in the terms that you and I understand that. I have been a Commonwealth senior executive officer for 10 years and I have worked on IDCs leading up to the Sydney Olympics and elsewhere. There is no IDC that operates in mental health that brings together the various portfolios, even within the Commonwealth's jurisdiction, on this issue. Hence, there is not that cut-through in terms of programs and connection that you need that comes from IDCs.

One of the other things that would be a benefit to the Commonwealth is for portfolio budget statements to specifically have in areas like employment and workplace relations outcomes that actually link up with objectives in Health, FaCS and DHS. Quite clearly, in employment, the Commonwealth's goal is to reduce the number of people who are currently recipients of DSP, the primary disability of which for about one-third is psychological. We clearly want to reduce that, but we know that programs such as DSP, PSP and others do not provide the linkage with programs over in Health. So IDCs and portfolio budget statements that include common outcomes and link to particular programs are one way that, within the Commonwealth, we can get much better outcomes in such areas that are certainly essential objectives for the government.

We have seen in recent times in Indigenous affairs the development of coordination not only of Commonwealth and state programs but also with local government and the private sector. The sorts of social coalitions that have developed there are delivering real changes to the circumstances in communities like Arakun and others, particularly in Cape York. We have seen that already. That is a very rapid turnaround from a quite desperate situation.

We would like to see a task force at the national level that links to COAG and oversees the implementation of programs, both Commonwealth and state, and also those that are delivered by the NGO sector and private sector. Increasingly, psychiatric services in this area are delivered by the private sector—they have an important role to play—and yet NGOs and the private sector are on the outside of the decision-making processes at the present time or are certainly given very little influence on them.

CHAIR—Just on that point, is there an argument for moneys to be pooled, if you like, and come under the jurisdiction of, say, an Australian version of the New Zealand mental health council? Do you see that kind of approach working?

Mr Mendoza—The pooling idea has certainly been explored in relation to Indigenous communities, but I think their circumstances are quite different because of the geographical factors alone. But in some way we have to better connect government programs and not have this shower head effect where people who are, say, on the PSP program for two years really do not have the economic means themselves, nor can the providers that are receiving that PSP change the circumstances for those people. So they simply remain maintained rather than having programs that can intervene effectively and change the circumstances. These people cannot even access information over the internet, let alone go through the Better Outcomes program—or CDMs, the chronic disease management items, as they are called under Medicare—and access psychological services. So they remain somewhat trapped in these situations. I think we have to look at ways like IDCs and shared outcomes statements and portfolio budget statements. They are two very practical and well utilised mechanisms, both at Commonwealth and state levels, that can start to join these programs together.

Prof. Hickie—There has been some pooling of funds under the Better Outcomes program through divisions of general practice to take federal money from a variety of different programs, more allied health specialists in rural areas, some Indigenous programs and others, to better integrate that with state funding in a number of areas. There have been some examples where more efficient use of resources has resulted. Perhaps even more importantly, people are not then competing for different work forces and skipping between different programs depending on who has money this month or pays higher. So there is a better integration of services at a regional level. There has been some experimentation under Better Outcomes through the divisions of general practice as one way. It is one of the biggest issues that we face. Each new Commonwealth, state and Indigenous program tends to increase the division of services in our particular area. I want to make one further comment about the Better Outcomes area. Indigenous persons in a number of youth networks are poorly served by the current arrangements where they have tended to be excluded. There is underutilisation in the groups in greatest need through some of the existing mechanisms. It is only where funds have been pooled across a number of areas that there has been an efficient use of resources. That is one area where we have had great trouble with the Commonwealth Department of Health and Ageing in making any progress towards more efficient use to meet general community needs.

Senator MOORE—Mrs Ozols, one of the issues was of consumers' and carers' voices. It is all the way through your report. It is all the way through all the reports. Can you give us something more than what you gave us in your opening statement about how you feel it is operating across the current situation, because every group has some kind of guideline that says that, on any kind of managing group or decision-making process, consumers will be heard. From your experience and what you know across the country from your executive position, how do you think it is really operating?

Mrs Ozols—It has been ad hoc. In some places people do not get it; in other places it has been an evolution. One of the committees that I am involved in where I have seen a huge change was through the Better Outcomes initiative. That was the General Practice Mental Health Standards Collaboration, where we have been looking at GPs' training and at training providers. What has

happened over the four years that I have been involved in this committee has been an evolution. We wanted, or hoped, that we would get some consumer and carer participation at the training provider stage—that they might be consulted to participate and put their expertise, thoughts and views into training programs for GPs so that GPs are able to get access to the views of consumers and carers through their training in the Better Outcomes program at level 1 and level 2.

Initially it was interpreted that consumer carer participation meant that someone would go and develop a training program, send it into the national standards collaboration and say, ‘Yes, we’ve had consumer participation, we showed the program to some consumers and carers and asked them to rubber-stamp it, to tick the boxes and say, “Yes, we’ve done it.”’ That is not what we meant. What we were envisaging and what we went back and have slowly been explaining to all the training providers, and likewise to the GPs, is that how we interpret consumer carer participation is that consumers and carers are involved at the beginning stages, the stages of considering a training package, of sitting around the table and discussing all the elements that need to be considered in a training program for GPs and then being able to go through the whole process, even perhaps delivering a component or an element of the training program to groups. So we have been seeing that evolution happening. In fact, one of the big milestones of the standards collaboration is to say that in January 2006 it will be compulsory in the standards that all training providers, when they submit an application into the standards collaboration, must show that they have had consumer and carer participation that is genuine. They have to be accountable for it in the documentation proformas that we have developed so that we can ensure that it is genuine and not a case of just rubber-stamping it and saying, ‘Yes, they’ve been there at the end of the process rather than throughout the process.’

Mr Wilson—I think there is a lot of frustration too for families and carers in that their role as de facto mental health workers is unrecognised and their input is not welcomed. To carers who are aware of the circumstances that affect their family member, it is unbelievable that the huge amount of knowledge they have about that situation goes unacknowledged and unused. It came to my attention in a stark way recently when I was talking to a carer in the regional town of Albany in Western Australia. This lady had a son with severe schizophrenia. She had worked as a caseworker in aged care in her professional life and she had become the caseworker for her own son. She was in a special position where she could do that. She was the one who coordinated his care. She brought in that care from community agencies that were set up to provide respite, assistance in rehabilitation and so on.

This shows that one of the major deficits in mental health services is that, while they talk a lot about the need for caseworkers and coordination of carefully prepared mental health plans on an individual basis, it does not happen. But when it does happen it has a remarkable effect. This woman, of her own volition, has shown that this has made a dramatic difference to the care and to the progress her son has been able to make. He now lives independently. She has to see him everyday, which she does—just as a good caseworker does—and she coordinates his care. That is what you see. You see remarkable individuals doing what can be done and you wonder why the system cannot do that. I think until we have a very carefully established caseworker approach to mental health care where there is coordination of all the daily needs of the person who is seeking to recover, then little progress will be made because we will continually lapse back into a fairly complacent view of achieving a fairly low standard and being satisfied with that.

Senator MOORE—That almost leads on to the work force issues which once again permeate the report. Mr Wilson, you started talking about effective caseworkers. It is about that level and then on to all the different kinds of professionals that are linked there. Everyone says they are doing something about it and everyone says it is an important issue. From the council's point of view, what do you think should be done and who should be doing it? That's a simple one!

Mr Mendoza—I will make a couple of comments. There is a claim that this is now being addressed by the National Mental Health Working Group and an advisory committee on work force has been established. That advisory committee has had one meeting and the minutes of that meeting indicate that they have no resource even for a secretary for the committee. They have no resource to actually conduct an audit of what is going on around the country and, hence, they are stuck.

This gives you the sense that the work force problems have only developed this year or have only emerged in recent times. Demographically, the work force issues have been emerging for 20 years. When you look at the age profiles of mental health nurses and psychiatrists in particular, those problems have been developing for two decades. Certainly, in our submission to the Productivity Commission's inquiry we have made that very clear, and there has not been a concerted and coordinated national response to this. Jurisdictions have been starting to do their own thing. In particular, what we see is jurisdictions heading off on overseas fishing expeditions, to find people and bring them back to Australia. They bump into one another in Europe—in Britain and in other places—but, guess what: they are not all that successful in attracting them, because there is a shortage worldwide of the skills they are looking for.

One of the things we said in an article that was published in the *Sydney Morning Herald* on Monday of this week was that the great untapped resource in terms of work force is already out there. It is in the private sector. I can provide that article as a document for the committee, if the committee is agreeable. We have psychologists in large numbers working in organisations—in organisational psychology and in other areas—and we are not bringing those people in to provide these services. A lot of those people will not work for state bureaucracies, but they will work for other providers. So we see great potential in ramping up the work force very quickly to meet the mental health needs of the community—through NGO providers and private sector providers. We will not find more mental health nurses and more psychiatrists very quickly, but we will find people who are grossly underutilised working in the private sector and the NGO sector. That approach can meet the demand, and we can then put in additional strategies that can in the longer term provide renewal for the key specialist work forces.

The other thing we have said in our submission to the Productivity Commission is that consumer operated services are a bit of a novel idea. When we have spoken of them at the National Mental Health Working Group they have not been enthusiastically embraced. Yet there is good evidence to support consumers playing a role—not only in an advisory or consultative way but also by actually working alongside patients in the delivery of services. Those are a few points we think are important on the problem of work force shortages. I am sure there are others.

Prof. Hickie—I will make a few additional comments. I think something that is often not well represented is the fact that there is agreement across the whole medical and psychological health work force. All we need is an integrated work force. We need people to be working in partnership with each other, particularly at the primary care level and at the specialist level. We

are different in Australia, in that we do not recognise psychologists as mental health specialists in the way they are recognised in other systems, and we do not use them effectively. In Australia that has contributed to the lack of expertise in the health sector that otherwise our universities train for. So, as John has mentioned, that is very much at the heart of the matter in terms of rapidly overcoming the issue.

There is also, in psychiatry, because of changes in the medical system, a rapidly deteriorating situation. The Commonwealth has been tracking this since 1995-96. We have data in another publication, which I can provide to you shortly—and the Commonwealth has the data on this too—which shows a 6.5 per cent reduction in psychiatric services since 1995-96. That, as you might imagine, has resulted in a 48.6 per cent increase during that period in the out-of-pocket expenses of seeing psychiatrists. When the work force becomes short in supply the costs often go up as well. So we have a situation that is difficult but that could be solved by more innovative methods. A variety of methods have been suggested to the Commonwealth. There has been no significant movement within the MBS. There has not been an attempt to use mechanisms for psychiatrists that have proved more successful with general practitioners and there has not been a significant increase in the use of psychologists as mental health specialists to support GPs and other primary care work forces—something that could be done.

So a little innovation would go a long way. The fundamental recognition of what psychologists would add in partnership with psychiatrists in support of the primary care sector has been at the heart of much of the discussion through Better Outcomes and other mechanisms. But it has been a discussion about keeping the work forces working together to respond to what has been the principal consumer and carer issue, which is integrated medical and psychological care rather than further separation of medical and psychological care, so that people get the mix of treatments they need at different stages of their illness. We have not seen significant issues. This has been on the National Mental Health Working Group and AHMAC agenda for a very long time and no significant progress has been made.

Mr Wilson—I would like to say also that—

Senator MOORE—Despite your feelings about the national working group?

Mr Wilson—I will not go on about that! One of Burdekin's recommendations was that psychological services be covered by Medicare rebates. While that is still an issue, I do not think just proceeding to that would provide the integrated care that Professor Hickie has said is desirable. But I think some greater incentive for psychologists to have some rebate under Medicare would be a major step forward.

One of the things that is emphasised in our report is that what consumers say to us most often is that the greatest help they get is from these talking therapies—from psychological counselling, counselling and psychotherapy. That is what is in shortest supply. It is no wonder that, without that and without that being coordinated alongside psychiatric care and primary mental health care, we are never going to make much headway. Again, I think that is an issue that can only be tackled at prime ministerial and premier level. It is going to take a lot of resolve for any government, which will see that as opening and emptying the Treasury at a great rate.

The other perspective, of course, is that it can only be tackled by Commonwealth and states working together. The Commonwealth has such a large say in the funding of tertiary training. Unless that level of operation is working in close coordination, with the states providing the work force to run the services, there will never be an effective way of improving the work force outcomes that we have avoided for all of these years as being too hard.

Senator MOORE—Do you think it is a budget issue?

Mr Wilson—There are budget issues. That is always the issue that is raised. The Commonwealth has clearly moved. But I think it is important to say that the systems are quite different in terms of their out-of-pocket expenses. The recently introduced mechanisms under the chronic disease management items—and I think there was some confusion here when the Commonwealth was presenting—cost a person up to an additional \$50 or \$60 out of pocket to see a psychologist. You might get a \$45 rebate, but it will cost you over \$100. In the Better Outcomes mechanism the psychologists have mainly been contracted, so for many people there is no out-of-pocket expense or there is a small copayment of \$5 to \$10.

I think that, worryingly, in the Commonwealth's most recent trip into this area, it has still left a very large burden of out-of-pocket expenses on those who wish to access those services. As well, fundamentally they are restricted to people who have chronic medical problems in addition to their psychological problem. So it is a restricted access and a high out-of-pocket expenditure system. Although there is some increased degree of support, it is quite different to the system that the council and most other professional groups have championed under Better Outcomes, which essentially involved no additional out-of-pocket expenses or a small copayment.

One cannot help feeling that, when the Commonwealth goes forward, it is looking for ways that still impose a very large out-of-pocket expense for psychological services. It exceeds the out-of-pocket expenses typically to see at least a GP. The out-of-pocket expense to see a psychiatrist currently is also extremely large. That means that psychiatry is going the way of dentistry and locating itself more and more in communities where people will pay large copayments. So the equity issues in fact are getting worse in the current system and they are not being attended to in the Commonwealth. I think that people are worried that the Commonwealth's most recent trip in supporting psychology has been one that still leaves very large out-of-pocket expenses.

CHAIR—I am wondering what the role should be for psychologists if you do not include psychologists in Medicare, give them an item number and allow them to practise in the private sector and treat people who approach them either through a GP or directly, or if you do not have them in salaried positions. I think it was suggested a lot would be unwilling to be in those positions. I might take issue with that, because I think there are some quite good models in some of the clinics that are set up particularly in Victoria, in the community health centre model. What is the right model for psychologists? Do we just expand Better Outcomes and make it more accessible? I find it difficult to understand why psychologists should not be in the same category as psychiatrists.

Prof. Hickie—On that issue I think psychiatrists and psychologists actually agree. Fundamentally, this is an issue for the psychological profession itself. But if those who agreed to reach a certain standard of training behaved as mental health specialists, just the way that

psychiatrists do, and then saw people essentially on GP referral then I think you would have absolute agreement between psychology and psychiatry.

CHAIR—But isn't that the proposal being put? We are talking about clinical psychologists here—

Prof. Hickie—That is right. I think there is absolute consensus on that issue. If the Commonwealth were to immediately recognise the number of psychologists who would automatically meet that—there is some debate about that number but there would be somewhere around 2,000 psychologists—and they were to behave like the 2,000 psychiatrists we have working in practice, we would immediately double the mental health specialist work force, and it would not kill the Treasury.

CHAIR—So you would not oppose that notion—

Prof. Hickie—No, not at all.

CHAIR—of a direct relationship with Medicare?

Prof. Hickie—No, because that would leave us with an integrated system, which is what we are seeking. It has been more contentious that some areas of psychology have argued that it should be the same as general practice, that somebody should be able to walk in off the street and see someone in a primary care role and receive their psychological care independently of any other aspect of the medical system. It is that model which has created much more contentious discussion, because it would be a more divided model, where psychological care and medical care would not necessarily come together. You would essentially have another primary care work force separated from the other work forces. So the issues of working together and immediately recognising those who obviously have the expertise—and the numbers vary, but there are 2,000 to 3,000 psychologists in Australia—would be a very effective, immediate solution to the specialist side of the problem.

CHAIR—If I can press you on this, if the GPs are the gatekeepers in all of this would you recommend that GPs who have not undergone the Better Outcomes training should be able to make these referrals?

Prof. Hickie—That is one of the sets of issues. That is what happens across the rest of the medical system, of course. Again, there is not an argument about that. The argument is about improving the quality of the system continuously and for a limited resource that was immediately available. What you see is that those GPs who have undertaken further training actually make more referrals, not fewer referrals. There is a belief system, which I think is quite wrong, that if GPs get more access to these items themselves or further training they will not refer. All the research evidence shows the opposite. The better trained people are, the more aware they are of what they cannot do and the more aware they are of options and of what others can do. So, in fact, the evidence is the opposite: they make greater use of psychological strategies themselves and they make more referrals.

CHAIR—So what does that lead you to think about the idea of GPs not trained in these areas being able to refer? I am not sure that I follow your line of argument.

Prof. Hickie—There would be no reluctance against that if in fact the moneys were available for that degree of psychological service and support. One of the things that is misunderstood about Better Outcomes is that there was only \$23 million available over four years, over the whole program, for those GPs. The feeling was that those GPs who had started to reorganise their practices and undergone training and were committed to providing better quality health should be those who had first access for their patients to work together, to build a better system.

CHAIR—No-one would disagree—I assume you would not disagree—that a program in place to encourage GPs to take training in mental health services is a good thing to do. So our problem is the carrot and stick approach, isn't it?

Prof. Hickie—Exactly. The GPs who underwent the training were also then able to access the additional service incentive payments and the additional Medicare items, so the issue that there are rewards for training and for practice reorganisation is a fundamental one, including better access to services. On your additional point, there are many other ways of employing people. NGOs, often in the rehabilitation and recovery area, will employ psychologists. States can employ psychologists. The issue has been the work conditions under which they are employed. So there are a variety of other models, and we have the work force out there.

CHAIR—I am reminded that we are about to lose a quorum because of flights, but I wonder if I can put some questions on notice, if you have the time—

Mr Mendoza—We can act like a department and take them on notice!

CHAIR—Excellent. Another big funding issue is the grants and project based funding versus the recurrent funding. I did not see this in your recommendations but I wonder whether you have a view about reform of that system. Also, what have you discovered in your work about public attitudes? You say that funding overall for mental health services should be increased from six per cent of the health budget to 15 per cent. Is that backed, in your work, by attitudes out there in the general public? If the government go down that path are they going to be criticised or congratulated on it?

One of your recommendations is that drug and alcohol services and mental health be integrated. What does that mean? Does it mean that we should close down drug and alcohol services and create a new body or a new model that does the work of both mental health and drug and alcohol services?

It would be interesting to have a response from the council to the remarks that were made when the department presented to us. Its response—which I think was half in jest but probably fairly realistic—to the reforms being slow was, 'Well, 25 years would not be a long time.' It would be useful to have your realistic assessment of what is possible should all the parties have the leadership and willingness to achieve the reforms that are necessary.

I have one final question. The committee has found amazingly good examples of practice; it is patchy—one in one state and one in another. Do you think it is reasonable for us to suggest that we highlight these examples of good practice and suggest that we even make them a bit prescriptive? I know that it is difficult because you have horses for courses, as it were. But it seems to me that a youth service that works in the western part of Melbourne must be applicable

in other parts of the country. It must be the case that a good program in New South Wales for eating disorders could also be replicated in other places. Do you see any dangers for the committee if it were to go down that path?

Prof. Hickie—Sure. The department made the comment that, in Australia, there was no relationship between health burden and health expenditure. Again we have data that that is not the case. There are relationships between health burden and health expenditure. To make a prediction about it, if you applied it to mental health, you would spend considerably more money than we are proposing. In fact, the more chronic the disease, the more money you spend. Where people die prematurely, you spend less money. Of all the disease areas in Australia, the big exception is mental health. The notion that what we are asking for is unreasonable because there is in the rest of health no relationship between expenditure and burden is wrong and we have statistical evidence of that, which we would like to table.

CHAIR—That was another question we were going to ask you, so thank you for providing that. I thank the council again for all the effort it has put into this inquiry process; we very much appreciate it. We know that we can rely on its advice, so thank you again.

Mr Mendoza—We have just received permission from the Department of Employment and Workplace Relations to release a report we produced on creating supportive workplaces for people with mental illness. I have brought here enough copies of that report for all members, although I understand there might be a problem in formally accepting it.

CHAIR—Is it the wish of the committee that that be tabled? I hear no objection. Thank you.

Mr Mendoza—One other report, which you may have noted already, is the Victorian Auditor-General's report on their 2002 audit. They released a follow-up yesterday, which is very interesting; we will provide a bit of commentary to it. But I have saved you the trouble of searching for it.

CHAIR—Thank you very much, Mr Mendoza. Thank you very much to all those who have participated—it is the third time for some of you. I thank those who have come along to participate and to listen.

Committee adjourned at 4.34 pm