COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

WEDNESDAY, 1 FEBRUARY 2006

HOBART

BY AUTHORITY OF THE SENATE

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Wednesday, 1 February 2006

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

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

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WITNESSES

Committee met at 9.02 am

BURKE, Mr Gerald Ian, Executive Director, Tasmanian Division, Australian Red Cross

LANGFORD, Ms Lorette, State Coordinator, Mental Health Programs, Australian Red Cross

TICKNER, Mr Robert, Chief Executive Officer, Australian Red Cross

CHAIR (Senator Allison)—This is the 16th 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 in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

I have pleasure in welcoming representatives from the Australian Red Cross. Mr Tickner, thank you for travelling to Hobart for our hearings today. We very much appreciate that. You have lodged with the committee a submission, which we have numbered 468. Are there any amendments or additions to that document at this stage?

Mr Tickner—Not other than matters that we would canvass with you in conversation and in response to questions. There are no formal additions at this stage, but I understand there will be an opportunity to make a relatively brief opening statement.

CHAIR—If you would like to make a short statement, we will go to questions after that.

Mr Tickner—The first thing is that the Australian Red Cross very much welcome the involvement of the Senate in this extraordinarily important area of public policy. To be frank, mental health issues need a lot more friends and supporters. We are delighted that the Senate is involving itself in this important inquiry and we thank you all for your personal participation in it.

You were kind enough to mention my visit to Tasmania. What I would like to say, as someone from the mainland, is that this program is a great credit to the people of Tasmania and, indeed, to successive governments. It is a program that enjoys incredible cross-party support and a very rich vein of support within the Australian community. It is quite interesting that a smaller state like Tasmania can often be the pacesetter or the innovator in trying and doing things. We all know that Tasmanians are increasingly proud of their record of innovation in many areas.

The MATES program—Mentally ill people And Their Equal Supporters—is essentially based on a number of key aspects. They are very straightforward. Firstly, it is a very simple program. This is not rocket science. This is a program that is able to be replicated at relatively little cost in terms of the Commonwealth's national health expenditure—I would even say at negligible cost—across the whole of Australia. It is a tremendously exciting program. It is almost like an idea or a concept or a program waiting to happen for this country.

Apart from being simple, it is also focused on changing community attitudes and reducing stigma. I think if we all search our own hearts none of us can comfortably put up our hands and say, ‘Never in our lives have we been guilty, on any occasion, of having a kind of prejudice against or a dismissal of some people somewhere with mental illness.’

We, as a country, use disparaging language about mental illness. Indeed, people around the world use disparaging language. It is a slow process of change but increasingly—certainly in countries like Australia—we are becoming conscious that a lot of the language we use can often be highly damaging and prejudicial, hurtful and harmful, to people with mental illness. The greater the level of education of our community on mental health issues, the healthier will be the quality of our democracy. And it will have a direct impact on the quality of life of people with mental illness, so educating the wider community is important.

The next underpinning principle is the focus on combating social isolation. There would not be a senator who, through their own work as a senator, would not have gained an intense awareness of the impact of social isolation on individuals and on a community. We are a relatively affluent country in global terms, but there are, as you know, many hundreds of thousands—if it is not in the millions—of people who live very lonely and socially isolated lives. That is bad enough when you have good physical and mental health, but if you have a mental health issue that social isolation can exacerbate and deepen the challenges you face. One of the key elements of our program is that it is very much focused on addressing social isolation.

The next point is the key role of volunteers, and the not-for-profit sector more generally, in delivering programs of this kind. It is with no disrespect to the public sector—or to wonderful public servants, committed as they are, in state and Australian government departments of health—that I say that on their own they cannot address this issue. Nor, with respect, can clinicians of various kinds around the country—in their current numbers and availability, on their own or with those public servants—address the magnitude of the problems that this country faces in the mental health area. It also warrants a community response.

So if, hypothetically, this Senate committee has the opportunity to brief people in high office about its work and findings as a committee, our hope would be that you would deliver a really powerful message about the need to support, from a government level, important community based programs from the not-for-profit sector with a big potential focus on volunteers, such as our Australian Red Cross MATES program, an important case study.

I am going to finish up in just a moment, but let me be open and frank with you about the motivation for coming here today. We are not here to score a political point. Australian Red Cross is neutral and impartial. We work with all political parties and all governments. As advocates for a better deal for people with mental illness, all governments need to do more in this area. We believe that, with minimal levels of funding, programs like this Victorian MATES program can be expanded across the country. Our hope would be that governments at all levels see this as a very valuable program to support and roll out across the country. That is certainly one of our objectives of being here, but it is not the only objective. We also believe that it is not just governments that have a role here; so does the corporate sector and others who are able to support the creation and roll out of a national MATES program of this kind. We want to champion the program to encourage wider community interest in it and to secure funding by whatever means we can properly achieve to roll out the program on that national basis.

Let me conclude with a brief history about the program. Some of you may know that before I was in this position—way back, as I am fond of saying, before the war—I had a position not unlike your own. I am privileged now to be in this job. Prior to me back in the nineties, Jim Carlton, who was a respected Minister for Health, was in a position I am now in in Australian Red Cross. Do you know what? One of the first things he said to me when I met with him after I was appointed was: 'Robert, you've got to do something to get this MATES program rolled out nationally.' He tried to that back in the nineties. We acknowledge in Australian Red Cross that at that particular time our capacity to deliver that program was more limited because for 90 years Australian Red Cross had operated essentially purely on a state or territory basis. The organisation is now reformed with, amazingly, so little pain and has developed a cohesive national framework, whereby now the great bulk of the functions and operations of the organisation report to a national board, for which I have responsibility as the CEO. Our divisions, like Tasmania, as you can see, still flourish vigorously with their own innovation and work, but the message is we are now in a position to do what Jim Carlton wanted to do back in nineties: to roll this out. Forgive my enthusiasm, I am on a bit of a mission here and I am tremendously excited by this program. Thank you for the opportunity to say those few opening words.

CHAIR—Mr Burke and Ms Langford, do either of you wish to say anything?

Mr Burke—I think we would like to respond to particular questions that the committee might like to ask us.

CHAIR—Thanks, Mr Tickner. We are very pleased to have your unbridled enthusiasm. Many of the stories we have been told are not enthusiastic at all; they are actually quite worrying. You say you are now ready to expand this Australia wide. At the present time your funding is two-thirds from the state government and the other third is from fundraising and your own resources. Have you talked with state governments? Have they given you the nod for this in other states? Will they fund it?

Mr Tickner—I would like Ian Burke, if he could, to supplement this. We have been busy doing our homework, preparing the documentation, the program guidelines and the training manuals to be able to expand it. We have done our own homework within our own organisation building support for this initiative. It forms a key part of the strategic plan and implementation plan adopted by Red Cross, in the latter case only a few months ago. So we are ready to start that process, but we have not made the systematic formal approaches that we certainly intend to do in the period ahead, including to the Commonwealth and Minister Abbott.

CHAIR—We hear a lot of complaints about the lack of integration in our mental health system at every level. What efforts do you make in Tasmania to work with other mental health service providers, GPs and hospitals? How do you link with those sectors and with the community generally?

Mr Burke—Perhaps I can start and Lorette can add some more detail to it. I have been in this position for nine months now and one of the first things I did was to meet with Des Graham, who is the head of mental health here in Tasmania. That department has for many years been a strong supporter of MATES. In explaining how we want to not only roll this out nationally but also look for other ways of integrating this program in this state, Des has offered to write to each of his counterparts in the states that we want to look at developing into to explain what a great program it has been. Lorette, would you like to make some comments on the way it has integrated with local clinicians and other programs?

Ms Langford—Having been a clinician, I come from a very clinical background in mental health. If a program is too big or too complicated, you are not going to support it or run it. When we go and talk about the changes in MATES or get feedback from our clinicians in the community, it is simple, so the clinicians are quite happy to just run with it. They have the overriding clinical responsibility. To keep them updated and to ensure our continued partnership with them, we meet with them on a fairly frequent and regular basis to look at their concerns and to support their needs, and they in turn support ours.

I come from working within the government department for many years, so I have a lot of linkages within there. They then will have the linkages that Australian Red Cross have forged before my arrival in the department. Through our funding body, a lot of the not-for-profit organisations meet twice a year, so we get to know one another and each other’s innovations, and we spread the word through the Mental Health Council and through the organisations that meet through our funding body.

It is also about legwork. It is about getting out there, looking at the health providers, going to see them personally, supporting them and being available to answer what they need answered. The promotion of the program is a lot of dedicated legwork. It is passion that drives the legwork to make the program work for people with a mental illness.

CHAIR—Can I pursue this a little further? Would a GP who perhaps has a patient who might be working with a volunteer be aware of how this system is working? Would there be any dialogue between them? Can you describe what happens on the ground in terms of that integration?

Ms Langford—The GP is the primary health carer. They would have to be part of the referral process to the MATES program. They are supplied with full information on the MATES program. They are aware that we do not take a clinical role and that they retain overall clinical responsibility. Our communication with them would be regular, particularly if we sense that an individual’s mental health status is declining. Usually, our relationships with our primary health care providers, who can range from community nurses through to private psychiatrists to GPs and psychologists—so the range is quite large—is very regular, so we support them and they in turn support the program.

CHAIR—But the volunteers themselves have no contact with the primary health carer?

Ms Langford—No.

CHAIR—Any feedback or information that needs to be passed on comes back through the organisation?

Ms Langford—Yes, that is right. The volunteer's perspective is as their friend. It is a friendship service, so we do not want to lumber the friend with a whole lot of other responsibilities. We are saying: 'Go and be their friend. It doesn't matter what disorder they have. It is not your concern. You are there to see the person, not the illness.' That is how the program is run. All the other stuff is run by the coordinators.

Mr Burke—That is a very good idea.

CHAIR—Would they be aware of the nature of the illness—the diagnosis of the person they are attached to?

Ms Langford—No. They are aware that the person that they are attached to has a mental illness. They are not aware of the diagnosis, because it is a labelling thing. They know someone suffers from a mental illness. They go through five days of rigorous training where they are taught all the different varieties of mental illnesses that are most prominent. If there is a likelihood that they will be matched with someone who has an exception to one of the illnesses we present then we make sure that they have information on it. They are never told that they suffer from that illness; they just know they have a mental illness. The emphasis is on treating them humanely as a person, rather than as a person with an illness.

CHAIR—Thank you.

Senator TROETH—Have you done any external evaluations? How has it been assessed?

Mr Tickner—Great question.

Mr Burke—Over a number of years now—on four or five different occasions, I think—the University of Tasmania's Department of Psychology has been asked to do a formal evaluation of the program. From the manual we have here today we can give you some information on the outcomes of those evaluations.

Senator TROETH—Yes, that would be useful.

Mr Tickner—In fact, if we have time we can get you copies of those evaluations.

Senator TROETH—That would be very helpful, thanks.

Ms Langford—To add to that, with the new roll-out of the program, the focus will be on six-monthly internal evaluations of all MATES and volunteers within the program as well as on external evaluations. The evaluations will spread also to the training materials, which will then be discussed at advisory panel committees that we want to set up with consumers, volunteers, health care professionals and coordinators. We will get a continual assessment of the viability and the goods and bads of the program so that it can be kept current and free and we can stick to as many of the principles as possible. They will be expanded even more, which is a good thing.

Senator TROETH—I presume that you looked at this particular program in response to a need. You might like to elaborate to the committee on why you chose this avenue and what the shortcomings were in the present treatment that led you to focus on this type of program.

Mr Tickner—I guess part of that involves the history. I started as CEO of Australian Red Cross not quite 12 months ago and was responsible for appointing Mr Burke, who in turn was responsible for appointing Ms Langford. If Jim Carlton were here, I am sure he could tell you the history of the nineties. It really does date back to then, but, having said that, I can confidently answer that the motivation for starting the program was the same as that for continuing it: this social isolation suffered by people with mental illness is just one more boulder to carry—one more challenge for people to just get through life and maintain themselves. That social isolation is also an impediment to those who are able to overcome the illness. I had raised with my colleagues the idea that perhaps one of our clients could come along and speak today, and I have certainly talked to a number of clients and volunteers in the program who themselves have had mental illness. The testimonials that those people give in face-to-face conversations really bring out the importance of this critical issue of social isolation. We could present the committee with three written testimonials, but perhaps Lorette could paraphrase one of those to highlight this question.

Ms Langford—I will read out the first one:

> I wouldn’t have achieved what I have achieved if it wasn’t for Red Cross MATES.
>
> It’s the truth, it’s as simple as that.
>
> I couldn’t go anywhere by myself, now I can spend 2 hours at Eastlands by myself.
>
> I like having a mate to talk to, to help me get used to going places, I would be still house bound. I was house bound for 4 years, I couldn’t step outside the front door, now I go out for 2 hours or more by myself.
>
> If I had no-one I’d end up house bound again.

Further to that, the government services do what they can with what money they have in resources to care for people with a mental illness, but theirs is a clinical perspective. It is focused on the treatment of an illness. We acknowledge that, through all the advances in mental health, an illness is about a person. That has been achieved. I have seen that through the many years I have worked in the industry. When you work as a case manager in the community sector for mental health, you go and visit someone, you have coffee and you develop a friendship. But at the end of the day the person would say, ‘You come here because you get paid to.’ Unfortunately, that is the reality.

With the MATES program, it is not like that. The volunteer knows nothing about the person’s details. They go and see people because they care. That is not to say that mental health workers do not care. I love people with mental illness and respect them wholeheartedly; but at the end of the day I was fulfilling my role because of the wage and the expectations of my position in the department. With the MATES program, the volunteers have to go once a week, but many of them go many more times than that.

Senator TROETH—Are the volunteers given any training? I understand from what you said that they are not told about the illness that the person has, and they are not to have any particular expectation or lack of expectation. But what sort of preparation are they given when they agree to be volunteers?

Ms Langford—A lot of preparation happens before the matching of a volunteer and a client comes about. First, a lot of details are taken from the volunteer, and there are the normal background checks into character and all the rest of that. Then we look at suitability with a client and interests. It is about everything. You have to look at the volunteer and the client holistically: their interests, their character, their beliefs and whether they would be compatible. Once that has been determined, they are then put through five days of training. That looks at law, stigma, ethics and the impact of visiting someone who has a mental illness. A lot of our volunteers, to their credit, have either been affected by mental illness themselves or have relatives with a mental illness.

The training is very inclusive. It is five days, and we have just updated the training to make sure that the information they are provided with is the most up-to-date information. They are further kept up to date with monthly support meetings where further information is provided to them, and there is a very good support system in place with the coordinators at any time that they need to access them.

Senator TROETH—Do they also attend the mental health first aid course—which is another program that you run here in Tasmania?

Ms Langford—Yes. The course is open for them to attend, but some aspects of mental health first aid are taught throughout the training. They are taught how to help someone who is having a panic attack and someone who is experiencing a psychotic episode. They are taught what to do and what the expectation is. They are very well trained. It is one of the best training courses I have seen in many years,

Senator MOORE—When something comes out that makes such commonsense, it seems like such a straightforward idea. I want to know exactly how much it costs. I can see that the Red Cross has got it in their forward planning, and I am interested that you are looking at rolling it out. I come from Queensland, and I am struggling a little bit with the way a program could extend across a geographical area—

Senator WEBBER—Don’t steal my question.

Senator MOORE—I will not go there. I will leave that to Senator Webber. But I am looking at the cost. This program has been going since the late 1990s, you have had evaluations and you are obviously enthusiastic about it. The limitation must be the funding. What does it cost, in terms of the impact, and how do you ensure it is not a pilot? One of the things we keep hearing is about the desolation of having something put in place and then withdrawn through lack of funding. From your understanding, what does it cost now? What kind of costing, and from whom, would you hope for in order for this to be a long-term program?

Mr Tickner—I will start and then my colleague Ian Burke will come in from a Tasmanian perspective on costs. We are currently working on the costing to roll out the program nationally.

The first thing I would say is that, because it is such a volunteer based program, it is incredibly cost effective as compared to a program that relies on paid staff. Having said that, however, the last thing that we would ever countenance is delivering some half-baked, poorly resourced program that did not involve the intensive, systematic and thorough training of the volunteers—as Senator Troeth raised in her question. So it is cost effective but it has to be properly resourced to the level necessary to make it work.

The second point I would make is that, in an ideal world, there would be one source of funding to allow this to happen. The reality is of course that that may not happen. Therefore, we are exploring a whole range of alternatives, including national funding and funding from the states and territories, and we are also very actively talking to a number of corporations about their potential interest in the program. That is not ideal, but I have to say that I am optimistic that, if it is coordinated on a national basis, that mixture of funding could well work.

We are also very respectful of and have engaged with quite a number of not-for-profit organisations—because the last thing we would ever say is that we are the fountain of all wisdom. These days the Australian Red Cross seek to build collaborative arrangements in the not-for-profit sector—which, sadly, are not as frequent as they should be. We should be doing a lot more of that—talking to each other, working together, forming strategic alliances and doing things. If you do not mind, I will put my colleague Ian Burke in the hot seat to comment on the specifics of the cost of the program.

Mr Burke—The program in Tasmania costs us about $¼ million a year to run, in total—

Ms Langford—There are around 150 MATES statewide and around 100 or 110 volunteers. So we have a shortage of volunteers currently.

Mr Burke—Bear in mind that Tasmania is regionally dispersed, so we have to support that program with staff in the north and the north-west. We have restructured internally to make that more efficient and have appointed a state director for that purpose. Two-thirds of the money comes from state funding. The rest of it comes from a cross-subsidy that we get from our Mental Health First Aid program, which actually makes a surplus. So we help to fund one of our mental health programs with the other. There is also direct fundraising—and while I am here I will put in a plug for Red Cross Calling, which is coming up in the next few weeks.

In taking the program to other states, we will have to look at the same sort of funding mix at this stage. What we would like to do, of course—and Robert has been very active on this—is to try to find a program sponsor nationally who can help us roll the program out. In your deliberations, it would be wonderful if you came across an opportunity that could symbiotically help the program’s development.

In terms of the importance of this program, Robert has put it very much at the forefront of our agenda. In our new strategic plan and at our national conference in November, mental health was highlighted as one of two areas that the Australian Red Cross will be very serious about rolling out programs for in Australia over the next five years. At our national conference we had the CEO of Lifeline Australia and a senior youth person from beyondblue speak with us. Whether we do it ourselves, whether we do it with government funding or whether we do it with the support of corporates and beneficiaries or fundraising or in alliance with those organisations, for us, we just have to do it.

Mr Tickner—I suppose the advantage that we have in capacity is that we are truly a national organisation with an enormous amount of regional coverage in the towns, regional cities, hamlets and villages across the country. I might acknowledge that one area where we as yet do not have a presence is in the far north-west of Western Australia—which we must do something about.

Senator WEBBER—We are coming to that.

Mr Tickner—I thought you might. I did my homework.

Senator MOORE—I will leave the regional questions to Senator Webber, and I know she will not forget Queensland in those questions. Ms Langford, you said that you were a bit short of volunteers at the moment. I have two questions, because we always have limited time. Firstly, how do you actually attract volunteers? What do you do? I know that Senator Troeth touched on that, but I ask in terms of encouraging people to come into this particular sphere of volunteering, with all the other claims on volunteers' times and demands from every aspect of social justice. Secondly, what do we do to ensure that privacy is maintained? Your submission speaks very strongly about your awareness of privacy and so on. I would imagine that parts of Tasmania have very small communities. How do you then balance the anonymity of someone who is giving their time with the closeness of communities and people's needs? There are so many other questions, but they are the two that I would like to focus on.

Ms Langford—I will address the first part of your question about attracting volunteers. I guess I am quite lucky to be part of Australian Red Cross because it has a huge volunteer base. So, by working on the basis that you already have, as a natural rollover you attract people. A lot of volunteers have many different areas of Australian Red Cross that they volunteer for. Volunteers are just good people who care about people, and that is the basis of a volunteer. The mental health first aid training, which goes out to the general public, has brought in its own share of volunteers. I think it is just the public awareness thing to say that someone with a mental illness is not a scary person. Someone with a broken leg is not scary, and someone with a depressive illness or someone who suffers from a psychosis is just as unscary as them; it is just that we do not know about it. Educating the public tends to bring in the volunteers.

Again, it is difficult because people are busy. Society demands that people are busy. So, to be able to find those people in the communities is just a matter of general marketing, advertising and brochures. Our linkages with other not-for-profit organisations and our government sectors have helped to bring in our volunteers. That is where the alliances between departments are very helpful. Word of mouth is the most powerful tool of promotion that I have ever seen and it tends to bring them in. It is a shortage thing. Volunteers come and go for lots of different reasons, mainly because they begin work and life stresses themselves mean that they take some time out, but we always attract volunteers. Not having volunteers has never been a problem. The program supports the volunteers very well, so we tend to retain them quite nicely as well.

The second question was about anonymity. It is difficult to do that in Tasmania, but the program is fairly strict. Because of the boundaries of the program, it tends to say, 'You don't know what kind of mental illness a person has. You know they have the mental illness. You are not to discuss medication. You are not to discuss illness. You are to be a friend.' I guess it is an agreement between the people involved and the MATES as to whether they want to make it known that they are part of the MATES program. But both parties sign a confidentiality agreement—not just the volunteer but also our MATE. We all sign confidentiality agreements and we work very closely to make sure that dependency issues are kept intact and that someone's anonymity is monitored. If we have concerns then we address them fairly quickly because that is something that can really put a bad light on a program such as this. But, touch wood, it has been going since 1997 and has managed to spread itself since then. That has never been an issue for us, so that is good.

Senator WEBBER—We will continue on with the volunteers bit first. We will get to the specific challenges in a minute. In Western Australia, a very good friend of mine had to make a difficult decision a couple of weeks ago about discontinuing his career and that has led to a debate in our community about the stigma that having a mental illness contains. I would have thought that developing that volunteer base, particularly in regional communities, is probably the most useful way we can look at educating our community and removing some of the stigma. What kinds of mechanisms do you have in place to actually support volunteers in the isolated regional communities—and, firstly, to generate the volunteers? As Mr Tickner would know, some of our regional communities are very small and there are the issues of generating the volunteer base and then providing them with the support that they need so they do not get into the dependency issues and other problems.

Ms Langford—That certainly was an issue back in 1997 and with the program growing. The Australian Red Cross has seen that we need regional coordinators, people that can actually be mobile to provide that support. We have certainly answered that need here in Tasmania. We provide them with as much support as they feel they need. In saying that, we give them monthly support meetings. They all come together as a group of volunteers and they talk about common pressures that they may feel and common problems and achievements that they have within the program. We share ideas. That is a group supportive network for them. They also have the number of the regional coordinators and they are encouraged, time and time again, to ensure that if there is any problem they contact a regional coordinator. I guess that is the basis of the support. The other support is making sure that we train them, that we keep them up to date with contemporary issues, often things in the media. People read newspapers and we provide them with support around stuff that is contemporary.

Senator WEBBER—Does that training have to be face to face or do you have alternative delivery models available?

Ms Langford—With the initial five-day training package, we acknowledge some people cannot actually come in to be trained so it has also been developed to be a self-directed training package where they can actually do the training at home. We supply them with videos, DVDs, current articles and whatever is contained in there; we make sure that they have enough information. Then the coordinator will go out a few weeks later, sit down, spend time and go through the package with them to see what areas they did not understand. Then the coordinator will assess whether or not they believe that they have got a good handle on things, enough to be able to be a successful volunteer within the program. It is a very closely monitored program. It is a good thing to have a training package such as this that you can adapt to both areas.

Mr Tickner—As I mentioned before, for 90 years the Australian Red Cross operated with a pre-eminent focus on state and territory organisation. That meant that at the beginning of last year one of the manifestations of that was that there were eight separate volunteer policies for the Australian Red Cross, one for each separate state or territory. Obviously, that is untenable in the new millennium, so, under the new framework of national functions we have, the key areas of human resources, finance, marketing, fundraising and communications and many others now come under a national purview. We now have one best practice national volunteering policy. That is very important to us, because the Red Cross, as you may be aware, has seven fundamental principles globally, one of which is voluntary service. So to get that right is really important. But I do agree with your opening remarks about the benefits to the volunteer. It would be true—would it not?—that the benefits of the program do not just go to the client but also to the volunteer.

Senator WEBBER—Absolutely.

Mr Tickner—Which was your point.

Senator WEBBER—I have to say that I did not know much about the program until I got my folder and read your submission. I think it is a very innovative model in terms of helping to also address some of the shortfalls, the enormous gaps, that we have in dealing with probably one of the largest challenges facing our community. To return to the challenges of extreme rural and regional communities and the incidence there, if we are looking at a national roll-out, what kind of thought has the Australian Red Cross given to the way this program would work in isolated Queensland or throughout Western Australia? I am not quite sure that the Tasmanian model would absolutely fit us.

Mr Tickner—We are quite open to looking at the need for regional variations but I must say that all our assessments of the program, over quite a long period now, would suggest that it is suitable for regional centres and indeed smaller towns—and Lorette may give examples of that, but we just lead with it—so we are very confident it is a good model. The Australian Red Cross is very decentralised. In the case of Queensland we have offices all over the state—a significant presence. We have regional bases of operation, for example, in New South Wales. In Victoria we have a significant presence. Nationally, to be frank, the one area where we do not have a significant presence is the north-west of Western Australia, and I am going to do something about that.

Senator WEBBER—More than happy to help.

Mr Tickner—Good. We actually formed the Parliamentary Friends of Red Cross group. It is cross-party. Although Red Cross is strictly impartial and neutral—we do not get involved in politics—I think that elected members have a tremendous potential to be able to assist us on a strictly neutral basis in building public awareness and building volunteers.

Senator WEBBER—I know we are pressed for time so I have just one more question and one more comment. In progressing that model you would need to make some variations in monthly meetings and what have you because of our distance. But we do have modern technology and we are very good at that in the north-west. How do you see that this program would, particularly in dealing with Indigenous communities, fit with the way those communities work?

Mr Tickner—First of all, Ian mentioned the two priority areas that Australian Red Cross was determined to do more about. One was mental illness and the other is Indigenous vulnerability. I have to say that that is not my doing—truly—and I am really proud of that. Before I came to the organisation there was awareness that, over 90 years, its track record in this area was not nearly as good as it should be. We are absolutely determined to do things but we are not rushing into this, because there are some really important ethical underpinnings to get right. We are not about going and getting involved in a government contract and doing things in an ad hoc way. We want to do it the right way, so we have a policy, which is being implemented, of essentially developing our protocol for how we are going to do things.

We have already started quite a number of initiatives in Indigenous communities. They include the work that we are doing in Palm Island with the support of the Queensland government and opposition. We see this as absolutely an important area for Indigenous communities as well, and we would seek to link those two priorities together. We all know that the fact is that if you are in any community, but particularly an Indigenous community, in a remote part of Australia, your access to services is significantly and demonstrably less than for someone who might be living in a major regional centre. Whether you look to the Commonwealth Personal Support Program or whatever, there is just not enough happening. So we would seek to bring those two priorities together.

There is one other area that, again, I just want to flag as an area of interest. Lorette has not spoken of her personal background, but I am sure I can say that immediately before working for Australian Red Cross she worked in the Tasmanian state system, but with a focus on prisons, which is another area which in fact brings together quite a number of the topics we are at the moment looking at. As we know, increasingly in prisons there is a disproportionate number of people with mental illness. So that is another area. And of course there is a disproportionate number of Indigenous people—sadly, and as we all know.

Ms Langford—Can I just add about the Indigenous communities that we have spread a lot of the word about mental health issues and brought in a lot of volunteers and public awareness through Mental Health First Aid. They are rolling out variations of that program, and one of those is an Indigenous program, which will help to facilitate that. The beauty of MATES is that it is basic. To me, you just have to adapt it culturally and the program can slot anywhere you want to put it in. It is hard to compare Tasmania to other country areas; you drive in Tasmania for five hours and there you are.

Senator WEBBER—That is right—and you think you have travelled a long way.

Ms Langford—But with linkages with your health care professional and your coordinator those regional things can, I believe, be sorted. It just needs commitment.

Mr Tickner—We will come back to you with those evaluations.

Senator WEBBER—Thank you.

CHAIR—Ms Langford, you mentioned earlier about not having read all the testimonials. Is it the wish of the committee that these be tabled? There being no objection, it is so ordered. I have a couple of questions about consumers. Do you have a consumer involvement in your organisation? Is there a rep on the advisory body to deal with all of this?

Ms Langford—The new modelling of the program is looking at having a strong emphasis on consumer representation in the constant monitoring and evaluation of this program. Consumers are certainly valued now, but they will start to have more of a say in relation to the program in the update.

CHAIR—Has it been recognised as a deficiency in your current arrangements?

Ms Langford—Probably more of an oversight than a deficiency. I know that the idea of the advisory panel was raised a couple of years ago. But, with resourcing and time, the program has been through a lot of changes. It is certainly something that we hope to have up and running within the next six months, and consumer representation will be strong on that advisory body.

CHAIR—In your objectives you talk about access to the community and broadening horizons. To what extent do your volunteers work with people on a long-term basis and to what extent do they try to make themselves redundant by putting these people into real-life social connectedness?

Ms Langford—It is just simple things. To decrease social isolation, it might be something as simple as walking to the coffee shop or going to the pictures.

CHAIR—My question is: do your volunteers expect to be able to extract themselves from this relationship because someone has been, if you like, facilitated back into the community? Are people becoming normalised by this? I can understand how it is beneficial for them to be out of the house and so forth, but even in your testimonial that person said, ‘If they were not here, I’d go back into the house.’ How successful are your volunteers at actually re-integrating them into society?

Ms Langford—We have not had any crude measures to actually measure that. It varies with the individual who is participating in the program, depending upon the impact that the illness has had short term or long term. We do not try to foster dependency; we try to increase their individuality. It is a difficult thing to measure. Some involvement has been for six months; some participants have been there since the opening of the program in 1997 and have become more independent. It takes some time to regain your confidence and your self-esteem, so obviously the longer they have been in the program the more successful they have been at maintaining some independence in their lifestyle.

CHAIR—Finally, we are interested in your guidelines for the volunteers. I do not know whether it is a huge document or a brief document that the committee would benefit from seeing. Have you done any evaluation of those guidelines and the extent to which they are complied with? What happens in circumstances where there are breaches? We are also interested in the screening of your volunteers. Is it that two out of three are suitable? Can you give us some indication about when you find people who present not to be suitable for this task? If we can prevail upon you to give us responses to that in writing at a later stage, we would be grateful for that.

Ms Langford—Certainly.

CHAIR—Thank you very much for your submission. Good luck with rolling this out, and we will see what we can do to assist.

Mr Tickner—Thank you.

[9.55 am]

FLANAGAN, Ms Josephine Cecilia, Manager, Social Action and Research Centre, Anglicare Tasmania

LAMB, Mr Daryl Graham, State Manager, Community Services, Anglicare Tasmania

CHAIR—Welcome. You have lodged with the committee a submission which we have numbered 464. Do you want to make any amendments or additions to that submission?

Ms Flanagan—We would like to make some comments. There is some further contextual information we wish to provide verbally.

CHAIR—I invite you to do that now. If you make a short opening statement, we will then go to questions.

Ms Flanagan—Firstly, we want to thank you for your concern about this issue and for giving us the opportunity to speak to our submission. We want to begin by introducing our organisation and stating our credentials about this area. We are possibly the largest non-government organisation in Tasmania—we have been around for 20 years—and we have quite wide service provision across the state. In terms of mental health we provide a recovery focus service that provides social support, enjoyment and benefit for adults with mental illness. We have supported medium- to long-term accommodation and short-term residential respite for people with mental illness and have community based and social support and housing initiatives which are aimed at supporting people in long-term supported accommodation and a project which works with parents with mental illness, particularly where they have young children.

I want to comment quickly about the limitations of our submission. In rereading it, I am conscious that I wrote it eight months ago and that the research it drew on was conducted in 2004. Some of the information in it is out of date and that is some of the contextual information we want to provide, because there has been some movement at state level around mental health services. The three pieces of background information we would like to provide are about some changes in state government funding. Since the time the submission was written—and reference is made to this in the submission—there has been a $47 million four-year state government package to mental health services in the state. It was announced in 2004 but, in the last eight months, we have started to see the money being rolled out. Specifically, it has meant increases in the government mental health service work force, increased service provision to older people and adolescents, a range of facility upgrades and plans for a government-run high-needs accommodation service. On the non-government side, it has meant one supported accommodation service established and two more planned, 65 packages of care made available and one recovery service established with another five online—and all those are around the state in various sites.

At the time of writing the submission we were not clear about the directions of welfare reform, so we were speculating on what had been available in terms of the newspapers. We would like to reiterate that there have been certain positive changes within the welfare reform process—the reduced taper rate on allowances, the increases to mobility allowance and the increased investment in services for job seekers—but we remain concerned about the lower level of income available to people with disabilities and to sole parents who are placed on Newstart allowance.

Also of concern is the potential loss of access to key state government concessions if they lose eligibility to pension concession cards—and in Tasmania the state concession system is particularly poorly targeted and disadvantages people who are on health care cards. We are concerned about the suspension of income for non-compliance with work obligations, the impact of the suspension of income for non-compliance for sole parent families, the assessment requirements for the DSP and the compliance regime for very long-term unemployed people. From our experience, we would suggest that many of them may be experiencing undiagnosed mental illness and/or comorbid disorders. We are also concerned that the system remains complex, confusing and highly stressful for a proportion of Centrelink clients, particularly if they have mental health problems.

Finally, we would like to draw senators’ attention to the ongoing scarcity of affordable housing in Tasmania. I am not sure that all mainlanders quite appreciate the straits we are in down here, because there has been a longstanding understanding on the mainland of how cheap house prices are here. However, in the last five years we have had a housing boom in Tasmania which has had a significant impact on low-income households. In fact, last year we released a report called *The Dark Side of the Boom*. Housing stress is now a widespread problem in Tasmania, particularly for low-income households. Average rental costs around the state have risen by 27 to 40 per cent in the past five years and vacancy rates are extremely low, which makes competition for rental properties very fierce. Clients of our private rental support service are on average paying 40 per cent of their income on rent, with some groups, particularly those on the Youth Allowance and Newstart, paying up to 60 per cent of their income on rent. We have found that in this housing market people with complex needs face enormous difficulties in finding and maintaining housing.

However, we do think that the key themes of our submission remain current, and we would like to bring those forward—particularly the service delivery issues, such as the need for further investment to develop a range and sufficiency of community based support and recovery services; the ongoing need for services which provide social support, and in that we support the points that previous speakers were making; complementing this, the need to properly fund the process of deinstitutionalisation by funding the functions that were once provided by psychiatric institutions, including the provision of low-cost housing; the need for greater coordination between services, particularly acute services and SAAP services; the work force issues faced by mental health services, both government and non-government; the barriers to service delivery which arise from working with clients whose incomes are at subsistence level; and the issues facing consumers, such as the inadequacy of current income support payments.

We would particularly like to draw your attention to that part of the submission which highlights how the unrelenting difficulties of life on a low income can exacerbate mental illness, particularly through social isolation, and the vulnerability of people with mental illness in the income support system. We would also like to comment on the issues facing carers, such as the virtual absence of services for carers and families; the need for greater support for the carers and families of people with mental illness; and the need for greater support for family members who are providing care to the children of people with mental illness. So our submission contains a wide range of recommendations which go beyond the mental health service system, which was the framework for the inquiry. But we would like to end with a request that the committee look at the issue broadly, acknowledging that issues like income levels and housing affordability can have direct health outcomes for mental health service clients.

Senator WEBBER—I would like to pick up on your comments on the impact of the housing boom and the increased housing and rental prices. Certainly in the hearings I have been able to attend for this inquiry, we have not really focused much on the crisis in meeting the accommodation needs of the more vulnerable members of our community. To what extent would you say—just roughly; I know it is pretty hard—that the people who you are concerned are falling through the cracks in that housing boom are those who suffer from mental illness or are their carers? Would they be a large proportion of the client base that you are worried about with that?

Mr Lamb—We think about the client profile that moved through the SAAP service system. We know that it is a significant proportion. In terms of directly quantifying in Tasmania, it is a bit harder to know. There are some particular difficulties that people with mental illness might face when you have a tight housing market such as we are experiencing. For example, when people become ill and require a period in hospital to recover before they can go home, often they are in rental accommodation. That will fall over during that period, and when they try to come back out again they are facing a major crisis in accommodation. But that is quite a common scenario. In fact, Anglicare has put a submission to the National Homelessness Strategy to try and prevent that kind of scenario.

Ms Flanagan—People also report that in a tight housing market, where you are having to apply and provide referees in order to get a rental property, it becomes very difficult if you have had a series of crises in your tenancies. People even report that once they write on applications that they live on Centrelink benefits they are disadvantaged. One of the earlier questions was about anonymity in small communities. There is very little. People who may have periods of being unwell are known, and that can have an impact on tenancies.

Senator WEBBER—That might be a significant issue. You made some comments about the lack of targeting of the state government concessions—you did not feel that that was working as well as it should. Can you expand on that.

Ms Flanagan—I think it is a problem across Australia but I am most familiar with Tasmania. Most of the concessions are targeted at pensioners, because historically they were the people who would be on benefits for the longest period of time. In Tasmania we have a very long-term unemployment problem—around 50 per cent of our unemployed people have been on unemployment benefits for two or more years. So they are on very low incomes for very long periods of time, but they are not entitled to key transport concessions on certain bus routes and things like that. They are not entitled to a 12-month electricity concession; they only get it for the two winter quarters. There is a whole range of concessions but they are the key ones that health care card holders do not get.

With respect to the welfare reform changes, our understanding of what will happen is that people who are eligible for pensions and who will be moved onto the Newstart allowance will keep the pension concession card, but if they have a level of earnings the cut-off comes in more quickly if you are on the Newstart allowance than if you are on a pension. So you will lose your pension concession card and be moved onto a health care card, which means you will then lose entitlement to these concessions.

Senator TROETH—On page 14 of your submission you have recommended, in recommendation 4, that the Commonwealth government should increase expenditure on mental health by $1.1 billion per year over the next 10 years. That is a reasonably large amount but it would obviously compound. Could you expand on how you have reached that figure? Also, how should any increase in mental health funding be allocated?

Ms Flanagan—These larger figures involve recommendations to the Commonwealth. Our work is very much focused on the state government, so we support the recommendations of the national bodies to whom we are affiliated. That is a Mental Health Council of Australia recommendation. I cannot speak about how they worked out that costing, I am afraid.

Senator TROETH—From your experience, if you could see an increase in the budget of that amount, what would be your preference for allocation of that money and in what particular areas?

Ms Flanagan—We had a long conversation yesterday about the complexities of Commonwealth and state funding. In the end, we felt that all we could say to you in all honesty is that we do not understand how these things work.

Senator TROETH—Let me put it as generally as this: if you knew that the Commonwealth government overall was going to expand funding for mental health services by, let us say, $1 billion per year, where would you spend that money?

Ms Flanagan—We would like to see a large expansion in community based mental health services. Obviously, in Tasmania there is a much greater need for supported accommodation. We talked about the package that is being rolled out by the state government, but it only brings our expenditure up to seven per cent of the total state health budget, which the Mental Health Council has estimated to be the national average. I assume you have been hearing around the country about the difficulties with current funding levels. We would like to see investment in community based services brought up to about 14 per cent of mental health service budgets. At the moment in Tasmania it is 3.8 per cent.

Senator TROETH—You have also noted particular difficulties with recruitment, retention and remuneration of mental health workers in Tasmania. What would be necessary to address those work force issues? That is my first question. Secondly, is it a matter of funding or are there systemic and work force culture issues as well?

Mr Lamb—That is a big question. It is probably worth noting that the department in Tasmania have initiated a project in relation to recruitment and retention. The unit that they have created has a plan, and it will start its work in the next little period. There are high levels of concern in both the government and the non-government sectors about the capacity to even staff the current initiatives that came from *Bridging the gap: the statewide review of mental health services in Tasmania*.

The issue is complex because it is also related to the way that the service system is structured. One example of that in Tasmania—I am not sure about other jurisdictions—is that many government positions are tagged as nursing positions. A debate needs to occur about what skill sets are required in what roles and in what proportions that could lead to an amelioration of some of the pressure in that part.

In the non-government sector there are some difficulties in recruitment as well, because there are simply not enough people in Tasmania who have a background in mental health service provision. In the medium term, I think that will be more readily addressed. It will involve a range of initiatives around marketing, particularly to young people who are looking at career options et cetera, and probably a range of new qualifications that are not at the nursing level but targeted to community based mental health services work.

Senator TROETH—In what direction should those other qualifications be targeted?

Mr Lamb—There are a range of levels to that. The witnesses appearing before talked about mental health first aid, which is almost like a floor-level qualification. We are looking at a qualification that might be an equivalent to an enrolled nursing level qualification but would not go through a generalised nursing process; it would be specific to mental health from the very beginning and so it would be a mental health qualification. Something of that sort is needed in both the government and the non-government sectors.

Senator TROETH—We have had comments about that in other submissions, so that probably ties in.

Senator MOORE—There are so many questions, and one of the things that I particularly like about your submission—and I do not say this often because it sounds so patronising—is the way that you have put mental health in the wider context. So many issues here were raised in the previous Senate committee inquiry into poverty; there are so many common themes.

I have a couple of specific questions. One of the ongoing issues for this committee has been the linkage of drug and alcohol issues with those of mental health. There are different approaches across the country. From your perspective, with the client and professional bases that you work with, do you have any comments to make on particularly drug and alcohol dependency and how those issues are treated? I know that in Tasmania they are still being treated separately.

Mr Lamb—Nothing earth-shattering—except to say that in Tasmania there is an initiative to create specialist units that would look at co-morbidity as a whole thing rather than, as you are suggesting is occurring at the moment, two separate things. There are a range of initiatives to try and better link the various parts of the agencies that will remain separate. That is the approach being taken here. Beyond that, I do not think there is much else to say.

Senator MOORE—Your submission leads to a question about the interaction between various community groups and welfare agencies and how they operate together in terms of responding to need. I would like to get some comments on that. You have said that Anglicare is the largest agency in Tasmania and that that is unusual: it is not the largest in other states.

In terms of people with need, what is the interaction between the various groups—and there are many of them—that have particular responsibilities? How is that operating in terms of people who need help? How is mental health as an issue handled by interagency groups? Is there cooperation? Should there be more? What kind of general response has there been to the issue?

Mr Lamb—Up until quite recently, that has been very poor in Tasmania. Prior to the initiative in 2004, there was a very small non-government involvement in mental health services in this state. As a consequence of that, there was next to no interaction between the various groups. There were a number of small peer support and family support groups that were essentially unfunded and not very well connected.

More recently, as part of the initiative and off to the side of that, there has been the development of a peak body for mental health in the non-government sector. I notice its representatives will be speaking to you later today. It is at an early stage but it will develop as a networking body that will draw together all stakeholders around the state. Parallel to that, the department have a number of initiatives in relation to carer and consumer participation in particular and also coordination in the three main regions of the state. So it is a prospect for Tasmania, and it is being approached in quite a structured way, but to date it has been really quite poor and has served the consumers poorly as well.

Senator MOORE—Who is driving that change?

Mr Lamb—The mental health services division of the department is driving it.

Senator MOORE—So they have the ownership of it. There is some mention of that in the department’s submission, but sometimes submissions and people’s perceptions are different. So from your perception, as an organisation within the community, the department is driving that.

Mr Lamb—The department is driving the coordination element, I suppose, for service delivery, and the Mental Health Council is beginning to drive and will ultimately drive the broader issues in relation to mental health and would be the conduit through which the voices of consumers, carers and service providers in the non-government sector, for that matter, will be able to speak about things that they are concerned about, across not only services but the act itself—the way the department is delivering its services et cetera.

Ms Flanagan—It is another facet of life in Tasmania that, with the sector being quite small, it is possible to develop quite collegial approaches to things. So in the sense of crisis that led up to the funding package that was announced in 2004 there was a great sense of unanimity across parties and across the sector about what was required and what direction we wished to see reform take.

Senator MOORE—I have one last question. It is to do with the role of the media, and that has come out at different hearings of this committee. From a Tasmanian perspective, do you have any comments about media coverage of issues to do with mental health or whether there is interaction between the media and the community in trying to improve those things? Do you have a general comment? We have had comments of that nature from other states and I would think that your organisation, because of your experience, would be well placed to make some comment about your perceptions in the Tasmanian environment.

Mr Lamb—As Jo said, leading up to the political decision to inject the new funding, the media was very supportive and very active in keeping the issue in front of the community. I think that assisted the department and the non-government sector in bringing appropriate pressure to bear. I think that would be a fair statement.

Ms Flanagan—I am not sure, but we might have the same issues. Again, being a small community, we have a lot to do with the media and perhaps in that regard they are listening more to the sector. But it may be interesting—

Senator MOORE—I wondered if there was any difference in the relationship in Tasmania and in other states. Do you have any comment along the lines of sensationalism?

Mr Lamb—They can fall into that.

Ms Flanagan—Yes, it certainly can happen, but there are strict protocols around how they handle suicides which they respect. But, yes, there are tabloid newspapers.

CHAIR—One of your recommendations is that Tasmania be granted debt forgiveness by the Commonwealth to the tune of $260 million. How did that debt accumulate? What are the circumstances behind it?

Ms Flanagan—That is the housing debt. The grants for housing that were issued to the states from 1945 onwards were in the form of loans, not grants, and that is the size of the debt that Tasmania has accumulated. I am not sure of the exact figure, but I think around 80 per cent of the income that comes to Housing Tasmania is returned to the Commonwealth in the form of debt repayments. Being a small state, we do not have the capacity to generate income from our housing stock, so we have a small and ageing pool of public housing. We think that public housing has a critical role to play in providing housing to people to compensate—

CHAIR—Relatively speaking, is Tasmania worse off than other states in this respect? Does it owe more money than Victoria or other states?

Ms Flanagan—Large debts were accumulated in some states but some states have actually retired their own debts. Tasmania has been facing particular financial disadvantage for a very long time. In terms of context, too, a third of our population are dependent on Commonwealth pensions and benefits—an extraordinarily high level. The next nearest is South Australia, which is only 28 per cent—we are 36 per cent. Our household incomes are 20 per cent lower than mainland states, so we are only just starting to experience some economic gains from the national economy.

CHAIR—Would you like to see the Commonwealth-State Housing Agreement designate housing—or at least put aside specific budgets for supported accommodation—for people with mental illness? How do you think that can work in improving the access to affordable housing for such people?

Ms Flanagan—I think there needs to be a commitment at all levels of government to public housing—again, looking at it more broadly because not everybody who experiences mental illness will necessarily need supported accommodation. But there are people who need security of tenure and affordable housing. At a local level we have not seen a lot of success in a liaison between Housing Tasmania and Mental Health Services, historically. So to formalise those linkages at a Commonwealth level I think would be a very positive move.

CHAIR—Many submissions have criticised the National Mental Health Strategy for its failure to have objectives spelled out in it. If I can go back to the Commonwealth-State Housing Agreement, do you think there ought to be an objective in there, some sort of time frame and some goals to be met to deal with the housing problem for people with mental illness?

Ms Flanagan—I am responding off the cuff, but it certainly sounds like a good idea.

CHAIR—You mention the $47 million from the state government in your submission; so at the point of writing you knew it was coming. But you did say that substantial additional funding will be required from the state government to address the recommendations of *Bridging the gap*. To what extent does $47 million fall short, in your view? What should that figure have been?

Ms Flanagan—The recommendations were very broad. Sorry; I am answering broadly again, but one of the recommendations was an attempt to bring work force levels up to New South Wales benchmark levels, and we are nowhere near that. I have not seen any costings of what it would be.

CHAIR—So that is the only area where you would be disappointed, if you like, in the response. I am just trying to get a grasp on things. We have the government coming later this afternoon.

Mr Lamb—We are probably not in a position to quantify in terms of dollars, but in describing what is required from what is currently planned, our view would be that there will be further supported accommodation settings required. At the moment, given the ones that are already there, there are about half-a-dozen. It will not be enough. Sixty-five packages of care across the state will be hopelessly inadequate. We will probably need four times that many at the end of the day. The recovery services will probably be adequate. As it is a completely new initiative it is a little hard to know with that one. There are some gaps with what has been put on the ground already.

In regard to the previous conversation that you were having around social exclusion—there really is not much in the initiative to date that addresses that. In our view, there needs to be a range of peer support, social kind of programs. Anglicare has one that it is funding itself in Devonport in the north-west. I think there are about 35 or 40 people who regularly drop in there and engage in a range of social and recreational activities. So those kinds of programs are needed. As we have said in the submission, there is next to nothing for families. There has been a pittance of money thrown at ARAFMI, for example. I think the north and south are getting about $30,000 a year. I don’t know what kind of support you can provide to families with that sort of money. I think what is needed is a range of specific support programs for families.

At its worst, what happens when someone requires hospital treatment is that they will be discharged with next to no planning and thrown back to the family. When people become ill, families really do not know where to go. Unless they happen to know someone who knows someone who knows ARAFMI, and there is a link-up of some sort, they are left to fight it out on their own. People who are living in the community with a mental illness who are socially isolated face the range of income barriers that Jo has been talking about in getting connected into the community. It comes down to quite simple things. Even if you wanted to join an aquatic club or something, the cost of that is significant and a significant barrier to a person wishing to engage in that kind of activity.

So, for example, when Anglicare made our submission to tender for packages of care, we had in our budget an amount of brokerage money to try and fund some of those sorts of things. The department made us take that brokerage money out at the point where we were successful and, lo and behold, as we are now delivering that program we are continually hitting up against this difficulty.

Jo and I were talking yesterday about mobility allowance. Mobility allowance is quite targeted towards the notion that at some point in the future the person might get a job or be engaged in some peripheral activity—in a centre usually. One thing that potentially could be done is that mobility allowance could be broadened out to be an allowance for people who have difficulties in engaging and becoming involved in the community—who have a disability, which, in this case, would be a mental illness—to meet some of those sorts of costs so that they can do that.

Senator MOORE—So the definition of mobility would be widened?

Mr Lamb—Yes. Broaden out what the functional mobility allowance is—make it so that people can have some mobility in the community in a general sense.

CHAIR—Can I ask you about the supported accommodation here. The committee travelled to Shepparton in Victoria where the area mental health service is linked up with a supported accommodation provider, and this means that there is clinical support for those people who are in supported accommodation. Do you envisage that coming out of the package that the state government has announced? Are there any models working in Tasmania along those lines?

Mr Lamb—Yes, that is what is intended. What have been established in Tasmania as part of the system are what are called—rather poorly, I think—‘maximising recovery panels’. Referrals come through those panels and people then do or do not get a package of care or supported accommodation link-up. If they do, it comes with the non-government agency social support program plus clinical connection from the department. So in theory it would work the way you are describing, as in Shepparton, but it is a bit early yet.

CHAIR—Would it be available 24 hours a day, seven days a week?

Mr Lamb—There is on call—there are community mental health crisis teams that are to respond, and a range of new positions were created as part of this initiative. But it is early days to know whether or not that will work well. Certainly, historically, from Anglicare’s point of view, we have been quite disappointed with the support that we have received from the department in our service provision, but we are ever optimistic.

CHAIR—I invite you to expand on that disappointment. What does the department not respond to that you—

Mr Lamb—That is in terms of clinical support.

CHAIR—Let us talk a bit about the prison population here and their housing needs once they are on parole or they are released from prison. What services are available to them with regard to housing?

Mr Lamb—Not much.

Ms Flanagan—No, very little. The Salvation Army run one or two.

Mr Lamb—Yes. I think they have one position at the moment. That is quite recent. Up until then there was nothing really. There was a volunteer activity around that issue, but that was all.

CHAIR—And the Commonwealth Supported Accommodation Assistance Program?

Mr Lamb—That would be commonly where people would go for support if they were released from prison and they had nowhere to go.

CHAIR—Do you have any experience in what happens to such people—assuming that quite a significant proportion of them have a mental illness? Is that your experience here in Tasmania?

Mr Lamb—Yes. We run outreach services, SAAP services, all across the state. Their experience would be that they would come in the door, along with the many other people who come in the door, and their workers would face the crisis in affordable accommodation in the private rental market that Jo was referring to. Potentially, particularly if there is a family involved, we have access to some government owned properties where we can house people short term while we try and find either public housing accommodation or private rental, but they go through that crisis. That is what happens.

CHAIR—Your submission says:

> … training and support for primary carers in the recovery and support of people with mental illness … provided in Tasmania is woefully inadequate.

I invite you to expand on that. What services do you think ought to be available to people who are carers?

Mr Lamb—In effect, they need a form of case management support. There is very little regard given to the huge cost savings that families are providing to the community by providing care to family members with a mental illness. They pretty much do it on their own. They are lucky to get information, let alone anyone to talk through the issues that they are facing. Organisations like ARAFMI do a terrific job through a volunteer base, but we need to lift that to a different level. With the recovery centres that are being established in Tasmania there is an opportunity there to involve families more in recovery—with client consent. ASPIRE, the organisation that is establishing those services in their model, has that intent, but there needs to be some direct support and contact with families.

CHAIR—Do you think there is a need for there to be training of GPs and psychiatrists in this field as well? The committee has had numerous submissions from carers, mostly parents, who say they are excluded. You have the person themselves excluded from society, but you also have primary carers who are often excluded from the process, from the medication regime to almost everything to do with their son or daughter. Is that the case in Tasmania? What sort of model do you see as being appropriate to overcome that?

Mr Lamb—It would be useful if a parent were at their GP's and talking about things that were causing them difficulty and the GP was skilled to respond to that. Obviously that would be a good thing, but it would be an expensive thing to achieve as well all the way across the nation. My preferred model would be to see specific programs on the ground where families can go and get the help they need.

CHAIR—Are there no family carer support groups here at all? Are there any organisations?

Mr Lamb—There are peer support volunteer groups, but it needs to go up to a different level. It is not sufficient as it stands.

Ms Flanagan—And they have such limited resources. When families enter the system they are told what the service system is for them, and it is a 0.5 worker.

Mr Lamb—For me, when a family are pulling their hair out because they just do not know what to do, they are at desperation point, who do they ring? At the moment the answer is no-one, because there is no-one; there is nothing there.

CHAIR—But who do they ring? Lifeline?

Mr Lamb—No, they probably ring their sister, brother, neighbour—

Ms Flanagan—GP.

Mr Lamb—That is the reality of what is there at the moment.

Ms Flanagan—Our research included carers within it. One of the things we were interested in tracking—we could not quantify it—was the impact on carers' own health and mental health. A number of them told stories of the decline in their own resources. They had to move homes or give up public housing or whatever in order to accommodate people again, because their sons or daughters could not get housing. They also had to give up work or they had very inconsistent work patterns so they knew they had no superannuation; they lost their marriages and those kinds of things as a consequence. It seems to me that families were particularly hard-hit where it was a young person who was developing the illness because of the intensity of their feelings of responsibility around that person. They certainly were taking on the role of a case manager with this young person while, at the same time, they were trying to deal with the grief of loss of that young person's hopes.

Mr Lamb—And trying to negotiate their way through complicated social security systems. They are left on their own, basically.

Ms Flanagan—They are very, very stressed.

CHAIR—I notice in your submission you have a program for parents with a mental illness who have small children. Is there a program in Tasmania for supporting the children directly through schools and through GPs and so forth?

Mr Lamb—Not so much through schools. There is the program we have referred to and the programs for children are through the Kids in Mind initiative by the state government. It is camp based peer support.

CHAIR—And that is available to children throughout Tasmania, or just limited areas?

Mr Lamb—They are technically based in Hobart and up in the north-west of the state, but available to all. If there was a child in the north, they could go to a camp that was being organised in the north-west somewhere.

CHAIR—Can you spell out how that works?

Mr Lamb—I am not that familiar with that because we do not run it.

CHAIR—So the state government runs that program?

Mr Lamb—Yes. The Mental Health Council would be able to give you more information on that, because it is currently under their auspice.

CHAIR—Thankyou very much for your submission. I am sorry it took us so long to get to Tasmania to hear from you, but thankyou for coming today. It has been most useful.

Proceedings suspended from 10.35 am to 10.50 am

BLANCO, Mr Antonio (Tony), Member, Victorian Branch, Health and Community Services Union

DAVIS, Dr Maryanne, Member, Tasmanian Branch, Health and Community Services Union

GUPPY, Ms Denise, Assistant State Secretary, Victorian Branch, Health and Community Services Union

KLEYN, Mr Thomas, Senior Industrial Officer, Tasmanian Branch, Health and Community Services Union

THOMSON, Mr Craig, National Secretary, Health Services Union

CHAIR—Welcome. Do you have anything to add to the capacity in which you appear today?

Mr Blanco—I am a registered psychiatric nurse at the Inner West Area Mental Health Service, which is part of MelbourneHealth in Melbourne.

Ms Guppy—I am a psychiatric nurse and I work for the Health and Community Services Union in Victoria.

Dr Davis—I am a clinical psychologist and I am working in the Eastern Districts Community Mental Health Service in southern Tasmania.

CHAIR—I thank those who have travelled from Melbourne and beyond to appear before us in Tasmania today. We are very grateful for your efforts in doing so. You have lodged with the committee a submission that we have numbered 223. Do you want to make any amendments or additions to that document at this stage?

Mr Thomson—No.

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

Mr Thomson—The Health Services Union, and HACSU, are well equipped to comment on the crisis in mental health services. We have more than 72,000 members around Australia and there is hardly a section of our membership that is not touched by the problem. For the benefit of the committee, our membership is involved in the direct provision of mental health services, and includes psychiatric nurses, social workers, program and support workers, and allied health professionals such as clinical psychologists and occupational therapists. Our coverage varies between states, but amongst those of the union's membership in the general health sector who are also affected by the shortage of services in mental health are nurses, allied health professionals, ambulance officers, aged care staff, disability workers, and drug and alcohol workers.

The view of our members is that we have a mental health system which is dangerously dysfunctional. The integrated mental health system envisaged under the National Mental Health Strategy has not eventuated. What we have is a crisis-driven, reactive model of care with major gaps in the provision of services. Where mental health services are lacking, the pressure goes onto other areas of the health system—it does not go away. It goes to ambulance officers, emergency departments or community health workers, and many of those people are ill-equipped and not trained to handle the mentally ill.

There are serious work force issues in mental health that must be addressed as part of a solution. As our branch representatives will set out shortly, there are sufficient resources to expand services, but health services are often prevented from doing so because of chronic staff shortages. The committee should understand that the key work force issues relate to work force numbers, distribution, training and education.

The recruitment and retention of mental health staff is being hampered by the fact that for many people it is becoming a more stressful and less fulfilling job. The most pressing shortages are in nursing, where you also have a rapidly ageing work force and a lack of graduates prepared to go into mental health. In the union’s view, that is largely due to the fact that there is a lack of specialist psychiatric nursing courses, which sees nurses given little understanding of or training in mental health during their education.

These education problems are also apparent in psychology, social work and occupational therapy, where the shift from institutional care to community care for the mentally ill is not being matched by a corresponding increase in the focus on mental health in undergraduate education. Postgraduate mental health qualifications must be developed in areas of subspecialty practice—that is, community mental health or aged persons mental health. Barriers that exist which limit the capacity of current employees participating in undergraduate and postgraduate courses must be removed—that is, enhancing the access to training schemes and providing support for learning and development opportunities. The pool of health workers from Indigenous and culturally and linguistically diverse backgrounds must also be expanded.

We note that the Productivity Commission’s recent report on the health work force raised the idea of a special mental health work force strategy, and that is something that we strongly support. The issue of beds is an issue that we wish to raise as well. There are roughly 3,700 beds in mental health. This figure has remained largely unchanged since 1993—and it simply is not enough.

We believe that funding is inadequate. We believe we should be setting a target of 20 per cent of the health budget being spent on mental health. Currently the federal government contributes seven per cent of the health budget to this area. In comparison to the figures in other countries this is woefully inadequate. Countries such as the United States and the United Kingdom are contributing around 20 per cent to mental health issues.

That is where I would like to finish my opening statement. We have five people here and I want to give the others the opportunity to say something, then we will welcome questions on our submission.

CHAIR—Thank you. Mr Blanco, I neglected to acknowledge your submission, which we have numbered 223A. Thank you for that. Does anyone else wish to make an opening statement?

Ms Guppy—Yes. Thank you, Senators, for the opportunity to speak to you today. You are aware of the issues and gaps identified in other submissions and in the HSU submission regarding the National Mental Health Strategy. The HSU submission has a strong work force focus. Our union's work is strongly focused on work force and training issues affecting our members. Those issues are focused around new graduates entering with inadequate training, the impact on experienced staff of the preparation of new graduates coming into mental health, recruitment issues and the ongoing educational opportunities for the existing work force. I would like to focus my discussion briefly on the area of work force and training. These issues have also been identified in other submissions to the inquiry.

The union and its members are confident that an improved national mental health strategy will come from this committee's work. The union believes that there must be a national approach to work force as part of that strategy. We believe it is really hard for the National Mental Health Strategy to happen without a skilled work force. There has to be a work force plan. There also has to be an implementation plan with targets and time lines. In Victoria we have had the experience of a lot of well-meaning plans that really have not eventuated because there have been no implementation strategies.

In relation to work force, having a responsive mental health system that meets the community needs is not just about building capacity and resourcing, developing and building new services. It is about having a skilled and knowledgeable work force that meets the needs of consumers and their carers. Work force and training are fundamental to the running of state provided mental health services. To give you examples: in Victoria recently there have been new in-patient units and expanded beds in existing units which have been delayed in opening, and we have had closures of beds because of the lack of appropriately qualified staff to work in those units. In Maroondah, Dandenong and Frankston hospitals the inability to attract, recruit and retain people has caused bed closures.

Craig has touched on work force statistics and we touch on these in our submission. The issues here include not being able to attract more than four per cent of new graduates into mental health. In Victoria only six per cent of nurses choose to work in mental health. Craig also touched on the issue of the ageing work force. The average age of a psychiatric nurse is 46. The Department of Human Services analysis of supply and demand for nurses shows that currently the nursing shortage is 480, and that is projected to be 1,300 in 2011. There is also the issue that not attracting enough people into mental health has a huge impact on the existing work force.

Craig touched on the issue of specialist training for both nurses and other health professionals. There has to be an improved educational process for beginning-level health professionals and nurses working in mental health. There also has to be better preparation for all health professionals and nurses working with the general population around mental health issues. Our union has a range of recommendations looking at nurse training. We see that there is a role for the Commonwealth to facilitate and fund universities to offer other approaches to courses and also for looking at other workers in mental health, certainly state enrolled nurses. Those nurses are trained through the VET sector. I think the other issue for our work force is having research that will impact on the state of knowledge looking at prevention and best practice in care for people with mental illness. I will leave it at that. Thank you.

Mr Kleyn—I have a few points; I do not want to take up too much more time. On the issue of the work force, the Tasmanian government recently committed itself to an additional $47 million over four years. As part of that expenditure, there are some 48 new positions being created within the state. One of the difficulties being faced already is the difficulty in attracting people to fill those positions. While it is commendable that these positions are being created, we have a peculiar problem in Tasmania with the recruiting of trained and skilled professionals into most areas of the health sector, and mental health is probably a little bit more of a problem.

One of the other issues that I want to address is the issue of the role of the non-government sector. Certainly it is a concern of ours that often governments see the non-government sector as a cheaper option in which to provide services. The staffing profiles in the non-government sector generally have fewer professionally qualified people. I believe government needs to consider the non-government sector as a partner in the provision of services rather than as a cheaper option. It needs to fund them adequately to provide skilled professional people and to provide reasonable wages and conditions to attract and retain people.

The only other comment I would like to make—and it probably has been made a number of times throughout your hearings—is the need for greater Commonwealth-state cooperation. There needs to be a lot less of the blame-shifting and buck-passing that occurs generally in the health system, and probably the mental health system is very much the same. There needs to be much more of a focus on cooperation and how we are going to address this problem of meeting the unmet needs of the mental health clients and this blaming. I will leave my comments at that.

Mr Blanco—I speak from my experience as a community psychiatric nurse for about the last 15 years. I also have some experience as an in-patient nurse. I have three main roles. I have a caseload of about 30 clients in a community mental health clinic. I also have two other portfolios. One is predominantly the training of nursing and other staff as well as undergraduate students as they come through during their clinical placements. The third role is as the transcultural portfolio holder for the area. My role is to develop and oversee the implementation of policies, programs, groups and education for how to use interpreters, for example. I see that as a huge area with unmet needs as well.

I have four main areas that I can speak on from my experience. They are excessive caseloads for clinicians, lack of available beds, lack of discharge options and work force and undergraduate preparation for psychiatric nursing. I can either read from a prepared statement or focus on one of those four that you are most interested in. Certainly for me the three that are closest to my heart are the excessive caseloads, the work force undergraduates and getting people into hospitals, which is a big issue. Should I start with the caseload issue?

CHAIR—We have all had your statement for some time and we have all read it, so we can just go to questions on it if you wish.

Mr Blanco—All right—if you want to.

CHAIR—I might do that because I thought your submission was interesting and valuable, you being a practitioner and having that experience. Can I ask you about how you divide up your typical week in hours terms? How many hours do you have to spend with your 30 clients in a typical week?

Mr Blanco—On paper I am supposed to spend about 0.7 per cent of my time, which works out at about three or four days, seeing clients and the rest on my portfolio work. What actually happens is that I fit in my portfolio work whenever I can, after hours or early in the morning, and I deal with the crises that come up with the 30-odd clients that I have. The problem I face is that, because I have such a large case load—even with other portfolio holders, other case managers, having up to 40—I often cannot do a lot of work with families and early warning sign work with clients, so I am often left just dealing with crises as they come up, and they often do. My average day can vary wildly. I could be trying to deal with someone’s accommodation issue. They may have just been kicked out of the family home because of a substance abuse issue or because they have stopped taking their medication, so I have to find accommodation for them. That might take two or three hours. I then have to work on the training session I have to run the next day. So as you can see I am constantly running. That is my overpowering sense anyway.

CHAIR—How do the 30 clients that you have come to you—how do they end up in your care? Are there 30 more who need the services of someone like you? What is the unmet need for the service you provide? The west area mental health service—

Mr Blanco—It is the Inner West Area Mental Health Service. It covers the municipalities of Melbourne and Moonee Valley in the central west parts of Melbourne.

CHAIR—Do you effectively deal mostly with outpatients?

Mr Blanco—Mostly.

CHAIR—The people you case manage are outpatients. How often would they come to see you? Sorry; I am adding more questions without letting you answer the first ones. Maybe you could just take us through that.

Mr Blanco—There is a vetting process that is uniform across Victoria. There is an intake process, through which clients are referred to our service. Essentially people have to be quite unwell to see someone like me. The intake workers screen clients and try to work out any other available option—a GP, a private psychiatrist or just no treatment. Those people are then booked in with me for an assessment and, if they are suitable and unwell enough, I take them on as a client. I see most clients on average weekly or sometimes two-weekly; it is rarely monthly. If they get to monthly then they are on the way out; they are too well.

CHAIR—Can you describe the cut-off point that you have in terms of wellness or illness? How sick does someone have to be? We have heard in this committee that you have to be a threat to your own or someone else’s life before you receive this sort of care.

Mr Blanco—You have to be quite unwell. Essentially you have to have serious social difficulties, not just a mental illness like schizophrenia. You really have to be in a position where you cannot access GPs or private psychiatrists, you cannot make appointments on time or at all, or you refuse to have treatment and under the Mental Health Act it is deemed that you need treatment—you might be an involuntary patient. There are also serious compliance or medication adherence issues and other issues like substance abuse. I would say 70 per cent of my clients have reasonably serious substance abuse issues, which complicate the picture. They reduce their options and make them unwell more often, generally speaking. At any one time, probably three or four of my clients should really be in hospital but are not, so we manage them with a combination of appointments with me or with CATs, crisis assessment teams. I rely heavily on families to assist.

CHAIR—Is it your job to work with families to train them or advise them in how to deal with—

Mr Blanco—Yes, within the bounds of issues of confidentiality, which sometimes presents a problem. The Mental Health Act at the moment allows us to communicate quite freely with caregivers where it is essential. I speak to parents, families, mothers and daughters all the time, every day. They are basically the primary caregivers, so they are an important part of the whole treatment.

CHAIR—Ms Guppy, you talked about the need for targets and goals, and you are not the only one to say that to this committee. Do you see a good argument for us to fund mental health workers on a per capita basis? We may say, ‘For every 100,000 residents, there ought to be this number of mental health workers—300 or whatever it is—designated to that population.’ Would you support that approach, leaving aside the availability of staff for a moment?

Ms Guppy—I think it is a commendable notion. The added complication, if that is the right word, relates to the particular demographics across a city. A place where Tony works has high levels of homelessness, low levels of home ownership, high levels of single males living in single accommodation, low levels of ability to access education and so on. In Victoria there has been a lot of debate about what is called population-weighted funding. I think that is the term that describes those sorts of demographics.

CHAIR—Which is not that difficult to do.

Ms Guppy—It is not that difficult to do. There is a figure that is put in relation to access to inpatient beds, which is about 25 beds per 100,000 of the population. In Victoria, there is great difficulty in the growth areas, and I am sure it is the same across the country where there are growth areas in the outer suburbs and services just cannot meet the needs of those growing communities. To answer your question, I think that it should not only be a per capita calculation; it should also take into consideration those issues that are included in a population-weighted funding formula.

Dr Davis—I would like to speak about rural issues with regard to that kind of funding. Although Tasmania is a small state, we still have problems giving adequate service to people in more remote areas of the state. Although there have been attempts to address this, it is still hard to access adequate services if you have a mental health issue if you live at, say, Bicheno, King Island or the more remote places of the state. Your choice is much more limited, so your ability to access a clinical psychologist, for example, would be lower if you lived in those areas.

Mr Thomson—If the question is about improving the coordination of the mental health dollar through uniformly having a per capita basis, that is something that we would support. All of those factors of remoteness and the particular locations that are there just need to be taken into account.

One of the key problems is the different approaches that can be taken by the federal government and the various state governments and the different levels of funding that occur in the states. As we pointed out in our submission, they range on a per capita basis from the $84.83 in Queensland to $110.82 in Western Australia. There may well be reasons that we would factor in as to why there should be some differences, but those differences certainly cannot be justified by remoteness or the make-up of the particular community that is being looked at. I hope that assists if that was the motivation behind that question.

CHAIR—It was really to explore that statement that you made, Ms Guppy, about the need for targets. The committee is now reaching the end of this inquiry and it is trying to tease out what those targets might be and what we ought to be calling for. So it is in that context that I am asking the question. There is also an issue, I think, with work force. What we are told is that people leave—psych nurses leave their profession and even GPs get out of mental health services—because of the huge pressure that is applied to them. It is a bit chicken-and-egg. If we started with an approach that said, ‘This should be the entitlement to this group of 100,000 people,’ whatever the various formulae applied to that would be, would it assist to break that cyclical problem of work force dissatisfaction and people leaving the work force? I do not know whether you want to comment on that or not.

Mr Thomson—The issue that we see with work force is just as much about education at the appropriate time for both undergraduates and graduates. If it is not provided and it is not there then it is more difficult to attract and retain staff when they are not trained in that particular area. So it is more complicated than just saying that we have a certain amount of money. I think Tom has already referred to the situation in Tasmania, where there is more money being made available but they are not going to be able to fill those positions. Work force needs to be a crucial part of any recommendations that come out of this committee because it is such a labour intensive area. It relies on the people who work there being properly trained and given the opportunity to train, not on bricks and mortar.

CHAIR—On that point, Ms Guppy, you say that six per cent of nurses opt for psych nursing. What is an ideal proportion? Should it be 10 per cent or 15 per cent or something else? Are there any benchmarks that we should be aiming for?

Ms Guppy—That would be in the work force data that looks at exits—the data covering the exits from the field and new entrants into the field, if I can actually say that. The union’s and my view about work force is around doing those demand-and-supply figures. It appears there is no coordinated national approach to the mental health work force and an analysis of the work force—that is, who is exiting and what needs to happen to actually provide suitable numbers to maintain a service. So, in the work force strategy that I envisage, the research around work force demographics is absolutely central to work force planning.

CHAIR—Is it available or not?

Ms Guppy—It is not coordinated, so the states do different things. It has only been recently that our state has actually started to collect that data from registration bodies. The nurses board knows how many new nurses are registered and how many are not registered and not working. So it is about actually using that data to plan a health work force.

Mr Kleyn—I would add specifically what undergraduate students tell me. At the moment we have a comprehensive system where you do general, psych and various other specialities. It is only after three years that you can actually then decide that you want to be a midwife or a general nurses or a psych nurse. They tell me basically that the ones who want to be psych nurses have to go through three years of stuff that they will never use. They have no intention of working in a general hospital and they only want to be a psych nurse. So they decide not to do it. We only get people who are not interested in psychiatry. General and psych nursing are very different, really, in a lot of ways. It is still nursing, but they are fundamentally different.

CHAIR—Is it the view across the board that psych nurses should not go through the general nursing training or are there any disagreements?

Ms Guppy—It is contentious.

Mr Kleyn—I can only repeat what undergraduate nurses tell me. They are actually discouraged—these are quotes that I have—and are told, ‘No, don’t do psych nursing. Do your general; psych nursing you can pick up later and it’s not real nursing anyway.’ That is what they are told at the universities, which compete with each other for places et cetera.

Senator TROETH—Apart from the question of training and how people might be trained usefully, how do we retain both doctors and nurses in the psychiatric area? Your testimonials and personal descriptions might mean that people start but then give up. What are the collective views on how we retain people, having gone to the trouble of training them?

Mr Thomson—I will start in a general sense and then I am sure my colleagues will give examples that are more specific. If not enough people are there to handle the workload, there is added stress. Mental health is crisis driven. As Tony said, he gets to see only the very sick people. There is no early intervention. He rushes around, as do all mental health workers. Coupled with making sure that people are trained properly, you need to make sure that enough people are there, enough beds are available in hospitals for the very sick and enough support exists for family and carers, who are playing a vital role in mental health as well. It is not just education, although obviously that is one of the things we are focusing on; it is the range of issues that directly relate to work force.

Senator TROETH—Are there any other comments?

Dr Davis—Workload is a really important issue in retaining people in the work force. I would make the point that the mental health work force is made up of not just medical practitioners and nurses; quite a lot of allied health professionals are employed in the sector as well. The satisfaction you get from your work is limited if you are only doing crisis work and responding to crisis. Trying to get people into housing is not our prime clinical role, but it is part of what we have to facilitate; therefore, our specialised skills and knowledge are often underutilised, which means that people get tired of the sector. Many of those in my profession go into private practice, where perhaps the clients are not as demanding and there are fewer stresses of the kind we have spoken of. If caseloads were a bit smaller and you felt you could use your full range of skills with your clients, it would add to work satisfaction in the sector.

There is also an issue with the attractiveness of community care, which is now the focus of the mental health system. In Tasmania, three of our psychiatrists work in the community; just in the hospital sector here in southern Tasmania, there are about seven. Access to community psychiatry for other involved professionals is often one of the really stressful things about working in the sector. Sometimes you just have to have that prescription pad.

Ms Guppy—Perhaps I could add that there are issues also around satisfaction. We have talked about workload for a community practitioner, such as a case manager like Tony, doing family interventions, drug and alcohol work with clients who need it and a range of other things. But community practitioners work in teams, such as the crisis assessment teams referred to by Tony. If one of Tony’s clients shows signs of becoming unwell and Tony believes he cannot support that person and provide them and their family with enough contact, he makes a referral to the crisis team. They then visit and it may be deemed that the client requires closer supervision and/or hospital admission. Our clinicians and members—practitioners—report that for six hours they can be on the phone in their car in someone’s front yard phoning around to state hospitals, trying to chase up a bed. This is an experienced clinician who wants to do a good job and assist in keeping someone at home but who sometimes, with the client and their family, makes the decision that their client requires a hospital bed. To find then that the client cannot access a bed creates an unacceptable level of frustration—and not only from a consumer and family point of view. From a professional point of view, the frustration is that in our mental health system we should not be using our time doing that.

I have been a clinician. You just think, ‘What am I doing?’ You are not doing the best job possible, which has a huge impact on your professional ethics. That then gets pitted against your finding a bed, for which another service is competing. Our clinicians, members of our union, get very dynamic when discussing which client has the highest priority.

Tony, in his submission, refers to another issue. Certainly, when I was a community practitioner, I would know clearly what a client’s relapse signature would be. I can think of one gentleman who used to wear hats. I would know that, if he had a hat on, something was happening for him and I would check that out. I could do a pre-crisis admission. He could go into hospital for two or three days while we got things back on track and could then be released. Tony, in his submission, describes not being able to do that anymore. So people relapse; they might be living on their own or with family. You have to wait until crisis point is reached before being able to access a bed.

However, sometimes you cannot access a bed and people have to sit in accident and emergency departments. We might debate whether that is an appropriate pathway of care, but that is the system we have in Victoria. People then may need to be shackled to a trolley. In Tony’s area, we have experienced someone waiting 64 hours in an accident and emergency department. Then there are issues about the structure of accidents and emergencies and there is debate about whether we need to put funding into little units. That adds to the frustration. People just will not work like that; they get tired.

Senator TROETH—Mr Blanco, you mention in your submission the need for a databank or database of available beds. Like you, I know that such a database does not exist in Melbourne. I take it that they do not exist in other states either.

Mr Thomson—That is right.

Senator TROETH—Obviously that would be a step on the road to knowing what beds were available and where.

Mr Thomson—That would assist. However, as 95 per cent of beds are occupied all the time, there is also the issue of the number.

Senator TROETH—Yes, we need more beds—full stop.

Mr Kleyn—It would tell you only that the units were full.

Senator TROETH—Yes, that is right. However, if you knew there weren’t any beds available, you would not need to spend six hours on the phone trying to find one. However, as there is no database, you cannot do that.

Ms Guppy—You have referred to the chicken-and-egg issue. The issue then becomes whether we have enough community practitioners and enough funded psych disability support services looking for accommodation. In Victoria, including Tony’s area, we have what is called a step-up step-down facility that can break that cycle of hospital admission. If a person goes to that unit, which is supported by psych disability support workers, they do not have to take the accident and emergency pathway and be placed in an acute unit. I am looking at this from a very Melbourne-centric perspective, because that is where I come from. However, these issues certainly exist in remote areas, and how you support people who are 100 kilometres away is a challenge.

Senator TROETH—We are hoping that the Council of Australian Governments, COAG, will be looking seriously at the question of the agenda for mental health. Given your comments about buck-passing and so on earlier—and we have all seen this, I think, to a lesser or greater degree—what practical solutions would your union offer on a macro scale to try and break the impasse or the road blocks that we can see existing?

Mr Thomson—We have recommended that a national mental health strategy be committed to and funded, so it is not just the writing up of a paper that sits on the shelf and everyone goes, ‘It’ll be wonderful if we can do that,’ and then they go off and do their own thing in different states and the money is not coordinated. There needs to be a strategy that is coordinated, that is committed to by all levels of government and is funded appropriately. From our point of view it needs to focus on all those issues we have gone through in terms of work force, bed numbers, case loads et cetera. Until you have that, there are continually going to be gaps that people fall through that are not seen and Australians are not going to get the proper mental health care that they deserve.

Senator TROETH—Do you think the National Mental Health Strategy in its existing form is going in the right direction?

Mr Thomson—We believe that the National Mental Health Strategy is a good document, but all it is is a document.

Senator TROETH—It needs to be funded.

Mr Thomson—Yes.

Senator MOORE—You have mentioned all the issues with the existing system. We had similar evidence from your group in the aged care inquiry, and I think a similar statement about a crisis-driven, reactive process. From all your experiences, what is your view in terms of the availability of people who could be brought in to work in the system? There is competition to get trained personnel across all the professions. Your submission is very valuable because it concentrates across the board, not just on one area. Your submission talks about things that could happen once people are already in the system. However, are there people who can be brought in to work in the area? What is stopping people from entering the area now? I do not know the answer and I would like to hear your professional perspective on what we can do.

Mr Blanco—If I could repeat what students tell me. I know there are young people out there who could potentially choose psychiatry as a career option—and I can only speak about psychiatry—but will not because they are not going to go through three years of stuff they will never use again. You have to take a long-term view about this. Nothing will happen now. I would like to see the situation we are in now in ten years time. We have a large group of nurses who have gone through this new course called specialist psychiatric nursing. It includes general as well but, predominantly, it is psych training. All they do is specialise in psychiatry. They enjoy it. They can have much longer clinical placements as opposed to just two weeks in the three years of training—that is all most of them get. So they will stay and that means we are happier—the older ones—because we do not have to leave because of stress. I think that is a good start, along with everything else that has been talked about.

Ms Guppy—I think we certainly need increased access in the VET sector. Mr Lamb referred to classifications other than nursing—that has its controversy. There has to be some commitment from the Commonwealth to fund some other courses, possibly in the VET sector. There is a barrier in getting people with some life experience. It would be terrific to get a few more blokes, but blokes usually come with a mortgage and maybe a family and kids, so they probably do not want to come out at the end of three years with a HECS debt. There are certainly some of those barriers involved.

It also needs commitment to funding the courses. Within universities there is a real battle amongst the deans around who gets the places. Also, it needs articulation for existing staff; making it easier for people through pre-employment, getting rid of employment barriers, and allowing people to study and work at the same time.

In Victoria we are looking at some different options for people who will then possibly take on mental health. For example, instead of student nurses working for $12 an hour in a fast food chain, they could come into a health service—in a classification that exists in our agreements—to actually get a taste of it and understand what it is like. We could have those kinds of flexible employment arrangements, but make sure that people work within the current award system. But certainly we need commitment from government to fund and facilitate alternative courses that are specifically attached to mental health.

Mr Kleyn—Looking at this question in a broader sense, I think that as a community we do not value these professions highly enough. I think we value you if you are a good football or a good cricketer; you get fortunes. But if you are a good nurse or a good psychologist, you do not. I do not think we make aged care, child care or health care attractive enough in terms of wages and conditions. They are generally seen as caring professions, and those are generally seen as women’s roles and an adjunct to the family, rather than being seen as valuable, worthwhile professions. I think all governments have got to take some leadership in this and encourage and foster more people into the industry. But also I think it needs to be recognised that the wages and conditions in health across the board—health and community services—are generally lower than they are in, say, engineering, science and some of the more male-dominated areas, and that is one of the dilemmas that we face. So if we want more people in these caring industries, then we need to face up to the fact that we need to reward them.

Ms Guppy—The other issue, too, looking at some of these submissions, is that the general consumers experienced the stigma of having a mental illness. The student nurse population, and probably the OT and social work student populations, have the same sorts of prejudices that the general community have. Part of the National Mental Health Strategy was an advertising campaign around what’s different. I can recall the one about the kid who is going away camping with his mate who has a broken leg, and the kid who is going away camping with his mate who has got a mental illness. We have to raise the community’s awareness, because the community has those sorts of prejudices and that actually stops people from entering work in the area.

Dr Davis—We have been hearing from other people who are working in mental health who do not find it attractive. It is not going to be attractive, is it? If the current work force is dissatisfied, your progression into a newer, younger work force is going to be a bit stalled.

Senator WEBBER—Thank you. My apologies for not being in the room when you were giving your statements earlier. I am from Western Australia, so the time zone difference means I have to catch people on the phone when I can, unfortunately. I will go back to and focus on those work force issues. When the committee had hearings in Melbourne, Jeff Kennett was one of the witnesses. He gave evidence that he did not think we were going to be able to deliver the services that we needed until the public sector was prepared to pay as much money as the private sector does to get those professionals like psychologists and psychiatrists back in there to deliver services. So it goes back to some of the evidence you were giving before, Dr Davis—that when they get better pay and working conditions in the private sector, how can you keep them in the public sector? Would that be your view as well?

Mr Thomson—There are elements of the private sector that are very poorly paid as well. That was part of the submission at the start that, unfortunately, you were not able to hear. We need to make sure that both the non-government and the government sector are integrated and, flowing from that, they should both be paid the right amount of money to attract people that are there. There are particular examples where some private sector people are paid more, but that is not generally the position across the board.

Senator WEBBER—Yes. I was thinking more of the upper end of the service delivery rather than the direct caregivers.

Mr Thomson—Yes.

Mr Kleyn—A private psychiatrist would earn more in private practice than they would for any government.

Senator MOORE—Yes, we have been told that.

Senator WEBBER—It is certainly the case where I am. Following on from that, before I started in this job I used to work for the Western Australian government and our then Minister for Health. One of the challenges, it seems to me, that state governments have—apart from the fact that we seem to be destabilising the delivery of health care because we all poach from one another; you need a stable work force too—

Senator MOORE—Is that a comment on Queensland, Senator Webber?

Senator WEBBER—Yes, you are the latest offenders. It is very hard to deliver quality health care across the board if you do not have a stable and happy work force and they are always moving. One of the problems state governments also have is that they are given a pocket of money to deal with wage increases and what have you. First off, they deal with the doctors, then they deal with the nurses—and I know you have some—and then in come the rest of them. By the time you have dealt with the doctors and nurses, you do not have much money left to deal with the rest of them. Then all of a sudden we have a crisis in the delivery of psychiatric nursing care. That tends, certainly in Western Australia, to be under a different agreement to the ANF agreement and that of the rest of the allied health professionals.

Dr Davis—To give the Tasmanian government its due, it has just awarded the allied health professionals a wage rise that will be quite helpful, hopefully, and a career structure, which is considered to be quite important.

Mr Kleyn—That, in effect, brings us up to the national level. It does not put us ahead; it brings us up to where Victoria is. We are always lagging behind somewhat in Tasmania.

Senator WEBBER—Not in everything, though.

Mr Kleyn—No, not in everything.

Ms Guppy—In relation to Victoria, in the 2000 EBA, to retain and attract back senior nurses, there was a commitment from the government to a senior nurse structure. That had been dismantled, with respect, under Mr Kennett during the nineties. There were 63 funded senior nurse positions that, I believe, had an impact on retaining and attracting senior nurses back into the system.

Senator WEBBER—There is one final point for clarification. It is not that we do not understand; I just think it is important to get it on the record. When we talk about bed shortages, we are actually talking about staff shortages. We are not saying that there is not a room and a bed as such. We are saying we do not have the staff to support that bed.

Mr Thomson—That is right.

Senator WEBBER—There are hospitals full of wards that cannot be opened up because you do not have the trained staff to deal with them.

Mr Thomson—Yes.

Ms Guppy—In Victoria it is also a bricks and mortar shortage.

Senator WEBBER—I know, for instance, in Western Australia we have a hospital called Sir Charles Gairdner Hospital that is full of wards that we cannot use because we do not have the staff to look after people in a safe environment.

Senator MOORE—I have a question on the availability of training. Once again, it is directed across the board to all the different professions that work in this field. I know you represent Victoria and Tasmania here, but, Mr Thomson, your union goes across most other states—not mine, but most other states. In terms of training places for the specialist areas of psychiatric care in nursing training, Mr Blanco has talked about the set number of hours within the standard program. In Tasmania and Victoria, are there facilities now providing training for doctors, nurses, social workers and psychologists?

Are all those facilities available easily for people within your own states? We will hear from Victoria first and then Tasmania. Access to training needs to be there on hand. I have heard stories that there has been a curtailing of where people can do particular training, particularly if they want to specialise. In Victoria can students actually access specialised training in all those professions that you need?

Ms Guppy—There is a requirement for postgraduate courses specifically in mental health. Nurses come out of an undergraduate course with a minimum amount of mental health.

Senator MOORE—With three years basic training at university.

Ms Guppy—Yes. Plus, on top of that, to achieve recognition of an additional qualification in psychiatric nursing with the Nurses Board you do a two-year postgraduate course.

Senator MOORE—Is that easily available? Do lots of places do it?

Ms Guppy—It is costly.

Mr Blanco—It is costly. They are run by the health services. For instance, NorthWestern Mental Health, who I work for, run that postgraduate course. There are probably about 20 students. It is nowhere near enough—not even approaching enough—to replace. I actually teach in that course, so it is more time for me. They use me. They do not get resources from elsewhere. It is staff who are already there who contribute time to put lectures together. It is nowhere near enough—now, anyway.

Ms Guppy—Certainly in relation to OT, social work and psychology, if people want to continue in a specialist area of mental health, they can do postgraduate courses in case management, mental health, drug and alcohol or child and adolescent. There are those subspecialties, but they are expensive university courses.

Senator MOORE—And Tasmania?

Mr Kleyn—In Tasmania they are probably the only professions we train, actually. We do have access to medical school for doctors and postgraduate work.

Senator MOORE—There is one in Tasmania?

Mr Kleyn—Just one, yes. We do train social workers and psychologists. We do not train occupational therapists. We have to recruit those from the mainland. All other health professionals we have to recruit. They are basically the only ones we do train here. So in a sense it is a little bit easier for mental health than it is for some of the other aspects, but there is a whole range of other reasons why people do not stay in Tasmania.

Senator MOORE—But those facilities are here in Tasmania.

Mr Kleyn—Yes.

Senator MOORE—We heard evidence in the aged care inquiry—and I will not give the actual figures because I cannot remember—when speaking to people from the nursing schools, about the very small number of people in the graduating classes that stayed in Tasmania. The numbers that were given to that particular inquiry were frightening. Is that the experience, from your knowledge?

Mr Kleyn—I am not sure. I really cannot give you any figures on how many nurses who are trained in Tasmania stay in Tasmania. I know that the state government attempts to recruit much of them, if not all of them. But there are significant numbers who go interstate. I would suggest that that would be for better opportunities, better pay, better conditions et cetera.

Dr Davis—In psychology we do retain quite a few of the people who go through the masters and PhD program in our mental health services, because that is the biggest employer of psychologists in the state. But there obviously are people who go interstate as well.

CHAIR—Thank you so much, for coming to Tasmania in particular but for appearing before us and for your submission, which was terrific. We would like to have had another hour with you to do it justice, but we need to move on. Thanks again for coming.

[11.50 am]

BERKERY, Ms Priscilla, Consumer Representative, Mental Health Council of Tasmania

BEVAN, Ms Georgia Anne, Coordinator/Support Worker, Mental Health Council of Tasmania

MACGREGOR, Mr Roderick Peter, Executive Officer, Mental Health Council of Tasmania

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

Ms Bevan—I am here as a carer representative of the Mental Health Council of Tasmania. The suborganisation I represent is called ARAFMI, which is the Association of Relatives and Friends of the Mentally Ill. I will speak from a carer perspective. We are part of the council.

Ms Berkery—I am also a carer but mostly I will speak from a consumer perspective.

CHAIR—You have provided the committee with a submission which we have numbered 455. Are there any amendments or additions to that document?

Ms Berkery—I wish to have a look at Welfare to Work.

CHAIR—We will ask you to make a brief opening statement shortly. Is there anything you want to say to the committee about your submission?

Mr MacGregor—No, there is not.

CHAIR—Then I ask you to make a brief opening statement and then we will go to questions.

Mr MacGregor—As you know, we are the peak body. The Mental Health Council has been established about six months in Tasmania. There are now peak bodies in every state, which is excellent. I have been in the position of executive officer for approximately three months. I have been seconded across from the department to establish the operational side of the peak body. My contract goes for six months and then the position will be advertised.

Our role is to represent the non-government mental health sector in Tasmania, so it has a state wide focus. We work very closely with our members drawn from service organisations, consumer organisations and carer organisations. Our constitution dictates that we need to have equal representation right across the state. So we draw on the carer, service provider and consumer organisations around the state, when they are there. Our consumer network at the moment is not fully represented. We are certainly working towards that.

I had about 13 years in the mental health sector as a social worker. I worked in child and adolescent services for many years at Clare House. I was principal social worker for the state for a number of years before I moved across to the government sector, back to child protection. Now

I am in the Mental Health Council. One of the main reasons I was asked to come over is because of my broad experience across all sectors.

What has interested me since I have been in mental health is the way things have almost gone full circle. When I joined mental health services way back—close on 20 years—it was held up as one of the best mental health services in the country. At the time the services had been moved out of the main hospital settings and the instruction was to go out into the community and work with the community—establish bases in the community and work from there. The idea then was that you did not establish clinical bases in the community but community development centres with a small clinical focus. I remember Dr Ruth Redom at government house back then saying to all the personnel, ‘Your job is to get out at least 50 to 60 per cent of your time to work in the community with families, friends, children and everyone else.’

In the years I spent there the focus tended to contract from the community to much more of a clinical focus. By the time I left about five years ago the focus in mental health was primarily clinical. What has happened now is that the new initiatives the state government is putting into place have reversed that and the response is now primarily a case management response, which I think is very good and I support that. I think it is overdue that we return to that and start looking at a case management community focus again.

I think that the state services need to be careful that they do not throw the baby out with the bathwater. They have to be careful that people who do have specialist clinical focus skills, as Maryanne was talking about a moment ago, do not neglect those skills because they are asked to go out and do work that they in fact are not accustomed to. We need to be very careful that we get the balance right, that we have our small clinical focus and that we also have a community focus. I am very pleased, as EO of the peak body, to see that that is happening. I applaud the government for putting that in place. I hope that they are successful.

I know that the cultural change necessary to make that shift is proving very difficult, and that is not unexpected. People’s expectation is that we do not go out in the community and that the community has to come to us. That is a lot to ask of a mentally ill person: to come in on an appointment basis, sit there for 1½ hours or whatever it is, tell their story and then leave. If they do not turn up, they say, ‘That’s not our problem. We’ll just bring them in again. If they can’t come in, we’ll just fill the gap with someone else.’ I think it is important that you have preventative measures in place and really work the community very hard, because a mental illness is not just a mental illness: mental illness is a whole-of-lifestyle sort of thing. You need to work with other issues. People are talking about housing, unemployment and relationships with family, friends and everybody else. It is critical that you maintain those as well. We in the council will certainly be looking at that.

Ms Bevan—Since this document was placed in June, some changes and improvements have been happening, particularly under the Bridging the Gap initiative. So, since June, things are moving and happening. I am sure that you will get news of that when you speak to Professor Graham, the state manager. So some things there are improving.

To give you my background, my son has schizophrenia. That happened about 11 years ago. I have been working in the mental health system either as an admin worker or, for the last eight years, as a volunteer working with ARAFMI. I provide support and meetings for families, friends, partners and relatives, and if consumers require our services, we respond. We do not discriminate. In the meantime, I have educated myself in mental health. I have a Graduate Diploma in Mental Health from a Melbourne university, and that informs a lot of my practice. I keep up-to-date on the internet with electronic journals et cetera.

I would like to talk to a few points I have raised in my submission, which you have, and also a few more points that are not spelt out in the document if we have time. A key one—and Priscilla will also talk on this issue, so I do not want to steal her thunder too much—in my experience as an ARAFMI person and as a family member, is section (b), about personality disorders. I have talked about this in the submission. A lot of people who come in for our help have a combination of issues. They will have some personality disorder issues even if they are not diagnosed—you will hear it in the way they speak—they may have a substance use disorder and they may have an anxiety disorder, schizophrenia, bipolar or whatever. Then they will have justice issues because of offending due to the untreated or inadequately treated mental illness. They may have children in their care or they may have an elderly parent whose house they are staying at, and she is 60 years old, in a wheelchair or whatever. So there are complex issues and complex cases.

My concern is particularly for the second generation: the upcoming generation, the children of parents with mental illness/substance use/personality disorder, because those things often come together. My fear is that, if we do not adequately address the parenting needs of these children, we as a society are shooting ourselves in the foot by allowing children to grow up in families where parenting skills—love and affection, appropriate attention—have been thwarted.

That is not to blame the individual person who has a mental illness, so this is not a blaming thing. But this is something that we need to address as a community, because what is happening is that unwittingly we are allowing a generation of children to grow up that will have far higher risks of personality disorders, substance abuse disorders and mental illnesses because their early socialisation experiences have been thwarted. In Tasmania—I cannot speak for the rest of Australia—we have a group called Grandparents Raising Grandchildren. I do not know if you have had a submission from them. I am going to speak to the group next month about borderline personality disorders; they have invited me. Their whole brief is that these people are volunteering to be the raisers, the socialising parents, of their grandchildren, because with the children—adult children, teenage children—parenting skills have been so threatened by a combination of whatever it is. They are not very vocal and you do not hear about them but, from their point of view, they are at least trying to address that problem.

I do not want to speak about my personal experience too much. Let us just say that we have to sometimes encourage families to think about the needs of the children involved who are not able to access services for themselves. Child protection may have to be involved in a minority of cases. Sometimes I am in a position of encouraging a grandparent to contact them, to make that call, so that at least an assessment can be made. So my concern is that Australia wide—and it is not just the white generation either—this is a serious issue and we are having generational inheritance of emotional non-wellbeing, and we allow that to continue at our communal peril. That is one point.

On another issue, I talked about acute beds for the state. There are currently only six high-acute beds long term and eight beds short term, in addition to the three inpatient wards in the three regions in Tasmania. However, that will be addressed by the new secure mental health facility that will be just outside the boundary of Risdon Prison and will have funding for 35 planned beds, so that is an improvement on that score. However, in relation to adolescent in-patient needs, because of our dispersed, small population, we do not have any committed adolescent in-patient unit here. Currently, a young person will go to the paediatric ward—say, down at the Royal—and the nurses are complaining that they do not have the skills to deal with the challenging behaviours, the disordered personality interaction, the mental health problems et cetera. Even if we do not get a specialised in-patient unit for young people, there are other options. Let us train a particular set of nurses in the paediatric field who will be conversant in mental health issues and personality disorder and substance abuse issues. So that is one way out of it if the population pressures are not sufficient to demand a separate adolescent in-patient unit, but people have been complaining about that for some time.

Similarly, a lot of younger teenagers are placed in adult wards and of course they are traumatised or freaked out by seeing people who may be a lot older and a bit more outgoing and perhaps aggressive in their mode of interaction. We do not hear of much patient-patient aggression, but I think the young people are freaked out about associating with these people, especially if a person has psychosis. The psychosis itself threatens the capacity for rational interpersonal perception and so the younger one might be misperceiving quite badly and getting freaked out and traumatised by that. Most patients are quite highly distressed. I go to visit hospitals on a monthly basis and I have hardly ever had any sort of problem with aggression, so I do not want to give an impression otherwise; that is not what I am saying. I am just saying that, given the age brackets, having young people in an adult ward is not quite appropriate.

In relation to point (g) in your terms of reference, in relation to carers, I did not make a note in our submission, but I would like to now, if I may. I have a vision for the future where a really well-functioning crisis team would actually have a carer worker on deck. When the crisis team goes out to a home and deals with a patient who is extremely distressed, the family member—or whoever it may be—that has probably run the CAT are probably highly distressed and behaving inappropriately and non-therapeutically to the patient. If the carer worker could come out and calm and settle them down and provide some empathy, support and skills over time, I think that would be a vast improvement.

Alongside that issue, we have to make sure that the Privacy Act is not interpreted too broadly so as to let us, as clinicians, not listen to the family member. Unfortunately, a lot of not listening to the family member is still happening. And even where it does happen it is happening inappropriately; we hear this on our telephone helpline. The clinician goes back to the patient and says, ‘Your mother said you are feeling suicidal and aggressive.’ That is so bad, because it means that the family member’s relationship with the patient is doubly jeopardised, when that patient has enough psychosis to render their capacity for rational, interpersonal perception as being out the window. There are other ways of getting that information. Any good clinician should be able to go to their routine assessment and say to the patient, ‘We have to go through these routine questions.’ They should do that anyway, and they should include a suicide and a risk assessment. So there is no need to go and spill the beans that mum has said, ‘Blah, blah, blah.’ That is really iniquitous and very harmful to the family relationship. We would like to have that kind of issue addressed.

Partly, there has been some progress on that issue since our submission was made. The Royal Australian and New Zealand College of Psychiatrists now have in their guidelines a need for each psych registrar to have X amount of hours with a carer organisation hearing carer and consumer perspectives, and we applaud that. It is a really good move. It needs to be given a bit of a kick under the backside here in Tasmania, because that program has stalled a little at the moment. But last year, yes, ARAFMI did participate in that activity. We had about six or eight carers and about nine psych registrars, and we had a bit of conversation. We did talk about the confidentiality issue and how it is misused, so that was good. That is an improvement.

Ms Berkery—I am a consumer and a carer, but I will primarily stay with the consumer perspective. My background is that I have been a home economics and religious studies teacher. Then I trained to work within a mental health situation. In the year 2000, I started my masters degree in community mental health in the primary care model, which is mentioned in the submission. At the moment, people in the sector are not following the primary care model. That is reflected in some of the decisions that have been made about, for example, Aspire, the rehab service. They do not take referrals from GPs; they are taking referrals from psychiatrists. About 17 years ago there were about 17 doctors working in the public sector. Those 17 doctors are now out in private practice and most of them charge. Only a couple of them are bulk-billing and it is very hard, or almost impossible, for people to get in to see those doctors.

I would like to comment on the Mental Health Act. Each state has its own mental health act. When I was at the National Carer and Consumer Forum meeting I raised the question about mental health acts and particularly community treatment orders. In Victoria they said that the number was increasing. Then I asked how the state was using the guardianship board, because here in Tasmania there is a risk. While people are competent and on community treatment orders, the guardianship board would place an order on them that takes away informed consent, and that is not okay for somebody who is competent but maybe is not taking their medication. Unfortunately, treatment here in Tasmania is regarded as being what you can take as medication. When I was on the committee for the guidelines for the Mental Health Act, the risk of suicide was regarded as not being an important issue to consider when deciding whether a person was going to be hospitalised or not. That was of major import for me, because I was on that committee. Not many people outside of that committee knew that that was how people saw it.

The other issue was that you could get a second opinion. If a doctor saw you in DEM and could not or would not allow you to be in DEM, you were then transferred to DPM. You would be taken out. That has happened to several people. They have been told to go and they have committed suicide when they have left. So the Mental Health Act needs to be tightened up so that there are not loopholes in it.

CHAIR—Could you tell us what DPM stands for?

Ms Berkery—The Department of Psychological Medicine. It is the acute ward. Regarding community treatment orders, I could talk about my son, for example. He is highly mobile and can move from, say, Hobart at the least whim and go elsewhere. He has no referrals to doctors in other states. There is no talk between teams here and teams on the mainland. Community treatment orders cannot be carried across borders. It would be handy—and I think the national consumer carer forum will be looking at this, and I started exploring it—if we could overcome that. Hopefully Des Graham sees the importance of having the states working together on national mental health strategy standards, because they do not have much sanction.

I would like to talk about personality disorders. My diagnosis was bipolar, plus dissociative disorder and post-traumatic stress disorder. When I went to DPM, when I was referred there, they could not treat the dissociative disorder other than by drugging me so that I was non compos. Right across the board, they say that personality disorders cannot be treated, which is nonsense, of course. We need to have a sufficient number of psychologists, OTs and social workers based at DPM. I think we have only one who specialises in PTSD and dissociative disorder, and that is Kereth West, a psychologist. I have often asked the department to have nurses' and doctors' training in dissociative disorder and PTSD. After all, the men who have served overseas with the Army, Navy and Air Force can get free treatment for PTSD. They go to the clinic here in Tasmania and they get cover for care, but if you are in the private or public sphere you do not get the same care. It is paid for for the veterans but not for anybody else.

I think that there are one or two doctors—and I am fortunate in having one—that specialise in dissociative disorder. At the moment they say they do not have a treatment. In fact, they go further than that: they say that nobody can be treated if they have a personality disorder. But that is so broad ranging. You are told that there will not be a bed for you. That is why I am sacrificing everything to be able to go to a private hospital. I find that the standard of DPM is really low when you compare it to what you get at the Rokeby clinic where they care for all sorts of disorders.

CHAIR—Is it at that clinic where the psychologist is available to you?

Mr MacGregor—There are three. And there are nurses and doctors trained in it as well. Paddy Burgess-Watson is well and truly recognised in the state for caring for people like that. I could go on forever about that.

CHAIR—Perhaps we will leave it there then.

Senator MOORE—I am interested in your role with the council in terms of the funding for the council in Tasmania. Has that come through the package that was announced last year by the state government?

Ms Bevan—The Mental Health Council has always had a little bit of funding—about $3½ thousand a year.

Senator MOORE—Yes, but it has increased recently, has it not?

Ms Bevan—Yes. It is certainly a commitment of Des Graham to extend the funding. We are looking at the budget now so that it has adequate funding. In fact I think Des Graham established the first peak body in Canberra, so he is very supportive of it.

Senator MOORE—We heard evidence this morning from Anglicare where they mentioned funding levels for ARAFMI in Tasmania. Their comment, which is on the record, was that they felt that was not adequate across Tasmania. Ms Bevan, you have identified as being from that group. Do you have any comments about that?

Ms Bevan—Yes, as you would guess. In previous years, the ARAFMIs in Tasmania have been funded through schedule B and then schedule G under the National Mental Health Strategy. It was an annual grant and it was a pittance.

Senator MOORE—And that was federal funding?

Ms Bevan—National Mental Health Strategy funding, yes. Just recently both north and south ARAFMIs have been granted about $27,000 for just under a year. That finishes at the end of June. After that, I have not a clue what is going to happen. That money is now funding me for 2½ days a week and the northern ARAFMI worker for four days a week, I think, for about six months. With that level of funding for employees, there is so little we can provide compared to what is provided by ARAFMIs on the mainland. The northern and southern ARAFMIs provide a telephone service, library, monthly meetings and workshops. In the south, we provide some personal counselling, through me, and public presentations where requested. But we cannot do anything like providing in-home support for families. It is just not on. It just cannot be done. We cannot provide any support during crisis events in the family home. We cannot maintain a hospital presence.

We cannot rely on volunteers any more because the economic conditions that allowed a lot of volunteerism to occur have changed. For instance, women who previously would have been supported by their husbands' financial situations are now out at work. For the high level of skilled support that we need to provide, we need to have skilled volunteers. You can see that skilled people are going to be out in the work force. So where the hell are we going to get our skilled volunteers from? That makes life quite difficult for us; hence we have had to go down the route of getting paid employees. We could easily do with a full-time worker. If we had a car and backup staff to do house calls, go out with crisis teams and that sort of thing, I would say it would be quite advisable.

Senator MOORE—The state government have not quantified the current funding for the council in their submission. They have mentioned that they are providing funding. What is the funding for the council?

Mr MacGregor—At the moment it is about 150, because we also run a resource centre at 97 Campbell Street. At the moment the service agreement is for funding me, and then we have a separate agreement to run the resource centre, which includes an admin worker plus some money for rent and the library.

Senator MOORE—Is that on a single-year funding basis?

Mr MacGregor—Yes. We are looking at triennial funding, and we are looking for about $270,000 a year to run the whole peak body. That is the resource centre, an admin worker, a policy officer and me.

Senator MOORE—Ms Berkery, you mentioned Welfare to Work in your opening statement. I know you probably want to add something to that later, but I want to talk a little about the role of the council and the people on it in providing support and training to government bodies such as Centrelink. We have had submissions across the board about the role of Centrelink in working with clients who have mental illness or are families of people with mental illness. I want to tease out the kind of relationship that Centrelink has with people like yourselves in terms of getting that training and awareness for their staff so that there is this understanding of the issues of mental health in the community. Do individuals within the council have that liaison role with the department?

Mr MacGregor—Not as yet. That will certainly be part of our core business. Last week I had an invitation to talk to some staff at the DPM. That is now the beginning of it. We are establishing a carer and consumer representative structure. We are just putting that in place now. We have had a lot of calls on that for people to go on the clinical reference groups in the mental health sector and on various other bodies as well. That has been put in place, so we need to do a lot of work in broadening our membership and basically getting those people registered.

Senator MOORE—Being bona fide to provide that kind of support—is that the kind of thing you mean when you say ‘registered’?

Mr MacGregor—Yes. We recommend certain people to sit on clinical reference groups et cetera. People register with us.

Senator MOORE—I know you have a role, Ms Bevan.

Ms Bevan—It started through mental health first aid training. I was a trainer. I delivered to Centrelink staff. I was invited by a social worker there to deliver a presentation. After that, we had two more requests for me to speak. One was an all-day training seminar on personality disorders for the international staff, because they are dealing—

Senator MOORE—We have had the hotline down here.

Ms Bevan—Their staff needed to have some handle on what personality disorders they were dealing with and how to put that into their judgments about whether the person was an appropriate recipient of Centrelink services et cetera. They were asking me questions regarding trying to make a clinical assessment of someone’s appropriate receipt of Centrelink benefit. They are playing god, and they have no skills with those decisions, so I gave them a brief, one-day training course on personality disorders, which, compared to what they are going to need, was a pittance. If you are going to have Centrelink staff making decisions about cutting off someone’s benefit when they are overseas, or even in Australia, they are going to have to have some clinical nous, because those are clinical decisions. Here we are with social workers who are making those decisions without any training in mental health. I was squirming, so I gave them what I could.

I would like to raise quickly the issue of mental health first-aid training. Currently in Tasmania it is run by the Red Cross. I am biased, but I believe that every government department, state and federal, and every major HR company or department needs to have at least one MHFA trained person on deck. That is absolutely crucial. That way we may be able to address mental health issues in the work force at all levels—and maybe we can encourage early intervention, maybe we can reduce the suicide rate, maybe we can increase work force productivity, maybe we can reduce unnecessary litigation et cetera.

Ms Berkery—I have been talking to consumers over the last few weeks, particularly those who have been put onto a Newstart allowance. One person was 60 years of age and was very depressed. He was put into training because of a report by a doctor. I find that most doctors do not know how the new law is going to impact on people. In this case the psychiatrist said for his report: ‘This person wants to work.’ That is quite true—consumers do want to work—but they do not want to have the limitations and boundaries and the hoops that have to be jumped to do that, to get the disability pension when it is appropriate.

The assessment procedure and the report writing are not geared to psychiatric disorder. As I said when I was talking to Janet Meagher at the NCCF meeting, the questions are designed for a physical disability not a psychiatric disability, and there should be a questionnaire and assessment procedure for psychiatric disability. It is awful to see somebody who is 60 and is now back in hospital because of the fact that, with very little training, he was told to care for somebody who was intellectually disabled and physically disabled, and he found he could not cope. Now he is terrified of what the reaction is going to be from Centrelink. And it is not just him—there are a lot of people like that, people who are in their 60s. I dread the letters coming in from Centrelink that will tell me—I am 63—that I have to go onto Newstart. That is my concern about the Welfare to Work legislation. In the reports the doctors write, particularly the psychiatrists, they tend to say: ‘This person has not been in hospital for six years,’ for example, ‘and they are compliant with the medication,’ but they do not know, they have to read, the literature and the analysis of the Welfare to Work legislation.

Senator TROETH—You have commented in your submission about finding a doctor who works under the Better Outcomes initiative. I want to ask you whether in Tasmania it is difficult to find a doctor who participates in that initiative? Could you give us some idea of the numbers or locations?

Ms Bevan—For people in the early stages of mental health problems I will often on the telephone, or at meetings, refer informally to Better Outcomes—or BOIMH, to use the acronym—but I always warn the caller: ‘It is very hard to find the GP who is participating, because there is no list.’ There was some talk that there might be a list made and put on a web site—I do not know how far that has gone. So I have to warn the person that while they are relatively well, or the family if they are calling on the person’s behalf: ‘You have to do a shop-around. You have to ring the receptionist and ask: “Is your GP participating in Better Outcomes?”’ That is not a fair request for somebody who is ill, to go around doctor shopping to find the right GP, because about 25 per cent take up the training in Tasmania—that is the figure I have been told—so you have to keep on asking to find the right one. And if you are living rurally—

Senator TROETH—So you do not have any idea of numbers or location or anything like that?

Ms Bevan—No. You are not allowed to have that information.

Senator TROETH—Do you think listing on a web site would be a suitable way for people to find out where they are?

Ms Bevan—I think it is appropriate because if the doctors' books are full, well, they are full. Just as anybody with a physical health problem rings up their GP or, if they have got a new condition, tries to find a GP to treat it and a GP's receptionist says, 'I'm sorry, the doctor's books are full for three months' or six months, why can't the same thing apply if a person is ringing up for a mental health BOIMH activity? I do not see the problem. The GPs are telling the divisions of practice that they are worried about getting swamped—probably swamped by people with personality disorder issues who want to just keep talking and talking. But you apply the same rationale: 'I'm sorry, the doctor's books are full until three months time,' or whatever. But at least you will know who the GP is, and you can book yourself in for three months time, perhaps. It is a start.

Senator TROETH—You have also mentioned that government allocations focus on acute care but only half the recommended numbers of high-support beds will be provided. Are beds currently bought from the private sector in Tasmania?

Ms Bevan—Yes. They buy them from Hobart Clinic. I am not sure about Hamden ward.

Mr Berkery—From St Helens, with the people who are suffering from post puerperal syndrome after or before the birth of the baby.

Senator TROETH—How well does that system work in theory?

Ms Bevan—We have not had any feedback, but they are doing it because they simply do not have any beds or enough staff. Statewide we have had those six acute beds at Tyenna and eight at the Psychological Intensive Care Unit at the RHH for the last few years. It is not enough for the state.

Senator TROETH—Do you think there is capacity in the private sector for the public sector to buy more beds?

Ms Bevan—It is tricky because the private sector hospitals cannot take—because they are not geared up for—involuntary clients who have got a high-risk assessment. Only the public system can enact the Mental Health Act and detain people involuntarily. So if they cannot get into PICU or Tyenna Blue, at least in the south, there is almost nowhere else to go. There is DPM, but you can get out of DPM too quickly and too easily.

Mr Berkery—The position being that Hobart Clinic, for example, has to provide care for the whole state.

Senator TROETH—So there is a natural limit, in that sense, on the number of beds that could be provided.

Mr Berkery—Yes, very much so.

Senator TROETH—I understand that the Tasmanian government is going to more than double the number of clinical positions in child and adolescent services to 26 full-time equivalent staff. Do you think that is a sufficient measure to address the problems that you have spoken to us about?

Ms Bevan—The different CAMHS operate according to different policies, procedures and eligibility criteria, and that is going to be addressed. It is going to be a statewide CAMHS now. But until that happens the CAMHS down here at Clare House, I think last year or the year before, transferred from a primary model, where a mother could ring up and make an appointment, to what they call a secondary model, where Clare House will only receive referrals from school guidance counsellors, GPs or some other clinician. Therefore their capacity for early intervention has been eroded. I am hoping that with the doubling of the staff—mind you, that is not all at once; it is over three to five years—maybe they will have enough staff to be able to actually handle a primary intake service so that mum and dad can ring up and make a booking. They used to have waiting lists of 100. I do not know what they are like now, but it was only about a year and a half ago that they made that change.

Senator TROETH—Does your organisation have a view on the project based funding that has applied to some services here?

Ms Bevan—A strong view.

Senator TROETH—Can we hear what it is?

Ms Bevan—I suppose it is because of the way the National Mental Health Strategy money is divvied up amongst the states. All over Australia, if you want to run a new service—bearing in mind the state governments will not be funding it as part of their state mental health funding—a new program or a new project for an ongoing need, you have to go and apply to National Mental Health Strategy funding or whatever.

Usually these funding proposals are for one year or a maximum of three years, and after that time the program is supposed to be self-funding. It astounds me—where are we going to get this money from? These people are not going to be paying-clients. How are we going to make services for children self-funding? Basically, you have a project notion of funding. Projects and programs are funded as one-off pilots and you throw in your evaluation, but there is no promise of any ongoing funding. The need has not gone away. The needs are probably increasing because of social and economic family breakdown. The money is limited, so you get Auseinet, for instance. Are you familiar with Auseinet?

CHAIR—Yes.

Ms Bevan—They have booklets on all these fantastic programs and pilots, and some of them just make my eyes pop out they are so fantastic, but they stop after a year. I think that is absolutely ridiculous! So the state governments, the politicians, get kudos for running these projects, but the need continues and what happens then? I am afraid that really does bother me.

Mr MacGregor—It is difficult too for staff retention. I worked in Colony 47 as a community services manager for three years and you just get these people worked up and trained and the program running really well and then the funding is pulled, and then these people just drift off—they are out of the state in a flash because someone else is going to pick them up, so you have lost the skills base. That is happening all the time. You cannot retain them. You then put in a lot of time and effort putting in another submission for another little project, you get new people in, quite often new graduates, and you train them up and it is just a cyclical thing. It absorbs a lot of time and resources in an agency like Colony 47.

CHAIR—Could you give the committee a list of those Tasmanian projects and the time frames? That would be useful for us, if it is not too much work for you.

Mr MacGregor—Yes, I can do that.

Senator WEBBER—Indeed, this is not the only place that has complained about that. The evidence we had in the Northern Territory indicated that they felt like they were the land of the pilot project rather than ongoing support. Given the time constraints, I would like to briefly return to the comments you have made about the Privacy Act, not only in your submission but also in the evidence you gave, Ms Bevan. Given the relative smallness and closeness of the Tasmanian community and the role of carers in dealing with adult children who are suffering from some form of mental illness, how do you think we get that balance right in terms of carers needing to know something about what is happening with their adult child if they are going to provide that important role, but also protecting that individual's privacy within a closed community, and sometimes therefore protecting their relationship with their health professional and wanting to keep that separate from their relationship with their parents?

Ms Bevan—I do not see it being as difficult as some people initially see it. A lot of the difficulty is where the clinician will not listen to the family. The family often comes to ARAFMI to get information on how to respond to challenging behaviours. We can give that. If the family member just tells us what the behaviours are, you can usually work out what better, more appropriate responses there are—it may not be the best response but it will be a better way—and list them as options. It is the clinician listening to the family and not using the privacy and confidentiality as a barrier to listening. If the clinician does not listen to us, they are going to miss out on an awful lot of clinical history that may be absolutely crucial for diagnostic purposes. Things like watching the side effects of medication, how the medication is working, how long it is taking to kick in and maybe keeping a medication diary—there is an awful lot of information that family members can offer if they are questioned appropriately.

In regard to clinicians giving information to the family, if the person is living at home and receiving medication, and in particular antipsychotic or mood-stabilising medication, those medications often have some pretty nasty side effects, so if the person is living at home with whoever—and it might be a wife or a husband—it is wise, let's face it, for the support person to be familiar with the nasty side effects. Their quick response might save a life, because there is a certain percentage of people who can die from particular medication side effects. So it is wise that at least that minimal information is provided to the carer, family member, or whoever.

In terms of diagnosis, it is not the diagnosis itself that is the crucial information for a family member to receive; it is how to respond to challenging behaviours. That is where they need the assistance. It does not really matter what the diagnosis is—and often we can work it out anyway.

Senator WEBBER—Can we re-educate clinicians under the existing act or do we need to change the act?

Ms Bevan—I am not familiar with the act in detail. I confess that I have not read it. I have the summary on my wall somewhere.

Senator WEBBER—In terms of your gut feeling, do you think—

Ms Bevan—My gut feeling would be that I think clinicians are scared of being sued for revealing information. But, under duty of care provisions, if a person is living at home and they are mentally ill, there is a minimum of information that needs to be provided—and it will be to do with the name of the medication, the side effects of the medication and the proper dosing regime. Certainly, to enhance the person's wellbeing and their recovery process, it would be very good if the family members were educated in how to respond better to delusional material because to respond appropriately and therapeutically is absolutely counterintuitive as to what to do.

Senator WEBBER—I have a final, leading question. I liked your analogy rather than the one I gave of, say, a husband and wife relationship. You talked about the side effects of medication. I was wondering whether your gut instinct would say that there is a difference in the way clinicians treat family members with respect to the side effects of medication when it comes to mental illness as opposed to, say, the side effects of medication for someone who has a chronic heart condition.

Ms Bevan—Precisely. Why are we so fussed about this? Of course the wife knows that hubby is taking X antihypertensive and knows about the dosing things. There is no problem in getting that information. Why do we have to be so precious about the fact that this person has bipolar? We are restigmatising mental illness by treating it in this manner. We should treat illnesses as illnesses. A mental illness is simply an illness that is affecting the brain, which is just another physical organ of the body—like the heart, the spleen or whatever. By acting in this way in the Privacy Act with confidentiality, clinicians are actually restigmatising mental illness—and that is bad.

CHAIR—Do you wish to add anything to that, Ms Berkery?

Ms Berkery—With respect to privacy, some people really do demand that information is kept private. Everybody at the clinic wants to own the information. If they decide that they do not want to share information, I think they need to have that on the information. I once went to a meeting which was open to the carer and the one who was cared for. That was an opportunity for sharing, and it worked very well. That is not done often enough. They could do that within DPM as well. They could have a forum for the primary carer. That could be done in the public sector as well. It would be very useful. Is it possible for me to talk about Aspire—the new rehab?

CHAIR—We have only a few more minutes. If you could keep it short, that would be fine.

Ms Berkery—I have gone to several meetings with Aspire. They are a mainland firm that is dealing with rehabilitation here in Tasmania. Their building has just been finished. They are moving into a building near the Silos down by the wharf. I have some concerns about how people are referred to Aspire. Evidently, in southern Tasmania, they can have only 36 people going at any one time, and that could be from a couple of months up to three years. The money follows the individual. It is individual funding.

Referral has to be from a psychiatrist—they are not going to accept GP referrals, which will cut out a lot of people—or a case manager. At the moment, they are cutting back particularly on high functioning consumers. I would be in the same boat. I would not be able to have a case manager because they think I talk too much and I read too much. You have to jump through hoops, and people are not yet aware how difficult it is going to be to have access to rehab. Some people are going to need far more support than others. Is there going to be enough money following those people to give them what they need, whether it is ongoing support or housing? Petrol costing as much as it does is going to be an issue for people who are running cars. They are going to need them because we do not know where the rehabs are going to be sited yet—whether they are going to be long distances away.

CHAIR—Thank you very much for your presentations today; they have been very useful.

Proceedings suspended from 12.46 pm to 1.36 pm

JORM, Professor Anthony Francis, Private capacity

CHAIR—Welcome. Thank you for travelling to Hobart from Melbourne today. Do you have any comment to make on the capacity in which you appear?

Prof. Jorm—I am from the ORYGEN Research Centre in the Department of Psychiatry, University of Melbourne. I am appearing on my own behalf.

CHAIR—You have lodged two submissions with the committee—one jointly with Ms Betty Kitchener. We have numbered these submissions 47 and 178. Do you wish to make any amendments or additions?

Prof. Jorm—No.

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

Prof. Jorm—I have outlined the main points in the written submissions, but I want to give a broad overview to give a context to my submissions. What I want to focus on is the various levels of intervention that we have for mental disorders. Basically, there are three levels. We can intervene at the very early stage and at the milder stage in the community. I am thinking here of activities like prevention, early intervention, self-help and first aid. We can intervene at the primary care level, which is mainly funded by Medicare in Australia, or at the specialist mental health services level, which is mainly funded by state health services.

I am sure you have heard a lot about the problems, particularly with the specialist care sector, and maybe with the primary care sector as well. I want to concentrate my comments on the first level of intervention—that is, the general community. When we look at what are the major health problems in Australia, No. 1 is heart disease, No. 2 is cancer, No. 3 is mental disorders. I think we can learn a lot about intervention in the community from looking at the big two—heart disease and cancer. If we asked a typical person about various things they can do to prevent heart disease and cancer—prevent them in their children, to intervene early, to do first aid—people know quite a lot. But if we ask the same things about mental disorders, people do not have the same degree of knowledge. I do not believe there is any technical reason why we cannot have exactly the same approach.

I would like to give you some examples of the sort of things I think need to be disseminated better in the community. There are some things that need to be universally known—that is, every member of the community needs to have some basic knowledge of these. For example, in the cancer area, we have messages like ‘slip, slop, slap’. You prevent skin cancer by these three actions—‘slip, slop, slap’. It is very simple. Why can’t we do the same sort of thing with risks for depression? I believe we can. I believe it would be possible to have messages about prevention of, say, depression that the whole of the community could know about.

An example would be this: there is a lot of research showing that, if children grow up in an environment where there is a lot of conflict in the home from the parents, they are at greater risk of developing anxiety disorders and depressive disorders when they grow up. The critical thing seems to be that the children are involved in or witness the conflict. If all parents knew not to involve the children in arguments, not to argue in front of the children and not to involve them—it is a very simple thing—they could then take the personal action that is going to reduce risk. That is a preventive action.

Secondly, there are self-help actions. People develop disabling states of psychological distress or minor mental health problems all the time—they cannot function well at work, they have problems within their families—but most of those problems get better spontaneously or through the self-help actions that people take to try to cut them short. Sometimes they go on and become problems for the health system. Some of the self-help things people do are very good and probably work and some of them are silly—things like using substances, using alcohol heavily. I think we could give people universal messages about self-help things that are useful. For example, there is a lot of evidence that physical activity, exercise, is good for depression and anxiety. So we could give everybody the simple message that physical activity is good for your mood.

Thirdly, I think everybody should know about first aid, because all of us are going to have contact with other people who suffer from mental disorders. We just need the one-in-five message to know that all the people in this room will have that contact every day. There are some basic things that we should all know. A lot of research shows that if people with mental disorders are criticised by those close to them, that tends to give them a worse outcome. Unfortunately, it is a very natural thing for all of us when we do not like the way people behave to try to change their behaviour by criticising them. We naturally fall into it, but it is a destructive thing to do and it is a self-defeating way to try to change people's behaviour. So a very simple message that everybody in the community should know is that criticism only makes it worse. So they are just three examples. I have given you a preventive message, a self-help message and a first aid message that could be known universally. I do not see any technical reason why we cannot identify those messages and promote them across the community.

The next thing is that there are some people in the community who need to know more. There are people who have a greater probability of contact with people with mental disorders. I am thinking of people in human services occupations such as teachers, the police, people who work for employment agencies and people who work in welfare housing. There is a long list of them. They have a greater probability of contact, and they need a greater degree of knowledge. For those people, training programs like mental health first aid, which was the subject of one of my submissions, are the sorts of things that we need. I think we need to get to the stage where with some professions—for example, I think teaching would be a prime one—we need to say: 'A mental health first aid certificate is required for you to work in your profession. You need this degree of knowledge more than the rest of the community. It is not learning a level of knowledge that makes you a mental health professional; it is just basic first aid skills, the very simple things that you can do.' So that is the second level of knowledge. We have the universal, simple things that everybody should know—the 'slip, slop, slap' sort for mental disorders—and the more involved messages that are necessary for human services workers.

Lastly, the most detailed messages are needed for consumers and carers. Again, we can learn a lot from areas of physical ill health which are just so far ahead of us—for example, in areas like diabetes, heart disease and asthma. If you develop one of these disorders, it is recognised that it is chronic. For example, if you develop diabetes you have a chronic disorder and your GP is not going to manage that disorder, you are—and your family. Because you are the one who is going to have to live with it all the time, you have to be equipped with the skills to manage that disorder. People in that area do what is called patient self-management education. If you develop diabetes in Australia, you will commonly get referred to a diabetes educator. The educator will show you how to use insulin if you have to use insulin. If you do not have to use insulin, they will educate you about your lifestyle—about the need for exercise, what you have to do about your diet, what you family needs to be told, how to manage your medication, how to respond to emergencies and so on. There is no reason at all that we cannot extend that sort of approach to people with mental disorders. Although these are not generally chronic disorders, they are frequently relapsing—in other words, people recover but they are at risk of experiencing a further episode later in life.

I think we need this patient self-management approach to be done with everybody when they first develop the disorder. When somebody has their first identified episode of depression, anxiety disorder or whatever and the GP detects this and is treating it, the GP should refer the person, often a young person—and their family, if necessary—to a depression educator who can say: ‘You will recover from this, but you have an increased risk and we have to help you to manage this. You have to learn what you can do to reduce your risk of having a relapse and, if you feel you are having a relapse, you have to learn what sort of action you or your family can take to try to cut it short.’ What I am advocating is greater activity at the community knowledge level—both intensive universal knowledge for human services workers and more intensive knowledge for consumers and carers.

The problem with all of this, and I think some of the witnesses before raised this, is how you fund it. There are a lot of demonstration projects. They get funded and people say: ‘Been there; done that. Yeah, we’ve done prevention in schools.’ How do you keep it going long term? I have a suggestion. People who suffer from mental disorders are major contributors to one area of tax—that is, the tax on substances. Looking, for example, at tobacco use, something like 70 per cent—I am giving you approximate figures here; I am not carrying them in my head—of people with schizophrenia smoke, compared to about 20 per cent of adults in the general population. For people with anxiety disorders and depression, it is something like double the rate of the general population. So those people contribute a lot of tax money through their smoking. It is similar with alcohol misuse. Looking at the heavy end of alcohol use, and alcohol is heavily taxed, people with mental disorders are major contributors.

We tax that money and we do use some of it for health. We use it to promote health in areas like cancer and heart disease. Some of the organisations that do this, like VicHealth in Victoria and Healthpact in the ACT, will say, ‘Oh yes, we do mental health promotion.’ I disagree. What they do, in my opinion, is wellbeing promotion. I think this is a worthwhile activity, but it is not the same thing. They are promoting human happiness and wellbeing and life satisfaction—the positive end. They are not helping people at the disabled end, and mental disorders are the major drivers of substance misuse in Australia.

I think what we need is a redirection of this tax money on substances to help the people that are overrepresented in terms of generating that misuse and are taxed accordingly. I think that would be a sustainable way of funding those activities. What we should not do is look to state health budgets to do it, because, as you have heard, state health budgets are so stretched dealing with the people who have the more severe disorders. Who would want to take away resources from that? We have to look at bringing in new sources of funding. That is my overarching opening statement.

CHAIR—That is very refreshing at this point. I think it is fair to say we have been looking for some straightforward suggestions on prevention and early intervention. Thank you for that.

Prof. Jorm—I think it is very simple. There is no technical reason why, if we said in Australia we want to do what I have put forward, in 10 years we could not do it. There is no reason at all why not. We have the knowledge to do it.

CHAIR—Does any other country do it well?

Prof. Jorm—No. But Australia has led the way in a lot of things. I think beyondblue has been a marvellous thing. I have been involved in evaluating that, and it has definitely had a demonstrable effect. What it has done is raised awareness and general knowledge. Now we need to go to the next level and say, ‘Okay, people are aware this is a big health issue and something’s got to be done.’ These specific messages about prevention, self-help and first aid are the next step, and I think, just as we have done with beyondblue, we could do it.

CHAIR—Do the programs that address diabetes, heart disease and so forth show us that this needs to be ongoing or would you have a massive campaign and then revitalise it 10 years later? What is the formula?

Prof. Jorm—I think for the whole-of-community messages it is ongoing. I think you can then add new messages. It is not very hard to increase people’s knowledge. We do that as a society all the time. What is harder is to change people’s behaviour. You can give them the knowledge. Then you have to get them to translate that into behaviour. Tobacco control, for example, has been going on for decades now but we are still driving usage lower and lower. I think mental disorders are probably the factor that we have to deal with next because they are the big driver of what is remaining. I do not think that will stop. With things like patient self-management education, we could get people at first onset and give them that knowledge so they and their families could better manage these disorders. That could be a one-off intervention that might then have a lasting effect.

CHAIR—You promote the idea of mental illness first aid. We have had submissions from groups that have suggested that hairdressers, for instance, and almost anyone who has regular contact with people can play an important role and that the more they know—not that they diagnose—the better able they are to assist people. Would you stop anywhere? Are there those that you think should not dabble in this business of mental health first aid?

Prof. Jorm—No, I think if we get into the notion that there are professionals who have the expertise and that only they should know and the whole of the community should not, then I think we will never solve it. The number of people affected by mental disorders—I do not have to quote the figures; you know them—at least by the common disorders is very large. There is no way that specialist mental health services will ever cope with those. Specialist mental health services will manage at best to cope with the severe psychotic disorders and comorbid disorders.

We have to share the responsibility and the skills across the whole of community to cope with that.

CHAIR—What about specialisation? Earlier this morning we heard from the HSU—and I think you were present—the idea that those who work in the sector are underprepared, particularly when they come out of undergraduate training, for the level of specialisation needed. Do you agree with that? Is that your experience too?

Prof. Jorm—I guess in their submission they were talking more about people who work in the specialist mental health sector. There certainly is a growing crisis with people wanting to work and train to work in that sector and with retaining staff. But I think there is an even greater need in general community for just very basic skills. People who are working, for example, with the Family Court deal with people in marriage or relationship break-up situations which they have been unable to resolve themselves—they can drag on for years in legal proceedings. They are very stressful. There may be bad blood and children may be involved. Those staff have a great probability of coming across people with mental disorders and they are not trained in that area. That is not their job. They could do basic things to assist and detect that and refer people to appropriate help, for example. There are just so many areas where people are not health professionals and that is not their primary role, but their role brings them into greater contact and they need a more basic level of skill than professional health trainee staff get.

CHAIR—Do you say that those people who do not have that training tend to criticise people with mental illness? Are you seeing that in the court system as well? Do judges, without that knowledge—

Prof. Jorm—I do not know whether that is the case. We know from community surveys in Australia that there is a proportion of people who believe that mental disorders are due to personal weakness and it is something that people can personally control. That is not true at all. That belief is declining, but it is still there in a significant number of people. There is quite a lot of research looking at family carers which shows that critical interactions in family carers can produce a worse outcome in the person who is being looked after. Family carers can learn to have more constructive interactions and that can improve outcomes. I think that result can be generalised across the whole community in a basic way.

Senator TROETH—I was interested in your national cohort of instructors who would go out and do wider training. Who would conduct the training for that and who would be trained?

Prof. Jorm—The mental health first aid work was started by Betty Kitchener, my wife, and I as a sideline, basically. It was a community activity. It had nothing to do with our work. It has grown and grown. She was originally the only instructor. Then we moved into training instructors. We work in a partnership model with whatever organisation will sustain it locally. So, for example, in Tasmania the Red Cross run it. I did not hear their evidence, but I think you had them here earlier. In other parts of Australia, Lifeline or Anglicare or area health services run it. We say, ‘You run it on the ground there; we will provide the training and the backup but you do it,’ because we are not in a position to try to run this thing right across Australia. Similarly, in other countries—it has spread to a number of other countries now—we work with local organisations that can sustain it and provide the initial training. We continue to do research on it to improve the course and the evidence base of its content.

Senator TROETH—So the trainers are NGOs, church groups such as Anglicare—

Prof. Jorm—There are basically four groups that the trainers fit into. The first would be NGO groups like Red Cross and Anglicare. The second would be area health services. That has been particularly the case for rural area health services. A number of them have trained their staff in the area. The third would be employers. There are number of, for example, universities and government departments who have trainers to run the course for their staff. The fourth would be people who do it as private practitioners on a fee-for-service basis.

Senator TROETH—How did you estimate the cost of $400,000 to do the first group of 100 trainers? Is that on the training provided?

Prof. Jorm—The whole thing is sustained currently on train-the-instructor, which is a week of training. But it requires the person to have a lot of background knowledge and good communication and teaching skills to start with. They pay $2,700 for that and they get a kit and back-up with it. The other cost was made up of their travel and accommodation and so on. It was a ballpark estimate.

Senator TROETH—Once that initial group has been trained, do you see any priority list for who they would train? With your experience, what do you regard as the most important place to start—for example, with schools, with mental health professionals?

Prof. Jorm—We have consistently found the greatest demand is in rural areas. That has been consistent in every state. In fact, there has been a bigger penetration in rural areas than in capital cities, which is the opposite of what you normally get. I think that is because of a lack of services in the area, so there may be a greater community concern to look after each other in those areas. One of the reasons we are going is that the fertiliser company Incitec Pivot donated some money for scholarships in rural areas. Once it gets out and the area health services and the NGOs see it, it sort of gets going. You have just got to get it primed and then people see the need and it will continue. Ultimately, if we could get certification—and we are trying to develop national mental health first aid standards to be the basis for certification—required for training in certain professions, I think it would definitely be self-sustaining. There would be no turning back at that point.

Senator TROETH—And you are also looking at developing a youth mental health first—

Prof. Jorm—We are working with the Department of Education and Children’s Services in South Australia. They made the approach to us. They see teachers as having a duty of care for health problems in their students. For example, if a student suffers from asthma, the teacher has to know what to do in that circumstance. The department see mental health problems and mental disorders in the same light. So we are working with them, and we have got a grant application in. We will see how it goes but, if it goes well, we will work with them to develop a version for adolescents that will run in South Australian schools. The big thing they have done and the big difficulty is actually getting teachers to get time out of their classes to do it. They have said they will do that because they really want to. We said, ‘Great, we want to work with you and do it and, if we can get the funding, we’ll go ahead.’ Then we hope that, if it goes well in South Australia, it will spread to the other states and territories.

Senator MOORE—I am interested in the third part. I totally agree with you on parts 1 and 2. For the third bit, where you have that more intensive support for people who identify and their families, who do you perceive as providing that support? In terms of your model, where would that go—back to the public health system?

Prof. Jorm—I think it would be better linked to primary care. It could be something linked to the Better Outcomes in Mental Health Care approach. I think it would be feasible to have, for example, depression educators who are attached to divisions of general practice. If the GP recognises somebody as having a depressive disorder or an anxiety disorder—one of the common disorders—they could refer the person to the depression educator who could run it in, say, a class type setting and do individual consultations as necessary.

It is interesting: we did a national survey of community mental health literacy recently. In that survey we gave people descriptions of different mental disorders like depression and early schizophrenia, and then we asked them whether they thought different professions would be helpful: ‘Would it be helpful for this person to see a GP, a psychologist’ and so on. One that we asked them about was ‘health educator’. Health educator came out to be pretty well No. 1. That is really interesting, because they do not exist! Mental health educators of that sort do not exist, but the public believe in them: they are well ahead of psychiatrists and psychologists and even better than GPs. This is a profession just waiting to be developed. There is a demand for them.

Senator MOORE—It is a bit like the tooth fairy, though, with the same kind of belief mechanism.

Prof. Jorm—But it helps, because often we are putting forward things that people do not believe in and it is an uphill battle. They want it, so the concept is there. Part of the reason that mental health first aid went is that there was a cultural niche there. We have this concept of first aid—something that has been around for a century in Australia—and you say, ‘We’ll just extend this to mental disorders,’ and people get that. We have this notion of diabetes educators and health educators. We have just got to extend it sideways and it will fit in. It is not something totally foreign that we are trying to impose.

Senator MOORE—So there is a kind of familiarity, a comfort zone, with it.

Prof. Jorm—There is a familiarity there, yes. It is a role we understand.

Senator MOORE—In the recent inquiry on the issue of cancer in Australia there was a lot of support for the concept of practice nurses with particular knowledge in this area who would take on this kind of immediate role with families and patients. People get caught up in the whole system. They have all the specialists that they go and see, but the person that they have the most trust in and the one that families spoke about turning to when they wanted to know what to do were these nurses who, in some states, are available. They are usually funded by the Cancer Council. Is that the kind of model?

Prof. Jorm—Yes. I think nurses would be a suitable group to do that. For example, diabetes education is an area that nurses have moved into as a more specialist area. I gave you the model of working in primary care, but it could certainly work with various state peak bodies or NGOs—some of which you heard evidence from this morning—that could host mental health educators of that sort for patient self-management education. But I think it is important that you try and do it in a context that is non-stigmatised. That is the advantage of linking it to general practice. There is still stigma around. You say, ‘Go along and see this person who works for the Mental Health Council,’ and they say, ‘Hang on.’ If it is just somebody in the general practice, that may be much more acceptable. I see that as a more likely model to be accepted by the public.

Senator MOORE—I have one question on the submission you put it on research. One of the things we have heard is that there is little research done on the issue of mental health in Australia, that in comparison to other forms of illness or need it is underfunded. That seems to be the message in your paper. Do you have any idea about what is needed in terms of research? Is it through more grants or more acknowledgement for the NHMRC? What is needed? Your paper did not actually say, ‘We need this and this.’

Prof. Jorm—You need more resources but the thing is to not get the resources sidetracked into something else. I have been involved in a lot of NHMRC things and it does a lot of great stuff but I fear that a lot of it would get sidetracked into a type of research that may not be what the community most wants. I have also worked with the Australian Rotary Health Research Fund on their scientific committee. I am not a Rotarian; I am just a helper, as it were. I really admire their work. It is a very lean approach. It is philanthropic money. It is peer reviewed. It has consumer input into the evaluation of the grants. It is very practical research. I think the best bet for governments wanting to put in more—and I argued this in my submission—is to give it to Rotary on a matching basis. They will get more community support for it and they will run it at a fraction of the cost of a government organisation. I think they will have more community response and support for that sort of research.

The other thing is that in Australia we have no philanthropic organisation supporting research at a national level. There are a number of small ones that are connected with particular research bodies at a state or territory level but Rotary is the only one that is really doing that at a national level and on a large scale. But Rotary is not permanently committed to mental health as an area. They started off with cot death and then they moved their topic. Now they are on mental illness. They have stuck at that for a while because we are all saying: ‘You’re wonderful, Rotary. We love it.’ They are getting a lot of kudos from the community and a lot of their members are interested in it. My hope is they will stay for good. That is the best thing we could do to get a further injection of funds—to get the Rotary Health Research Fund to stay for good in that area. The best thing would be if could give them some public funds as well on a matching basis.

Senator WEBBER—I want to return to the issue of the whole public awareness campaign. I am sorry I walked in when you were discussing that.

Prof. Jorm—Do you want me to repeat it all?

Senator WEBBER—No, that is all right. You can just repeat the bits I missed after I have asked the question. You were referring to some of the advertising and education campaigns that we have to increase awareness. One thing I would appreciate your comments on is how you would envisage a mental health campaign and whether it needs to be ongoing. In comparison, we do ongoing tobacco health campaigns and what have you. We also had that very high profile AIDS campaign that we then discontinued. In recent times we have had an increasing incidence of AIDS again in our communities. How do we match the high profile, big bang, sudden burst campaigns bringing everybody up to speed in terms of awareness versus ongoing campaigns?

Prof. Jorm—I think the thing with AIDS was that it was a new disease. There was a perception of crisis and that something had to be done. There was that big bang at the beginning. But there has been ongoing work on it. When you compare Australia to a lot of countries in the world, we have done really well. It is a great Australian success story when you look at the problem in a lot of countries. It really has been contained. I think it is the same for mental disorders. I do not think we can do a one-off in that area. I am absolutely delighted that beyondblue got refunded, because there is evidence that they actually did have an effect. If you look back at the effect we found over an eight-year period, which we could attribute partly to beyondblue, and we just project that ahead for decades, we will get some really major gains in public health terms. But it does require that. There are other groups doing it. It is not only them. It is the Rotary Health Research Fund with their community forums; SANE, with their StigmaWatch; MindMatters in schools. Where I work, at ORYGEN, there was a Compass project, which is now finished, getting greater awareness for early help-seeking in young people in western Melbourne and Geelong. They are all great projects. It is just a matter of sustaining all of this activity. That is where I think the substance use tax money could be put to very good use. People with mental disorders are big contributors to that.

Senator WEBBER—Indeed. Following on from that, when you talk about this new category of people that we have a lot of confidence in but we do not yet have—the health educators—you talk about your mental health first aid. I come from Western Australia. Service delivery in Perth is a bit of a challenge, but it is an even bigger challenge the further north you go. I was wondering, in terms of not only the training you provide for mental health first aid but also in the ongoing support for these health educators or people who have done that course, about the appropriateness and what kinds of modifications would need to be made for those very isolated communities and also Indigenous communities.

Prof. Jorm—Absolutely. Mental health first aid is not an approach that we think can be applied just as it is 100 per cent over all communities. It does need some local adaptation, and we encourage that. For example, we have been working with the Centre for Rural and Remote Mental Health in Orange—they do mental health first aid—to develop a rural version for farmers. Most of that will be the same—90 per cent of the content will be the same—but there are particular rural issues and rural resources that have to come out. They will train people like rural financial counsellors. We are working on an Indigenous version. There are three Aboriginal mental health first aid instructors currently. We are developing that with Commonwealth funding. It has been a very slow process, but that is our aim—that we will train a cohort of Indigenous mental health first aid workers who will have adapted material suitable for Indigenous people.

We also work for culturally and linguistically diverse Australians. We have a Vietnamese Australian version and Croatian and Italian ones, and we could do others. For example, in the western part of Melbourne where I work, around Footscray, there is a big Vietnamese community. There are two instructors who run mental health first aid there. It has been translated into Vietnamese and culturally adapted for Vietnamese Australians. They have been training the Catholic and Buddhist clergy because they say that, in their culture, they are often the first point of contact for people, but they do not have the knowledge. It has been very successful. So we could do lots of adaptation for particular occupational groups, language groups and cultural groups. I think that is absolutely appropriate.

Senator WEBBER—I want to ask about the work you are doing with the Indigenous people and the funding you have got for that. I appreciate that almost every achievement we are making in the area of Indigenous health seems to take a lot longer than it does for other groups for a variety of reasons—not cultural reasons; some of it is the isolation. I do not know what it is like in other states but, in Western Australia, the important person there is the Aboriginal health worker. Has any thought been given to making sure that there is the capacity for them to do your mental health first aid?

Prof. Jorm—That is absolutely the aim. When I say that we have funding, what we have funding for is the cultural adaptation of the manual. We do not have any funding—but we certainly have the will, and we will do it—for cultural adaptation of the training. We have trained three instructors in the mainstream course. One of them I know, in Victoria, in Gippsland, has adapted it for Aboriginal people in his community. Aboriginal peoples are very diverse across Australia, so there may not be a single adaptation. We recognise that. Also, one of the people who works in our group, Len Kanowski, has trained the Aboriginal mental health workers at the Djirruwang Centre at Charles Sturt University in mental health first aid as part of their training. We see them as a network. Potentially, if we could train them up as instructors, they could run it in their own communities and spread it that way. It is all about improving community capacity to respond to these situations, not something imposed. It is saying: we will try and give you the skills and you try and manage it.

CHAIR—Professor Jorm, can I ask you about the preventative message you would want to send, particularly to young people? The committee has heard conflicting advice about the effects of cannabis, heroin and other illicit drugs and their causative effect on mental illness. In your programs to advise people on how to avoid mental illness—for example, ‘Don’t argue in front of the kids’—would you also include this area, or is this an area of the unknown?

Prof. Jorm—I am not an expert on cannabis, but my view from what I have read is that there is sufficient evidence now that you would have to say to people, ‘Cannabis use is increasing your risk of serious mental disorders’—like psychotic disorders. People should be advised of that in a public health message. It is at the stage that it is not ironclad, but you get to a stage where you say, ‘This is potentially serious. We’ve got to take action even if it’s not ironclad.’ There were many years when the link between tobacco and lung cancer was not ironclad either, but you reach a point where you ask: ‘When are we going to do it? Do we wait, or is it too serious to wait?’ And I think it is too serious to wait.

CHAIR—Thank you for coming to Hobart for us and thank you for your submission. It has been very useful.

[2.19 pm]

GRAHAM, Associate Professor Des, State Manager, Mental Health Services, Tasmanian Department of Health and Human Services

MUSKETT, Mrs Coral, State Director of Nursing, Mental Health Services, Tasmanian Department of Health and Human Services

CHAIR—Welcome. The Tasmanian government has made a submission to the inquiry, which we have numbered 502. Do you wish to make any amendments or additions to that document at this stage?

Prof. Graham—No.

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

Prof. Graham—I would like to open by saying that I am a relatively new Tasmanian—

Senator MOORE—How long have you been here, Professor Graham?

Prof. Graham—Since the end of October.

Senator MOORE—We are doing a bit of a test around the country. So you have been here about four months or five months?

Prof. Graham—Yes, that's right.

Senator WEBBER—The standard has been three months.

Prof. Graham—Is that right? I will draw on my experience, however, because I have held state-director type positions in South Australia and the ACT, and regional director positions in New South Wales.

On behalf of the Tasmanian government, I appreciate the opportunity to make a contribution to this inquiry. As I anticipate that the inquiry will ask questions more generally applicable to mental health services across Australia, I would like to make only passing comments in relation to the national situation and take the opportunity to talk more specifically in relation to Tasmania's mental health programs.

Regardless of the current deficits or challenges facing mental health services nationally, I would like to acknowledge the work of those individuals who have placed mental health services on the political, government or community agendas. If nothing else, the National Mental Health

Strategy has gone a long way to ensure that much debate has resulted in the mental health arena. The detailed discussion of and inquiries into models of care, approaches to service delivery, partnerships, consumer and carer participation, priorities for service delivery, funding and other related factors associated with quality mental health service delivery are all topics largely associated with the development of the national strategy.

The strategy itself, however, is of course a result of the recognition of the need to address the quality and quantity of services for the significant number of people with a mental illness and those who care for them. Tasmania is fortunate that it has a government, a health department, a community and a broad range of other stakeholders who want to see mental health services improved. This commitment has culminated in an additional $47 million invested through an initiative known as Bridging the Gap and in the drafting of a new strategic plan for mental health services to be launched on 9 February 2006. This plan introduces a new model of care which enhances existing programs and is built on the principles of: single-point accountability; customer focused partnerships; comprehensive service provision, integrated and standardised models of service, mainstreamed programs, least restrictive care, evidence based practice and outcome measures, population based planning and service delivery, early intervention and assertive case management, and a skilled and supported multidisciplinary work force.

Tasmania’s new mental health programs will have a vision of partners in recovery. The strategic plan has been developed in close collaboration with consumers and carers, the non-government organisations, and staff of mental health services, with input from wider stakeholders, including medical fraternities and the department of health, and other related government agencies. It focuses on six strategies, including: a model of care, participation in partnerships, governance and leadership, work force development, quality and safety, and sustainable resources.

A Tasmanian model of care is important because of the unique characteristics of Tasmania. In particular, Tasmania has a low population base but is highly decentralised. Tasmania, for example, has a population density of some seven people per square kilometre, compared to 13 in Canada and some 70 in Ireland. Tasmania has 38 per cent of its population living in a capital city, compared with the next most decentralised state, Queensland, which has 52, and Victoria, which has 73.

Bridging the Gap is facilitating the development of a non-government sector which will be an important partner in mental health service delivery. The non-government sector has grown in Tasmania from three per cent of its total expenditure in 1992-93 to 5.2 per cent in 2002-03. It is anticipated that, under Bridging the Gap, the non-government sector expenditure will continue to grow. Mental health services will focus on the development of effective partnerships with a wide range of other agencies that also deliver services to consumers and carers, including welfare, housing, employment, support services and so on.

I am confident that the Tasmanian strategic plan articulates the most effective and efficient model of care to best meet the needs of people with mental illness and their carers in Tasmania with the available resources. I am also confident that Tasmania has closely listened to the discussions and observed the trends in service development and reforms at state, territory and Commonwealth level, and that we have positioned Tasmania not only to progress those trends but also, in some cases, hopefully, to showcase our achievements.

Some of these trends include: greater focus on early intervention, in the form of treatment, rehabilitation and support for people during the course of mental illness; greater community literacy and the need to continue to decrease stigma and discrimination; the promotion of mental health awareness in the community; and aligning service delivery with agencies and services where collaboration is effective. Comorbidity and the provision of services to young people are two issues where this will be very important. Similarly, it is important to work in partnership and continue to integrate mental health services with other health care providers, particularly primary health care—GPs—so that coordinated services are delivered effectively.

As reflected in our vision, Mental Health Services recognise that they are not able to address the total needs of consumers and carers of mental health in isolation. Partners will be critical, as will the belief that people with mental illness can improve the quality of their lives with appropriate support and treatment. These partnerships will go a long way in addressing our local needs. However, there are critical areas that will require immediate work to commence, particularly work force planning, development, recruitment and supply. The undersupply of mental health workers in the ageing population of this work force has created a critical issue for immediate resolution if mental health services are to avoid either reduction in quality or reduction in quantity of services.

Locally, Tasmania has responded by establishing the Workforce Innovation and Development Unit, opened on Monday. The unit has responsibility for developing a work force development plan, establishing an ongoing calendar for mandatory training, establishing partnerships with vocational training organisations, promoting the effective participation of consumers and carers in those training programs, developing a university partnership to promote entry-level recruitment of graduates and improving mental health curriculum in undergraduate courses. The unit will also explore opportunities for multidisciplinary postgraduate programs in mental health, covering the diversity of the community, and it will collaborate with all work force development initiatives across the Department of Health and other government agencies. The unit will facilitate collaboration. The unit will have a reference group comprising educational institutions, related services in the Department of Health—such as disability, alcohol and drug services—correctional health, the non-government sector and, of course, consumers and carers.

However, a national approach to the critical areas of recruitment, supply, retention, marketing and the development of a mandatory skill base are all matters which are critical. Tasmania’s structural changes are still taking effect, and our new model of care is embryonic at least, but we look forward to the anticipated results of an improved quality of life for consumers and carers, with the available resources and the partners under our new strategic plan.

CHAIR—Thank you very much. This new plan is related to the announcement late last year of the additional $47 million over four years—is that right?

Prof. Graham—It is part of Bridging the Gap, yes. Bridging the Gap was an initiative as a result of a number of inquiries into mental health services in Tasmania. We had some 14 inquiries over an 18-month period. Some inquiries into service delivery were more routine, if you like, but we also had some critical incidents that resulted in a much more in-depth inquiry. That culminated in the development of Bridging the Gap. Following out of Bridging the Gap, there was a need to recruit a state manager, and part of my role is to bring all of those inquiries, recommendations and the investment of $47 million into a logical infrastructure and forward plan, which is the strategic plan.

CHAIR—Are you able to provide the committee with statistics for Tasmania— the number of forensic patients, the number of those in prisons with a mental illness and the number of people in the community receiving treatment in one form or another? Do you have those stats readily available?

Prof. Graham—We have them readily available, and I can provide them to the inquiry. One of the distinctions in Tasmania is that the forensic mental health program is not part of Mental Health Services. It is owned by another part of the health program—complex and support services is the program, I think. Forensic mental health sits in there. I can tell you that our information system in Tasmania is rudimentary at best, and we are providing a significant investment into a new information system. That means that some of our data has some flaws in it, if you like. If we take the national average of three per cent of the population with a serious mental illness, we believe that the specialist mental health programs in Tasmania are currently providing services to between only one and two per cent of the population. There is at least one per cent of the 500,000 people who live in Tasmania—some 5,000 people—who have a serious mental illness and are likely not receiving a service. Some of those service delivery issues are around resources, but some of it is also about having in place an efficient and effective model for service delivery.

CHAIR—As for this new plan to be announced in February—obviously, you will not be able to tell us too much about it—will it have goals and targets and objectives which are measurable and have time frames associated with them? The great criticism of the national mental health plan is that it does not have these. Will your plan have these?

Prof. Graham—I think there are two things there. Firstly, I will comment on the National Mental Health Strategy. Having been the inaugural CEO of the Mental Health Council of Australia, I know that one of the cries in the second national mental health strategy and certainly in the third national mental health strategy is to do with the lack of agreed key performance indicators and outputs for financial investment from the Commonwealth or the state. I think that is something that has got to be addressed so that there is agreement, because at the end of the day if we are going to have a national strategy then it has to be agreed by all the parties. In terms of our local strategic plan, not only do we have KPIs that reflect outcomes; we also have output measures—so what are those measurables that let us know whether in fact we have reached an outcome? But I think we have gone one step further, in that we have made a commitment in our strategic plan to report to the community annually. The plan is for a five-year term, and we will report against our outcomes and our outputs on an annual basis not only to government and parliament but to the community. We will make it readily available.

CHAIR—Will those outputs or KPIs, however you describe them, go to driving change through things like the number of people per capita who are in forensic hospitals—so driving that figure down—or the numbers of people—again sticking with the prison sector—who can be diverted from the criminal justice system? Is it going to be couched in those sorts of terms or not?

Prof. Graham—Certainly in terms of prevalence, we will count numbers. But more importantly, what we want to see is this: we want to demonstrate health outcomes—so this person when they first came into our system presented in this mental state and we want to be able to measure their mental state so that at the end of the day we know that what we are providing has or has not improved their health outcome. There are multiple health outcome measures now. In fact, part of the National Mental Health Strategy is what is readily known as NOC, national outcome classification, which is about all states and territories measuring health outcomes for defined population groups—child and adolescent, adult and the aged—using agreed tools so that we can compare how well our different service models are doing in terms of health outcomes. If you go to some jurisdictions, Queensland, for example, has done a fantastic job in implementing NOC. In Tasmania we have got 26 per cent of it implemented. When you go to comparisons, even though we might have agreed on the tools, the implementation has been staggered so the success of that initiative is wanting. So we will count the prevalence but what we think is more important is around the quality of life for those individuals who come into our service.

CHAIR—What about counting per capita funding across your mental health budget? Will you lift the percentage of the total health budget significantly? Will your per capita spending match other states in the country? Where is Tasmania at? Having said that, I might say that before we started this process I think almost every state announced new funding in that 12 months, which is a very good thing. Where does Tasmania sit?

Prof. Graham—We have got our $47 million investment that came in October 2004. With that investment we are sitting around the national average per capita. But I think it needs to be put in context. There are two issues around resourcing. One is that if you have got 30 per cent of the total disease burden for the health system and you receive 7½ per cent of the funding, then you are always going to struggle—so that is the first bit. As with most other health priority areas—there are cancer, diabetes et cetera—we would always welcome additional resources but what we have got to get better at is using much more efficiently and effectively the resources that we have currently got. For example, we have structural deficits in Tasmania, which are part of the new model of care. It needs to address those. We have replication of assessments. We have discontinuity of care. So within the resources that we have got we know that we can provide better services under a new model of care. We have got to be much more diligent with the funds we have got, but if somebody has got some extra cash we will gladly take that as well.

CHAIR—I will press you on this issue. Is the budget for mental health services within the health services budget going to more closely match the disease burden?

Prof. Graham—I would have to take that on notice.

CHAIR—I know we can do more with what we have got but to what extent is Tasmania going to bring that up to a closer match?

Prof. Graham—Within the resources we have, we need better distribution.

CHAIR—Within health resources overall?

Prof. Graham—That is right. As I mentioned in my opening statement, what we need to do around partnerships is recognise that mental health services will not be able to provide all the services, regardless of the investment of funds that we receive, unless we have partners. We are very poor real estate agents. We do not want to purchase accommodation; we want to ensure that the non-government services are able to provide supported accommodation. Philosophically, as landlords they do a much better job.

CHAIR—Is this not also true for diabetes or surgery? Is it not true for all areas of health?

Prof. Graham—There are two things. I have read some of the submissions calling for additional funds to purchase accommodation and housing et cetera for specialist mental health programs. I would not support that. What we do require is more investment into the non-government sector. At least 25 per cent of Tasmania's investment of $47 million will go into the non-government sector. I think it is a difficult question. The Premier as the Treasurer may have a better spin on whether total expenditure on mental health programs in Tasmania will increase in the forward estimates.

CHAIR—This new plan does not spell that out?

Prof. Graham—The new plan talks about the investment that is currently provided to Tasmania's mental health programs, including the $47 million. It articulates how that $47 million will be spent.

CHAIR—I will stick with funding just for a moment. You said sustainable resources is one of the goals of the new vision. This committee has heard ad infinitum the complaint that funding is almost never sustainable in the sense of being ongoing. Do you recognise that? Are you going to draw away from the short-term project based funding model which, as we heard this morning, is so debilitating for workers and consumers across the board?

Prof. Graham—I absolutely agree. The necessity for the health department, for example, to invest in long-term sustainable partnerships with, for example, the non-government sector, does not come around by 12-month contracts. We need to invest in the non-government sector and give some realism about long-term investment—say, five-year contracts—to ensure that we have within the forward estimates of government sustainable resources so those partnerships are developed. That is the first point.

The second point is that I am not sure that, in the second and third national health strategies, for example, jurisdictions were good at quarantining their funds. In times of disease burden, funds available from different programs were often shared. That is no longer acceptable. We need to quarantine our funds—funds provided to mental health services are mental health services funds—in order to sustain ongoing service delivery.

In project funding it is always very difficult to say no to any project type funds that come. But you need to recognise that often they develop a demand for a service and, if those resources are not continued, then there is a demand without a delivery. We need to become more vigilant about what we use those funds for and argue that if there is a service need then the funds invested in that are recurrent.

CHAIR—Here is a big question for you. Do you believe, as many do, that there has been a breakdown, if you like, between Commonwealth and state governments on mental health issues in terms of a collaborative approach to getting outcomes, which was the aim of the National Mental Health Strategy? Do you agree that something has to be done to break the current impasse in developing cooperative arrangements with regard to funding?

Prof. Graham—As I said in my opening statement, if nothing else the National Mental Health Strategy at least generated that discussion. Without that investment from the Commonwealth there would have been some enhancements, but some of those would have been limited enhancements. Regardless of where we find ourselves now—15 years down the track and in a relationship that is falling apart—we have to acknowledge that the national health strategy at least generated the discussion. In a sense that is why we are here today, because we now recognise that mental health is an important health issue.

The relationship between the Commonwealth and the states absolutely has to improve, but how that occurs is dependent upon the recognition that each jurisdiction has a different population, has different geographical challenges and is at a different place of service development. For example, I talked about the information system earlier. When I was the state wide director for clinical reform in South Australia the second and third plans were being rolled out while we were still implementing the first one. While the larger jurisdictions in particular—New South Wales and Victoria, I guess—were advocating new enhancements and new models of care and building on the platform of the plan, we were still implementing the first one. Those relationships need to take into account where each jurisdiction's development is at.

CHAIR—Can you explain that a little more? Why would South Australia be so far behind?

Prof. Graham—It has different challenges I guess: different political imperatives, different government processes, different recruitment issues, different cultures within the mental health programs, different priorities, different geographical challenges, different cultural beliefs. South Australia has, for example, one of the highest per capita ratios of Indigenous populations and a dispersed population outside of Adelaide. It has about 1.6 million people living in it, and then there are 500,000 people dispersed across the rest of the state. There are all sorts of challenges. There are a lot of variables that influence the implementation or the delivery of mental health programs. So too in Tasmania: 38 per cent of the population lives in Hobart. No other state has 62 per cent of its population living outside of its capital city. Try and deliver services to the north-west. If the government would like to do something, get some information technology put into the north-west of Tasmania. We would very much appreciate it if we could have videoconferencing—I guess that is another point about legislation. For example, some jurisdictions—New South Wales, I think; not to be quoted—allow videoconferencing assessments now under the mental health act. We do not have that here in Tasmania at this point in time, although our act will be reviewed in the immediate future. They are the sorts of impediments or barriers or lack of resources or variables in total that influence where states are in terms of their service delivery patterns.

CHAIR—So targets and timelines are not going to suit every state? You were talking about states being at different levels and having different barriers, is that what you are saying?

Prof. Graham—Yes, that is right. We all have the same principles, and I do not think any of the states or the Commonwealth would argue that we should not be providing services in the community. We should have a community focused, recovery orientated mental health service. Everybody would agree with that; that is a principle. But in terms of some of the targets, it is hard. If someone says, ‘Let’s invest 14 per cent of the funds into the non-government sector’, Victoria might be able to do that, because they are at 12. Tasmania is at 5.2, so for us that is a significant growth to be happening in the non-government sector. So our capacity to meet those targets is minimal.

The better mental health outcomes and the GP uptake, for example, was a great initiative. I was involved in the development of that with the Mental Health Council. It was a great initiative. But one of the most disappointing things in my life is that we trained a relatively large number of GPs in terms of access to the new MBS numbers but, if you dig down and have a look at the data and find how many of those medical officers are actually using those MBS numbers, it is relatively low. So we recognised GPs were the front door to mental health programs: let us train them up; let us give them MBS items et cetera. We did that. Are they using them? Not really, not to the extent that we wanted them to.

CHAIR—And we do not know why. Is that what you are saying?

Prof. Graham—I think we do know why. They are overburdened and, in terms of provision, if you are a rural or regional GP and you have a disproportionate amount in comparison to your metropolitan colleagues—I think Professor Hickie talks about 140 per 100,000 psychiatrists or thereabouts and around five or six per 1,000 in rural areas—then you are overwhelmed. GPs would have triple that. So if you are a GP in a rural setting and you are looking after coughs, colds and sprains, delivering babies and doing a range of other things, mental illness is probably not the sexiest thing that you want to be engaged in. There is also plenty evidence to show that GPs feel that they are undertrained in the provision of expert mental health advice.

In a lot of settings, regardless of the jurisdiction, the available expertise in terms of specialist mental health programs is not available. They are not on site. So I think for GPs taking on case management for people with, for example, schizophrenia, that is okay nine to five on Monday to Friday and nine to twelve on Saturday. But—guess what—most people with acute illnesses tend to come to light after hours: on Friday nights and on Sundays et cetera. If the GP has taken on the case management, they become liable.

Senator TROETH—I want to ask you more specifically about the integration of services as a result of the funding that you have announced in the recommendations of the *Bridging the gap* report. In almost every state we have come across comments that there is a multiplicity of services which are not particularly well integrated. Could you tell us how, in the work you will be doing under the new funding, you will have better integration of services?

Prof. Graham—When I first arrived, I did an assessment and an audit of the current continuum of care, if you like. For example, if you are a 17-year-old who has gone to a rave party, taken a shot of psychostimulants and ended up at the Royal Hobart, you will have an assessment at A & E. You will then potentially be admitted to the psychiatric intensive care unit, so you will have another assessment. You will then be told, ‘You are 17, so you will be referred to the child and adolescent mental health program, where you will have another assessment.’

You might be 17 but 100 kilograms and six foot four so not really, in terms of their scheme, a child, so you will be referred to the adult mental health program. The adult mental health program will do an assessment. They will determine that you need a whole range of provisions. One might be supported accommodation, so you will be referred and some assessment will be undertaken by the nongovernment providers. Unfortunately, if we do not follow you up assertively enough and, as a result, you go to the next rave party, you will go back through the Royal Hobart and the whole thing will happen again.

So part of our program is about providing a comprehensive range of service through one provider. We currently have, for example, a mobile intensive support team, which provides limited but intensive activity for a limited number of people. If you live over 25 minutes beyond Hobart, you do not get that service. So if you live in Launceston, Devonport or the north-west, it is not available to you. So that is a silo. We have a crisis and assessment team which, again, is limited to Hobart and, if you live 25 minutes beyond the CBD, it is not available to you. It also works in isolation from the broader community teams. Psychoeducation is a different silo. Recovery programs are a different silo.

So part of our new model of care is that specialist mental health programs—the psychoeducation, the rehab, the mobile intensive support functions and the assertive case management—will all become one team. You will have a referral come through. The individual who is on triage will make the assessment, refer it to the team, and the person will be allocated a case manager. That case manager will then be responsible for crisis intervention, psychoeducation, rehab et cetera. They will provide some of it themselves and some of it will be provided by regional programs. Talking about efficient and effective use of resources, rather than having one individual provide services to like persons in 10 different sessions it might be that we have a high prevalence disorder such as anxiety—and we know that group therapy for anxiety works well—and we have 10 people sharing their commonalities in terms of their illness, so we have 10 people in one session. That is much more efficient and is provided within that comprehensive service.

So integration by structural reform is one bit. The second bit is around the external stakeholders—for example, the non-government sector. Consistency in agreements, whether it be through memoranda of understanding, policies or protocols, will provide an ease of flow in continuity. Somebody who requires specialist mental health programs but also supported accommodation will not go through a range of assessments with the chance of falling through the gaps—hence bridging the gaps—but move through on a clear and concise continuum of care to the non-government sector. GPs, housing and other health and welfare type services will all have those protocols in place to ensure that we all know who is doing what.

Senator TROETH—So you will be moving more towards a state where a person has a case manager who will be able to draw all of those services together rather than one where a person has to go to those services on an individual basis?

Prof. Graham—That is right.

Senator TROETH—Are you confident that you will have enough case managers to be able to do that?

Prof. Graham—We know that, if we continue down the model that is currently in place in Tasmania, with the increasing number of referrals, we will not be able to address the need; hence the need to become more efficient in the way that we do business. For example—and again I use the high-prevalence disorder of anxiety—an individual with anxiety might be referred to a single community team. There might be 10 case managers providing 10 sessions: cluster 1 session of 10 individuals over 10 weeks and reassess. Using a chronic disease management model, they liaise back to the GP, who then becomes responsible for the ongoing maintenance. We provide the chronic disease education and the person becomes responsible for having the skills to manage their own illness. That will be one approach in the populations in which we can do that.

The other thing is that a lot of services lack the assertive case management that is required. For example, if we want to prevent hospitalisation and the impact on the quality of life of an individual, on occasions we have to assertively provide our services. For example, somebody with schizophrenia, who is paranoid, is unlikely to knock on our door and ask for services. It is the same for somebody who is suicidal. It is going to be a cultural and generational shift in some cases for the workforce to be assertive in the provision of case management. Within the realms of the mental health act, without breaching rights, we will pursue people and say, ‘We are here to provide services for you,’ and do that assertively, so that at the end of the day there is no deterioration in their illness or readmission. Again, it becomes much more timely and effective.

Senator TROETH—You are going to double the number of clinicians in child and adolescent services to, I think, 26 full-time equivalent staff. You would obviously see that as an improvement.

Prof. Graham—Absolutely. ‘Bridging the gap’ is the first round of funding. We will do a business case and seek additional funds as ‘Bridging the gap mark II’, which we will start drafting towards the end of the year. Child and adolescent health is a key focus. We have just about completed a new operational plan for child and adolescent services, with new clinical reference groups that will guide the delivery of services.

If I can just go off the track here for a little bit: child and adolescent services is a key issue in recruiting specialist staff to work in those specialist programs. In my experience, I have never encountered the difficulties that we are having in Tasmania in recruiting staff, particularly experienced and skilled staff in specialist areas, such as child and adolescence. We have funding for positions to which we cannot attract staff. I think that is a national issue. The states, territories and Commonwealth should be able to agree on it because it is a universal problem, not just a Tasmanian one.

Senator WEBBER—Returning to the issue of silo treatment, which you were talking about, you are now going to have a new treatment model, which sounds very encouraging. How will that new treatment model integrate with the other silos for drug and alcohol treatment, disability and all the rest of it so that people do not fall through those gaps, get shunted from one sector to the other and receive three different assessments in those areas as well?

Prof. Graham—Tasmania has interesting approaches to that. One is that drug and alcohol, forensic mental health services, mental health services, disability services and what we call complex care all sit under the same directorate, so we meet fortnightly and we share our experiences. We also have what is called the Board for Exceptional Needs. Where there is an issue in terms of comorbidity or there is a reluctance by a service to say, ‘This person is our customer,’ it is referred to the Board for Exceptional Needs, and the board makes a determination about who will be the primary carer and who will provide additional support or secondary support. That is a relatively straightforward and well-adapted model here in Tasmania and it seems to work efficiently.

Looking at drug and alcohol particularly, that is a bit of the focus nationally. Depending on what evidence you read, somewhere between 50 and 85 per cent of all people with mental illness have a comorbidity illness, or vice versa. There are a couple of things happening here in that area. We are about to appoint two comorbidity positions. Their primary role will be to provide education and training in a partnership or in a joint service delivery between mental health services and drug and alcohol and to provide expert assessment in partnership with those workers. We have got that MOU, if you like. The minister has also recently announced the establishment of an expert task force on comorbidity, which is drugs and mental illness. So there are a number of initiatives here. Again, it is broader than just the government sector, though, because at the end of the day GPs, for example, see a whole range of people that they require assistance with but, as a specialist mental health program, we do not necessarily believe they are our business. So there has to be the development of a relationship to acknowledge them, and we might provide consultation and liaison. Rather than saying, ‘No, that is not our business,’ we will be developing a consultation and liaison service throughout our age programs. We might not necessarily take the referral but we will provide consultation and liaison to support that individual or that service.

Senator WEBBER—It sounds very encouraging. I would like to congratulate you on the government’s recognition of the role of the non-government sector. Not only is it often a more effective and efficient way of delivering services but also I think it has a useful role in helping to fight the stigma within our community, when we have members of our community assisting and delivering some basic services rather than making it all government and therefore medical and pretty scary stuff. So congratulations on that. Could you expand on the role that the government sees that the non-government sector can take on here?

Prof. Graham—There are a number of service provision areas. One is accommodation, so there are providers of accommodation and also providers of support within that accommodation. We have purchased packages of care and the infrastructure for both those areas, under Bridging the Gap. We have also recently purchased rehabilitation—that is, psychosocial rehabilitation to be provided through the non-government sector. Again, it is embryonic and it needs to grow, but it is a start. So they are three key areas, but more to come—for example, psycho-education. We would anticipate under our new model of care that in partnership we would want to provide psycho-education to not only consumers but also to carers—for example: this is what your son/daughter/mother/child’s illness is; this is what schizophrenia is about et cetera. So there is psycho-education. There is direct care in terms of psychosocial rehabilitation—the living skills type of activities, things that allow you to have a good quality of life with your illness. And there is supported accommodation and actual accommodation.

Senator WEBBER—Finally, this is probably a bit more of an apology than anything. I am sorry to have been flippant about the ‘three months’ comment that was made before. It is just that in our travels with this committee we of course meet lots of people and, because governments have now recognised the priority they need to give mental health because it is such as significant challenge in our community, we keep meeting lots of new people in positions that are part of this revamped government look. I am from Western Australia and we currently do not have a director of mental health because Queensland got our predecessor in that role. So my apologies for that.

Prof. Graham—No apologies were needed.

Senator WEBBER—Thank you.

Senator MOORE—Professor Graham, what role does the consumer have in the plans that you have put forward, in your strategic plan? How is the consumer voice heard and then funded—or funded and then heard, I suppose?

Prof. Graham—They can be separate. They can be heard and not funded. Our minister in this state has an independent advisory body of consumers and carers, the Tasmanian Community Advisory Group. Most jurisdictions had them. They were a model developed in the mid eighties under the National Mental Health Strategy, but most of them have dissolved, if you like. But the minister here—I think strategically—has wisely kept the Tasmanian Community Advisory Group. It has both consumers and carers. They are volunteers. They are funded a sitting fee, but they are not employed, so to speak. So I think you can have a voice and not be paid.

In terms of the mental health services specialist programs, after some six months worth of consultation across the state we have drafted a consumer and carer participation plan. It is a dedicated plan for the delivery of services in partnership and the active involvement of consumers and carers in the specialist programs. That will be endorsed, we hope, within the next month, and certainly we anticipate that it will be endorsed before the election. That plan has money that goes with it, and we are working through the implementation.

For example, the plan has four dedicated positions, two consumers and two carers, that will work both in central office and through the area management programs and develop partnerships with consumers and carers but also, we hope, influence the non-government sector in terms of consumer and carer participation. Those four positions will be responsible for overseeing the implementation of the plan, advocating where required and holding Mental Health Services accountable for the implementation of the plan. We have a series of key performance indicators against that which, again, we will report to the community, and we will be happy to be held accountable to that.

I think that is where we start. I do not think that is where we finish, but I think that is the start. Through those four positions we will learn more about what are the best models for consumer and carer participation. Internally, we would anticipate that the consumer and carer participation will occur, for example, within our service agreements with some of our providers. It will occur at a local level, within wards. For example, Ward 1E, which is based at Launceston, now has consumer and carer participation on its management committee, so there is active involvement there.

Senator MOORE—Did that come straight out of the review? Was that a recommendation of the review?

Prof. Graham—No, it was not.

Senator MOORE—That was separate?

Prof. Graham—That was separate, yes. I probably should disclose that I was part of the independent investigation before I took on the job as state manager. Consumer and carer participation on the ward management committee was not part of the recommendations, but the recommendations did say that consumer and carer participation needed to improve. I think the appointment of consumers and carers on the ward management committee was to trial that partnership and, if successful, roll it out across all health services. So we would anticipate that, if we have good reviews from that partnership, all services or all teams will have consumer and carer participation where available. In some areas there are not consumers and carers who want participate as such. So, where they are available, those offers and opportunities will be made.

We also have a state operations committee. There is some conversation at the moment about having consumer and carer participation on that. It will most likely be one or more of the consumers and carers who will be appointed under the specialist mental health programs. But again, their linkages will be back into the community, into the peak organisations—taking the ear, if you like, of consumers and carers in the community and feeding that in.

Senator MOORE—Will the four positions you identified as that start, that key, be appointed by the minister?

Prof. Graham—No, they will be appointed by Mental Health Services.

Senator MOORE—By the department?

Prof. Graham—Yes.

Senator MOORE—So they will be distant, then, from the political process?

Prof. Graham—That is right.

Senator MOORE—They will be more out of the admin process?

Prof. Graham—Yes. TasCAG, however, is a ministerial body.

Senator MOORE—Yes, and that is appointed by the minister. We had evidence this morning from the Mental Health Council of Tasmania. They were talking about the fact that they are very newly formed in this state. Is there a state government funding role for them into the future?

Prof. Graham—Is there state government funding for them?

Senator MOORE—Yes.

Prof. Graham—Yes, absolutely.

Senator MOORE—And that is separate again?

Prof. Graham—That is separate again.

Senator MOORE—The other group we heard evidence from this morning was the MATES program through the Red Cross. They were also talking about their funding process into the future. From which box would a claim for funding for a program such as MATES, which is not clinical, come? Where would their funding stream come from? I still haven't quite got my head around your structure, because every state calls it different things. To me, it is a mental health issue, but where would a claim for funding for them come from?

Prof. Graham—MATES is funded through the specialist mental health program. We recognise that as a service provider that assists mental health services in terms of consumer care outcomes. It is funded through us. Of course, we would also encourage them to seek funding from other—

Senator MOORE—It was clear they were going to, but my question was in terms of the way each state, whilst coming from similar backgrounds, seems to have slightly different titles and also processes. That leads me to my last question, which is to do with the interaction between states. There is the national mental health process, and we now know that COAG is going to have a role and that has been made very public. My question is about sharing knowledge and expertise—allowing for the vulnerability of sharing personnel, which is always a bit difficult—and sharing best practice. How is that working currently? Exactly how do people learn what is working well in Tasmania if they happen to be in North Queensland? I have not really seen much evidence of that on the ground.

Prof. Graham—I think it is limited. There are probably around 20 individuals at state or Commonwealth level where we sort of shift seats. There are about 20 of us—say, state managers, like me, from the other jurisdictions—who get together under the National Mental Health Working Group and share information. At the grassroots level it is probably happening at conferences; it happens a bit through research papers; and through collegiate relationships, where you run into a colleague and for whatever reason you develop a collegiate relationship. But in terms of broad-ranging formal sharing on a regular basis, I do not think we do that well at all.

Senator MOORE—Is it something that could happen?

Prof. Graham—Yes, I think it could. If we go back to the establishment of themes—the mental health service conference—I think that is what that was meant to do. I think that, unfortunately, it has become a bit dated, and in terms of those who attend it is probably a bit repetitive. I think we need other avenues or other venues now to share our information. Probably the Commonwealth could take a lead role here. They are reasonably good at producing Commonwealth type documents under the National Mental Health Strategy—the information strategies, the policy, the statements of rights and responsibilities et cetera—but there is a whole range of other national activities or shared information which the Commonwealth could take responsibility for disseminating.

Senator TROETH—In agriculture, for example, there is a standing committee on agriculture and resource management, which is the officials level, that meets regularly. Is there nothing like that?

Prof. Graham—There is the National Mental Health Working Group, which is a subcommittee of AHMAC. At that, the state directors—people like me—of all the jurisdictions get together. In addition to that, the Mental Health Council of Australia has a seat there; the Australian Mental Health Consumer Network has a seat there; there is a representative from Veterans' Affairs; and there is one other, which I cannot think of.

Senator TROETH—I probably should not ask you, but is that useful for exchange of information?

Prof. Graham—I think it is useful. I think we need to look at the agendas of those, but I would hate to see, whatever COAG or AHMAC decide, that lost. I think the state directors, whatever happens, need to get together to share information. That is particularly the case, for example, here in Tasmania, where we have some dependency on Victoria because we do not have the infrastructure or the population to have all the specialist programs that are required. Most recently, for example, we had a five-year-old boy who was extraordinarily complex. I will not go into the detail, but he required a family assessment in an inpatient unit for over a month. We do not have a specialised, dedicated child mental health program here. The service themselves had difficulty in getting access to the beds in Victoria, so they contacted me. I rang Dr Ruth Vine, director of Victoria's mental health programs, and said, 'Ruth, can you help me here?' She said yes, and within a couple of weeks that was sorted. I think that is important.

Senator MOORE—I have one more question, which was has been stimulated specifically by your last answer. We have had evidence—I do not remember where it came up most—of 'interstatedness'. The kind of thing that you have just described as happening between you and your counterpart in Victoria seems to us to be really sensible. I think it was the Northern Territory or—

Senator TROETH—It was Alice Springs working with Adelaide.

Senator MOORE—That is right. Sometimes, for something that is very small geographically, the complexity of arrangements and extra pressure put on everybody are astounding and quite infuriating. That group that you discussed—

Prof. Graham—The Tasmanian Community Advisory Group?

Senator MOORE—Yes. It seems that place is an agenda item that needs to be looked at seriously. In some states there just does not seem to be any willingness to look at the border as not being important. I am speaking about Port Hedland; I will dob them in because it seemed to be so stupid. In northern Western Australia, a person had to be taken to Perth for treatment instead of across the border to Darwin. There could be similar circumstances, I imagine, between South Australia and the Northern Territory. That seems to be a very important issue that needs to be picked up. Also mentioned specifically were particular treatment orders that were in place in one state and their inability to be transferred across state boundaries.

Prof. Graham—Most jurisdictions are working now on their mental health acts to ensure that cross-border transfers do not dissolve the legal order. In most cases, the importance of a legal order that you are under in Victoria does not change if you go to New South Wales. That is something that most jurisdictions recognise. I have to say that I agree with your comments, though, that sometimes some of the complexities associated with transfers or legal orders et cetera outweigh the need to provide good comprehensive care.

CHAIR—When can we expect to see nationally consistent laws, for instance, on treatment orders and service provision?

Prof. Graham—I was the director of ACT mental health services and I remember that, about eight years ago, the Commonwealth and the states and territories made a significant investment in order to come up with what we call model mental health legislation. I think jurisdictions picked up the need for and the principle that we should have common clauses within acts to allow transfers to occur; but, as for model mental health legislation being consistent across jurisdictions, it just did not happen. The investment for reaching agreement on the principles that underpin those acts by health ministers, Attorneys-General, mental health programs and all the other stakeholders across eight jurisdictions was very difficult and, as a result, it did not happen.

CHAIR—In your view, will it happen?

Prof. Graham—I do not think it will. I think we will get cross-border agreements; they will allow for the transfer and sustaining of legal orders when people cross borders. But as for a consistent model mental health legislation, I do not think that will happen.

CHAIR—Are we talking here about bureaucratic or political barriers? What exactly are the contentious matters?

Prof. Graham—It is probably all of that. Key individuals have different philosophies. For example, another person’s definition of ‘least restrictive care’ might be very different from mine. If we were to put the principle of least restrictive care into an act, how would it be interpreted? It would be interpreted in eight different ways. That would be only one of 500 points for discussion.

CHAIR—We were due to finish at quarter past three but, if it is all right, I would like to keep you here for another 10 minutes.

Prof. Graham—Sure.

CHAIR—We started a little late and there are many other things I would like to raise. Your remaining here for another 10 minutes will give my colleagues an opportunity to ask another question as well. Can I come back to ward 1E? That seems to have been a fairly problematic situation. Did you say that you were on the task force for that?

Prof. Graham—That is right.

CHAIR—Would you like to tell the committee what was the matter with ward 1E?

Prof. Graham—What was the matter with ward 1E? There are two parts to that. Firstly, just so we are clear and I do not come into conflict with myself, as the state director for clinical reform in South Australia I was approached by the Tasmanian government to be involved with the Health Complaints Commissioner to investigate a series of incidents and complaints in ward 1E. That is that bit. Then, when I was appointed as State Manager for Mental Health Services, I was asked to sit on the minister’s task force into addressing the recommendations from that. So I just want to be clear about where I am coming from.

I think mental health services, regardless of where you go, have different cultures, approaches and interpretations of duty of care, and they have different governance structures. Again, regardless of which jurisdiction you are in, there are difficulties in providing governance and leadership to a broad area. For example, I was responsible for the far west mental health service in New South Wales, which made up a third of New South Wales but was responsible for lots of pockets. To have effective governance and leadership there was actually extremely difficult. Ward 1E, I think, had some of the symptoms of a poor governance structure. It had no single point of accountability; it had multiple lines of accountability. In my mind having multiple lines of accountability means that no-one takes on accountability, so no-one becomes responsible. I think that over a period of time there were some cultural issues in ward 1E that were not productive, were not customer focused and were not consumer sensitive, and there were some outdated practices.

CHAIR—Were those hangovers of institutionalised care?

Prof. Graham—Some were. Hospitals themselves are institutions. If you work in a hospital, the chances are that you will be institutionalised, because it will have particular attitudes, values and beliefs. That is why you either like where you work or you do not like where you work. So there was some of that, but that was not all of it. Some of it was to do with, again, the cultural issues, some of it was around staff beliefs, some of it was to do with outdated practices and policies and some of it was idiosyncratic individuals saying, ‘We don’t do it that way, we do it this way, and I am the boss and you will do it this way.’ So a range of issues resulted in poor delivery of care—unacceptable delivery of care—and breaches of professional conduct and other matters.

CHAIR—How many beds did ward 1E have? Presumably there is a general hospital in Hobart that also has an acute ward—how many does that have?

Prof. Graham—Yes. There is. I think we have just under 100 beds across the state. We are in fact a bed-rich state. We have more beds than the national average. In fact, I think we have more beds per capita than any other jurisdiction. Some of that is associated with the fact that the Derwent, which was the large institution here, only closed some four years ago, so we have a very high number of beds. In the acute facilities we have some rehabilitation beds and some of the beds that we call, if you like, step-down beds. But Launceston has 24, I think. Spencer Clinic, which is in the north west, has, currently, 18.

Mrs Muskett—Ward 1E has 20 beds—and four supernumerary beds that they use as high-dependency beds. Spencer Clinic has 19 beds, and they also have five high-dependency beds, which are currently supernumerary. DPM is a 35-bed unit and PICU is an eight-bed unit. Those are our acute unit bed numbers.

CHAIR—In this new reform, is it likely that there will be any limits on the numbers of acute care beds that will be in one place? I noticed that you were talking earlier about mainstreaming care—does this mean there are going to be more beds in acute centres in mainstream hospitals?

Prof. Graham—All our acute beds are mainstream, so they are all in general hospitals, if you like. We have some step-down beds that are provided within specialist programs in isolation from those. We anticipate for that population group we will continue to have those facilities. We certainly are not looking at increasing our bed stock; in fact I think we probably have more beds than we require. But, again, as I mentioned earlier, some of it is about a generational change or a cultural shift. Tasmania has historically had a bed based service so it is going to take some time in order to introduce the reality of what community based mental health programs and assertive case management are. If we do a good job with assertive case management we anticipate we will have too many beds.

CHAIR—Can you tell us a bit about the correctional health and forensic mental health services, in particular the secure mental health unit for which some state legislation has just passed to establish that unit. What reforms does this come about from?

Prof. Graham—I cannot answer those questions, unfortunately, because it is not an area that I am responsible for.

CHAIR—Is this the one that is in a different department?

Prof. Graham—That is right. I think I can say in general that, as for most jurisdictions implementing least-restrictive care, there are people who are found not guilty of a crime by reason of mental impairment who, as a result, need some containment and that Tasmania has the same population with serious mental illness who commit crimes. As a result the development of a secure mental health unit was required. I think historically the forensic mental health principles, which were endorsed by the National Mental Health Working Group pending endorsement by the attorney-general’s departments in various jurisdictions, there was a recognition that we needed to improve the way we delivered services to forensic mental health patients or consumers of forensic mental health services. So this move is in fact state-of-the-art. It is probably the most recent forensic mental health program in Australia.

CHAIR—On page 9 of your submission it says:

> The first action by Government in improving health outcomes for prison inmates was the strategic decision to transfer Correctional Health Services from the Department of Justice to the Department of Health and Human Services in July 2001.

Doesn’t that mean that those services are part of your portfolio?

Prof. Graham—They are not part of mental health services. They are part of the department of health but not mental health services. I am responsible for mental health programs and somebody else is responsible for forensic mental health services.

CHAIR—Is there a problem with that distinction?

Prof. Graham—Not to date.

CHAIR—The committee visited the Thomas Embling forensic hospital in Melbourne and was very impressed with the principles that drove that and the work that was being done there. To your knowledge, does this new secure unit reflect those principles? Was it assisted by the association?

Prof. Graham—All of the above.

CHAIR—So it is indeed world’s best practice. There are no guards beyond the entry; they are all mental health workers.

Prof. Graham—That is right. Again, the point I want to make is that there are issues in terms of work force recruitment. It is a specialty area and it takes a special individual to want to work in a forensic mental health service.

CHAIR—And yet Thomas Embling has no work force issues. People are apparently very satisfied with their work experience in that place, which is very interesting.

Prof. Graham—It is a good program. It is well-known and internationally recognised. The secure mental health unit in Tasmania has not opened its doors yet, so nobody knows it. Taking my hat off as the state manager and talking just as a health professional, when I came across as the independent consultant for the Health Complaints Commissioner my intent was not to come across as the state manager for mental health services. As a mainlander you go: ‘My God. Why would you go to Tasmania with all the problems they’ve got? It’ll be the end of your career.’ The reality is that once you get here and you see the opportunities, the investment and the goodwill by the non-government sector, the partnerships with consumers and carers and the want to improve mental health services, it opens your eyes to a whole new mindset.

What we need to do is market our mental health programs and forensic mental health services on the mainland so that we are attractive. Tasmania’s programs are not well enough known on the mainland. As long as forensic mental health nurses can get jobs at Thomas Embling, why would they come to something that is unknown in Tasmania? If you are a psychiatrist and you can get a job anywhere at the beach on the eastern seaboard, why would you come to Tasmania? But if you go to the north-west, it is beautiful country and the rewards are as generous as anywhere. We pay more here than any other state for our psychiatrists, but we have to compete.

CHAIR—Forgive me for jumping around a bit here; I am just picking up on things that we did not ask you before. It was suggested to us earlier today that the funding of the care packages that was announced—62 packages of care over the next four years—is a fraction of what is needed. How do you arrive at the number of packages? Do you start with the dollars and then decide what that will buy? If this is a four-year program, does that mean there is no opportunity for more care packages for another four years?

Prof. Graham—No, it is an initiative, so it is the commencement of what we hope will be a growing program. Sixty-two packages of care is absolutely right. However, we do not want those 62 packages of care to become stagnant; we want to improve people’s quality of life and see people rotate through those packages of care so it will address more than 62 people. But when you are talking about three per cent—

CHAIR—I am sorry, I do not quite follow that. How does a package deal with more than one person?

Prof. Graham—That is an excellent question, because the belief that people with a mental illness will always have a mental illness and will always be dependent is an historical one. What we want to ensure is that we move people into a recovery program so they are not dependent on mental health services and, at the very most, that we have a partnership with them. So 62 packages of care would mean that person requires some additional support because they cannot live independently and they require a range of other supports in order for them to live for that period of time and have some quality of life. We would hope though, over a period of time—it might be six months or it could be six years—that those individuals, during their recovery and the delivery of rehabilitation and psychosocial skills and living skills et cetera, would move through those packages of care into independent living with follow-up support from community mental health or from their GP or the implementation of a chronic disease management model and that they would be self-sufficient, so to speak. Just like asthma. With asthma you can have exacerbations. If you have an exacerbation, you make sure you take your medication, you see your GP et cetera.

CHAIR—I forget now what the factor of inadequacy was, but it was something like six or four times as much is needed—I do not recall, but it is in that order. So if people are moving through these packages of care, they might be on for six months, 12 months or a longer period of time. You are saying that this will reach a greater number of people over time. But what happens to the other five times 62 people who need them now? Are they not building up to be a greater problem for the mental health system?

Prof. Graham—Again, there is a population that requires those services today that we are not able to provide for. And again, that is about building our infrastructure in order for that to occur. Infrastructure is not just about dollars; it might be the capital works program or it might be the skill sets that are required in order to deliver the care. Having a facility is only part of the solution, or having the funds is only part of the solution. It is a nice part of the solution, but if you do not have the skills then the purpose is what? The second part of *Bridging the gap*—I talked about *Bridging the gap* mark 2 earlier—where we would want to see further investment is into additional supported accommodation packages, and we anticipate that the non-government sector will grow.

CHAIR—One final question: is there any advice you would like to give the committee about possible structural change in either funding mechanisms or the Commonwealth-state relations that might sort out some of the problems we identified a little earlier?

Prof. Graham—Hopefully one of the key outcomes from this inquiry will be a recognition that states and territories and the Commonwealth have got to agree on those key performance indicators. There has to be some flexibility for states and territories for their recognition of where they are at, so to speak. Again Tasmania is a classic example. It was deinstitutionalised pretty much four years ago. New South Wales was deinstitutionalised with the Richmond Fellowship. So the cultural shifts, the structural investments et cetera are significantly more advanced. So to impose sanctions because we have not been able to deliver some programs under the Australian health care agreement, because we did not meet those KPIs that other states have been able to meet—

CHAIR—You need the carrots and not the sticks, is that what you are saying?

Prof. Graham—Yes, that is right, so be nice to us.

CHAIR—Thank you so much for appearing before us today. I wish you luck in your new job, and I look forward to hearing some of the outcomes of your work. That brings to a conclusion today's hearing. I would like to thank you and all of our other witnesses who have given evidence to the committee today.

Committee adjourned at 3.31 pm