



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

SELECT COMMITTEE ON MENTAL HEALTH

(Subcommittee)

Reference: Mental Health

THURSDAY, 4 AUGUST 2005

BRISBANE

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH

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

Senators in attendance: Senators Allison and Humphries

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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Subcommittee met at 9.05 am

CHAIR (Senator Allison)—I declare open the ninth hearing of the Senate Select Committee on Mental Health. A subcommittee has been formed for the purposes of this hearing, owing to the ill health of one of our members. The inquiry was referred to the committee by the Senate on 8 March 2005 for reporting on 6 October 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 giving 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 an in camera session. It is important that witnesses give the committee notice if they intend to ask to give evidence in camera.

[9.06 am]

CONNOR, Ms Helen, Chair, Australian Mental Health Consumer Network

MEAGHER, Ms Janet, Patron, Australian Mental Health Consumer Network

CHAIR—Welcome. You have lodged with the committee a submission, which we have numbered 322. Are there any amendments or additions to that document at this stage?

Ms Connor—Not at this stage.

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

Ms Connor—As we stated in our submission, we believe that it is the responsibility of the Australian government to provide innovation and leadership around mental health in Australia. In particular, we would ask that all governments involve consumers fully in orienting the mental health system towards recovery and, in doing that, make consumer operated and peer run services a mandate. We also ask that you ensure that access to consumer operated programs offering a comprehensive range of services and supports be developed and supported as part of the array of options for mental health consumers. We recommend a minimum of 25 per cent increase in consumer operated programming capacity for each state by 2008.

Services for consumers need to be diverse and there needs to be choice for consumers in those services. There are so many ways that consumers can not only support each other but also take some of the heat off professionally run services. As the mental health work force is ageing and difficulty is being experienced across all the jurisdictions in getting mental health staff, consumers would appear to be the logical choice. However, there needs to be training. I have brought some evidence papers about consumer operated services for you.

The second point that I would like to make is about the overrepresentation of people with mental illness in the criminal justice system. The best Australian estimate asserts that up to eight per cent of males and up to 14 per cent of females in prison have a major mental illness with psychotic features. I will just give you a very small vignette of what was in the paper here last week.

A woman was sentenced to prison because the judge said that there was no other place where she could be safe. She has been banned from two of the major mental health services in Brisbane, has had many suspended sentences and does things like lying on train tracks and whatever. I find it incomprehensible that a public mental health service would ban someone and that the judge would feel that sending someone to prison so that she could get treatment was the only alternative. I will now hand over to Janet, and she will talk on a couple of topics.

Ms Meagher—I want to respectfully remind the committee about the need to protect the human rights of people with mental illness, primarily because they are part of the general community and should come under the UN rights instruments, secondly because they come under rights instruments for people with a disability and thirdly because they come under the

provisions of the human rights convention—I cannot think of the proper name for it—for the care and treatment of people with mental illness. All these provisions in UN documents are pretty basic requirements. However, what we are experiencing over and over again throughout Australia is services and service providers ignoring the requirement that people should be primarily treated with dignity and respect.

Even though we have enshrined rights, documents and standards for mental health services in Australia, the mental health services standards apply only to services offering direct government based services and not to non-government organisations and other organisations providing service. Some of those organisations come under the provisions of the disability service standards and others do not. I would like to see the National Standards for Mental Health Services apply across service provision in Australia for people with mental health problems and that that be made a lawful expectation of service provision.

People's rights are constantly being eroded both through discrimination and by less obvious forms of stigma. That means that people can no longer effectively access appropriate education, advocacy and policy input. People are being sidelined from being able to access basic living criteria in their lives. I think of people like myself who need to travel quite a bit. I cannot legally get travel insurance because of my schizophrenia. For many people, like me, who have and admit to having a mental health problem, the sin is admitting to having a mental health problem and not actually having the mental health problem. The sin is admitting to it. Most people would recommend when you are filling in forms that you just ignore the fact that you have a mental illness. I deliberately do not ignore it because I think it is time some of us spoke out. Most of us do not speak out because the membership of this organisation has too many hurdles if they speak out too openly about things like insurance.

Senator HUMPHRIES—Too many what, sorry?

Ms Meagher—Too many hurdles. If I apply for certain types of positions, I know I will be knocked back. Either I have too many qualifications, not enough qualifications, am not appropriate, too old, too something. The reality is because I will openly say I have a mental illness. The fact that I have not been actively treated for that mental illness for over 20 years, except by myself by just getting medication from a GP and managing myself, is totally irrelevant. Most people I know who are in a recovery phase are very similar, but if they admit to having a mental illness their job prospects plummet. In the context of welfare reform and in the context of rights and discrimination, we are still very actively discriminated against, but the law still does not make provision for taking action against things like vilification. Many people lose their accommodation and their jobs because of vilification.

I want to talk a little bit about research. We have very little input into genuine research programs that would improve the status of services, the effectiveness of services and the relevance of services. We would like to see that consumer focused research programs occur. We would even like to run our own research programs if the appropriate people—and the appropriate funding, of course—were available. There are opportunities, by doing this in a simplistic sort of way through consumer exchange programs, interstate or internationally, where there are important things happening.

I want to make a general comment about reports, reviews, inquiries and so on. I have done quite a bit of research in the past—it is long gone now—on the history of mental health services in this country. There are hundreds of reports written about the state of mental health services in this country. There are thousands upon thousands of recommendations. If you look back even to the 1820s, reports were written then and some of the issues remain the same. Captain Arthur Phillip had problems with overcrowding and lack of places, and he took over the Liverpool court house, for instance. He wrote reports back to England about the drastic state of lunatics in that era.

If we are looking at trying to make a difference through this inquiry, I humbly suggest that we look historically at the failure of the medical model system for bringing about improvements, and we look to a more holistic, community based system. The present system has failed over and over; perhaps it is time to break out of the structures and look elsewhere to some new models. Maybe, with the work force problems that are occurring, we should be looking more and more towards developing consumer models of intervention to run parallel to and in conjunction with health services as they exist today.

CHAIR—Thank you very much.

Ms Connor—Now will be the hard part!

CHAIR—We hope it will not be hard at all. Ms Connor, the first point you make is that you think there should be a mandate for the peer run programs. You put a figure on it of a 25 per cent increase. Do you have any figures, either in Queensland or more broadly, on the current level? It is 25 per cent of what?

Ms Connor—Unfortunately, there are very few—almost none—genuine consumer run programs and organisations running peer run services in Australia. Different states fund NGOs in mental health in various ways. Victoria is much more upfront about funding; other states give a very small proportion. I would like to see an increase in what they currently give to NGOs, but specifically I would like that increase to go to consumer operated services.

I talked about the Australian government having leadership. The US released last Wednesday a document from a coalition of people—from psychiatrists to consumer national organisations—calling on, amongst other things, their federal government to take a leadership role. It is important to me that the Australian government also takes a leadership role in persuading the jurisdictions that there is a need for consumer led organisations and services, ranging from peer support, to alternatives to hospital, to other peer led services.

Peer led services are very powerful. They can initiate an awful lot of change and hope for people. There are economic benefits to government in keeping people out of hospital and keeping people well. As well, somebody will have a much better life than they had before. But, if there is not the continual revolving door going through in-patient units and community mental health, if nothing else, that takes a financial burden away.

CHAIR—I just want to focus on the recommendation, though. For instance, if the committee were to make such a recommendation, we would not be clear what 25 per cent meant. If there is

very little by way of funding for consumer groups at present it does not mean much. So that is really why I was asking you that question.

Ms Connor—There is very little spent. Victoria, New South Wales and Queensland have consumer workers working within mental health services. If that were increased by 25 per cent across the country, it would enable that for the other states that do not have it.

CHAIR—To what extent, in your experience, are consumers involved? I think you have called for involvement at almost every stage of the design of mental health services right through. What is happening in Queensland? Do you get a foot in the door, as it were? Does anyone listen to what you have to say?

Ms Connor—A lot of it is token. A lot of it is about ticking a box. That is shown in the *National mental health report*. The jurisdictions have to account for the consumer participation in it. The Queensland government has disbanded the Queensland consumer advisory group, which was a ministerial advisory group. That ended on 30 June last year. Nothing has been put in its place. The consumer workers in the state meet, although it is only the people in the south-east corner who have the opportunity. There are five part-time consumer workers in Townsville. Obviously, they cannot come down every four to six weeks to meet. I am unclear as to what that consumer workers meeting is about. It is generally about support and getting information, but it is certainly not about advising the Department of Health.

CHAIR—Was there an explanation for the cessation of that group on 30 June?

Ms Connor—Not really.

CHAIR—Would you like us to ask the government about that?

Ms Connor—I would love you to ask the Queensland government about that, yes.

Ms Meagher—In answer to that question, across Australia I think there has been a deterioration in what was a fairly effective consumer and carer voice nationally. The original national community advisory group structure had a sunset clause in its lifespan and it was replaced by the National Consumer and Carer Forum. The survival of that organisation is looking quite fragile. It is regarded as an arm of the Mental Health Council. Its decisions and deliberations go through the Mental Health Council's board. So it does not have an autonomous voice, nor does it get consulted on issues of significance in policy arenas.

CHAIR—Are you members of the Mental Health Council?

Ms Connor—The network is a member and I sit on the board of the Mental Health Council.

Ms Meagher—I am a former chair of the National Consumer and Carer Forum.

Ms Connor—And I am currently the deputy co-chair of the National Consumer and Carer Forum.

Ms Meagher—It is incestuous. I feel that the commitment to consumer and carer participation to date in this country is becoming more and more about rubber-stamping and less and less about true consultation. Most of us do not get input into documents of significance until the last foray of the document. We therefore do not seem to have the ability to influence documents. We feel that we should be the first port of call, particularly as the peak organisation for consumers in this country.

CHAIR—Can I ask you a difficult question. I think it will be difficult to answer; it may or may not be. There is a fairly broad range of views amongst consumer groups about services. I struck this perhaps more in Melbourne than in Sydney yesterday. You have the groups, for instance, who do not want anything to do with families, the groups who are very strongly opposed to involuntary treatment and seclusion, and the groups with different views about emergency departments and the separateness of psychiatric units within them. Do you think this is one of the reasons why the sector can be ignored in the way that you complain of? Do you seek to reach common ground on some issues to present to agencies and governments a consensus view on a range of issues, or is this not a problem?

Ms Connor—We reach a consensus on many major issues. Some people feel more strongly about certain issues like, as you say, forced treatment and emergency department medication. That is their right. They have very valid reasons. In the network we try to take a consensus view. It depends on how much certain things are going to affect consumers. We can speak out quite strongly on those things. We try to have a reasonable view.

Ms Meagher—But there is room for diversity; there is much room in a consumer movement for diversity. Everyone's view is valid, given where they are sourcing their view from. All of us are not experts on everything. I dare say if you spoke to psychiatric nurses or psychiatrists there would be many issues about which they would be disparate in their views. Likewise, in the consumer movement there are many voices that would be disparate on particular issues. I think the government's concern to always speak to a unified voice is a way of devaluing the input of those who have a disparate voice. I think organisations like ours have an opportunity to bring together a communal view on things and, at times, bring forward the fact that there are disparate voices. Those disparate voices have validity. It is wrong to always inexorably seek a consensus view. I think in your own parliament you would find that on many issues a consensus view is lacking, but on major policy issues there would be a public consensus view. It is likewise for us.

Ms Connor—We certainly have debates internally. They are quite strong debates, and I am sure you have them in the Senate privately, over dinner or something.

Ms Meagher—There are issues of contention like ECT, seclusion, forced treatment and so on, that within our organisation there are volatile discussions about. Some of us are totally anti this or anti that and pro this or pro that, but we would come up with a view that would, hopefully, conciliate between the majority of the views.

Senator HUMPHRIES—I would like to start by thanking you for the submission. It is a very comprehensive submission and, despite the fact that it is quite long, it is also very readable. There is no problem in sitting down and reading this, because it is a quite interesting and well-written submission. Thank you in particular for that. Frankly, I wish more people could write like this. It would make it easier to get through all of these submissions.

Ms Connor—There was a lot of 2 am editing.

Senator HUMPHRIES—It does not show, if that is the case. I will start by asking you about nomenclature. We were hectored yesterday by one witness who said that the term ‘consumers’ is quite wrong, that people are not consumers of services. She said that they are survivors more than consumers. You mention in your submission that a variety of terms could be used. Do you have any adverse reaction to the term ‘consumers’?

Ms Meagher—You might have gathered from the very vigorous non-verbal language that we have many reactions. I could forward you a chapter of my book which explains the term ‘consumer’, but I will say, so I can be taken out and shot, that I was one of the people responsible for the term because I am one of the oldest consumer activists in Australia—and I mean oldest in terms of having been active for the longest period of time, and probably the other way too. A group of us who were trying to motivate people way back in the early eighties looked at what was being used internationally and by whom. The term ‘consumer’ was most common in Canada and the US. In their interpretation, in the early eighties, if you are a purchaser of a product you have rights and expectations. We saw ourselves, radically at that time, as purchasers of a product—a psychiatric service. We wanted to have rights and expectations, so the term was chosen because it had the inference of rights and expectations. Other people since have put other connotations on it. The term ‘survivor’ internationally refers, generally speaking, to people who prefer the non-psychiatry view—the anti-psychiatry view.

Most people who are consumers in Australia would regard themselves as having survived, in some way, the psychiatric services but, for the instance of the clarification of the term, I would say that, generally speaking, internationally, survivor is an anti-psychiatry identification. I do not believe it fully has that meaning across Australia. The other term in use internationally, which is creeping in here more commonly, is ‘user’. ‘User’ in Australia has other connotations that they do not understand overseas. I am not a user because I do not exploit people nor do I take illicit substances. So the term was chosen for good and holy reasons, but the reason we exploded when you mentioned it was probably because, whenever there are difficult things to discuss in a consumer meeting, someone will always come up with the statement, ‘I don’t like the term anyway,’ and it distracts everybody. It is the ultimate red herring. So, call us what you will, but in the end we are purchasers of services—with rights.

CHAIR—I think it is fair to say, Senator Humphries, that that was said in the context that there are no services to be had.

Senator HUMPHRIES—That is true. I will use ‘consumers’ and hopefully not get into too much trouble. I want to come to another term that is used, and that is the term you used of ‘recovery’. I am trying to work out why we have such a disparity between the burden of mental health in the community and the amount we are spending on it. There are two major issues with respect to that. One is that many people consider that recovery does not mean cure; it means survival, managing the issue rather than overcoming it and having the disease written off at some stage. The other issue that impacts on the question of attention to it is the difficulty in defining a class of people who will consume the service and ensure that they continue to come back for that service—the cohort of people who use it is defined and clear the way it would be for cancer services, diabetes or whatever. They move in and out, they sometimes do not want services and so forth. Should we be changing the emphasis in dealing with public information about mental

health away from the idea of beating or overcoming mental illness to living with it and managing it—understanding that it is always going to be there but that we have to work out coping strategies?

Ms Connor—I believe that yesterday in Sydney somebody talked to you about the WRAP program.

Senator HUMPHRIES—Yes.

Ms Connor—That is one set of tools that can be used. I am doing some WRAP programs at the moment. When I work with groups of consumers around recovery, I talk about recovery as almost taking back control of your life so that the illness is not controlling your life and the whole focus in your life is not the illness. As a person with mental illness myself, there are a whole lot of other facets to my life. My illness is one of them and, unfortunately, mental health service providers tend to focus on the illness, symptom control and medication compliance. They often do not look at the other part of people's lives. So someone's whole life is focused on the fact that they have illness. If you have diabetes, you do not focus your whole life on your diabetes. It is just part of your life and you learn to control that and to get on with the rest of your life. I think, in a simplistic form, that is what recovery is—being able to enjoy the fullness of your life as you wish. Your recovery, Janet's recovery and Senator Allison's recovery would be very different to mine. It is very much an individual journey. Often now services are starting to grab on to the word 'recovery' and say, 'We're a recovery focused service.' That looks very nice in a brochure. It looks very nice to say, 'We're recovery focused,' but what does that actually mean to the people who are using that service?

Senator HUMPHRIES—Do we need to further explain what recovery is to the broader community? Is there a role for doing that?

Ms Meagher—Absolutely. I think there is a role for explaining to consumers, first of all, what it truly is because some of them are becoming imbibed into the bureaucratic way of thinking about recovery, which is a 'word find' in all existing documents: you look for 'rehabilitation' and you replace that word with 'recovery' and you then have a recovery program. It does not work that way. It is about changing the culture to be individualised to find out what, in that person's life, has value and to work with that to get the person focusing on something external to the disorder, something they can work with, something positive to relieve the damage caused to their self-esteem and their personal lives by the symptoms. We go to services because services have a lot of emphasis on symptom management. I think the reverse is true of a recovery program.

A recovery program puts symptom management in its place. It is one aspect of that person's life. For instance, every day, every moment of every day, I have very active and vigorous voices telling me things about myself and about the world I am in. I am happy to live with that. I think it is amusing sometimes and I think it is upsetting at other times. But I manage my life despite that. I am a person who happens to have that—like you might have freckles or grey hair and I have red hair. It does not matter. It is just part of who you are. Recovery is about changing the attitude. It is about accepting and liking the fact that you are who you are and bringing that into the treatment focus instead of the other way round and having the illness as the enemy. It creates aggression because you have to fight all the time instead of adapting. With other disabilities people learn to adapt to their disorders, to their lack of functioning in one area or another. Why is

it, in mental health treatment and care, we are not learning to adapt? We are always trying to conquer and we know we will never succeed in conquering. So let us take on a recovery focus where we adapt to what we are, what we have and take whatever medication or treatment is required to help us live an optimum life.

Ms Connor—I will give you another small vignette about a consumer whom I work with. Up until December he was having constant admissions. Every time he had a fight with his father he would take an overdose and go to emergency. In December he learned about WRAP and did a WRAP plan. Since December his family situation and his illness have not changed, but he has not been to hospital, he has not taken an overdose and he has learnt different ways of managing his illness. He is enjoying life and facilitating a program with me now that he never thought he could do. Everybody remarks about him. People say, ‘Every time I see him he’s smiling.’ It is like a penny dropped for him and he learnt ways of living a fulfilling life.

Senator HUMPHRIES—That makes sense. Ms Meagher, in your opening comments you said something about the national mental health standards—you might have said disability service standards; I forget now—

Ms Meagher—I mentioned both.

Senator HUMPHRIES—needing to apply to non-government services. It is very hard to argue with that proposition. If a service is being offered, it should not matter where it is coming from. It is also true that most non-government organisations would probably struggle to reach those standards, given the extra resourcing it would entail.

Ms Meagher—Never. State and territory mental health bodies constantly carp about how much it costs to implement the standards. I am sorry, but it costs far more to ignore them. We would not be having this inquiry if the standards had been implemented across all services that dealt with people with mental illness. Read the standards quietly when you have time to yourself. It is all about attitude and involvement. There is not a lot of cost involved. It is the structures you place on top of them that make them expensive. Implementing the standards can basically be summed up as providing services that treat people with dignity and respect.

Senator HUMPHRIES—Do you think non-government service providers would welcome it if we made a recommendation that they should adhere to those standards?

Ms Meagher—If they truly understood them and had a say in what bureaucratic requirements were attached to them, yes, I think they would.

Senator HUMPHRIES—You say in the submission, when you are talking about emergency department or crisis services, that you are very opposed to separate facilities being built in public emergency departments to ‘house the mad people’. I was surprised when I read that because other evidence in the hearings has suggested that there is a need for some separation to provide privacy to people who are experiencing a psychotic episode, for example. Is that the consensus in your organisation? Would there be other views about that in the community? On page 20, under the heading ‘After-hours crisis services’ you say:

After hours crisis services do need attention however ...

Et cetera.

Ms Connor—People need privacy, obviously. But you need privacy if you are going there because of a heart attack or a broken leg as well. The work force needs to be trained in dealing with mental illness and seeing that somebody in crisis with a mental illness is just as much in crisis as someone who has had a heart attack. There is a NICS—which stands for God knows what—program happening around Australia now in emergency departments. It puts mental health staff in the emergency departments, which I think is a good idea, and trains the emergency department staff about how people present and why they present in certain ways.

Senator HUMPHRIES—So separation is a definitional problem, is it not? Presumably you would not mind, if people wanted it, a waiting area that was separate so that if they have a relative who is floridly psychotic they can take them there for a little bit of separation.

Ms Connor—I would not be opposed to that. Often people need a quiet space and emergency department waiting rooms are very distracting. But I would hate to see a situation labelled, ‘This is where the mad people go.’ They would not put ‘mad people’, but they might put ‘mental health’ or something similar. I do not think it needs to be labelled.

Ms Meagher—It could be a quiet area for any person in distress who is arriving at an emergency care facility. I do not think it needs to be specifically for mentally ill people.

Senator HUMPHRIES—You have a real go in your submission at research and you mentioned it again in your opening remarks. You say that the situation where medical research, which tends to avoid the holistic approach, as you put it, to mental health represents:

... the systematic and deliberate discrimination against some essential research questions, which in turn represents a stigmatising discrimination against the consumer experience and a fundamental failure of current mental health research in Australia

Those are very strong words. Is it really appropriate, to put it bluntly, to democratise research priorities by saying, ‘This is what the consumer movement wants and therefore this is where dollars have to be spent’? Would there not be some who would say that research needs to be based on clinical assessment of the areas of most need to develop responses in clinical terms?

Ms Meagher—I think it shows a misunderstanding of where research goes. There is such a thing as social research. Not everything in social research is clinical. Clinical research actually re-emphasises the medical model and the I-am-the-patient-and-you-are-the-genius mentality. The biggest impact of mental illnesses, as most research would show, is in the psychosocial arena rather than the symptomological arena. I will not use percentages, but if we looked at current research we would see that it would be almost wholly involved in symptomological based programs. I challenge that thinking. I think our organisation challenges that thinking too. If the majority of the impact of mental health problems and disorders in our community is on the psychosocial, why are we emphasising the clinical?

Senator HUMPHRIES—Can you specifically suggest a couple of areas where we ought to be putting research dollars at the moment?

Ms Meagher—Employment. You have a government that is impacting on our client group and our peers with employment based programs that are so generalist—I am speaking out of turn here; this is speaking personally, I am getting very personal—that they do not assess effectively a person's psychiatric disability at all. They ask questions such as: can you dress yourself; are you able to feed yourself and shower yourself? Of course our client group is able to do that. So how do they get assessed effectively when we have to manipulate those questions to get them into an employment program?

Where is the research in this country on the employment needs of people with psychiatric disabilities? There are only two current papers that I know of. If we are going to make policies in this national arena, we ought to have at least some research base for those policies. I run an employment program and I know what I am talking about. I think there are also other areas, such as consumer operated services, that need to be researched in this country. Look at their effectiveness and see what forms of collaboration are possible with health services and consumer operated services. Let us bite some bullets and get some real stuff on the agenda.

Ms Connor—There is very good evidence now from the United States. The United States they are very fortunate; they have the ability to have consumer researchers working in generalist mental health research. A woman called Jean Campbell, I think from Missouri, has been doing a longitudinal study since 1988 of consumer run services. I have an annotated bibliography here of hers about consumer operated services. Different kinds of consumer operated services have been evaluated in the US, and we can learn from that experience. Our services here possibly need to be different. We do not have the same sorts of systems and things as they have in the US. We need research and scoping studies in Australia into what would benefit people. I see, from small organisations that I have contact with, the benefit for people of peer interaction. Research into those sorts of areas would be very worth while.

CHAIR—We could no doubt ask you questions all day. I want to thank you for your submission and for appearing before us today. I think it has been very valuable.

Ms Meagher—Thank you for your empathy for what we are trying to say.

[9.52 am]

KOLAITIS, Ms Elizabeth Rodothea, Queensland Branch Program Coordinator, GROW

LUCAS, Ms Mary Anne, National Executive Officer, GROW

CHAIR—Welcome. The committee has received your submission, which it has numbered 224. Are there any changes or additions you wish to make to that document at this stage?

Ms Lucas—No, not really. I have done a summary, as you asked.

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

Ms Lucas—Our first concern is the inadequate funding provided for mental health care in Australia. While the Commonwealth has increased its funding considerably, the growth in contribution of states and territories has not matched that. Funding for mental health care over the past decade has increased, but increases in expenditure on mental health care have mirrored those of other forms of health care—slightly higher. Funding for mental health is meant to be quarantined but, with the ever-increasing demand in the general health sector, such funds could be diverted. We support the notion of an independent commission to oversee mental health expenditure and its distribution.

With the projected increased demand on the mental health care system over the next decade, there is a temptation to provide more psychiatric hospital beds. A return to the days of the asylum has even been suggested and talked about somewhat in very recent times. While hospitalisation and medication are absolutely essential for good mental health care, we do not believe that on their own they will stop the revolving door syndrome. Sadly, for many who have a mental illness, the revolving door syndrome now, since deinstitutionalisation, applies not only to the hospital but also to the prison.

We believe that when adequate support and intervention are provided to the individual within the community, the likelihood of re-admission to hospital is reduced, the cost to government of hospitalisation is reduced and, more importantly, the quality of life of the mentally ill person is greatly enhanced. Additional funding is needed to support individuals in the community so that they can maintain a quality of life that incorporates work, healthy relationships, social and recreational activities, and personal and spiritual growth. We believe that community support, not just more and more hospital beds, is the answer to stopping many re-admissions.

GROW has provided support in Australia and overseas since 1957—mostly on a shoestring budget, like most community mental health organisations. We believe it is now time for NGOs to be funded adequately and to be provided with additional funding to allow them to expand their work in the community.

In the area of education, the work of beyondblue and MindMatters have been instrumental in educating the Australian public about mental illness, and we believe this good work needs to

continue. Young people need to be educated about mental illness and issues surrounding mental illness, such as eating disorders and suicide, as well as the dangers of drug and alcohol abuse. We recommend that mental health education be written into the school curriculum. As many people with a mental illness still fear informing their employer about their illness, the need for education and enlightenment of employers still exists. A collaborative and coordinated approach by all levels of government, together with input from all stakeholders—education, health, communication, employment—is required to provide ongoing education in mental health.

We believe that an initial media blitz, which did happen in the 1990s, followed up by regular and ongoing advertising—not just a one-off thing—could not only educate the community about mental illness but could serve to reduce the stigma and hopefully encourage those with symptoms of mental illness to access services, which is something that many do not do now. Such a media blitz may also serve to combat the media accounts of mental illness that instil fear in the community and help keep the stigma. Media professionals could be educated in the responsibility they have to help reduce the stigma, rather than to perpetuate the myths and misunderstandings often associated with media reports. Community based support is our big theme, because that is what we do.

GROW began in 1957—almost 50 years ago—in Sydney, when a group of people with mental illnesses came together to support one another. They developed what is now GROW's 12-step program of recovery and prevention. Some psychologists have likened GROW's 12-step program to cognitive behavioural therapy, but that is not what we call it. GROW currently operates in all states and territories in Australia and has been exported to the USA, New Zealand and Ireland. There are currently around 300 GROW groups operating in Australia. GROW runs supported accommodation programs in Brisbane and in Canberra, and there is a residential rehab program located in the western suburbs of Sydney for individuals with a dual diagnosis—although most of the people who live there are polydrug users as well as having a mental illness.

In the 12-month period ended 30 June, some 7,000 adults attended GROW's 10,000 weekly meetings, with 55,000 attendances recorded. A large proportion of these individuals participated in the ongoing social activities, residential training and community weekends offered by GROW.

The organisation is consumer driven, with members involved in the planning, delivery, evaluation and management of the service. Some 600-plus volunteers are involved in GROW Australia wide. The majority of these volunteers came to GROW initially seeking help, used the program to recover, and remain in GROW to help others in need by sharing their experience and knowledge of the program and the process of recovery. It is really mutual self-help.

GROW has been researched—over and over again—and researchers have, on numerous occasions, verified GROW's data which shows the need for hospitalisation is significantly reduced by consumers' involvement in GROW. There was a big research project in America by Professor Julian Rappaport at the University of Chicago, over seven or eight years; there was one by Jim Young in Tasmania; and there was a more recent one by Lizzie Finn, who has done her doctorate on GROW. That is due for publication, at Curtin University in WA, in about a month.

As well as that, we have some qualitative evidence which we sent in to the committee—personal testimonies of people who have used the program and how it has helped them to get

back on their feet, not to have to use the hospital system so much, to be able to reduce medication, and, quite often, to return to the work force. I want to finish with the words of Lizzie Finn, our most recent researcher:

It is important for mental health professionals, consumers, and the public at large to realize the very real benefits which mutual help groups such as GROW can offer, and to see them as being potentially complementary to mainstream ... as well as an important stand-alone aid. Mutual help groups such as GROW are an important ingredient on the platter of therapies which can be offered to people addressing mental health programs and can serve an important role in psychiatric rehabilitation and wellbeing in general.

However, more funding needs to be directed into community based organisations like GROW—we know we are one of many—to allow expansion, to meet increasing needs, and to provide intervention when people leave the hospital and support for them in the community.

CHAIR—Thank you for that very good and interesting submission. Are you members of the group that appeared before you—the Australian Mental Health Consumer Network?

Ms Lucas—No. We are on the National Consumer and Carer Forum, and I have certainly met Helen and Janet at the NCCF.

CHAIR—You talk about the need for mental health funding to be quarantined. Does that suggest that there is money being wasted or used in other areas?

Ms Lucas—We do not know that, but we suspect that.

CHAIR—One mechanism for tying down the states, or tying down the Commonwealth—depending on your point of view on this issue—might be through the Australian Health Care Agreements. You would be familiar with that tortured process.

Ms Lucas—Yes.

CHAIR—Why would this not be an appropriate way of doing the quarantining you are talking about by negotiation?

Ms Lucas—It could be, but the money changes hands so much. It is diverted to the states and then it is diverted to the regions. If it could be, that would be fine.

CHAIR—Do you have a view about the Commonwealth's contribution being largely to do with medications—that it is the PBS, GPs and, to some extent, private psychiatrists?

Ms Lucas—From what I have read, a huge percentage of the money goes into pharmacology—the drugs and medication. I know that is necessary, but it means that there is not much left for the hospital system and community based support, which was meant to be what happened when deinstitutionalisation occurred—that people would to be given adequate support in the community.

CHAIR—Does your organisation suggest, as some do, that we need a fundamental restructuring of the health system, whereby the Commonwealth or the states take over the whole service? Do you have a view about that? Would that improve the situation?

Ms Lucas—I know the Commonwealth did fund services many years ago. No, I really do not have an opinion on that, as long as there is funding injected into it and there is a reassessment of where the money needs to go.

CHAIR—The committee was told by a professor of psychiatry that in regard to consumer based programs—I assume, such as the 12-step program that you provide—there was no significant evidence to suggest that those programs had any efficacy. You give us plenty of evidence that this is not the case. But to what extent does that evidence just rely on consumers filling in surveys and to what extent does it have the rigour of a more clinical or qualitative approach to that work?

Ms Lucas—I can only talk about the research I know about. Certainly, Julian Rappaport did his research on GROW in America. GROW is set up exactly the same there as it is here. He had a control group and another group of people who were matched up—it was pretty scientific. Over a number of years, they followed up the people who went to GROW and the people who did not go to GROW. The outcome was very different for those who did go to the GROW groups. There was a significant reduction in the use of hospitalisation and also what he called ‘quality-of-life’, ‘building relationships’ and ‘learning to problem solve’. Lizzie Finn’s research was both quantitative and qualitative over a number of years. She did send out questionnaires all around Australia, but she also attended groups over a period of 12 months. She was really immersed in the whole organisation in Western Australia. She had two different types—the qualitative and the quantitative—and that was where her research came from.

CHAIR—Were those studies peer reviewed?

Ms Lucas—With Lizzie’s, I know that she has not quite got her PhD; she will have it soon. Her markers are someone in America, who is regarded as one of the top professors in consumer programs, and another one from Sydney. She has had really good reports on her type of research and the way she has put her PhD together.

CHAIR—How do you suggest we overcome this problem of the psychiatrists saying, ‘There’s nothing going on out there in consumer land; that we shouldn’t be putting money into these kinds of services because they do not work.’ How do we get the message across?

Ms Lucas—We had another lady recently do some research in Victoria as well. She has just got her master’s degree in community psychology. She talks about what she terms ‘professional centrism’, and says a lot of professionals say exactly what you say the psychiatrists have said: that the programs do not work and they are not much good. They have absolutely no evidence to base that on. I do not know; maybe we need to educate people. We are doing that. We are around the country at the moment presenting Lizzie Finn’s research to as many professionals as we can, because hers is a good research project.

CHAIR—I do not know whether there is time to do this, but it might be useful for the committee to receive a quick rundown of the 12 steps. If it would take too long, do not worry about it.

Ms Lucas—I will just explain how it works. We have the 12 steps, and then there is a little blue book which is an enlargement of the steps, because the steps are just one-liners. Then we have other literature which people use during the meeting. These are quite thick books that have been developed over the years by people in GROW. We have also borrowed other readings, anthologies, which are in line with GROW's philosophy. I suppose GROW's basic philosophy is the belief in persons. We believe that all people are valuable and worth while, no matter how sick they are and no matter what their physical, mental or spiritual condition.

The first step is that we admit we are inadequate or maladjusted to life. The second is about cooperating with help, so within a group people would be encouraged to cooperate with the help of other members in the group who are more experienced in the program, but also to cooperate with their doctor, their psychiatrist or their psychologist. The third step says, 'We surrender to the healing power of God.' That is an optional one. We always say that belief in persons, in the value of persons, is important in GROW—belief in God is optional. The fourth step is to make a personal inventory and accept ourselves. The fifth is to make a moral inventory and clean out our hearts. The sixth step is that we endure until cured, and in our program this step is sort of in the middle because it is ongoing. It is hard work to make changes; it is hard even when you are well, so we acknowledge that it is going to take a long time—that it is not going to happen overnight. The seventh step is that we take care and control of our bodies—that is the physical one. The eighth is that we learn to think by reason rather than by feelings and imagination. The ninth step is that we train our wills to govern our feelings. The tenth is that we grow daily closer to maturity. The eleventh is that we take a caring and responsible place in society. The twelfth step is that we carry GROW's healing and transforming message to others in need. People who come through the program—and it does not work for everybody, we know that—are encouraged to reach out and share what they have gained through GROW with other mental health sufferers.

CHAIR—That is quite impressive, being able to remember all those steps. Would it be possible to send the committee your little blue book? We do not want reams of material, just enough so we have an idea of the sort of work you do.

Ms Lucas—Absolutely; we would be happy to.

Senator HUMPHRIES—Did I hear you say, Ms Lucas, that you had 10,000 meetings of GROW groups a week across Australia?

Ms Lucas—That would not be per week; that would be in a year.

Senator HUMPHRIES—10,000 a year. I see. I am sorry; I thought you said weekly.

Ms Lucas—They meet every week and the meetings last for two hours.

Senator HUMPHRIES—I see the recommendation you make about better education in schools—that we need to have education about things like eating disorders, depression and suicide within the school curriculum. I have to confess that in my mind the jury is still out on the

question of whole-of-population education about mental illness. One of the academics in Melbourne said to me that, whereas you can have health education about weight loss, smoking and exercise, for a whole range of conditions, there are not really any equivalents of those sorts of preventative approaches for mental health. There are certainly measures that can help with early identification of the signs of mental illness and early diagnosis and treatment.

There was also evidence before us of a group in Canberra that had done intensive work with schools in the ACT. They reported that the evaluation suggested that there were less than expected levels of destigmatisation occurring among the students that undertook their programs and fairly low levels of people self-referring to help as a result of those programs.

Ms Lucas—And that was at high school level, was it?

Senator HUMPHRIES—I think it was primary and high. It was mostly high, but it might have gone earlier than that. Have you any particular programs that you have seen operating that you would consider to be best practice in terms of school based education?

Ms Lucas—I have not seen any working in primary. I think MindMatters is a good program.

Senator HUMPHRIES—Is MindMatters operating in Queensland schools?

Ms Lucas—I think it is still operating. It certainly was. It is information and education about mental health and mental illness. I sometimes wonder whether talking about things that can prevent mental illness might be something too. The whole thing of bullying in schools is a good beginning, because that has a profound effect on children and their mental health. So maybe doing the positive stuff might be a better way to go too, as in teaching the children how to be friends and how to care for each other rather than how to bully one another—that sort of thing.

Senator HUMPHRIES—Fair enough. You also talk about the media and the need to change the way that the media approach these issues. I wonder if there has been any attempt by mental health advocacy groups in this country, or bodies like yours, to collectively make an approach to peak media bodies on that question. I suppose, personally, I am reluctant to see governments go to the media and say, ‘We think you should be saying this and saying less of that.’ I think that is an unhealthy phenomenon. But community based organisations saying: ‘We represent many people who are affected by your depiction of mental illness in the community. How about you be sensitive to this, this, this and this?’ Get them to respond to a community based concern. If that has not happened yet, do you think there would be interest among community based mental health organisations to see that occur?

Ms Lucas—I know GROW is a member of the Mental Health Council of Australia and I know they have certainly done that. Quite a lot of community organisations are members of the MHCA and they are better equipped to do it than any of us really.

Senator HUMPHRIES—They are the sort of group that I was referring to. If we were going to push the issue of media depiction of mental illness in this report, it would be useful to be able to point to recent examples where there have been bad or unhelpful representations of mental illness in the media. Have you got any examples that you could point to that we could cite in that context?

Ms Lucas—There have been a couple in Queensland over last five years. I would have to do a bit of research, but I know there have certainly been a couple. They focus on the fact that somebody has schizophrenia—whether they have been diagnosed with it or whether they have just decided they have it. I am sure I could find some. I can think of a couple, I just cannot remember the details.

Senator HUMPHRIES—That is fine. If you could take that on notice and give that information to the committee, it would be very helpful. We all, in the back of our minds, have examples where we see that and think, ‘That’s not very sensitive’, but it would be nice to actually mention some of those examples in the report if we choose to make an issue of it. That would be helpful. You make a very strong case in your submission for there to be a greater emphasis on community based responses to mental illness and a funding shift to support that work by organisations.

Ms Lucas—Maybe it needs to be additional funding?

Senator HUMPHRIES—Yes, you are quite right—additional funding. Obviously you base your activities on the offerings and the volunteering of people who have been or even are still mentally ill within your organisation.

Ms Lucas—We do employ staff.

Senator HUMPHRIES—But you also rely on volunteers to make those meetings work, do you not?

Ms Lucas—Yes, absolutely.

Senator HUMPHRIES—Do you see value in engineering better training programs for volunteers specific to mental illness and for funding to be directed to that kind of activity?

Ms Lucas—We do an awful lot of training. Most of the work of staff is training our volunteers. If there were extra funding for that, that would wonderful.

Senator HUMPHRIES—If volunteers in Queensland were to be funded to run mental illness programs and the volunteers could be used in your programs, that would be a useful tool for you?

Ms Lucas—Yes, it certainly would be, particularly if it did not cost much. The biggest percentage of people who come to GROW are on disability benefits.

CHAIR—Do those who come to your service suffer from the full spectrum of mental illness and disorders?

Ms Lucas—Yes; I have the percentages for last year. We send a questionnaire to all our members around the country. Last year about 800 questionnaires were returned and 85 per cent have received a diagnosis; 40.5 per cent with depression; 17 per cent with bipolar and 17 per cent with schizophrenia. They would be the major diagnoses of people who have come to GROW. The remainder are there for prevention. They do not have a diagnosis. They have life

problems—maybe a divorce, a death or they are unemployed. Most of them say that it prevents mental illness.

CHAIR—Do people come in and out of the program or do people start with step No. 1 and, next week, step 2? How does that work?

Ms Lucas—No. I will send you a group method card, too. At the group meeting we would always have somebody share a personal testimony—we sent the local ones to you—which we see as inspiring hope in new members who are still quite mentally ill. Then there is a time for sharing problems. We do not get into the medical aspect of the illness. We do not ask for diagnosis. We ban medical terminology from the group meetings. We are not medical people so we do not get into that. If people want to talk about their medication, we say, ‘You need to discuss it with your doctor.’ They might say they have depression. We say, ‘How does that affect you?’ ‘I can’t get out of bed till 12 o’clock.’ That is the problem the group would deal with.

The group might challenge them to try to get out of bed by 11 o’clock during the next week. It is not just a group meeting; they support one another during the week. They would be given part of the program to help them get out of bed. ‘You can do it. You can overcome that feeling to stay in bed. You can make yourself get up, even though it is really hard.’ At the next group they would be followed up. We would call that a ‘report on progress’: ‘How are you going?’ Even if they succeed one day out of seven, they would get lots and lots of affirmation. Gradually people will get back to nine o’clock, eight o’clock—over a long period; it is a slow process—and then get to, maybe, washing up and doing whatever is necessary.

Plus the relationship part. We call it a community and we encourage the groups to really care for one another, to learn to care for themselves and to give that care to other people as well. So when people come to a group, mostly what keeps them there initially is the acceptance and warmth and welcome that they will get. The groups love to get new members. I think it is the friendship and welcome and feeling that they are valued in the group that keeps them there because initially most people are not well enough to even read the program, let alone use it.

CHAIR—Do you encourage people to come along with their partners, children or other carers?

Ms Lucas—We encourage that initially if they are having difficulty coming on their own, but after a short period of time we say, ‘We hope you’ll come on your own.’

CHAIR—Why do you like people to come by themselves?

Ms Lucas—Because some people may not share as much or as freely if there is a husband or a partner there.

CHAIR—Typically how many people would turn up to one of your meetings?

Ms Lucas—The average group meeting, based on our stats, is six.

CHAIR—It is quite small.

Ms Lucas—Yes. They vary in size from five to 12. When they get to 12 we try and start another group. It is too big.

CHAIR—If you have the full spectrum of mental illness represented, presumably on occasions there are people who are highly anxious, psychotic or delusional. How do you deal with that?

Ms Lucas—Parts of the program can help people deal with their delusions. We do not get people who are acutely mentally ill. They are in hospital.

CHAIR—We have been told that most of them are not in hospital.

Ms Lucas—You are right. A lot of people in GROW certainly have delusions.

Ms Kolaitis—They do. If somebody was quite unwell, the group would help them to get the help they needed. A person might agree to go to hospital with them and support them if that was the case. Usually in a group people are at varying levels of wellness, and it is not often that all the membership of a group is unwell at the same time. So there is the ability for them to help each other and get whatever help might be required.

CHAIR—It sounds extraordinary.

Ms Lucas—You are welcome to attend a meeting if you would like to see how they go.

CHAIR—Perhaps that is something the committee should do.

Ms Lucas—You would be more than welcome. We encourage observers, and the groups like having them because they think their groups are wonderful.

CHAIR—It sounds like there are similarities with AA or some of those other highly structured self-help groups.

Ms Lucas—That is actually where GROW came from. In Sydney in the fifties people were discharged from institutions and just left in the community, and a number of them drifted into AA. That was where they found acceptance within the community. After about 18 months in AA they decided to get together and start their own program because they were not alcoholics.

CHAIR—That leads me to another subject. Presumably some people in your groups would be in the dual diagnosis, co-morbidity, co-occurring disorder—however you describe it—category. How do you cope with addiction issues?

Ms Lucas—If it was drug addiction, we would refer them to somewhere where they could get help for that.

CHAIR—Do you accept them into the group?

Ms Lucas—We would, but we would encourage them to get additional help for the addiction, and it is the same with alcohol. They can come to GROW, but they need to go to people who can help with the alcohol or the drug. We would find a place to refer them to.

CHAIR—That is most interesting. Thank you very much for your submission and for appearing today. It was very helpful.

Ms Lucas—Thank you for the opportunity.

Proceedings suspended from 10.29 am to 10.48 am

KLINTBERG, Mr Neville Stuart, Cofacilitator and Member, Brisbane Obsessive Compulsive Disorder Support Group

LAING, Mrs Joan Margaret, Member, Brisbane Obsessive Compulsive Disorder Support Group

MINNAAR, Mrs Patricia Ann Theresa, Coordinator, Brisbane Obsessive Compulsive Disorder Support Group

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

Mr Klintberg—I am a sufferer of obsessive compulsive disorder.

Mrs Minnaar—I am the carer of a young adult obsessive compulsive disorder sufferer.

Mrs Laing—I am a carer. My daughter has obsessive compulsive disorder and schizophrenia.

CHAIR—The committee has your submission, which we have numbered 197. Are there any changes or additions you want to make to that document at this stage?

Mrs Minnaar—Not to that document, but I would like to add some other comments if I can.

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

Mrs Minnaar—My friends would also like to make a brief statement. The Brisbane Obsessive Compulsive Disorder Support Group, BOCDSG, would like the committee to understand the real nature and story of OCD, not the Hollywood or the *A Current Affair* version. How serious is OCD? OCD can: be a secret problem that sufferers are often too embarrassed and ashamed to talk about; be a crippling fear that harm will come to others if rituals are not performed; and be chronic, debilitating, isolating and life-threatening. It has an impact on education, employment, financial security, relationships, social opportunities, physical wellbeing and quality of life. It affects a wide range of age groups, from the very young to the elderly.

OCD sufferers can self-harm; attempt suicide; be tortured by a myriad of disorders, including depression, schizophrenia and bipolar disorder; misuse over-the-counter medications, illegal drugs and alcohol in order to gain some relief from persistent thoughts and exhausting rituals; require medication, including antipsychotic drugs; require electroconvulsive therapy; require hospitalisation, regular cognitive behavioural therapy and mental-health services for a lifetime; and undergo psychosurgery. OCD sufferers can wash their skin until it is cracked and bleeding; spray their loved ones with disinfectant and wipe them with Dettol; use harsh chemicals such as drain cleaner to achieve hygiene; make unreasonable demands on families to accommodate the disorder; verbally and physically abuse loved ones when challenged or thwarted; live in one dwelling, with their families obliged to live elsewhere; and challenge hospital staff and patients in a general ward.

OCD sufferers can stand on one spot for hours and hours, immobilised with fear; spend 24 hours on the toilet and 36 hours in the shower; threaten to throw themselves in front of traffic unless the loved one says ‘the word’; refuse to take medication for fear of hurting an unborn child; fear that they might put their newborns in the microwave; crumble in the role of motherhood and oblige elderly grandparents to raise grandchildren; confront the law over issues of gambling, shoplifting et cetera; be hauled off to hospital on an involuntary treatment order by police in front of neighbours; be evicted by health authorities for hoarding in their homes; refuse to have visitors, not leave the house, not answer the phone or mail; go through life too afraid to hug their children; be isolated, friendless and homeless; and die unnoticed.

This is the tragic face of OCD, not what you see from Hollywood or on *A Current Affair*. A Brisbane psychiatrist says, ‘If you let it, OCD will engulf you.’ Yet, ironically, some medical documents do not give OCD a mention. Thank you for the opportunity to represent OCD sufferers, families and carers in Queensland.

Mr Klintberg—I would like to mention what doctors generally think causes OCD. Basically, OCD is an anxiety based disorder. There is some contention about the cause of it. The general feeling amongst professionals is that it is a chemical imbalance in the brain. It may also be caused by psychological factors in one’s life or childhood. I am a sufferer of obsessive compulsive disorder. The severity of OCD varies immensely. On a personal level, my disorder is probably six or seven on a scale of 10. A lot of people are a lot worse than me. I want people to know that OCD is a very serious condition. It overwhelms people’s lives. I was an electrician when I was younger, but OCD gradually consumed me, bit by bit. But I do manage it; I do my best. I am a forklift operator now. I do my best to manage with yoga techniques. I have abused alcohol and things like that in the past to get by, but I do manage.

I wanted to come here today to say, from a sufferer’s point of view, that OCD is a very serious disorder. Some people suffer in a very minor way, but it consumes some people’s lives to a stage where they cannot work. I am very grateful to the government for the way they help and support mental health services and providers, but I think there are certain areas where it could be done better. I could go on forever about how debilitating it is for some people: the anxiety manifests itself in so many different ways. There is help out there, but basically we would like government to help us to help ourselves. Certainly, GPs, psychologists and psychiatrists are a big help, and obviously the support group which we all helped to put together is a very important thing.

Without the very sincere work of Pat, the support group would not exist because most of the sufferers are too unwell to spend the time and effort required to put the group together. Pat has put in thousands of hours of voluntary work. Without the support of volunteers, the sufferers would be without anyone to turn to. Professionals can only take you so far. Basically, there is a lot of misunderstanding in the community about OCD. It is a very serious disorder but by its very nature a lot of people do not understand it because of the complexities of how OCD manifests. In general, I think there is more community awareness, but that is what we are here to present to you today.

Mrs Laing—As I stated, my daughter suffers schizophrenia with OCD. I think the impact of OCD is not focused on enough. Quite often it is associated with other illnesses which are considered more serious—that is questionable—like bipolar disorder or schizophrenia. I will give you one example of how it impacted greatly on my daughter. She is under an involuntary

treatment order; she is currently in hospital. When she became unwell, the doctors decided that she should be in hospital. She was reluctant to go, so they sent the police around. They did not advise her I suppose because they thought she might abscond. Having the police come to her door at 10 o'clock on Saturday night—she is 26—was enough to unsettle her. But the police did not understand that she also suffers OCD and she needs to check things. They would not wait for her to check the locks on the door and everything for 10 minutes, so her anxiety levels went to extreme heights and she did end up absconding. It was primarily the OCD that made her do that.

Even though the schizophrenia is more serious, the OCD has debilitated her in the last couple of years. She was working, she was under medication but the OCD was not focused on. I kept saying to her doctor that the OCD is preventing her from getting out of the house and going to work, which will then have a cumulative effect on her self-worth. But they did not focus on that enough—that is my personal opinion—and they kept on focusing on the schizophrenia and the psychosis. I thought I would tell you that story to demonstrate how OCD impacts. Some people consider it a sideline illness but it impacts greatly on people. There are some other stories that Pat tells about people spraying their children and those sorts of things—the tentacles reach out so far, as with all mental illnesses.

The other thing I would like to say is that I have found a lot of very young people suffer from it—children before their teen years. It seems to be becoming more prevalent in our society, as with all mental illnesses. My daughter was in Wolston Park, which was a mental health hospital; it has since been closed down and demolished. I recall asking the doctor why they were closing it down, because there were a lot of long-term mentally ill people there. That was before I was aware of the Richmond report that was the basis for deinstitutionalisation. She said, 'To remove stigma.' That was her reasoning for putting mental health units in big city hospitals. I said, 'I think it'd be better if people were educated.'

Money should be spent to somehow teach our young people that mental illness is something that can happen to them. It should be taught in schools maybe or with television programs or ads on TV that educate people about mental illness. Not only will it educate people but I believe that it will help when young people, from my daughter's experience, start suffering these terrible symptoms and depression. They do not know where to turn and they are embarrassed by it. The last people teenagers and young people go to are their parents when they are going through that, but I think we need to educate young people and to tell them where to go for help. We need to say: 'If you are feeling these sorts of feelings or symptoms, seek help. Don't go and use marijuana or illicit drugs.' A lot of them do that because the help is not there. I think education is where we could really start to educate parents and children. We are all inclined not to want to know about these awful things until they impact on us in one way or another. I think education is very important; I am sure it would empower some people.

CHAIR—Can I start by asking what usually happens when someone who has one of these disorders goes to the GP? Mrs Minnaar, you referred to doctors thinking it is either a chemical imbalance or a psychological event—some sort of trauma presumably. Is there any consensus about what has given rise to OCD? How much do GPs know? What do they do when someone presents? Do they refer them elsewhere? Do they refer them to your organisation? Can you paint a picture of what typically happens to someone who seeks help?

Mrs Minnaar—Of course the adult and adolescent groups are different. My experience is with an adolescent. With my son 10 years ago, the GP really did not know what she was dealing with, and I certainly cannot blame her. I did not know either. When you are an adolescent you may hear doctors or anyone saying: ‘This is just typical adolescence. It’s puberty; it’s testosterone and hormones and goodness knows what else.’ I can assure you, when you are a carer—and this is why families have to be listened to—and you are seeing all of this behaviour going on in your home, you know that no testosterone or hormone would facilitate the behaviour you are seeing. Therefore we must not put too much emphasis on the adolescent side of things. This is odd behaviour. It is weird, unique and bizarre, so let us look further.

From the lovely GP we had, I would have liked not so much procrastination. At the same time, to be fair, she had to work out what treating psychiatrist was available. There was a huge waiting period and in one way I regret that waiting period. Anyway, to cut a long story short, we had to go around all the traps. We had to do the rounds of shopping around for a psychiatrist while we waited for a public health psychiatrist from the GP, who was not quite sure what she was dealing with—and all that sort of thing. So, GPs need to be informed. They need to be mental health trained. This has changed over 10 years.

People need to access GPs. There are shared care GPs around. Unfortunately, no-one knows who they are because they do not advertise. So that makes it a really complex situation. I have had parents on the phone to me over many years saying: ‘Who do I go to? What GP do I go to?’ GPs are the first port of call and unless the GP is au fait with these disorders—particularly OCD, being a very secretive and bizarre type of disorder—carers and families are pretty confused and frustrated. And goodness knows what happens to the sufferers. The more you prolong the period, before you know of the medication to be used or you get some sort of treatment, the worse the suffering gets. I wish we had had immediate care for my son without having to watch the chronic debilitation that happened.

You asked about where you refer them. As a carer and a consumer, I had to force the issue and get help for him. It seems that OCD is, as Margaret said, not well understood in the community. It was 10 years ago for me but I still see it happening now. I have university students phone me and say they found out about our support group on the Internet. No doctor, GP or psychologist had referred them to a support group. So that lack of knowledge and understanding is still there. I had to shop around and at times I had to say, ‘I can’t get off the phone unless someone allows me to see a psychologist for my son to have CBT, because he needs it and I can’t be responsible for his suicide, and I’m sure your service wouldn’t like to be responsible.’ I always said it very courteously.

But there is an urgency there and that is why we are here to reiterate that OCD is an urgent thing. There are self-harm, suicide attempts and sometimes a death. So, in order to get help, carers have to be quite assertive and medical staff have to be very responsive and absorbing of our needs and concerns. They have to listen to us.

Eventually, we found a psychiatrist and we were very happy. We were the lucky ones. Some people have had so many dramas, and stories go around about psychologists and psychiatrists. Psychologists are unaffordable for a lot of people. Medicare does not cover them. To see a private psychologist in town would cost a lot of money. Believe me, if you are a family or a struggling single person, you just cannot afford this. Sometimes the psychologists available are

excellent at managing OCD. I can name a few in this town already that we suggest people use because they are so wonderful, but they are unaffordable and inaccessible, normally.

If they do access the public health service, some people find it very difficult because the follow-up consultation periods are strung out. They might not see their doctor for another two or three months and I guess they become disappointed and disillusioned. We were lucky. We were in private health care so we could have a private hospital for our son. But I know some adults who are not in private health care. They had to wait and wait and push and shove and assert themselves and it has not been to their advantage. They have put services offside. They have become confrontational, and people do not like that.

These people require help. They have been told they should be in a hospital, but they cannot get to hospital. They are not self-harming. They are not threatening to hurt anybody. It is difficult when you are really sick with OCD and depression. We are talking about some adults who have had shock treatment already. They have a history of serious illness and lack of family contact. The support just is not there.

There is one member who—and I am no Mother Teresa—if it were not for me driving him to the support group and making it easy for him to access services in the community. I do not know where he would be. Some families do not want to know you. It is too embarrassing to have people around with OCD—they do some really strange and funny things. At the same time, when they are not working and they are adults, people do not understand. They say, ‘Why aren’t you working? You are bludging off the system.’ And their mother tells them that they are bludgers. These are all the ramifications of having mental illness. There is grief, and a loss of identity. People say, ‘You used to be a teacher’—or this or that—‘and now you are not anymore. What is wrong with you? Pull up your socks. Get a life.’ Sometimes support agencies will tell you, ‘Go home, fix your OCD and come back and we might be able to give you a job.’ You do not tell people to go home and fix their OCD. People cannot fix their OCD by themselves.

CHAIR—Can you tell the committee more about psychiatrists’ treatment. Do people with OCD only go to psychiatrists if there is another clearly diagnosed mental illness that accompanies their condition—like depression, bipolar disorder or schizophrenia? If they go to a psychiatrist without those other conditions being apparent, are they medicated? Is there an effective medication for OCD?

Mrs Laing—Sometimes antidepressants are used; not always successfully.

CHAIR—What is the evidence base for that, do you know? Does it work? How do we know it works?

Mrs Laing—They will try various medications to see if one works. Just as an antidepressant might not work for someone who is suffering depression, they might have to try another one. CBT does help some people. It depends on the severity of their condition and how often they can have CBT. As Pat was saying, a good psychologist trained in CBT would assist greatly but they are few and far between. Most people cannot afford them because these psychologists are in the private system. There would need to be continued and frequent therapy. OCD can be so debilitating. For example, it is difficult to get out of the house because they are in the shower for

five hours or they are checking a lock. I emphasise this point. It prevents people from taking that first step to self-help.

CHAIR—If a psychologist is available, how many sessions might be required? You say it is no use having one session and another one in two months time.

Mrs Minnaar—Can I backtrack a bit? As an ex-teacher I believe that for the young people who fall through the cracks, the educators, the teachers, could be more aware of signs and pick it up in the preschools and the schools. I have had a day care coordinator phone me about a two-year-old in the play group sandpit with severe OCD. We have to start in the family psycho-education area and in the schools, the tertiary institutions and so forth, for everyone to be able to pick up these signs a bit easier. We all have to be educated.

Young people do not want to see a psychiatrist. That is why it is important to see a GP who is mental health trained or at least knows about mental health issues: because kids do not want to see a psychiatrist. You were asking about the effectiveness and so forth if they do get to see a psychiatrist—unless they have got some other disorder. Some psychiatrists are very good and some do not really have a clue. I recall talking to a GP about OCD—and I was prattling on, I suppose, like I normally do—and he thought I was talking about AC/DC, the heavy metal rock band. I am serious. It happened to me. All these things happen to me.

The point is: we all need to be educated—community, educational institutions and certainly doctors. Professionals have to change their attitude a lot. With schizophrenia and bipolar the families may be a bit more involved, depending on the age group and so on, but certainly families have to be involved with OCD, because it is a family problem. The children and the adolescents are acting out within the family, or the adults are acting out and therefore marriages break up and the kids are affected at school—the bullying, the teasing. It impacts on every aspect—the social life. I have had to drag my son to places to have a friend. I should not be dragging him. He is 25 now and I am still dragging him a little bit—not a lot. I do not like to control or drag anyone. I manipulate the system but, when people are so demotivated and so sick and unwell and depressed and suicidal and they have no self-worth and their ego is stripped and the self-esteem has gone, there need to be people there who are going to help them, and you cannot rely on the medical profession totally.

Medications are effective. Antipsychotic drugs and antidepressants are often used very well for people with OCD. But then some people are treatment resistant. There may also be shock treatment, long stays in hospital or whatever it takes. Inevitably, if people do not get out into a community which is supportive, where they have continuous follow-up, with supported accommodation—which is so important; you have to have support workers on site 24 hours a day or whatever—case management and this sort of thing, if they do not come from hospital and have all that sort of continuity and follow-up of care, then, unless the families are around to help them, once again they will be back in the health system. It is a whole structured format we have to really put in place, like in a school.

CHAIR—The reason I ask you about the number of sessions one might need with OCD—perhaps not with schizophrenia or other symptoms being present—is because there is a Better Outcomes in Mental Health program that is currently funded by the Commonwealth which allows GPs to refer to psychologists for six sessions or 12 sessions if necessary. Sadly only 18

per cent of doctors can do this, because they are the only ones who have done the preliminary training in mental health services. Of the people who contact you, how many have happened upon a GP who has done that training and is able to refer to a psychologist for these sessions? This is only a fairly new thing, so it will only be in the last 12 months or so. Can you advise whether this has been successful in six sessions or do people with this condition need lifelong support in this way?

Mrs Minnaar—The people who have contacted me largely have not accessed a GP who has been able to refer them to a psychologist. I assume you are alluding to a shared care doctor. They do not know who shared care doctors are when I talk to them about it. I have learnt about it myself. It is really hard. They do not know where to access the service. In terms of sessions, if you start very early with children, you could require more than six sessions. With my son it has been 10 years and it has been a long trail. That is with medications, with family support and with very good psychiatrists. He has not had a lot of CBT, but then a lot of people do not want to access CBT. It depends. Some young children might do the CBT, but adolescents are not too keen to and a lot of adults are not too keen to, because it is very confrontational. I think a lot of people would need a lot more than six sessions, but then I am not an OCD sufferer. I have anxiety. I would say it is pretty anxiety-provoking to go and get CBT. I think that, for some, it would be a lifelong thing, but then a lot of people cannot afford lifelong CBT.

Mr Klintberg—When I developed OCD in my late teenage years I spent probably an initial period of about three months with cognitive behavioural therapy, and that was very helpful. The sort of outcome the psychiatrist will look at is teaching you to use certain techniques to deal with your own particular problems. So probably initially between 10 and 15 sessions once a week or once a fortnight within a 12-month period is very helpful. The disorder typically waxes and wanes, so you may need to revisit the psychiatrist. Sometimes new anxieties and new behaviours can creep in which need to be dealt with. Sometimes the individual can deal with them very effectively. Certainly in my experience it is good every now and then, if you have a good psychiatrist, to visit them. Sometimes you will fall through a crack and feel yourself going downhill, and you need that support.

In my experience, it is like anything in life. There are very, very good psychiatrists and there are very, very bad ones and everyone in between. So it is very important for us as a support group to get feedback from people to find out who are the good ones and who are not. In general, psychiatrists are very good. A lot of doctors and psychiatrists, obviously, are very good generically with disorders and diseases but it is very hard to find a psychiatrist, for example, who is specifically good with OCD because of the nature of their work. So it would be very helpful if more research and funding went into all the different areas of mental illness. Obviously, there is not a bottomless pit of money. Certainly a lot of it is a funding issue.

You might be surprised to know that in Australia it is estimated that 450,000 people—two to three per cent of the population—have some form of OCD. So it is out there and, as Pat said, it can be very debilitating for some people. Seeing professionals and training professionals is very expensive. In my case the experts with OCD I have found are psychologists. I work for a living but the cost of housing and living in general these days, particularly if you have children, is expensive, and there is not much money left over. To see a private psychologist costs \$120. For people who do not have private health cover it is out of the question; it is inaccessible.

Senator HUMPHRIES—Some mental illnesses are episodic in nature—you have periods where you are not affected at all and others when you are quite badly affected. Is OCD like that?

Mr Klintberg—In the general sense, to a large extent OCD is a lifelong problem; it is a chronic condition. But there are exceptions to that, where people suffer a bout and then never, ever suffer any recurrence of it. But in general it is an ongoing, waxing and waning condition and varies very much in the degree of how severe it is.

Senator HUMPHRIES—So on some days you have it really badly and on other days it will not be much of a problem.

Mr Klintberg—From talking to other people—I think I can speak generally for people who suffer OCD as I have spent four years with the OCD support group—it will wax and wane in that you might feel severely affected and perhaps depressed for a period of two, three or four weeks, or maybe up to a couple of months, and then you will have a couple of months that are okay. Then for a couple of weeks you may feel yourself going down. What affects that is lifestyle. I say at the support group that it is very, very important to take responsibility for yourself and eat a good diet and do exercise and try and look after yourself. But some people, obviously, with severe OCD cannot do that—they are so depressed, they are so sick. I am lucky that I have been able to manage it with yoga techniques and breathing and relaxation and diet, but some people cannot do that; they are just too ill. They are sick over a very long period of time and they wax and wane down along the bottom. Other people, like me, can manage to come out of it. I will be fine for three or four months and then I will see myself falling back so I will do my relaxation more and put in more of an effort to watch my lifestyle—and watch my thoughts mainly; make sure my emotions do not wax and wane too much. It really does vary from person to person. But in general that is the case.

Mrs Laing—I know of a young person who had OCD. He was 12 when he first started to have symptoms. This person is now 34. He came down from Bundaberg in regional Queensland and was in hospital for nine months. He had good CBT and medication, and went to school from hospital. He is now totally cured, but he might clean a little bit more. He maintains it is because he was given the skills very early in life and was educated about his condition. He was shown how to handle it, which grew his confidence. I think that is why it is very important that it is caught very early in life because of the impact it has on other aspects.

Senator HUMPHRIES—I see you mentioned in the submission that you have to be concerned about young people—from 15 to 25. Does OCD tend to manifest for most people in that age range or is it spread pretty evenly across the population in terms of age?

Mrs Minnaar—You would probably find that a doctor would say something differently but I know one psychiatrist in Brisbane said that out of three children presenting at his waiting room two would have OCD. I have been a contact person for the OCD support group for 10 years. Most of the callers are from families with young children, ranging, as I say, from two years to teenage years. Then of course you get the adults phoning through. With reference to your question before, I often suggest they go to see a certain number of psychologists that I am aware of in the Child and Youth Mental Health service—the CYMH service—or somebody else that I might know privately who is very au fait with OCD and deals very well with it. I think it is

probably across the board. It is more common than schizophrenia and it is almost as common as asthma and diabetes. So we are looking at a serious problem.

Senator HUMPHRIES—You make a call for more support for groups like your own, which you describe as like a one-man show, or one-woman show, I assume in this case. You say that your problem is that you are reliant on the support of unwell volunteers—people who themselves have this illness or this condition—and that you need reliable volunteers who are able bodied and able minded. What is the barrier to you getting those sorts of people involved in a group like your own? Is it that you have people who are willing to help but who are not properly trained, or do you not have people who are willing to be involved in that way? Are there other people in the community who might, for example, suffer other kinds of mental illness, who are capable of constructively being involved in a group like this to assist because they have not got this particular illness but when they are well are able to assist in supporting your members?

Mrs Minnaar—I do not know about barriers so much. I honestly have not really been asking around but since the submission I have talked to Volunteering Queensland. They told me about some project they had about eight years ago where there was a mentor system with a psychologist and other people on board, who were virtually on site for whatever group or organisation in the community. But that folded because of the lack of funding. Since then I have also talked to the Mental Health Association, who are my employers now. They are talking about student placements. So next time they have a round of students, who are obviously familiar with the mental health arena or at least interested and committed, they might send them over our way. We have probably made a bit more progress since the submission.

I think a lot of people in this day and age still do not want to be affiliated with a mental health support group. Even within the support group itself, people do discriminate. Believe it or not, some people with anxiety, depression or whatever may not wish to participate too much with people with schizophrenia or bipolar. The sad thing is that in our group we have a range of everything—a real package. If you can break down the community barriers then you might get students coming through. They are very good but I have students phone me and say, 'I'm doing psychology but I don't want to disclose that I've got OCD,' or whatever. So you have to get past those barriers or just an attitudinal problem of professionals. If you are not going to be disclosing, or owning up as such, to having problems yourself or an understanding of those problems, it is a bit hard to get those people to come in and support you.

There is certainly a little bit more available now. We are allowed as a group, now that we have public liability insurance—which almost killed us last year—to access Volunteering Queensland, so we will pursue that. There might be some volunteers out there who might tap in, plus the Mental Health Association are talking about students. We have had medical students in the past, and we are in partnership with the Princess Alexandra Hospital; but funnily enough, this last year they have not turned up. They are very good, too, but I guess the stresses of life and their busy workloads may have prevented them. You would like to think that universities and teaching hospitals would encourage those students to come on a regular basis, tap in and develop a mentor system.

I think it is mainly about attitude, not so much the resources that are not there. It is about making time. Many psychologists have said to me that they cannot organise social functions for children with OCD on the weekends, because they will not get paid. These people were running

CBT classes for families as well, and I might add that there were none for adults. There were no psycho education family programs for when your child becomes an adult. I have done courses on schizophrenia and I have done anxiety courses, but I have not had one family education program in OCD—whereas the children have.

I have been a volunteer for many years and I organise a lot of social functions, because I see what happens when children and adults do not have social contact. When people with OCD are so badly isolated and debilitated, they are in their homes and nobody knows, and they cannot get out to tell anyone. That is when you have these sad people dying unnoticed and so forth. That was actually highlighted to me by a support agency. It is so strange. You get three agencies and they are all phoning around everybody. They phone me first and then they phone everybody else, and then they come back to me and say, 'Pat, would you mind organising a volunteer to come to this man's house to help him with his OCD?' Basically, the resources are not there. I could tell you a hundred stories, and it is so ludicrous. If we all talked to each other a lot more, if we listened and communicated and shared the resources and funding—obviously with a bit more funding thrown in—we would not have such a tragic face of OCD.

Senator HUMPHRIES—What is the significance of the dolphin in your logo?

Mrs Minnaar—You swim with the dolphins, you see, to get peace of mind and tranquillity.

Senator HUMPHRIES—I see. I was curious. Thank you for that.

Mrs Minnaar—You are welcome.

CHAIR—Thank you very much for your submission and for coming along this morning. We really appreciate it.

[11.27 am]

ARTHUR, Mrs Lily, National Secretary, Origins Incorporated, SPSA Queensland Branch

BRYANT, Ms Linda May, Queensland Coordinator, Origins Incorporated, SPSA Queensland Branch

CHAIR—Welcome. The committee has your submission, which it has numbered 420. Are there any changes or additions you would like to make to that document at this stage?

Ms Bryant—Yes. There was a submission put in from the branch in Queensland and one from Victoria, but on the internet it has our submission as No. 420, and that is the main office submission. We both sent them in and had confirmation that they were accepted.

CHAIR—We will check that. Could I ask you to make a brief opening statement, after which we will go to questions.

Mrs Arthur—I will give a brief explanation. Origins Inc. was established 10 years ago, mostly as a support group for mothers who lost their children to past adoption. The statistics are that from 1950 to 1998 150,000 newborns were adopted throughout Australia. One in six children and at least one in 13 people are directly affected by adoption in Australia. The average age of mothers was between 15 and 19. The infants were newborn and usually the first child of the mother. We work mainly with mothers and families who have lost children to adoption, people who are adopted and other people who have been removed from their families through state intervention. We gave a submission to the inquiry that produced the *Forgotten Australians* report, because a lot of those children were later taken into care and adopted out, so it was very much a case of adoption related issues there. We deal with ex-state wards, we have quite a number of women who have lost children to adoption whilst under the care of the state and we deal with Indigenous groups.

The main focus of our organisation has been on the known mental health damage—our research goes back to the 1940s, when they recognised the damage to our children—and the unlawful practices. I will briefly describe the unlawful practices such as the incarceration of mothers. During the birthing experiences women were tied down to the bed, shielding them from any eye contact with their children so that they did not bond. There was the overuse of drugs to stupefy mothers and the use of carcinogenic drugs such as stilboestrol to stop them lactating. Mothers were forbidden to see their newborns and were transported away from the hospital and away from their babies while they were in a stupor. Mothers were forced to sign legal documents surrendering their children without any type of legal representation or caution about the effects of any adoption consent. There were also the practices of swapping live babies from unmarried mothers with stillborns of married couples and hiding the children under the adoption acts.

After an inquiry that we called for in 1997, hearings were held for 2½ years and in 2000 they handed down the report, where they said that the practices that were occurring in most hospitals in New South Wales were unlawful and unethical. The practices described as routine have been carried out through most public hospitals in Australia. So we now know that the practices were

basically Australia wide and were carried out within the confines of public hospitals by employees of the state. When we started doing research into the mental health issues of adoption, we found a mountain of information—papers in medical journals et cetera—about the known damage that it did not only to us but to our children. So they were well aware of the mental health damage at the time when they were performing their unlawful acts.

We say that since the 1960s when the peak years of adoption were in progress the state governments in every state in this country breached their fiduciary duty to the mothers by avoiding the statutory requirements to prevent the fraud that was occurring within the hospitals. They knowingly ignored the statutory requirements of the adoption acts by denying mothers their inalienable right to see and have unrestricted access to their children before a consent was signed. The mother legally was the sole guardian of her child until an adoption consent was taken. They were taking children from the birthing table and hiding them in the confines of the hospitals, forbidding mothers to see their children that they had given birth to.

They failed to protect our best interests by depriving unmarried mothers of the same standard of care that was afforded to other mothers—those who were married. We got different treatment altogether within the hospital. They failed to protect our mental health and our emotional health. They failed to obtain consent upon admission to the hospital to authorise any operations, medications or procedure contrary to a normal delivery process. They exercised undue influence against mothers for the purpose of bringing about an adoption transaction. They caused us to sign adoption forms based entirely on anecdotal information. A mother had never seen the child that she was surrendering—she did not even know if she was surrendering the right child. They wrongfully took possession of our children at the moment of birth and deprived us of them permanently through fraudulent means. They coerced mothers into signing consents to legalise their unlawful actions, knowing full well the potential for mental health damage that they were causing while they were doing it. I can honestly and categorically say that the state of my mental health is completely due to the unlawful practices that were committed against me.

Ms Bryant—My statement is about some of the psychiatric damage that we find as a support group. Queensland, as you know, is a very big state. We have some volunteers who run a support group in Cairns. Other than that, we in Brisbane handle phone calls, emails and letters from all over the state and sometimes from interstate and overseas because some adoptees and mothers may have moved to another state or overseas. At the moment there are no paid staff. I am just a volunteer. I use my own money for access—it is about a 40-minute drive. Petrol, as you know, has become very expensive. But we feel that if we fold up, if we do not do anything, there will simply be no help for these people. A lot of the mothers suffered secondary infertility. An estimated 50 per cent of those mothers who had their children removed never had another child, so it was their only child.

With regard to the effects on the mothers, Dr Geoffrey Rickarby, a psychiatrist who gave evidence at the New South Wales parliamentary inquiry, has been treating mothers and adoptees for many years. He is quite elderly now. The psychiatric disorders come in different forms, including pathological grief. When a baby is taken and it is still alive and it goes off to live with strangers, it is not like having a baby and you can say that it died, where you can actually have that memorial or funeral, and people come and give you sympathy and bring you casseroles, flowers and things. As a society, we need that to go through the grieving process.

When we were discharged from the hospital, we were just sent out into the wild blue yonder and told that we would forget about it in 12 months. We were told to get on with our lives, go out and get married and have other babies and everything will be fine. They knew that it would not be fine. That is what really angers us. They told us all this and we ended up with post traumatic stress disorder, which I have suffered from, major depression, dissociative disorders, panic disorders, anxiety disorders, dysthymia and situational stress disorder. Situational stress disorder is associated with the reunion. A reunion is not the end to it; a reunion is just another beginning. All that grief for the mother and the child comes back again and it has to be worked through. Sometimes it can take up to 10 years to actually get onto some regular relationship.

We find a great many adoptees and mothers in alcohol- and drug-dependent situations. They have personality damage, educational failure and poor employment status. Many of the mothers, if they had their baby at 17, left school because of their pregnancy and never returned to further study. They had a failure to bond with subsequent babies. When many of them married and had other children, they always had that fear that they were unfit mothers because that is what they were told. That fear was transmitted down to the next lot of children and many of mothers suffered problems trying to bond with subsequent babies.

I move to the effects on the adoptees. We have adoptees ranging from the age of 18, which is when you can legally access your information. I have had some adoptees in their 70s come looking for help, who have said they have never ever discussed their adoptive status with anyone else. Their first point of call is with us. We find now that the internet is an anonymous way of asking a lot of questions without having to front up and talk to someone. Our web site has been invaluable to us, especially for overseas adoptees who are looking for help to find their families and so forth.

There is an awfully high suicide rate amongst male adoptees. Some research has been started by the Central Queensland University and that is ongoing at the moment. Dr Susan Gair is conducting that research. Adoptees feel a lack of identity. They do not know who they are. They have perhaps never fitted into their adopted families. They have different personalities and abandonment and separation anxiety. Many of them have ongoing problems with relationships with the opposite sex because of abandonment issues. There has been a fair amount of abuse of adoptees by adoptive parents, both physical and sexual. Adoptees have to deal with that as well as their adoption. They have self-destructive coping mechanisms like drug and alcohol dependency and inflict self-mutilation. A number in our group have been hospitalised for cutting themselves.

There is a lot of anger, especially amongst the males. They feel anger at being rejected by their mother and when they find out upon reunion how their mother was treated they feel anger at other people—the doctors and the system. Unfortunately, the anger that a lot of those young males feel tends to make them drink excessively, take drugs and sometimes they end up in prison. We have a list of adoptees who have been in prison. Many of the serial killers are adoptees and I have a list of those as well.

There is cultural and genetic bewilderment. Many of them come from different cultures to the ones they are adopted into. They may come from Maltese, Italian or whatever backgrounds and may be adopted into Anglo-Saxon or German cultures. They are brought up in the way of their adoptive family and they find out that their culture is totally different. It is a bit like the

Aboriginal stolen generation being brought up in a white family and losing their culture. These adoptees have actually lost the culture of their original families as well.

Also, here in Queensland, we are now the only state that has objections to contact and access to information so, for a lot of the adoptees who have applied to get their information and the mothers who want to know where their children are, objections have been placed by the other party. That causes further rejection, anger and, unfortunately, in some cases suicide. We also know that the Queensland government knows of the trauma that this has caused, and we are still waiting for some sort of acknowledgement and redress. Queensland is also the only state without a post-adoption resource centre, so there is no official centre where adoptees, mothers and anyone interested in finding family can go and have access to counselling, libraries, support groups and so forth.

I am very fortunate that the Mental Health Association of Queensland have given me one small office from which I run the support group. We do not get any funding from any government. The only funding we had was to run our last conference at Wacol. That was last year, and we had some funding from the gaming benefits fund of \$4,200. We put on a conference with volunteers with that money, which we were told was quite exceptional. I have the papers of that conference on disk and I would like to send that to you. I have not got access them to at the moment because they have just been printed, but I would like to add those into our submission.

We are looking for outcomes for the mental health of a huge proportion of the population. We find that, when we have somebody who we feel is beyond having support in a support group and who needs professional help, we do not have anywhere to refer them. We have referred them on to different psychiatrists and psychologist and we have the same problem as the previous group. There is just nobody that we know that you can send them to who has a good knowledge of adoption loss and grief. They have knowledge of loss and grief in other areas, but there is very little research being done. These people do not get satisfaction when they go.

Also, we support people who have been before the courts. We have mentioned their adoptive status and the way they have reacted angrily and punched somebody or done something but the judges just say that that has no relevance at all. There are too many cases of this in Australia and New Zealand, especially here in Queensland. The Childers backpacker fire, which killed 15 people, was set by an adoptee. Julian Knight, who was the Melbourne Hoddle Street murderer, was adopted. The Strathfield murderer, who killed seven people, was adopted. There is a whole list of them. No-one is recognising that this mental health harm has been caused by a government who knew that they were going to cause it in the first place and are now turning around and not giving us any support in addressing this and helping these people who are suffering.

Mrs Arthur—I think there is a deliberate resistance to organisations like ours because we confront the government with their past unlawful practices. They minimise the damage they have caused people by referring it down to loss and grief. They give people like us generalist counsellors when we should be seen to by professional trauma psychiatrists, because they did not just cause loss and grief for people whose human rights they abused and took away; they caused major psychiatric damage, particularly in our children who, when they were separated from us at birth, were left to languish in hospital nurseries for anything up to three months

without any bonding of any kind. No-one can tell me that a child that has been through those sorts of situations early in its life would not come out of it without some sort of major trauma.

CHAIR—What was the reason for the delay?

Mrs Arthur—A lot of the time they may not have lined up suitable adoptive parents. They had to match the child with the parent. They may not have had somebody lined up for that particular child or there may have been a medical problem with the child.

Ms Bryant—The babies had to reach a birth weight of five pounds before they could be signed over, so any baby under that had to stay in hospital until they reached five pounds. I do not know what that is in kilos. Also, if they were any medical reasons, as Lily said, they were what they called delayed adoptions, so they delayed them until they got those sorted out. They did not ever adopt out a baby with any medical diseases or anything that they knew about. They had to be perfect.

Mrs Arthur—In a paper by Dr Ferry Grunseit, he talks about the health of newborns also putting it down to the level of drugs that were given to the mother during labour process. The child was born and had to be incubated. They were suffering from withdrawals and that sort of thing after the birth.

CHAIR—Were the births induced?

Mrs Arthur—Yes. A lot of times they were. We have it in some of the research that we have done that they actually left mothers labouring without giving them Caesareans for at least 36 hours because they wanted the mother to try to give birth naturally, so that her sin would not show because you could not disguise a Caesarean scar. So there are the issues of women who were kept in long labours throughout the birth process most of them suffering their first birth. That is why 50 per cent of women never gave birth to another child—because of the trauma of the delivery and the labour of the first child and then having nothing to show for it.

Ms Bryant—They emotionally and mentally shut down. A lot of the mothers who come to us have emotionally shut down at the age they gave birth. They have not emotionally moved on into middle and old age. They still have that feeling of shame. We have heard stories that when the doctors were stitching them up after an episiotomy they would say, ‘Stitch her up tight so that she won’t be back here again’—things like that. The mothers were treated abominably by some of the doctors and nursing staff. They were very cruel, especially in some of the Catholic hospitals where the nuns were in charge. The stories are just unbelievable.

Senator HUMPHRIES—The practices you have talked about in your comments and in your submission, using tricks on women to get them to adopt their babies out—

Mrs Arthur—They were not so much tricks, it was a concerted effort. The practices were the same throughout Australia. They denied the mother access to her child.

Senator HUMPHRIES—Have those practices ended or are they still going on?

Mrs Arthur—In 1982 when they finally discovered that eventually they may get caught out, the Health Commission of New South Wales put out a policy to stop the practices on the grounds of legal issues and mental health. It took the hospitals many years to stop doing those practices. We have heard from one of the key social workers in New South Wales, who sat on the committee that warned the health department that they were acting illegally, that the practices never came to a halt until the late eighties.

Ms Bryant—That is our evidence too in Queensland. I think it was pretty much one department in one state talking to the other. That usually happens. They get together at family services meetings and so forth. I think it pretty much stopped at the same time.

Mrs Arthur—The practice may have stopped, but they did not warn the mother of the lifelong mental health problems for her and her child until the Adoption Act 2000—

Senator HUMPHRIES—Which state is this?

Mrs Arthur—New South Wales. Our organisation wrote the consent-taking part of the act because, until 2000, they still were not warning of the lifelong damage a mother would suffer by surrendering a child for adoption. In an adoption a few years ago, somebody sued the government for the psychiatric damage she suffered. So only now are they starting to warn people about the lifelong damage that mothers can suffer.

Ms Bryant—In Queensland at the moment, the 1964 adoption act is under review. We have been inputting into that at different forums. I think the draft of that legislation comes out for public review in September.

Mrs Arthur—Under Section 39 of the old act, people could lodge a contact objection so that no information could be given about a lost child or parent. I have been working on this section of the act with the Queensland government for the past eight years, telling them how harmful it is to deny a mother knowledge of where her child has gone or to deny an adopted person any information at all about their history. The government have known the level of trauma that has caused. We have a copy of an internal document in response to the New South Wales parliamentary inquiry into adoption in which the government acknowledges the trauma, the psychiatric damage and the unlawful practices in Queensland. But they still refuse to review that section of the act; it is the only part of the act which is not up for review. That part of the act has been deliberately kept there because of the vested interests of adoptive parents who, I might say, have very close leanings with certain ministers in this government.

Senator HUMPHRIES—You talk about the mental health implications of adoption practices. You have quoted a lot of information in your submission. I have not read the Queensland submission yet, but the—

Ms Bryant—That is an overview of what is going on here in Queensland. It was an attachment, I believe.

Senator HUMPHRIES—I assume it adds to the information which is in this other submission. Mrs Arthur, you have spoken about the general impact of adoption on the mental health of people who are involved in it, particularly the mothers. Do we have any information

about how widespread that problem is? Would every mother experience mental illness as a result of that experience? Is there any information about what proportion of the population is likely to be affected in this way?

Mrs Arthur—We have a fair idea. Most of the people who have accessed our group—we have had at least 4,000 contacts from women—all have the same story. They have never got over the loss of a living child, particularly when the child was taken off them at birth and hidden. They do not know what they have lost until they actually see what they have lost. The problem becomes more compounded in the reunion process. When you meet the child who has grown up day by day in your mind, seeing an adult at the door is a shock. Women grieve the loss of the baby. They do not grieve the loss of a 30-year-old person. That is the problem with reunions. After a mother meets the child, in her mind she has to kill off the baby. If you do not kill off the baby, you cannot have a reunion process with the adult. That leads to major complications with mental health because you finally have to go through a mourning period. You do not mourn the loss of a living child.

Ms Bryant—You were never allowed to. You were told never to tell anyone, and it was almost like they were sending you out there as a recycled virgin to be on the marriage market again, in the sixties.

They were satisfying what they thought were the adoptive parents' needs, but a lot of adoptive parents come to us too, especially some of them who have had children in jail. I have one couple who are the adoptive parents of a recently sentenced man, now in Sir David Longlands prison, who murdered two prisoners in jail. That couple went looking for help for that child very early on and were told, 'It is nothing to do with his separation from his mother; it is nothing to do with his adoption; he is just a bit of a larrikin.' That boy has been in and out of jail since he was 18. I think he has spent about two years out of jail, and in that two-year period he raped a 15-year-old girl—and giggled. So we're looking at terrible mental health damage that nobody seems to have recognised, even for the adoptive parents.

Mrs Arthur—The governments themselves know the damage that has been caused by their practices, but they have not funded any type of independent organisation to deal with the damage. They refer them back to their own departments. In Queensland, to service 250,000 people directly affected by adoption, there was one departmental worker counselling these people.

CHAIR—One psychologist?

Mrs Arthur—One psychologist counselling all these people. Their files are full of people who have accessed the department looking for answers, looking for counselling. We have referred people down in New South Wales to the only couple of psychiatrists that we know of who can deal with, or just understand at least, the issues that were involved. The trouble is illustrated by my own case. I have had 150 visits to my psychiatrist over the last four years and he has said to me, 'There is no resolution for you because the fact is you cannot change what has been done.'

You have the most hideous human rights abuses committed against you and when no-one is accountable or acknowledges the mental health damage and everything else, it creates a further

problem with mental health because there is no resolution to the human rights crimes and the damage. Every time I even hear my son's name I am constantly thrown back into a state of trauma, of trying to deal with the crimes that were committed. This goes on with every one of us mothers. The governments, and the governments of these states, must admit what they have done and become accountable for it, and at least treat people decently instead of with contempt—and they do treat us with contempt because we remind them of one of the greatest human rights crimes that have been committed against people in this country. And this was all done in breach of the common law. It was not like they legislated to do what they did to us. They breached the Crimes Act. They refused to look at that and they have refused to provide any sort of services to women such as ourselves.

Senator HUMPHRIES—I am not quite clear about what you say is the state of information or research about the trauma associated with adoption. You say in the submission:

... never once has the trauma caused by the interference of the biological sequence of birth between a human mother and child even been considered let alone researched.

But you have also said that there are mountains of information about the damage done through adoption. So I am not clear—

Mrs Arthur—Most of the research that we have at our office—and believe me, we have thousands of papers from various sources—was done overseas. And that was on the ordinary type of adoption, where the consequences of the adoption were followed through from, maybe, an informed consent.

No research has been done into the punitive practice here, and they said in 1965 at a conference, 'Stop doing these punitive practices against mothers, because they are harmful.' There has been no research into the trauma that was created by having a child ripped from the woman's body during the birthing process, hidden away from them and then filling them with drugs to make their experience so unreal that they could never get in contact with the way that they felt about what was usually their first birthing experience.

Ms Bryant—The problem is that research costs money. Several universities that we are in contact with, and several researchers, have applied for funding to do this sort of research and just cannot find the funding. As I said before, Dr Susan Gair from James Cook University in Townsville has received some funding, I believe from overseas, to do some research into adoption and suicide. But there needs to be funding by the government to do some of this research. We have heaps of anecdotal evidence, but that is not official documented professional research. That is what needs to be done. One of the things that we want done is for governments or somebody to fund these universities or people to do this research.

Mrs Arthur—We have been told—and I have met with the minister in New South Wales at least twice, most recently two months ago—that organisations like ours should compete with other organisations for funding. It is very difficult to compete with other organisations when the people like ourselves that are running our organisations have major mental health problems. Every time you get a rejection that says you are not worthy enough to spend a few dollars on, it puts you back in the same capacity of, 'Aren't I deserving of trying to get some sort of information? Why isn't the health department issuing kits?' Our mental health conditions were

created by the health system. It is as simple as that. Their unlawful practices created this mental health disease within us, and not one cent of government money has been spent trying to rectify some of the damage that the health system has caused us. Instead, they want us to go away and die somewhere so they will not be confronted by the crimes that they have committed against people like us.

Ms Bryant—Also, in New South Wales they set up PARC and in Victoria VANISH, which I think are partially funded by the government, and the Benevolent Society, I believe, puts in some funding in New South Wales. They employed former consent takers to counsel the mothers. I have actually been there when a mother from New South Wales was in my office, rang PARC and she got the same woman who had coerced her into consenting to adopt her child out when she was 15 years old, who was now going to counsel her.

Mrs Arthur—It is like sending the victim back to the rapist for a pap smear.

Ms Bryant—Exactly.

Mrs Arthur—That is the equation that we put on it.

Ms Bryant—That girl then just went into hysterics and she started to swear. This woman on the other end who had taken her consent said, ‘Oh, I do not need to listen to this bad language.’ This woman was virtually on the floor screaming. Fancy doing that to somebody. They need independent, well-trained psychologists and psychiatrists to do this counselling, not former consent takers.

Mrs Arthur—I think we need to get rid of the misconception throughout society today that we were the only group of women in a short span of time that willingly gave away our children en masse to strangers. That is the attitude and what they have been promoting over the last decades in order to dismiss us. The fact of the matter is that we now know that the system was set up to very conveniently remove our children from us and then put the blame back on us.

Ms Bryant—I have had a former consent taker say, ‘They were just bags of trash anyway, and they deserved to lose their babies.’ This is the attitude that we get from these people who are now trying to counsel mothers. That was only in November last year when this woman said that.

Mrs Arthur—That was very recent.

CHAIR—You point to the lack of evidence. As a result of that, you probably cannot answer this question, but are similar post-traumatic stress disorders being exhibited by women who give up their babies to adoption in more humane circumstances, where it is truly voluntary, at least at the time of consent?

Ms Bryant—In Australia and in my group I have only come across one such mother. She was in her late 20s and worked as a gynaecological nurse, so she was well educated. She decided that adoption was best for her child, went into a private hospital, had a private doctor, called the social worker and arranged for the adoption. I facilitated her reunion because her daughter had rung our office looking for her mother. That was the only such mother out of the thousands that we have had contact with. She said that, even though she arranged that adoption herself and it

was her decision, she still suffered terrible grief and loss. I do not know about any of the others because very few of them made a conscious decision to adopt in that era of the late fifties to the mid-eighties.

CHAIR—So there are no longitudinal studies of either the women or the children.

Mrs Arthur—We have a couple of women in our organisation who gave birth within the last decade. Their children are now between seven and nine. The situation they were in at the time they were giving up their children was temporary, but adoption is a permanent solution to a temporary situation. After thinking that they were giving their children up because they could not manage and it was the best idea, they found themselves with major depression and a sense of grief and loss and the sorts of issues that went along with knowing that they had a child growing up somewhere who they were not with. In order to counteract the grief, loss and depression they were suffering, they went into disassociation. Most women who lose children to adoption live a dissociated life because the mind does not understand the loss of a living child. Adoption is not a natural act; it is something that people think at the time will be a good idea. They have to live with unnatural circumstances and their body reacts to that. The mind cannot cope with it.

Ms Bryant—It is similar to child sex abuse. The child can dissociate and put that part of its life into a compartment. Many of the mothers and a lot of the adoptees put part of their feelings into a compartment and do not go there. It is separate. They marry, have other children and try to get on with a normal life. I have had women who have had a child die from leukaemia or gone through a divorce or something, so there is another loss in their life—and I have spoken to the hospital social workers about this—and their losses have compounded and come forward and they have fallen in a heap. Some of them can manage a half-life for many years until something else happens and the whole thing overwhelms them. They are usually the ones who end up in hospital having shock treatment and so forth.

CHAIR—Would most adoptees or women who give up their children think to mention this as a possible trigger for mental illness further down the track?

Ms Bryant—No, and that is the problem.

CHAIR—Do GPs ask?

Ms Bryant—No. I have had the same GP for 17 years and she has been through all of this with me because I have had a psychiatric breakdown as well. She said to me that she would never think to ask: ‘Are you living with your natural family? Are these the only children you have ever had or have you ever lost a child?’ She said, ‘I would never think to ask that when someone presents with anxiety, depression or whatever.’ She said, ‘We’re not trained to ask those questions, but now I do.’

Mrs Arthur—Do not forget that we were branded as women who willingly gave our children away. That was the idea of society—you gave your child away—and that is one of the reasons why women do not speak about it. Women who lost children to adoption never speak about it to strangers because it leaves them open for judgment. At the time, they were told that if they loved the child they would give it up to a happy, healthy two-parent family. Having given up the child because they loved the child, they were then classed as women who willingly gave their children

away. You were put into a situation where you were an aberration—you were an aberration to womanhood and to motherhood, where you could willingly give your own child away. That is what our children have had to live with. When they find out they are adopted, the first thing in their life that they have to live with is the fact that their own mother gave them away. When you can get over that, then you might start living a normal life.

Ms Bryant—I have had many adoptive mothers, including my own daughter's adoptive mother, say to me: 'I don't know what was wrong with this child. For 12 months we walked the floor; she cried for 12 months.' Research that has been done overseas says that these babies are in grief. They have been in a mother's womb for nine months, hearing her voice, knowing her smell. They are born and that act is very violent because they are not allowed to be on their mother's breast or with them. They are just taken straight from the room. They are left, usually, in a part of the nursery near where there are babies of married mothers. There are people coming and going to those babies, but these babies are isolated. Then they are taken home by strangers at about three weeks old and the strangers do not smell right, they do not feel right, they do not sound right; they are actually traumatised. That is what has been coming out: the children have been traumatised as well. We know now that when a baby is born the first thing that should be done is to put it on its mother's breast and have its mother stroke it and talk to it to reassure it that the trauma of being born is okay and that she is still there. Our children were denied that.

CHAIR—That is very interesting; it is very sad too. Thank you so much for your submission. It is good that you are doing the work that you are doing. We will see what we can do to get you some support. Thank you for appearing.

Ms Bryant—Thank you very much.

Mrs Arthur—Thank you very much.

[12.20 pm]

WONG, Ms Christina Hoi Yan, Private capacity

FULLER, Mr Brian, Private capacity

CHAIR—Welcome. Can you tell us the capacity in which you appear today?

Ms Wong—I am here in a personal capacity.

Mr Fuller—I am here to support Christina. We have been fighting the government on certain issues for about three years now, trying to get justice for Christina.

CHAIR—The committee has your submissions, which it has numbered 493, 493A and 493B. Are there any changes you want to make to them at this point?

Ms Wong—No.

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

Ms Wong—It is a little bit complicated, so I will just explain what is going on.

Mr Fuller—It has been a very traumatic and complicated time over the last three years. To make it easier for you to understand it, Christina will go through the process that she has been through.

CHAIR—Take your time.

Ms Wong—I want to express my gratitude to the senators for this opportunity to present my case. My grave concerns relate to ongoing mistreatment, injustice and discrimination against me due to actions of the Queensland medical, legal and political systems. This is due to failures, medical negligence and lack of proper supervision of me as a junior GP trainee doctor from July to October 2001 by Queensland Health, the Medical Board, other doctors and supervisors.

I was a former doctor and psychiatric registrar treating patients in major psychiatric hospitals throughout Queensland. Due to personal and family tragedies and stresses, I became a psychiatric hospital in-patient myself, regulated at times suffering severe depression. While heavily sedated and totally unwell physically and mentally, I was encouraged and allowed to treat patients at the Inala Community Health Centre from July to October 2001. This risked my life and recovery and my patients' safety. In my petition to parliament on 20 April this year I said:

... I, Christina Wong, strongly protest, unjust, illegal treatment and discrimination against myself, a former doctor suffering depression and Chinese immigrant from Hong Kong.

... ..

This abuse risked my life and patient's. The Ombudsman's report, exposed gross negligence by Queensland Health, Inala Health Centre, Queensland's Medical Board, Toowong Private Hospital and other supervisors. My Inala Health Centre, Medical Board supervisor and Toowong Private Hospital primary treating psychiatrist, totally failed their duty of care to me and patients. The Medical Tribunal covered up the true facts of my case. This resulted in a miscarriage of justice, perversion of Queensland's legal system and deregistration.

My submission on 27 April 2005 states:

I believe I have been and are at present, discriminated against in the workforce both directly and indirectly, as a former Queensland junior doctor and GP trainee. This is due to the gross failure and breakdown of supervision while I was working at the Inala Community Health Centre.

... ..

I was ... extremely unwell both mentally and physically. At that time I was on very high levels of sedation and drugs, clouding my consciousness and judgment through side effects as detailed in the report by my present psychiatrist, Dr Elizabeth Molnar.

I was very sick, depressed and insightful and a regulated and involuntary mental patient, but still allowed day release to go to work from the Toowong Private Hospital during July to October 2001. I believe there was a total breakdown of proper supervision and duty of care to me by my employer, Queensland Health, the Medical Board, supervisors and others. This negligence in supervising me as a junior doctor with a mental disability risked my life and health and that of my patients.

This was exposed in the Queensland Ombudsman's report last year, in which my complaints against the Medical Board and others were upheld. The report states in conclusion:

I have decided to substantiate your complaint against the Board to the extent that it is considered that it's monitoring of your participation in the HAM—

the health monitoring program—

at the Inala practice was deficient and constitutes maladministration.

I further detail this discrimination against me has continued, I believe, since then to the present. This is due to the fact that, as a person suffering a disability, my position was terminated as a doctor. I was suspended in October 2001 and in the Queensland medical tribunal decision in October 2002 I was deregistered for five years unjustly. The result is that this negligence and discrimination, I believe, has now destroyed my career and reputation and damaged any future prospects of employment as a Queensland doctor. For me and my family it has devastated our lives over the past three years.

The Bundaberg Hospital Commission of Inquiry has now exposed here in Queensland how medical staff—nurses and doctors, including junior GP trainees like me—have been victimised, intimidated and bullied to keep the failures of Queensland Health hidden from the public. I believe these failures have been covered up by the Queensland government and medical and

legal systems for over three years. As a junior doctor, I am a scapegoat to protect those in senior medical positions over their failures and negligence of me and my patients.

Misuse and abuse of psychiatric testing by Queensland government departments, not to heal but to bully, has also been widely exposed in the media and by Dr Bruce Flegg MP in his parliamentary speech of 11 November 2004. This perversion of Queensland psychiatric treatment and testing to intimidate and silence dissent echoes the methods used in Soviet Russia and Nazi Germany. The *Sunday Mail* editorial in October 2004 said, 'If true, the misuse of such tests is little short of criminal and should be dealt with accordingly.'

I believe the psychiatric work assessment used to refer me to the medical tribunal in October 2001 was totally inappropriate. I was a very sick, sedated, regulated hospital in-patient at that time. This test has now been criticised by several prominent psychiatrists. Dr Bruce Flegg MP in his speech detailed how I was duckshoved with false claims in two letters from Queensland health ministers. These letters originated in draft letters from the Medical Board that misled them and other members of the Queensland parliament about my case. A recent report, on 7 June 2005, authorised by the Queensland Minister of Health and the Director-General of Queensland Health, has asked for justice and the reopening of my case.

Dr Jonathan Phillips, consultant psychiatrist, member of the Australian Medical Council and former president of the Royal Australian and New Zealand College of Psychiatrists, has stated: 'I am left uncomfortable about the premature if not permanent closure of Dr Wong's medical career. I fear that there could have been a miscarriage of justice in Dr Wong's case.'

Similarly, Dr William Wilkie, Fellow of the Institute of Australasian Psychiatrists, in his report requested by the director-general on 27 July 2005, stated: 'There is an odium associated with the deregistration of Christina Wong by the Health Practitioners Tribunal that will not go away, a public unease about the unfair way a diligent, competent young doctor was struck off the medical register. To say that the tribunal's judgment cannot be changed is intolerable in a democracy and is against principles of natural justice. In my opinion the Medical Board of Queensland and the Health Practitioners Tribunal should recognise the harm that has been done to Christina Wong, reinstate her registration and allow her to work under supervision in psychiatry.' I believe the Queensland medical tribunal was perverted in its judgment and processes by including false and misleading evidence, withholding the facts of my case and having a conflict of interest and concerns related to the legal defence of my insurer, United Medical Protection.

Article 1 of the United Nations International Convention on the Elimination of All Forms of Racial Discrimination states:

... the existence of racial barriers is repugnant to the ideals of any human society,

Alarmed by manifestations of racial discrimination still in evidence in ... the world and by governmental policies based on racial superiority or hatred ...

There was blatant discrimination against my Chinese heritage and beliefs and my previous mental health disability regarding these issues. Sean Parnell in the *Australian* in July this year highlighted that over 90 doctors still practising despite having drug, alcohol and health problems

in Queensland are in question. As federal senators of the Commonwealth and members of the Senate Select Committee on Mental Health, I would sincerely seek your deep concern and inquiries. This could include ongoing support, help and contact into the future with a letter written to the Queensland Premier, Minister for Health and Attorney-General requesting the establishment of a parliamentary committee of inquiry. This is to uncover the truth, gain justice here in Queensland and the return to my medical career in psychiatry, healing the sick. Thank you.

CHAIR—Can I just ask you what the status is now of the complaint that you made to the board. Are there any other ongoing opportunities for you to appeal against the actions taken against you?

Ms Wong—Once the complaint was referred to the Health Practitioners Tribunal I was told that initially you have 28 days in which you could appeal against the tribunal's decision and that you can only appeal on an error of law. In my case, the problem was that all the relevant facts of the failure of supervision were not highlighted in the tribunal. As a result of that, I cannot put in extra facts that had not been previously presented; you can only appeal on an error of law. You are left in a situation where you cannot appeal against the tribunal's decision. So basically I cannot appeal against the Health Practitioners Tribunal.

We wrote a complaint to the Medical Board of Queensland a month after the tribunal's decision was released, and I was intimidated in a letter by the CEO of the Medical Board with statements such as, 'The board was not aware that you were a regulated in-patient,' which was disagreed with by the Ombudsman in his report. He said that the board was aware that I was a regulated patient as early as August 2001. Also, the board had made a statement in the letter that they had no duty to supervise any doctors in Queensland, which is obviously not true. So the board had failed to address any of my issues.

I also complained against my primary treating psychiatrist, and the board's statement was that I was the one who chose the psychiatrist and therefore it is nothing to do with the board. That is obviously a ridiculous statement because the board has a duty to supervise all doctors in Queensland. The board failed to investigate Dr Young, even though at the same time there was a psychiatrist who had put in a complaint against the same treating doctor who sat in the tribunal and the board had been taking that very seriously. So the board had taken a different approach according to who was the doctor who put in the complaint, I believe.

Mr Fuller—We have done a lot of research into this whole issue over three years. The whole process has been flawed, discriminatory and totally illegal, I would say and believe—even the process where Christina was referred in the first place and was suspended. She was a very sick in-patient in hospital. She had suffered from deaths in the family and a relationship breakup. Dr Wilkie in his report said that anybody suffering similar stresses would probably end up in the same situation.

She was dragged out of hospital while she was totally doped up and drugged. She could barely walk. She had no memory, her eyes were going and she was leaning on things. She was dragged in front of a psychiatrist by the Medical Board and did a work assessment in that condition. She failed that medical assessment. It was very similar to if you had gone down to the cancer ward, disconnected a cancer patient from a drip and then put that cancer patient through a work

assessment in that condition—and then, when they failed the assessment, you suspended them from work as a preliminary to referring them to the tribunal, I believe.

CHAIR—So the purpose of the work assessment was to get you back into your job.

Ms Wong—I believe the work assessment was actually to get me completely out of medicine. I was a regulated patient at the time when the assessment was done by a board nominated psychiatrist. Normally, if any patient is regulated they are not in a position to be assessed for work assessment. Basically, they dragged me out of the hospital even though the psychiatrist was well aware that I was very unwell. We had FOI documents that showed the board's nominated psychiatrist was well aware of my condition and yet she did an inappropriate assessment of me when I was in that condition. This was actually criticised by my current psychiatrist, Dr William Wilkie, and also Dr Elizabeth Molnar, who happened to be the secondary psychiatrist when I was at the Toowong Private Hospital—the inappropriateness of assessing someone in that condition. The board had their own nominated psychiatrist to write work assessment reports and so there was no impartiality, I believe. You just do not assess any patient that is regulated. Because I was a psychiatry registrar myself, I have a fair understanding of how things should be done in psychiatry. I do not think anyone would have condoned the assessment done by that psychiatrist.

Mr Fuller—That assessment has now been criticised by Jonathan Phillips, ex-president of the Royal College of Psychiatry. It has been criticised by Dr Wilkie, who I believe is a fellow of the psychiatrists institute. It has been criticised by two of Christina's treating psychiatrists. The evidence of the psychiatrists who did the assessments at the medical tribunal was what the deregistration was mainly based on. Christina's assessment in some aspects was race based. It depreciated Christina's Chinese beliefs and also her heritage and used the fact that Christina had Chinese beliefs to cast doubts on Christina's honesty et cetera. We would like to speak to you later in camera on those issues, because they are fairly sensitive. It was a double issue of discrimination in regard to someone with a mental illness and also discrimination of someone who is of Chinese origin, I believe. With the number of overseas doctors throughout Queensland at the present time, if that discrimination is going to continue in the Medical Board and the medical system against people who have a disability or people who have overseas origins, you are going to end up with what you have right now—a total mess in Queensland Health.

Ms Wong—Also, I was trained at the University of Queensland medical school. To treat me like an overseas doctor is inappropriate. Treating anyone from overseas like that is inappropriate anyway. Furthermore, I was trained in Queensland. While I was working as a doctor, when I was not hospitalised at the Toowong Private Hospital, all my references were above 'satisfactory'. Even the board had congratulated me, even though I suffered from a depressive condition. My work references were still brilliant. To crucify someone because of the treatment they receive and have them deregistered is inappropriate.

Even though after this drama happened at the Toowong Private Hospital I was deregistered for five years, I went back to study law part time at QUT, and I was getting high distinctions for all of the subjects that I was studying. In one of the subjects I was the second highest out of 650 students. You are not talking to somebody who does not know what they are doing. To treat me like that in Australian society, which is supposed to be democratic, is ridiculous.

CHAIR—You have exhausted all the legal and other options available to you in this process?

Ms Wong—Yes.

CHAIR—Does that lead you to suggest that there should be some mechanism or other legal opportunity created for appeals of the sort that you would like to mount?

Ms Wong—At the moment, I cannot appeal against the Health Practitioners Tribunal. However, my case has been referred to the Queensland Anti-Discrimination Tribunal. I have had talks with my lawyer, and he has told me that the Anti-Discrimination Tribunal is equivalent to a Supreme Court, which is above the Health Practitioners Tribunal—which is a District Court. I was told that the Anti-Discrimination Tribunal has the power to overturn the decision of the medical tribunal. So, even though the Medical Board was not right, there is no other way except to take them to court—which is not how the system should be running. If you are not happy with someone, you have to take them to court. That is going to cost a lot of money, and that is why all the lawyers are getting so rich. All you can do is to take them to court.

CHAIR—And that is not something you want to engage in?

Ms Wong—As Dr Wilkie said, if the Health Practitioners Tribunal is final, even though there is overwhelming evidence that it has made the wrong decision, somebody should be able to overturn that. If you have gone through all that trauma and then you have to figure out a solution, that is not very good for recovery, after what you have been through. First of all you are told you cannot appeal after 28 days, and your medical insurer had not highlighted the failure of supervision. It is like you have to be the one who does everything. Even though you are not a lawyer, you have to figure out legal solutions.

Mr Fuller—In the last three years, we have had two meetings with the former health minister, Wendy Edmond; we had a meeting on 20 March with Gordon Nuttall and the Director-General of Queensland Health. We presented a very thick folder, similar to what we have presented you. Both the health minister and the director-general came up to us afterwards—on 20 March—and said they felt very uneasy about the whole situation. They authorised a medical expert from outside of Queensland to investigate it, and that was the Dr Jonathan Phillips report that we have given you. That was authorised by the health minister and director-general.

We were then called into the director-general's office on 7 July. He presented the report in the presence of the senior advisor to the health minister and the CEO of Queensland Health. He basically said, 'This exonerates you. This proves that everything you have been saying for the last three years is true.' He went on to say, 'I have no power over the Medical Board.' The adviser to Gordon Nuttall seemed to insinuate the same thing—he had no power over the Medical Board. You have an authority here in Queensland—the Medical Board—that oversees all doctors and all psychiatrists and is not responsible to parliament. It has no overriding authority. It is a power unto itself.

Senator HUMPHRIES—Chair, I am quite happy to ask questions based on the information that I receive in the in camera session rather than at this stage.

CHAIR—We have had a request that the remainder of this session be conducted in camera. Is it the wish of the committee? It is so ordered.

Evidence was then taken in camera but later resumed in public—

Proceedings suspended from 1.03 pm to 1.47 pm

DOYLE, Mrs Jacqueline, Department Manager, Envision Support Services, Auspice Family Support Group Australia

REID, Ms Wendy Kathleen, General Manager, Kids Help Line, BoysTown

WALSH, Ms Karyn Joan, Coordinator, Micah Projects Inc.

CHAIR—Welcome. The committee has your submissions, Nos 67 and 241. Are there any changes or additions to those documents that you want to make at this stage?

Mrs Doyle—I would like to add one document, please.

CHAIR—Okay. As there are no objections, the committee accepts the document. I now invite you to make a brief opening statement, after which we will go to questions.

Mrs Doyle—I am from England. I have been in Australia for six years now. I am a social worker and I worked in England for over 15 years in community mental health, so my background is quite strong in the mental health area. When I came to Australia I got quite a shock to see what the system is like here. The main issues for a non-government organisation that have impacted on our organisation are issues like bed blocking in the mental health services. No-one is able to get in and out of hospital; so you cannot get in and you cannot get out. There is no funding to support people in the community. Families are at breaking point. There is a lack of housing for people trying to get out of hospital. There is a lack of proper assessment in the community. Many mental health workers—and I feel for them—are really burnt out and not able to have the passion that maybe a lot of mental health workers do need. There is poor treatment in the community for people with mental illness and there is division between Queensland Health and Disability Services Queensland.

My view is that the system and cultures need to change in the mental health area because at the moment all this is leading to high suicide rates, people ending up in correctional services and increased stigma in the area of mental health. As an organisation, most of our funding comes through DSQ and there is a great lack of funding for people with mental health problems. We have a very small amount of funding for mental health for children and families but that is very small block funding. We need flexible funding to be able to support people through the system and that is the model which I have just presented.

CHAIR—Would you like to take us through the model?

Mrs Doyle—This model has one central referral system because at the moment people are not getting assessed in the community in time. A lot of the carers are having to take out JEOs to try to get assessments done. By this time it is too late and it ends up with the police being involved which is an unnecessary resource. This is about taking hospital workers out of the hospitals and putting them into a community team. It is a very specialised community team. As you see in the model, all referrals go centrally to that community team where assessments are done by social workers, psychiatrists, occupational therapists—people trained in those areas. They can obviously then refer if somebody is really acutely unwell and needs to go to hospital; they have

access to the hospital. If that is not the case then they can refer to non-government organisations which hopefully will have block funding and can then look at all the other issues for those people. It may be that they can be treated in the community because the aim of the team is to keep people out of the hospital system. A third of people do not need to be in hospitals, so that is their aim. There would be mental health clinics where they would take on case management, so they can continue to do what they are doing now but have access to the acute community mental health based team when they need to have the expertise to come in and do those assessments. The system is a rounded system so that the hospital can then move people out. You do not need more hospitals; you do not need more institutions in the community. You need to free up those beds. There are ways to do it and it does not have to be expensive.

Ms Walsh—I am representing Micah Projects. We have a number of activities to work with people who disadvantaged, socially isolated and where mental illness is a serious issue which affects the quality of their lives. In particular, every year for the last five years has seen an increase in the number of homeless people who have a recently diagnosed serious mental illness or who have just been released from hospital to home, or to a place of accommodation which is not necessarily home, without the appropriate clinical or non-clinical supports coordinated for them. Last week we had a person who suicided 24 hours after being discharged. The issues for us are also about supported accommodation and the lack of connection between appropriate affordable housing and a supportive framework, which can keep people housed in the community. Most models are very tightly funded. They are individual packages. We actually do not have a supportive housing framework that would provide the range and mix of services that people need to live in affordable housing. We are seeing people go through hospital, to the streets, to prison, back to short-term accommodation and then out on the streets again.

There is a problem at the diagnostic end. Many people who are homeless are not even able to access a proper assessment where a diagnosis can be made because of drug use and the whole issue of drug addiction and mental illness and who will see, treat or assess a person first before any comprehensive support system can be put in place. The age range comprises younger people, including the impacts of chroming, right through to people who need to get into appropriate aged care. There is a mix of ages. There are also Indigenous people with long-term alcohol dependency. Again the assessment issue is a major one in terms of what appropriate treatment or clinical support people need which must be complemented by general social and non-clinical support.

Certainly, there is overrepresentation of people who have been in the child protection system in the states. We would certainly recommend that you consider the Senate Community Affairs Committee's report, *Forgotten Australians* and the issues that were raised in that in terms of the long-term disadvantage of people who have come through child protection institutions and systems in Australia. We think there is a lot of background information in terms of the trauma, the impact of institutionalisation on people and how they have been left as adults without the skills or the appropriate mix of services to support them through their adult life.

CHAIR—Thank you. Mrs Doyle, can I ask you, first of all, roughly what year you first came to Australia?

Mrs Doyle—It was about six years ago.

CHAIR—You were able to observe a deinstitutionalisation process in the UK, presumably?

Mrs Doyle—The process came in at that time.

CHAIR—All right. What was different about the UK? Was it the national health system structure—the fact that there was, essentially, one level of government responsible for health—that made better services available in the community? How do you explain, if you can, the difference between the two approaches?

Mrs Doyle—At the moment, what you have here are two organisations—health and Disability Services Queensland—and they are not working together. In England we did not have that issue; funding was given to the local areas to distribute. Social services took up a lot of the health funding and we worked with the psychiatrists as a team. So, health came together with the local social services departments. I do not know whether that helps at all. It is hard to explain two different systems, isn't it? You have a very big split here—you have disability services with some adult lifestyle support funding and then you have health sitting in with other support. Who do you go for? Who is responsible for these people in the community? I think they both are, but they have to work with together.

CHAIR—There is another player, of course, in the federal government, which deals with Medicare and psychiatrists.

Mrs Doyle—And then GPs need to be much more heavily involved in what is happening on the ground level.

CHAIR—Okay. Presumably, central to the approach of the model you describe is the referral system as the first port of call. What does that look like in the UK? Is it distinct? Is it a place? Is it a geographic arrangement of people? Is it in a clinic?

Mrs Doyle—It was community based. We were based out in the community, we were not in a hospital.

CHAIR—The GPs, the police, justice, community and family were together in one place?

Mrs Doyle—No. The doctors were, obviously, in their own surgeries. When you work a patch system you know the GPs in your area and you link into their local meetings, so you are aware of what is going on and they know who you are. This means they can refer through quickly when they pick up something. The GPs were quite active in the area of mental health and the police were, too, because we linked into the local police stations. When there was an issue they would say to us, 'Look, this is happening' and we would get in early and try to avoid admissions in the community.

CHAIR—So the police were not there to intervene when there was a crisis in the community—or were they?

Mrs Doyle—As an approved social worker, yes, you would call them in if you knew an order was going to be made and someone needed to be taken to hospital. At that point you might involve the police. That is how it used to happen. You got the ambulance and police if the

admission was going to happen. We tried to avoid that by early intervention and involvement with those people in the community before admissions were necessary, but admissions did occur, obviously.

CHAIR—In New South Wales, there are area mental health services which, I think, do assessment. Is there such a beast in Queensland, and why don't they do what you are suggesting?

Mrs Doyle—I think there is a big fear. You can spend days trying to get an assessment organised. The clinics are overloaded; you cannot get to see a doctor for a couple of months down in Palm Beach. If you try to go through to the hospital there is a big screening system. If there is any sign that somebody might be aggressive then they back off very fast.

We find the best way is to get a JEO and get an assessment that way, through the courts. A JEO is an order through the courts to have an assessment done within a certain period of time. Even that could just mean that the health services would ring the family up and see what the situation is. It may not mean that they go out. There is a lack of people saying, 'Come on: let's get out there and get on with the work. Let's get in there early with the families and start working through some of the issues.' That does not happen and it needs to happen.

My idea is to get away from the hospitals: get workers out into the community and base them in the community. It is their responsibility to respond to those people, not somebody else's. It is their job to do that; to get out there, do the assessments, follow through and make arrangements for people so they get the support and medical assistance that they need.

CHAIR—Can you confine this just to your area: what extra staff would be required to make this work?

Mrs Doyle—That is a hard one, because I am not exactly sure what workers they have in hospitals. You could pull out some of the workers who already exist in the hospitals and then add components for the social workers and community nurses. They need to work as a team. It is a team responsibility. When referrals come through, they are screened by whoever does that screening process initially and it goes to the team. It may be that it is more appropriate for the psychologist to pick up a referral; it may be more appropriate for a social worker and psychiatrist to go out and do a visit. They need to actually go out to the home—that is how we used to work. The psychiatrist was one of the members of the team. He did not have seniority or anything like that. Everyone was on the same level, I suppose, and that is how it worked.

Ms Walsh—We have similar teams where that occurs, but the caseload and management of those referral processes is highly inadequate. You would have to do an analysis of the workload of the mental health teams. Certainly from the point of view of the client, they do not get access to those team members as often as they might need such access. It is not individually driven; it is driven by the teams' appointment base and when they are next available, which could be in two or three weeks time. When people are in the early stages of diagnosis or are dealing with the early signs of side effects of medication, they are trying to also work out what other interventions would assist clients, particularly if the diagnosis is recent and they do not know why they are in the trauma that they are in. They cannot access the state government mental health services here. There are massive waiting lists and people say that it is due to the case

ratios; that they are far too high. There are certainly no complementary non-government services able to provide more regular input on a day-to-day basis.

People need daily visits when they are very ill. When they are released from hospital, they are just released and the appointment is put in. It might be that the appointment this week involves two visits, next week it will involve one and then it will be a month until the next visit. That is not consistent. People are left to cope on their own with quite a significant change in their lifestyle. Trying to access the sort of support that they need is something they often cannot do because they are ill. Getting the energy and the ability to do it during that acute stage is really difficult.

Our outreach workers could spend up to four hours at a hospital admission with someone who has demonstrated extremely violent behaviour. They could have been quite psychotic in our office or around the surroundings of where we work. They could be at risk to themselves and may have been threatening staff or other people. One of the major issues is the assessment process and how those assessments actually take on board the experience, observation and input of another professional into the process of assessment. Instead, what just happens is the person goes in, they are asked a few questions, a judgment is made and then they are told they can go home. The person is in exactly the same position as they were when they arrived. That person may not be able to comply with any reasonable standard of behaviour in the place in which they are accommodated. They may potentially be a risk to themselves or other people because in the face of any conflict they get very aggressive or violent very quickly. We see quite a number of those scenarios in the homeless population—they are at a particular end of our work. We certainly are very frustrated by the clinical skills and the assessment of need. We want to know what role non-government organisations can play in that and what skill base we need to engage workers who can adequately participate in the assessment and planning of what somebody needs in order to live in the community.

If we say we want some intervention because this person has been at risk of sexual offending or people have made complaints about their inappropriate sexual behaviour or they have tried to assault someone at the residence they live in, we have been told it is a criminal justice issue. We are saying we would like to prevent the crime from happening and we want some intervention. Oftentimes it is about getting the history of that person and all the work that has been done.

In one case we had a man who was quite a risk to himself and the community. When we finally went through his chart at the hospital with a doctor there were 10 occasions where all the symptoms were listed but with a question mark about diagnosis. The reason he could not access the mental health services was that no diagnosis had been made. So you just go around and around in circles. On each occasion that we had to take that person to the hospital it involved up to four police and two of our staff. We were wasting our time and not getting to any reasonable conclusion. The person also had an intellectual disability. It was only through our advocacy and through us saying, 'There is a protocol between these two departments; you need to access the information,' that anything happened. There was also the information from his childhood, when the sexual offending started. Nobody had had that information.

So as to the way in which integration between departments occurs—where the person's history, including their medical history, is kept and how that informs a diagnosis and a plan—there was no plan ever for how this person would be able to live in the community and be at less

risk himself, because he was often a victim of crime on the streets though also potentially an offender. At no stage in the mental health engagement did anyone even consider a plan, and that process went on for five months. It involved our staff for five months trying to work out how we could get to the bottom of this, because there was something impacting on his ability to cooperate. When we finally got to the bottom of it, it was by paying a private psychiatrist—by getting the patient himself to request his files and taking those files to a private psychiatrist a solution could be found. But that is the most time-exhausting and ineffective way of doing it. That person was able to get access to an individual package, but not everybody can and the individual package process is quite an issue in itself, I suppose, because people with mental illness do not always require the same level of support every day of their lives.

Mrs Doyle—That is why you need flexible funding, so you can come in and out of people's lives; you do not have a fixed amount of funding for a person. They do not want to stay in the system anyway. They would really like to get well, get back into the community and do the things they should be doing.

CHAIR—Ms Reid, would you like to make a brief opening statement?

Ms Reid—I am here on behalf of young people. Our clients are in the age group of five to about 25 and we are seeing an increasing load on our services by young people who are exhibiting early signs of quite severe mental health symptoms. Our services include the telephone and online counselling we offer nationally through Kids Helpline and we also have a number of services on the ground dealing with a whole range of client groups, but the one thing in common is that they come from a background of disadvantage and falling through the school system.

CHAIR—Senator Humphries, would you like to begin with some questions?

Senator HUMPHRIES—We have three non-government organisations here in front of us. Can you tell me about how you cooperate, not necessarily with the others at the table but generally, with other non-government organisations in the same field in Queensland, if at all? What are the shortcomings of those relationships? What could government collectively do to help make those relationships and collaborations better from your point of view?

Mrs Doyle—We have a working party on the Gold Coast that has been going for 1½ years now. Unfortunately, all the people seem to change. You go to each meeting and there is a different person from another organisation. People move on from non-government organisations, which is a problem, and that may be for whatever reasons. There is a lack of real passion for the area of mental health. People may only have a very small part of funding for mental illness on the coast so there are not a lot of people who are very involved. From our point of view, we tap into everybody's little bit of funding they might have to provide short-term support for people. So that is one of our areas.

We have quite a strong linking with the Alliance, so they are quite heavily involved in what we are doing. It is a difficult area. I do not know what you could do to help that—maybe more stability in non-government organisations, allowing a bit of viability funding because there is none of that there. We see 150 people a week, and I have got two or three coordinators. They are flat out all the time; they work very hard. We cannot afford to put more staff on. I have got 38

staff at the moment. That is quite a lot, especially in this area of work. But they are not doing a lot of mental health work. It is through disabilities. So we have actually moved into the area of mental health and intellectual disability because that is where the funding is and those are the people who are getting the funding through DSQ at the moment. Those people have extremely challenging behaviour so that is where the organisation has shifted over the years—into that area as well. We want to stay mental health focused but we cannot assist people because there is no funding out there for them. We want to support them. That is really it in a nutshell.

Ms Walsh—Staff from our organisation on a daily basis would work with other non-government agencies in direct referral for service provision. We have developed interagency networks that try to link housing and support together. We have four significant agencies that have funding for homelessness around HAC, SAAP and housing. They try to look at how we can target the responses in a way that will reduce duplication to get the people who are most eligible for the funding the organisation has into that service quickly.

I think the biggest issue for collaborative work in relation to mental health is certainly government and non-government, not non-government and non-government. We have had Southside Homeless Action Network, and the most inconsistent people at that are government service providers. I mean the service delivery end. Partly it is because of the change of staff—whether people have the authority to participate and make suggestions or decisions about how their office can actually relate or do things differently in a local area—whereas non-government organisations tend to be able to make decisions about how they are going to work and implement that.

We have been very unsuccessful at getting any shared implementation across a government service and a non-government service where we would have similar clients. The idea that mental health service case managers would link with us around the case component or the case work that we do is just a myth. It would not ever happen, except to respond to a crisis. So if someone needed to change their accommodation and they want housing, they might ring us for the housing. But in terms of any proactive planning and saying that across the organisations these are the areas of expertise who can provide this part of the puzzle that needs to be put together—how the person themselves can direct that—is something that is not really in our scope of even being able to dream about in terms of the resources that we have got and the staffing that you would need to do that. Certainly in other countries, the staffing models around how individual client driven work is done are quite different from how we interpret it here.

The amount of time we now have to spend sorting out people's Centrelink payments, their ability to show whether they have participated or not, the issues around their income being stable and being able to keep up with where they are living requires individual advocacy. Usually workers have to get involved to make sure that the information gets through, so people who do not have access to a worker miss out. You do not get to know of those people until they have no income and have been living in a park for some time. To answer your question about non-government organisations working together, I think we do extremely well under difficult circumstances. The challenge is really how government service delivery and non-government service delivery can work together when it comes to clinical and non-clinical issues around the needs of a person with a mental illness.

Ms Reid—There are not a lot of non-government agencies for children. However, we maintain a database with about 7,000 agencies in all parts of Australia that we can search very easily by location and key word—for example, ‘6520’ and ‘mental health’—and agencies will pop up on the screen. For people under the age of 18, there is not a lot there. We do not provide specific services for mental health. We provide generic services for young people. As I said, the load of kids presenting who then also have mental health problems is increasing.

Generally when we are interacting with other NGOs it is for things like emergency accommodation. There are not NGOs for severe bullying or for kids to easily access for, say, a family relationship breakdown. The NGO sector is very targeted at adults. In terms of what the government could do to assist, it could help all NGOs break down barriers for access so that young people and adults can access services very easily. We would really encourage modes of access other than fronting up at the door. Because we are a 24-hour service, we pick up heaps of kids after agencies shut down at five o’clock. Their message says: ‘Ring Kids Help Line or email.’ We are picking up that after-hours load as well. I would be encouraging the government to assist other NGOs to develop modes of access that could include things like email, web and telephone. For kids and adults in rural and remote areas there are not other agencies anyway, so we really need to look at being quite innovative in how we deliver services.

For example, last night at 11.30 a 16-year-old boy rang, whose parents were domestically violent. He was sick of it after years and years. They live on Macleay Island, which is a little island just off the coast of Brisbane. He was so sick of it he had gone into the ocean and tried to swim out to the ocean—to just keep swimming. Then he had changed his mind because he thought about how it might impact on his mum, and he had come back. He had rung us from under the emergency services shed. And of course there is no-one in the emergency services shed after five o’clock at night, so how do you get people out? We could just keep that young person on the phone, keep connected, and encourage them to call back again and keep working with us. That case perfectly highlights how difficult it is to work together sometimes, either when there is nothing for the target group or when other services are shut.

Senator HUMPHRIES—Staying on that question of the telephone service that you operate through Kids Help Line, you say in your submission that you responded last year to 5,100-odd phone calls.

Ms Reid—There were around 500,000 phone calls all up. Probably about 5,000 of those were about mental health issues.

Senator HUMPHRIES—Around 5,000 were diagnosed with a mental health disorder.

Ms Reid—That is right.

Senator HUMPHRIES—And this is telephone calls, emails and real-time web contacts.

Ms Reid—Yes.

Senator HUMPHRIES—How do your counsellors recognise and diagnose by telephone or email that a person has a mental illness?

Ms Reid—All of our counsellors are paid and they all have tertiary postgraduate qualifications. Our model of service delivery is very different from Lifeline—which, by the way, also does a fabulous job. Everyone is highly trained in the risk assessment of mental health disorders and suicidality, but we would never diagnose over the phone and we do not proclaim that we can make a diagnosis. It is the same for kids who ring up about child abuse: we do not say we can validate that over the phone. But it is interestingly evident and easy to spot people who are having a psychotic episode, suicidal progress or whatever, not so much by e-mail, because that is delayed, but certainly in real-time mode.

Senator HUMPHRIES—That is useful information. What do you do when a person rings the Kids Help Line and the counsellor identifies symptoms of schizophrenia—when the person has a problem and they are agitated and so forth? How do you organise referrals to other services? Do you get the name and address and contact those services? Do you suggest that they contact the service?

Ms Reid—In that sort of case, where there is evidence of psychosis or an immediate intention of suicide, we would not say: ‘Hey, we suggest you ring ... Goodbye.’ We would do a three-way session. But that involves building enough rapport and trust for the person to tell us who they are and where they are. We are very honest with kids about our duty of care and that we cannot keep something confidential when they are at risk of harming themselves. Generally, that does not stop the young person from telling their story or agreeing to accept a referral, as long as they get reassurance that they can keep contacting us as well after the referral has been made. We do a three-way link-up most often, and we have protocols with mental health around the country and also child protection. I keep mentioning child protection because the end result of child abuse is almost always mental health issues.

Where the young person is reluctant, or refuses, to tell us who they are or where they are, a supervisor, a director of counselling and I make a decision to breach confidentiality and enact a trace. We can do that over the phone or by pinging an IP address—our system shows the IP. That is fraught with difficulties in that it is easy to do but we have to involve the police. We have to engage the police in Brisbane and they connect with the police wherever this young person is. Then the police will follow up and perhaps go to the young person’s house or whatever. We work very closely with the police and they do a fantastic job around the country, but their skills are not always child centred. For example, two weeks ago a young girl came onto the web with a clear and immediate intent of suicide. She had a terrible personal history of abuse, foster care and this, that and the other. She had no ambivalence. She was ringing to say goodbye and have someone witness her life. She refused to tell us who, or where, she was—she was in Box Hill in Victoria—and we immediately enacted a trace. The police were quite slow in coming to our offices in Brisbane. All of our counsellors operate out of a single site. We have 100 counsellors operating here in Brisbane and we deliver nationally from here. The police contacted the police in Box Hill. They went to the young girl’s place but she freaked out. She ran out the back. There was a train line and she hid there. Ultimately, there was a fatal outcome.

Senator HUMPHRIES—So there was a fatal outcome in the case.

Ms Reid—Yes. She hid along the train lines and would not come out when the police were calling for her. She waited for the train to come. So that is quite a sad and bad impact of how we attempt to pick up such cases. There have been cases like that with psychosis where the police

have gone too late. Perhaps there has been a change of shift and they have briefed the next police who have come on and then they, in turn, have not got around there until midnight even though we might have enacted this at 2 pm. I am thinking of one particular case where a kid was clearly psychotic but the police did not get there until midnight and then the parents had not picked up the child. The 14-year-old girl was psychotic and they were really frightened. The little girl was eventually taken to hospital and hospitalised and the outcome was good, but the transfer is not always seamless and not always child centred or client centred.

Senator HUMPHRIES—Do you have a problem applying those sorts of protocols across different states of Australia? There may be different laws in different states about, for example, dealing with children under the age of 18. Are there issues there?

Ms Reid—We have taken—for want of a better word—the strictest line. We have just decided that even though laws vary between the jurisdictions we will enact duty of care to the highest level. We simply cannot afford not to with our client group. They are too precious. So I get around and we have developed protocols. I talk to the agencies and the police.

Senator HUMPHRIES—Ms Walsh, you recommend that there should be compulsory fully funded training about mental illness for all private sector workers in the accommodation industry. What sorts of people are you referring to there and why do you pick out accommodation as an area above others?

Ms Walsh—In Queensland a significant number of people with mental illness live in privately owned, supported accommodation facilities. The skill level of the owners and staff in those facilities is often not up to the standard that you need for the needs, behaviour and characteristics of the people that are residents. At the moment they certainly do not put the investment in or do not have the money to put the investment into training their staff. They are dealing with a whole range and mix of people from those with quite severe mental illness to people with less severe mental illness and the ability to manage—we are talking about places that can have up to a hundred people—is important. The quality of care that that then leads to in terms of the impact of residents' behaviour on one other is quite significant and the control that people have to exert when a crisis occurs could sometimes be avoided with a better skills base and staff.

Senator HUMPHRIES—Are you talking about hostels, boarding houses, backpacker facilities and things like that?

Ms Walsh—Not many people who are homeless can access a backpacker facility these days. The standard has changed. Today they explicitly say that they will not take people on Centrelink. There is a major accommodation issue in Brisbane around what sorts of facilities are available. We refer people regularly to substandard accommodation only because they say that they desperately need to get out of a park. So the range of accommodation options for people who have a mental illness, whether they are well or not well, is limited. When they are well they need something that can maintain a certain standard where there is not so much conflict. The level of conflict that people have to manage in a boarding house, for example, which does not have supervision, is considerable. Usually one of the residents is given the responsibility of being the supervisor and the ability to manage conflict will be the most dominant reason that leads to things getting out of control.

With regard to Kids Help Line, I think the after-hours component is a really major issue. There are very few services funded for after-hours availability. We have an after-hours service that works until 11 pm and there are very few services that you can ever refer to. Also, with homeless families, we are seeing much more children with parents with a mental illness who are really in need of support after hours. The only thing we can do is give them the Kids Help Line card and say, 'If you really need to speak to someone between now and tomorrow, this is the number to ring.' They often report that they have rung that number and it has eased their feelings of isolation and fear, but it is not the answer to their problem. There needs to be much more consideration given to what children in families in which either one or both parents have a mental illness need during stages when their parents are not well. There is often a heightened fear that we are going to involve child protection agencies and that the only solution will be removal.

A whole lot more work needs to be done around the kinds of services that we could put in place so that they still can live with their families but have access to the support that will ensure their protection. Services are very much having to resort to child protection intervention in order to say that their duty of care has been met, because they are unclear as to whether the behaviour of the parents is going to be harmful or not harmful. We only get a little snapshot. We do not have the capacity to send a worker out regularly to check on them, because we just do not have that range of services that can assist people in that situation.

CHAIR—Can I get some advice from anyone who cares to answer about the concept of case management, which seems to work in many circumstances but seems to be all over the shop in mental health? Ms Reid, perhaps you could start, because you are one of the many who suggest case management. How would it work with an agency such as yours, which is basically a telephone service? Are you the holder of that case management? Where should it reside?

Ms Reid—In the case of working with young people on the phone for the long term, if we realise at the first presentation of a young person that this is going to be a long-term relationship of delivering counselling and therapy to this young person, we will start our own case plans, which are all electronic and can be drawn up on the counsellors' computers.

CHAIR—If someone answers the phone and a young person gives their name, do you immediately bring up something of their history of phoning you?

Ms Reid—Generally, a young person will work with their same counsellor across a period of time. The counsellor will say, 'Ring me back next week at this time.'

CHAIR—So names are exchanged and all of that?

Ms Reid—Yes. Kids do not have to say their name if they do not want to. That is one of the things that makes them feel safe about our service. If that young person is also involved in a mental health agency or with another mental health professional, our counsellors will often talk to that other mental health professional about a combined approach. For probably 10 per cent of our clients, our counsellors are working with their mental health professional. They might see that professional once a week or once a month for their face-to-face, but we pick up their support across the rest of the time. Basically, it is just touching base between the counsellor and the

worker on the ground to make sure that they are working in the same direction with the young person.

With regard to our other BoysTown services, we offer support and accommodation to kids referred to us from the mental health system. That will always be a case management approach, and it is case management that is developed with the young person, because there is not much point in deciding what is going to happen to them without their engagement and the outcomes are always a lot better. In case management, everyone knows where you are going. There is a plan. There are some goals. You can measure progress and change the case plan. It is a way for the client and the counsellor to have an agreement, but it is also a way of other people involved knowing the plan.

We had a young woman in Sydney who was hospitalised for a mental health problem but had been allowed out for the weekend. The weekend had gone wonky, and she had rung us in a crisis. She was cutting and harming herself terribly and was terribly distressed. She told us what hospital she was at, and we rang them. Because it was the weekend, her team were not there. The people there could not work with us because they were not allowed to get into her case plans and her file. All the time we come across terrible obstructions in trying to deliver something seamless to kids and young people. There are privacy laws and policies in place so there cannot be information sharing, and that works against providing seamless support. We would advocate some freeing up and sharing of information about clients, with their agreement, so that, when the crisis with the hospital is finished and the young person is out in accommodation, if they are accessing an employment service, schooling or whatever, there can be a holistic working together.

CHAIR—If you were to relax the privacy laws to achieve that, would you not need something else in their place, such as protocols or standards of care, to protect people and make people understand what they are allowed to do with that information?

Ms Reid—Absolutely, and always with the permission of the client. It is quite hard to get informed consent from a client having a psychotic episode, but I believe that we could have protocols and ways for professionals to work together across the government and non-government sectors. I think privacy laws are for agencies and professionals. They are not really in the interests of the client. I think they are about professionals protecting themselves. I would like to see them re-looked at in the light of what is going on and the burden of mental health.

CHAIR—Can you expand on that? What are they protecting themselves from?

Ms Reid—Litigation.

CHAIR—By their malpractice, inadequate care or what?

Ms Reid—Our experience across the sector is that professionals engaged in delivering therapy or interventions are reluctant to make their practices transparent. You do not know what happened or what the exchange was during a lot of stuff that goes on, such as appointments between clients and therapists. All you know is whether or not young people or even adults are improving, getting therapy or having drugs across a period of time. I would like to see greater transparency and accountability across the whole profession.

We were forced to go there because our clients wanted online versions of intervention and therapy. We knew we had transcripts that could be read, and that meant we had to be very highly trained and supervised and very careful in our practice that what we were delivering was always above the board. I am not implying that what goes on is below the board; fantastic work is happening. It is about being able to make the content of interactions and the agreement with the client around case plans and case notes available to other professionals.

One person has highlighted how staff get lost across NGOs—they are there one week and gone the other. So clients are always retelling their stories. They take two steps forward and two steps back. I think if there was more sharing of information in the best interest of clients and less paranoia amongst professionals about what might happen or people suing them or litigating, the interests of clients would be better served.

CHAIR—Mrs Doyle, do you agree with that? Do they do this better in the UK with regard to privacy inflexibility?

Mrs Doyle—I do not know what it is like now—it might have changed—but we were talking across agencies at the time when I was there. I was just thinking about the Project 300 people, which you are probably aware of—the guys that came out of the institutions. When they came out, we had no history about them. They had been in institutions for years and years, and we got hardly any information about them at all. That is an example of taking on clients who required a high level of support with no history about them; we had to learn about them as time went on. I want to refer to those people. They were in 24-hour support and then they were in the community. Initially the set up was that the health department was involved, DSQ funding, housing—so they had all those, and the support services were set up for them.

Those guys are not in institutions now; they are still in the community. They do not need high levels of 24-hour support; they might be on 30 or 40 hours of support. You still have people in hospitals, like Robina Hospital. There is no Project 300 funding for them anymore. They do not need to be there. I have had a disagreement with one service. ‘They need 24-hour support,’ I was told. I said: ‘They don’t. You’re just making a judgment. You’re assuming they need 24-hour support. They’ve not been given that opportunity.’ We need to look at who is in those hospitals. What are they are doing there? How long have they been in there? We are institutionalising people again. They are in there for years—some of them are still in Robina Hospital from Wolston Park. We need to address those things. We want to support them; they do not need to be in those hospitals. We have got to get it right for them.

CHAIR—Hence your comment in your submission about it being difficult to get out of hospitals. Ms Walsh, did you want to comment on that point?

Ms Walsh—It is in relation to your question about our case management. I think it is a term that is overused these days, and I think that different people mean different things by it. I would be really cautious about an answer to effective case management or effective cooperative work between professionals and people who are accessing our services, and professional to professional changes in the privacy laws—even though I do accept there are some things at times that are difficult, particularly with the medical profession. I agree that professionals need to be more accountable. But we would see just as much harm done by people sharing information that they should not be sharing and judgments being made by information or

comments that have been made without consent. It is an area where professionals need to be much clearer about how they do their job and how they work with individuals and how individuals direct it.

With regard to your first question about where case management should be located or who does it best, I have a strong view that the non-government sector uses case management theory quite regularly, but there are different applications to that. The thing that the non-government sector seems to be able to do is to provide more flexible application of that theory to the needs of people around the clock, around the 24-hour spectrum. We are able to respond to holistic needs. We are not in the box—some agencies may be, but we do not have to be—that says we will only work with your mental illness. We can sit with people and plan their housing, their health care, their social and recreational needs, and their support with their families. Government case management practices cannot always do that, because they are there with a lens.

We have people who have three or four case managers—a probation officer, a mental health worker et cetera—and it is a question of who is in control. We have really got to work towards a position where the people are in control of their own lives—directing us as to how we can best support them to live in the community, to live the quality of life that they determine themselves. Whether that is living in independent accommodation by themselves or living in a communal situation, whichever they would prefer, we need the range and mix of options to offer people so that their needs are being better met.

The non-government sector does not have the funds to adequately provide the planned and negotiated support that many people with a mental illness need. We do not have the staffing that could go anywhere near that. The case management that I see the government deliver is quite specific and it is about one issue at a time, then they have to find the other agency that will do the other bit. But I think the non-government sector is in a really good position to provide the kind of mix and range of services that can provide holistic outcomes for people, rather than focus on one particular issue in their life.

CHAIR—We have talked a lot about the public sector and the non-government sector but, Ms Walsh, I think you talked about the inadequacy of the public sector. Others have talked about the ease with which you can access services at a much earlier stage of an illness through the private sector—particularly in private hospitals and, if you live in the right—

Ms Walsh—I would not say we did it with ease, but we did in the end access them.

CHAIR—Also, access even to psychiatrists, if you have enough money to pay—or if you have even more money to pay—a psychologist, who does not come under Medicare, of course. Is there a way that non-government organisations or even smaller public sector organisations—area mental health centres or whatever—could be there for people who cannot afford private health? I am asking for a comparison of the two and whether we should apply some of the principles that we apply to access mental health services in the private sector to the public sector.

Ms Walsh—I think both can do it better, if they are adequately resourced and if there is a clarity about what role people are playing. Where are the real limits of it? The public sector might say they do the case management and provide a holistic service as part of the aspiration of what the mental health service does, but in reality they do not. They do not have the staffing or

flexibility to do it, they do not have the cars available for people to go out and the same could apply to a non-government organisation. So it is really about being clear on the resources that people need in order to be responsive; whereas, at the moment, people with a mental illness have to fit into how an organisation organises its resources, rather than organisations looking at how we manage our resources to better meet the needs across a 24-hour span.

CHAIR—Finally, I invite you to discuss the problems associated with comorbidity. Ms Reid, I imagine that, to some extent, the problems are more acute in your area than in adult services. We hear the rhetoric about treating both conditions but it seems that it is still easy to tell people they have to stop using substances before they can be treated for their mental illness. What is your experience?

Ms Reid—Our experience is that the use of drugs or alcohol, deliberate self-harm or eating disorders are symptoms and ways of coping, and removing those things from someone depletes their range of tools by which they get through their life. Even though we find those tools horrific and not fitting in and a lot of services say, ‘You’re not allowed in here while you are doing those,’ I think that excludes a whole range of people. We need to understand that people engage in those sorts of things as a way of dealing with their pain and trauma. In fact, if they had access to services that started to help them verbalise and unravel the pain and trauma that they had suffered, a lot of mental health would go away and with it would go those associated symptoms, such as drug and alcohol abuse, self-harm and disordered eating et cetera.

We see that time and time again, and that is why, when we talk about mental health, we should also talk about child abuse, violence and generational conflict. I guess I am swinging it towards early intervention and prevention. They are all fine words, but time and time again that is what we see and those behaviours would drop off with some regular support in some other way. Treating people for a mental health issue denies them the right to be treated as a whole person with everything that they bring. I am sure the other witnesses present see it all the time too.

Ms Walsh—We certainly see that there is a problem with getting any intervention that is appropriate in a crisis, because of this passing of the buck of whether it should be the mental health system or the drug and alcohol system. I agree that we need more holistic services. You cannot separate primary health care, mental illness and drug addiction in some groups of some populations. Those populations of people need a more integrated response to their circumstances. It is costing a lot of money to do it the way we do it now, even though everyone is horrified when you say what a holistic response would be in the long-run. It would not be more expensive than what is being done now.

It is the transition that is the problem—having the money for some of the early intervention and holistic responses and to make the transition away from the tertiary response and the crisis response. We see people go from the watch-house to the psych ward to detox. There is no coordination. People are going through those places all the time and there is no capacity to try to take hold of walking someone through it in a way that will bring it to a conclusion where they can get a range of support.

I could not agree more about the importance of trauma. The psychiatric system does not really tend to validate the need for people to talk about trauma and the impact of violence in their lives, against which they tend to medicate. A lot of people self-medicate because they cannot cope with

the medication they are receiving through a psychiatric assessment or psychiatric service. There are several people that I can think of immediately who finally got a psychiatric assessment because of being at a real crisis point, only to be put on drugs and encounter a lack of human engagement when they got there. For example, they see the psychiatrist for 10 minutes or people make a 20-minute assessment about what is going on. There is no direct link to any thinking that a patient should have access to a system where they can unravel how the trauma has built up and the impact of it in their life. Certainly, in the *Forgotten Australians* report from the Senate you would be able to read about that in more detail.

It is the same whether it is in a family or in an institution. It is the accumulation of violence and trauma in people's lives that the system, both in the community and in government institutions, does not create any space for so that people have enough human engagement with a person with the skills to work that through. A woman said to me the other day: 'I was under the assumption that if I went to a psychiatrist they would talk to me. All they have done is give me medication.' People are caught in that cycle of not having the appropriate mix. They really need the medical and clinical, but they also need the therapeutic, counselling and social support.

CHAIR—The committee has been told that, when admitted to an in-patient service, whether it is through emergency in a mainstream hospital or through a psychiatric institute of some sort, people's treatment consists of being observed for two days and having their medication stabilised. Is that what you are talking about?

Ms Walsh—That is similar, yes.

Mrs Doyle—We do not have a lot of success, unfortunately, with the process where a patient has to give up drugs before going into a drug unit. It does not work that way. We have had some poor responses to that from our guys. For example, you might take a pill for a headache; they have a joint to stop the voices and things that are going on in their heads. Yet you cannot take one away from the other. It is a part of life now, and you have to deal with everything as a whole.

CHAIR—Is it clinically possible to treat someone who is using heroin, for instance, for their mental health problem?

Mrs Doyle—I think you have to; otherwise you are ignoring the whole group of people.

Ms Walsh—Plenty of people on heroin are capable of telling you the trauma and violence they are trying to deal with, or what issues in their lives are creating the turmoil. Unpacking that might lead them to make choices about their heroin use. The way people are labelled and pigeonholed according to which system they are treated by has to be more responsive. I am sure people will tell you whether they think their treatment is appropriate. When they go to a psychiatrist or a mental health service—or a drug service for that matter—they often have a request about what they would like provided. And they are often told, 'No'.

CHAIR—It is most interesting. I think we could have talked with you for the rest of the afternoon, but we do have other witnesses. Can I thank you sincerely for making your submissions and for appearing before us today.

Proceedings suspended from 2.56 pm to 3.09 pm

BEDWELL, Mr Kingsley Jon, President, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

CHEVERTON, Mr Jeffery Stephen, Executive Director, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

KILROY, Ms Debbie, OAM, Director, Sisters Inside, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

CHAIR—Welcome. Would you care to elaborate on the capacity in which you are appearing.

Ms Kilroy—I am the Director of Sisters Inside but I am here as a member of the Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

Mr Bedwell—Sisters Inside is also a member of the alliance.

CHAIR—And you will reappear as a representative of Sisters Inside after this?

Ms Kilroy—Yes.

CHAIR—The committee has your submission, which it has numbered 288. Are there any changes or additions to that document at this stage?

Mr Bedwell—No.

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

Mr Bedwell—The Queensland Alliance of Mental Illness and Psychiatric Disability Groups represents a considerable community of interest of consumer, family and community groups, but its voice, nonetheless, is small in the midst of some very powerful voices in the mental health debate. We do appreciate, therefore, this opportunity to present our perspective as witnesses to this inquiry. There has of course been a lot of comment in the media over recent times on mental health issues, and no doubt the Senate committee's activities would have contributed to that. A lot of the comment has been about how the service system has not been working and that deinstitutionalisation has failed. These statements seem to be linked by some people. However, I believe we need to analyse the failure of policy or the poor execution of good policy, including the failure of the National Mental Health Strategy, as well as look at areas where the system has worked for people, rather than have a debate about the pros and cons of deinstitutionalisation or the implications of noninstitutionalisation.

The fact is that, for a significant number of people, deinstitutionalisation meant transinstitutionalisation. It meant their commodification in the marketplace. It meant their exploitation. It meant abuse and neglect. It meant a sentence of long-term chronicity in private-proprietary boarding houses. The fact also is that for some people it meant homelessness and for others periods of imprisonment—and that continues to be the case. However, for a significant

number of people, deinstitutionalisation also meant a preferred and satisfying life in the community, outside the oppression and horrors of institutional life. People's stories are many and varied and sometimes inspiring. These outcomes have sometimes been the result of good policy and planning—and we in Queensland have a wonderful example of good policy and policy implementation with regard to institutional reform and we hope to have an opportunity a bit later to discuss that—or they have been in spite of the system, when resilient people have found a caring community of support within the community.

We need to examine these successes and not reinvent the wheel. We need to make sure we keep the things that worked for people. For the new generations that have not been subjected to institutionalisation, we can be thankful that our sons and daughters are not going to unnecessarily have their most basic rights taken away from them because of their illness. Again, there have been some wonderful and inspiring stories from this new generation about their recovery journey. My paid role is as chief executive of Richmond Fellowship Queensland, which is a mental health service provider. We have been around for 30 years and have made a submission to the inquiry as well, but I just want to mention here, hot off the press, this DVD, *Journeys of Recovery*, produced by a group of consumers who use our services. These are truly inspiring stories of people having their needs met in the community and achieving lives of some satisfaction.

It has also been the case for a significant number of people that the system is not meeting their needs, and I am sure this is what the committee has been hearing a lot about. However, it would be unconscionable and facile to relate system failures to the closing of obsolete institutions. This was good policy, not bad policy. I want to make that point in my opening statement. It is also, at best, an inadequate response to say—and I am sure senators would have heard this often—that, yes, we have some cracks in the system that people fall through and what is needed are more resources to patch up the system: more public hospital beds, more investment in the public community services, more public mental health professionals, more case managers, maybe some further realignment of the deckchairs on the Titanic of the public mental health system.

However, we know that New Zealand, for example, have taken a different approach to community care alongside their deinstitutionalisation programs and their outcomes have been much better on a number of indicators. We know, for example, that since deinstitutionalisation in New Zealand criminal offending behaviour rates have dropped because their community care systems are in place.

Consumers have also been telling us through the recovery movement for over a decade that they want to be recognised as a person, not a mental illness. They want to have their specialist medical needs addressed as only one aspect of their lives rather than to have all their needs addressed or enveloped in a bureaucratised medical system of care. To assist with their recovery, consumers are looking not for a homogenised system but for a diverse range of rehabilitation and support services and opportunities, in addition to supported housing and vocational opportunities. Families also want these services for their loved ones. They want to be mum and dad; they do not want to be a human service agency; they do not want to be a de facto mental health professional.

We are saying that we need services that achieve the best outcomes for people, and where the significant investments should be in mental health is where people are living their lives in the

community. Community owned and managed services and supports have a much better capacity, more appropriate value systems and the ability to be flexible and responsive and to quickly adapt to rapidly changing environments. Our position is also that significant investment in our sector is not simply to complement or support the public system but in a number of areas—not all of them—to provide an alternative system of care to those services. As I have indicated, this is not a radical proposition but is an approach implemented by our cousins across the Tasman.

To conclude this opening statement, after 35 years of involvement in this work in a variety of roles, including at senior levels of the bureaucracy and in the provision of policy advice to government, I want to make this observation: it is not possible to comprehend the failures of mental health policy and policy execution, including the failure of the National Mental Health Strategy, or the systemic failures we hear about without recognising that the mental health policy environment is ‘a strife of interests’—that is a phrase that someone else used. We need to apply the political economy test if we are to comprehend those failures. In other words, whose interests are they and who benefits? It is for this reason and because of the history of our failures that the Queensland alliance is strongly advocating with others for the establishment of mental health commissions at both federal and state levels. Senators, thanks very much. I look forward to a discussion with you.

CHAIR—Ms Kilroy, did you plan to make a statement?

Ms Kilroy—No.

CHAIR—Mr Cheverton?

Mr Cheverton—No.

CHAIR—Could I start by asking about Project 300. You have given us a copy of the evaluation, which suggests that this is a good service model. What is its status at the present time? Is it confined geographically? Are there plans to roll it out more broadly? Is it going to be a long-term approach to mental health care?

Mr Cheverton—It is confined financially. That is my understanding. There was a certain amount of funds allocated and allowed. I think it says in the report that there are something like 218 people to be supported. I do not know that we actually got to 300. It is difficult for us to give you any other information because the Queensland department has not given us this information. There was a certain amount allocated and that has enabled the support of the number of people who have come out, so it has ended.

I worked for the housing department when that program was initiated and implemented and then I moved out of mental health for a while. I was quite surprised when I returned to discover that investment had gone into community care units, which are slightly different to psychiatry wards, rather than the funds going into a Project 300-type model. This evaluation was only done 18 months ago but the evaluator, Tom Meehan, has done a follow-up, five years later, which is soon to be published. Of the 218 people who had come out, only three returned to long-term care. Of a sample of 53 from the 213 whom they spoke to, all were extremely happy about living in the community. One consumer commented: ‘The outside world is a good place. You wake up in the morning and the outside world is there. You are always free. You can do what you want as

long as you don't break the law.' That is obviously quite different to their experience in a psychiatric hospital.

So we are surprised that this successful project—which was, I think, the only time three separate government departments actually signed off on a memorandum of understanding and implementation—has not flourished. We advocate strongly programs such as this. We would probably make some changes now. The community sector has learnt some things. There are some additional and different things that we would do if we were to go around again, but to date we have not been able to get the interest of the state government in expanding the program.

CHAIR—And there was not a reason given for lack of expansion?

Mr Cheverton—No. Financially it is a good deal. If you look again at the costings that are in there on average for those people, it was about \$57,000 per person. I think prison is more expensive than that, and certainly they have got the costings of psychiatric hospitals, which are \$160,000 per person per year. These figures are not adjusted for inflation, so it would cost a bit more than that now. But it is quite clear that funding to non-government organisations to support people on their recovery not only meets clients' needs but is cost-effective. It comes back to what Kingsley was saying: whose interests are being served by maintaining a medical approach? Our perspective is certainly not the interests of people with mental illness.

CHAIR—So they did not use psychiatrists as much or drugs? Who is missing out by this model?

Mr Bedwell—The Project 300 policy was part of a capital works program in the early nineties. So the original purpose or rationale for it has probably been lost now. But the approach taken was to ensure people have had their treatment needs met within public mental health services which included the psychiatrists and case managers, to make sure their housing was looked after and to make sure that all their range of other needs were met through non-government services. So it was a cooperative project, both at departmental levels and at the service delivery level, which worked exceptionally well.

CHAIR—How is it that only 218, fewer than 300, were chosen? Were there more who could have been involved in the program?

Mr Cheverton—All the people whom Jacqueline spoke to you about in Robina Hospital, for example, obviously if they each had an individualised package of support priority access to public housing and access to mental health services, they would not be in that hospital anymore. One-third of people in psychiatry wards are only there because they cannot be discharged to anywhere safe. Again, if this funding were available to them, they would be out of those psychiatry wards, at a \$100,000-a-year saving to government.

Mr Bedwell—There was also discussion—this is a few years ago now—about using a modified version of the model to relocate and move people out of the private boarding houses which were used from the late 1970s even to this day, which I call transinstitutionalisation. In New South Wales the government, just a few years ago, under the name of the Boarding House Relocation Project, did precisely that, using the non-government sector as a place to provide supported accommodation and a range of other supports for these people. So there has been a

closing down of those private boarding houses. We had successful model here, which we are very grateful for and which has some wonderful stories that flow from it. But we are concerned that we have not picked up on that and run with it.

Senator HUMPHRIES—On that last point about savings by moving people out of the psych wards, I suppose that a cynic would suggest that you move the people out of the psych wards and the wards will be backfilled by other people who cannot presently get services of one sort or another. So there goes your saving if you do that. Notwithstanding that, you make a very good point. The point was made to us yesterday by another peak organisation that the real need is for those community based services to put people in the most appropriate settings and get them on the road to recovery. With respect to the general situation in Queensland, you say in your submission that here you experience the ‘lowest per capita funding in mental health of any state/territory’. Is that simply a reflection of lower health spending on services generally or is mental health disadvantaged even relative to that?

Mr Bedwell—I cannot give an accurate answer to that. I know that mental health expenditure in Queensland in terms of the overall health budget is well below what it should be if we were looking at the burden of disease and those sorts of things. But I think that is the case Australia-wide. I think that it is fair to say that Queensland does have a history of a lower level of service delivery, and the mental health issues and problems may just be consistent with that pattern.

Mr Cheverton—Just in response to the comment that once people get out of hospital there will be heaps of other people coming in: again, we know that, if there are sufficient psychosocial rehabilitation services provided by non-government agencies in the community, there will be fewer people presenting. It is well documented in other countries that providing non-government community based services actually keeps people well so that they do not end up presenting. There will always be some people who will of course—there always will be a need. We are not suggesting the complete abolition of psychiatric wards just yet, but there is just nothing until you hit crisis point and even then there may still be nothing other than jail or the streets. We find it quite hard to understand why it is that the non-government sector with so many successes has been ignored for so long in the mental health area.

Senator HUMPHRIES—You also comment in your submission that community mental health services are being managed by hospital executives at district levels and they are increasingly resembling outpatient and outreach services of hospitals. Why is that occurring? Is that simply a consequence of an administrative arrangement that suits the Queensland government or is there a conscious model change there that has brought that about?

Mr Bedwell—That is right. If we go back 15 or 20 years the community services were administered in a quite different way—in fact, centrally—and the hospital services were administered within the regions or districts or by hospital boards, depending on what part of the history you go back to. I suppose that under the National Mental Health Strategy of continuity of care and mainstreaming—which of themselves sounded like wonderful ideas—and because of changed organisational arrangements in Queensland in the administration of health services, for which we have regionalisation and subsequently districts, the responsibility for these community services was at one level the responsibility of the director of psychiatry in a public hospital.

What we have seen is the trend over time—because of the director of psychiatry sitting in a hospital being preoccupied with hospital issues—for community services to increasingly resemble outpatient services rather than community based services. In fact, we have seen examples of those services being relocated from outside the hospital campus onto the hospital campus. If we had any hope that public community mental health services could meet the needs of people in the way that we have been talking about—and I remain a cynic about that regardless of where they are sitting in the community—that meant that people were just getting follow-up services for symptom management and fairly low tertiary level services.

Mr Cheverton—It is a work force cultural issue as well. Institutions dominated mental health for a very long time, until only recently. There have not been enough resources to necessarily upskill people. People who have worked in Wolston Park may move to a position called ‘community nurse’ but their values may not necessarily change. Queensland Health has just done a whole range of training with workers presenting the recovery model, which we strongly support, but it is still the case that a lot of people have been grounded and trained in Wolston Park, Mosman Hall or Baillie Henderson. When I visited Arthur Gorrie, a remand reception centre in Brisbane, not only were a lot of the people in the health service there people with mental illness but the nurses were also ex Wolston Park nurses. It was almost like the whole thing had been shifted down the road to Arthur Gorrie.

There is a culture of containment, medication management and control: ‘I am the professional and I have the knowledge, while you are the client and I know what is best for you,’ which is clearly a paradigm that is not going to shift just because your job title changes. The medical model operates on that basis. Non-government services are not coming from a medical model; they are coming from a position where the person is a whole person and they are not just an illness. We are focused on their recovery and on trying to support them on their journey of recovery. We have a diversity of organisations doing that. You can choose which organisation and which model best fits you. The Richmond Fellowship might be what you want, but Open Minds might better suit another person. An Aboriginal non-government organisation might better suit someone else. I think there is far greater capacity in the non-government sector to meet the diversity of needs as well.

Senator HUMPHRIES—Can you give me more information about how this mental health court works? Perhaps Ms Kilroy might be the best person to ask about this—the idea that a Supreme Court judge, with two psychiatrists in tow, sits and helps divert people with a psychiatric condition away from the conventional court system or at least the correction system. How do cases get before that particular judge? Does it cover the whole of Queensland?

Ms Kilroy—I am not actually completely au fait with that. I suppose my line around mental health courts—and this is from Sisters Inside and not necessarily Queensland Alliance; Jeff or someone needs to speak to you about that—is that our concern with mental health courts, as drug courts or Murri courts, is widening the net. We look at diversion but, if we do not have resources in the community for diversion to occur, we are just widening the net and criminalising more people. That is our concern with those types of diversionary courts: because there are not resources in the community, lots of times, to pick up, assist and support the people who are being diverted, they get criminalised. Our concern is widening the net and criminalising more people who have mental health problems or mental disabilities. In regard to how people end up there, I imagine that lawyers make recommendations to get there. Do you know how, Kingsley?

Mr Bedwell—I might make a comment and then Jeff can. I was involved—in a different life in the mid-1980s—with the then director of psychiatric services in developing the legislation. It was then called the Mental Health Tribunal but it was a Supreme Court judge diverting people—in terms of addressing issues of criminal responsibility and fitness for trial—into a more inquisitorial environment rather than the adversarial system. That system has worked wonderfully well—it is a very humane system—over a long period of time. Unfortunately, with the review and reform of the mental health legislation in the 1990s and the expressed concerns of some victims of crime groups, the concept of that system was under some threat. I had a role in the late 1990s advising the then health minister about the arguments for retaining the system.

There are some concerns, though. I think the director of mental health can refer people through the Magistrates Court—a legal defender can refer someone to the Mental Health Court. There is an issue with people coming before the Magistrates Court. The Legal Aid people do not have much time and do not make proper assessments. We have met with the Attorney-General about our concerns.

Mr Cheverton—It seems quite difficult to get diverted to the Mental Health Court, and it seems that most lawyers do not even know about it and do not use it. People are churned through the Magistrates Court so quickly that the duty lawyer turns up and has a minute to find out what is going on before he appears. He appears for five minutes and neither he nor the judge figures out that the person has a mental illness and thinks to ask whether they want to plead that they do not have the capacity. We support the Mental Health Court because it takes people out of the criminal justice system and into the health system, but it is not well used and the criminal justice system does not seem to recognise it.

There is a disability law project happening in Toowoomba, the only project of its type we are aware of in Australia, whereby a lawyer, through nongovernment organisations and being in the Magistrates Court in Toowoomba is able to offer legal support to people. He has been endlessly surprised by the duty lawyers' lack of knowledge of the Mental Health Court. Through his intervention, he has been able to refer quite a number of people to the Mental Health Court. In fact, he is responsible for 22 per cent of the referrals that have gone to the Mental Health Court in the last three months and he works in only one of, I think, 80 districts in the justice system. He should be responsible for two per cent of referrals, but he has been responsible for 22 per cent of them. So, clearly, while an avenue for getting people out of the criminal justice system is there, it is not used.

Another complaint we hear is that, because the Mental Health Court is underresourced, people wait for a very long time even though there is only a small number of people going through it. If they are on remand and waiting to appear before the Mental Health Court they can in fact be incarcerated for longer than if they had simply pleaded guilty to the original offence.

The other problem is that you have to get psychiatric assessments. We all know the Cornelia Rau case. You are aware of how psychiatrists determine whether or not someone has a mental illness and how hard it is to get a psychiatrist to tell you that. That is quite difficult. It is also expensive. It costs \$300 or \$400 to get a psychiatric assessment, so it is not easy for people. It is a great idea. It is the only example in Australia of a nonadversarial way of looking at whether somebody is fit to plead in terms of a mental illness.

Mr Bedwell—Internationally.

Mr Cheverton—Internationally, it is the only nonadversarial system we are aware of that takes people out of the criminal justice system and into the health system. But the legal system is just not up with it and the capacity is not there. There are two people, in Brisbane Magistrates Court and Townsville Magistrates Court, who are employed by Queensland Health, as part of the public mental health system, to try to identify people with mental illness who are appearing. Again, there is such a volume of people—and you cannot tell by looking—that they really only identify clients who are known to their particular service, and people who are so florid that it is obvious they are not in a fit state. Only last week a District Court judge sentenced someone to eight months. The judge said the woman had no capacity to understand the consequences of her actions. But there was not enough support for that person to live properly in the community and she has been sentenced to jail.

It is very unjust if that is the way the justice system responds to someone who clearly needs support and treatment, not incarceration and punishment. Such cases can be reported in the *Courier-Mail* and nothing is done. I spoke to that District Court judge and asked her why this person was not referred to the Mental Health Court. She said, ‘The barrister has to ask for it.’ There could have been a range of reasons—for example, the person may not have had a diagnosed mental illness; they may have had a personality disorder. There are some options there but the legal system is very challenged.

Mr Bedwell—It has to be an indictable offence to be referred to the Mental Health Court. I think there is a big need not just in this state but Australia wide to look at diversionary programs within the magistrates jurisdiction. That would be a significant development.

I want to pick up on the case of the client that was recently sentenced, because I know her. We have two clients with similar profiles. Often, the profile is one of mild or moderate intellectual disability and various psychiatric or personality disorders—sometimes depression. These two cases provide interesting examples where in one case it is working and in one case it is not. In one case the system is coming together to work for that person and in the other case it is not. Someone is spending eight months in prison when we know that without much more resourcing they would not be in prison. These are tragic individual examples, I suppose, but it is why I emphasised in my opening remarks that I think it would be wrong to say that all the system is bad or all the system is wrong and that there are not some wonderful examples where people’s lives are being changed and they are experiencing recovery. I do not think we should lose sight of the good examples.

Senator HUMPHRIES—Let me be clear regarding how this works. If a person is diverted to the Mental Health Court and the court decides that they are probably not fit to plead because of mental illness, does that mean they could still end up in the criminal justice system if there is no suitable program for them in the community? Let us assume that they are guilty of an act of violence in some respect and they need to be in some sort of protective environment. Would they necessarily escape the criminal justice system because of that finding of unfitness to plead or could they still end up in the criminal justice system?

Mr Bedwell—Not necessarily. Because it is a Supreme Court judge, they will make a judgment, just as they would in any other case, about whether the person receives bail, whether

the person is remanded in custody, whether the person needs to receive treatment in a secure hospital or, indeed, in a general hospital. So there could be any range of responses to that situation of unfitness to plead. Of course, the other responsibility of the court is to determine issues of criminal responsibility—in other words, if, at the time of the offence, the person met the criteria for not being responsible for their actions, in which case they are then diverted into the mental health treatment system.

Senator HUMPHRIES—You say in your submission that between 70 and 90 per cent of prisoners have a mental health problem. It would seem to suggest that if that 70 to 90 per cent of people were diverted through the Mental Health Court, you could shut down half the prisons in Queensland. Obviously, it is not just a question of access to the Mental Health Court that is stopping that happening, surely.

Mr Cheverton—It is like what we were saying earlier—a lack of support. The reason why these people are coming to the attention of police is because they do not have any support in their housing and they do not have anyone supporting their recovery. Research is pretty clear on there being no inherent link between mental illness and criminal behaviour. It is also about poverty, social isolation and those sorts of things as to why people end up in the criminal justice system.

Mr Bedwell—We are talking about a lot of people who have been traumatised and you have got what we might describe as challenging or even antisocial behaviours, but there are fundamental reasons for those behaviours which relate both to their intellectual disability and to their experience of abuse, which needs to be managed in various ways. But the system is not sophisticated enough, or homogenised, to respond to those individual needs. I find it remarkable that community organisations with the barest of resources can respond to many of these people's needs very successfully when we have got these high cost treatment systems that are not responsive at all. We make assumptions that some of these services we talk about are sophisticated. They are not sophisticated services. For someone who presents at a psychiatric unit, for example, at a major hospital in Brisbane here, their management at that hospital will be to get the security guards to remove that person and throw them out into the car park. Coming to a community organisation there may be a very different sort of management of that person.

Mr Cheverton—The woman that we are talking about who was sentenced to eight months, it was reported in the paper that she was excluded from both Princess Alexandra Hospital health service and Royal Brisbane Hospital. So the public system did not respond. One of her first charges was an assault charge against a public health worker who pressed criminal charges against one of their clients. The reason she was sentenced to eight months was because she went to lie down on the railway tracks to end her life and the police came to take her away and she assaulted the police. This is not someone doing some random act of violence. People are more at risk of harming themselves than they are of harming others. These are the chains of events: it is the failure of social services and health services to respond to people's needs that produces these sorts of tragedies.

Ms Kilroy—When you say that the majority of the prison population would be released or diverted, I think we need to understand about the Mental Health Act and how narrow it is about who is fit for trial and who is not. There are different types of illnesses, axis 1 and axis 2. Your axis 1 illnesses will be handled within the Mental Health Court if diverted, your schizophrenia

and bipolar, because they can be treated. Under corrective services' own research here in this state, 57.1 per cent of women in prison have been diagnosed with a mental illness. But when we look at those women the majority would be around depression and personality disorders and a smaller percentage with schizophrenia, for example, that can be treated. That is why they are captured within the criminal justice system, not necessarily diverted away as such. It is about what is within that piece of legislation and how narrow it is.

Senator HUMPHRIES—I have one more question. You mentioned that the cost of a diagnosis was \$300 or \$400. When a person is coming before the court, surely the court system picks that cost up, not the person being accused.

Ms Kilroy—If you have a legal aid lawyer, it is about legal aid picking it up, so then it is about legal aid deciding whether they pay for that or not. If legal aid decides not to pay for that then that assessment will not be paid for. The woman or man obviously does not have the capacity to pay for that themselves.

Mr Bedwell—Within the Mental Health Court every person appearing before it must be represented. Because it is an inquisitorial role, the court will be calling for reports, so it is not one side calling for reports and the other. In a particularly complex case there could be six psychiatric reports. If it is more straightforward there might be one or two. All those things are the responsibility of the court.

CHAIR—I have a quick question to finish off. I was interested to see on page 10 your account of the preference some people make for general prison rather than a forensic unit on the basis that at least they know they will get out, they have got access to work and study, friends and family can visit and it is a more normalised environment. The committee has heard great things about the Thomas Embling centre in Melbourne and we plan to visit that over the next few weeks. Is the forensic unit here in Brisbane of such a poor standard as to give rise to these complaints about it? Sydney is about to put in a new forensic unit adjacent to Long Bay. What has been the policy debate about forensic units here in Queensland? Are they bad places to be in or are they effectively able to release people into society successfully?

Mr Bedwell—Up until the early nineties, the responsibility for these facilities was with the prisons department, or what we now call corrective services. It was a major, enlightened development to have the responsibility shifted from prisons to health, and so the forensic facility in the John Oxley Hospital that we talked about was a purpose-built facility back in the early nineties. I have not seen it for many years, but I know that it is a facility that is focused on rehabilitation. People do have the opportunity of moving into the community with appropriate constraints. But I think there are a lot of issues around that. We have also had a facility open up in Townsville in North Queensland. Is the committee going to Townsville?

CHAIR—We are going to Cairns tomorrow.

Mr Bedwell—You might ask people in North Queensland what they think of that facility. I have not seen it. I think it is important to have more of these facilities around the place so that people are closer to their communities. One of the problems we have in Queensland is the geography. That is always a factor. We need facilities. Some people need very short periods of containment when they are in crisis. The issue we have is that that containment is indefinite. We

should be flexible and responsive to people's needs. If we have got resources in the community then they do not need to be in that sort of institutional care. If they need to be there, it should be for only a very short period of time.

Mr Cheverton—I would just add that it should be a last resort. It is a nice idea from the 18th century that you are looking at—psychiatric hospitals were born from the notion of prisons. I cannot believe that it is on the policy agenda. I would point you to everything that we have said so far, which is that, if people are well supported, this sort of incarceration or involuntary treatment may not be necessary. However, as Kingsley said, there are going to be times when people may need something like the old-fashioned notion of an asylum. However, it should not be a horrible institution but a place where you can feel safe and not have to deal with everything else that is going on because of what is happening in your head. We would not be advocating that you take a great interest in solutions that are hundreds of years old.

CHAIR—Thank you for your submission—it is really useful—and for coming before us.

[3.53 pm]

TANIN, Ms Michelle, Private capacity

PATE, Ms Kim, Executive Director, Canadian Association of Elizabeth Fry Societies and Consultant, Sisters Inside

KILROY, Ms Debbie, OAM, Director, Sisters Inside

WARNER, The Hon. Anne, President, Management Committee, Sisters Inside

CHAIR—Welcome. Do you have anything to add to the capacity in which you are appearing?

Ms Tanin—I am a client of Sisters Inside.

CHAIR—The committee has received your submission, which it has numbered 283. Are there any changes or additions you want to make to the document at this stage?

Ms Kilroy—No.

CHAIR—I invite you to make an opening statement. Who will be making the opening statement?

Ms Warner—I am afraid I am a little incapacitated today I have a fairly bad cold and flu so I am just here for support. I do not actually need to sit at the table.

Ms Kilroy—Sisters Inside is an independent community organisation which exists to advocate for the human rights of women in the criminal justice system and, alongside women in prison, to address and meet their needs and gaps. Basically our structure is one where the organisation started from women inside. Women in prison are still part of a steering committee that meets or has been allowed to meet with a management committee up until June last year in regard to policy directions and service provision for Sisters Inside. We are glad you have read our submission. We are happy to take questions today which you may have around our submission. We have asked Michelle to come to talk directly about her experience within Brisbane Women's Correctional Centre, the crisis support unit and how she has been treated within the prison system as a woman who has been diagnosed with a mental illness. Kim is working with us at the moment and is from Canada. The parallels happening in this country and in Canada are amazing. Australia buys many of Canada's programs and classification systems et cetera within the prison system and in many other areas. So I thought discussion around what is happening in Canada might be a way of shedding some light in case the committee is deciding to buy or to recommend buying anything from Canada for Australia. I am happy to turn it over to Michelle, if she is feeling okay to tell her story.

Ms Tanin—I am a 33-year-old woman. I have been involved with the mental health system since I was 14. I have also experienced the treatment given to me and other patients in Brisbane Women's Correctional Centre. About two years ago I was charged with a number of criminal

offences and as a result ended up being remanded in custody. The first thing I want to talk about is the public mental health system. From my experience and from the experience of other mental health patients, many of the beds at PA are taken up with drug and alcohol patients. These drug and alcohol patients are regulated by doctors. Marijuana, speed or any other drugs cannot be removed from the premises; they are regulated patients under the Mental Health Act. PA will very quickly turn away a mental health patient before turning away a drug and alcohol patient, so I am not sure whether we just built a multimillion dollar mental health facility or whether we have just built ourselves another multimillion dollar drug and alcohol facility. I have spoken to the staff who say that they are powerless to do anything about that because they are regulated under the mental health system.

I have had conversations with nurses at the PA who have stated that they probably laid eyes on Cornelia Rau only eight times in the whole time she was there. The unit is now so big that you cannot find a nurse. It takes an hour and a half to find a nurse—it is just absolutely huge. A nurse who wore a monitor effectively walked from town and back in one day walking around that unit. It is just absolutely humungous and the locked units they have, which they never used to have, are just like Brisbane women's S4. You are still lighting your cigarettes off the wall, yeah, you are getting stripped, you are getting handed suicide notes, you are not allowed any belongings; it is very prison like and very contained.

The community support for mental health that I receive is four minutes from a psychiatrist every two weeks for receiving medication. If I am upset they, do not want to see me. If I ring up upset they do not want to talk to me because it hurts their feelings that I am distressed. They do not want to hear you are upset: 'Don't raise your voice, don't cry because you have just hurt my feelings and I don't want to talk to you anymore.' So they hang up on you or put the phone on the desk so you talk to the air. I have been told to go home and die and that was witnessed by staff and patients and looked into by the nurse in charge of the nursing committee. And this happens not just to me but too many, many patients.

At times that I have been taken to the hospital to be treated, I have been left in accident and emergency on a trolley and released in the morning without being seen—many, many times, as Debbie can well verify. And now I will move on Brisbane women's S4, or as known to me at times the enhancement unit, which was the old Crisis Support Unit.

Ms Kilroy—It is actually the Crisis Support Unit—that is the name of it within the legislation. However, prison management used to call it the enhancement unit until that was challenged. Now they call it S4 and, as we discussed in our submission, we allege that it is called S4 because they can put women in there with mental health issues that are not necessarily under a crisis support order, so they cannot be legally reviewed—that is in part of the legislation. When Michelle talks about S4, it is the Crisis Support Unit.

Ms Tanin—When I attempted to get the piece of paper that Debbie was talking about, I was told by several different officers that they would bring it down the next day. When it came to the crunch and Debbie got her sister to write to them, they wrote back telling me that if I wished to challenge the matter I must get the form through freedom of information, and we did. When I said, 'I want to see the form; I don't believe you've got one,' he said, 'I'm going to go and write one out.' What do you do? You can say, 'Get your pen and paper and off you go, and I'll ring Kilroy.'

While I remained in custody I was first placed in a padded cell, which shocks me as they are deemed illegal and inhumane in our psychiatric hospitals. During the first days I was shuffled backwards and forwards from the padded cell to the detention unit, living in a suicide gown because the magistrate had said, 'PA mental health will not assist her; we will put her in prison and protect her from herself,' and made a notification of a possible suicide risk. I was then placed in S7 in an observation unit with a camera and the lights constantly on. I had been taking my normal medication, which was 10 Valium three times a day, and they immediately stopped it. As a result of withdrawing from that medication, my own mental illness and the stress of being where I was, I became highly agitated and ended up in a body belt and handcuffs in the unit I now know as S4.

It took me a few days to work out what was going on in S4, but when I did work it out I was not real impressed. There were five prisoners and three male screws at all times. There were 24/7 cameras, the lights never went off and you were on 24-hour observation. There were seven TVs and they watched you constantly. I have observed them on more than one occasion making fun of women's bodies, degrading them and threatening them with the male screws. There was a young woman who should not have been there, but the prison office said that the psychiatric hospital was full, so she had to be put somewhere. I watched her being dragged naked from one end of the room to the other, thrown in the padded cell and just left there—she screamed all night. She is a well-known mental health patient; what is she doing there? They say the mental hospital is full. I do not understand that.

We had a woman with the mentality of a six-year-old. We observed them attack her with the riot gear. She was already handcuffed in a padded cell. Why is it necessary to attack her with the riot gear? Then they patted her on the back and said, 'We'll play a board game with you now,' and she said, 'Beauty, yeah, okay.' It is like with my six-year-old: 'You can play with the Sony. Just be quiet.' None of them understood or complained to say that what was happening was incorrect. Inmates in the rest of the jail are strip searched after visitations; we were strip searched six to eight times a day. Every time we left or entered our cells we were searched, and we were not stripped like the rest of the prisoners; you had to take it all off, and they were to give you a gown whenever it suited them and they were going to stop making derogative comments towards you about who you are or what you are. Food was always left on the table for 30 to 40 minutes before anybody got to eat it because there had to be three prison officers on the floor at all times before cells could be opened for five prisoners—one with the mentality of a six-year-old, one not there and three incapable of doing absolutely anything. What were we going to do?

The lights were constantly on. In the three months that I was there I never slept with the lights off once. In the whole time I was in S4 I never saw a doctor once. I was deemed a management problem, as I made complaints. But I was appalled. I truly believe that this is Australia in the year 2000 and we do not treat people in that manner. It was totally animalistic, and the complaints that I made to the GM and the Ombudsman about an assault that I suffered and about another incident were never followed up back to me. It was never spoken about. I was quite severely assaulted and no-one ever approached me concerning any of those things. The only thing was what the GM said about them in my police report, which I got hold of. It basically states 'Warning: homicidal prisoner—she may attack'. I am not homicidal; I never have been. So I never got any report back from the GM or the Ombudsman. We were not allowed to view the video. It was all about what they said. I could not understand why we could not see a video that

was supposed to protect us. They hold the videos for six weeks. The police were allowed to view it, but we were not allowed to view it to prove that what they said was incorrect.

Ms Kilroy—When Michelle talks about ‘we’, she is talking about when her lawyer was not allowed access to that video to view what had happened when she was body-belted, double handcuffed and carried by her wrists behind her back by the handcuffs.

Ms Tanin—That is one incident that I would like to enlarge upon. It was on about 20 April—I think it was just after my birthday—that I had an incident with a prison officer over a strip search. I was really quite distressed about the incident. She left the cell. In our cells all we had was a suicide gown, a camera and a bed with a suicide sheet. There was not much you could do. I started kicking the chair backwards and forwards. They came in and they cuffed me and left. I kept kicking the chair backwards and forwards because I was not happy.

They came back, and I could hear them outside the room arguing about ‘who is going to grab her?’ I heard ‘We’re not touching her. I’m not touching her.’ They came back in, grabbed me and carried me face down in a suicide gown, with the gown rolling up round my neck, from S4 to the health centre. At this time I said and did nothing. They carried me at the front and middle of the cuffs. There was an officer on each side and there was one officer on each side carrying my feet. I was face down. The officer behind me said, ‘You’d better watch out because I just might kick her in the head.’ The ones in the front were making derogatory comments. There are videotapes of what happened all the way to the health centre, but they refused to allow them to be viewed to prove that that incident occurred.

They then put me in the padded cell. At no time did I yell, scream or make any sort of comment, because they would have said, ‘That’s why we did what we did.’ They left me in the padded cell in a body belt and double handcuffs for 10 hours. I could only kneel or stand. By about 11 o’clock that night I began to menstruate, which was the only reason they took them off. But I had to go through explaining that to one of the senior officers before he would remove the handcuffs and body belt. Many times in S4 women were not given sanitary napkins or other things to use. They were just told not to bother. I was locked in the padded cell for those three days, menstruating, and when they had to come in so that I could change there would be blood all over the mattress but they would just say, ‘Flip it.’ I said, ‘I’m not flipping it.’ They would say: ‘You’re nothing. Just flip it. Don’t worry about it.’ I said, ‘I’m not flipping it; I’m going to clean it.’ They would just flip it and walk out.

Ms Kilroy—I would like to talk about that. I did get a lawyer in to see Michelle. She did have a big mark on her face where her face was grazed along the bitumen. From the crisis support unit to the health centre is about 150 metres in the open and in full view of the prison, and they carried her. We did report this incident, obviously. The police were called in and we reported the whole incident to the CMC.

CHAIR—What is the CMC?

Ms Kilroy—The Crime and Misconduct Commission. The lawyers could not get hold of the video surveillance tape which the police had access to and the CMC, and when we FOI’d everything (1) they would not give it to the lawyer, (2) Michelle could not get access through

FOI and (3) the Crime and Misconduct Commission said that the prison officers had used reasonable force and that what they did was quite appropriate.

CHAIR—But the police have access to the tapes?

Ms Kilroy—Yes.

Ms Tanin—Yes. I forget the name of the sergeant.

Ms Kilroy—We have the documentation. I do not know whether you have a capacity to call for that videotape to view yourself to see what reasonable force actually is.

Ms Tanin—They probably only hold them for six weeks, so they would now be destroyed. I found all these things out. I did not know; I was stupid. In the first four days I found out exactly what was going on. I freaked out. I saw the TVs and worked out exactly what was going on with these women. This is just insanity. This is Australia. It just got worse. The more I spoke to Debbie the harder the it got. We had been discussing the number of strip searches that went down in the last week of my detention at Brisbane women's, and they said to me and another inmate, 'Debbie Kilroy has been making complaints about the number of strip searches, so now you can just stay in your cells.' So thanks, Deb. They locked us in our cells all day, so they did not have to do the number of strip searches that Sisters Inside were complaining about. I do have grave concerns for the women still locked in there.

CHAIR—So you were stripped as soon as you came out of your cell?

Ms Tanin—You get stripped every time you come out of your cell, and then every second day you go for a risk assessment with three different people. So you leave your cell and go to a little room, so that is another three strip searches.

CHAIR—Why?

Ms Tanin—Because you have left the premises. You may have got yourself a bobby pin—I do not know; it was just because they had the power to do so. You get locked in your cell four times a day, so that is another four strip searches. It could be anything from six to eight strip searches a day. They are not stripped as the legislation says they are to strip people.

CHAIR—What are they?

Ms Tanin—It is just a case of, 'Take it all off and do what I say,'—not the top goes off and it goes back on, the bra comes off and it goes back on.

Ms Kilroy—We apparently have a dignified strip search legislated here, where the policy is you take the top half of your clothes off and leave the bottom half on, then you get your bra back, then you take the bottom half off and then you squat and cough. However, in the crisis support unit the women are stripped fully naked. If you want to call the first search dignified and the second search not, I would suggest that both are not at all dignified.

Ms Tanin—There has been more than one occasion when officers would not dare to do it, in case there are lots of complaints. I observed a female officer standing in a padded cell, speaking to a young woman who has the mentality of a six-year-old and, while seeing her naked, making fun of her body, telling her, ‘You don’t think I like looking at you, do you? If you don’t do this and you don’t do that,’ and just asking her to do unrealistic things. ‘If you don’t do it, I’m going to get the male screws. Do you want your suicide gown?’ It was really cruel. They would say, ‘We’ve been watching the tapes again, and we’ve just watched the shower four times.’ I do not really care. It involved mostly males dealing with these people who could not possibly hurt anyone if they tried.

CHAIR—It is mostly male personnel who do the strip searching?

Ms Tanin—Yes, or who are there on the block at all times. There must be three prison officers at all times on the block when we are out of our cells, and it is usually three males.

Ms Kilroy—Everything is monitored by 24-hour cameras, anyway, so male officers are monitoring those cameras at all times.

Ms Tanin—They watch the shower and they will make jokes about how they have just watched the shower three times. I think, ‘That’s nice.’ It is just incredible; it is like a cinema. They sit there and it is like *Big Brother*. You are not allowed to go to the library or have a visitation with your children or undertake any educational programs. You are not allowed to do any sort of exercise or go to church. And absolutely nobody knows that this tiny section at the back of Brisbane women’s is there, because most of the women in there are forgotten about. They do not have family or friends questioning where they are or how they are. They are easily able to use these women, and they are very vulnerable, as nobody is asking ‘Are you okay?’ because they are forgotten.

CHAIR—How do you get out?

Ms Kilroy—Because Michelle was on remand we got bail for her and got her released. However, women who are usually released have done their full time or they get bail et cetera.

Ms Tanin—Or they wait for a bed. One woman waited for a bed in the psychiatric hospital for 14 months and another one waited for a bed in a psychiatric hospital for 12 months. During that time they were being beaten and bashed and treated like animals until a bed became available within our psychiatric system.

Ms Kilroy—Or an assessment will be done by the psychologists within the prison system acknowledging that it is okay for that woman to be released and put into the mainstream of the prison population and slowly integrated into management plans, which have no legal standing, et cetera. But we are very concerned about this. We asked Michelle specifically to come and talk about this. As the days go by we as an organisation are more worried about women within that crisis support unit because no-one other than prison officers and general managers has access to it. We used to have access inside all the prison, but we have been locked out since June last year. Our services can only be provided from the visits area, so we have no access to women within that crisis support unit, let alone being able to support them to ensure their wellbeing.

CHAIR—What reason was given?

Ms Kilroy—We lodged a human rights complaint with the Anti-Discrimination Commission against the Queensland government and from 17 June our services have been restricted and curtailed.

Ms Warner—The stated reason was that the prison officers were threatening to go on strike if we were allowed in the prison.

Ms Tanin—Another amazing thing that I want to make a point about was what happened when I filled out an incident report when they insisted on taking a photo of the mark on my face. The incident report that I filled out was for an incident when a prison officer has been injured. I said to the officer whom I was filling it out for, John Cameron, ‘We’re really important; we actually have a form for prisoners who have been injured.’ He said, ‘There aren’t any forms for prisoners who get injured.’ I thought, ‘That’s nice.’ Obviously, no-one has ever complained before.

CHAIR—Maybe it has never happened before?

Ms Tanin—I do not doubt for one second that it has happened before.

Ms Warner—The other piece of information that you might want to get hold of is that at the time of Michelle’s experience in the prison there were a range of other incidents that we were aware of. We made representation to the director-general of corrections at the time. He responded by saying that these were very serious allegations and he set up an internal inquiry, which was conducted by a man called Chris Watters.

Ms Kilroy—It was the inquiry that Cornelia Rau gave evidence to—a so-called independent investigation—established by corrective services. He was head of ethical standards inside corrective services.

Ms Warner—Michelle told her story to him too, as did I think 26 other women who are still in prison and a number of other people outside the prison. So you may want to get hold of him. We can send you a copy of the report that he brought down, which basically suggested that the women were unbelievable or had mental illnesses.

Ms Kilroy—So everything was dismissed. However, we do have 15 copies of tapes of the evidence that women gave. That inquiry did undertake that I would get copies of tapes of all the evidence given. However, when we asked for them they said, ‘No—the women have to reapply.’ Obviously, some of them did; some did not.

But we do have 15 copies of the evidence given. It is quite horrifying stuff. I am really amazed that it was dismissed. One of the women gave evidence that she was given no medical treatment although she was feeling quite ill and was bleeding for a long period of time. She was taken to hospital after seven or eight weeks. She came back to prison but was still not told what was wrong with her. She told the other women in her unit that she felt like she was giving birth—she had had two children before. They buzzed the medical staff, who came down. The nurse knelt in front of her as she was sitting on the toilet and said, ‘Oh yes, you are pregnant, so you are

obviously having a miscarriage.’ When she got up off the toilet the nurse pulled out the foetus, snapped it in half and put it in two plastic containers.

That is evidence that was given to that inquiry set up by corrective services. However, their report said very clearly that the women were unbelievable or had lied and that Indigenous women could not be relied on anyway, because they are Indigenous. We have a copy of that report. They said they would make it public. Three recommendations came out of that report: (1) that it become a public document; (2) that they look at the mental health facilities; and (3) that they fix up broken machinery—for example, washing machines and dryers—within the prison.

Ms Tanin—One of the biggest factors too is that no-one ever gets assessed, so they have no fear of anybody. I used to hear them many times say: ‘Don’t worry about the people in town. They are in town; we are here. We work here and we make the rules.’ And no-one ever came. The only time the GM was ever seen on that block was after I made two complaints and Debbie was raising hell. He said he wanted to come in and see that new shelves were built. No-one ever gets in.

CHAIR—What about prison chaplains?

Ms Tanin—No. They are not allowed in—or they do not know it is there.

Ms Kilroy—Prison chaplains are gagged. They are not allowed to speak publicly and they do not usually raise issues with prison management. They are there for spiritual services alone and not to raise or advocate on any issues that they may see or hear of.

Ms Tanin—We were completely isolated from the rest of the prison. If we went anywhere inside the prison we had to be escorted by two prison officers.

Ms Pate—An interesting point arose when I met with the Anti-Discrimination Commission here as a result of trying to provide some additional information based on a similar review that was done in Canada. One of the things we talked about on the particular issue of mental health was that in Canada, when the Canadian Human Rights Commission went to look at what was happening, particularly for women with mental health disabilities or when they went to the isolation units, they were often told that in fact it would be too upsetting for the women or that the women would not want to speak with them. The anti-discrimination commissioners with whom we were meeting both sat back, looked at each other and said they had just gone to a unit and were told exactly that when they went to go in.

So it is usually characterised as in the interests of being benevolent and of not wanting to be seen to be upsetting individuals—that is the rationale usually used by correctional services to prevent others from entering into the units. I would say we are now seeing that not just in this country and in this state; certainly, it has been our experience in some of the work we are doing internationally that it is a common experience. Human Rights Watch looked at this in the United States and found very similar issues. The extent to which the light is not shone on what happens in these units is quite profound. It is something that we would certainly be happy to provide more information on, if that would be of use.

CHAIR—So Canada does not do it better?

Ms Pate—My view would be, no, Canada does not do it better. In fact, we are further ahead on some of the movements that may be being looked at here and in our experience some of what is being looked at here, like mental health courts and separate forensic units, has led to the increased criminalisation of more people with mental health issues because that has essentially become the default position—the only system that cannot say no—and so more and more people end up in it. We do have some judges and some mental health courts that are more interventionist and will take a strong position that people should be kept in the community. And we do have some legislation, mostly in the youth justice area, that specifies that people should be kept in the appropriate system where possible and in the community as a normative standard, as opposed to looking to institutional care. But, overwhelmingly, what we are seeing is that some of our fastest growing prison populations are people with mental health issues, and that is particular the case for women since we had the elimination of some of the national standards for which Canada has historically been well known.

In 1996 the Canada Assistance Plan was removed and what we saw was a virtual elimination of many of the national standards, so we saw the progressive move to deinstitutionalise that you have already had some discussion about in your proceedings here and in other states. We saw a really progressive move with strong community supports eviscerated by the changing of national standards in terms of how our provincial authorities, who had jurisdiction over health and mental health, could spend those moneys. We saw more and more people literally having the rugs pulled out from under them, ending up with virtually no resources in the community and so ending up in the criminal justice system.

As you have heard from the previous panel of witnesses and also from Michelle, in an oversubscribed mental health system in the community, if anybody is seen to be problematic, if the person resists a restraint or if the person yells and is difficult, increasingly mental health workers are telling us that they are being instructed to call police. If those people go into the mental health court system, generally that has led to a false sense of security in our country that the issues are being dealt with. When they end up in the prison system, they are most likely seen as some of the most difficult to manage prisoners—not surprisingly, with mental health issues—and so they end up in the most isolated conditions. Often, their mental health conditions are exacerbated by their isolated conditions of confinement. That makes it more and more difficult for them to get out. They often end up with longer and longer sentences as a result of incidents that arise in the prisons.

I work at the national level and normally we would not carry a caseload, but we are currently working on about 18 women's cases right now. Some of them are women who started with very short sentences, as low as 18 months, and who are now doing more than 18 years, all due to charges that have been accumulated in the prison system—things like resisting a restraint, yelling and swearing at the guards, sometimes more serious things like assaulting staff, but all things that are linked to mental health. And when we started to raise some of these issues one of the things we found out was that the corrections systems would restrict their own psychologists from speaking out, even when they themselves had concerns. As a result, last year at around this time we were forced to withdraw from a series of interventions, most notably an inquest into the death of a woman with a mental health disability in one of our prisons, because we could not find any psychologist willing to testify, either because their livelihood was threatened or, if they were doing research, their access to the prisons was threatened. So there is a huge and growing

issue about the ability to get independent assessment and the ability to look in a very realistic way at what we need to be intervening in.

I do not want to take up any more time, because I know there are other issues you need to talk to Sisters Inside about, specifically about what is happening in Queensland. But, if you want a bit more information, our DisAbled Women's Network of Canada looked at this issue—separate from corrections; their focus is on disabilities—and the submissions they made to the Canadian Human Rights Commission might be instructive for the committee. Similarly, there are some recommendations that Louise Arbour, who is now the UN High Commissioner for Human Rights, made when she looked at some of the situations of women prisoners. She recommended for all prisoners in our country an automatic review of their sentences by the courts when the treatment they receive in prison is so restrictive or otherwise inappropriate that it amounts to correctional interference with the sentence; that is, it causes the sentence to be made worse than was intended by the judges. Those reports are just a few of the things that you might want to look at.

Also, just before I left to come to Australia, I received through our equivalent of the FOI system—our access to information system—a memo that was agreed to by all of our deputy wardens of women's prisons in Canada, indicating that, based on the information they were receiving from not just our organisation but many others about the impact of strip-searching on women, they were recommending that strip-searching not be used except where there is specific cause. So that means not in a routine manner and not in the way that it is generally used by the correctional service, and in fact the memo recommended that that be taken out. It has not been implemented; that is why I had to go through access to information. It was obviously not seen as something our correctional system wanted to have well known, even though those who are essentially heads of security in our women's prisons had agreed to that position. I think there are a number of issues that are very similar in Canada and Australia that it might be useful for you to have a look at.

CHAIR—Thank you for that; we will follow those up. Can I ask about chemical restraints.

Ms Tanin—Chemical restraints as in they give you drugs?

CHAIR—Sedation—

Ms Tanin—I cannot take certain medications, and the prison was aware that I am allergic to antipsychotic medication, but what they usually would give a prisoner in Brisbane women's is a drug called Largactil, which is a very dirty drug.

CHAIR—What do you mean by 'dirty'?

Ms Tanin—It is a very old drug; it has been around a very, very long time. They found it to really slow people down so that their motor functions do not function correctly. We obviously now have better drugs like Serenace and Haloperidol and things like that, but they continue to use Largactil in the prison system very, very regularly. For most things, I get Panadol. One of the prison officers one day mentioned to one of the other officers that they had given out about 325 Panadol that day. If you wanted to kill yourself, seven Panadol would do it. Your body just shuts down; every one of your organs shuts down. If you do not get the antidote within the first 24

hours, you are dead. Largactil is usually the drug that they will give you—Phenergan is another drug that they will generally use.

I cannot take Largactil because it makes my jaw stiffen up and my muscles stiffen up, and I cannot walk. Before going to court, in the first 10 days that I was in the DU, I was told that if I did not take the Largactil and the Phenergan I would not be allowed to go to court. So they gave me 15 milligrams of Valium, Largactil and Phenergan, and put me in the police paddy wagon. By the time I got to the Children's Court I was unable to walk. I had to lie down. I was really, really unwell. I said, 'I feel like I'm going to fit.' They rang the prison and the nurse said to the officer in charge, 'Oh, yeah, tell her she will feel like that.' The other officer actually had to be the judge and say: 'She can't come to this hearing. We need to take her back. She can't even walk up the stairs.' They took me back to Brisbane women's. On getting back to Brisbane women's, I had huge bruises all over my arms from being thrown back and forth in the van. They opened up the door and I just fell out. They put me in a wheelchair, put me back in the padded cell and just left me there. After that, anytime they wanted to do something like taking handcuffs off, it was 'only if you take Largactil', which is a medication that I cannot use.

CHAIR—Did you say, 'Children's Court'?

Ms Tanin—For my son. I was going to court at the time for my child. Usually they take away medication rather than give medication, which really does not make sense to me, because it makes a more volatile situation. They tend to take away people's psychoactive medications that they have been on for years and years rather than give it to them to help make the situation better.

Ms Kilroy—I just need to say that Michelle's story is not an isolated one. These are stories we hear over and over again about women with mental health disabilities and how they are treated within the prison system in this state and within the crisis support unit. It is not an isolated case; it is an experience that occurs today. Regarding the woman that Jeff spoke about before, who was sentenced to eight months recently, I would make a bet today—right now, with you—that that woman would be in the CSU and probably body belted and handcuffed in a padded cell as we sit here now. I would be very surprised if she were not.

CHAIR—But we have got no way of finding out.

Ms Kilroy—No, we have got no way to find out because we cannot go into the prison. We do not have access to the women in there, let alone access to any of the other women. My staff and I had a lot of contact with Cornelia Rau at the very beginning, at the time when she was first put in Brisbane Women's Correctional Centre. We would never have access to women like her again—we would not see her. We assisted Cornelia on a daily and weekly basis because she needed someone to talk to regularly, which we did. However, when we were locked out in June, her mental health, if you look at her records, deteriorated rapidly because she did not have contact. She wrote to us a number of times, pleading for us to come back in as she needed to see someone and needed to speak to someone. But we could not get in there. By the time it was approved for us to see her in the visits area, she had already been sent to Baxter detention centre.

Senator HUMPHRIES—I am still not sure I understand the point that, I think, both Ms Pate and Ms Kilroy are making about net widening. How does a diversion program lead to net

widening? How does a person who would otherwise theoretically end up outside the justice system end up inside it because of diversion?

Ms Kilroy—The idea of diversion is initially that they have to be assisted in the community with some type of program and support. However, if that support and program failed, or was not in the community, you are back in court, because you cannot be diverted. So we net widen; we actually create—

Senator HUMPHRIES—But, if you are coming to the attention of the Mental Health Court, wouldn't you have been in the system anyway, but for the diversionary program?

Ms Kilroy—Not necessarily. It depends on what is happening. I think we need to go back to the point about how police are the ones who are interacting with people on the street first and foremost because of the behaviours with mental disabilities. A program of critical incident teams has just been launched in this state, which involves the police, the department of health and the Public Advocate. Police will be able to take mental health workers with them when they go to the home of a person whom they know has an illness or a mental health disability so that the person does not get criminalised. That is diversion but, as you can see, they have come into contact with the police, so next time their address is flagged on police computers they are already known to police and there would be more of a chance that they would be caught up in the system; hence the net widening.

Ms Pate—The reason for my comment is that I think we go back to even before people are criminalised. The reason that our human rights complaint was made against the government of Canada was that we were looking at the broader systemic issue of what happened when national standards were virtually eliminated. The Canada Assistance Plan directed how federal tax dollars would be spent by provinces. Before the elimination of that in 1996, each province had to spend moneys received in accordance with the national standards set for welfare, mental health, other social assistance, education and the like. All of those standards were virtually eliminated, so it was left to our provinces, the equivalent of your states, to spend as they chose, which meant that most of those services were cut significantly. It is the subject of complaints to the United Nations right now. The federal government of Canada has been sanctioned because we have virtually made some sectors of the public—aboriginal people, poor people and people with mental health issues—more and more marginalised and likely to come within state care. The state care that they are more likely to come into is the criminal justice system because the other services have been cut.

So you are right that there has to be some triggering event. But the point that has been made by mental health workers working with us and the disability community, particularly around mental health issues, is that, previously, behaviour that would have been seen and recognised as symptomatic of the mental health label the person carries—and, in fact, when we are able to get people into the mental health system now, it is still seen that way—once they are within the criminal justice system is seen as symptomatic of bad or criminal behaviour. What is the police officer to do who is called when someone is having an episode in the community? What is the judge to do when someone comes before them? What is the prison to do when they have someone who they see as out of control and they have no training? Even if they have training, their first priority is security in a criminal justice construct. What we are seeing in Canada is that

those people who are historically overrepresented in mental health areas—women, young people and aboriginal people—are now overrepresented in the prison context in those same categories.

We have been doing sessions with judges. The judges are sentencing people to prison in the hope that they will get treatment—because treatment programs are being set up—or they are referring them to mental health courts in the hope that there will be appropriate services. ‘Hope’ is the operative word—with the evisceration of those programs in the community, it is only a hope. In fact, people are becoming more and more disabled and their mental health conditions are being made far worse. We have women who are not getting back into the community. A woman I have been dealing with—or not dealing with—since I have been here is one of the woman who, as Michelle described, has been repeatedly chemically restrained in the prison system.

One of the complaints we have had against some members of the college of physicians and surgeons—and many doctors will not even work in prisons anymore—is that doctors are being asked to start the mental health certification process when someone refuses treatment and then abandon it before the review or what we think of as the ‘due process’ requirements kick in. My background is that I am a lawyer by training. What we have effectively seen is a circumventing of both systems. Hence not only is there a net widening but also more and more people are being locked into that system for longer periods of time, sometimes for life.

Senator HUMPHRIES—So what you are saying is that a diversionary program of some sort is not necessarily a bad thing, but it has to be designed so as not to lead to that net widening either because the services are not there in the community or because you have designed it in such a way that it actually brings people into it because it is seen as somehow a better system than the alternative?

Ms Pate—I would say it is a bandaid in an attempt to look to be addressing issues when in fact we are not addressing them in the first place.

Ms Warner—I think the critical thing to remember is that our experience of institutionalisation in almost every state is that it was done without appropriate resources. It is the same thing with diversionary strategies. If it is all done without resources then it does not work properly and it is just, as Kim says, a bandaid.

Senator HUMPHRIES—And it can be counterproductive.

Ms Warner—Yes.

Ms Tanin—When we did a Supreme Court bail application the psychologist in the prison—I forget what his name is now, but I had never actually met the man—rang the judge personally and spoke to him about not allowing me to leave the prison because I was too unwell to leave the prison. They had photocopied my journal and were able to present that to the judge to show why I should not be released from the prison. My doctor, who is now the head in Brisbane, wrote to the judge and said, ‘No, you need to release her, because you are just exacerbating the situation and making the self-harm situation much worse.’ When instructed by the judge that this other psychologist actually write it down, he refused to put it on paper. It was not the first time he had done that.

Ms Kilroy—Even up until a few weeks ago, psychologists who are employed by Corrective Services have been undertaking assessments without seeing women face to face. They actually make written assessments and forward them to the parole board or courts. Those documents have a lot of weight in decisions being made. It is an issue that has been raised with the director-general, but we have not heard back in regard to that situation yet. But it is not uncommon that the psychologists do not see the women face to face to assess them.

Ms Tanin—He refused to put it on paper but actually talked to the judge personally on the telephone.

Senator HUMPHRIES—Are the psychiatrists and other—

Ms Tanin—He is a psychologist—they do not have a psychiatrist.

Senator HUMPHRIES—Are the psychologists who work in conjunction with women in these circumstances employed by the Department of Corrective Services?

Ms Tanin—Yes, that is correct. I never met the man.

Senator HUMPHRIES—There are no visiting psychologists or other health professionals?

Ms Tanin—There are visiting psychiatrists from the Royal Brisbane. The psychologist is always there.

Ms Kilroy—What we have is the prison mental health team. We have 1½ workers for all of the prisons in that area. At Wacol we have five prisons in that area.

CHAIR—And how many women?

Ms Kilroy—In the women's prison there are about 250, but they also service the men. So we have 1½ mental health professionals—one is a social worker and the other half is a psychologist—who actually do all of the assessments on anyone that comes into prison and is referred to them for mental health disabilities. They are just snowed under. They just cannot move. They will say very clearly that the only thing they can do if a person is psychotic is refer to a psychiatrist that they bring in and the person gets chemically restrained. They cannot do any other treatment but hand out medication. They are very clear about that. There are only 1½ people, yet we are talking about 3,500-plus prisoners at any one time. That lack of resources is absolutely huge and it is just ridiculous. That situation needs to be addressed in this state.

I need to reiterate our concern that the women who are isolated there now will continue to be isolated and have been isolated. They have no access to anyone. Corrective Services will say that they can speak to an official visitor or ombudsman, but these women do not necessarily have the capacity to do that or understand how to fill out the right forms to do so. Then there is the fear of retribution; you are threatened for speaking out. We need an independent person who can go into these prisons and into the dark corners, because that secrecy does breed abuse.

I travel interstate and meet with many women in other prisons and it is not something that is isolated in Queensland. On the Thomas Embling centre, women speak quite terribly about their

situations when they were there. We were in the Victorian women's prison, Dame Phyllis Frost Centre, a couple of weeks ago and people talked about the horror stories there. I do not know who spoke to you about that particular service there. I cannot comment on that directly other than knowing that there was a woman raped within that system who fell pregnant, and the only reason that that prison officer has been charged is because of DNA, otherwise he would never have been brought to court. He fronted court just the other week and it has been adjourned at this point of time.

These things happen when we have closed institutions, whether they are prisons or psychiatric units. I would not be advocating at all to building more closed systems, because they continue to breed abuse again and again against the most vulnerable in our society. We need the systems opened up. We need to address issues of poverty, treating people with respect so that they are in the community and can walk with us as individuals who may be ill at some times but are okay at other times. We need to be walking with those people and not isolating them and seeing them as the other, because that is what prisons and psychiatric hospitals do: treat them as the other and they are branded as that for life. That is very distressing for them as well as for the majority of us in the community.

Ms Warner—It is counterproductive to recovery, I suspect.

Ms Tanin—You are boxed and labelled and you are put in a corner, and the hospital decides who they will and who they will not treat. 'If you've got schizophrenia we will treat you because we can treat you with medication. If you've got bipolar we will treat you because we can maintain you with medication. But if you've got personality disorder or anything else we don't want to treat you because you are too hard to handle, you are too difficult to deal with, you are too this, you are too that.' So box you, label you, push you in a corner. I know a lot of people with personality disorders and their files are flagged: the first thing a doctor reads is, 'Do not admit.' That is the first thing the doctor reads, so he does not even bother.

Senator HUMPHRIES—What is the evidence for the comment you make in the submission that Queensland is now witnessing a marked increase in the number of people with cognitive and mental disabilities who have been criminalised?

Ms Kilroy—It is Corrections' own evidence. They did some research which is footnoted there, Hocking, in this decade in regard to the health survey of Queensland prisoners.

Senator HUMPHRIES—That is the one you are referring to. Okay. You do not make any recommendations in your submission. What do you suggest, other than bringing this matter to light, that we should do?

Ms Kilroy—Sisters Inside is an abolitionist organisation. I do not believe in prisons for women at all. We see women with mental disabilities, Aboriginal women, people from poverty and abuse being incarcerated over and over again for minor crimes that could be addressed with regard to the legislation that is enacted that captures these women and puts them in prison. We need to address the social issues, we need to have better resources in the community: equal access to education, health and accommodation. Homelessness is a huge issue for women, as is poverty. We need to address those issues fundamentally as a society, and we do have the resources to do so. We should do this not under the guise of crime prevention. Why is it a crime

prevention program to feed a young pregnant woman who is poor? I think that is a right, not a crime prevention strategy. It is about how we look at this and reframe our whole community to address these issues as such.

Right now we need to open up the prison system. It needs to be open and transparent. We need to have independent investigators who can go in there and advocates who can go in there to see what is happening. We need support for women. In our prison system at the moment we have, as I said, 1½ mental health workers for 3,500 prisoners. Prisons have become the de facto psychiatric units but with no mental health professionals. That is going to be a bandaid as well in the short term. What we would like to work towards is the abolition of them and better resourcing within the community.

Ms Warner—I suppose we can start with a recommendation that might look okay on a Senate report. Rather than the abolition of prisons, which I suspect you could not go away with right now, it would be to begin the process of decarceration, particularly for those with mental illness.

Ms Tanin—If you got hold of one of those tapes from S4 you would have them closed within a week. I do not care whether it is from now or when I was there, you would have that place shut down within a week. But they do not give them to you.

Ms Pate—If you look at the example of the Youth Criminal Justice Act that has been implemented in Canada, the direction in the legislation specifies that jail should not be used, that youth should not be criminalised. The presumption is that young people should not be criminalised if they have a mental health issue and they should definitely not be jailed but the system to look to should be the health system.

Since the proclamation of the YCJA, we have seen a halving of the number of young people in custody in Canada. We used to jail the greatest number of young people—even higher than the number of adults we jailed and higher than the number in the United States. Within two years of passing that legislation, just by making those recommendations and implementing those two legislative provisions, half the number of young people are in custody. It is only about a third when we look at aboriginal youth and young women with mental health issues. Still, a third is a significant move towards the recommendations that have been made. We need to also think about the fact that the investment of resources in community, particularly in health, is going to have more long-term human and financial benefits than continued investment at the very end of the criminal justice system to try and address something that is not being addressed much earlier on.

CHAIR—In your opinion, are women being treated differently from men in prison?

Ms Tanin—When I first got out of prison, I talked to *A Current Affair*. In the morning I was in the hospital trying to get them to help me. He was commenting—I think I mentioned it to Debbie—about a unit down in Sydney, one of the Sydney prisons, exactly the same as S4 at Brisbane women's. So I do not doubt at all that it is very similar in the male sector and the female sector. I believe there is the same sort of thing happening.

Ms Kilroy—There are crisis support units in the men's prison. We need to be aware that more women have been diagnosed with mental health disability than men. Even the prison mental

health team that is part of Queensland Health will say that. They get the most referrals and the hardest referrals from that prison at Wacol, the Brisbane Women's Correctional Centre. We can also see how women are treated differently when we look at what women are breached for and when they are held in segregation—

Ms Warner—the high levels of control—

Ms Kilroy—and what happens in regard to the men. So there are differences, yes.

Ms Pate—Internationally the trend is that the rates of criminalisation of men are not increasing the same as they are for women. We are seeing what is described as an increase in the rate of commission by women of violent offences, most of it where women have reacted to or defended themselves from violent attacks, in situations involving violence against women. If people believe imprisonment has an important role, then they usually see it as a role in terms of public safety, and yet there is a recognition that women usually are the least likely to pose a risk to public safety. Yet they are the fastest-growing prison population internationally.

CHAIR—which suggests discriminatory practices are taking place.

Ms Pate—Certainly the Canadian Human Rights Commissioner has found discriminatory treatment of women prisoners in Canada. Given that ours is often touted as one of the best systems in the world, I guess you can draw your own conclusions.

Ms Warner—The law and order strategies that characterised the nineties and the so-called war on drugs have adversely impacted on women because typically women's criminal behaviour is more related to drug taking. You have break-and-enter for the purposes of purchase and you have prostitution for money, which again goes back to the point that you have a particular section of the population who tend to be criminalised and large numbers of women. On our estimates, when we did a study in the prison, 89 per cent of women reported having experienced sexual violence at one time or another. So you have this pattern of early abuse leading to drug behaviour, drug dependency and the need to find the resources to feed the drug habit. So you turn to crime. That is the syndrome. So anything that is described as a zero tolerance policy or whatever impacts most adversely on women.

Senator HUMPHRIES—Are any of these prisons we are talking about private prisons in Queensland?

Ms Warner—No, they are state prisons.

Ms Kilroy—But they are run in the same way.

Ms Warner—The ideology of running prisons was, I think, captured by economic rationalism some time way back in the nineties—the whole notion of working towards a profit line. For instance, educational facilities that used to be available in the jail are much less available than they used to be. There is more emphasis on work. It is called training, but in fact it is labour at very low rates of pay—\$3 a day or something, depending on what you are doing. Somebody is making a profit out of that. The whole ethos of prisons has been captured by the economic

rationalist debate. So what is going on in the private sector is being mirrored and copied by what is going on in the public sector. But that is another debate.

Senator HUMPHRIES—This culture of problems in prisons goes back 200 years. It far predates the period of privatisation.

Ms Warner—It is a failed experiment. It started about 200 years ago. They thought it was nicer than cutting off people's hands and legs, or chopping off their heads, or sending them to Australia and other diversionary activities like that. We can probably say that it does not really protect the community. The larger the number of people that you have in prison, the higher the crime rate, because prisons in fact criminalise people. Because we have had an increase in the prison population, the number of people who will be tomorrow's criminals or whose children will be criminals is a large and growing section of the population. So it does not protect the community and it does not rehabilitate those who serve in prison. The recidivist rates are—

Ms Kilroy—Sixty per cent for non-Indigenous women and 77 per cent for Aboriginal women across the country.

Ms Warner—So, as a deterrent, it does not stop people from committing crime—

Ms Kilroy—Community safety and rehabilitation are the twin mantra lies that governments use.

Ms Warner—and it does not protect the community. It makes a lot of money for a lot of people.

Ms Kilroy—It traumatises people.

CHAIR—Thank you. We do have to finish there. You have provided us with some very shocking and disturbing evidence.

Ms Warner—We suggest that you can get hold of that inquiry report. Should you want to listen to those tapes we would have to ask the women if that would be okay.

Ms Kilroy—The women have given their permission already, so that is okay. Also, in relation to the human rights complaint that I talked about—the reason why our access has been so restricted since June last year—the anti-discrimination commissioner has done a review into women in prison across the state with regard to a lot of these systemic issues and that report should be out within the next few weeks. The commission said, 1½ months ago, that it would be ready in two months, so before you write your report it might be worth having a look at it.

CHAIR—Who did you say was doing this?

Ms Kilroy—The anti-discrimination commissioner here.

Ms Warner—They have done a fairly major inquiry.

Ms Kilroy—The complaint has also been lodged in New South Wales and Victoria. I have been working with every jurisdiction across the country to lodge a similar complaint with regard to the systemic discrimination against women prisoners. In Victoria and New South Wales it has been lodged, and in South Australia it will be lodged in the very near future. We have some final work to do in the Northern Territory, Western Australia and Tasmania, but hopefully it will be lodged in those states before the end of the year and, if not, early next year. We are looking for each of those independent commissions—equal opportunity or anti-discrimination commissions—in those jurisdictions to do an inquiry similar to that done in this state. HREOC has said informally that it will collate those reports, and then we will take that information to the UN.

CHAIR—I look forward to that. Thank you for coming today and giving us your evidence.

[4.54 pm]

BOARDMAN, Mr Ian, Public Advocate, Office of the Public Advocate Queensland

IRONS, Mr Lindsay, Senior Research Officer, Office of the Public Advocate Queensland

CHAIR—Welcome. The committee has your submission, which has been numbered 303. Are there any changes you wish to make to that document at this stage?

Mr Boardman—No, thank you.

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

Mr Boardman—Thank you for providing us with the opportunity to appear before you today. It might be helpful if I summarise our submission. The office has established a particular interest in a broad range of mental health issues over the four years of its existence, with topics as diverse as the stigmatisation by the media of people with a mental illness; the reform of the boarding house industry in Queensland and the referral of vulnerable people into these boarding houses from acute mental health care; the way in which police and other emergency services respond to people experiencing an acute mental health crisis; and the need for an across government commitment to a recovery strategy for people with mental illness. This broad based interest stems from the fundamental perspective that a range of social forces impacts on the quality of life for citizens who live with a mental illness, not just the hospital based health system. A range of reforms are needed if we are to improve the lot of this highly vulnerable group.

Chief among the social forces is the culture that exists in Australia of misunderstanding and ignorance, marginalisation, stigmatisation and social exclusion of people with a mental illness. It is my view that the policy and funding wasteland that mental health occupies at both the Commonwealth and state levels is a mirror of the social stigma that Australians with a mental illness face in their daily lives.

In responding to the marginalisation of vulnerable people, it is the Commonwealth government's responsibility to advance narratives of acceptance, understanding and social cohesion. Instead, the current Commonwealth government has propagated narratives of divisiveness, suspicion and further exclusion of anyone considered 'other' or 'alien'. Nevertheless, the Commonwealth still has an overriding responsibility for mental health—as the driver of the national mental health reform process, as the 40 per cent funder of mental health services provided by the states, and in demonstrating leadership in modelling the whole-of-government approach that it has consistently asked of the states.

My submission canvasses good practice examples from Queensland which I believe could be applied in other jurisdictions. My submission addresses issues of funding. It is interesting that Commonwealth funding on mental health is a small fraction of its health budget—about seven per cent, I believe. I think it is reasonable, if the Commonwealth wants the states to spend more money on mental health services, that it should lead by example. There has been an erosion of

funding too for public and social housing, an initiative of the Commonwealth. Many people with mental illness have very tenuous housing and are at additional vulnerability to homelessness and incarceration.

A point not raised in my submission but which I would like to raise now is the further threats to vulnerable people who are on the disability support pension. Australians with a psychiatric disability are the second largest group of DSP recipients—about 25 per cent of all recipients. The episodic nature of many mental illnesses raises complex issues regarding their capacity to participate in work and the particular type of support they need to do so. I am concerned that the Commonwealth's proposed changes may further harm many people with a mental illness by forcing them off the DSP and onto the lower level Newstart allowance if they are deemed to be able to work 15 hours or more unsupported.

My submission supports recommendations of others for a national commission for mental health, as appears to work reasonably well in New Zealand and the United States.

CHAIR—Thank you for your submission. Does the Public Advocate have jurisdiction over the prison system?

Mr Boardman—I should have started by explaining what my role is, because it is unique in Australia. There are public advocates, as you know, in other jurisdictions. In fact, my counterparts in South Australia and Victoria, I understand, have made their own submissions to your inquiry. However, my role is different from that of my counterparts in other states and, as I said, is unique.

In Queensland we have the most recent legislation with respect to guardianship and administration of any jurisdiction, and we believe that we have developed a model that other jurisdictions might look at. One of the features of our guardianship and administration regime in Queensland is that systems advocacy as a function has been separated from the other traditional roles of guardianship and has been given its own statutory position, the Public Advocate. Another way of explaining it would be to say that we have a Public Advocate and an Adult Guardian. Most of the traditional functions of guardianship are conducted by the Adult Guardian here in Queensland. The Public Advocate's sole duty is systemic advocacy on behalf of people with impaired capacity.

The legislation gives me very few powers. I have no investigative powers. The legislation says that I have essentially three functions: one is to promote the protection of people with impaired capacity, which includes of course people with mental illness; the second is to promote good programs; and the third, as the legislation states it, is to monitor and review the delivery of services and facilities to the adults. So, in answer to your question: notionally, yes, I have coverage of the prison services, corrective services, as I have coverage of all other silos of human services, with my three staff.

CHAIR—Could you get yourself into locked units or women's prisons?

Mr Boardman—I can knock on the door. If I am told to go away, I do, because I have no powers to require entry into any facility. My statutory responsibility is to monitor and review

services and facilities. The Adult Guardian in Queensland has very strong investigative powers, including powers of entry.

CHAIR—Who is that person?

Mr Boardman—The Adult Guardian in Queensland is Ms Paula Scully.

CHAIR—I will pick up on that last point you made about the threats to those people on disability support pensions from the pending changes to federal legislation. The statistic you gave us—that 25 per cent of all participants have a mental illness—is interesting. I have not seen that figure before. Presumably it is a public figure; it is not a Queensland statistic?

Mr Irons—No. I will just clarify that. That is from the Department of Family and Community Services 2004 report *Characteristics of disability support pension customers*. That is an Australia-wide figure.

CHAIR—Your concern presumably does not just relate to the risk of a lower income by being put onto Newstart; it is presumably about the capacity to work and fulfil the work activity requirements. I invite you to expand on that statement.

Mr Boardman—I think we are dealing with the intersection of proposed new requirements for persons in receipt of DSP or Newstart allowance and the episodic nature of mental illness. That is the essential point. Following from that are questions about what happens to a person who has been deemed able to work unsupported for 15 hours a week, when they have a mental illness that is episodic—what happens to them when the mental illness is active, given that a person with a mental illness may have a number of episodes in any single year. Lindsay might want to say more.

Mr Irons—Yes, just to follow on from those points: we know that the research tells us that employment is and can be very significant to people who live with a mental illness and is part of their recovery process. I guess there are several issues here. There is the balance between carrots and sticks, and the question about whether sufficient and appropriate types of support are going to be provided, realising that for people with a mental illness or psychiatric disability to enter a workplace successfully the issues are really very different from somebody with, say, a physical disability.

That is not to minimise the threats that might apply to other disability groups, but for people with a mental illness the nature of the support is quite different. There is a need for much more sensitive human support and the issues around discrimination and stigma in the workplace are significant. A number of national bodies have drawn attention to those over the last couple of years, including SANE Australia. So we are not in any way saying that barriers should be put up to people entering the work force, because that is a good thing, but we have concerns about whether the mix of support is going to be appropriate and sufficient and whether the particular models being used are going to work. We heard that in the early days of the case based funding trials the results were quite negative in terms of the capacity of people with psychiatric disability to sustain employment in the long term. A whole range of complex issues need to be taken into account for people with psychiatric disability.

CHAIR—One of your recommendations is for access for the crisis intervention team ‘to non-lethal weapons, for the safe and humane resolution of critical mental health incidents.’ It is my understanding that in Queensland there have been a number of incidents of people with mental illness being shot. This is what gives rise to your recommendation, presumably. What sort of non-lethal weapons ought to be provided and how we can avoid those incidents?

Mr Boardman—It is true that in recent years there have been three lethal incidents, I think, involving a person with a mental illness and the police. I am aware that the Queensland Police Service has become increasingly concerned about this. My office has worked with the Queensland Police Service and the mental health program here in Queensland to devise strategies to address this concern and to minimise any future lethal incidents. As part of our submission we attached an issues paper from my office, entitled ‘Preserving life and dignity in distress: responding to critical mental health incidents’. I commend the Queensland Police Service and the mental health program here in Queensland for the very fine work they did around this. I note that in the recent state budget funding has been provided to resource critical incident response teams in Queensland. Today I was talking with an officer from Queensland mental health who was at a conference in Victoria last week. Already there is significant interest from other jurisdictions in the model that has been introduced in Queensland. As to non-lethal weapons that might be used, Lindsay may have something to say about that. I do not have the expertise to provide you with any comment.

Mr Irons—In the discussion paper we did address that issue, but we stopped short of recommending what types of non-lethal weapons should be used, precisely because we acknowledge that we do not have the technical expertise in those matters. Having surveyed the breadth of literature out there, mostly from the US, we know that there is a range of technologies from capsicum spray to tasers to beanbag guns to all kinds of things. We are also aware that concerns have been raised about a number of those technologies. The technical expertise for that lies outside of our office. The points we would make are that, firstly, ongoing research needs to be conducted to make sure that the best and safest technologies are available and that, secondly, officers need to have access to those technologies.

The point that needs to be made in the paper is that a good response will hopefully de-escalate a situation long before some kind of instrument is needed. I acknowledge that that is not always possible, but the thrust behind the critical incident team approach is that you involve the police and the mental health personnel together and that they employ well-researched and well-founded de-escalation techniques to safely and humanely resolve the situation and enable a person to access crisis care.

Senator HUMPHRIES—Mr Boardman, you spent quite a lot of time in the submission attacking the philosophical and practical expression of the Commonwealth’s actions in mental health and, incidentally, attacking the Prime Minister fairly personally as well. I am unsure how you feel that adds to the quality of the submission, but I suppose that is your prerogative. I am surprised at the way in which you ignore the issue of the Queensland government’s neglect of mental health. We have heard already today that Queensland spends less per capita than any other jurisdiction in Australia. One academic from the University of New South Wales yesterday described Queensland as being at the bottom of the totem pole when it came to mental health performance in Australia. I do not see much reference to it in this submission. What do you feel about the performance of Queensland in mental health? You mentioned approvingly what is in

the pipeline as far as budget initiatives and so forth are concerned, but you have not had much to say about the past performance of the Queensland system. Do you think that Queensland is performing well enough in these circumstances? Could it do better?

Mr Boardman—I will make a couple of responses. I was one of the original four directors in the first national mental health strategy in Canberra and I was responsible for helping mental health consumers to become part of the policy-making process. What was very evident to all of us who worked in that first national mental health strategy was the perception of mental health consumers that underlying the very poor service response to people with mental illness was the encompassing issue of stigma and discrimination. The words, the actions and the messages that our national leaders give to the Australian community are tremendously important when it comes to the issue of stigma and discriminatory behaviour. That is what underlies my criticism of the national government in recent years. With respect to Queensland's performance, you are no doubt aware that much is being said at the present time about the Queensland health system. I am certain that other submissions have adequately covered—

Senator HUMPHRIES—Whereas yours has not.

Mr Boardman—many of the perceived failings in mental health services in Queensland. I advocate very strongly within Queensland, as a statutory officer of the Queensland parliament, to the Queensland government and to the different human services, including to the mental health service and to Queensland Health. I advocate strongly, critically and unequivocally. I see that as part of my responsibility. I think my responsibility in this jurisdiction, in the jurisdiction of the Commonwealth, is to apply my critical lens to the role of the Commonwealth.

Senator HUMPHRIES—I am surprised to hear you say that. It seems to me that the responsibilities you have got at this level, which you need to discharge in respect of mental health, are just as strong as any responsibilities you might have before a committee like this to make the comments that you do. I will give you an example of that. You mentioned that Cornelia Rau was, as you put it, wrongly incarcerated in Commonwealth detention for a period of many months. We heard evidence immediately before your testimony about mistreatment of the same woman at the hands of the Queensland government authorities. As the Public Advocate in Queensland, what did you do about Ms Rau's circumstances here?

Mr Boardman—It is very appropriate that that information has been laid before the Senate by Sisters Inside. As to what I did, I need to return to what my statute tells me I can and cannot do. I have those three functions of protection, promotion and monitor and review. If you look at the legislation that covers my position, I have no powers. At the time that Cornelia Rau was incarcerated in Queensland, I knew nothing of it.

Senator HUMPHRIES—That may be the case, but you do presumably know about it now.

Mr Boardman—Indeed I do.

Senator HUMPHRIES—And you have taken the time out to talk about Cornelia Rau's treatment at the hands of the Commonwealth, but you make no mention of what you know about or what you reflect on with respect to Queensland's treatment of the same woman. Doesn't that connote a certain lack of objectivity on the subject?

Mr Boardman—I think not. In the last eight weeks I have made four submissions on mental health issues—one to the Senate, one to the Bundaberg inquiry, one to the review of health services and one, which was originally to be confidential, to the then health minister. I do not think I have been remiss, and nor do I think I have been unobjective. I think what we need to discover is the consequences for people with mental illness of the actions, the attitudes and the program responses of different levels of government. I think I have adequately covered those in the jurisdictions where they rightfully belong.

Senator HUMPHRIES—We will have to agree to differ on that point. I note that you commented before that the Commonwealth should be leading by example when it comes to increased funding to mental health. You may or may not be aware that in fact the jurisdiction that has contributed to the largest increase in funding in regard to mental health in the last 10 years has been the Commonwealth, in the order of 124 per cent.

Mr Boardman—It stands at seven per cent of the total Commonwealth health budget. Queensland's contribution to mental health services is slightly over eight per cent of its total health budget.

Senator HUMPHRIES—It delivers services directly to people with mental illness. The Commonwealth does not deliver any direct services; its services are generally delivered indirectly through funding the Pharmaceutical Benefits Scheme and through Medicare rebates to GPs. That is its main contribution, and that is an indirect contribution to the mental health system. I am just commenting because I am surprised about the lack of a balanced picture that I see in the submission. But, as I say, you are entitled to say what you wish to the committee, and I suppose the committee has to weigh that up in considering what weight it gives to the report.

Mr Boardman—Senator, I suppose the point I would make is that Queensland shares many of the difficulties and many of the shortcomings of every other mental health service in every other jurisdiction in the country. I referred earlier to submissions by my counterparts in Victoria and South Australia. They do address specifically a range of issues with respect to the delivery of mental health services in their own jurisdictions. In the generality, I have no trouble in supporting what the public advocate in South Australia and the public advocate in Victoria have to say about the delivery of mental health services. I am not trying to say that Queensland is without fault. What I am saying is that Queensland shares a range of deficiencies with every other jurisdiction. I think the point I am trying to make to the Commonwealth—and I am in the Commonwealth jurisdiction right now—is that the Commonwealth has an essential and significant leadership role to play, and that includes in modelling what it would like to see the states do. For one example, it is interesting that out of Commonwealth Health comes a requirement that the states should have whole-of-government responses to mental health services when I have already alluded to the disparities between Commonwealth housing policy and Commonwealth mental health policy and how they work against each other. If the Commonwealth wants the states to adopt whole-of-government approaches—and that is precisely what I advocate to the Queensland government and what my counterparts advocate in their jurisdictions—then let the Commonwealth model that for us.

Senator HUMPHRIES—I should say that this is not an inquiry into delivery of services by the Commonwealth to the mentally ill; it is an inquiry into services for the mentally ill across Australia at all levels of government.

Mr Boardman—Absolutely, sir.

Senator HUMPHRIES—I have no more questions, thank you.

CHAIR—I will pick up on the point that you made, Mr Boardman, about divisiveness and exclusion. You do pointedly criticise the Prime Minister for his actions in this respect. But it is mostly in the speech that you attached to your submission rather than in the submission itself. How do you see what you describe as divisiveness at that most senior level reflected in what we might have heard about today at the table in a seclusion area of a women's prison? Does it have an impact on the psyche of the nation, and what sort of evidence have you got to suggest that?

Mr Boardman—I think there is no doubt, Senator, that it does impact on the national psyche. In the speech that was attached to my submission I made the point that I am not blaming any government for the stigma and discrimination experienced by people with a mental illness, nor indeed by Aboriginal people, nor indeed by other oppressed and marginalised groups. The point that I made is that the national government has a responsibility to establish a discourse or, if you like, a national or a community narrative that supports social inclusion, that supports cohesion. What evidence do I have? I guess I would have to move to my subjective response to much of what has occurred in our community in recent times. I think I asked in the submission: how is it that we can deport one of our own citizens; how is it that we can incarcerate a permanent resident in a refugee detention centre?

Senator HUMPHRIES—Or in a Queensland prison.

Mr Boardman—Or in a Queensland prison indeed, at the behest of the Commonwealth, I understand.

Senator HUMPHRIES—It was as much the responsibility of the state government as it was of the Commonwealth government that that occurred.

Mr Boardman—We can agree to differ. The point that I would make is that these are new things. I wonder how much worse it can get than us deporting our own citizens? This was a woman who, from what I know, was experiencing brain trauma from an accident just days before she was deported. How could it happen? Are we saying that the national discourse promulgated by our national leadership has nothing to do with that?

Senator HUMPHRIES—What is the connection? How has anything John Howard has said contributed to the deportation of Ms Solon? Are you suggesting that there is some sort of policy process, initiated by the Prime Minister, which has led to that?

Mr Boardman—There are a couple of points I would make. I have the greatest respect for the Prime Minister.

Senator HUMPHRIES—Is that right?

Mr Boardman—I think I said in my speech that I chose him as my example for a couple of reasons. Remember, this was a speech made more than a year ago. Firstly, he was outside the Queensland jurisdiction. I think I said it was safer for me to choose someone outside my own

jurisdiction. Secondly, he is extremely well known. Prime Minister Howard has been well known to the Australian community for many years now, and he therefore provided a good example of our national thinking. I also made the point that Mr Howard is not much different from other parliamentarians and that parliamentarians, no matter how much we like to dislike them, are not much different from the people they represent.

So your assertion that I was deliberately and unobjectively attacking the Prime Minister is not correct. As to whether there was some conspiracy to arrange the deportation of an Australian citizen from their own country—I think for the first time ever—that proposition, with respect, is absurd. I am not suggesting that at all. I am trying to make a connection between the discourse—the narrative—that is established by our leaders and the consequences it has for the most vulnerable people in our community. Can I give you statistical evidence to support that connection? No. Does it make reasonable sense? I think yes.

Senator HUMPHRIES—With no evidence, it makes sense, does it?

Mr Boardman—I beg your pardon?

Senator HUMPHRIES—You say you cannot give us any evidence of what you are saying, but it makes sense. I do not understand that. How do you work that out? This is a subjective response, really, isn't it? There is no objective evidence for it at all, is there?

Mr Boardman—We seem to be returning to this again and again, and maybe at some point we shall indeed have to agree to differ. Nevertheless, you asked me to comment. Is there objective evidence? I think there is emerging evidence about the consequences for vulnerable people of the narratives, behaviours, policies and programs implemented by our national leadership. I am uncertain why you would have trouble making that link.

Senator HUMPHRIES—The reason is that there is no evidence to suggest in my mind that what happened to Ms Solon, for example, could not have happened under another government's tenure. It was a most unfortunate incident that amounted to a breakdown in the administrative processes at work in the Department of Immigration and Multicultural and Indigenous Affairs. You can suggest that there is some connection between the rhetoric of the Prime Minister and that occurring, but you need to back it up with some kind of evidence. To suggest that because the Prime Minister said these things and then a deportation occurred there must be a connection between the two facts—

CHAIR—I am not sure that that is what Mr Boardman was saying, Senator.

Senator HUMPHRIES—I am not sure what Mr Boardman is saying in that respect. As one of the parliamentarians that you, as you put it, like to resent and revile, I feel—

Mr Boardman—I have not attributed that to myself at all. I have the greatest respect for parliamentarians. The work that you do is some of the most difficult in the country. Please do not attribute that to me.

Senator HUMPHRIES—So you are saying we like to resent and revile them? Do you mean that you like to resent and revile them? Is that what you mean?

Mr Boardman—It is part of the national narrative that has been there for decades. It is the general view—it has been discussed endlessly, particularly over the last 10 to 20 years—the average Australian citizen has of politicians. I assumed that I was speaking to a community that at least had some awareness of these things. My apologies if I have not been able to make myself clear to you.

CHAIR—We might move off this topic. We have to finish fairly soon. There is one point I want to ask you about. A systems man—as you describe yourself—has suggested that we look at the New Zealand Mental Health Commission model, which we have indeed done. We met with some commissioners a few weeks ago. That has yet to be funded for the next phase, so we are not altogether sure how secure it is. What difference do you think that would make in this country? Is the main advantage of it the constant reviewing of the achievements or outcomes of a national mental health strategy? Is that what you see as being the great benefit or is there something beyond that?

Mr Boardman—I will say a few things and then ask Lindsay to elaborate. What we are not after is another complaining body that continues to recycle demands for public inquiries and so on. What the commission—and I am talking about a permanent standing commission—can do is to work collaboratively with all levels of government, providing advice and, indeed, leadership in a whole range of key areas. Hopefully, the commission would be informed by the lived experience of mental health consumers and mental health carers and would identify the most pressing gaps in service delivery. I would hope that a commission would provide an external, independent accountability mechanism as well. I do not know if Lindsay has anything he would like to add.

CHAIR—Before you answer, I will interpose a more complicating question. The more we know about the mental health system in this country, the more we understand how diverse it is, how very different it is in the city compared to in the country, how very different it is from one area to another in New South Wales—for example, some provide services for people with eating disorders and most do not. It is an enormously complex system. It has obviously grown like Topsy, rather than by design. How would a commission get a handle on that? We are struggling ourselves.

Mr Boardman—The federal system has benefits and drawbacks. One of the benefits is that we can learn from each other. I suppose one of the drawbacks is the topsy-turvy nature of what happens as different governments respond to emerging community and political concerns. The democratic process is all about mediating a complex range of community issues and concerns, which is why I am filled with admiration for those people who take on the parliamentary job, because that is what I see you doing all the time—mediating all the conflicting demands of what is a complex society. I have lost the thread of where I was heading to. Perhaps Lindsay can take it up.

Mr Irons—I think Ian has mentioned most of the important points. We are not necessarily seeing that as a panacea for all problems, nor are we necessarily suggesting that the US or the New Zealand model is the perfect one. The hope in having such a body is that it would be a credible, reputable voice in the mental health landscape, which is very important; that it would represent some measure of external accountability—external to both the Commonwealth government and the state governments—so we would get some independent reporting on how

well our systems are doing in implementing the vision of mental health reform; that, as Ian mentioned, it would be able to promote good practice across jurisdictions; and, importantly, that it would be—and perhaps this is a massive ask for such a body—connected to and informed by the experience of consumers and carers on the ground. I think those are the main points.

CHAIR—Thank you very much for your submission and for coming along.

Mr Boardman—Thank you very much for the opportunity to appear before you.

Subcommittee adjourned at 5.37 pm