COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

Reference: Mental health services in Australia

THURSDAY, 27 MARCH 2008

SYDNEY

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SENATE STANDING COMMITTEE ON
COMMUNITY AFFAIRS
Thursday, 27 March 2008

Members: Senator Moore *(Chair)*, Senator Humphries *(Deputy Chair)*, Senators Adams, Allison, Boyce, Carol Brown, Lundy and Polley

Participating members: Senators Abetz, Barnett, Bartlett, Bernardi, Birmingham, Bishop, Boswell, Brandis, Bob Brown, Bushby, Campbell, Chapman, Colbeck, Coonan, Cormann, Crossin, Eggleston, Ellison, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Johnston, Joyce, Kemp, Kirk, Lightfoot, Ian Macdonald, Sandy Macdonald, Marshall, Mason, McEwen, McGauran, McLucas, Milne, Minchin, Nash, Nettle, O'Brien, Parry, Patterson, Payne, Ray, Ronaldson, Scullion, Siewert, Stephens, Sterle, Stott Despoja, Troeth, Trood, Watson, Webber and Wortley

Senators in attendance: Senators Allison, Humphries, Lundy, Moore, Webber

Terms of reference for the inquiry:

To inquire into and report on:

1. Ongoing efforts towards improving mental health services in Australia, with reference to the National Action Plan on Mental Health agreed upon at the July 2006 meeting of the Council of Australian Governments, particularly examining the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities.
2. That the committee, in considering this matter, give consideration to:
    a) the extent to which the action plan assists in achieving the aims and objectives of the National Mental Health Strategy;
    b) the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care;
    c) progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A national approach to mental health – from crisis to community*; and
    d) identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.
3. That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health.

WITNESSES

Committee met at 9.04 am

GOULD, Ms Deborah Helen, Clinical Psychologist, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

MURDOCH, Mr Lachlan James, Deputy Director, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

CHAIR (Senator Moore)—Good morning. I declare open this public hearing in which the committee is taking evidence for our inquiry into mental health services in Australia. I welcome the representative from the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors. Ms Gould, you have told us that Mr Murdoch is on his way. We always begin by acknowledging the traditional owners of the land we are on, so I put that on record. We have the submission that your organisation has provided. If you would like to start by making some opening statements then afterwards we will get into questions.

Ms Gould—I think some of you were present at the initial committee meeting in April 2006.

CHAIR—Yes, quite a few of us were.

Ms Gould—I am hoping that there will be enough of a continuity between the two for you to have your minds refreshed. I would like to say that I am a clinician primarily, so in the opening address I might skip some of the more technical funding related matters that Lachlan will speak more to.

CHAIR—Sure, and it is in your submission anyway.

Ms Gould—Exactly. I am much more comfortable with a question and answer session. We have also prepared a few case studies that will illustrate some of the points that we will use, if you are interested. Obviously I have to adhere to the promise of confidentiality made to our clients. We are funded by PASTT—the program of assistance to refugee torture and trauma survivors—so we are accountable to this mental health plan as much I suppose as any of the others who are going to present today. STARTTS is a New South Wales state-wide service providing a range of treatment contexts to refugee torture and trauma survivors. I will use the word ‘refugee’ just for the sake of ease, but we do recognise that the clients we see are survivors of torture and severe trauma. The services are comprehensive to the extent that they are not just individual psychotherapy based services but also include community development work, which is fundamental to our work. There is a personal support program which is part of the Department of Employment and Workplace Relations. We also provide a training program where we have quite strong links with mainstream mental health providers, and that comes into the submission quite a lot. Possibly that is on the increase as a result of the plan where mainstream service providers not only consult with us on particular clients but have also requested training for their staff in cultural competency in working with severely traumatised people and so on.

We also have an early intervention program, and we make quite strong reference to early intervention health promotion and prevention of mental illness. Our early intervention program is for newly arrived refugees who are specifically at risk for a variety of mental health presentations. I will not be using the word ‘mental illness’, because with refugees it is particularly true to say that the symptoms they present with—the psychological symptoms—usually do not fall into a diagnostic category. So often they do not, technically speaking, have diagnosable mental illnesses. They do present in higher state of distress with symptoms that appear often to be symptoms of severe mental illness. One of our case studies, I think, will illustrate the importance of taking a person’s context as a refugee into account when making diagnoses and doing an assessment of the client. So that for us would be a very important part of putting the plan into effect—that is, to provide specialist training not just generic training to mainstream service providers.

The early intervention program is for newly arrived refugees. It is funded through the Department of Immigration and Citizenship. The program has been running for about 10 years now with a fair amount of success. Part of the plan was quite a strong reference to providing a context for refugees’ lives. That includes housing, employment, language skills and so on. I would like to assume that everyone here recognises the importance of that. For example, when we are doing trauma counselling, in a sense, before we can really get to the nitty-gritty of it, we have to be sure that clients have a degree of safety and stability in their environment. So housing needs to be consistent and longer term and there need to be prospects for employment and the learning of language skills. We cannot speak to that too much directly, but we do recognise that a lot has been done in that respect, particularly plans around housing, and that is referred to in our submission.

On the mental health promotion issue, we have seen fairly big gaps in the provision of information to communities and individuals and their families on issues about mental illness and refugees. For example, there is still quite a big stigma attached to seeking mental health services. This exists in a variety of communities, not just refugee communities, but perhaps particularly so in the refugee community. The mental health models we follow here are quite foreign to many people. We also have to question whether they are appropriate, but I think that is perhaps another issue about research and more academic matters. I think what I am referring to is that counselling is a methodology that most Westerners would accept as a way of relieving emotional distress and dealing with symptoms, but that is not true for all communities.

Mental health promotion typically focuses on the distribution of written information. In fact, when we looked at what is available, we saw that it is usually written. Some refugee clients are not literate even in their own languages. That would not be true for most, but written language is not necessarily the best way of getting this kind of information across. We are very interested in other agencies who are exploring other media for dealing with promotion—for example, radio or theatre. There could be a variety of things. We have been involved in the past in youth initiatives, which are typically quite energetic approaches to health promotion generally. I am not sure if that has been funded by this mental health plan but it is an example of STARTTS working with community organisations. I really hope that I am not giving away too much of what Lachlan wanted to say.

CHAIR—You have the microphone, Ms Gould. It is your chance.

Ms Gould—And this is not karaoke!

CHAIR—That is right—go for it.

Ms Gould—The second point that he really did want to make—and I hope that it is not too much out of context—is around the workforce. That covers a fair amount of our own submission. This work is very difficult. Of course, all health work is difficult, but I think refugee related mental illness work is particularly so. We all have particular vulnerabilities. Some of us will have experienced depression in the past and I think we are all becoming more aware of the incidence of depression in the non-refugee population. Doing this work certainly does touch on people's personal vulnerabilities. There are ways of dealing with those in the context of organisational support—usually STARTTS support. I think perhaps that is something that is missing. We have been focusing on the training of staff, and skills are not the only thing that we work with when we are working with clients and doing this kind of work. So it does evoke our own vulnerabilities and it really does challenge the skills that we have been taught in our particular professional training. Those are two levels we would like to address: support for staff and training of staff.

The one level of training that we are very interested in is so-called cultural competency. Most professional programs—allied health, psychiatry, social work, community development and so on—are increasingly integrating cultural competency into other competencies. Usually this has been around Aboriginal identity in local Indigenous cultures and perhaps in other migrant cultures. There are fairly big mental health programs for several migrant groups.

The cultural issues in relation to refugees are quite different. They include things like integration and assimilation with major language differences and being part of minority or fairly isolated religious groups for example. These are all important aspects of any culturally oriented training that staff might need. In addition, we cannot typically apply our usual counselling methodologies, so mainstream staff will need to be challenged and perhaps skilled up a little in alternative ways of using our taught skills. Perhaps the one issue that is most obvious is the amount of people available. We recognise that there are staff shortages in every mainstream health service but particularly in mental health. That is characterised not just by shortages but also by high turnover. Some of that turnover is related to work stress, payment and so on. The profile of staff working in mental health centres tends—and Mr Murdoch will comment on this better than I—to be that of an aging population. So we are going to lose them within the next 20 years and we are yet to see how they will be replaced. Obviously, they will be replaced by people who have been trained in the way I have referred to here.

On the issue of how we work with mainstream service providers, it goes both ways. There is always a tension with specialist services: do we work with mainstream services so that ultimately they provide the service in a comprehensive way or are we a specialist service that they refer to? We have tended to take the latter approach that we are a specialist service. We welcome the initiatives described in the plan for consulting with and working directly with mainstream service providers so that there is time and money allocated to those relationships. Obviously that would have happened as part of our work outside of this. It is what mental health workers have always done—that is, work between specialists and primary and secondary care staff. But I think in relation to refugees a little more time is taken. Some of it is very labour-intensive, but we are committed to working with mainstream providers over particular clients as well as in a more general way by informing them about current refugee issues and settlement profiles that they do need to know about.

The final thing to mention before we have more of a discussion is the issue of temporary protection visa holders. I know that it is a fairly complex political situation with the changes in Senate profile and where things started in relation to temporary protection visa holders—

CHAIR—I think your organisation gave significant evidence on those issues in the last hearing.

Ms Gould—We did.

CHAIR—So it would follow on from that.

Ms Gould—Absolutely, the follow on is simply that we are still seeing the impact of that. There is less of an impact of incarceration in detention centres but the very nature of services available to temporary protection visa holders remains less than ideal. They certainly have access to our service and several other services, thanks partly to the funding that we receive via the national plan, but there are a range of other support services that they do not have access to. Perhaps, psychologically speaking, the thing that clinically we see the most at STARTTS is the lack of certainty about the future and the difficulties that these clients face with family reunion and so on. That separation from family is one of the main things that people present with—the distress about separation. That is a very brief comment on the TPV issue. Lachlan will arrive and remind us of other issues.

CHAIR—This could be Mr Murdoch heading towards the table now.

Mr Murdoch—My apologies for the problems this morning.

CHAIR—We understand, Mr Murdoch.

Ms Gould—I am afraid we have finished your bit.

Mr Murdoch—Already!

CHAIR—Ms Gould has gone through some of the key issues, and she made reference consistently to the fact that some of the areas were yours. If you would like to highlight some of the things you would like to do, we will then get to questions. We talked about workforce; we talked about the specific issue of people from non-English-speaking backgrounds and the difficulty of adapting technique to working with them; we talked about training needs; and there would be other things. But particularly with workforce and funding issues Ms Gould said that that was your area.

Mr Murdoch—Yes, certainly. I can talk first, if you like, on the issue of funding. In our response to the first terms of reference for the inquiry we noted that there had been an historic underfunding of mental health services in Australia in comparison with funding levels of other OECD countries and corresponding to the expected future burden of disease in terms of issues of depression. But we also recognise that there have been improvements in the situation of funding in relation to the attitude of both the federal and the state governments.

I am not sure if we have mentioned this as yet, but certainly in the case of the torture and trauma treatment services around Australia there was a substantial enhancement to funding that took place. That was announced in the most recent federal budget. The extent of that was $12 million over four years. That, taken in conjunction with existing funding, was certainly a substantial increase for funding of counselling services for torture and trauma survivors here in New South Wales. The base funding had been in the order of $500,000 through the program of assistance to survivors of torture and trauma. The additional funding has been in the order of a further $1 million. So that has certainly been something we welcome. I see that as being a recognition of the needs, particularly, of refugees who are survivors of trauma.

The other thing to say, just quickly, in relation to the issue of funding is that there has been other recognition of the needs of torture and trauma survivors, which has taken place over several years. In the late eighties there was the establishment of a program to assist recently arrived refugees in relation to their physical and psychosocial health needs and to provide an early assessment and intervention program. That has continued to be funded through the Department of Immigration and Citizenship. Again, this is a recognition of the needs of torture and trauma survivors.

I suppose the other thing we would like to say in relation to funding is that there is still considerable stress within the mainstream mental health system. That does impact on our clients. We certainly have contact with mainstream mental health services that are providing assistance to our clients. The general scenario is one in which those mainstream mental health services, which do struggle at times for resources, are required to assist people, often, in the acute phase of their illness. That then impacts on the capacity to provide ongoing care. So there are continuity of care issues that we have raised in our submission.

Beyond that, there are stresses which exist for the workforce itself. Deborah may already have made reference to some of the workforce issues. We raise concerns around the opportunities for training and professional development and the possibility for there to be clinical supervision of clinicians who are working with an increasingly diverse population. I think there is a lot of willingness on the part of mainstream mental health services to engage in those processes. The difficulty arises where there are other pressures that exist. It can be quite difficult for people to be afforded time away from direct client contact that then allows for the process of professional training that assists in dealing, for instance, with exactly those issues of cultural sensitivity: the understanding of and openness to the background of a diverse cultural and linguistic client group; use of interpreters; and a whole variety of things that can be very helpful to understanding the needs of refugees and others who come from diverse backgrounds and who require treatment by mainstream mental health services.

CHAIR—The next witnesses are from the Multicultural Mental Health Australia consortium. A large part of their submission is on the same issues.

Mr Murdoch—Yes, and certainly I think that what we have to say today is reflective of some of the issues that have been raised in their submission as well. We are part of the Multicultural Mental Health Australia consortium, so much of what we say today will be re-emphasising some of the points that have been made in that submission.

CHAIR—We will move to some questions.

Senator HUMPHRIES—Thank you for that update on the important work that your organisation is doing. You mentioned in your submission that you had a waiting list of about 148 at the time of the submission. Has that gone up since the previous submission that you made to us? I cannot recall. Was it about the same?

Mr Murdoch—Yes, it has been fairly consistent for a while but what has happened is that there has been some greater capacity to address the issue of the waiting list for our clients.

Senator HUMPHRIES—That is with that $12 million, is it?

Mr Murdoch—Yes, that is with that $12 million of funding that I referred to. That is national funding. It is $12 million over four years. Basically it is $3 million per annum nationally. So there has been a capacity certainly on our part to reduce the number of clients waiting for services.

Senator HUMPHRIES—What do the numbers stand at at the moment in terms of those on the waiting list?

Mr Murdoch—On the last occasion we reported to the Department of Health and Ageing in relation to our waiting list numbers there were in the order of 65 to 70 clients waiting.

Senator HUMPHRIES—That is a lot better.

Mr Murdoch—Yes. It does move around a little particularly in regard to those communities that seek our services to a greater extent. So where we have significant numbers of arrivals from certain parts of the world it can be difficult to service that particular client group. Currently we have a large number of Arabic speakers who are using the service, many from Iraq and some from parts of the Horn of Africa as well. For that group there is significant demand which requires mobilising resources in relation to interpreters, and bicultural counsellors at times as well. So we can sometimes have a spike in demand for a particular community, which will then affect waiting periods for that group and which may then not be reflected in relation to others.

Senator HUMPHRIES—In your submission you make reference to the advent of the 24-hour mental health access phone line which was going to be tied in with interpreting services and bilingual counselling staff. Has that begun now and if so do you know if it is the sort of thing that is being accessed a lot by the people who you are assisting?

Mr Murdoch—I think that was a state initiative that was identified as part of the response to the National Action Plan on Mental Health. We certainly do make use of access lines. Deborah, you might be able to comment a little more about the utility of those. For a number of our clients that has been quite a helpful service.

Ms Gould—Our clients access the line through the information that we provide, usually. In acute situations we contact the access line. We have found in particular areas that they are very responsive and that they do the kind of follow-up care that is perhaps ideal in an acute setting. So rather than getting people admitted they do provide support on a daily basis. Some of the issues about interpreters are much more obvious there because they are going into people's homes and they need telephone interpreters as opposed to being able to use face-to-face, which does pose a number of difficulties. So they have been very responsive to our calls.

CHAIR—So that 24-hour line is operational?

Mr Murdoch—The 24-hour line in response to the CALD communities?

Ms Gould—This is the general—

Mr Murdoch—This is the general one that you referred to.

CHAIR—So it is up and running?

Ms Gould—Yes, the general line is up and running. They function slightly differently in different areas.

Senator HUMPHRIES—What kinds of things would people you deal with typically seek from that line? Would it be a crisis call or would it be seeking reference to services?

Ms Gould—They are usually crisis calls in relation to suicidal intent and distress around suicidality. When clients speak about thoughts about suicide or an intention to harm or kill themselves, we as clinicians are very clear to give these numbers and we usually make the contact ourselves as well. It is mainly around suicidality, which would be for any client, really, but our clients do not have access to family and other resources that the rest of us would have.

Senator HUMPHRIES—On page 12 of your submission you make reference to additional funding of $3 million promised by the Department of Health and Ageing. Is that the $12 million that you referred to before?

Mr Murdoch—It is actually $12.2 million over the four years. That was a particular announcement at the time of the last budget.

Senator LUNDY—Can you tell me what difference the $12 million has made to the waiting list for services?

Mr Murdoch—As I said previously, it has reduced the number of people waiting. Obviously that also depends on referral numbers as well, and they have been fairly consistent. At times they can increase and at other times there can be slight troughs in referrals. It has reduced the number of people waiting for services, which has been an important development.

Senator LUNDY—By how much?

Mr Murdoch—At the time of our submission, we indicated that 145 or 148 people were waiting for services. On the last occasion that I reported to the Department of Health and Ageing it was more in the region of 65 to 70 clients who were waiting. That may be due to the fact that, in the initial phase, we have been able to address a substantial number of needs by bringing on some extra staff. As I say, the trend in relation to waiting lists will depend on the referral patterns into the future, but it has made a difference. There is some degree of caution in relation to certain groups. We receive significant numbers of referrals from certain client groups, and it can be harder to respond quickly when you get a large number. Presently, the most significant demand is amongst Arabic speakers. It also depends on the capacity to mobilise interpreter resources by cultural counsellors et cetera. In terms of bringing on new staff, there is the whole process of recruitment, induction, training and professional development. It is an important process that we have to engage in. This work requires some specialist skills and knowledge, so it can take a bit of time for new staff to come up to speed to be able to assist clients directly.

Senator LUNDY—Ms Gould mentioned the cultural differences and that that kind of support is considered culturally acceptable as a form of treatment. How do you determine that and how do you respond to it? I would imagine that it is quite challenging sussing all of that out in the first instance and then trying to tailor your services to be as practical and meaningful as possible. I would like to hear a bit more about how you confront that challenge?

Mr Murdoch—First and foremost, it is recognition that we do not know everything about how to work with clients, particularly as new groups arrive and as there are differences in terms of newly arrived refugee communities. It is about trying to understand the world view of people who have come from various parts of the world. We have clients from over 60 different national groups and they speak about as many languages, so it is a very diverse population. So the first thing is being open to understanding and learning from our clients about the world view that they have. It is also about a focus on clients and identifying in our own practice that some of the things that have worked with other communities might not perhaps work with a new group although the mindset and approach might be similar. We also use a range of modalities, so we are offering different possibilities to clients and options as well. There will be engagement in individual counselling, and that might be really helpful for some client family approaches. As for some groups of clients, they might be much more comfortable with a group approach to engagement with the service.

There is the use of innovative methods and modes of treatment. At different times we will make use of art therapy and play therapy and, sometimes, music and dance. A number of our counsellors have been trained in the use of dance, and dance therapy can be very useful for some of our clients who are more comfortable in expressing themselves in that way. Also we are keeping abreast of international developments in relation to treatment. For instance, one of the things that we have developed in the last couple of years has been a neurofeedback clinic. That has been useful in our working with clients who have had substantial impacts in terms of brain function as a result of their trauma experiences. That is something that we are developing further. Obviously, that use of neurofeedback is not necessarily appropriate for all of our clients. It is a quite intensive form of assistance. It is only really directed at those clients who have intractable issues around the impact of trauma. We have been finding that to be a useful treatment approach as well.

So it is about providing various options, and I think the emphasis on client focus is very important so that we are able to meet people where they are at to understand something of their situation. Many of our clients have been through extreme experiences of trauma. They have also been having trouble with and experiencing difficulties in adapting to a new place and adjusting to a new way of life and to changes that can take place in the family in relation to family roles and responsibilities in a very new setting. Those things can be equally disturbing for clients. They are things that we need to work through, so as well it is about being open to that.

Ms Gould—In the last few years we have been able to train so-called bicultural counsellors. These are people from a variety of other countries who speak a variety of languages and may or may not have any counselling experience. We have been through rigorous selection things and then we have managed to work with four or five people—from Somalia, Sudan, the Congo and so on—training them in counselling and then getting a lot of feedback. It really is about discovering on the job. As for the client focus, as Lachlan has been saying, that is the starting point and then there is sharing skills with these other staff. So our mode as clinicians was actually on the spot training with the client—me working with them—but they had other support as well. We used them a lot in community development in looking at working with a community as a way of healing individuals. So I think that was actually a huge initiative to have. In fact, most of them chose to stay at STARTTS as staff members, which was really useful.

Senator LUNDY—In terms of all of that knowledge that you are creating by virtue of the work that you are doing, are you able to share that with similar services elsewhere? Is there a professional network whereby you can share that knowledge and build a common pool of understanding across the services in Australia?

Ms Gould—That has been a huge frustration for us; we are so busy with the clinical work that it is often hard to reflect. But there are a number of fora. One is that we provide internships for postgrad students from a variety of universities, and that is one subtle way. Obviously the universities want to know what we are doing to see if we are appropriate and so on. But there is also the regular old training we do. With the University of New South Wales we have quite strong links.

Mr Murdoch—Yes, in terms of research. There have been other initiatives that we are a part of. There is the development of a national forum, the Forum of Australian Services for Survivors of Torture and Trauma.

Senator LUNDY—That is the sort of thing I am talking about.

Mr Murdoch—We have been an active participant there. That brings together all the torture and trauma treatment services from around Australia. There is a service located in every state and territory. Through participation there, we hold regular conferences—not, perhaps, as frequently as we would like. It is a bit like the Olympic Games; they happen every four years. Obviously, there are not quite the organisational responsibilities associated with that sort of venture! But it certainly brings people from around Australia and also from New Zealand—the services there have participated in those conferences as well. The most recent conference was held at the end of 2005 here in New South Wales.

Senator LUNDY—Would it be helpful, do you think, to have more opportunities to share information and knowledge with colleagues undertaking similar challenges in other states? Is that something that would be of benefit?

Mr Murdoch—Yes, that would certainly be very helpful. Certainly the feedback we get from all of the people who attend those conferences is that it is a very positive experience. There was a national conference, organised just recently by the Diversity Health Institute, which a number of our staff also participated in. I am sure you will hear a little bit more on that from the speakers from Multicultural Mental Health Australia and the Transcultural Mental Health Centre. That conference was just at the start of this month.

Other initiatives at the level of the national forum include the very recent commencement of a bulletin board type discussion group and that sort of use of those sorts of technologies. That has just got underway in the last month or thereabouts. It has been, I think, a very positive thing for those people involved. Obviously in New South Wales, and perhaps in other states which are receiving significant numbers of refugees, there is a critical mass in terms of the development of the services to a significant size. In some states and territories, which do not receive quite the same numbers, there are smaller services that are in existence. It is important for those people to also be able to connect with professional colleagues.

Senator LUNDY—They would not have the capacity to develop new understandings or knowledge in the way that, perhaps, you do.

Mr Murdoch—There is not the same possibility to confer with colleagues at close hand, but certainly there has been significant participation from all the torture and trauma treatment services throughout the country. As I say, one thing that has also been, I think, positive has been the connection with colleagues in New Zealand as well. We are involved at the level of some of the international organisations as well. There is the International Rehabilitation Council for Torture Victims; that is based in Denmark and funds services around the world. We are a participant in the council meetings there. There is also a body called the International Society for Health and Human Rights, and our current executive director, Jorge Aroche—who unfortunately could not be here today—is the secretary general of that society. They are involved in conferences; there is actually a conference taking place later this year in Peru that will bring together people from around the world who are working with people who have experienced torture and trauma. So there are a number of things. But it is helpful to be able to confer with colleagues, to get together and to meet.

It is interesting that at the level of the Forum of Australian Services for Survivors of Torture and Trauma there has been a lot of coalescing in relation to the models of treatment and quite a bit of sharing of experiences and ideas. But in many ways there is quite a similar philosophy in terms of how we work with our clients and what we see as the strengths and resilience of our clients, but also the importance of working with refugee communities and being connected at that level because of the impact of trauma not only on individuals but also on communities. So there are community-development approaches, capacity building, training and things of that nature.

Senator ALLISON—On the question of asylum seekers and those who may come to your service who are in detention at the present time: can you give the committee an indication of how many there are and where they are?

Mr Murdoch—In terms of asylum seekers, the number of clients will move around from time to time depending on the numbers of people entering Australia. They form about 10 to 15 per cent of our client group within our general services program. At any one time we can have between 20 and 40 clients who are asylum seekers. There are those in the community that we work with and there are also those who are in detention. At a policy level we took a decision many years ago not to provide services within the detention centres. But at various times over the course of the 20 years that STARTTS has been in existence there have been arrangements whereby people can be brought to our offices on accompanied visits and provided counselling in that fashion. One of our locations is in Carramar, which is quite close to the Villawood detention centre, and in the last few years it has been possible for people to be brought to us to receive assessment and counselling through accompanied visits.

Senator ALLISON—Does this mean that all of those who would need or want counselling now have it available to them outside detention centres?

Mr Murdoch—If that is something that the detainee indicates, then we are approached in relation to that. There are some services also within the centres that are provided. There are various requirements that those running the detention centres have in relation to the health needs of detainees. We do not go into the centres ourselves; people are brought to us when there is an indication of an interest in receiving the service. Often people are identified as potentially having had a torture or trauma experience and requiring some form of assessment, and there is the capability for those people to be brought to us. It is an important aspect to our work. At different times we have been able to provide evidence in relation to the situation of asylum seekers in detention, which, on occasions, has resulted in alternative arrangements with regard to their detention or release for the purposes of further follow-up and treatment.

Senator ALLISON—What is your overall take on the impact of detention—particularly for your clients, if we can put it that way? Are we doing better in this country? At the last inquiry it was raised, and it has been raised for a number of years now, that detention is detrimental to the mental health of people. If you were to put a score on it in terms of improvement in the last few years, what would it be?

Mr Murdoch—There has been significant improvement in the last two or three years. The capacity for people to be brought to our service on accompanied visits is an example, because that was not previously possible. For a score out of 10, I would probably give a four to a seven or something. There has certainly been significant improvement. I think we indicated in our submission—and, had I gone through the opening statement in detail, it would have indicated—that there has been the establishment of a Detention Health Advisory Group.

Senator ALLISON—Yes, I noticed that. I was going to ask you about it. You indicated that health standards were being developed for use in detention centres. Your submission was written a while ago. Can you update us on that.

Mr Murdoch—That process has continued and the Executive Director of STARTTS is a member of the Detention Health Advisory Group. It meets regularly and has been progressing a number of aspects of the provision of health services and advice around the provision of health services in detention. So it has been a very positive development, bringing people from a range of NGOs that are interested in the issue to participate. Again, that is a substantial improvement on where things were a number of years ago.

Senator ALLISON—So the standards will drive some change. Is that change already being implemented, and what are the key features of it?

Mr Murdoch—I would anticipate that that process of standard development will certainly inform the provision of health services within detention centres. There are already some standards that are contractual, that are required, so it is about revising those and adding to those, in a sense.

Senator ALLISON—It is not just documenting the status quo.

Mr Murdoch—No, exactly. I think the process of bringing in, as I say, a number of people from various interested NGOs has been very positive in essentially taking the knowledge that is developed within the wider health system, particularly in relation to mental health treatment issues, and bringing that into a context where it can then be utilised in relation to detention centres.

One thing it would be helpful to say is not specifically in regard to detention. We also highlighted in our submission the situation of temporary protection visa holders. We conducted a study. It was researched a few years ago now and it was published in 2006 in the *Medical Journal of Australia*. It was joint research between STARTTS and the psychiatry research and teaching unit of the University of New South Wales.

CHAIR—You quoted from that in your previous evidence.

Mr Murdoch—Yes, we did. The study certainly found that the situation of people who have been through detention, largely the conditions and the duration of detention, can have a significant impact on the mental health of those former detainees. But the other factor in all of that was the temporary protection visa and the effect of the long-standing limbo for many people in the community, which we think is actually counterproductive to good mental health outcomes and good health outcomes generally, particularly in relation to the extended periods of separation from family, which can ultimately result in quite problematic circumstances.

Senator ALLISON—What about the actual mental health services for people on bridging visas? They do not have access to Medicare.

Mr Murdoch—The bridging visa group is a different group. Bridging visa E—

Senator ALLISON—So where do they get their services? They cannot go to a GP.

Mr Murdoch—That is a group that we think is substantially disadvantaged.

Senator ALLISON—What is happening on the ground? What is happening in effect?

Mr Murdoch—Those people, and many of the bridging visa E holders, do not have work rights and as a result do not have access to Medicare. The result of that process is that there are a number of NGOs and various people within the health system who are trying to fill the gap. A good example is the Asylum Seekers Centre here in Sydney.

Senator ALLISON—Are they funded specifically for providing mental health services?

Mr Murdoch—No. The Asylum Seekers Centre draws its funding from a range of charitable groups. It would be largely reliant on a range of NGOs and others. Its health program would probably focus more heavily on physical health, but there is certainly a mental health need and it is responding to mental health issues for that population as well. But it is really trying to fill a gap, I suppose, which is quite large. Again, we identified in our submission that people on bridging visa E, who do not have work rights, are not able to access Medicare. There has been a review of the whole bridging visa system. As yet that has not been finalised. I think the review has been concluded but there has not been an ultimate decision in relation to the direction that the Department of Immigration and Citizenship will take.

Senator ALLISON—Do they have access to state run community health centres where they are available, like in Victoria?

Mr Murdoch—That would depend. I would anticipate in most cases that people would, but only where they are not required to present a Medicare card.

Senator ALLISON—I think they need to present one at those centres, don’t they?

Mr Murdoch—The approach to that would differ, I think, across area health services and in different states and territories, so it is a bit hard for me to comment.

Senator ALLISON—Okay. We will follow that up elsewhere. I just had trouble identifying the $12 million that you get over four years for improvements in treatment services in the national plan. Do you know what heading that comes under?

Mr Murdoch—It comes under the National Mental Health Strategy. It is the PASTT program, the Program of Assistance for the Survivors of Torture and Trauma.

Senator ALLISON—So it is nothing to do with the COAG agreement that came out after—

Mr Murdoch—It is nothing to do with the COAG agreement. We just highlighted it because of it being an improvement in funding.

CHAIR—The New South Wales government claim it is one of their initiatives. It was not directed by COAG, but New South Wales, in listing their achievements, list it.

Mr Murdoch—Yes. PASTT funding comes from the federal Department of Health and Ageing. It is included within the National Mental Health Strategy initiatives.

Senator ALLISON—Yes, that is what we needed to know. In fact, the only item I can find in the national action plan is $1.2 million for eight transcultural mental health workers in Queensland. Are you able to advise us about the progress there?

Mr Murdoch—I cannot give you really clear information about that, unfortunately. Possibly our colleagues from Multicultural Mental Health Australia would be able to advise more directly on that. Certainly we identified in our submission that there were some issues with the action plan in relation to the lack of focus on culturally and linguistically diverse communities. But that is one initiative that perhaps others can comment on more directly, because I am certainly not abreast of it.

Senator ALLISON—That is fine. Your submission does say that there have been some improvements with housing under the HASI but that the problems are still current. Can you give us some indication of the scale of the unmet demand and how much those improvements have improved that situation?

Mr Murdoch—Yes. I suppose what we have said in our submission is that it would be very helpful if there were to be monitoring of the access and take-up of services like the HASI, the Housing and Accommodation Support Initiative, by diverse cultural and linguistic groups.

Senator ALLISON—So you are saying we do not know?

Mr Murdoch—I do not have any detail on the degree of take-up of those services by refugees or people from diverse backgrounds in general. What I can say is that Sydney, where we are working—and I suppose New South Wales more broadly as well; we are certainly doing work in places like the Hunter—is an extremely tight housing market. There are lots of problems for newly arrived people in securing accommodation and quite a few difficulties in newly arrived refugees being accepted for longer term accommodation by real estate agents.

Senator ALLISON—Do you mean there is discrimination against them?

Mr Murdoch—I would not necessarily say that directly. I think it is a product of an extremely tight housing market, where there is a lot of demand and very little supply. People who do not have a rental history, who are recently arrived in the country, will find it difficult in that sort of environment because they do not have a set of references from tenanting elsewhere, which other people will quite likely have, based on the fact that they have been resident in the country for however long it may be. For newly arrived refugee clients, that is quite a big problem. I think the issue of supported accommodation is one that it is certainly very important to address, and we welcome, as we have said in our submission, the HASI project. We would like to find ways to encourage monitoring of the degree to which refugee clients would actually take up a service like that.

Senator ALLISON—And you have would have particular problems with some of the African families, with large numbers of children?

Mr Murdoch—Yes. The size of families is an issue that always arises. You raised the issue of discrimination. I am not discounting that that is possible in some cases, but I think it is also within the context of an extremely tight housing market for renters, where people cannot provide evidence of having been good tenants elsewhere because they simply have not tenanted in Australia before. Yes, it is about family size and composition of families as well. Certainly, in many cases, there are large numbers of children. Those children generally have biological parents present, but there could also be situations where children brought to the country have been added to families because of the experiences of trauma and, in some cases, the loss of their parents, so they are brought within family groups. So, yes, we do find a tendency towards quite large numbers of children in many families.

Senator ALLISON—You urged that the mental health groups in each state should have a representative of an organisation such as the one you represent, Multicultural Mental Health Australia, and Transcultural Mental Health Centres at state and territory level. Did this happen?

Mr Murdoch—I cannot say that that has actually taken place. Again, it is probably better to hear from Multicultural Mental Health Australia in relation to that. Certainly we are supportive of the involvement of not only people who are working in the area but also consumers and carers from diverse backgrounds. Those groups are often not well represented. I would hand that over to those coming after us to present more in relation to developments and progress with regard to that.

Senator ALLISON—Are you able to access the PHaMs program?

Mr Murdoch—I am not familiar with that.

Senator ALLISON—The Personal Helpers and Mentors Program.

Mr Murdoch—The fact that I am not familiar with it would suggest that it is not something that we make use of. In many cases, our clients are in a situation where they access assistance from various volunteer groups. For instance, within some of the initiatives that are funded by the Department of Immigration and Citizenship, there is access to support for newly arrived refugees through volunteers.

Senator ALLISON—This is specifically about mental health services. You might look into that anyway.

Mr Murdoch—We will look into that.

Senator ALLISON—I do not know that there is a prohibition on you tapping into that field, so it might be an opportunity.

CHAIR—Ms Gould, are you aware of the program? Have you done cross-referrals? It would seem to me that your area would be using that.

Ms Gould—No. There are others—in DoCS, for example, and in the school system—for mentoring, but I am not familiar with that. We will follow that up, thank you.

Mr Murdoch—We will research that, thank you.

CHAIR—It is a federal program run by Families, Housing, Community Services and Indigenous Affairs. Thank you very much. If there are other things that you would like us to know that you think about later, please come forward with it and send it to the secretariat. We have run out of time, but I am particularly interested in issues around gender—there is one segment in the process—and also around distribution of your clients, about whether they are costed in the Sydney area or whether there are regional groups in New South Wales. If you have any information on that, it would be very useful.

Mr Murdoch—I can very quickly say that the bulk of clients are resident in metropolitan Sydney. About 75 per cent of refugees reside in metropolitan Sydney. Even in south-western and western areas of metropolitan Sydney, there would be about 75 per cent, but there is a trend for settlement in other parts of metropolitan Sydney and, beyond that, to places like the Hunter and Illawarra, and further into rural and regional areas.

CHAIR—Which then puts more pressure on your service delivery.

Mr Murdoch—Yes, to respond. In the last three years we have opened an office in Coffs Harbour, for example.

CHAIR—Of FaCS?

Mr Murdoch—Yes—basically to provide support to an emerging refugee community in Coffs Harbour.

CHAIR—In the north. Thank you very much.

[10.05 am]

MALAK, Professor Abd, Executive Director, Multicultural Mental Health Australia

CASSANITI, Ms Maria, New South Wales Centre Coordinator, Transcultural Mental Health Centre

SANDFORD, Mr Phil, Senior Project Officer, Transcultural Mental Health Centre

CHAIR—I welcome representatives from Multicultural Mental Health Australia and Transcultural Mental Health Centre. We have received both of your submissions. Do you have any comments to make on the capacity in which you appear?

Prof. Malak—I appear as chairperson of Multicultural Mental Health Australia, which is a national body consisting of transcultural mental health centres, torture and trauma services and consumer carers as well as a number of non-government organisations. In my day job I am Executive Director, Workforce, in the Sydney West Area Health Service.

CHAIR—I know you have given evidence at these types of hearings before, so you have heard instructions on parliamentary privilege and the protection of witnesses in giving evidence. The committee has the two submissions that your organisations have put in. I invite you to make an opening statement and then we will go to questions. You heard the previous evidence. There is much carryover from there, so those are the kinds of questions we will be asking.

Prof. Malak—There has been a significant improvement in mental health services over the last 10 years, and we have to acknowledge that, from both the states and the Commonwealth. There is still a lot that needs to be done but there has definitely been a strong improvement. I would urge the committee and the Senate to continue to have a watchful eye on it for the next 10 to 15 years, because this issue has become a flavour of the month and it will suddenly disappear and nobody will be interested in it.

CHAIR—Absolutely, yes.

Prof. Malak—Everyone has been talking about mental health issues but I would like to take a minute to repeat how significantly mental health affects the whole community, with one in five people being affected. The burden of mental illness is very high, when you look at the costs to the community of treatment, lost productivity and the affect on families and carers, compared with how much we actually invest in mental health. In Australia or even internationally we spend anywhere from 70 to 80 per cent of taxpayers' dollars, health dollars, in approximately the last two years of people's lives. I am not saying that is not important; I argue that everyone has the right to the best health service till the last day of their life. But we spend the majority of our dollars in the last two years of life. If we spent significantly fewer dollars in mental health we can get up to 50 years productivity out of one patient. They can be productive in the community and it can reduce a lot of stress in the family and the community at large. That highlights how important mental health is. People can recover their mental health; they can be very active and do well. In addition, while spending on mental health and looking after the more seriously ill people, which is important, we are not putting an emphasis on people with minor mental diagnoses who can be looked after very quickly.

To deal with mental health we need more resources and other investment, but dollars are not everything. Fixing the mental health service, or the health service at large, does not just require a lot of dollars. I do not think that in the health system we are very efficient in using the dollars we have; I do not think we are very productive or that we use the dollars in the right way. We need to remember that putting in dollars is not the solution and that paying people in the workforce more money is not the solution either; it is more than paying people more money.

One of the challenges with mental health in general, I think, is the shortage of workforce; the previous witness talked about it. Workforce for my organisation and elsewhere in mental health is significantly more difficult than with other health professionals because we do have a huge percentage turnover of staff. We get in a new graduate, and probably the system failed to provide appropriate orientation and support for them to be able to help them to maintain their work. I think we probably have not got strong leadership skills or the ability to manage strategically and to think about what is the best way to do it.

Although we in mental health have very few dollars, we do have a lot of duplications. We rediagnose the client up to 20 times; there are a number of files about the client. A typical mental health client usually has mental illness issues or possibly drug or alcohol issues, possibly they have diabetes or some chronic illness and they have been managed by up to 10 different health professionals. They have different people look after them, and there is a lot of wastage in that. I cannot see how we can get out of that. There are a lot of resources wasted and a lot of suffering imposed on the patient by the system not being able to work together and deal with the client as a whole person, not just as somebody with diabetes or a mental illness.

CHAIR—You are making that statement about mental health generally as opposed to people from a multicultural background particularly.

Prof. Malak—Yes, I am just starting with general issues.

CHAIR—Yes, I just wondered. I think the comment is absolutely real for everyone, but I was just trying to reinforce that that is a comment across the board.

Prof. Malak—Yes, that is right. And, of course, it is about the whole health system, not just mental health. With people from culturally diverse backgrounds, language and culture have played a very important role in mental health diagnosis and treatment. In mental health we assist people based on their body language, how we talk to them and how they express themselves. This means that—Maria, from the Transcultural Mental Health Centre, will talk about some of the clinical evaluations—there is a significant level of misdiagnosis of clients. For instance, a client was given drugs when they probably needed counselling, support and intervention more.

Culture and language are significantly important in mental health more than elsewhere in health. With the current utilisation of mental health services and access—I heard Senator Allison talk about some of the mental health programs and some of the housing services—it is too difficult to generalise and say that everyone from a non-English-speaking background is not accessing the service, because the reality is probably that a large number access it. But it depends on what language skills, educational level and background you have. That contributes to whether you can access the service or not. But probably if you compare them at large they significantly underutilise the service compared with anyone else.

One of my last points—a quick one—relates to working with family and carers, which is vitally important. With people from culturally diverse backgrounds there is still some sort of family commitment and family support. They are a resource we really need to harness and utilise—it is vitally important—and unfortunately we are not putting enough resources or effort into it.

The last group I will talk about is old people, especially people who came after the Second World War. I know we are strongly concerned about people detained in detention centres, but I remind myself and everyone about the one million old people being detained in their homes without support. They suffer from loneliness; they suffer from mental illness; they drug themselves. That is a group which I am really frightened that we are going to ignore, until they die. For this group, when they arrived after the Second World War or the Holocaust, there were no services available, and there are no services available to them up to now.

CHAIR—Ms Cassaniti and Mr Sandford, you are both welcome to make a statement.

Ms Cassaniti—We are also part of Multicultural Mental Health Australia. We are a consortium partner. I can reiterate a lot of what Professor Malak has said. We have been around for 15 years, and we have grown our business as much as has been possible within the funds that we have. We have seen a lot of demographic changes and all the things that the previous witness said. We have developed a wonderful service that is able to, as equitably as possible, offer services to clients from culturally diverse backgrounds. The model that we have developed uses 160 contracted bilingual practitioners and tries to distribute resources as equitably as possible. I think we have been successful over the years. When you look at the early 1990s when we only had bilingual counsellors in different area health services, that was a good model in and of itself, but we did not have the sharing of resources across the state and across area boundaries. That is what we have achieved now.

We were allocated some money a few years ago to evaluate the model and drill down. There are diagnoses and misdiagnoses; World Health has shown that at a global level and we have shown that at a state level. Utilisation data that we collected from research that we did in the early to mid-1990s indicated that CALD clients were not accessing us readily, so that has been established. But what we have learned from the model that has been set up, and what has come out loud and clear, is the humaneness of our clinicians. Culture and language are covered in the consultation assessment work we do, and that is what we are hearing loud and clear from the clients’ point of view: the humaneness.

From the data, we are looking at the impact that a model like ours has on the referrer. What we do is to understand the referrer’s point of view and what they are not understanding in the clinical situation, and also where the client is not connecting. What we are doing in a very small number of hours, which is a very interesting way to do business, is actually connecting CALD clients to mainstream. I think there is a gap still for older people. We are not seeing as many older people as we would like, and we have certainly done some promotional work in the last year, via SBS, targeting 15 language groups. There are certainly a lot more that we can target, but the numbers are starting to go up. We have had a significant impact because of the money that trickled down with children and families back in 1999, when we were able to do some campaigns for child and family. We saw the benefits of that straight away and the numbers in that age group went up.

The other great thing about the model, and it has been commended from overseas as well, is that we work across the lifespan and across the migration experience. When you look at our client data, there is no significant migration time frame that the clients are coming from. So it is not the first five to 10 years necessarily; it is across the time frame. And that is quite interesting, because that is not something that we assumed at the beginning. We were initially set up to be a complementary service—very much to complement mainstream—and we still do that. We work with NGOs and with GP divisions as well, but now 25 per cent are clients themselves, and families and carers, so that has changed how we do business.

We are now getting first point of entries, which means more work when they come in, whereas before it was more about consultation and assessment, so if there was a an acute crisis it went back to mainstream. That has had an impact on the service and the numbers have gone up. From the beginning to now, we have more than tripled the numbers that we are getting just to our sessional client pool. Our first point of entry is always phone consultation. If we can resolve a matter by phone consultation and not take it to a sessional clinician, that is what we do. That is how the model was set up. Last year we did over 10,000 phone consultations and 2,000-odd clinical consultations that went to what we call our sessional worker pool. So our business has more than tripled from the beginning but our funds have nowhere near tripled. I guess that is our biggest dilemma at the moment.

Another thing that has happened in New South Wales has a bit to do with our health restructure. In the mid-1990s to late-1990s we did mental health promotion work and there was a lot of money put behind prevention. We were funded as part of that and we did a lot of that work. That has now slowed down, but I think it is starting up again, which is welcomed. Due to all of the education work we did for communities around mental health, they are starting to come through the doors but we now do not have the money to match the previous work that was done.

In a nutshell, they are our biggest things. But, on the bright side, we have done a lot of great work. There has been a lot of change and there has been a positive impact with the different work that has reflected the overall national strategy. So there has been a lot of great work, and we would like to see a lot of the work become part of core business—being what mental health does as a whole in New South Wales.

CHAIR—Mr Sandford, do you have anything to add?

Mr Sandford—Since I am, I think, the fifth person in a row that has spoken about these issues, I will just be brief.

CHAIR—But it is important that it is on the record, Mr Sandford.

Mr Sandford—I will not belabour the point about culture and mental health, but it is certainly a very important issue. It has recently been recognised in DSM-IV—which is the psychiatric system classification. For the first time they have actually incorporated the importance of cultural issues, and not just as a moral issue. Issues like misdiagnosis have enormous implications for costs—apart from the human suffering of the people affected by it.

I will briefly comment on our section on partnerships. We have now established some very important partnerships with organisations like the Children's Hospital at Westmead and the Centre for Rural and Remote Mental Health in Orange, which has helped expand our work in a number of areas.

Ms Cassaniti—I am not sure how much you know about the model, but the model is very much based on partnership—and that is how it has grown. Underpinning that whole framework is not only support for diverse communities and for diversity itself but also the realisation—after lots of work that has been done since the sixties around transcultural mental health—that to effect change in this area you cannot do the transcultural work in isolation. So there are partnerships very much at the strategic level and at the grassroots community level.

Our most current work has been with the children's hospital and the Centre for Rural and Remote Mental Health, but we do have partnerships at all levels. Consumer and carer partnerships have been very fundamental from the beginning and we have very much embedded the perspectives of consumers and carers. We were fortunate to be set up in an era where the consumer voice was very important and so we started very much from that premise. Partnerships are at the heart of everything that we do.

I am confident enough to say that things have changed. I think we have had an impact on mental health business across New South Wales, and I would like for that to continue. We heard in here that the national action plan did not include cultural and mental health, and I would like to think that is due to the fact that Australia is moving to a viewpoint that we are culturally diverse. I would like to think it was not an omission but rather that it was about the fact that we are diverse. That is the language that we are trying to move towards. If that is not the case, I would like cultural and mental health back in there so that we constantly get reminded. I think we are still probably two decades away from actually achieving the view that we are all culturally diverse and that all our services have to basically work from the framework that Transcultural Mental Health has. If someone asked me where we would like to be in 20 years, I would say that we would like the whole health system—the whole Commonwealth and the way we provide our health services—to be very much like the way we run Transcultural Mental Health at the moment.

CHAIR—That would be the next national plan—20 years time or so.

Ms Cassaniti—Yes.

Senator HUMPHRIES—Can I ask, first of all, about the way in which we train people in mainstream services in Australia—not those dealing with mental health issues particularly, but those that have some intersection with those services—to identify and understand that and to assist people from culturally and linguistically diverse backgrounds to obtain the help they need? You mention in your submission that some very good cultural or competency training is going on among court and law enforcement officials. Can you tell us a bit about how that works? What principles or work could be extended from there to other agencies, particularly of government around Australia, that would assist in identifying and dealing with these issues?

Prof. Malak—In general, I personally believe that in the health area any clinician who swears an oath to do the right thing by the client is required to be aware of cultural diversity, gender diversity and all of that. We need to work with the client, no matter who the client is. Clients are a diverse group. Unfortunately, there is no emphasis in our education on doing that, although there is some encouragement now from different universities. I am involved with the Western Sydney School of Medicine, which has a very strong program that talks about diversity issues, such as gender, and how people differ.

Senator HUMPHRIES—But they would be people who have training in the health professions. I am thinking more of those professions that do not deal with health related issues. Your submission mentions the courts and law enforcement officers.

Prof. Malak—The courts have a very interesting project. My understanding is that a course has been run for the judges. The police have the Australian and New Zealand commissioner groups; they run a multicultural service with many strong training programs. Just two weeks ago at the Diversity in Health Conference in Sydney, in partnership with the Federal Police—especially in the area of missing persons—we had a training forum on research and how to work together. Victoria Police have done well in being able to work and become very familiar with the community. New South Wales Police are catching up.

If you work with the community, as well as being more effective, you are able to find out where there are problems and crimes and to solve some of the issues. For courts to have competence is not mysterious work, really. How I deal with people is different from how others may deal with them. I am sorry, I am trying to get away from professional words because they are confusing everyone and they are confusing me as well. I think it is about how, as a police officer, I can work with and respect people who are different from me. However, even with courts and police, it will depend on individual skills and individual leadership. With local leadership, there is the issue of how you are going to push it and make sure that it is happening. Training and skills building are not one-off; they are about ongoing support and ongoing monitoring. I hope I have answered your question.

Ms Cassaniti—With the New South Wales Police, a person who is trained in cultural competencies works with and trains police in the area we are speaking about. In fact, she presented at the missing persons forum. She also works under contract for the Transcultural Mental Health Centre. So that work in New South Wales has commenced. From that whole session, which I attended, and the discussions I have had with her, I am aware that she is starting to change police knowledge around how, when they are working with different cultural groups, they ask questions about an incident that has happened. I was quite impressed. If you would like, we probably could get her to provide more information.

Senator HUMPHRIES—I am looking really for a good model that could be applied in other areas. I am thinking particularly of people in public service agencies, such as Centrelink and DIAC, which are dealing with people continuously. I assume that DIAC has pretty good culturally sensitive training for its public servants.

Prof. Malak—Centrelink is a very good example.

Senator HUMPHRIES—I wonder what other agencies are like, particularly at the state level.

Ms Cassaniti—I think there is a lot of possibility to transfer how we have done business, because this is not just for mental health; some of the systems that we have put in place could work across different agencies. This is about bringing those different systems together and talking. But I think there is work commencing. I think at this point there is still a long road ahead of us as to how strategic and systematic it is in New South Wales.

Prof. Malak—You mentioned Centrelink. I have to put in a strong plug and say it is one of the best accessible facilities. People complain about whether they receive a cheque or not, but at Centrelink you can access a language service at any time. You can access information in different languages on video and on audio tape. I think they have a very good model.

CHAIR—It has taken 20 years to get there.

Senator HUMPHRIES—You mentioned the interpreter symbol that is being used on cards and so on. What does the interpreter symbol look like? I would probably recognise it if I saw it, but I am just not sure what it looks like.

Prof. Malak—The interpreter symbol we use mainly in what you would call long-term, day-to-day service, like if you need to give somebody food or you ask them if they like the food or the temperature. It basically asks, ‘Do you want to eat?’ You have a symbol that says how to eat. It is like the basic symbol of the ‘Stop’ or red light symbol, which says stop or do not cross. As you aware, symbols are culturally bound. People have different understandings of them. We usually use them more in nursing homes. It is usually done, for instance, where the family work with the nursing home—you have a list for the specific client, which is really very minimal. I am happy to send you some examples.

Senator HUMPHRIES—That would be good. You mentioned, Ms Cassaniti, that there had been a tripling of your workload. What is your funding base like at the moment? Have you had a tripling of funding at the same time?

Ms Cassaniti—No.

Senator HUMPHRIES—It never works like that, does it!

Ms Cassaniti—No, it does not work like that. Our recurrent funding has not gone up in the clinical service area for six or seven years. Our area health service, within which we live, has really had to wear that. The discussions have commenced directly with the department about that, and I am hoping that the response is going to be favourable. In terms of the other side, which is the project side, some of the work, like the carers program that started as a project, has moved into program form, so that has recurrent money. But certainly the different population groups for older people, for child and family, and for youth have to move into program mode. They have to move to some kind of recurrent money. The area health and mental health units within the areas have got their money, so their buckets of money are going out; but we are a specialist service and we have missed out, so we have to continue to put submissions in for different things. If we are going to be part of core business then we need to start thinking along the lines that we are another consultant and assessment service that works within the mainstream and so our funds have to go up as mental health demand grows, which it will. That is the prediction and we do not have to say any more about that because it is at a world level that that has been very much set.

Senator HUMPHRIES—Is that project funding you talked about mainly Commonwealth funding or is it mainly state funding?

Ms Cassaniti—It comes from the Commonwealth but then it gets allocated at the state level.

Senator HUMPHRIES—By state agencies?

Ms Cassaniti—That is exactly right—from the department.

Prof. Malak—In all of the transcultural centres in Australia for the last five or seven years, the only state that has appropriately supported transcultural centres is Queensland. They put in a lot of recurrent funding. New South Wales and other states have a lot of one-off projects, but there is no specific recurrent and clinical funding. The opportunity comes through the Commonwealth through Medicare funding some of the psychologists and counsellors. There was some support for some of the work which Maria and her team are working on. Without that they were really having a hard time. But it is not going to be for the whole cost.

Senator HUMPHRIES—I have been dealing with some issues in my territory to do with the funding for migrant resettlement programs, which are designed to expire after a couple of years. If the number of new migrants falls after that time, the funding goes down. You would be in the position, I assume, where your funding needs to go up the longer people are here, because the more that they become aware of services and the longer their mental health problems go unaddressed the more need you would have to deal with, wouldn’t you?

Ms Cassaniti—Our viewpoint is that the business has grown. Obviously, we have been successful at promoting our service to communities. Then again, mental health as a whole across Australia has been promoted quite widely, so that trickles down into CALD communities, and demographics have gone up and diversity has increased—it has not decreased in the decade and a half since we have been around. I mean, it is a successful business because it has grown. It has not grown unpredictably. This is what you would have predicted with any business that is going to be successful and that is going to meet the initial objectives. Certainly, our business has changed. One thing that we did not anticipate was the increase in carers and consumers directly coming to us, and that is a successful thing. It is not that we have moved away; it is just something we did not foresee at the beginning.

Senator HUMPHRIES—Is it true to say that one of the reasons that you have been experiencing an increase in your workload is that people often come from societies which are culturally intolerant of the signs of mental illness, and when they come to Australia they find more understanding and acceptance of that and the longer they are here the more they are willing to go and seek assistance for problems that they might not have sought assistance for in their home countries? Is that too broad a generalisation?

Ms Cassaniti—I think that is a research study in and of itself. I do not think we can answer that without some research behind it. Anecdotally, yes, there is much more education here. Mental health is an issue across all cultures. We understand it in a certain way from a Western perspective. Our knowledge and how we promote what we do is very much from a Western perspective, but we are sympathetic to different cultural views and psychologies and that is what we try to bring in. When the department has done a promotional piece of material in the past, we certainly change it conceptually to make it make sense to migrant and refugee communities.

I think there is a question around migration and mental health in and of itself. We know that migration in and of itself does not increase mental health issues, but because of global changes around the world in the last 10 years particularly there are issues that migrants and refugees come with that impact on their mental health. The migration experience, and what we know from the literature, is that it then trickles down in the second generation. That is one thing that we do not recognise. We do not recognise it in the stats that we collect in hospital admissions either, but I think we are working towards that. Also, young people from culturally and linguistically diverse backgrounds that are born in Australia present as an Australian person, but we have not done enough in understanding how the migration experience impacts on them. We know a lot anecdotally and, when we pull together and get different academics and clinicians around a table, we know that there are issues of culture and mental health that impact on the family experience. We have done a lot in embracing that and working with that. Part of our School-Link initiative, as well as our young people’s project work, works very much with schools, has a very strong partnership with schools around this and promotes our service to young people. Sorry, I have answered that in a roundabout way. My gut feeling is: probably yes, especially with a new and emerging community, but research would have to support that, really.

Senator HUMPHRIES—Thank you very much.

Senator WEBBER—I want to return to the issue of the need for greater understanding of the role of language and culture in diagnosis. You talk about that as being one of the gaps in the national action plan. Is that the main gap that you see we need to put more emphasis on or is there something else we need to bring to the attention of all governments as well?

Ms Cassaniti—I think it is working from the premise that we are all diverse. As Abd was saying, all good counselling is cross-cultural counselling. That is the bottom line and we just have to constantly remind ourselves of that when we support this in policy. That is the struggle that we constantly have: policies come out and they are still very much servicing a monocultural perspective or a majority population. We need to get better at writing that policy. We have to be very proud in Australia of how far we have come in doing this and we have certainly got a lot of the globe’s attention that we are doing this well, but that does not mean we have to stop the benchmark there. I think we have to constantly struggle and work together on how we improve the language to really service diversity. As I was saying to Senator Moore at the beginning, it is too early to not have culture in mental health because people still have not got what we are trying to say.

Prof. Malak—There is definitely a lack of services in the national program and the state programs as well. They have either excluded them or have them as an add-on. They only have an insignificant number—25 per cent of the population. I think we need more pressure on the data we collect to be able to see the outcome and do some evaluation of what works and what does not work. If Maria’s centre was able to keep two clients out of beds every night, it means there is a lot of cost effectiveness and they are doing the right things for the clients. It has a lot of economic benefits as well as benefits for the clients and community, actual data on performance, quality and what we are doing or what we are not doing.

Ms Cassaniti—I go back to the fact that in our evaluation we have always had multiple methodologies, but this is probably our most comprehensive evaluation. If the clearest thing that has come out of it is clients saying we are providing a humane service, what is that saying? Is it that they have not been able to get this before? That is a big outcome as far as I am concerned. That was unexpected for me; that was the last thing I thought. I thought they would say 'Yes, we can access and understand mental health services better and it has improved our pathways into them.' They are actually saying, 'No, the workers we are getting are actually listening to us. We have never been listened to before.' That is significant.

Prof. Malak—One of the biggest challenges facing the mental health sector is our mental health staff stigmatising mental health clients. In the mental health profession we have more difficulties with stigmatising people with mental health issues. The community at large is much better than us.

Senator WEBBER—Following on from the discussion we were having earlier about misdiagnosis due to that lack of understanding, I am not aware of any data that would show me the incidence. Can you just expand on how frequently you feel that may be occurring, the challenges attached to that and perhaps some examples of where that has caused significant issues for people?

Ms Cassaniti—Even before our centre was established there was work that other colleagues had done around culture and mental health, at a global level and at an Australian level, that showed misdiagnoses. There is that body of literature to do with culture and mental health which shows that people are being overdiagnosed, underdiagnosed and overall incorrectly diagnosed. Certainly, of the people who come to our service, in one evaluation that we did there was about a 40 per cent change in diagnosis. That was in the early period. That is not to say that—and I have to be fair—the diagnosis that we gave was the correct one either. We have to look at that as a whole.

However, now we are starting to have funds—hopefully we will have ongoing funds—to study longitudinally whether our diagnosis was a more correct diagnosis than the previous one, and that is a whole research. What we know is that, once they leave our service for that short amount of time and we evaluate them three months later, they are better, they feel more connected. We cannot at this point argue scientifically that our diagnosis is more correct; we just know that the client is better off, and that is the pattern. We would have to look at all of that in a drill-down kind of way to really say, 'Yes, we definitely had the correct diagnosis.' It would take a number of clinicians to all agree on that as well. But certainly our preliminary evidence shows that we changed diagnosis, something has changed, or we changed treatment outcomes and we came up with additional options that the previous practitioners had not come up with, and that was to do with understanding the culture of the mental health situation in that client's overall clinical situation.

Senator WEBBER—Thank you for that. Lastly, going back to the funding issue, Senator Humphries was talking about the one-off funding that tends to happen. We often talk about it in terms of pilot programs and getting funding for a certain amount of time, then it becomes someone else’s problem and we play the cost shifting game between different levels of government. It has always concerned me—and I would be interested in your perceptions of it—that, particularly when you are dealing with people that come with additional issues of language or culture in terms of accessing services, it takes longer to establish that service within that community. You have usually used up most of the pilot program funding by the time the community has accepted that service, so it disappears before you have got useful data in terms of establishing need.

Ms Cassaniti—That is correct. I want to give you a good example. Our rural project at the moment was funded for four years and we very much welcome that. Even though we have slowly chipped away and it has taken so much time to set up structurally across the rural area health services, that at least has given us a good pilot period to build evidence that what we are doing is going to be really good in the long-term for the new and emerging communities, because of course we have got all the literature of what we did not do for the older communities now. With anything, trickles of money can at times do more damage than good, because they set up issues that are not sustainable without ongoing money and they set up false hopes. I think the longer pilot periods—if there is no money to do the recurrent—are for a five-year period, so we can at least build some evidence around what works and what does not work.

Can I also add something that I did forget about culture and mental health. The other great thing about our service that I think I have learnt over the 14 years I have been there is that sometimes the cultural issue is used as the excuse as well. That is the great thing about the phone consultation—it can be decided when culture is the excuse and mainstream is just ringing us up to send us a case that they can really deal with. That is the great model. It goes to phone consultation and we can easily pick that up there where we give them some options of how to move on with a particular client, but it does not become a costly activity where we bring in clinicians that are at that point not needed because culture may not be the issue. It could be that they are facing challenges they would have with any client. That is the other good thing about the model. Sorry, that went away from the pilot issue, but I needed to add that.

Senator WEBBER—That is okay; it has reminded me of something else I wanted to pursue.

Ms Cassaniti—I think it is really important to understand how we do our business, and this is also supported by the literature: sometimes culture is used as the excuse as to why someone is not improving as opposed to looking at the system as a whole.

CHAIR—Which may not be used if it were a broken leg.

Ms Cassaniti—That is exactly right.

Senator WEBBER—Professor Malak, I wanted to go back to one of the comments you made earlier about the older people who are isolated within their homes. I do not in any way want to denigrate the services that we offer to others that are in detention or newly arrived or what have you, but it does seem to me that there is that part of our community that is particularly isolated and that we have not had much of a discussion about. What do we need to do to ensure that we incorporate their needs into the national action plan and into service delivery?

CHAIR—This is about mental health issues for older people generally, and in particular for people from multicultural backgrounds.

Prof. Malak—There are a lot of things. To start with, we can get them out of their homes and get them connected. There was a small project done in Sydney which was basically having a clinician hold a phone conference with 10 older ladies at home once a week. In the end, he stopped dealing with them and they continued the phone conference, giving them their only contact with outside. So over a phone conference the 10 ladies had a chat together. It just connected them with the community, identified their issue of need and gave them a little bit of respect.

The cultural issues are a little bit different. Their needs are a little bit different. They are sometimes people who came after the Second World War who worked hard in a factory all the time. They have problems with language. Even if they had good English, they switch back in their old age to their original language. They are probably living at home. Their kids have probably grown up, or they never married or never had kids. If their kids have grown up they become lonely. Sometimes they worked hard to look after their kids and their perception is that the kids are not grateful and do not look after them, which they probably expected. We do not expect from our kids what our parents expected from us.

All of this is a challenge. There are a large number of people, especially from Russia, Croatia, Serbia and that area, who have done a lot of work in factories. There are a lot of single men and single women, and the single men sometimes become alcoholics and use poker machines. We need to be able to reach them and deal with them. Personally, I think we have to have a role for them, to get them involved with the churches and with the community, doing volunteer work. I remember a situation we had in Sydney where it was difficult to access one of the senior citizens centres because a group refused to allow this group to use it. In the end there was a lot of community pressure and they were given a room, but they locked the toilet.

CHAIR—That is useful!

Prof. Malak—Access to existing facilities is important, and getting them out of their home and using their skills. We talk about workforce shortages. This is probably one of our good sources of workforce, if we can tap into it. But we need someone to champion them. I am sorry to use the word ‘detention’—in saying they are detained at home—but I thought I probably had to be a little bit outrageous to identify that there are a million people who are not being looked after at home.

Senator ALLISON—I am interested in the extent to which the CALD community, if we can shorten them to that, has been able to access some of the more significant programs that are part of the COAG agreement and this new action plan. Of course, the biggest of those is access through Medicare to psychologists and psychiatrists. Ms Cassaniti, is your service able to tap into that program, or can your refer on to psychologists and others who might have specific training or interest in CALD issues?

Ms Cassaniti—We are reluctant. We do refer on at times when we are confident with who we are referring on to and their level of skill with culture and working cross-culturally. The thing with Medicare—I think that is what you were referring to first—is that obviously we have no control over the skill pool out there and whether they are transculturally trained. That is probably the issue. There are discussions underway on how we do the reversal of that, how we use our own pool of clinicians and then access funds. So those discussions are underway in the area, but it will still only service probably—Abd might need to back me up—about 20 per cent of the current group that we are not getting funds for.

Senator ALLISON—Why is that? Why is there a barrier?

Ms Cassaniti—The depression and anxiety clients that we are getting through are probably the ones that will benefit from Medicare, probably because that equals that group of clients. With the more complex cases—and that is the other thing that the evaluation has come up with—there is a group that very much benefits from, at most, four hours of care, because we basically assess the situation and then work with mainstream areas. With the more complex clients that we are starting to see, Medicare and the way that is set up may not be able to address those cases.

Senator ALLISON—Why is that? Can you spell out the problems?

Prof. Malak—There are a lot of reasons. With Medicare accreditation, not all languages have health professionals able to apply and be accredited—that is No. 1. No. 2 is that health professionals with different languages are somewhat overbusy. They do a lot of work and they are not really interested in doing more. If they have the energy, the psychologists offer help. In addition, if you are overworked you can get what you call an easy client. For people with different cultures, the only clients you get to see usually are the difficult ones. If you can do the easy ones as quickly as you can and get the same payment and you can do more clients in the day, you do that. We should try to encourage people to do it through Medicare and try to recruit new allied health professionals and skill them enough and help them to be accredited. That means developing some sort of source of workforce to do that.

In addition, there are private clinicians or stand-alone clinicians, and a lot of them are funded by Medicare. There is a lot of waste because there is no assurance of professional training or quality outcomes and no guarantee that a person has not been overserved or underserved. Basically you have eight sessions or 12 sessions, and you get those 12 sessions. We know some clients will never need 12 visits—they may need two or three—while some will need many more. The dollars are not it. It is probably the same argument that applies to Medicare. If I am a service provider, a doctor, I make my money and if I need a million dollars I see more people; I ask people to come and see me more. It is controlled by the interests of the professional more than those of the client.

The other issue which was raised before was the issue of some of the COAG initiatives, like some of the housing services. Unfortunately the NESB community have not accessed them, for a lot of reasons. A lot of them have been funded through non-government organisations or groups and there is no strong energy or group from the NESB community able to stand up or to compete for funding. The majority of the charitable organisations which manage to succeed in doing that have a very good will, but the ability for them to actually do it in a more culturally relevant way is a challenge.

Senator ALLISON—And you have not been able to step into the breach and apply for those funding programs yourself on the basis of your expertise in this field?

Prof. Malak—A lot of our service is actually government funded or government sponsored, which means we are not eligible to apply for NGO grants. All of the Families and Community Services grants which have come under COAG for the last five or six years have targeted NGOs for housing, which is great—

Ms Cassaniti—Discussions had started with FaHCSIA, directly with Evan Lewis, around the personal mentors, but, by the time that trickles down to the state level, that might take some time. Certainly discussions have started at the higher level, but CALD positions need to be set aside and we need to learn how the whole program works with culturally diverse communities and whether it is relevant and whether changes need to be made to, I guess, enhance how it works with diverse population groups. Only discussions have commenced.

CHAIR—Is that one of the PHaMs programs? I know Senator Allison has lots of questions on them and we are running out of time. The PHaMs programs have been geographically based until now—

Ms Cassaniti—Yes.

CHAIR—and I think that there has been some consideration, for some of the next rounds, of looking at the particular issues of people from diverse backgrounds—Indigenous people, homeless people—because it has all been geographic until now.

Senator ALLISON—I think it is a central question. The Commonwealth government’s proposals did not accord entirely—in fact they accorded hardly at all—with our previous Senate inquiry recommendations, and I think it is useful for us to find evidence of where this is going down the wrong path, particularly for certain groups of people but also for certain geographic areas and the like. It seems, to me at least, that we have got organisations such as yours in a bit of a bind, because they are not able to tap into some of this by virtue of their relationship usually with the state government and their funding arrangements. It could be argued that this half a billion dollars which goes to GPs and their referring allied health workers has bypassed people who you serve.

Let me ask you another question. Postnatal depression comes up in your submissions as being an issue with significant unmet need. Beyondblue has just been given a major contract from the Commonwealth to undergo research into both postnatal depression and suicide prevention and so forth. To what extent has the CALD community been able to tap into that? Your message throughout your submission is: ‘You do not ask. You do not consider. There is a lack of consideration generally for this group of people.’ What happens when you actually try to engage and apply for this kind of funding?

Prof. Malak—To be blunt and honest, beyondblue and Black Dog are the only groups that I feel are significantly addressing this issue. With a change in their leadership, we have started to have a very strong partnership with beyondblue, probably for the last year, and we have had quite a measure of success with our work. I can see there is a way forward with beyondblue, but that is after five, six or seven years of work. But definitely the change of leadership and direction in beyondblue is significantly refreshing, and we are able to work with them now in a more cost-effective way.

Despite the fact that we argue about what we are or are not doing well, if you travel internationally Australia is still probably the only place where modern things are happening, such as with the World Federation for Mental Health, which I am very involved with. Actually we are the only social, cultural and multilingual resource for them.

CHAIR—How about in New Zealand, Professor?

Prof. Malak—New Zealand is very interesting.

CHAIR—We will not get into the full discussion, but in terms of process—

Prof. Malak—New Zealand is doing well with the Maori community but they are not doing well with other diverse groups.

CHAIR—That is what I have heard. That is not their strength. Senator, I am sorry but we are considerably over time. Can any of your questions be put on notice?

Senator ALLISON—I just have one along this theme—the psychology interns program. Have you been able to influence the way in which psychologists coming into that program might be a bit more diverse than they probably are?

Ms Cassaniti—Certainly, and that is the intention of the intern program. It was very much set up on a cost recovery basis—basically it is not funded from anywhere. It is funded by the psychologist interns themselves, and there is a bit of money that we match them with put into it. But certainly they leave. We do everything that the psychology board requires but, on top of that, we very much focus their skills on working with diverse communities, and then they move into jobs and hopefully have an influence. What we have not been able to measure is, I guess, the impact that they have over time, and that would be interesting in and of itself. But certainly the whole intern program is geared towards working across cultures.

CHAIR—Do we need some more information on that? Your submission mentions that the program exists and it says that, to the best of your knowledge, it is the only one. But it would be very useful to have more information about numbers, how long it is going, how many people take it up, the gender and ethnic background of those who choose to do it, which I think is interesting, and where they end up working. It is one thing to have the training, but it is interesting to see where they end up. That would be very useful.

Ms Cassaniti—I will get our program coordinator to write a report.

Prof. Malak—And, with your permission, we can get Maria to send you some information about a clinical supervision program which they run, because that would be very useful as well.

CHAIR—The other question that was directed to the previous witnesses was a question about representation on the COAG formed groups—under the COAG process, each state was supposed to set up its own advisory group, at the Premier’s level. Are you aware of whether anyone specifically representing the issues of CALD is on that group?

Ms Cassaniti—We went to the initial meetings—

CHAIR—That is good. You got an invitation.

Ms Cassaniti—Yes, that is what I am saying. It is at that high level and then it trickles down. Multicultural Mental Health Australia got an invitation to that and so did New South Wales, when it was in New South Wales, and as far as I am aware similar invitations happened across the other states as it moved around.

Prof. Malak—As well, I have been a member of the national suicide board for the last five or six years.

CHAIR—We are not blessed by having the department or the government giving evidence to our committee but we would be interested to know how that committee is operating and its impact on mental health issues across the state. We will be referring that question to the department but we wanted to hear that from you. These submissions came in a while ago, so if there is anything else you think we should know, particularly about the issue of the training, we would appreciate being informed. Your submission says that the evaluation process was going on and I take it from your evidence that it has been completed. Anything that is able to be shared as a result of that process would be appreciated as well. Thank you very much.

Proceedings suspended from 11.06 am to 11.20 am

BATEMAN, Ms Jenna Maree, Chief Executive Officer, Mental Health Coordinating Council

HENDERSON, Ms Corinne Deborah, Senior Policy Officer, Mental Health Coordinating Council

CHAIR—Welcome. Information on parliamentary privilege, the protection of witnesses and the giving of evidence has been provided to you in the standard way. We have received your submission. I now invite you to make an opening statement before we go to questions.

Ms Bateman—MHCC is the peak body for the mental health community organisations in New South Wales. We have 170 member organisations and branches across New South Wales ranging from small, single focus organisations to specialist and large mainstream NGOs. MHCC works primarily in the areas of policy development, sector development, information dissemination and inter-sector and across-government liaison. Input from MHCC to this inquiry has focused on the mental health system as a whole in New South Wales, but a particular reference to the NGO community based sector and distinct recognition of its contributions and development needs have been prioritised. New South Wales has experienced a mental health system geared towards management of clinical symptoms, with inadequate attention being given to the disabling effects of mental health problems on whole-of-life issues such as social connection, occupation and housing. The statistics over the last 10-plus years in the national mental health report show that funding to the NGO community support services in New South Wales is well under five per cent of the mental health budget—and there has been a clear imbalance in the system.

The Commonwealth dollars under COAG have made a huge difference to the conceptualisation of what makes for a good mental health system. The decision to fund NGOs directly, through programs such as PHaMs and Support for Day to Day Living in the Community, has had three important outcomes. Firstly, it has increased access to assistance for people who are unable to get service from public health services due to the absence of acute mental illness and for those who do not wish to engage with clinical approaches. These are generally people who are not acutely depressed or psychotic but need help with the activities of daily life, without which they tend to isolate themselves, become disorganised, eat badly, become unwell mentally and physically and then lose their jobs, their tenancy and their connection to family and friends.

Secondly, the Commonwealth programs have allowed the field of NGO mental health providers to increase, with capacity building in mental health occurring in a number of mainstream organisations as well as mental health specialist organisations. This has meant wider mental health literacy and has provided a platform for these organisations to continue to develop their ability to assist people with their health and complex needs. Thirdly, there has been a rebalancing of the mental health system, with the role of NGOs being given greater value and recognition as part of the mental health service system.

This last point cannot be underestimated in importance. Prior to COAG, New South Wales had recognised the potential of formalising partnerships between public clinical services and NGOs via the Housing and Accommodation Support Initiative, known as HASI, and also through the family and carers program. However, places in HASI are limited to those fortunate enough to gain one of the relatively few places, with entry to the program restricted to direct referral through clinical providers.

Under the Commonwealth programs, NGOs have been able to enhance their role in community development and social inclusion and raise their profile as autonomous community based services responding to local need and creating local linkages with other community groups, agencies, businesses and services, including clinical providers such as private psychiatrists and GPs—although it has to be said that the open tender process which occurred under COAG has worked against recognition of the importance of local connections in a number of areas, with tender-writing skills, rather than local connections, being prioritised in the awarding of tenders.

However, it is clear that there is a renewed energy, commitment and confidence in the sector since the COAG initiatives. The number of staff in NGOs undertaking training has increased. The number of organisations exploring the implementation of consumer outcome monitoring and quality improvement systems has increased, and the overall professionalism of the sector, including involvement in research and linkages to universities and other academic institutions, has also risen. It has to be acknowledged that the COAG initiatives have not achieved all this on their own. New South Wales Health has demonstrated commitment to the role and function of NGOs through funding HASI and the family and carers program and has supported MHCC to establish a mental health learning and development unit. It has also provided infrastructure and research grants to the sector. However, the COAG initiatives provided the sector within an enormous boost to morale and the opportunity to meet some of the glaring unmet need not targeted by state NGO programs.

PHaMs and Support for Day to Day Living in the Community are extremely worthwhile programs, filling serious gaps in the spectrum of care in New South Wales. They should remain autonomous, community based programs with enough flexibility to allow innovation to meet local need and circumstances. One organisation I know in the day-to-day living program is beginning to move towards a project based model whereby, rather than providing a living skills type environment where there are a range of excursions, classes or activities available, there is instead an agreement by a group of service users to start a particular project, such as getting a choir going or doing an oral history project, in which skills are developed within the context of achieving a larger aim. Such an approach encourages self-determination, problem solving and negotiation, an achievable end product and transferable skills. The flexibility and innovation possible in progressive NGOs can mean real and immediate gains for service users. On the downside—there was going to be one—

CHAIR—It was going really well!

Ms Bateman—On the downside, the PHaMs and day-to-day living programs have a patchy, often uncoordinated spread of services across the state, and the lack of plans for formal evaluation is of concern. We know from HASI in New South Wales that the comprehensive evaluation of the program has been responsible for its ongoing funding. Without serious evaluation demonstrating effectiveness in terms of consumer and carer outcomes and coordination within the service system, it will be harder to maintain and increase support to these programs.

At the national level, the COAG programs have provided impetus for the NGO peaks in each state and territory to come together under an alliance designed to support the development of the community based mental health sector across all states and territories and to increase cohesion and share capacity by developing collaborative projects, resources and tools that can be used across the country. The alliance is also working to establish effective partnerships with national stakeholders to achieve shared mental health reform goals. Already there is joint work being completed on workforce skills development, career pathways and establishment of a minimum training qualification for the sector at the national level. However, there is currently no specific funding for this group, despite the fact that it is the only body providing an industry development role for NGOs working in mental health at the national level. As the community based NGO service component of the mental health system becomes more and more established, there is increased need to build an industry research and development base for the sector through this group, similar to other national industry groups.

In conclusion, in many ways the COAG initiatives have heralded a new era for mental health services in Australia by recognising the needs of people beyond clinical service interventions and putting dollars directly into the NGO sector to support the recognition that people need a variety of pathways to care and support and that not all seek help through clinical services. Funding FaHCSIA and DoHA to do community mental health was a huge step towards creating a more balanced mental health system that understands that social inclusion, connection to family and friends, occupation and a decent place to live are as important as medication and clinical care to recovery from mental illness. The task now will be to ensure that NGOs can continue to operate autonomously and not be tied to service contracts that inhibit innovation and responsiveness to community needs but be able to demonstrate effectiveness.

MHCC has five recommendations to make to the inquiry today: firstly, that programs currently funded by the Commonwealth continue to be funded that way at least until comprehensive evaluations of the Commonwealth’s COAG initiatives have been undertaken, including program coordination at the state level; secondly, that a commitment be maintained to access to PHaMs and Day to Day Living via diverse referral streams, including self-referral, and that it not be restricted to assessment and referral by clinical services; thirdly, that all state COAG committees have representation from the NGO sector to ensure that the philosophy and approach of NGOs as a component of the service system does not lose priority in future service planning; fourthly, that the Commonwealth dedicate funds under the ‘increasing workforce capacity’ action item of the National Action Plan on Mental Health 2006-11 to develop a national approach to workforce development in the mental health NGO sector in consultation with the NGO state peak alliance, Community Mental Health Australia; and, fifthly, that the diverse nature of NGOs in terms of their size, their function and their role in community development and social inclusion is recognised and valued as being important to the creation of healthy communities and the prevention of mental illness.

CHAIR—Ms Henderson, do you wish to add anything at this stage?

Ms Henderson—No.

CHAIR—Ms Bateman, are those five recommendations additional to the 63 recommendations in the written submission?

Ms Bateman—It is a summary of what you will find in the written submission.

CHAIR—I know that they cross over.

Ms Bateman—They certainly do cross over. This is just putting it in a more precise format.

CHAIR—I thought it was really brave to have 63 recommendations, and I did like it. But those five recommendations are the core things you are bringing to us?

Ms Bateman—I think they are the core at this stage. We have also done a lot of work on the MBS. If we have time, Corinne will present some of that.

CHAIR—We are particularly interested in that. It might be something we can lead off with, because it has been kind of added onto in previous issues.

Ms Bateman—It would be great if we could talk about the NGO stuff first.

CHAIR—We are happy to be in your hands. But before we do that I want to refer to one of the opening statements in your written submission. You said there was a sense of surprise that this inquiry is happening. Because you have made that statement, I just want to put it on record that some of us would have preferred to have an ongoing role through a continuation of the Senate Select Committee on Mental Health. As there had been so much effort across the community and across the country with the Senate select committee, there was a hope that we would be able to maintain that hands-on interest. That was not approved by the Senate. The alternative recommendation was that this committee be set up. We thought it was important to come in in the very early stages of implementation so that we could hear about what was going on. That is the background to the committee. As you have made that statement, I thought it important that you know that.

Ms Bateman—Thank you.

Ms Henderson—There was a problem at the time we did the consultations. People said that some of the things had not been implemented and the money had not actually come through so they could not actually comment. That was back in August.

CHAIR—And we had that little hiccup with the election! The other thing is that we would hope that this process of discussion around what is happening with mental health in Australia will continue to be on the agenda. When the committee reports, I anticipate there will be an expectation that there will be more and that we cannot let this go. I wanted to get that message back to you.

Your submission is very good. It is very detailed, as we would expect from your organisation. So we know there are going to be lots of questions from the senators. You said you would like to have some discussion around the NGO process first. So we will ask questions about that first. But we guarantee that we will get back to the MBS process.

Senator HUMPHRIES—I wanted to pick up the point you made—which has been made by a number of other witnesses so far—about tender-writing skills being more valued than local knowledge. The simple question is: how do we fix that problem? Should we build in a bias towards small organisations rather than big ones? We could certainly build in a bias towards those organisations using talking therapies as opposed to the clinical ones. Is there a more scientific way of being able to engineer the kind of change that you are seeking?

CHAIR—Also, this issue is not peculiar to the mental health area. It is not only evident in this area; it is a much wider statement and it has been mentioned a few times. We would love to hear your suggestions.

Ms Bateman—I think NGOs traditionally form part of society because they have a particular role: that is, around community development and the creation of local connections—bringing people together. That is one of the underlying bases of NGOs. Of course, there are many NGOs that do not operate like that—they have very large, cross-state functions—and there is a role for them as well. I think it is about diversity: we do not want all large or all small. You need a range. But I think, when you are putting tenders out, perhaps there should be consideration of a more select tender process where, if you are planning on putting services up in the northern area of New South Wales, organisations operating in that area are prioritised and there is, perhaps, a weighting for organisations that can actually demonstrate their local linkages, because to create local linkages takes time and energy. Organisations that have never operated in an area and suddenly find themselves needing to provide a PHaMs service, for example, struggle with questions like, ‘Who’s who?’, ‘Where do we go for that?’ and ‘How do we make those relationships work in a short period of time?’

Senator HUMPHRIES—One of the models that we might use in this area comes from when, some years ago, the Commonwealth government was outsourcing IT services. When large multinational players like IBM were seeking contracts, they were required to demonstrate that they had partnerships with smaller companies on the ground.

Senator LUNDY—Except that never happened.

Senator HUMPHRIES—Well, that was the theory.

Senator WEBBER—You are very brave raising that given who else is here.

CHAIR—Senator Humphries, you are very brave to raise that issue when Senator Lundy is here. We do not have enough time to go into that.

Senator HUMPHRIES—Taking the theory of this concept, do you think that that might work to achieve what we are talking about here?

Ms Bateman—I think they should go to the smaller organisations or other groups and agencies in the local area and ask them to submit support for the organisation, because I think a lot of organisations can say they have links but when you actually come down to it they are pretty scant—it might have been a phone call two days before the tender went through or something like that. They are not real linkages. I think what you are saying is perfectly right. I think that process could work, but it needs to be backed up by a little bit more than just the say-so of the organisation.

CHAIR—Ms Bateman, I know Senator Webber is dying to get into questioning, but are you aware of any process of tendering that actually picks up those issues? Is there a model in any of the circumstances with which you have worked—because your organisation works across a large part of New South Wales—or is there any modelling process that currently operates that does meet those requirements in terms of giving a weighting to or understanding local services?

Ms Bateman—Certainly I have been involved in the HASI tender process.

CHAIR—Would that process be better?

Ms Bateman—No. They did make some attempts to include community connections but the weighting was not adequate, and so we found that the ability to write a good tender which talked really well about recovery processes and models of care outweighed any value that that particular item had. I guess it is about a greater weighting and, as I said, asking those local organisations to support the application. I think that is a demand that it is fair enough to make.

Senator WEBBER—I was not intending to, but I will follow on from that issue. I am from Western Australia, and in a lot of the delivery of regional services there we do not have strong community based activities outside Perth in the area of mental health. So there is a lot of criticism that if you were to fund locally based NGOs then they would not be the traditional health allied ones. Do you think that would be a problem? It would be the local Rotary or something like that that has that strong community base, but we do not traditionally see them as delivering those health services. So would that be a problem, do you feel—because it is quite controversial when I put it to other people?

Ms Bateman—There are two aspects, aren’t there? As I said in the first statement—and this is one of the things that PHaMs and the Support for Day to Day Living in the Community program have done—it is great to bring more players into the field so there is greater mental health literacy more generally. I think that it is important. But, if you just start up a mental health service from an NGO, you need a skills base, and I think that does need to come from a specialist mental health NGO. I think to expect a generalist NGO to pick up that skill base is just not a realistic ask. It comes back to partnerships and to NGOs being expected to demonstrate their partnerships.

Senator WEBBER—Continuing on with what you were saying about the PHaMs program being patchy and uncoordinated, how much of that can we attribute to the fact that it is a brand-new way of doing things and a brand-new program in terms of the way we are involving NGOs and trying to offer that service in the community? How much is it due to that and new players in the field and how much of it would be due to the way FaHCSIA is administering it and the guidelines under which it offers and funds the service?

Ms Bateman—I think there was an opportunity missed, which was about consulting organisations like MHCC when the program was first being designed. We were not consulted in terms of what some of the areas that had higher levels of need would be or even in terms of creating an evaluation upfront so that you could actually look at areas of higher need and areas of higher multicultural populations so you could evaluate the program across some of the different service streams. That did not happen. It all seemed to come out very fast with other impetus, I guess. So it was a missed opportunity. There has been a great deal of confusion over some of the postcodes under the COAG, or the PHaMs in particular.

CHAIR—In rounds 1 and 2?

Ms Bateman—In round 1 in particular, I think.

Senator WEBBER—That is the one where there was the big hurry?

Ms Bateman—That is the one where there was a big hurry.

CHAIR—It was three months late.

Senator WEBBER—It was still a big hurry.

Ms Bateman—I think there is less concern in round 2. That is what I am hearing.

CHAIR—So they are learning.

Ms Bateman—I imagine that that must be true. I have not ever heard it put that way before. In the first round a Westfield car park was one of the dedicated postcodes. People were having trouble filling PHaMs because the area that they were able to access people from just did not have a high level of need. There was another that was a university campus. So someone just had not done their homework, and I go back to the fact that they had not consulted local organisations in deciding where they were going to go.

Senator WEBBER—It is the importance of local knowledge.

Ms Bateman—Yes.

Senator WEBBER—One of the NGOs we were talking to yesterday at our hearings raised the issue of how they had worked previously. They were aware of and worked with the National Mental Health Strategy, the 03-08 document, and now we have the national action plan, so we do not seem to worry about the strategy document. We have now moved over here to something else. I was wondering (a) if that is your perception and (b) if we have lost anything by moving straight from one to the other. Have we lost anything good in that transition?

Ms Bateman—I think it has been confusing for the sector. They did overlap and one seemed to take off in a different direction. Have we lost anything? I would not put it that way. I think there is a willingness for people to move towards what is on the table at the time. It is now 2008, so that strategy is now in the past. Is there anything you want to add, Corinne?

Ms Henderson—My understanding was that one was more about implementation and one was more conceptual. That was my understanding of it, and that the plan was more about a population health framework.

Ms Bateman—They are very different pieces of work. It was not like there were two plans.

Senator WEBBER—No. It is just that we do not talk about one anymore. As soon as the other one came along, we stopped talking about the first one.

Ms Henderson—In our submission—I think it was the submission; we write rather a lot of submissions—we draw some distinctions between the plans at the time.

Senator ALLISON—In fact, I would say that is very useful. Yours is one of the few submissions that have tackled the terms of reference. It is not easy, and you recommend that there be a review to see what fits with what.

Ms Bateman—And there is another plan on the table, isn’t there.

Ms Henderson—I think we drew attention at the time to the fact that the plan was very much about promoting mental health and preventing mental health problems. There were actually four documents that came out. The other one that we were talking about, which I think was the national action plan—that was the second one you mentioned—was very much about prevention and early intervention. Talking about things like increased workforce capacity were priorities in that, which was not evident in the National Mental Health Plan to the same degree.

Senator WEBBER—Ms Bateman, I want to go back to the point you made before about the need for NGO representatives on state COAG committees. That is not happening?

Ms Bateman—No, that is not happening. There was one initial meeting where they got community members to attend but since then they have not done that again.

The CHAIRMAN—Have there been further meetings?

Ms Bateman—Yes.

CHAIR—So it is not that nothing is happening; something is happening but you are not involved.

Ms Bateman—We are not involved. I actually did put it forward to the director of mental health services that this is something that needs to happen. He was not against the idea but it still has not happened. I will continue to lobby for that. I think it is important.

CHAIR—Who is the director of mental health services?

Ms Bateman—David McGrath.

Senator WEBBER—This is not quite on the role of NGOs but it would be interesting to get your perception. Now that we have a lot of Commonwealth funding, the national action plan and state activity, what is your perception of how well they are working together? Is there just a bit of cost shifting and everyone being pulled in lots of different directions?

Ms Bateman—I am a big fan of the fact that we have two funding streams at the moment. I am a really big fan because New South Wales has a long history of being very clinically focused in terms of the way it approaches mental health. As I said in the opening statement, these programs have allowed a space for NGOs to develop, grow and rebalance the system. I am nervous that if programs like PHaMs and Support for Day to Day Living in the Community were to come under the state government at this point in time, we would lose some of the value of NGOs—that is, those different referral pathways and accessing people who do not want to access clinical services. I think that would be of concern.

There is already under care coordination a move to have people in the PHaMs program always assessed by mental health services. If they are assessed by mental health services as not being appropriate then they are not given entry. For a start, I do not think it is a preventative mental health approach. I think that if people are able to access mental health services early at that level then it may keep them out of acute care. I would like to see the programs stabilised much more and a full evaluation done before consideration of handing them over to the states was done, so that they could be more established. I am not sure of the degree to which it is being talked about that they will go to the state but there are rumours.

Senator ALLISON—I want to pursue a bit more what you might do in terms of tendering differently so that you do not get duplication and new organisations coming in from miles away without experience. I must say I have not seen the tendering documents themselves, but do we rely too much on the non-government organisations to spell out what they would do rather than make it clear what is expected? Is that an issue? Is that what leads to someone who writes good grant applications getting in over those that are really more focussed on the on-the-ground provision of services?

Ms Bateman—I think there should be room in tenders for organisations to be able to demonstrate, once the need is identified, how they would go about it, rather than a model being put in front of them that is much more prescriptive about how it is expected that that program be delivered.

Senator ALLISON—So you are not suggesting any change in the way in which tenders are approached? You are happy with the tender documentation and the flexibility for meeting the broad objectives? I am just trying to understand how you can give advantage to local groups that might not write the most clever applications, without taking away some of the need for showing that innovation.

Ms Bateman—As I said before, it is difficult for organisations which are small to get in the expertise needed to write an academic piece of work for a tender. The tenders need to be structured to prioritise what it is that NGOs are good at—or what they see themselves as being good at—at the local level. Sometimes, with the way tenders are structured, there is not the opportunity for them to really be able to demonstrate that ability.

Senator ALLISON—So you are saying they are too highly academic and bureaucratic—if I can paraphrase you—for some small groups to be able to respond to adequately.

Ms Bateman—And therefore they are culled, when in fact they may be exactly the organisation that is able to deliver that targeted level of service.

Senator ALLISON—Should the committee be concerned in any respect about the capacity of these small non-government organisations to get it right? Is money being wasted in some of them? Let us be honest: are some of these small non-government organisations wrongheaded or unable to do the task that is set for them?

Ms Bateman—I think there are minimum standards and minimum qualifications that staff within NGOs should be working to. Organisations have to have a way of demonstrating outcomes for people who use their services. They have to be able to demonstrate that they have quality systems and that they have training programs for staff. All organisations which are running these sorts of programs need to be able to demonstrate that. So, yes, some organisations will be too small to be able to provide programs like PHaMs and Day to Day Living and should not be given those tenders.

Senator ALLISON—In response to our questions about the tendering process resulting in a patchwork of services, the federal department told us that, where there is no capacity to provide services—no application is made and therefore the money does not flow into those areas, despite the need—they were now filling in those gaps. Is that your experience here in New South Wales?

Ms Bateman—Yes, it is. Of course that is one of the advantages of having a number of organisations which are large enough to move to areas where there are no existing NGOs and set up an office and begin to develop their service. That is the beauty of it. Where there are none, I think it is more than reasonable that those larger organisations go and start operating.

CHAIR—I have one question before we move on to the MBS, because I know Ms Henderson is ready to go—

Ms Henderson—Not at all.

CHAIR—Has the information that you have just given us about the tender process been given to the department? Have you had the opportunity to sit down with the department and express these concerns?

Ms Bateman—No. I have expressed them as we go through processes like HASI tenders but not in relation to their Commonwealth programs.

CHAIR—We know that the department will be reading the *Hansard* of this inquiry. It would be very useful, in terms of the feedback which seems to be coming from a number of areas about this particular process of tenders, if that could get back, because it has got to be part of the learning process. I suggest we now move on to the MBS program, which I know that the senators are very interested in. This is the process for access to psychologists and other professionals.

Ms Henderson—We put together a little paper.

CHAIR—Can we get a copy of that? It would be very useful.

Ms Henderson—Yes, I have brought you copies of that. The scheme received widespread support in the community. However, a number of concerns have been raised over the course of consultations. A report that was published by the Mental Health Council of Australia, which you may have seen, presenting an analysis of the first six months of the new program identified that there had been a large uptake of the new MBS items. But, according to that report, even with no increase in the level of services funded, the likely minimum 12-month cost would exceed $220 million. So the original figure allocated of $538 million over five years was obviously not enough.

In terms of access, distribution of services across Australia is not uniform, with some states making much higher levels of claims for the new services on a per capita basis, and the distribution of claims appearing to broadly match the distribution of health professionals. One of the problems that seemed to be highlighted was that many of the accredited psychologists do not bulk-bill or charge fees that match the MBS fee. So the out-of-pocket expense frequently represents a barrier to access for many consumers. There was some feedback also from GPs that many of the clients using the MBS scheme represent those already accessing services privately, so we were concerned that this may be causing a shift from services for the seriously mentally unwell to those better able to access referrals and pay the gap.

We support the concept of the GP as the most stable provider for clinical care, but the scheme fails to include a mechanism through which the GP can be upskilled to manage assessment and care plans and monitor consumer symptoms or work closely with the NGO sector to ensure the client’s social, employment and other needs are met. We are particularly concerned that there is difficulty in locating GPs who can provide assessments and care plans in rural and remote locations.

We feel it is important to highlight the need to ensure that the scheme is coordinated with existing service delivery and to develop models of practice whereby GPs can work collaboratively with community services so that consumers can access services in the most useful way and make choices as to the manner in which they receive care. One of the things that also came up was that many GPs are not sufficiently trained to understand the particular appropriateness of a modality that a psychologist might deliver and to match that to the client’s needs. The implementation of the MBS access excludes practitioners other than psychologists and social workers as service providers by excluding trained professionals who may be appropriately qualified to deal with a multitude of complex presentations and who are offering a broad range of therapeutic modalities. The process is underutilising a resource of skilled mental health practitioners. We suggest that the scheme be expanded in order to utilise those other practitioners.

One of the problems that one of the earlier presenters talked about was the problem with the number of sessions that are available, which is normally six to 12. I understand that in exceptional circumstances 18 are available. This can still present a duty of care dilemma since some clients may require ongoing therapy, and we particularly highlight clients who are victims of trauma or childhood abuse.

Of particular concern is the availability of suitably qualified professionals in rural, regional and remote locations. We suggest that a review be undertaken of proposals from national and state-wide professional bodies to provide accreditation for suitably qualified allied professionals.

We note that the expanded options for access to mental health care under Medicare—such as group therapy, symptom management and psycho-education services outside of specialist consulting rooms and remote phone counselling—are almost negligible. We suggest that might be due to the fact that these options might be more appropriately placed within community services utilising a broad spectrum of mental health practitioners. It would seem to be a lost opportunity to provide equity to a broad spectrum of consumers.

We would also like to highlight the issue of accountability in terms of independent reporting of outcomes of mental health services and treatment of care. A mechanism has not been established to obtain information from GPs as to whether mental health plans and initiatives are having an impact on mental health or providing effective early intervention. We feel that such outcomes need to be evaluated under the scheme. So, in view of the degree to which the MBS has been taken up, it would seem prudent to be able to measure its effectiveness. Were funding allocated to a broader spectrum of community services and allied professionals, this not only would prove to be very cost effective, I believe, but could provide improved access to services and offer a level of service options and affordability to the consumer.

CHAIR—Did that come out of the same range of consultations that the other comments came from?

Ms Henderson—Parts of it, but also what has been talked about subsequently, because it has been talked about at a lot of the professional associations. The MHCA brought out their report. They in fact addressed it at a conference—

Ms Bateman—A CEO forum.

Ms Henderson—A CEO forum. So there has been a lot of information. There have been a lot of articles in the professional journals and people talking anecdotally, asking questions.

CHAIR—So that is your current opinion.

Ms Henderson—Yes.

Senator HUMPHRIES—I want to put to you comments that were made to us yesterday by the Australian Counselling Association in Brisbane. I assume they are one of the other professionals that you referred to there that we ought to be able to broaden the system to allow access to. They suggested that they should get an MBS item number to allow them to access services. Coupled, though, with the idea of self-referral by people, is there a danger that people will end up at the wrong level and that there is no capacity—or motivation, perhaps—for people at different levels to push a person with a particular kind of illness into the appropriate level at which their illness is best treated? In other words, is there a danger that people will be seeing councillors when they need to be seeing psychologists or psychiatrists or vice versa? How do you fix that problem?

Ms Henderson—There is no reason that it should not still go through the GP, if somebody goes to discuss with their GP initially what might be the appropriate person for them to see. But there would be this broad spectrum of practitioners out there, so they can access and get some information about who they might see.

Senator HUMPHRIES—Didn’t you support in the submission the idea that there should be more self-referral, that people should be able to choose which level they go in at?

Ms Henderson—Yes, but I think it would be appropriate for it to be in discussion with a GP or an NGO. There is no reason why it should not go through an NGO. If somebody is accessing services somewhere else in the community, an NGO might be able to appropriately refer them to another practitioner.

Senator ALLISON—This is a very difficult area, I appreciate, but some of your recommendations strike me as being contradictory. On the one hand, you say we should broaden the spectrum beyond psychologists and psychiatrists to include psychotherapists and councillors, but then you also point out that what this has tended to have done with psychologists is draw them from public services and into private practice, which I think we may share your concern about, for reasons of copayments and general access. Apart from saying that GPs should be able to demonstrate the outcome and the effectiveness of their programs, what do you put in place that would ameliorate that situation?

How do you overcome the issue of training? We heard yesterday from the counsellors that someone could be accredited with a diploma which could be done in 12 months and which might or might not take into account prior experience. What the psychologists say is that you have to set the standards high and that their clinical training is essential to make sure people get good service.

Ms Henderson—There is no reason why the standard should not be equally high. They are just different. Many people who have studied counselling or psychotherapy have done so for many years. To get clinical accreditation to one of the organisations you have to have a certain amount of experience, a certain level of qualification and a certain amount of supervision. Obviously those standards have to be set, and that has to be done by negotiation with the professional bodies as to what is appropriate. I agree with you that you cannot just accredit everybody who is out there, but there needs to be some level that is set by those organisations as appropriate and agreed to by the government.

Senator ALLISON—Wouldn’t it be better with counsellors and psychotherapists to have them engaged in much the same way as the PHaMs or through non-government organisations instead of encouraging them to set up in private practice where you perpetuate the silo approach to delivery of mental health services?

Ms Bateman—I think it is a cost consideration. They are very expensive. I think it needs to come under the MBS if it is going to be affordable for the people who need it.

Senator ALLISON—But the MBS is not capped and it has already blown out its budget times 50 per cent, at least, at this stage. The figure is probably even higher than that now—it has probably doubled—there is no control over that expenditure. Surely if you were to provide non-government organisations with a set amount of funding and say, ‘You can use this for psychotherapists and counsellors in the work you do,’ that would give you those controls.

Ms Bateman—If that were possible—if that funding were made available, that would be great but it certainly is not available. I mean, I agree.

Senator ALLISON—I have been one who has advocated expanding the MBS for a long, long time, but I also agree with the points you make about the downsides of doing that and expanding it beyond the current confined groups.

Ms Henderson—I think it is important to have a level of choice as to how people access services. You are right: ideally, it would be great if people could go to NGO services and receive care through those services, but I suppose we were looking at it from two points of view—that the MBS was there and what we might do to improve on that and what the other alternatives might be. It does look as though we are sometimes saying two things, but there are two things happening out there.

Senator ALLISON—Let me ask you about GPs. You diplomatically couch your doubt as to the adequacy of their training. Now that Better Outcomes has given way to one where a GP is not required—I know it is available to them—my understanding is that there is a very low uptake of training. Do you have any evidence on the ground of GPs abusing this as a result of being able to refer without training? We heard the stats, which said that around 50 per cent of care plans do not involve referrals at all, that GPs are presumably doing the treatment themselves. Do you have any level of anxiety about this?

Ms Henderson—I do not think there is abuse. I think that ‘abuse’ is a strong word to use. I think there is just an absence of a broader understanding of what might be required. It strikes me that very often the GP may be looking at the APS site and at who is available in a certain area, rather than what the approach is and whether it is suitable for that particular client.

Senator ALLISON—And what about those who are now accessing the item for producing a care plan for people but not referring? Do you have any evidence about how successful those plans are?

Ms Henderson—I have not heard anything very much. We have only really heard about the referral.

Senator ALLISON—I agree with you—it is hard to get a grasp on what is going on and the effectiveness of the current arrangement.

Ms Henderson—All I can say is that there is some anecdotal evidence of people going to GPs, receiving a prescription, and then going somewhere else for treatment, because it is not working for them. They are getting medicated and that is the treatment that they are getting, and they need something else. So they might then try to source other help from NGOs.

Senator ALLISON—Anecdotally, does the GP explain why it is that they are not being referred for talking treatments?

Ms Henderson—No, I have not any evidence around that.

CHAIR—I apologise for keeping you waiting. One of your first recommendations was a suggestion that there be an annual report on the progress of the COAG intervention and how it is working. My understanding is that there is discussion at the COAG level about how evaluation and reporting will be done. I know that your organisation had a series of consultations, as did the following witness. I am trying to get a sense of what would be the best way to include people who care about this in the further development of good policy. Do you have a suggestion or do you want to think about that and get back to us in some way? It is critical that the public, consumers, carers and providers are all involved in making sure this stuff works, and I am trying to get a sense of what you think would be the best way for that to continue.

Ms Bateman—What you are after is a consultation process within the states?

CHAIR—Yes, and rather than being ad hoc or up to individuals, that it be regulated in some way. I know funding has been given to the Mental Health Council to do some work in the future, but it would be useful if people were thinking about how they would like to be involved, so if you could think about that.

Ms Bateman—Certainly from the NGO sector’s perspective, it is something that we would like to take on. We see it as one of our roles to do that sort of coordinating process and feed back what is actually happening on the ground. As a peak body, even though we have close connections with our members, we do not know all of the stuff that goes on on the ground. If there is a more formalised consultation process that feeds in, I think we are going to get much better information to make decisions with. So we will certainly put something forward on that.

CHAIR—That information process should be done without fear or favour, because a lot of the members are also seeking tenders. It is difficult when you are consulting to make sure that when you have an issue it is raised with confidence.

Ms Bateman—Yes, thank you. I have brought some documents you might be interested in, particularly a document we did on social inclusion—it is important to mental health—which I think would be relevant. Also, this is our sector newsletter, which will keep you up to date on what is happening in New South Wales.

CHAIR—Thank you. Some light reading!

Ms Bateman—Yes.

[12.14 pm]

OAKLEY, Ms Karen, Acting Executive Officer, NSW Consumer Advisory Group - Mental Health Inc.

CHAIR—Welcome, and thank you for your patience. You have information on parliamentary privilege and the protection of witnesses. We have some information about you and we have your submission. Would you like to make a short statement? Tell us what you want to talk about.

Ms Oakley—I would love to make a brief statement of introduction. Firstly, I would like to thank you for this opportunity to represent the views of mental health consumers and carers to the inquiry. The New South Wales Consumer Advisory Group - Mental Health Inc. is the independent statewide organisation representing the views of mental health consumers and carers at a policy level, working to achieve and support systemic change. Our vision is for all mental health consumers and carers to experience fair access to quality services which reflect their needs, so we feel that this is a really appropriate inquiry for us to be representing at. While I am not able to represent the views of all consumers and carers in New South Wales, my representation today is informed by consultation with mental health consumers and carers throughout the eight area health services in New South Wales; the input, experience and views of consumers, carers and other key stakeholders comprising our network of over 700 members; and the perceptions and experiences of mental health services reported by consumers through the MH-CoPES questionnaire that is currently being used throughout adult public in-patient and community mental health services in New South Wales.

There are two key aspects to our submission that I would like to highlight today. The first is really around the gaps that consumers and carers feel there are in the current mental health system. Of primary concern are the gaps in mental health services, both in the NGO sector and more largely in the public mental health sector. Although the national mental health plans have highlighted the importance of these community services, in our consultations we are consistently hearing that services are inadequate to support consumers to recover, to remain well and to live a fulfilling life in the community.

Specifically, we hear that case workers and managers have case loads of often 40 to 60 people, which limits the contact with and meeting of individual consumers’ needs, and there are many consumers who require case management who are not receiving this. After-hours crisis services in the community are limited and in some regions of New South Wales do not exist. This results in a need for consumers to access emergency departments rather than remain in the community. Many consumers also need non-crisis after-hours services to assist them to remain in the community, and these are largely non-existent. There is a need for a safe, non-hospital environment for people to go to when they feel overwhelmed with their mental health problems. Follow-up with consumers after being discharged from acute and non-acute in-patient services is also inadequate, impacting on the consumers’ successful transition from the hospital to the community. Coordinated care within the community is also inadequate, with poor and often no information sharing between the staff working with consumers. And then there is a lack of housing, both supported and independent, for people with mental illness.

The result of this lack of supportive community services is that frequently hospital and emergency departments are consumers' only options for assistance, although often not their preference. Additional results, as I am sure you are aware, are the revolving door syndrome of re-admissions into in-patient units, the high rate of homelessness amongst people with a mental illness, a high rate of people with a mental illness being represented in our jails and forensic system, small non-government organisations that are not resourced to provide crisis support and family and carers bearing the brunt of the inadequacy of crisis and support services. A substantial number of consumers who, with adequate support and services, could be discharged from in-patient services to the community are forced to remain in in-patient services, which both uses valuable bed spaces and risks a deterioration in their mental health.

Whilst there are good programs emerging from COAG to address some of the gaps in the community services, particularly HASI, the PHaMs program and Support for Day to Day Living in the Community programs, which we see as vital additions to the mental health services, the limited resources for these programs mean that there are still many consumers not receiving the services they need to stay well and remain in the community. We urge the inquiry to consider this issue and for more comprehensive implementation strategies to be included in the Commonwealth and state implementation plans.

Of significant concern in in-patient units is the lack of adequate discharge planning. We have anecdotally heard from consumers who have been discharged without accommodation to go to and then returned directly to the streets. This is highly related to the availability of community services, obviously, but also reflects the workload of staff and the culture and attitudes within in-patient units. Indeed, we have heard from consumers both in consultations and through MH-CoPES of the need for greater resources for in-patient and community services and of the need for a change in attitudes and culture within services, a change towards a recovery orientation that places the consumer and their individual needs at the centre of services and a respectful attitude where staff work in collaborative partnerships with consumers. We also see and consistently hear of the lack of services, both in-patient and community, for consumers with comorbid substance use and mental illness problems.

Secondly, and as highlighted in our submission, New South Wales CAG and our constituents are concerned that the Commonwealth and state implementation plans do not identify how mental health consumer and carer participation in state and service policy development and service delivery and planning will be addressed. Indeed, we consistently hear from consumers and carers about the lack of genuine opportunities to participate, both in the consumer's own treatment and care and in the broader system. We seek commitment to addressing this to enable the National Mental Health Plan and the implementation plans to adequately meet this objective of the National Mental Health Strategy. We see our invitation today to address this committee as an important step in acknowledging the importance of and incorporating consumer and carer participation into policy and service development.

As we seek our vision for all mental health consumers and carers to experience fair access to quality services which reflect their needs, New South Wales CAG advocates the need for a shift in the culture of the current mental health system, a shift towards the people that the mental health services serve being the centre of all policy, legislation, planning and decisions affecting consumers and carers, a shift towards a culture where consumers and carers are involved in a collaborative partnership, both on an individual and on a systemic level.

CHAIR—Thank you, Ms Oakley, and thank you for your patience. Before I hand over to the other senators, can I just clarify from where you are funded. Is it New South Wales funding?

Ms Oakley—We are funded by the New South Wales Department of Health.

CHAIR—Where do you fit with the national consumers network, the one whose head office is in Brisbane?

Ms Oakley—As far as I am aware, we do not have any current strong connections with that network.

CHAIR—It is just in terms of the labelling—it is really difficult.

Senator HUMPHRIES—Is your group represented on that mental health group set up under the COAG arrangements in New South Wales?

Ms Oakley—I am not aware of that. This is my third day in the position of acting executive officer, so I would need to clarify that further in other documents.

CHAIR—Can you find out for us. That would be a really useful thing for us to know.

Ms Oakley—Certainly, that would be great.

Senator HUMPHRIES—The previous witnesses, from the Mental Health Coordinating Council, said that there was an initial meeting to which a number of the NGOs were invited and that was the last time there was an invitation to be part of that process. It just seems to me extraordinary that, if you are the advisory group on the views of carers and consumers, you have no ongoing role in that coordinating group. It is just extraordinary.

Ms Oakley—And that is also of concern for us.

Senator HUMPHRIES—I assume that, if you are given a seat in that process, it is open to you of course to put a consumer in that seat—

Ms Oakley—Yes.

Senator HUMPHRIES—to get representation on that body. We heard in Queensland yesterday that there is a 32-member mental health group for that state, and I think one was a consumer.

CHAIR—It had not met that often.

Senator HUMPHRIES—It had not met that often. So it is a major problem we have to talk about, I suspect, in our report.

Ms Oakley—Absolutely.

CHAIR—We should have asked the New South Wales government, Senator Humphries.

Senator HUMPHRIES—We should have asked them. We forgot to do that.

Senator WEBBER—The New South Wales government turned up. We could have asked them.

Senator HUMPHRIES—Indeed. I have just one question based on your original submission—I have not read the one that has appeared today.

Ms Oakley—I believe it is actually the same submission.

Senator HUMPHRIES—Is it? Okay.

Ms Oakley—Yes, it is. I think there were some pages missing from the copy you were given.

Senator HUMPHRIES—I see. You make reference to the people that you workshopped with saying to you that GPs' attitudes were 'not conducive to helping people access the support of allied health professionals'.

Ms Oakley—Yes.

Senator HUMPHRIES—You would have heard the discussion we had before about that. Have you got any suggestions about how we effectively break down the barriers there? Is it a good idea to channel people into services through GPs uniformly or should we be establishing alternative pathways through NGOs? Should we better train the people in those particular occupations to cross-refer where they find their services are not quite what the client needs? How do we do that?

Ms Oakley—I think the solution is a combination of all three. Certainly for consumers, no one option fits everybody. For some people, accessing the services through GPs works adequately. For other people who may not have regular contact with GPs for a whole range of reasons, other alternatives—such as through an NGO—would provide more opportunity and more access to those services through MBS. I think training programs around not only the MBS system for GPs—I am sure they are out there—but also the specific needs of consumers would enhance that process.

Senator HUMPHRIES—Do you think the training of all of those health professionals in that sort of cross-referral kind of exercise should be mandatory as part of the process of making sure people get the right level of service for what they require?

Ms Oakley—I think it would be a step in the right direction to mandate such training. Certainly if such training were to progress, another aspect that really needs to be covered would be the collaborative care approach and the coordinated care approach. So whilst people may be referred from their GP to the psychologist with a care plan in place, there is not always that consistent information sharing and updating, which is quite critical in managing the care of consumers.

Senator WEBBER—Where to start! The fact that there is no role for consumer and carer consultation and a voice to be heard is quite staggering, but there you go. What we have seen since the national action plan and the COAG emphasis has been obviously a dramatic increase of funding into the system. Has your organisation actually noticed any difference and has that been good or bad?

CHAIR—And can you say after such a short time in the job? It is very difficult.

Ms Oakley—I guess that is one difficulty. Certainly something that was highlighted in our initial consultations for this submission was that consumers were not actually aware of the programs that were coming out of COAG and therefore were not seeing or feeling their impact. Obviously that was about six months ago and the progression has changed. We have recently held two consultations: one in Sydney and one in Tamworth. The feedback that we got through those consultations indicated that, yes, there is a little bit more access to psychologists through the MBS program; however, there was no substantial change in the perceptions and experiences of the community mental health services or mental health services in general.

Senator WEBBER—This goes back to a discussion we were having earlier. Part of the increase in federal funding in particular has been some direct funding to NGOs to deliver services, particularly early intervention and support services. From a consumer carer point of view, is that the right direction to go in or do we need to look at perhaps increased funding for that crisis intervention?

Ms Oakley—I think we do.

Senator WEBBER—Are we getting the balance right?

Ms Oakley—It is one of the challenges. What we are hearing from consumers is that a lot of the community services that are available are crisis based. So for people who need ongoing care or who are at a point that is not deemed to be a crisis but for them is an escalation in their symptoms or in their difficulties in managing living in the community, access to those services is not available, because, as a result of funding and resource implications, we have had to move to a more crisis based service where we deal with people in crisis. That is obviously an important place that we need to focus on. But, in doing so, we are missing a lot of consumers and that continual care.

Senator WEBBER—One of the discussions we had at our hearing yesterday in Brisbane was about the obvious need for consumer representation in the variety of fora that we now have and for their voice to be heard when we are planning service delivery. There is concern that there may not be enough support for the few consumers that we do identify, that we obviously put on more federal bodies than state, it would seem. Has anyone been talking to organisations like yours about the need for more support and training to make sure that that consumer voice is heard?

Ms Oakley—I am not aware that people have been talking to us about it, but it is certainly something that we have identified as a real challenge. I guess it then leads to the tokenistic view of consumer participation and consumer input in that, if we say we have a consumer on our committee, we can tick the box. However, our experience is that consumers attending those committees need to have a certain level of skill, a certain level of confidence and a knowledge base to be able to actively and genuinely contribute. So part of that challenge is providing the funding, the training, the resources and the support for those people.

Another factor in that, though, is ensuring that consumer representatives on such committees are actually representing the broader views of consumers, which feeds into the question you posed to the representatives from MHCC about how we consult with consumers to make sure that the consumer representatives on such committees are representing the views of consumers. Our experience is that largely this is achieved most successfully through face-to-face consultations. There are a lot of funding and resource implications for that, because you actually need to go and talk to people and find out what is going on.

Certainly one of the most successful approaches we use at New South Wales CAG is going out to different regions within New South Wales and holding group consultations and forums where we are able to get those views. Whilst there are other forums, such as internet and email responses or phone-in lines, we typically find that they are not an adequate means for genuine consumer access and input. What all of that comes back to is making sure that those representatives not only have the skills and confidence to have that input and are empowered by whoever they are representing and by the committee but have the knowledge from the community of consumers and carers.

Senator WEBBER—I have one last question, and it is not a fair question, but perhaps it demonstrates my frustration and perhaps I should have asked the earlier witnesses as well. If the state have their COAG committee, there is no formal NGO representation and there is no representation from consumers or carers and the state government are not turning up today, how would you recommend we work out what is really going on in the state of New South Wales?

CHAIR—You could take that on notice.

Senator WEBBER—As I say, it is not fair.

Ms Oakley—It is a huge challenge, and it is a challenge we consistently face, in not just COAG related committees but other committees. We need to make sure we do not forget consumers in this. We need to have a voice. It is one I do not have a good ready answer for but one that I think needs collaboration with the NGO sector and with organisations such as CAG to find a solution.

Senator ALLISON—Some of your submission is quite disturbing:

- The atmosphere of hospital wards remains extremely negative.

… … …

- Follow-up is still inadequate. Participants spoke of waits of around three-weeks post hospital discharge before initial follow-up occurs.

Ms Oakley—Yes.

Senator ALLISON—And you had some 50 participants who—

Ms Oakley—Yes, there were over 50 participants in that consultation. Certainly, now that we have the MH-CoPES system happening, we are receiving similar feedback. I would like to say that we are also receiving feedback that there are some services that consumers are perceiving and experiencing very happily and they are meeting consumer needs. However, there are a lot of services where staff attitudes towards consumers are not positive, the service is certainly not recovery oriented and the follow-up care is a substantial issue.

Senator ALLISON—We heard yesterday in Queensland from the Brook Recovery, Empowerment and Development Centre, which is one of only two consumer run mental health organisations in the country, as we understand it. Has your body ever attempted to get funding for a similar kind of program? We understand that they actually go into hospitals when someone is about to be discharged, welcome them to the centre and assist them with services.

Ms Oakley—At this point we have not looked at moving into that. At the moment, we are a very small organisation. We have 3.1 full-time equivalents working to do the job, so it is a challenge to do what we need to do in terms of systemic advocacy. That is also more related to the individual advocacy in assisting people to move out. There are some initiatives through COAG that look at that such as the personal mentors program which will assist in that sort of thing. In New South Wales we have the consumer advocate or the consumer workforce who do some of that role, but again one of the major challenges for that workforce is its underresourcing. For example, one of the area health services in New South Wales has one person for eight hours a week to fulfil that role for the whole of that area.

Senator ALLISON—Did any of the group that advised you on your submission have experience of a personal helper or mentor?

Ms Oakley—I was not part of that, so I am not able to answer.

Senator ALLISON—It is not in the submission, so presumably it was not the case. I want to come to a couple of New South Wales specific parts of the action plan. One was helping people with mental illness enter and remain in employment. Are you able to tell us whether your members have been accessing that program? Does it work?

Ms Oakley—As far as our members and our consultations have been concerned, I am not aware of any of our consumers who have been at those consultations who have accessed that service. One of the concerns that we do have about employment services is that they need to be a little bit broader than getting people into what could be seen as jobs for the mentally ill. They need to be supported in a mainstream workplace.

CHAIR—What people call real jobs.

Ms Oakley—Yes, ‘real jobs’. So supporting that mainstream workforce employment rather than setting up a specialised—

Senator ALLISON—It was described in the submission as three F words. The first was food, the second filth—jobs in cleaning—and I cannot remember what the third one was.

Ms Oakley—It is the old version of sheltered workshops.

Senator ALLISON—What about respite places? The Commonwealth has made available funds for respite places which should benefit 15,000 families a year. Again, is this something you know anything of on the ground?

Ms Oakley—It is not something that we have explicitly consulted about. People at our consultations have not been talking about those kinds of services.

Senator ALLISON—New South Wales: 65 specially trained professionals in emergency care and $51 million. Is that evident anywhere?

Ms Oakley—Not from what we are hearing. One of the concerns about people presenting at emergency departments is a lack of knowledge of mental health issues and the needs of people with a mental illness. We know emergency department waiting times are often quite extensive. That is the same for people with mental illness. We could have 20 people in some areas in an emergency department for a considerable amount of time. While that is not ideal for anybody, it is particularly dangerous for people who are vulnerable.

Senator ALLISON—You were here earlier when we discussed non-government organisations and the tendering process. Do you have a view about that? Does your organisation have a position about better ways of tendering some of these grant based programs?

Ms Oakley—I would certainly support the MHCC's position that NGOs and bodies looking to submit and receive tenders need to be connected with the community to be successful programs. As was raised by Senator Webber, incorporating other non-mental-health NGOs in partnership with specific and perhaps smaller mental health NGOs might be a way forward in expanding into areas where mental health services are lacking. In the tender submission process—and I have not seen the tender form—it is important for the organisation to demonstrate both how they are going to meet the needs and present the services but also how they are going to do so collaboratively with the community and in coordination with the broader community that they exist in.

Senator ALLISON—You say that care plans are not well understood by services and consumers are not well educated about their care plan and the role that it can play for them. Can you perhaps expand on that statement?

Ms Oakley—Certainly. It relates largely to consumer participation and involvement in their own care. It largely comes back to the medical model that is often implemented: 'Doctors and clinicians know what is needed for the consumer.' The consumer will be told what their medication is, but that can often be the extent of the communication with the consumer. The broader considerations to do with their social and employment needs are not factored in, and they really need to be part of a care plan. The communication of that care plan is important. 'This is what we're thinking about doing. How does that sound to you? Is this going to meet your needs?' It needs to meet the needs of the consumer in that recovery orientation and partnership. Without that dialogue going on, consumers are not involved in the development of the care plan and are not notified of what the processes are, what that care plan does for them or what is happening in their care.

Senator ALLISON—Where is most of the criticism directed here? Is it to GPs? Is it to area mental health services? Who do you think is less well equipped to prepare good care plans?

Ms Oakley—That is a very difficult question for me to answer. I am going to sidetrack it slightly and say that the consumers at the consultations and the consumers that we talk to are largely speaking of services they received through area mental health services—in-patient services and community services.

Senator ALLISON—Is that because they mostly access services that way? Has there been any increase in people going to their GP in the expectation of being referred to a psychologist?

Ms Oakley—I believe that there has been. However, I guess the focus of our work is more around the public mental health system rather than the GP sector. With our size and funding restrictions, we need to be quite contained in what we look at. So it is partly about our restricted capacity in those consultation forums to investigate that.

Senator ALLISON—I understand. Thanks.

CHAIR—Is there anything else you would like to add? I know it is very difficult having just taken on the position, but it is an ongoing process we want to establish to hear what people are saying. We have asked you to follow up with a couple of things. If you could get back to us when you can, that would be good. A question I have relates to regional consultation. You said that in the last round you went to Sydney and Tamworth. Looking at what we know of the New South Wales government commitment to their expenditure since the 2006 budget, they have announced expenditure in the regional areas, in particular the establishment of a hospital at Lismore and upgrades in the wider Sydney area, Sutherland and Concord. Is there work with consumers in those areas when they are setting up those processes? Perhaps you could take it on notice and look at your files to see whether there is involvement of consumer groups in that process.

Ms Oakley—Yes. There may be. It would be at a more localised level, so not through New South Wales CAG.

CHAIR—Another question relates to the gender make-up of the people who come to your consultations and involve themselves, because they have to make the choice that they want to be part of them.

Ms Oakley—Absolutely.

CHAIR—I also want to ask about Indigenous involvement, particularly in Sydney and in the regional areas. Do you have Indigenous consumers who are prepared to come forward and be involved?

Ms Oakley—The Indigenous community is one that we have found it a challenge to access and involve in our consultations. We are currently reviewing how we can more effectively do that in a more culturally sensitive way, because our approaches may not be the best way to do that. During our last consultation we did have over 50 per cent who identified as Indigenous.

CHAIR—That is very high.

Ms Oakley—It was. Unfortunately, it was a group of five people.

CHAIR—So 2½ people!

Ms Oakley—But it was a good start for us.

CHAIR—It is, and those people have come forward.

Senator ALLISON—I am just remembering our first inquiry, where there was strong criticism of the New South Wales government for pulling services out of communities and into hospitals. I just notice from the list of initiatives in New South Wales that one of those was to establish psychiatric emergency care centres, attached again to hospitals. Does your organisation have a view as to this direction being the best for your people? Do consumers enjoy going into hospitals or would they prefer to have those kinds of services located in the community?

Ms Oakley—I would say that nobody really enjoys going into hospital. We have had positive feedback about the emergency care centres. There has been a bit of a review and evaluation of those. Certainly it is seen as a step in the right direction to have a specialised area of emergency departments who are able to cater for the needs of consumers. However, I think this needs to be an adjunct to similar community based services.

Senator ALLISON—What do they look like? Is it just the emergency department that has been partitioned off into a centre they call the emergency care centre? Is it in a building alongside emergency or somewhere else in the hospital? What are they?

Ms Oakley—That is one I will need to look into and get back to you about.

Senator ALLISON—Actually, you might have a look through all of the proposals and see if there is anything there that you can tell us about. As has already been said, we do not have the benefit of being able to ask the government this. We rely on people such as you who use them. Thank you.

CHAIR—Thank you for your evidence.

Proceedings suspended from 12.49 pm to 2.06 pm

GURR, Dr Roger Owen, Chair, Policy Committee, Comprehensive Area Service Psychiatrists Network of New South Wales

ROSEN, Associate Professor Alan, Secretary, Comprehensive Area Service Psychiatrists Network of New South Wales

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

Prof. Rosen—I am an associate professor at the University of Sydney in psychological medicine and at the University of Wollongong in public health. The capacity in which I am here today is as the Secretary of the Comprehensive Area Service Psychiatrists Network.

Dr Gurr—I am the Director of Mental Health Services for Sydney West Area Health Service. I am here today in my capacity as Chair of the Policy Committee of the Comprehensive Area Service Psychiatrists Network. Needless to say, the comments I make today are not necessarily endorsed by my employer.

CHAIR—Do you call your organisation CASPN?

Prof. Rosen—CASP.

CHAIR—Do either or both of you wish to make an opening statement before questioning?

Dr Gurr—We both want to make short statements.

Prof. Rosen—We think the priorities, in terms of achieving a recovery oriented desirable result for both service users and their families, are to address mainly funding and accountability principles and rationales, and to work out how to use those mechanisms to reach agreement on the shape of integrated, efficient and effective services that follow the evidence. Our first point is about a more rational funding methodology for services as this determines what is provided, whether by government, private or not-for-profit non-government organisations. For that point, I will pass you over to Roger.

Dr Gurr—As someone who is on the ground trying to run services and actually deal with the interfaces that now exist because of the various methodologies of funding, it has certainly brought home to me the total importance of the funding methodology, because you absolutely get what you pay for and exactly what you pay for. I think that almost none of our funding mechanisms actually gives us the outcomes that match the evidence—the outcomes that we really want to have. Clearly, the state situation is one where the state governments have not actually had adequate resources to provide all the services that one might desire. I noted with interest the Twomey and Withers paper on federalism and how Australia has the most fiscally imbalanced federation in the world, with the lowest level of direct taxation raised by the states. The states are only raising about 18 per cent of taxes but have to spend at least 40 per cent of the national dollar on providing essential services. So they are forever dependent on the

Commonwealth to really determine how much money they have available to provide the services.

CHAIR—I have to admit to my absolute ignorance of the paper to which you have just referred.

Dr Gurr—I will donate my copy.

CHAIR—I am sure that certain people would love that paper deeply, but perhaps we could table it. You have referred to it in your evidence as something that you have looked at, so we should look at it as well. We have economists on the committee.

Dr Gurr—Yes, and it is available electronically. I just googled ‘Withers’ and got it. That just sets the scene. I have always worked in the western suburbs of Sydney and, historically—this is probably pretty true of the western suburbs of almost any city—you are forever waiting for new money to deal with the growing population. There is a tendency to have to wait for a long time and the money does not actually keep up with the population growth. I have worked my entire career in areas such as the City of Blacktown, the City of Liverpool, the City of Fairfield and some of the parts of Sydney that have population growth but have had less opportunity to develop services.

We have always worked very hard at getting the best possible bang for our buck by being as efficient and as effective as we can be. But these are areas where we do not get much benefit out of Medicare; the Commonwealth funding that is available just does not go to those areas. I am the only private practitioner in the City of Blacktown, which has a population of approximately 300,000 people, and I do three hours a month. There is a lack of data on the department’s websites about where Medicare money gets spent. That data, I am sure, is kept hidden because of that sort of fact—that private psychiatry rebates are not spent in Western Sydney.

CHAIR—Pardon my ignorance, but is either Concord or Sutherland near to where you work? I know that Lismore is not; I know that much.

Dr Gurr—No. Sutherland is in the very southern suburbs of Sydney and Concord is to the east of my area. My area starts from Parramatta and Auburn; it is that sort of area.

CHAIR—So you are not getting the new hospital.

Dr Gurr—No, we are not getting the new hospital, but the state government is about to spend $34 million on mental health facilities out at the Nepean hospital. We are in the process of planning for that. The issue is that hospital services tend to get the money; there has been real growth there, and the New South Wales government has certainly been putting money in. The problem comes with community services. I do not think the Commonwealth or the state government wants to have more admissions than are absolutely necessary. It is really about making sure that we not only look after people well but also avoid admissions and enable early discharge. Admission to hospital for mental health is purely a risk issue; it is not a treatment issue. We can provide exactly the same treatments at home as we can provide in hospital. It is just a question of how much this person needs to be supervised for short periods while they are under the influence of drugs as well as psychosis or whatever, or who needs to be in hospital just because there are no supports at home to manage them in the acute phase or, for that matter, in the longer term phase.

My emphasis today is really about the community side of services and how we provide what is necessary to get people from the onset of their illness through to recovery. Ninety-seven per cent of our clients, in the public sector anyway, are in the community at any one time—a very small proportion is actually in hospital—so how do we provide for them? Virtually none of our funding systems provides the right incentives, whether it is Medicare which, if you are a psychiatrist, basically rewards you for doing things in an office for certain periods of time. You maximise your income by seeing people for 16 minutes exactly; for every minute that you go past that you start to lose money, comparatively. You do not get paid for liaison work. In discussing what is happening with a particular consumer and their relatives, you get paid less to talk to the relatives, you get paid nothing to talk to the GP and you get paid nothing to talk to another provider, whether it is a NGO, another discipline that is paid through Medicare or whatever. So there is no reward for properly communicating, yet the evidence in mental health is that you get the most effect if you provide continuity of care and seamless transition of care.

Case management is not a brokerage game; it is a psychological management game. Basically, when someone develops a mental illness, they go into a state of high anxiety—almost grief and loss—because you are stigmatised when you develop, say, a psychosis. It really makes people feel, ‘This is changing the whole trajectory of my life; I won’t be desirable as a sexual mate or a prospective parent. Nobody will want me. Perhaps I won’t be able to work due to my illness,’ et cetera.

So we have to actually assist the consumer and the family to work their way through the grief and loss and get to a point where they see a way forward and have hope for the future. It usually takes about two years on average, in my experience, to get through that. You actually have to get the consumer to the point where they will own their illness, not just rail against it, where they will then accept and take control of the treatment and their progress. You cannot get that through a brokerage model. You do not get that by handing the person from one provider to another. You actually have to provide somebody who takes the responsibility and provides that whole-of-family psychological management through the process.

The public sector tries to do that but I do not think that works so well with office psychiatry and it certainly does not work if the clinicians get painted into a corner—and I think some NGOs try to do this—as someone who prescribes pills and everything else can be provided by some other sort of provider by purchasing bits and pieces. However, the other providers employ staff who do not have the psychological skills to manage this psychological process. While they are very good at providing some support services, they cannot actually provide the direction and the management through the various phases. That is why we get a higher suicide rate amongst people with psychosis et cetera. They do not really get that help that takes them through to the other side of all the pain, grief and loss.

I am not here to talk anymore about that. I just think we have to re-review all those forms of funding to see how they really fit together. The new COAG moneys provide new silos of funding but they are not actually connected. There is no connection between those funding streams and the evidence that says this is the way we should be organising things. I work with our local NGOs. They have got their helpers and mentors funding and in New South Wales we have the Housing Accommodation and Support Initiative, HASI, the Support for Day to Day Living in the Community program and the headspace program as well. But all of these things are set up in such a way that we are actually causing a disintegration rather than an integration.

None of these things are new. We used to do those things in the City of Blacktown back in the early nineties when we had a better funding ratio. We apply the assertive community treatment program, which has been so well researched in the United States. The National Alliance for the Mentally Ill actually publishes a manual on how to do it. It is extremely well researched. If there were totally revamped funding mechanisms and the state or the private sector were able to do things in co-location with some of those other providers, then we would do a lot better. I am not saying the public sector needs to do everything. I am all for some contestability and so on, but we have to make sure that the purchasing is done in such a way that things connect. They need to connect in a real sense so that there is seamless communication, seamless use of information across boundaries and ongoing support.

Apart from the poor distribution issue—I think it is true that there are problems about how the money is actually being allocated in all the new funding streams—we really have problems because there are no quality measures, for example. There are no real controls. There is always the potential for cherry picking because all the agencies that get some funding and from which we are purchasing services get the opportunity to pick and choose who they will take. They will take the ones who are easy and then the state system gets left with whoever will not fit that nice little package here or that little package there. The other thing is that even when you package things, it does not actually fit. That is why case mix does not work in mental health. You cannot package based on measurable criteria as to who is going to need what amount of resources. Both Alan Rosen and I participated in the MH-CASC study many years ago that looked at case mix and found that you really could not apply it.

In the HASI program we have got an example of a state level where they tried to work out contracts that are designed on packages of different levels of care. So, if you got paid $56,000 a year, I think, it would supply a very high level of care—intensive care—to some people, and one agency will win the contract to provide that. Another agency might win the contract to provide lower level care. But, in fact, the people who start off in intensive care move, if they are well managed, fairly quickly to not needing that any more. They actually need this one down here but, because it is a different organisation, you cannot switch them. You can end up with one organisation, as I was told this week, swimming in money because they do not actually need to provide the level of service but they have been given the money for it. But their auditors will not let them use the money in some other way because it is not the purpose of the contract.

I can see those things happening at a federal level, again, with purchasing. If we think about packages, we have got to get more sophisticated about how we think about purchasing packages. I think this is the issue in New Zealand. They have gone through this whole phase—they have experienced the purchasing and having multiple contractors providing for it—and they ended up with too much fragmentation. I think they are going back now towards saying, ‘We need a bit more of a consolidated view about how we do this.’

We also need systems that really provide flexibility. There needs to be interaction between the clinicians and the agency and continuous decision making about the level of care a person needs. Otherwise, we will just end up wasting a lot of taxpayers’ money without getting the end result we want. We know resources are always going to be scarce. In mental health we are clearly still underresourced. I would like us to use effectively the money we have available to us.

If I could add one thing before handing back to Alan: some of these other packages like the Practice Incentives Program nurses are just not designed to work. Nobody really wants to pick up on it. The divisions do not see it as being of great benefit to them. The GPs are all small business men—too difficult. The public sector is not allowed to be an organiser for that, but we could be, or we could find some better way of providing that.

The one thing I think we should be doing and would recommend to you is that we have another go at what is called the integrated care project. Back in 1999 to 2003, or thereabouts, the Commonwealth funded an experiment and Kathy Eager ran the project for them. There were three sites for this. There was the Illawarra site, and I have got the evaluation report for that.

CHAIR—Is it as substantial as it appears?

Dr Gurr—Yes.

CHAIR—It is an in-depth evaluation.

Dr Gurr—Bill Barclay was the chair of the committee. Alan Rosen was part of the project that was done at Broken Hill. It was a remote project. The one in the Illawarra was semirural and semimetropolitan. The Melbourne clinic had an inner city Melbourne component to it as well. I have handed in a paper that is Kathy Eager’s and her co-author’s summary of the learnings from these projects.

CHAIR—I see. There is one from the mental health—

Dr Gurr—It is short enough to look at, with all the reading I am sure you guys have to do.

CHAIR—Are all those people still active in the industry?

Dr Gurr—I think they probably are. With the changes that came in with the Howard government, and with what has been happening in the states as well, the scene has changed a lot from back then. I think now is the time to say, ‘Let’s take these new funding silos and streams and so on that we have and actually get an area to create a structure that includes public and private to manage it.’ But we need to experiment again with how we could take the money that ought to be being spent in a particular area and tweak the systems to make sure that we are covering the gaps—maybe experimenting with changing some of the incentives in those programs. You do not have to change the whole country at once. We could do an evaluated process of changing the bits and pieces.

I have to say I do not think FaCSIA really understood the game when they had to come up with their proposals. It is a situation, I find, that, even at the state level, the head office staff—the policy makers—are not closely enough interconnected with those actually providing a service on the ground. What you need is a process where you experiment on the ground, working with the different interests and trying to work out how we get a balance and how we still allow for those other economic things you want achieve in terms of contestability and efficiency. But we need the effectiveness, and I think we have got programs happening that just lack the effectiveness because they have not been based on any good evidence.

CHAIR—Professor Rosen, do you want to add anything at this stage?

Prof. Rosen—I want to point out also that, if you would like more detail about the integrated care program I was involved with in the greater west—Wilcannia, Broken Hill, Menindee and those areas; rural and remote mental health—and how successful that was in terms of the outcomes, I can provide a paper on that.

CHAIR—That would be good. I do not remember you talking about this last time.

Prof. Rosen—No, we did not. The preamble part is how the COAG arrangements have been a force for good in terms of involving the NGOs a lot more. As in New Zealand, we would like to get up to a high level of NGO involvement, but the problem has been fragmentation because of how quickly the arrangements were put in place. Also I think it was probably part of the selective centralism push at the time rather than a push for integration. There is no funding, for instance, in the COAG arrangements for integration and coordination between the efforts of public and private mental health services and NGOs. An integrated care program would be able to provide the mechanism, for instance. So I think the next step is about how we now use all the elements and pull them together. The other issue—and Dr Gurr has given a number of examples of this—is how to actually make sure that there is enough flexibility in arrangements, whether they are state funded or federally funded, so that people can travel between streams and not occupy a heavy duty, high-cost stream when they have settled down and could go to a lower intensity stream.

The same thing occurs in assertive community treatment. Assertive community treatment is a field that I review internationally. I can provide you with a recent review on that, which was published in the States. Some of the spurious outcomes are where people are retained in intensive and assertive case management when they have settled and could be passed to other teams or to GP shared care. I think we have to look at the flexibility between streams, both in the public sector and in the NGO sector. I think that is really important. Again, integrated triage and coordination of management could do all these things, and I think it is now timely to look at all those aspects. Before I start my remarks, you brought up Concord. I was just wondering whether you had a particular interest in Concord.

CHAIR—No, it is just that we have not been blessed by the appearance of either officers of the department or the minister from New South Wales, but we have a list of what the New South Wales government have publicly said they are doing—

Prof. Rosen—With the Rozelle site at Concord?

CHAIR—with the money. I am just reading from the list. There is significant expenditure. There are hospital upgrades at Concord, hospital upgrades at Sutherland and also at Lismore, with a particular focus on mental health. That is why I asked Dr Gurr about his area—I was pretty clear on Lismore but I was not sure about the other two.

Dr Gurr—We have not given you the complete list. There are actually more than that. There is definitely $34 million for Nepean. I am just trying to think, but there are a few other places.

CHAIR—They must not have done a media release. We will be able to find it by having a better look at the web but we were grasping for what was public knowledge.

Prof. Rosen—None of these are my geographic areas where I work. As Dr Gurr alluded to, I think the problem is that most of the enhancements are hospital centred, either in in-patient units or in emergency departments—they are the big enhancements. I think the model is returning to fortress psychiatry, with staff being discouraged from moving outside the hospital boundaries to support families and individuals in their homes, whereas the evidence suggests that that is what we should be doing. I was not going to address the particular example of Concord and Rozelle today, but I can provide you with two papers. One is in terms of advice to the New South Wales government about what they should be doing with the current Sydney university proposal, which we think is wrongheaded. I am Sydney university Faculty of Medicine, by the way, but I do not think this arrangement with the university gives anything back to consumers or families.

The only enhancement that has come out of the closure of Rozelle Hospital has been a hospital enhancement at Concord. Basically, that site is worth a lot. If it is going to be turned over to the University of Sydney they should be developing initiatives which give consumers training and secure jobs onsite and developing training and qualification courses in being peer support workers. A university should take that up as a matter of pride if they are on a psychiatric hospital site. It is an issue of land rights.

CHAIR—And significant land.

Prof. Rosen—I acknowledge Aboriginal land rights here, but beyond that this land was dedicated for the wellbeing of people with mental illness. It is being given away for other purposes without any recompense to people with mental illness that would aid their recovery in any real terms. If you look at the similar situations that happened in Victoria and in New Zealand, a lot of psychiatric hospitals were closed and a lot of that money was transferred into both the hospital and the community for a range of services, including cluster home programs. They are almost like retirement villages, but people have their front door facing the street, so they are not so stigmatised in terms of housing. They had support and a clubhouse in their backyard. They had 24-hour support. A range of other services like that were provided. The money was not just put into hospital services; it was put into the range of community alternatives that were required.

While that has happened in Victoria and New Zealand, it has not happened to any large extent elsewhere. It certainly has not come out of the psychiatric hospitals. A lot of them have in a sense become part of the ambivalent non-model that we have in New South Wales, which tries to support every direction at once. It tries to keep the psychiatric hospitals going and tries to do some mainstreaming into general hospitals and community health—redefining mainstreaming as only being on hospital sites and retracting the community health centres, not just for mental health, back onto hospital sites, including Sutherland.

I have given you a document that we presented to the Garling inquiry into New South Wales health services. This gives you the list of services throughout New South Wales which either have been retracted from community to hospital sites or have been proposed to be retracted, plus the list of crisis services which have been dismantled or partially dismantled so that they cannot go out at night or on weekends. You have a crisis service in many catchments that is only funded to provide services on weekdays. I can understand management being under enormous pressure over funding and that these are the choices they have felt obliged to make. It is partly management and partly the loss of culture, where they do not see the point of going out at night or on weekends to support families and individuals with mental illness to prevent them from presenting to emergency departments. No wonder we have this crush on emergency departments. There are other factors as well, but we are adding to those growing factors of co-morbidity with substance abuse, which is putting pressure on our services, by relocating our services to the front door of the emergency department rather than the front door of people’s homes.

We have to reconsider what we are doing, particularly as the international evidence and the current reports—both the very recent Darzi report in London and the John Menadue report, which you and your colleagues put me on to—squarely support the development of more community health initiatives. We need to watch what is happening here, because by the time we sell off all the community centres—not just the community mental health centres—relocate them behind the boiler house and the laundry, where these things usually fit on hospital sites, and decide that they need to be back in the community at the shopping and transport hubs, we will no longer be able to afford to buy them. They are being sold mainly to support hospital rebuilding programs, and they are not making a huge contribution to that. You have to make a contribution locally to that, and it is put in terms surplus properties and economies of scale, and some people are unofficially using the capital charging ideology or language to do that, although they are not official mechanisms.

Treasury and assets management parts of the health departments are having a big say in what the priorities in health facilities are. Their priorities are to consolidate onto hospital sites. This is exactly the opposite of where the evidence is going. It is exactly the opposite of what is happening in London and what is happening in terms of the planning and the expert reports in Australia.

CHAIR—The paragraph beginning ‘This retreat to fortress medicine surgery ...’ is about that.

Dr Gurr—There has been capital starvation across the states in the system for an awful long time. In my area, I have a chief executive who is in favour of having things in the community. He endorsed us spending money on getting a strategic plan done for the next 15 years. But the sticker shock when they realised how much money might need to be spent on providing adequate community based facilities for community health, mental health and drug and alcohol—we work as an integrated set of services—made the deputy CEO’s face blench. It was seen as a slightly courageous political exercise to send this document up the line. I cannot talk more about it because it is not yet official. It is about to go to New South Wales Health. There has been a real issue. Along with the running costs and the recurrent starvation, there has also been a considerable capital starvation issue.

Prof. Rosen—The consequences of that are very dire. I also want to raise two other issues, if that is okay. One is the importance of the accountability mechanism for overall mental health services and mental health reform across Australia, and the precedence of having a mental health commission in New Zealand for quite a number of years now and the one that was initiated in

Canada last year. The importance of the one in Canada is that it is in a federated context. We were told several times by the Commonwealth Department of Health and Ageing that we could not consider a mental health commission such as they have in New Zealand because we are in a federated context and it is just not possible.

CHAIR—So you found one.

Prof. Rosen—We found one. It is not a figment of our imagination, although it could have been.

CHAIR—You responded to that argument.

Prof. Rosen—Yes.

Dr Gurr—There is government support over in Canada as well.

Prof. Rosen—I must say that Canada does look to the National Mental Health Strategy as one of its sources of information in their own planning.

CHAIR—So they look at our National Mental Health Strategy?

Prof. Rosen—Yes. We are hoping, as the Chair of this committee knows, that we will get the active mental health commissions in Australia together with your committee. We think it would be a good thing for the health commission and government generally to have an involvement with that. We hope that that meeting will occur by February 2009. However, it is important to note that they do not just have a narrow focus on accountability and on empirical and qualitative measurement. Those things are very important and I could address them separately. But to summarise the other two pillars, there are three legs of the commission in New Zealand. One is accountability, measurement of what is happening and what is not happening, costing the gaps and getting governments to commit, as they come into power, to fund those gaps. That has happened in New Zealand with huge enhancements compared to both the Australian public and private per capita funding combined. The second pillar is looking at the workforce and making sure that that is adequate. The third pillar is looking at community awareness, stigma and discrimination and dealing with that from a grassroots level up. That agenda is both for indigenous populations and for the wider population. We could learn from that. I have submitted a paper on the mental health commission to the original Senate select committee.

CHAIR—And that was the core element of your evidence at that time.

Prof. Rosen—Yes. I do not know if you want me to resubmit that.

CHAIR—We have got it.

Prof. Rosen—That is good.

Dr Gurr—I think there is a political advantage for a federation like Australia to have a commission. If you look at all our peak bodies they are all beholden to one vested interest or another. We do not really have any organisation in Australia that clearly takes a more dispassionate view of the evidence and the sorts of services and how they might work together et cetera.

CHAIR—Do the peak bodies agree with that assessment?

Dr Gurr—They may not, but, as an observer, I am saying that is our view. The Mental Health Council of Australia is a useful organisation, but you would have to say that it is mostly run by the non-government sector. They have the sway within that organisation. Other professional groups clearly have their own interests et cetera, so I think it is about how you have something that is arms-length from government that can assist in pulling together the evidence and proposals and what have you. The government does not actually have to pick them up, but it has at least got advice that can be pulled together without quite the same political stresses on the politicians having to make the decisions. So there is an opportunity then to be able to more easily go with what the evidence says you should be doing rather than just having it positioned as government making a decision in favour of this group or that group. But anyway, I just wanted to say that I think it is a mechanism. And I think other senior public servants say: ‘No, if you have a specialist commission or a specialist commissioner in the health reform commission, mental health will lose out in the long term. Somehow you’ll be sidelined.’ I do not agree with that. If you look at examples of where there have been commissions or stronger organisation structures to support mental health, mental health has done better. I think that is absolutely true in New Zealand; it was true in Victoria where the way the mental health was structured in that department, at least before they mainstreamed, meant they managed to have stronger services and implement more evidence based practices across that state. And I think the Canadian experience is probably going to bear it out as well.

Prof. Rosen—I would like to clarify something: both Dr Gurr and I are on NGOs that are represented by the Mental Health Council of Australia; we think they do a fine job. We think there is a balancing act involved though between different interest groups and constituencies. What we are really talking about is, firstly, supporting NGOs involvement; secondly, that they should meet priorities of local services and they should be coordinated with local services—that is not happening in either the state programs or the federal programs; it is to do with the funding mechanisms more than the NGOs as the NGOs apply for what is available—and, thirdly, we should therefore support the involvement of a mental health commission across the whole mental health sector, both federally and at state level. But one of the keywords is ‘independence’. A key idea is that it should be a standing commission, not a temporary commission.

Dr Gurr—I certainly do not want my remark to be seen as me being negative of the Mental Health Council of Australia because I am a great supporter of it as well.

Prof. Rosen—The last issue I wanted to raise was that of the Australian national mental health service standards. I am involved with the review of those standards through its steering committee. I will not address those deliberations because they are still within the review process. However, I was also a member of the authorship of the national mental health standards, which are the existing standards. I was part of a consortium organised through the Commonwealth government to have those standards produced and to have an accreditation survey process organised around them. We have watched their progress. We have been advocating for a review for some years, so we were really glad of it happening.

I also chair another committee for the Australian Council on Healthcare Standards, but I think there has been a problem with the review. That is that the Commonwealth department of health, rather than assigning a consortium to do the review—as there was to produce the original standards and to see them through—gave this job to the Australian Council on Healthcare Standards. I think there is a problem there in that they are too close to the work. What they are producing is a set of standards that are convenient for their accreditation process rather than a set of standards which will be acceptable to all the constituencies in the mental health field.

CHAIR—What is the time frame for that work?

Prof. Rosen—It should be reporting back to the Commonwealth in, I think, April or May this year.

CHAIR—So it is imminent?

Prof. Rosen—Yes. Part of it has been the pressure of the time frame. It is not just the Australian Council on Healthcare Standards. It has been the Commonwealth that have provided this set of contractual arrangements. Part of the input from the Commonwealth department of health has been, to some extent, to rewrite the standards in a much more longwinded form and also to somehow try to discourage what they call ‘aspirational standards’. Aspirational standards are what we would call optimal standards in terms of the quality improvement and standards area, where you encourage services to go from operational and from minimal standards to a more optimal way of operating which will suit both service users and their families a lot more because it will provide them with a recovery focus. I think public services are struggling to do this. The NGOs have taken on that task very squarely, and we are trying to get all services—public, private and NGO—to address those priorities. So ‘aspirational’ gets used as a sort of dirty word, and we would prefer that people look at the history of providing standards at a range of levels which try to encourage people to look to the ceiling and then make that the floor for their next step and to always try to improve their services. That is one of the issues.

One of the other issues is that there has been no mental health expertise employed by the organisation developing the standards. There is a lot of unpaid time of mental health professionals being employed to try and provide voluntary input. It has been willing input, I must say, and there has been some very high level input. But the problem is that, first of all, there are constituencies that have been left out of the process. There are no allied professionals: no psychologists, no occupational therapists and no social workers at all on the steering committee. We are told it is not supposed to represent any particular professions, but there are five of my colleagues, including me, on the steering committee and there is one nurse. Apart from that, I think there are other people in other organisational roles but there is no-one from the allied professions. There is some consumer and carer input, but I think it is sometimes a struggle to have their priorities heard in this process that we were talking about.

CHAIR—We have not had that drawn to our attention before today, so that is something we will certainly look at.

Prof. Rosen—There are no Aboriginal people in the working groups. Both social workers and occupational therapists had to protest to actually get a seat on those working groups. The working groups are not regularly consulted and I do not think that there seems to be any current plan to involve them heavily before the completion of this project. I might be wrong there, though, but they certainly have not been kept up to date on how the various steps of the process have developed.

It is a contractual process, so they have to complete it. I understand that—I think it should be completed and handed back to the department of health—but I think it would be terrific to have an independent look at these standards, to have some form of independent task group consult with the parts of the sector that have not been involved to make sure that we involve everybody who has an interest in having good mental health services. The existing set of national standards was very well accepted. They have their drawbacks, mainly because it is 12 years since they were implemented. They do need updating, but they were essentially very well considered by consumer and family groups. They stood up for them, held national mental health standard festivals and put out various bookmarks, fridge magnets et cetera celebrating the standards because they thought the standards represented a good thing. Should I use the term ‘aspirations’?

CHAIR—I think so.

Prof. Rosen—They represented their aspirations—and not in any derogatory sense. I think it is really important that we do not lose that goodwill and that we get the standards back on track. I would commend that recommendation to you. I am not sure how it should be done, but I would also recommend that an independent task group review the standards. I think that this time it requires mental health expertise within the task group to work on these. With the original standards we did have a very experienced mental health worker pulling them together. The objection that we heard in ACHS was: ‘This person is a nurse; how could they represent all the other professions?’ The person is question was a terrific person, working with a committee of different professionals, consumers and carers, and they were very good at consulting all professions. It does not matter which profession you have in there, but you do need mental health professional advice. I think that is one of the problems that has caused the struggle for the Australian Council on Healthcare Standards. Part of it was that they have had a huge turnover of project officers and there has been no project officer with any mental health expertise. The project officer is a key position in such a review, and it should be a key position in any independent review.

Senator ALLISON—Can I ask what qualifications this project officer had or has?

Prof. Rosen—There has been a sequence of them, but none of them have come from the mental health sphere. I know at least one who left was an occupational therapist but was not from the mental health arena at all. Mental health is such a complex sphere and you really do need that expertise. It has made it difficult for the existing project officers who do not have such expertise who are trying to anticipate what the mental health sector requires. I have some sympathy for the people who have been involved in doing this review. I think the way it has been set up has been unfortunate from the beginning. We should be able to retrieve it, and I believe the way to retrieve it would be through an independent review.

CHAIR—How long has it been going?

Prof. Rosen—It has been going for over a year. It started late 2006. I think it was September or October 2006.

CHAIR—Your evidence has covered a wide range of areas, but it all goes to what we are talking about. You have been putting forward your position, and I will now ask whether committee members have any questions.

Senator ALLISON—I have a general question. Why is it that the state government is going against the evidence in contracting services to hospitals? You have said that there is pressure on funding. Are there other factors as well? Is there a political imperative here? Is it that people do not want to be confronted by mental health centres in their communities? Is it a stigma issue, or is it just obstinacy? I do not understand how you cannot get this through.

Prof. Rosen—I do not think it is obstinacy. I can see all the pressures on funding that occur. I do not think it is stigma. It is creating stigma to put people on the backblocks of hospitals.

Senator ALLISON—So it is just about money, is it?

Prof. Rosen—I do not think it is just about money. As I mentioned before, I think it is partly about the monetary pressures and partly about loss of culture. People who were brought up with New South Wales developing much of the evidence in this sphere have now moved on and we have people who were not involved in those original studies or in implementing and generalising them at the beginning of the National Mental Health Strategy. Victoria took them up literally. In New South Wales, we always did them in a patchy way, partly because we have a system of regions, and now area health services, which tend to take some policy direction but go their own way in interpreting that policy direction. That has certainly happened in mental health, so there has been no consistency, for instance, in the intervention that Dr Gurr mentioned: the assertive community teams. There is a small handful of those in this state; they are spread out in most sectors of Victoria. They are evidence based, there is a very large literature on their effectiveness, but we have a small number here. In Kings Cross, where our homeless concentrate, and where the intensive assertive case management model has been shown to be most effective, it was dismantled, partly because of monetary pressures and, I think, partly because of loss of culture.

Dr Gurr—You have got to understand that decision making in health departments is usually done by people who have come up through hospital settings. You basically get people moving up through hospitals, then on to regional bodies and then into head office. So they are not usually people who have actually experienced working at a community level. I think, as Alan says, there are a lot of cultural factors that lead senior doctors to like to group together in large teaching hospitals, and the people that end up in management positions. I do not think it is uniform. Different chief executives have different views. Some are now more open than others to exploring hospital capacity management. Managing your bed-day budget means that you have actually got to think again about how much you avoid admissions, how you manage people in the community more effectively and how you allow for faster discharge. So case mix is about how you keep reducing the lengths of bed stays to reduce your costs, but to get good outcomes you need to be working on people in the community.

I am concerned, for instance, that in mental health there is no incentive for a psychiatrist to talk to a GP. I have done lots of training of GPs, I have been involved in all this Better Outcomes work and so on, I know that I can run any number of sessions, but they still will not actually apply the stuff because there is no supervision in practice. There is nobody to actually work with them in their practices on dealing with their difficult patients. My fantasy is to be able to get enough psychiatrists in the public sector so I can actually roster them to take off our computer the case lists that belong to a particular GP or their practice, go and have lunch with them and do a 'ward round': run through the patient list with them and discuss all those patients, then have time to talk to the GP about someone else that they have seen that they are concerned about—in a sense, treat them almost like registrars in training in psychiatry. In that way, we would build their competency and their capacity to actually do more of the work more effectively through their practice. The current mechanisms do not provide the incentives that really enable those effective things to happen. I think that a mechanism that enabled the Commonwealth to sponsor some processes would enable us to experiment with what I think are fairly obvious changes in motivation and incentives and to provide the ability to get together.

Headspace was an attempt to do that. It was the one-stop-shop idea of getting the GPs to go and then working with the NGOs and also having state clinicians there. But the trouble is that the model was flawed because, again, it provided some infrastructure money to start with but it was then assumed that you were going to keep the whole program going by charging facility fees to keep the infrastructure there. It did not understand that GPs are small business people in their own surgeries, and they do not particularly want to go to the one-stop shop. They are happy for you to employ people on sessions, but they are not going to leave their practices. What they want is the virtual team, and they want relationships. I have also been working with the HealthOne project in Mount Druitt. There is a major project there to work with the GPs to create a connection and relationships between general community health nursing staff, the GPs and the other disciplines. The GPs labelled adolescent mental health, youth mental health, as a key priority for them—a lot of public housing, a lot of substance abuse et cetera. But, in terms of actually implementing it and getting it together, the current mechanisms and incentives are just not right.

You need to have some flexibility. We need to be able to say, 'Okay, where a fee for service is an appropriate incentive and a way of getting the best bang for the buck, we should be using that,' but, when we actually need the GP or someone to do something else, we need a mechanism where we can pay them an hourly rate or some other thing to say, 'Now we need you to do this other function that will lead to quality or will lead to the discussion that is necessary.' Mental health is a lot about discussion. You have to impart a lot of information. You have to negotiate. You have to work out—because it is not clear cut. It is not a simple diagnosis, a simple decision. It is about multiple factors, how we are going to deal with those multiple factors and who can actually do what within a team that will work together as a true team. There are a lot of issues. I think it would be really good to have a seminar, a forum or something or other where there is a bit of concentration on just looking at all the funny methodologies and how they might be better worked, and get the best minds in Australia together to look at it.

Senator ALLISON—Just going back to the state government: the language they use seems to match what you are talking about. We have $699.7 million being spent on 'integrating and improving the care system', but, of those items, one is about a new forensic facility at Long Bay prison and many of the others are about emergency care in hospital—

Prof. Rosen—It is very interesting.

Senator ALLISON—improving beds, and people in hospital.

Prof. Rosen—That is right. I have heard some interesting terminology thrown our way. Those of us who support community mental health centres or community health centres—it is not just about community mental health; it is about community health, which is being removed back on to hospital sites and becoming traditional Outpatients again, because they are all being collapsed together into cubicles on hospital sites—are told we are 'anti mainstreaming'.

Both Dr Gurr's service at the time and my service were the prime examples of integration and mainstreaming used by the National Health Strategy under Jenny Macklin, when Brian Howe was the health minister, in starting up the National Health Strategy and then the National Mental Health Strategy. Mainstreaming, when it got put into those National Mental Health Strategy papers, was about getting people off stand-alone psychiatric hospital sites and getting them to where other people got their services, which was both hospitals and community mental health services. I think in this state—and maybe elsewhere, I do not know—they have redefined 'mainstreaming' as putting everything on hospital sites. They say that people who are not for that are anti mainstreaming. It is interesting. Mainstreaming, as Senator Allison would well know, comes from the education sphere originally, and we adopted it in the health sphere. Now it is being, I think, misused for convenient purposes, which I think are mainly finance related.

The other thing we are called is 'separatists'. Separatists are those who want community health centres on other sites than hospital sites. We are actually both partial initiators, amongst a large group of others, of integrated services—of making sure that hospital and community services in mental health were under one management. I think that preceded other hospital and community services getting together under one seamless management and one seamless trajectory between hospital and community. So we sort of object to being called separatists too, just because we want people to be able to access services where it is most convenient for the families and individuals involved.

Dr Gurr—I think the answer to your question is partly that it is a media driven problem, in that there was a real need to get people moving through emergency departments to get rid of access block and the problems that were occurring there, so more resources were put at the assessment front end, as the doorway. But we know that there are so many other doorways that you can use just as effectively. If I look across my area health service, I have at least three models I can look at. There is the Blacktown model, which I was involved in, where we had a much more effective community based 24-hours-a-day, seven-days-a week team that would assess people wherever. It has the lowest emergency department presentation rate, compared to just up the road at Nepean, where they have never been able to get a very effective 24-hour access team going, so people have learnt that you actually go to the emergency department—that is your entry point for mental health. Whereas, at the Cumberland Hospital end—which is a stand-alone psychiatric hospital now attached to the city hospital, with the Cumberland children's hospital and Westmead Hospital all contiguous—it has an admission office, so people turn up there to get assessed. That is because, again, their community service at that end was not organised in such a way that people really had much other choice. So we are in the process of turning that around so that we will be funding and using enhancement money that is coming in New South Wales—because there is planned and ongoing enhancement money coming into the community health services, including for these sorts of emergency health care. I think there is another $3.9 million in this coming financial year and another $2.9 million already flagged for the year after that.

Unfortunately, I think that the model of care had not been fully thought through as well it might have been. It is all very well to assess people, but then what do you do with them? The reality is that you need to have the staff who assess and also are able to provide acute care in the community, in the person’s home, and flow with them back to the place. Once you have made a rapport with the consumer and you have the trust of them and their family—you do not have to keep telling your story several times; you have told it once and it has been heard—then you are able to make sure that systems work as systems. It is the psychological management, it is confidence levels, that matter to families. Otherwise we create a system that says: ‘The only safe place is in hospital. That’s where you go and that’s the expectation. That’s where you stay.’

In mental health, we know from our studies that you need to base your senior decision makers, your psychiatrists and so on, actually in the community. They need to have their base in the community and visit the hospital in order to create the teamwork at the local level. We need the community centres because a large proportion of our consumers are on benefits. They do not have cars. They cannot travel to out-of-the-way places. A lot of new hospital sites are not particularly in the centres where the public transport hubs are. So our ongoing plan has been working out how we get back to having services based at the hubs so people can access them.

Prof. Rosen—Could I answer as well, just to supplement what Dr Gurr is saying. You were asking why a state government would rationalise that they are running an integrated service when the number of community services they are dismantling seems to run against that rhetoric. One of the things they say is: ‘Well, those services we have placed on hospital bases are not complaining. They seem to be getting people coming to them.’ I work also in the far west of this state, in Broken Hill, where they have done that. They have put the community health service, which was located in a community setting, now on the hospital site. Even during working hours, the bus only travels there every two hours. It is on the outskirts of Broken Hill; whereas the Aboriginal owned medical service and community services bought an old pub on the main street and converted it into a community health centre. Why do they know something that we don’t know about where you should be accessing the population? Why do we make it so difficult? Once you move onto a hospital site, you start serving hospital centred priorities.

Senator ALLISON—You get rid of your waiting list a bit, I suppose, as well, don’t you.

Prof. Rosen—But the other thing is that the state government quotes at me the particular hospitals and community services that have been co-located at hospital sites and it says they report no problems. The administrations of those are made up mainly of people who have been hospital based in their clinical experience. If you talk to the senior staff of those services, you will find that the hospital based people support the hospital co-location, and those people who have been moved from the community grieve the fact that they have lost the community location and the community connection. That is currently happening or has been threatened at Nowra, where they are being told that they cannot do home visits outside of 9 am to 5 pm Monday to Friday. They are putting three out of the 11 positions on their crisis team into the emergency department to run a 24-hour emergency department operation. That is in Nowra hospital—can you imagine that? How many presentations are you going to have to Nowra hospital after midnight? People are only allowed to twiddle their thumbs between these sparse presentations. What they have done in the past is to have a roster where people can go on call to community or home before that. So basically what they are doing is replicating these urban hospital base models—beefing up emergency department like you would want to do at St Vincent’s Hospital in the middle of Sydney or in Melbourne. But would you want to do that in Nowra? Or would you rather make sure that you have a mobile service that is connected with its community?

The same thing is happening in Bathurst. You have heard of the problems they are having at Bathurst hospital. Both the community health centre and the community mental health centre have been moved off King Street, the main street of Bathurst, and into the hospital which is again not anywhere near the centre of town. They are all based in little rooms that have no windows. So it is not a very welcoming context to invite people into.

Senator WEBBER—I have a couple of questions about the issues you raised about the methodology of funding. My first one is: when you talk about examining the methodology of new funding are you including the new MBS item numbers in that, because that is a huge part of the federal funding?

Dr Gurr—Yes. It is interesting how few of the people who are going and getting a referral from their GP and having the expensive plan written actually go back for a review. If you look at the number of reviews, you see that they are very low by comparison. That says to me that either people have gotten better or it is the easier end of the spectrum that is being looked after in that process. I do not know whether the patients are turning up or what is going on. You can only surmise. It was interesting, when I recently looked at the website to try to see what data is actually available for us to look at and analyse, to see that all you get is the gross figures for an annual basis or by quarter for the state or nationally.

I am saying that I have a problem because we have been looking at the effect of the MBS items for the other disciplines as well and again the model of care that that is based on is specific treatment behind closed doors in a room somewhere—which is not really how most of mental health work needs to be done. That is fine for certain diagnoses. If you want to have CBT for an anxiety state then that may be an effective treatment. In the UK they had a high-powered committee that recommended that the UK employ 10,000 more psychotherapists, particularly to do CBT. Lord Layard said, ‘Whatever you do, make sure you put them in groups of about 20 and give them a structured environment so that you can actually provide structured supervision, quality measures and the training et cetera.’ All the evidence for CBT has occurred only in structured environments where there are those factors. We have no evidence that CBT being done in individual therapists’ offices is all that effective. As someone who has referred many people to CBT and then had them returned unfixed, I can say that CBT also has a limited spectrum—unless you take into account the psychodynamics of what is happening as well as the purely behavioural aspects you just do not get the outcome you want. Of course the way it is set up in MBS is that you get X numbers of sessions, with repeats if the GP reapplies. My experience of private sector services is that people either use all of the sessions and then come back to the public sector, maybe in certain circumstances, or they may not actually get the treatment that is needed. There are no real checks and balances in the system to figure out what has happened.

Prof. Rosen—Could I add to that. There is further evidence, from a study by Jane Pirkis in Victoria, that the new item numbers for psychologists work better when the psychologists are co-located with GPs than when they are located in their own rooms; and that may be to do with the structured environment as well. What underlies this whole dilemma is that you cannot just have disembodied interventions costed. To some extent that is both the virtue and a problem with the work of Professor Gavin Andrews. Professor Andrews has produced a superb volume looking at each individual diagnostic state and looking at the interventions that are required for that and at the costings for that. There is not equivalent attention given to the vehicles or the vessels or the structured service systems in which those interventions have to be delivered. In other words, you cannot just provide to a particular geographic area, ‘This is the amount you’ve got for interventions,’ unless you build up the subsystems and the team structure and the management structure to make sure that they occur and that they get out to the people who need them. So, basically, when you are looking at evidence you need to look at the evidence based interventions and an equivalent list of evidence based service systems. I can provide you with that sort of list, if you would like it.

Senator WEBBER—You were talking about the need to review the methodology of funding. Do you anticipate that that needs to happen more urgently than the planned five-year review that was agreed with the COAG thing anyway?

Dr Gurr—I just think, with the Health Reform Commission process and the 2020 Vision process and all the rest of it, that now is the time—sooner rather than later—to have a good look at those things. What we do not want is another national health agreement and other processes coming into place before that review has actually occurred. I think it would not be all that hard, either. There have been a few articles about changing GPs’ practices through changing and tweaking Medicare for other issues in general health as well, because, again, the incentives are not quite right for—maybe for diabetes; I cannot remember what topic they were looking at, but chronic disease is clearly an issue.

Senator ALLISON—We have not had a chance to talk about a whole range of programs, such as PHaMs. Dr Gurr, you touched on the psych nurses and I think you suggested that that was a bit of a waste of money and time.

Dr Gurr—It was very difficult to implement. I do not know what the stats are, but I will bet it has not been taken up very much because—

CHAIR—We have been told it is ‘early’ in the rollout.

Dr Gurr—Well, it’s a whole year now almost, isn’t it?

Senator ALLISON—Why is it problematic?

Dr Gurr—It was decided that the only people who could actually act as agents, in the sense of facilitating it, had to be Divisions of General Practice or maybe some other sort of private entity. And the states were not allowed to have any involvement through their services in providing such an entity to help to organise it.

CHAIR—It was one of the ones away from the public health system.

Dr Gurr—Yes. So we have basically tried to work with our GPs because we could see that the target groups are exactly the same. The target group for people who are going to need at least two years of mental health services is the target group that these nurses in a practice or with private psychiatrists is supposed to be supporting. Then you have got the PHaMs, the Personal

Helpers and Mentors Program, which is aimed at that target group. And then you have got the people supporting the activities of daily living who are targeting a somewhat similar target group. The penny dropped for me and I thought: we’ve got this assertive community treatment theory and practice, and that target group is just the target group that actually fits that sort of program, so wouldn’t it be better for us to make sure that we provide some way of integrating the processes so that the practice nurses are clearly linked with a team that has the mental health clinicians who are targeting that group and with the other NGO that has got resources to actually provide support services to that target group? Even co-location is a simple way of doing it. The GPs themselves found it too difficult to organise the infrastructure to arrange for the nurses. The GP divisions in my area did not see any value to them in trying to organise it; it was just another hassle. I think the government then changed the rules and provided some sweeteners, I think, to Divisions of General Practice when they realised nothing was going to happen unless there were some additional incentives.

Again, I think this could be put into some sort of arrangement where we had a better regional structure to do the purchasing and the organising and that was not just linked to any particular group. The integrated project in Illawarra had a steering committee that covered that. There was representation of private services, NGO services and public sector services. Bill Barclay was the previous health commissioner who ended up being the chair of that, but he was in private practice as a psychiatrist at the time he was doing it. And that actually worked.

CHAIR—I am going to have to pull it up there because our next witnesses have arrived and they have got very tight time frames. Thank you for your time. Senator Humphries had some questions and we will send them to you, and let us know if there is anything else you would like to add. Dr Rosen, I know that you are sending us a lot of papers—we have got some today and you have others you want us to have. I have only one other question. We know that there is supposed to be a consultative committee on mental health set up by the state government. Is either of you two gentlemen on it?

Dr Gurr—I would not be, as a—

CHAIR—No. I am just putting it on record.

Prof. Rosen—No.

CHAIR—Thank you.

Prof. Rosen—Could I make one clarification. Regarding the issue about a separate commission rather than part of a general health commission, the wisdom we have had from other commissions that exist internationally is that, if you have a mental health part of a general health commission, the same thing will happen as happened in general hospitals: mental health goes to the bottom of the priority list and the bottom of the pile, which may be something to do with our internalised stigma as clinicians. So it is better to have a separate standing commission.

CHAIR—Your recommendation consistently has been to have a separate commission along the lines of the New Zealand model.

Prof. Rosen—Yes, and of the Canadian model. The other clarification is that the Mental Health Council of Australia also has been trying to plug away for an independent body of this kind—which they call a council—which is based more on the drug and alcohol council model. But the Canadian model is wider than that and the New Zealand model is even wider than that. The Canadian one also includes collecting best evidence for the best interventions and the best service systems, and they are very mightily funded for that.

CHAIR—Thank you for your evidence.

[3.22 pm]

JAMES, The Hon. Gregory Reginald, QC, President, New South Wales Mental Health Review Tribunal

CHAIR—Welcome. I understand that you are working to a very tight time frame and we appreciate your making time to appear today. You have appeared before the committee before so I know you have all the information on parliamentary privilege. Would you like to make a short statement, after which we will ask you some questions.

Mr James—Such as we can to assist the committee, we wish to do. New South Wales recently embarked on a 10-year consultation process yielding the Mental Health Act 2007. That act, however, was not passed in the form in which it was originally envisaged. As originally envisaged, it was going to embrace both involuntary treatment within the community and involuntary treatment of persons who had become forensic patients by reason of having been found not guilty by reason of mental illness, unfit for trial, or transferred into the mental health system having been sentenced. It was, however, determined that that latter group of people would be dealt with by separate legislation.

When I was appointed, I was asked to embark on a lengthy consultation process again, chairing a task force of some 25 agencies—which, if we had ever sat as one group, would probably never have concluded its deliberations, so they were consulted individually—and, in addition, to make recommendations for reform. A consultation paper was prepared, produced and circulated widely, and a review occurred with the report being handed to the government on 1 August last year. It is still under consideration and it may well be that, although it has not yet gone to cabinet, a copy of that report may be made available to the committee by request to the chief of staff of the Minister Assisting the Minister for Health (Mental Health). The acting chief of staff is Mr David Crudesom. It is expected that cabinet will shortly determine what course it will follow.

The principal issue in relation to forensic patients concerns the continued existence of the executive discretion in New South Wales, and there are recommendations in relation to that and a number of other issues. Similarly, questions have been raised as to whether the civil provisions now contained in the Mental Health Act 2007 will permit the utilisation of community treatment orders within the community not only of persons at liberty in the community but of persons within their jail communities, which would hopefully avoid the necessity to hospitalise people who do not otherwise require hospitalisation or to move them all over the state.

The Mental Health Act 2007 has as one of its primary concerns the position of carers and family. Until now, privacy legislation and health records information legislation have prevented—at least legally—full and frank discussions with persons who may be affected by the actions of those living in the community who suffer from mental illness. The present act has set up a somewhat complicated calculus for defining primary carers to whom such information can be given. It has widened the ambit of community treatment orders to permit them to be given to persons who have never been hospitalised. It has foreshadowed the prospect of such orders being given to persons who have not relapsed but who are severely at risk of relapse. Though, as the provisions are presently drafted, they are attended by a great deal of doubt. One has to look to a historical relapse in order to be able to afford compulsory community treatment orders to persons who object but who are likely to relapse without them. That is one matter that I would expect the government will address in the immediate future.

On the forensic side, Victoria has recently commissioned Professor Bernadette McSherry, with the assistance of an Australian Research Council grant, three PhDs, four doctoral students and a research staff to produce model mental health legislation.

CHAIR—Model legislation?

Mr James—Yes. Professor McSherry’s grant extends over some five years. I commend to you the result, but the committee might have to resolve the matters before then.

CHAIR—I know! Model legislation—that is interesting.

Mr James—In the mental health forensic field, however, the review that I have already done for the state government deals with a great deal of that. There is a consultation paper presently available and I can leave a copy of that paper and of the 2006 annual review from the tribunal, which sets out our functions in some detail and gives you some statistics. It is the 2006 review rather than anything more recent because we have changed our reporting year and, consequently, it is the most recent of our reports.

We deal, as you will have gathered from what I have said, with both the civil and forensic sides. Yesterday I addressed the judges of the District Court at their conference concerning the forensic side. There is still some difficulty until the new legislation—if it comes—is introduced with the judges knowing precisely how to make orders that give access immediately to the relevant hospitals or institutions.

New South Wales is building a new hospital immediately outside the walls of Long Bay jail together with a new hospital inside Long Bay jail. The hospital outside is primarily designed for persons who have been found not guilty or unfit. The hospital inside is for those transferred during their sentence to short-term care. The big problem area is not at that level. It is moving from there back into the community, and it is a similar problem that applies to civil patients.

The availability of mental health drug and alcohol care, particularly supported accommodation and rehabilitation accommodation within the community, is our single greatest need. I think that is widely accepted. It is widely accepted that such care can be provided, not only in urban communities but in the more rural communities, particularly through the assistance of rural doctors networks and trained, skilled paraclinical—if I can call them that—staff resident in the relevant rural communities. Funding for such operations will enable people to move from urban environments into such supported accommodation, where, frankly, they are much better off and much more obvious so their needs can be much more clearly met and people do not have to be confined in anything like the same way that they have to be to avoid them coming into trouble in the city. All of these are options that are under consideration, but it takes a long while for anything to move in this field.

The tribunal’s function is to monitor, essentially, what happens with individual patients. Whilst we talk about orders, we are making the orders that clinicians determine are appropriate. We ensure that they are made within the legal and clinical parameters, but we cannot take over from clinicians. We deal with some 10½ thousand hearings a year. We have approximately 100 members, of whom a third are lawyers, a third are psychiatrists and a third are others suitably qualified, usually coming from health clinical care and many years of experience. We have been lucky enough to be able to recruit recently half-a-dozen skilled forensic psychiatrists to enable them to sit on the tribunal. That always produces tension, because there are very few forensic psychiatrists. They tend to do peer reviews of each other’s cases, so they all tend to know a fair bit about what is going on anyway. But we are a specialist tribunal. We are not subject to quite the same strictures that judges might be, coming, for instance, to the trial of a criminal case. We are expected to rely on our professional skills and our knowledge and it is expected that the experts sitting on the tribunal will contribute to an analysis of the questions that arise within their areas of professional competence.

We have a fairly limited budget, which I think is some $3½ million a year. It has not really increased in recent years, although the wages for members, after four years of freeze, have recently resumed parity with those paid elsewhere. We have also been lucky enough to recruit a number of former judges. An enlightened superannuation scheme provides that after the age of 60 those who are working part time can enjoy certain benefits, and that has enabled us—

CHAIR—It attracts people.

Mr James—Yes. It is very helpful indeed for that to work. That has the advantage, particularly when dealing with forensic patients, that you have people that know the legal and corrective services systems and at the same time enjoy a degree of public confidence. Should the tribunal receive the executive discretion, of course, it will be imperative that the community have the confidence in the tribunal that it would have in the judiciary. So, from that viewpoint, the recruitment of forensic psychiatrists and the recruitment of former members of the judiciary is fairly important. It will be a problem drafting that legislation because every state and every territory enjoys their independent views of the rail gauge in this field as well. The tribunal, however, annually meets with the other tribunals in order to try to ensure such consistency as we can have.

Our function is really as an adjunct to the health system. But at the same time it is an important legal adjunct to ensure that the community is aware that people are not going to sit in wards lost, as they once did and as they still can. There are patients who remain in care or on medication for very lengthy periods of time. It is our task to monitor that and regard it, where we can, as appropriate or, if not appropriate, to refuse to allow it to continue.

We have provided to the committee a written submission dated 18 July 2007, a copy of the consultation paper and a copy of the 2006 annual report. Would there be specific areas of questions that we might be able to help the committee with?

CHAIR—Senator Webber, could you give an indication of the area of your questions?

Senator WEBBER—Treatment orders, cross-jurisdictional issues, civil CTOs and—

Mr James—There are heaps of cross-jurisdictional issues. Firstly, the rail gauge is not the same anywhere. Secondly, there have been agreements entered into under the provisions of both the old act and the present act between the eastern seaboard states to permit patients to have their care ordered in one state in another state and to permit transfer to some extent of civil patients. There is nothing about forensic patients. We have an Aboriginal gentleman from Aurukun, and it is impossible for us to get him home to his community. Strangely enough, it is much easier to have people in that capacity, if they are forensic patients, go home to an international destination. One gentleman went home to Nepal perfectly contented, and various people go home to Japan—where they can be treated.

CHAIR—But not to Aurukun?

Mr James—No. One difficulty has been overcome. Thanks to the sense and competence of the clinicians and the administrators involved, patients can reside in Queanbeyan and work in the ACT and receive their care in either, whichever is appropriate. In terms of cooperation, of all the states, the best has probably been Tasmania. Quite possibly that is because there is a limited number of people with whom to deal and a very high quality of care.

CHAIR—So you have a channel—

Mr James—When I say ‘probably the best’, there is perhaps an exception. Norfolk Island is a little unusual. That may have been said before in another context. Norfolk Island has one forensic patient and, by arrangement, that patient has come to New South Wales.

CHAIR—By agreement?

Mr James—Yes. The patient was admitted to a hospital here. The present statutory provisions dealing with that provide that a person may be admitted to a hospital. However, they provide that only a forensic patient can be discharged. This patient is not a forensic patient under New South Wales law. He is happily tucked away in the hospital and we cannot get him out unless or until Norfolk Island agrees.

Senator ALLISON—How long has that gone on, Mr James?

Mr James—Only about a year. Clinically speaking, it is going well. It all has to be at a negotiation level rather than at a policy and proper implementation level. A lot of our matters have to proceed that way. It is only by dent of having sensible, practical administrators that the system works. In some cases, it does not work—for instance, forensic patients to Queensland is an example of it. I do not think anybody wants to have people whose circumstances have been blazoned across the front of a newspaper, despite the fact—

CHAIR—By preference, that would be good.

Mr James—that there is no medical speciality area called ‘forensic patient’. They suffer from the same ailments as any other patients do. It just happens that the display may be more florid and more dangerous for those immediately concerned. We have been lucky. We have had the support of victims organisations, because they realise, as we do, that the usual person who gets hurt when somebody has a florid outbreak of mental illness is the person who is closest—the member of the family. The family are victims, carers and the loved ones.

The tribunal procedures, as a result, in the past two years have been especially readapted to the needs of victims to enable them to attend—by video link or telephone or such choice as they might make—or not attend if they wish. It is a bit difficult when you have got a closed ward or a jail, because you have got to try to persuade your hosts to let people in. Unfortunately we had an incident where a family became very upset and put in place an unfortunate scheme which led to victims being barred from Long Bay for quite a period of time. They were going to introduce a son with a nail gun. That has made it very hard to get other people in. So, in order to permit access and at the same time avoid distress for patients and permit such proper discussion as there should be publicly—because our hearings are meant to be public—we hold video link hearings where necessary. We will have victims at Gladesville on video link into Long Bay jail and so forth.

We will hold video link hearings wherever we can throughout the state in terms of remoteness. Quite a number of the psychiatrists on the tribunal are also on the Northern Territory Mental Health Review Tribunal by video link from our studios at Gladesville. Recently we had the luck to be hit by lightning. This has resulted in us having new video link facilities, which has been very helpful. That means that we can cooperate with other agencies and we can have electronic and immediate video link communication with them. It is a facility we are finding very useful.

CHAIR—Is there anything under the act that means that your professionals have to be New South Wales citizens? Can your tribunal actually use Territorian or Western Australian psychiatrists and vice versa?

Mr James—Yes, there is, but it is indirect. I am immediately reminded of the controversy that erupted a few days ago at the idea of a national register of medical practitioners. There is a requirement that the legal members be Australian legal practitioners, which means that they have to have registration in a state or territory, which will apply throughout Australia. With doctors there is not the same requirement. They do have to be psychiatrists. The term ‘psychiatrist’ is not defined in New South Wales. In practice what it means is a New South Wales registered medical practitioner who also is a fellow of the Royal Australian and New Zealand College of Psychiatrists or some equivalent. Provided they have New South Wales registration, it does not matter a hoot to us where they live in Australia. We would be happy to accept psychiatrists—because the standard of practice is the same throughout Australia—coming from anywhere in Australia. That is what has led to our psychiatrists and others sitting in the Northern Territory. Certain psychiatrists, particularly in the forensic field, are called in evidence throughout the courts of Australia quite widely—Victorians journey to Darwin and so forth.

From the practical viewpoint, there is no reason why there could not be a body that would oversee compulsory mental health care of all kinds throughout Australia, if you wanted it to. The difficulties relate to differing state and territory regimes and what they get their tribunals to do. There is a consistency about what they get them to do. Queensland has a most complicated system for forensic patients, involving the Queensland Mental Health Court, which deals with a very narrow range of issues in an extremely ornate, expensive and lengthy style. It may well be that, when and if you get access to the report I have done, I might have said something about that.

There is another major problem, and that is: what is mental illness? From the point of view of a judge dealing with a criminal trial, it is what used to be called the McNaughton defence—meaning that the person is not to be held responsible in law for the act or omission charged because they were suffering at the time from a disease of the mind occasioning a delusion such that they did not know the nature and quality of their act or that what they were doing was wrong. That person may or may not be fit for trial as well. Unfitness to plead or unfitness for trial overlap, but they are legal concepts, not psychiatrists' concepts. Our definition of mental illness in New South Wales is not the same as the definition that is used in other acts. It is a definition that turns on the symptoms a person displays and the remarkable term 'a mental condition'. This means it is a practical working clinician's definition. The detail of it is gone into often but, in practice, the utilisation of it produces a result which is remarkably the same as would be produced under any of the definitions in use in Australia. That is because clinicians are all of the same standard and come from medical schools which have a consistency about their education and training.

Many of our people, however, are not psychiatrists—not those on the tribunal but those who furnish us with reports. They are career medical officers or registrars working in the various hospitals. A number of them are psychiatrists or clinicians, including case managers, working in the community agencies—all of whom provide us with reports. So far as I have been able to tell from dealing with the other tribunal members and from seeing what goes on in other states and territories, they are of no real different standard or concern. Frankly, it does not matter whether you are dealing with a forensic patient or a civil patient; the underlying mental illness conditions are the same and the treatment is essentially the same. The difference is that forensic patients tend to be detained for perceived security reasons. Civil patients tend to be discharged on the basis that they can be accommodated in the community much more easily.

It is a little unusual in that the courts and legislatures of Australia have recently been very much concerned about preventative detention legislation for people convicted of multiple sexual offences. In order for such people to be detained, two or three risk assessments by competent psychiatrists have to be conducted, and much care is devoted to whether or not a sentence should be extended by an additional six months or a year by a judge sitting on a special application. On the other hand, persons who may have come into the system by reason of an assault or lighting a fire, as forensic patients, will not be discharged unless they have risk assessments to that effect, even though, had they been civil patients who had conducted themselves similarly and had been merely charged before a magistrate, they would have been at liberty long ago.

The system is, however, in every state and territory, rationalising and looking to the safety of the patient and the safety of the community, as well as the ability to give effective treatment and preferably on the least restrictive basis possible. Australia has adhered to a number of conventions and they are set out in the consultation paper.

Senator WEBBER—Just briefly, how does the tribunal deal with the issues of dual diagnosis, particularly around substance abuse?

Mr James—People talk about 'dual diagnosis' but there is also treble diagnosis. You get people who are cognitively disabled, vulnerable, take to grog, take to drugs and develop—particularly after long-term use of cannabis or amphetamines—situations that are referred to often as psychoses. Whether or not that is the right term does not matter; they are displaying symptoms of mental illness. We have no difficulty from our viewpoint, because we are looking to treatment and mental illness in that symptomology sense that I referred to. But there is a huge problem, because drug and alcohol rehabilitation units will not take mentally ill persons—psychotic persons. Institutions for the mentally ill will object to taking drug and alcohol patients. Early in my life in this job, I discovered a wonderful example of this when, sitting at Long Bay jail with a forensic patient who was suffering from treble, dual—or whatever one wants to call it—diagnosis, a bright, shining-eyed registrar said that she had found a place that would take him. This had been a big difficulty because the man had been rejected by so many. I asked, ‘Where?’ She said, ‘Peppers’. There was a horrible silence, because Peppers is a well-known upmarket resort at Toowoon Bay.

I thought this could not be right, but it turned out on inquiry that it was a drug and alcohol rehabilitation unit that had taken the same name down near Albury. It did not take people who could not care for themselves and would not take psychiatric patients, as a result of which it got a remarkably low number of patients. You will have run into the same difficulty. Calling it a dual diagnosis is to suggest that people have double trouble. It is the same trouble, manifested with a whole range of symptoms.

CHAIR—But what is the primary trouble—that is the issue?

Mr James—Overall, if you simply look at the symptomatology and say, ‘These symptoms show this person is acting in a way in which they require treatment for their benefit and for the benefit of the community, for everyone’s safety, and we can do it in a least restrictive way by giving them supported accommodation in the community with appropriate treatment,’ then it should be done. At this point, I should disclose that, prior to my being appointed to the Supreme Court in New South Wales, I was president of the Richmond Fellowship. Also, the family has had a long association with the Schizophrenia Fellowship. As a result of that, when, after eye problems, I retired from the court, I was asked to take the present role and to embark on the reviews that I have undertaken. If there is anything that we can do in writing or by way of further detailed assistance or suggestions, the tribunal would be delighted to do it because it does not see its function as simply limited to the routine task of conducting the hearings.

Senator ALLISON—Can I pick up the issue of privacy. You said that the privacy laws allow for information to be provided in a discreet but complicated arrangement with next of kin or near kin—

Mr James—A special amendment was made to the existing New South Wales law by the Mental Health Act 2007. That provides for the ascertainment, according to complicated rules—rather like the rules that used to exist for working out the next of kin under the Wills Probate and Administration Act—of who the primary carers are to whom the hospitals are required to give some information and from whom they can obtain information. Those persons get notice of applications being made to the tribunal and of the major steps in a patient’s care that the hospital might be taking. That is an exception to the usual regime relating to privacy and to health records. So far, the hospitals are coming to that—they are getting there—but that is primarily because Maria and my other deputy, John Feneley, are out and about giving lectures to all the agencies and the hospitals more or less continuously. Although it is not part of our formal function, it is the only way we are ever going to get the tribunal to work.

Senator ALLISON—So if it is in law but certain groups are ignoring it or do not know about it because you have not been able to give them a workshop on it or whatever, what recourse is there? Who can challenge that? Can a carer say, ‘But it is in the law; go to a court of some sort’? What is involved in that?

Mr James—They will not need to. If they have somebody who requires information and they are not getting it and they pick up a phone and call us, we will refer it to the Department of Health. If they pick up a phone and call the Department of Health legal office, they will be referred to the legal officers, and the legal officers will simply tell the hospital to do it. We are conducting workshops continually.

Senator ALLISON—And they are obliged to follow that advice?

Mr James—Yes. They are obliged to follow the law. The act is mandatory. It says you must tell the primary carer—

Senator ALLISON—Does this apply only to hospitals? What we heard at the last inquiry was that GPs seem to fall back behind this privacy provision all the time and that they were at least a big problem, if not bigger than the hospitals.

Mr James—The legislation does not relate to general practitioners who are treating people voluntarily for mental health problems. However, applications can be made to the Guardianship Tribunal in New South Wales for the appointment of a guardian or for the appointment of persons who can make more limited decisions than full guardianship, which entitles those persons to be given information.

Senator ALLISON—How long does that process take?

Mr James—Ages. That is hopeless.

Senator ALLISON—I was going to say: sometimes the issue is an urgent one—like tonight, in the middle of the night.

Mr James—You can have an urgent application made. Similarly, with financial matters, we can make determinations appointing a guardian, but it is an unwieldy process. The New South Wales Department of Health has for a long time been looking at this idea of ability to make limited disclosure, but it is a bit like informed consent for operations. The High Court’s decision in Rogers v Whitaker was fairly clear, but the implementation of it in the medical profession and getting them to give you information can either result in you being given far too little or you can get what happened to me when I announced that I was willing to have a shoulder operation—which will be on next Wednesday. The surgeon gave me this website on which I could watch every gobbet of flesh being removed and every bit of blood—it was the most gruesome thing of all time! But he was making full disclosure.

Senator ALLISON—To you, as a patient.

Mr James—Yes.

CHAIR—Mr James, I am sorry to interrupt you, because you are in full flow, but it is five to four and I committed to let you go by five to four.

Mr James—Okay. If we can help with Senator Allison's question concerning what might become—

CHAIR—It is a critical issue, the whole issue of privacy. Whilst, for your submission, we did not tell you that that was what we wanted to know about, if there is anything you can provide to us on the privacy issue, I am sure we would be very grateful.

Mr James—Bearing in mind that, notwithstanding that horrific experience of looking at the operation—

CHAIR—You are still making the decision to have it.

Mr James—I will be going in on Wednesday. This is a field in which we can probably provide you with the current policy and some submissions of assistance.

CHAIR—That would be very good. Thank you very much for making your time available to us this afternoon.

Senator ALLISON—And good luck with your shoulder!

Mr James—I will be better with it done.

CHAIR—Maybe you could get yours filmed!

Mr James—They can do that for you. Thank you very much.

[4.06 pm]

BESTIC, Ms Donna, Project Coordinator, Community Services and Health Industry Skills Council

FLYNN, Mr Robin, Research and Policy Manager, Community Services and Health Industry Skills Council

LAWSON, Ms Di, Chief Executive Officer, Community Services and Health Industry Skills Council

CHAIR—Welcome. Is there any thing you would like to add to the capacity in which you appear today?

Ms Bestic—I have been in my position for about three or four weeks.

CHAIR—We had someone appearing today who had been in their job for three days. You are a deeply experienced.

Mr Flynn—I have been with the council this time around for about 2½ years.

CHAIR—Have you given evidence to one of these committees before?

Ms Lawson—To a children's services review some time ago.

CHAIR—It is very similar. You have information on parliamentary privilege and the protection of witnesses. It is a standard process. Senator Webber has to leave at 4.30, so I warn you that she is not walking out on your evidence. I do not know about the other two senators, but I will be here and Senator Humphries is not allowed to leave until I do. The way we normally operate is people give us an opening statement or some comments and then we ask questions.

Ms Lawson—I have tabled for you some information about the industry skills council.

CHAIR—Yes, we have that; thank you very much.

Ms Lawson—We are one of 11 national industry bodies, which you may be aware of. All of industry across Australia is divided into those 11 councils. We represent community services and health industries. We are a private, not-for-profit company made up of a board which is nominated from AHMAC, the Australian Health Ministers Advisory Council; the community and disability services ministers council; the unions that represent our workforce; and the private sector, represented by the Private Hospitals Association and the Aged Care Association.

In terms of the industry skills council's work as it is flagged there, our main role is within the vocational education and training system—that is, we are the architects of the national training packages. We build the skills framework for developing the community services and health workforce within the vocational framework. Coming here today, one of the areas of work we are most interested in presenting to you is the challenges around skill shortages. We all heard COAG's announcement yesterday about prioritising skill shortages, and the new government has a new Skilling Australia policy, which skills councils are a principal part of in terms of allocating training places. From an industry skills council perspective, we have been doing a range of projects over the last five or six years, particularly in relation to mental health, Indigenous environmental health and Indigenous health workers strategies.

What we can bring here today from our experience is to identify the importance of skills mix reform in the workplace. One of the real challenges that we have, from our perspective, is that often the conversation that is had by decision makers in relation to the workforce is focusing just on the medical and nursing professionals. What we find is that there is a great omission that people do not appreciate, and that is that 50 per cent of the community services and health workforce are in fact vocationally prepared and not tertiary qualified at all. And in the mental health workforce, which is part of the community services sector, the proportion is substantially more, with about 80 per cent of the workforce for community services being vocationally prepared, not tertiary prepared. So the main challenge we see, moving forward, is the skills of the workforce to address the mental health requirements and services for society. We also have to understand and track the changing service delivery models that are impacting on the skills needs for our industries.

We are in the process of completing a review of the community services training package, which is the main piece of work that covers the community services industry. In doing that we are currently consulting with the NGOs as well as the public sector around service delivery. We are finding quite profound challenges in terms of how we restructure the workforce to ensure it is competent—and not just competent at the top end, in terms of psychiatrists and social workers and psychologists, but has the skills mix and competence in the entire workforce, particularly for regional and remote areas. As you would be hearing, the challenge of getting professionally or tertiary qualified workers into those areas is extraordinarily difficult. And here in New South Wales, for example, the challenge is not just for remote and regional areas; it is for outer metropolitan suburbs.

So we are relying more and more on the vocationally prepared workforce, but we would argue that there has not been enough effort going into investing in the skills development of those workers. More importantly, there has been insufficient effort put in by the jurisdictions, the health departments, around how they do the industrial relations work that sits behind restructuring the workforce to actually give capacity to those vocationally prepared workers to be a better fit in the workplace. That is the main thrust of where we are coming from, in terms of a presentation today.

CHAIR—Thank you. You are Sydney based?

Ms Lawson—We are Sydney based, yes, but we are a national organisation.

Senator HUMPHRIES—I want to know what the key challenges were from your point of view in meeting the greater expectations that our mental health system is now having to meet by virtue of the extra money which has been put in in the last couple of years. Where are the shortages or the inadequacies in the system that the work of your council might be in a position to address?

Ms Lawson—We ran a forum of our stakeholders. One of the things we have to produce as part of being a skills council is something called an environmental scan, which is a summative document that we are happy to provide for you.

CHAIR—That would be very useful.

Ms Lawson—It is a summation of where we see the priorities are for skills development for our industries. We consulted at the end of February with a group of our stakeholders from across Australia around the challenges.

CHAIR—The challenges within mental health?

Ms Lawson—Yes, as well as the broader community services sector. Mental health were represented in that forum. They were shared challenges for the community services industry, of which mental health is a part. One of them is around funding of NGOs, non-government organisations. There has been a shift identified by the sector from delivery of services from government organisations to delivery from NGOs. There is actually a shift in the moneys going to NGOs for them to be greater deliverers of service. In and of itself that is not problematic, except that the challenge then is actually finding funding models which are investing in those services to develop their workforce. So one of the key challenges that was identified for us in that forum is that insufficient funds are being allocated to NGOs, who are happy to take on the work and to try to expand and deliver quality services, because the funding cycles and the funding processes are insufficient to guarantee their ability to invest in the skills required of their workforce. So a key concern being expressed by NGOs is about the funding regimes that are being put out by the jurisdictions to deliver a service but also to invest in the skills development of their workforce. They are quite cognisant of the fact that there is a need to change models of service delivery and that we need to have more highly competent, vocationally prepared workers to compensate for the lack of professionally or degree qualified workers. They are quite up to the challenge of that, but the problem they have is that often their funds for service delivery do not take account of the fact that they need to develop their workforce. There are competence issues and maintenance of competence issues that are not being addressed in the workforce. That is a key challenge that has been identified by our work.

Senator HUMPHRIES—What about shortage of workers? Is that an issue that the council would address?

Ms Lawson—It has been identified. The difficulty for mental health is that so much of the data is in and around the degree qualified professions. So, obviously, the keeping of records as to the numbers of people who are psychiatrists qualified through registers, registered nurses et cetera has been a much easier number-crunching exercise. We do know that enrolled nurses, who are the second-level registered nurses in the system, are in much greater demand.

We have had a particular request in the health training package we just reviewed last year to increase the skills development for enrolled nurses to enable them to work more effectively in the mental health areas. That has been identified as a shortage. I cannot tell you what numbers are involved in that. But each of the jurisdictions has identified the need to use their enrolled nurses in different ways in mental health services, and they have specifically requested these new skill sets which they are now able to start putting through in terms of training.

In terms of the community end of the workforce, all the vocationally prepared—and for us it is people who have a certificate IV and a diploma that we are building now in mental health, or a certificate IV or diploma in drug and alcohol work, or youth workers—are the sorts of workers that we would tend to know more about. But again their numbers are not well calculated because NGOs are a very dispersed group and, by definition, do not necessarily have the resources to maintain data. So, one of the key challenges we have is to keep track of how many of these different workers there are and whether or not there are sufficient numbers of them to actually match the requirements moving forward for the new skills mixes. That is probably a fair thing to say. There is not sufficient data, other than when we look at numbers of people who are in training. We know the numbers of people who are in vocational training are insufficient to cover the needs that we are hearing from the ground as to the sorts and numbers of workers that people are looking for to deliver the services.

Senator WEBBER—We have talked about the need to train new workers. Is any work being done on the re-entry of qualified workers who have left the field, for whatever reason—looking at what incentives or refreshers we need to do to bring them back as a way of addressing our skilled labour shortage?

Ms Lawson—Certainly, from the registered nursing perspective, all of the departments of health have had campaigns to try to attract people back into the workplace to work in mental health. Probably the allied health professional representatives in each of the jurisdictions have also done their part around trying to attract social workers and other workers back into the industry. From our perspective, in a vocational sense, we have never had the opportunity to do that. This new government policy—the Skilling Australia policy—is the first time that it has really been clearly articulated that the Community Services and Health Industry Skills Council will have a role in identifying re-entry pathways that have actually been named as part of the process. We are at the very early stages of that in terms of starting to really look at it.

One of the projects we have just commenced is a project on mental health articulation—that is, looking at the pathways within regions for mental health service delivery and at the skills mix of workers to identify whether there are pathways for career development. One of the challenges for us is, if people are leaving mental health—as a youth worker or a certificate IV mental health worker, for example—but going on to university to become a degree qualified worker, that is not a bad story for us; but we do not have sufficient details to really understand exactly what that movement looks like and how it is happening.

Senator WEBBER—Following on from that, is there any work particularly being done on the pathways for Aboriginal health workers who have been trained up and then left—perhaps looking at a way of bringing them back?

Ms Lawson—We are working with a couple of projects. We have just completed the Aboriginal and Torres Strait Islander Health Worker project, which is the first time in Australia we now have two pathways for all Aboriginal health workers across Australia to be trained. One is a practice stream, which is more the clinically oriented work that you see happening in remote clinics, where it is more the sort of interventionist health type work. The other is the community care stream, and that is where all of the mental health and social and emotional wellbeing sorts of work occurs. There has been quite a lot of work done to start to prepare that ground.

The feedback we are getting from the various regions is that there are quite profound skill shortages. Examples that have been given to us—for example, from the Northern Territory—are that they have over 60 vacancies just in the public system for Aboriginal health workers at the moment, and those sorts of numbers seem to be common across Australia from the industry reference groups that we are working with. So we do have a pathway for that. We are not finding so much from the Aboriginal health workers perspective that people have dropped out to come in; their challenge more is that they have been doing the work for quite some time but do not necessarily have the appropriate qualifications. The challenge for that workforce is more about getting them into the training pathways where they have already been doing some parts of the work. They might have done a part of a course in social and emotional wellbeing or some bits of courses over the last several years, but they have not made up to a whole qualification yet. So part of the challenge we have in implementing these new qualifications is getting some of those workers who have the skills but not yet the recognised qualifications up to speed to meet the new standards that are required for mental health.

We also have a subproject working within that, which is out of the Department of Health and Ageing, at a Commonwealth level, and that is a mental health improving capacity project. That is a project which particularly targeted—and I do not know where the numbers came from—800 Aboriginal and Torres Strait Islander health workers to do a particular module of training related to mental health service. What we have done is taken a couple of units of competency from the new qualifications. We have made that the training program for these workers, and we have just built a resource kit with the industry itself. We have piloted it in three remote sites across Australia, and hopefully we will have that project ready to roll out to those 800 workers to train them over the next two years, which is the priority for that project.

So there are some things happening, but I think it is probably fair to say that it requires a lot of support. I do not think people often understand the time and investment that is involved in working with remote communities to build things that they will use themselves. Just going out and piloting something that looked good for the industry reference group, from our perspective, in a remote community with 10 Aboriginal people is a very different experience in terms of how you have to deliver that material. It is very challenging.

Senator ALLISON—I have often wondered what the equivalent of an Aboriginal health worker—mental or otherwise—is in non-Indigenous communities. Are you able to articulate that?

Ms Lawson—It is a highly political question, because one of the challenges that we have—and the reason we have these convoluted conversations about degree qualified and vocationally qualified people—is that the professions mark their territory fairly ruthlessly, shall we say, in terms of not wanting anyone else to do their work or the work that they perceive is their work. We look at the AQF, which is a levelling, so all qualifications across Australia are levelled on the Australian Quality Training Framework, or the AQTF, from certificate I through to level 8, level 8 being degree qualified, masters, PhD et cetera. Level 7 is where most degrees are pitched, and the vocational sector usually goes up to level 6 for advanced diplomas.

The Aboriginal and Torres Strait Islander health worker qualifications are pitched up to level 6, but it is probably fair to say that some of the skills that they are demonstrating as part of those qualifications are probably equivalent to those of some degree-qualified people. Some of the procedures that a certificate IV or diploma qualified Aboriginal or Torres Strait Islander health worker in the practice stream may well be doing are similar to procedures that you might find that a registered nurse or a physician is doing in an emergency facility here, in a metropolitan area. They are obviously doing it under delegation. They have things like the CARPA manual, which gives them broad parameters and directions to work under. They usually have a link back to mainstream medical services. From that point of view, there are aspects of skills that would be equivalent to what is happening in the mainstream system in terms of degree qualified professionals, but their qualification is actually titled at a certificate IV or diploma level because overall the work is meant to be at that level. Does that make sense?

Senator ALLISON—Yes, I hear what you say. It does assume that you do not need the training in order to achieve the skill set that is achieved by training in the non-Indigenous area. This seems to me to be something more than just the professions guarding their patch.

Ms Lawson—There is a history in Western society about how someone learns to do a certain job. Psychiatrists obviously study for six years to get the double degree, then they do a placement, then they embark upon psychiatric training and 14 years later they come out doing certain things. Then you have other people who have been a mental health worker, who might have a certificate IV in mental health. They are out there working in an NGO, and they are providing a whole range of services. There would be some things both of those people do that look the same. If you were just an observer looking at what a person is doing in a job, there would be some things people do that look the same. There are some things that we can commonly do. When one group of people—for example, someone who has got 12 years worth of extra study behind them—are doing a certain task that looks the same, they may well be thinking different things and problem solving in different ways, but the work itself actually requires this task to be done, not that thinking to be done, in terms of the levels. Do you know what I mean?

Even if you have a 12- or 14-year degree, all of the work that you do every day does not require a 12- or 14-year degree. Some of the work you do every day is mundane and routine, and other people can pick up and run with that work with a much lower level of qualification. Some people argue that, from a workforce redesign perspective, in Australia we train people for the potential of the disaster—so, if you like, we are the most prepared health industry in case the great disaster occurs. We even have it from the mental health perspective around the community minded or resources around mental health promotion, with people saying, ‘If only we had a GP in every school.’ Yes, you could have a GP in every school, but do you really need the skills of a GP to manage the schoolyard issues?

There are choices that we have to make as a society around the level of service that we can actually afford, and in amongst that conversation is a requirement about the competence level of those workers and what you are purchasing when you purchase that competence level. Some of us in workforce reform would say that sometimes we are paying too much for people that are more qualified than the job actually requires in the routine, mundane, day-to-day activity, and there is an inconsistency in that.

Senator ALLISON—With that approach, you need to be pretty confident that the skills acquired on the job, as it were, are actually acquired.

Ms Lawson—Correct.

Senator ALLISON—How do you do that?

Ms Lawson—In building the qualifications framework that we build, we go out and work with industry. We work with employers, unions, professional bodies and the like, and we ask: ‘What is the standard of performance required relating to this particular area of work? What are the key functions of the job role?’ We articulate that in our packages as national competency standards, which are grouped together to be qualifications, and we are very mindful that, when we articulate those competencies, other professionals may well have that same competency.

An example I can give you is that the certificate IV in drug and alcohol, which we have articulated in our training package, is the minimum standard required if you are working in a drug and alcohol service, for example in the Northern Territory. Regardless of your professional background, degree qualified or otherwise, the expectation of the government is that you will have met the requirements of that certificate IV in drug and alcohol. What they are saying is: ‘From a work perspective, regardless of whether you’re a doctor, nurse, physio or pharmacist, if you’re working in our drug and alcohol services, we expect you to demonstrate those competencies on the job. Obviously, if you’re a psychiatrist, you may well demonstrate those competencies at a higher level, but all we’re saying is that at a minimum we expect you to demonstrate those competencies here.’ In Victoria, they have taken a similar model with the drug and alcohol qualifications, and they have selected some of those competencies in the core and said, ‘If you’re working in our drug and alcohol services, you’ll meet four of those competencies in order to work in our services,’ and insisted on that as part of their service delivery model.

Senator ALLISON—How are they tested?

Ms Lawson—We have a standard process. The whole of the vocational system has, if you like, a recipe: ‘These are the competencies, and these are the processes that one undertakes in terms of assessment.’ There are standardised processes about how you assess competence et cetera. How that occurs is a fairly routine process for us. Registered training organisations which deliver the training in the package must meet certain standards about how they deliver and assess those competencies. There are 12 standards that all RTOs must meet in order to do that, so there is its own quality assurance process that sits around that.

CHAIR—Ms Lawson, when we did the Senate select committee a couple of years ago there was a lot of discussion, particularly in Queensland and the Northern Territory, about the qualifications for Indigenous health workers. We took varying evidence about the expectations, the knowledge and the assessment. I take it from your evidence that there does now seem to be some agreement.

Ms Lawson—Correct.

CHAIR—So that it is nationally agreed?

Ms Lawson—It has been nationally agreed. There is a certificate II, III, IV and a diploma and an advanced diploma for Aboriginal and Torres Strait Islander health work across Australia in the practice stream, and the same in the community care stream. Far North Queensland is the only area where there is some question about this, and that is because there is a particular training provider up in Far North Queensland who has a very specific and definite view about the fact that Aboriginal health workers should be degree qualified like their counterparts. From our research—and when I say that I would point out that we actually have sign-off from NACCHO and other groups in the community supporting this—everyone else across Australia, barring, as I say, that one group who have a particular view about degree qualifications in psychology and the like for their workers, has agreed a pathway. Queensland in fact now has a career pathway model. This is the most developed. It has actually utilised the whole of that qualifications framework into the new career structure with entry points, articulation, new job roles and descriptions, and career pathways that go with those qualifications. Other states are starting that process, they have just been a little slower in getting the new qualifications into their scheme, if you like, for processes.

Senator ALLISON—When will we see that translate into non-Indigenous communities?

Ms Lawson—To a certain degree it already has because we already have the qualifications for non-Indigenous workers, so we have certificate IV qualifications for mental health workers and we are building currently a diploma for mental health workers, which is an extension of the current role. In the last 18 months of our research, industry have told us they need a higher level worker than the certificate IV worker so we are now building a diploma level worker for mental health for industry to use. We would expect that new qualifications framework to be endorsed by the end of this year. Following the endorsement, it is then up to individual employers to do the work that they have to do from an industrial relations perspective to integrate that into new career and workforce models.

CHAIR—And salary rates?

Ms Lawson—Yes, and what they are going to pay people in terms of salaries and the challenges associated with that.

CHAIR—Yesterday we held a hearing in Brisbane and one of the issues that came up was the lack of training facilities in Brisbane. We did not even touch on the process in North Queensland and regional Queensland. We heard evidence that there are only two TAFEs in Queensland that currently offer certificate IV training for anyone in the workforce—it does not matter what their backgrounds are. If you want to get certificate IV training, which is now being talked about in the industry as the minimum standard—the same as III used to be for aged care—

Ms Lawson—Correct, and it still is.

CHAIR—Certificate IV is now being mentioned in terms of mental health. There is some concern about the availability of training. So even when you can find people it is difficult to guarantee their training. In Queensland, as in Western Australia, the mining boom is taking people. We hear evidence in just about every inquiry we do that you cannot keep trained staff because they can earn extraordinary wages for relatively basic tasks in a mining town. There is nothing to keep them on wages of between $30,000 and $40,000 a year in this kind of area. So, once you have established the level, is there any role that your organisation has in monitoring where people can obtain the training?

Ms Lawson—In the past that has been something that we did purely of our own cognisance as part of our own research. Under the new Skilling Australia process we are expected to have an allocations role. Part of the environmental scan approach to what we do is to actually prioritise so our environmental scan will be submitted to the new Skilling Australia body when it is in operation—hopefully by July—and our prioritisation of what our industry requires will be one of the bases upon which we will allocate training to certain priority areas. The issue that you have identified is a very real one.

We identified a few years ago, when we were doing a mental health related resource to the last training package, that there were very few TAFEs—I think here in New South Wales there was only one or two—that were actually delivering the certificate IV in mental health. What we have to understand about that is that training providers will not deliver training where there are no jobs. Vocational training is specifically applied to job outcomes, and we are very definite about that. In fact we heavily discourage training providers delivering training where there is no job outcome. So where there are no employers willing to employ people with certificate IV or diploma qualifications then of course there will be attrition at the training end because registered training organisations must organise placements as part of the training of these workers. If the placements were not there or the jobs were not being offered, we attributed that largely to the fact that the lack of investment in mental health services across Australia had led to a decline in the number of people that were being trained—because the jobs just were not being offered.

Obviously there has been a stimulus at the end of providing more funding to mental health services, but it will now take a while for those RTOs, training organisations, to crank up to realise that, if they do produce these workers, they will actually have a job at the end of it. So I think there has been a mismatch in terms of expectation. As I say, we have heard that as part of this consultation process to redevelop the new qualifications as well—that there had been a winding down of people delivering the qualifications.

CHAIR—We have heard evidence about an enthusiasm—quite rightly, I believe—for consumer based services. So you have the added expectation that there will be services that will be owned, directed and worked by people who are consumers. Often those people do not have the training in the area. They have the consumer knowledge and amazing life experience, but many of them do not have certificate IV or above in mental health. Has there been any discussion with your organisation about how to develop training that is particularly focused on consumers?

Ms Lawson—Yes. As part of the consultation to rebuild the new qualification—I will call it the 2008 qualification, because we are hoping that it will be endorsed in 2008; the old one is 2002—we did have a very delayed submission from a couple of jurisdictions—Victoria and South Australia, I believe—around improving the engagement of consumers, although that was not so much around individual consumers in terms of allocating services to them; it was more around consumers who are taking paid positions within services now and delivering services themselves as consumers. So there was some conversation around that. We did have one focus group around that, but it was too premature for us to get it into this package. We have prioritised that as additional work we need to do at completion of this process. We need to start to revisit that and find out exactly how that looks. Our consultation processes, like yours, are quite thorough, so by the time we do a lap around Australia and consult with all the various jurisdictions it usually takes us several months to really understand what the competence of those workers is.

CHAIR—From our submissions and from different discussions we have had, it seems there is considerable interest in consumers taking on the role of providing service, in getting their skills base matching and in generally raising competencies of consumers so that they can be advocates. A number of the consumer organisations in Queensland are running their own programs to give consumers the confidence to go out and effectively publicly talk about their own experience and raise community awareness of the issues around mental illness. So you have the certificate IV type competencies for working in a service, but you have a separate need and demand to raise people’s abilities to be public faces, public voices, to be able to stimulate focus groups—that kind of thing. Is there any work in that area?

Ms Lawson—That was certainly part of the submission that we received that came in too late for us to consider in this package review. But we will, as I say, put it on our schedule of work for later. I guess the main challenge that we have, again, is the fit of the VET system for volunteers. The VET system is meant to produce workers and, while the notion of a nationally consistent standard is desirable for volunteers, and we certainly have some competencies and qualifications in the package for volunteering, that comes out of the same issue. The reality is that they do fall in our brief, but then you are not going to be developing the training for them to give them a job. It is the same as with foster carers: you develop the skills sets for them to do caring but they are not necessarily in paid work in the sense of being employed in an organisation.

CHAIR—It is certainly my understanding from the consumer movement that they see it as an outcome of paid work rather than being the unpaid service group. They see that this is a way back in terms of raising the profile of their life experience and being able to train people to help others. It is not necessarily a volunteer outcome; it is actually a paid work outcome. Do you agree with the evidence?

Ms Lawson—The information that came to us from South Australia and Victoria was related to that—people who were advocates and that sort of competence area and how that would look. As I say, we have given an undertaking to do that work at completion of this process.

CHAIR—My last question is whether you have had a role in consultation with people like FaHCSIA as they have been developing programs such as their mentors program—Personal Helpers and Mentors, PHaMs—where people, through NGO networks, have a special paid role in terms of working with people with mental illnesses. There is no prerequisite for the training of the people working in those areas. As people have won contracts, there has been a whole range of expectations. In questioning yesterday, Senator Allison, I think you were talking to some of those people and they said that they thought level IV would be the minimum level and there would be a wide range elsewhere. In the development of these programs, in looking at how they are going to operate, has your organisation had any discussion with the department about how you could achieve those roles, what skills they would be and whether there would be a need for further training in the community?

Ms Lawson—We always invite FaHCSIA to be a party to processes. In fact, we shared FaHCSIA’s office at 1 Oxford Street for a number of years before we changed offices recently. We have what I would describe as an extraordinarily good working relationship with the

Department of Health and Ageing, who have warmed very well to the notion of a national workforce challenge and have, in fact, done a lot of work around the strategic health workforce framework et cetera, which we are working with.

CHAIR—They have a unit called ‘workforce’ don’t they?

Ms Lawson—Yes, they have. FaHCSIA have not got there yet. We have, I think it would be fair to say, endeavoured on many occasions as their skills council to attempt to help them understand the framework under which we are operating in. I think it would probably be fair to say they have not really taken up the opportunity, as we would have liked, as a skills council for FaHCSIA, to get involved. We have attributed that, over the last five years, to the fact that they are somewhat more fragmented than Health, and I think that is probably true to say of all community services delivery. They are a more fragmented service. From our experience, Health seems to have been able to get itself together through the strategic framework and through AHMAC, which has had a more deliberate and focused role around workforce. Our experience with FaHCSIA has been that they have not been as targeted around that. They seem to have lots of fragmented activities. We certainly worked with FaHCSIA on the family relationships agenda as part of the Attorney-General’s project for the new family relationships work that we did—

CHAIR—There was great discussion about the skills level of the people who are going to be in those units. It went on for hours. You were involved in that?

Ms Lawson—We developed the national competencies for the family relationships workers at a vocational graduate diploma level as well as at a certificate IV and diploma level for those. We worked with FaHCSIA on that, but I think it is probably fair to say that that particular branch of FaHCSIA does not seem to have influenced other branches of FaHCSIA to see the potential of what being part of the national process can be. Where we have, we have been able to work with them, but I think overall we have not had the same success with working with FaHCSIA around national frameworks around this as we have with the Department of Health and Ageing. Even CDSMAC—our skills council, historically, always used to have two nominees from CSMAC. We had two vacancies—

CHAIR—Could you tell me what CSMAC is? It sounds quite interesting.

Ms Lawson—CSMAC is the Community Services Ministers Advisory Council. Health has AHMAC, which is the Australian Health Ministers Advisory Council, and Department of Health and Ageing provide a secretariat function to that area of conversation. Community Services, or CDSMAC—as it is now that it has ‘disabilities’ in it as well—have a similar group that talk about national issues; and they bring the state jurisdictions together as well as the Commonwealth. We actually had vacancies on our board for almost the last three years because CSMAC seemed to not understand the priority of national consistency around workforce reform and the things that we offer as a skills council in that work. I think in the many conversations I have had with the deputy secretaries of FaHCSIA over the last few years, they have not been able to do whatever has to be done—whether it is with jurisdictions or whether it is across their own department—to really understand how you harness some of these national processes to actually benefit through a national training package, in the same way that the Department of Health and Ageing have. So there is work to be done there, which we are hopeful for, but they seem to have been a bit slow to come to the urgency of some of this national consistency workforce agenda compared with the Department of Health and Ageing.

CHAIR—Are there any more questions, Senators?

Senator ALLISON—I would love to ask you a question about competency in mental health amongst our general practitioners. I guess it is not your business to examine that area but, given that some of our GPs, if they were trained a few years ago probably did not have any qualifications or training in mental health specifically, is this a matter that exercises your collective minds?

Ms Lawson—I presented at the national safety and quality council a few years ago, talking about the training package for the health workers at that point in time and where we were going with that. The College of Obstetricians and Gynaecologists and the College of Anaesthetists both approached me at the end of that forum and said, ‘Why aren’t we in that package? We want competencies for our workers,’ which I found really interesting. The medical profession actually call their postgraduate learning ‘vocational’. They do not have the same stigma perhaps that some of the other professions might have around vocational language, because they are quite interested in that. Certainly the mental health articulation project we are working on will include GPs as well as other service deliveries to really look at what the common competencies are.

You might be aware that, in the UK, with their agenda for change for health, they did actually look at common competencies across the whole health workforce. I presented at the summer forum at the beginning of last year, where we had UK speakers talking about mental health. They were facing very similar challenges around skills mix and diversity of the workforce. They articulated exactly the same challenge that we have as a skills council, which is: how do you bring those parties together to talk about the common competencies, whether you are a GP, a nurse practitioner, a mental health worker, a psychiatrist or a psychologist? We think as a skills council that the way that we need to move some of this agenda forward is by having some of those conversations.

I think what keeps the profession separate and what makes them look like marking turf is that they often do not understand the common competencies that each of them have when it comes to service delivery. They come from their own model, their own perspectives, their own history and their own curriculum and therefore they think about the world from their own view. With the family relationships project, we developed the common competencies that covered off on barristers, lawyers, psychologists, social workers and psychiatrists. So we built a set of common competencies, which you can then use as a conversation around where you are similar to other people in your region and can deliver complementary services rather than us always seeming to be facing off with each other about how unique and different we are. We see as one of our key challenges moving forward as a skills council for the next five years to really influence that agenda to look at common competencies and how they can be shared in complementary services, because that seems to be what industry requires to improve the skills mix. They need to have those conversations in terms of process.

CHAIR—Thank you very much. I am sorry that it has taken us so long to talk to you. You have provided some very valuable evidence. If we get more questions about this area, we will be in contact with you.

Ms Lawson—We will send you a copy of the environmental scan.

CHAIR—That would be very useful.

Senator ALLISON—If you have the competencies that might apply within mental health, it would be good to have those if they are intelligible to lay persons.

Ms Lawson—We will send you some examples.

Senator ALLISON—That would be very useful.

Ms Lawson—We will not send you all of them, because they are very detailed, but we will send you some examples.

CHAIR—Thank you.

Committee adjourned at 4.48 pm