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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

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SENATE
SELECT COMMITTEE ON MENTAL HEALTH

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

Senators in attendance: Senators Allison, Forshaw, Humphries, Moore, Scullion and Webber

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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Committee met at 11.30 am

ALBISTON, Ms Dianne, Clinical Program Manager, ORYGEN Youth Health

CHANEN, Dr Andrew, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre

LUBMAN, Dr Dan, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre

McGORRY, Professor Patrick, Director, ORYGEN Youth Health and ORYGEN Research Centre

YUNG, Associate Professor Alison Ruth, Consultant Psychiatrist and Principal Research Fellow, ORYGEN Research Centre

CHAIR (Senator Allison)—Welcome. This is the fifth hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March this year, for report by 6 October. Witnesses are reminded of the notes they have received on parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public but, under the Senate's resolutions, witnesses have the right to request to be heard in camera. It is important that witnesses give notice of that intention to the committee. The committee has received your submission, which is numbered 284. Do you wish to make any alterations or additions to the document?

Prof. McGorry—There are no additions or alterations but I would highlight one or two things if that is possible.

CHAIR—Certainly. I invite you to make a brief opening statement. I am not sure how many of you wish to do so, but we will go to questions after that has been done.

Prof. McGorry—Firstly, we all appreciate very much the opportunity to give evidence before this inquiry. We passionately believe that this is a vital public health area of Australian health care that has been neglected. I am sure you have heard many stories, evidence and submissions on that. We would like to highlight some of the ways forward and to emphasise that it will be possible to achieve very significant advances in outcomes for people with mental health problems and disorders in the very near future. It is possible to achieve that now. There is enough knowledge and evidence available to dramatically improve the care of the mentally ill in Australia.

One of the ways we think this can be achieved is through a focus on young people. We have highlighted the reasons for this in the submission. Just to restate them: young people between the ages of 12 and 25 are the peak age group for the incidence and prevalence of mental disorders in Australia and around the world. In the absence of proven effective ways to prevent mental disorders, the best option in that situation, as we see in other parts of the health system, is early intervention. As we see with cancer and heart disease, it is accepted as an article of faith and it is

backed up by evidence. Increasingly so, that is the case with mental health. We see a big gap between the evidence and the logic and the implementation in Australia. This has created a lot of the evidence for early intervention in mental health. We see a tremendous delay in implementing this evidence around the country.

We know that in health care generally there is about a 14-year delay between the production of evidence and implementation in the real world. It is probably longer with mental health. It has certainly been the case with the early psychosis intervention reform. This evidence has been around for a significant period of time and still is not properly implemented anywhere in Australia apart from the north-west of Melbourne. We are concerned to ensure that another generation of young people does not go by the board and does not get sacrificed by this delay in implementing things that we already know will work.

I am sure you have heard this from a number of submissions but what we see in mental health care in Australia is too little, too late. The services that are provided at the state level are tightly targeted at people with end stage illnesses, severe chronic illnesses or in very acute, high-risk situations—they may be acutely suicidal, aggressive or behaviourally disturbed. So the care is reserved, in a sense, at a state level for that group of patients. The whole concept is to intervene early and prevent people from getting to that high-conflict stage—where they almost have to force their way into care—which can be avoided, but the current model of care and resource levels at a state level are impeding that. There is a resistance to this mind-set.

There is certainly resistance to further reforming mental health structures and practices. We have encountered this in a very difficult way at both state and federal levels. There is a reluctance to embrace the logic and the evidence around focusing services on adolescents and young adults as a cultural group of young people. As we know, adolescence has lengthened as a period of transition over the past few decades—it now extends from the early teens up to the mid-twenties. That almost perfectly mirrors the onset period for mental disorders. It is a phase of life which is very sensitive to the onset of a mental health problem. We see significant vocational and social impacts of developing a mental health problem, especially if it is neglected or not treated. All of this could be tackled if there were a will and, I suppose, energy and momentum for further reform.

The evidence base is there to address it. What is required is a different structure, a different mind-set and probably different skills in the work force. Different work practices obviously need to be brought into play too. Our main message is that this is an achievable goal. We do not have to wait for the cure for schizophrenia to be discovered or for the cause of schizophrenia or bipolar disorder to be unearthed. There is a lot we can do. We have never had more effective treatments in psychiatry than we have these days. They are just not funded and supported by the community.

You have probably heard a lot of evidence from the different professional groups. The professional groups have been marginalised and divided on these issues but that does not have to be the case. These problems can be overcome. We want to try to give an optimistic message—one that requires tremendous national momentum as well as momentum from the community if it is to be translated into reality. We do not want to see another generation of young people left on the scrap heap.

I will come back to these in my closing comments but there are five recommendations we would like to make. The first is that mental health literacy and mental health first aid programs should be available throughout the Australian community so the whole community is more knowledgeable and more able to deal with the milder end of the spectrum in the early stages. Just as people do first aid courses for physical injury, the community can be trained in those sorts of approaches. It is possible, through the work of Tony Jorm, for this to be done on a mental health basis as well.

The second level is the primary care level. We think there is a missing element in this structure, called enhanced primary care, where groups of general practitioners, supported by specialist psychiatrists, drug and alcohol workers and vocational counsellors, could be brought together in local communities and regions. That would lead to a more specialised model of care for young people short of the specialist mental health systems, something that is a bit more accessible and acceptable in terms of a youth health model. This is obviously being considered by the federal government at the moment under the new policy. That is a missing element which does not exist at the moment and perhaps explains why young people have such poor access to primary care.

The third level is restructuring the specialist mental health services to ensure that we have a youth stream of care so that we do not have a child and adolescent service on the one hand and an adult service on the other, neither of which can meet the needs of this age group. This would be a new stream of care, analogous to aged psychiatry for old people, for the adolescent and young adult group.

The fourth point of reform would be the integration of drug and alcohol services with mental health services. Basically, there is such a tremendous overlap between these two sets of conditions that it makes no sense at all to have separate streams of drug and alcohol services and mental health services. It is a recipe for fragmented care and very poor quality care, which I am sure you have heard from many submissions.

Finally, we think that the National Suicide Prevention Strategy needs to be significantly overhauled. It has lost its way. It is focused on diffuse population based strategies without really any measurable outcomes. Population based methods can work—such as reduction of the means of suicide and mental health first aid, as I mentioned—but the sorts of things that have been supported over recent years have been pretty ineffective and certainly fall well short of the mark and they are not evidenced based. The mentally ill and people with emerging mental illness have been virtually neglected in the National Suicide Prevention Strategy. This view would be supported by a number of people—for example, those who collaborated on an article in the *Medical Journal of Australia* recently which made this point. The five things that I have mentioned are concrete things that could be done to really progress things.

CHAIR—Does anyone else wish to add to that statement?

Dr Chanen—Not at this stage.

CHAIR—First of all, thank you for hosting us at ORYGEN this morning. It was very informative and very useful for us to be able to talk with young people. I will start with our first term of reference. It asks about the extent to which the National Mental Health Strategy has been

successful and implemented. Do the five points you have given us suggest that the strategy should be rewritten? Is the strategy responsible for what you describe as a focus on acute care, which is a very expensive and harmful approach to mental illness, ignoring particularly young people and early intervention and prevention? Can you comment on the strategy? Do you think that is the problem? Is that what is driving state governments down this path?

Prof. McGorry—I think the strategy has totally lost its way. The first National Mental Health Strategy was world leading. It tried to get rid of the old 19th century style institutions and replace them with a community based model of care. It was properly funded. It had money which went to the states but which was tied money, so certain things had to be done for the money to be allocated, such as the setting up of crisis teams and CAT teams. That was quite successful. That first wave of reform led to significant improvements and quality of care for people around Australia.

The second strategy was less well funded. It was much more diffuse in its aims and it moved on to new goals before the first set of goals had been bedded down. We have seen a total loss of reform momentum, so much so that the third strategy was a totally emasculated document, with a whole lot of diffuse, vague statements which everyone would support in principle but with no real practical strategies or goals set. Having some knowledge of how it was watered down, it was profoundly disappointing for people like me who wanted to see another wave of reform which would have made the first strategy work a lot better.

These days, you see that people doubt the wisdom of the deinstitutionalisation approach because it was so poorly followed through in terms of the second wave of reform and further investment. So you see people questioning it. There is no reason to question that original decision to dismantle the old institutions, but certainly there has been a failure of public policy in that it has not been properly supported into successive waves of reform to drive it home. Hopefully, that is what we are seeing in this process. We hope that it will be the way of regenerating commitment to both reform and restructuring. I think it has been very disappointing. The fact that the reform has died has let the state governments off the hook, in my opinion. They have colluded. We have certainly seen state directors of mental health colluding with the federal bureaucracy, almost stalling and just sitting back resting on their laurels, especially in the last five years.

CHAIR—And yet we are told that Victoria is leading the way on mental health services in this country.

Prof. McGorry—It is like Botswana being superior to Swaziland, in my opinion.

Senator HUMPHRIES—Professor McGorry, thank you for a very interesting visit this morning. You mentioned in your submission that if a person receives treatment at an early stage of their mental illness there are excellent prospects for a happy and healthy life. It has been a bit hard to pin down just what difference early intervention makes in quantifiable terms. Do you have any data regarding just how much the disease burden is reduced by virtue of the sorts of interventions that you provide at ORYGEN?

Prof. McGorry—There have been two large-scale randomised controlled trials of system reform based around this early intervention idea which have been published in the last 12

months, with probably close to 700 patients randomised in these studies. You see something like a 25 per cent improvement in outcome at around the 18-month to two-year mark.

Senator HUMPHRIES—Did you say 700 per cent?

Prof. McGorry—Twenty-five per cent. It is probably a substantial improvement in social outcomes. The symptomatic outcome from treating people early is very good. About 90 per cent of young people, even those with a severe illness like first episode psychosis or schizophrenia, will make a remission of their symptoms. So treatment is extremely effective at that symptomatic level. What is less effective is the social recovery. More specialised early intervention programs with recovery programs are needed, as well as the detection part of it, to ensure that that occurs. We know that social recovery lags behind the symptom recovery. Even in our service, at the moment only 50 per cent of those young people who make a remission will make a social recovery. There is recent data from the US showing that, with enhanced programs of recovery, you can get that up to 90 per cent as well. So 90 per cent of people return to work or school if there are additional inputs in the program. The evidence base is showing that, even with the most severe forms of illness, the vast majority of patients can make a full recovery both symptomatically and socially.

Senator HUMPHRIES—Without social recovery, presumably there is a greater chance of people falling back into a state of ill health?

Prof. McGorry—Not only that but, perhaps from your point of interest, there is a much greater chance of them ending up on the disability support pension. There is a big economic component, apart from the human side of things. These illnesses affect young people at the prime of their lives—in their late teens, early twenties—and if they do disable them at that point and they do not make a social and functional recovery then they are looking at decades on welfare and support, such as the DSP. We estimate that this can be substantially reduced by not only more proactive treatment and earlier detection but also much more comprehensive care in the first few years after the onset of the illness. The first five years would be the optimum period to provide the resources. What we see around the country is the resources being provided after maybe five or 10 years of illness. Only then do the patients get access to proper programs, and the bus has already left.

Senator HUMPHRIES—You mentioned that you are not getting political reception for the argument that early intervention and involvement in dealing with these problems is going to have a major social benefit and that you are frustrated by that fact. Can I put to you two things that seem to me, as a politician, to work against you. I would like to get your reaction to these things. One is that, clearly, with the huge burden of mental illness in the community—for example, depression has the highest incidence in the community and is the disease with the largest burden—so much of it is dealt with privately. People self-medicate or they curl up on the floor at home and never present to public hospitals or whatever to deal with it. If you start to grapple with the problem and provide services, you will open a floodgate of people pouring through the door wanting those services who do not access any at the moment.

The second problem is that I suspect some policy makers have a sense that recovery in mental illness does not mean cure; it means maintenance of a person on a reasonable level of control in their lives. Policy makers have a sense that you do not actually get people out of a schizophrenia

or bipolar disorder; you simply help them cope with it. You need to demonstrate that, with a funding boost of the order that you are talking about, you will actually significantly reduce the disease burden—that you can measure this and make a big difference. What is your reaction to those two points?

Prof. McGorry—The first point was the floodgate argument. I completely agree with you. In talking to politicians and bureaucrats, we picked up very quickly the concern about that. The first point to make is about the value statement there. That argument is more difficult to sustain, say, in heart disease. There would not be a resistance to meeting unmet need if people were experiencing chest pain and might be suffering from a heart attack. We are dealing with the same kind of life-threatening conditions in young people as occur in middle-aged people with heart disease, and yet that argument is not used in that area. Nevertheless, we did make an effort to quantify what you are talking about. On the basis of the National Mental Health Survey we estimate that, in our catchment area of one million people, 50,000 young people in our age range would be suffering from a mental health problem or disorder in any one year. At the moment, we are treating 800 per year. So there is a huge mismatch. It is a real floodgate scenario.

Despite large-scale public awareness programs, a completely open access system of referral, web sites and all sorts of publicity—through which we have seen a 50 per cent increase in referrals over the last three years—there are still only 2,000 people presenting with severe problems who need help. We are still turning away 60 per cent of those young people, and we are very worried about that. But the problem is not going to overwhelm budgets. Budgets may need a 50 per cent to 100 per cent increase. That sounds like a lot, but it is not of the order that you might derive from epidemiological surveys. It is something that is affordable. I can quote Norman Sartorius, a former head of WHO and the World Psychiatric Association, who said that communities in a developed world can afford proper mental health care and that it is a lack of will that is the problem, not the actual money. The money is there; it is a question of the will. Could you remind me what the second point was?

Senator HUMPHRIES—The second point was about demonstrating that you can actually cure people or, if you cannot cure people, that it is worth helping them maintain a level of competence and activity in the community.

Prof. McGorry—Because the public system has been targeted at people in the end stages of illness, you get the impression that you cannot cure people with mental health problems or disorders. That is actually not the case. A substantial proportion of people with mild to moderate disorders are essentially curable. Even people at the moderate to severe end of the spectrum—for example, people with psychoses or bipolar disorder—can still spend a lot more of their lives in a normal mental health state and normal functional state with proper care. We see this all the time with the young people we treat. They might have episodes of illness but, for perhaps 90 per cent of the year, they are fine, happy, have a good quality of life and are functioning well. One could use an analogy with asthma. You might not cure asthma—there is a vulnerability to having episodes of asthma, the risk of which can be reduced by treatment—but the impact of the actual episodes can be reduced by more adequate quality of treatment. So it is the same situation.

An editorial in a recent issue of *Archives of General Psychiatry* made the point that mental disorders are the chronic illnesses of the young. In a sense, you are dealing with something that is an ongoing vulnerability in many people. But that is still not an argument against treating it.

The burden of the disease can definitely be reduced, and some of the studies I referred to that have been published in recent years show how much it can be reduced. It is quite encouraging.

Prof. Yung—I have a point about the floodgates argument. Not everybody who has a mental illness needs specialist tertiary care. About 25 per cent of young people have depression at any one point. Not all of those will need to go to a specialist mental health service. But the tragedy is that, of the ones who do present to a service like ours, more than half of them do not get treated because we are not resourced to treat them. They are young people who have the guts to go to a mental health service, through various different routes, and then are turned away. And, as we heard before, a quarter of those people have tried suicide in the last 12 months and yet still cannot get a service. So I think we need to pay attention to adequately resourcing services for the people who do present.

Dr Chanen—Also, the pessimism about recovery that you are referring to is generated by people working in clinical services. There is a very famous paper about the clinician's illusion: if you only ever see people who do not recover, you will think that that is the natural outcome of a disorder. In fact, people who get well and have functional recovery do not come back to services, so clinicians do not tend to see them. But clinicians tend to be pessimistic because of course they end up with an ever-diminishing number of people who have a severe chronic disorder. At the moment, we are turning away people whom we are having to triage. We are having to triage the more suicidal from the less suicidal—not the suicidal from the non-suicidal—in order to provide a service to prevent those terrible outcomes, and we are unable to provide a service to even that smaller group at the most severe end of the spectrum to prevent those pessimistic outcomes.

Senator MOORE—I am torn between being optimistic and very depressed by this whole process. I have so many questions, but I will try to limit them to two. After talking with your group, I have a tremendous sense that something positive is happening, that something can happen and that change is possible. But it is a very small light in all this darkness. Your submission focused on the fact that your services are being offered in one health area in one geographic part of one state in the country. Have you given any thought to what the funding implications would be to provide the kinds of services that you are offering at a national level? You have spoken about increasing the numbers in Victoria, but these needs are everywhere, so I would like to get some information on that.

Prof. McGorry—We have prepared two submissions on that subject. One was a federal submission in the lead-up to the last election. We costed the implementation of this model at \$300 million nationally and, at state level, at \$40 to \$50 million within Victoria.

Senator MOORE—Can you provide us with that information?

Prof. McGorry—Yes, we can certainly forward that to you.

Senator MOORE—That would be useful.

Prof. McGorry—Other countries have picked up our model and disseminated it much more effectively than we have in Victoria or elsewhere in Australia. A lot of lip-service has been paid to it and there have been piecemeal attempts to pick it up. Finally, Victoria is starting to pick it up, to some extent. But it is limited to psychosis. It is not applied to the full range of disorders

and, as we discussed this morning, young people do not fit neatly into clear-cut baskets of diagnoses. They have multiple problems; quite often, they are ambiguous. Their need for care should be the criterion for getting a service, not what diagnostic group they happen to be in. There has been tremendous resistance in Victoria and in some other parts of Australia to this idea, particularly because it involves a restructure of the service structure from child and adolescent, adult, and aged—that is, a three-tier structure. We are arguing for a four-tier structure.

When I think back to when I started psychiatry, there was a one-tier structure at that point. Old people, for example, were all herded into acute in-patient units—85-year-olds with 25-year-olds. Now we have a stream of care which better meets the needs of old people. We are arguing for a stream of care that meets the needs of young people in a prompt and timely way, and that has been resisted, at a state level in particular but nationally as well. Other countries are much more open to looking at these issues. In Britain they are spending \$70 million on 50 new early intervention teams across the country—a much more ambitious and well-supported system of reform. It is disappointing that in your own country you do not get the sort of support that should be there. We could have been way ahead by now.

Senator MOORE—My second question leads directly on from that. You are operating within a system that is not sharing the work you are doing. You spoke this morning about referring people whom you cannot treat because you do not have the capacity. There are also the people you are working with who may have interaction with the other parts of the service. What does that do to the work you are doing? You have people you are working with and when they get too old for your service you have to refer them to other parts of the mental health services in Victoria. You also have people you are currently working with through your various processes who may have to go into another part of the service and back again. I would like some information on what impact that has when someone is used to getting the kinds of services they are getting through your area and then are not.

Prof. McGorry—You heard some of the consumers talk about that experience and what it was like. The international standard for this is three years of care following onset. It should probably be five. In fact, the other services that are being supported in other parts of Victoria are resourced to provide three years of care. We are resourced to provide only 18 months, which we believe is far too short. You heard what the experience of transition was like. Our suicide rates within the program are lower than the state average compared with other services while they are with us but when we discharge them back to the other services the suicide rates go right back up again. The experience is extremely adverse in the rest of the system for these patients, and I presume it is similar for patients who have never had the experience of this more youth specific service. We have been researching these questions and we are worried. We believe we should be able to treat people for a longer period of time and with more intensive sorts of treatments but it is extremely difficult to obtain support at a state level.

Dr Chanen—One of the explicit aims of some of the programs—and I run a program for early intervention for severe personality disorder—is to divert people from the adult mental health system because of the iatrogenic, that is, the medically induced, complications that attend that disorder. The very few people we do hand over who are obviously at the most severe end of the spectrum and who have not responded to treatment we dread doing because it is inevitably associated with a decline in their functioning.

Dr Lubman—With reference to linking with other services, one of the initiatives that we have really been trying to push is closer liaison with the youth drug and alcohol services in our region. We have a number of initiatives which we are working on very closely in partnership in addressing young people's needs. For example, we have completed a number of studies showing that around 70 per cent of young people presenting to drug and alcohol services have a lifetime history of a mental health disorder. There are high rates of mental illness in other drug and alcohol populations but in every other part of the system they are ineligible to access mental health care. In fact, if you present to traditional mental health services with a full blown drug and alcohol problem they will tell you to go away because they will blame the mental health disorder on the drug and alcohol use. It is quite frustrating for our partners because the partners we are working with also service other regions of Melbourne. They have very good service from us in terms of trying to offer a rapid and integrated response to people with both comorbid mental health and substance use problems, but if they live outside our geographic region they get told to go away and there really is nothing to offer them.

Prof. McGorry—I will make one comment about substance abuse: in terms of reducing the burden of disease caused by drugs and alcohol, 50 per cent of that could be reduced through early and proactive treatment of mental disorders in young people. It has been calculated by the well-known American epidemiologist Ron Kessler that 50 per cent of substance use disorders are explained by unrecognised and untreated mental disorders in young people.

CHAIR—This issue came up yesterday or the day before. I was not able to give a reference to that figure but I did attempt to quote it, so I am glad you have done that, Professor McGorry. Dr Chanen, can you go a bit further in what you have just talked about and describe in more detail the difference between the service you provide and the adult service that someone who has been in your system—or not in your system for that matter—would get? How different would those two experiences be?

Dr Chanen—From a professional point of view, the experience is explained in part by the culture in the services. As members of the committee have commented, there is a sense of optimism in the service that we provide. The kinds of things that we can do include an open, rapid response to problems, an openness to being available, a collaborative relationship with the patient and the provision of outpatient treatment that integrates both case management and psychological treatments. We are one of the few places where psychological treatments are widely available and are implemented, and there is ample evidence to show that those treatments should be implemented. But when I teach trainee psychiatrists and ask them if psychological treatments are available in their service, they inevitably say that they are available in very few of the services or, if they are available, they are available in very limited form.

So people will get a very high quality of case management of collaborative treatment and then, when it comes to the end of that very brief 18-month period, handing them over is a very mixed bag. There are clearly some very good practitioners in the adult system, but the culture of the system militates against any kind of preventive work, so people get turned away because they are not sick enough. The kinds of people that we could actually discharge to the adult system have to be really very severely unwell and you have to make a very strong case for those people to be taken on in the adult system. If not, there is nothing else to refer those people to. Young people will not access private practitioners in any systematic way. Private practitioners are reluctant to take young people on, because they are not reliable attendees and a practitioner's

income obviously depends upon the young person turning up. There is a very limited range of people that we can actually hand on to adult mental health services, and that really is restricted to the people that Professor McGorry has referred to—the chronic, severe psychotic patients. Everybody else really has very limited access. Some of the very severely personality disordered people can be handed on and the quality of care is very variable for those people across the state.

There is a culture within mental health services of pessimism toward those patients—the kind of expectation that Senator Humphries referred to of nonrecovery and chronicity—such that, once these people are in the adult system, the pessimism is pervasive and demoralising. The iatrogenic harm that is done by that is enormous, whereas in fact the research suggests that the natural history of, for example, severe personality disorders is toward recovery, not toward chronicity. But, as I said, if you only ever see those people that keep turning up, you would imagine that this is a hopeless situation. There are ample studies now that show that these disorders are treatable, yet there is a tremendous reluctance to take those people on for treatment, and they have extremely high rates of morbidity and mortality—a mortality rate around the same as that of psychosis at about 10 per cent.

Senator SCULLION—Thank you very much, not only for the very informative trip this morning but also for a very comprehensive and visionary submission. It seems, not only from my visit this morning but also from your submission, that a very important part of the process you provide for young people is the recognition of the value of the social support network—I think they were the sorts of terms that were used this morning. Can you tell me about the family participation program and the platform team. I know we will be speaking to the platform team a little later, but I wonder if you could just tell us what sorts of supports you need to give to those particular aspects of your process, both in financial terms and in human resource terms. What sort of training is required? What sort of support do you give those two essential items?

Ms Albiston—The social recovery and the family participation?

Senator SCULLION—Basically the whole social support network you have in place, with the family participation and the support platform.

Ms Albiston—Group programs are certainly part of the treatment modalities that we use. I mentioned those this morning. I think it is important to note that with the increasing focus on individual case management, which is to be applauded, there has been a decline in the use of group programs throughout mental health services. We find that the provision of group programs is absolutely fundamental for young people. Young people learn, grow and develop through peer support. We know that for most young people, following the onset of any sort of mental health disorder across any of the diagnostic categories, one of the first things that happen is that they withdraw from a lot of their peer support groups, from their vocational activities and from their families. We often have families saying, ‘My daughter sits in her room in front of her computer all day and won’t speak to anybody’—to that degree. So the capacity to enable young people to experience a sense of belonging to a peer group and to continue to work on those developmental tasks that are vital for all young people—things like developing a sense of personal identity, a sense of independence, a sense of responsibility and all of those sorts of things—are very important tasks, I think, for a youth mental health service. We certainly use the group program modality to do that.

We also provide group programs that are very closely related to the client goals. We run a menu of group programs, if you like. So it is not that you come every day, all day and sit around and drink cups of coffee and chat; it is very much focused on where those young people want to get to. The most common sorts of goals that they talk about are having relationships with other young people. Sometimes they will come in and say, 'I really need a girlfriend'—which we cannot help with. It is that style of thing where they are really feeling that loss of a peer support group. We can use the format of groups to make sure that there are some informal social groups where people can test their social skills. They often have very low self-esteem at that point in time. They wonder if they are of any worth to other young people or if they can feel comfortable with others. Social anxiety is extremely high in our young people, so this gives them a chance in a fairly non-threatening way to work on some of those problems that have resulted because of the onset of illness.

Other group programs look at specific areas such as vocational training and planning—those sorts of things. Creative expression is very important. Young people often find it difficult to talk about what is going on for them but can express themselves through other means. Psychological interventions often work very well in a group program format—particularly psychoeducation, where someone might come in after the onset of an illness, not quite understand it but then hear from other people in their group about what it was like for them and what has helped them overcome the illness. I think group programs, particularly for youth mental health services, are a very important component.

The family participation project has been going on for a few years. It is not funded in any great sense. We struggled to find the funding for a part-time person—Margaret, whom you met this morning. When you think about it, families are often the ones dealing with the issues for the young person. We might see someone in a couple of groups a week and we might do some face-to-face individual work with them, but it really is the family environment that they spend most of their time in, given the age of our young people. We have really tried to focus on what the families need in order to participate in the treatment and the care of that young person so that they fully understand what is going on. We also try to provide them with the emotional support that they need, through contact with other families and carers who have been through a similar situation.

As you heard Sue describe this morning, she was absolutely dumbfounded when her daughter experienced her first episode of psychosis. A lot of emotional support needs to be provided early on. Then as parents are trying to understand what is happening with their child, they need to be given the appropriate information. We run family education and information sessions. They are more about the initial stuff around how we see psychosis, because our view of psychosis is quite different. We talk about it being episodic and we talk about recovery. We describe to parents what we expect regarding psychosis, and we have tried a similar model with some of the other diagnostic groups for the young people that we see—depression and eating disorders. We also have family support groups which are more discussion groups for helping people get through it, if you like—more broad based support. They always include some information gathering but certainly provide a lot of emotional support—not from staff to families and carers but from carers themselves—so that they can support each other within the group format and outside.

We are also trying to find a way to provide contact—from our carer consultants, if you like—to families as early as possible. Phoning families in the first few weeks following admission to

our service is also very important. But, again, it is not something that we have ample funding to provide. We would really like to be able to employ carer consultants. Given that this is about the onset of illness, we really need to be able to work with the families as early as possible so that the impact of that onset does not reverberate forever within that family.

Senator SCULLION—We have heard a common theme through the hearings. It has been asserted, and I certainly think this, that being part of mental health is borderline and that it often crosses the border, in terms of human rights abuses. I heard from my new friends this morning that a standard welcome to the adult mental health process is for someone to sit on you and put a needle in your bum, but I do not see that in your organisation. I do not get that feeling from your organisation at any level or from some of your consumers. Do you have any particular standards that you try to work to? You have said: ‘These are standards that we employ. There are articulated standards about how we treat our clients or our customers.’ Is there any particular training? Obviously you have an ethos there but is it an articulated ethos?

Prof. McGorry—Senator Scullion, I am glad you brought this up. This is one of the things which horrified me when I first started work in psychiatry. One of the reasons I did not do psychiatry straightaway is that I knew this kind of thing was standard. This goes back 20-odd years ago. It is very distressing to see that it is still a hallmark of the system—not only that, but it is not happening in the institutions any more; it is happening in our emergency departments all around Australia. There are stories of people being shackled and injected without even being spoken to properly. It is an absolutely disgraceful human rights situation. It would not be tolerated in any other area. It is a vital thing to address and I have no doubt it can be addressed.

You cannot completely eliminate coercion from psychiatry, because of the need to have mental health acts and involuntary treatment, but it can certainly be minimised. It stems completely from having a philosophy, which is enshrined in mental health acts around the country, for the least restrictive environment. So much lip-service is paid to that rhetoric that it is just not funny. It has to be believed and valued at all levels of the organisation that that is the way to go: that you treat people with respect, that you really have great affinity with your patients and that you identify with being in that situation yourself. Those sorts of mind-sets and emotional connections to the patient have to be there. Often in mental health settings they are not there because of the demoralised nature of the work, the underfunding and all the things you have been hearing about. It is not necessarily the staff’s fault, but it is hard to maintain the morale and a philosophy of that type in a neglected public sector practice. I think it stems from believing in that value system and having leadership that believe in it and live it themselves. There are skills related to it. I have seen standards being worked on for 10 years in psychiatry and we are really not very much—

Senator SCULLION—I was more interested in the standards of your organisation.

Prof. McGorry—Okay. I think it is something that you can put in black-and-white measures, such as measures of how much seclusion you are using, how much involuntary—

Senator SCULLION—Have you actually done that?

Prof. McGorry—Yes. We have always had levels of seclusion below the rest of the system. We monitor that. We monitor the involvement of police in admissions, which I have also seen

rise back up from a period, say, five or six years ago when that was at a much lower level across the system. We see it as a failure if the police are involved in an admission, because it gives a bad message to the young person in terms of their entry into the service. Obviously we try our best to keep people out of emergency departments, where emergency physicians are in charge of the care of the patient and will overrule the mental health staff. There are practical things that can be done, but your own mental health service has to be imbued with this kind of philosophy and feeling for the patient. If coercion is involved then there have to be strategies to help the patient and the staff deal with what has actually happened, because it can be quite difficult managing some of these young people in that setting.

Andrew and I did a study about 15 years ago. We measured levels of post-traumatic stress disorder in patients who had been through these coercive sorts of experiences and found levels of about 40 per cent of post-traumatic stress in the patients. As you can imagine, such people are already psychologically compromised when they go through this. We have talked this morning about the case histories of people and I mentioned a patient that we treated in the EPPIC part of ORYGEN. On his first four or five admissions or episodes of care he had no insight at all; he had not realised that there was a need for care. He had been involuntarily hospitalised and had been quite distressed by that, despite our best efforts. Probably a year or so after he was transferred to the local area mental health service he, for the very first time, sought help.

Senator SCULLION—Would you go back and describe to me what actually happened after he had been four or five times to you? So he was still in denial, then he realised that he needed some help and he went to the hospital—and then what happened?

Prof. McGorry—This patient was obviously a bit of a slow learner but he was a very good person and when he was well he was a tremendous artist and a wonderful person. But he was a slow learner and it took him four or five goes at it before he got the hang of it and then he actually sought help for the first time. He was becoming manic and got himself to the emergency department with his parents. He was kept waiting for five hours and eventually said, in an angry tone of voice, ‘What have you got to do around here to get some assistance—commit suicide or something?’ At that point the emergency department staff seized him, shackled him and injected him.

Senator SCULLION—That is a pretty mean bit of detention, isn’t it?

Prof. McGorry—The whole insight process—the learning experience of seeking help—was completely shattered by that sort of response.

Senator SCULLION—That was obviously non-consensual. So there were no discussions about any of that?

Prof. McGorry—No. His parents witnessed this, so it was not just his account of the event available. This is happening all around Australia every day.

Dr Chanen—I will add something about the training issue and ORYGEN. The training of all case managers is, firstly, around early warning and early detection of relapse to prevent this kind of situation arising. Also, the training emphasises collaboration, which I think is not emphasised in the adult mental health system: it is a ‘doing to’ rather than a ‘doing with’ culture where one

orders people and takes control of the situation, rather than actually asking them what their needs are. It has always struck me in my work in emergency departments that as soon as you ask people what they want you can defuse situations very quickly. There are times when it is unavoidable, of course, but teaching a collaborative treatment approach is vital to this. The reason it is not there in the adult system concerns a hangover from the translation of that institutional culture into the community care culture, such that the culture carriers in that environment are still those people from the days of the old institutions who were used to this coercive kind of environment. But it can be changed.

Prof. McGorry—The other thing—and Dan just reminded me of this—is that the clinical practice guidelines for the treatment of schizophrenia and also the international early psychosis treatment guidelines are another way of influencing clinical practice. Evidence based guidelines were written and we convened a process nationally and made sure that some of these things were written into the treatment guidelines for schizophrenia, which were published by the college of psychiatrists earlier this year. So at least some of these principles are there. If people choose not to adhere to them, that is a separate issue.

Prof. Yung—As Pat was saying, we have the Australian clinical guidelines for the management of schizophrenia and early psychosis in particular. The early psychosis guidelines were first published several years ago, but they do not seem to have penetrated even the neighbouring suburbs. I was working at St Vincent's Hospital a few years ago, having come from EPPIC. I went to see what the management of early psychosis was like in that environment. I did a brief audit in which I found that even the published guidelines were not being followed and that police were being involved in about 40 per cent of the hospital's admissions, so about 40 per cent of the young people presenting there were actually coming in shackled. Intramuscular treatment—the injection in the bum, as Senator Scullion described it—was very common. The involuntary treatment was way more common than in EPPIC. I can provide you with a paper which we have published with that data in it, showing that even in the neighbouring suburbs those clinical guidelines were not being followed.

Prof. McGorry—To be fair to the state government, they are starting to introduce that approach to care for early psychosis, not for the rest of the mental health problems of young people, across the state but it is still too little, too late, too slow.

Dr Chanen—And an artefact of that coercive environment is, of course, that there is an increased need for beds. There is a kind of sentimental attachment to the old days when we had more beds, because we were more coercive and we could utilise those beds. In a collaborative environment the need for beds decreases, not increases.

Senator SCULLION—There are four things I want you to supply on notice: the published guidelines, the report that you collaborated on when Dr Chanen was 15, any training guides that you alluded to, and any standards that you have articulated.

Ms Albiston—We certainly have sets of clinical guidelines for our service and we also have manuals that are published and distributed. All of those things would be useful.

Senator SCULLION—If you could table those we would really appreciate it.

Dr Lubman—Can I raise the issue of morale within the wider psychiatric work force. One of the things that Andrew has already alluded to is that within our environment we offer a whole range of evidence based approaches where people are trained and supported, and so people feel optimistic and confident in being able to engage with people and work with them on their issues in a very collaborative sense.

Unfortunately, in other areas in mental health in which I have worked in this state, there is a very generic model of mental health care which reduces the level of competence in the staff so that people are not aware of many of the interventions that are available for adequately treating mental health problems. That leads to this issue of people being scared of being overwhelmed by the need in the community that everybody talks about and putting up walls to stop people getting in. Unlike our service, which is very much based on early intervention—getting people in early, treating them effectively and working with them through the crisis—in other areas of mental health it is very much a brick wall. To get in, you basically have to come in in crisis, and that is not the time to really be engaging with people and working effectively. That creates a lot of trauma and psychological damage that leads to ongoing morbidity for the individual presenting at the service.

Prof. McGorry—We probably ought to say that there are one or two other examples in Victoria where the service system is functioning well. They are characterised by the features that Dan just mentioned: specialised expertise, good funding and enough beds. The equity in allocation of services is variable. Some services are relatively well resourced, but the average level of resources and genericisation varies. There is resistance at the policy level to supporting specialisation in psychiatry. That is one of the things that went by the board over the last 10 to 15 years. There is this attitude that you have to bring every part of the system up to a certain minimum standard before you can support the sort of specialisation that Dan is talking about.

CHAIR—Were you describing a private sector service?

Prof. McGorry—No, there are some public sector services in Victoria that you could say are doing a good job. I think everyone is doing their best. That is another point. We are probably very critical of other services, but we do not blame people. We understand that it is very difficult. We have some advantages in our setting. Even though I suppose we would say we are neglected by the Department of Human Services on the clinical side, we have a lot of research resources which allow us to attract high-quality people to work in the service, so we can have a better impact and better morale. I think some of our colleagues in other parts of the state do not have that advantage.

Senator FORSHAW—There could be a million questions. Thank you for the opportunity to visit the facility at Parkville this morning. When we were there you mentioned that you have an in-patient facility at Footscray. Can you quickly tell us about that?

Prof. McGorry—There is a 16-bed in-patient unit. It was located at Parkville until about a year or so ago but was rebuilt at Footscray in a very good quality fabric, purpose-built environment. Unfortunately, the geographical separation causes us significant problems. This is part of this policy of co-locating in-patient units with general hospitals.

Senator FORSHAW—So it is part of a public hospital, is it?

Prof. McGorry—Yes. It is co-located.

Senator FORSHAW—In terms of early prevention—and of course early prevention requires early detection—one of the areas in which there has been an attempt to improve that is through GPs, the Better Outcomes in Mental Health program and so on. You have made some comments in your submission about referrals from GPs. Could you expand upon any ideas you have about how we can improve the capacity of general practitioners to pick up the signs. I understand that there are a myriad of issues—for instance, whether or not young people are less likely to visit an older GP than older people would be; they may not want to communicate the issues and so on. But it seems that GPs are still very often the front line, if you like, whether it is in private practice or even at the A&E at hospitals.

Prof. McGorry—GPs have definitely got a role to play in early detection. Every GP, you could say, would have it. But, in terms of referrals, only about 10 to 15 per cent of the patients that we get referred come via GPs. So, as you say, young people quite often do not have great connection with GPs. There is a whole range of other primary care structures that they do have contact with, like school counsellors and so on—other pathways to care. Obviously general practice is, as you say, the cornerstone of the Australian health care system, so it has got to be an element in there.

In terms of providing treatment and intervention: we get calls every day of the week from GPs who have tried something simple and are really at the end of their expertise, even though many of them have actually been trained in mental health interventions now. They are looking for something more specialised. They certainly cannot get that from the standard public mental health system, in terms of young people. They cannot get access to that. So there is a need for two things, we think, which I mentioned at the beginning. First of all is an enhanced system of primary care, and probably the prototype for that would be would have been the clockwork model in Geelong, which you may have heard of, where a central venue, a youth-orientated venue, was established in the centre of the town and sessional GPs come in and do sessions. They are interested in working with young people, they are confident and they are trained. It was and still is a strong resource to deal with primary care. Young people feel comfortable going there: they are understood, and there are other youth-orientated services nearby. It is around this idea of the youth precinct. It is not just services; other youth activities are also available in that precinct. So that is something a little bit above standard general practice. Obviously we are arguing—and we have argued extensively for this—that the public mental health system needs to be structured in a congruent way.

Senator FORSHAW—I assume that, if that sort of service were more widely available and more effective, it would actually take the pressure off organisations like yours and the psychiatric hospitals. Because, if it is one in four that may experience a mental illness in a year, it is not necessarily going to be one in four that ultimately goes on to develop a full-blown mental illness for the rest of their life, is it?

Dr Chanen—It would take the pressure off in one way, in that it would provide an avenue for treatment of that group of people who do not need a specialist service. But the sheer weight of numbers of people needing a specialist service would still be there. So in a sense we would see it not as taking the pressure off but as adding another tier to treatment. We get 2,000 referrals a year. The data that Professor Yung has presented attests to the fact that those people need a

tertiary type of psychiatric service. But we can only see about 800 of those. There is then another group that would benefit from that enhanced primary care model.

Senator FORSHAW—That is the one I am talking about.

Prof. McGorry—I think you do have a point, though: if you have an enhanced—in other words, semi-specialised—thing in the middle, with other resources like drug and alcohol counsellors and vocational counsellors, you will go a long way towards reducing the pressure on services like ours, but not completely, as Andrew said.

Prof. Yung—There is also the follow-up of these people. One thing that we can do is actually link them in with GPs, so that there are some people who, when they do have to be discharged from our service, can then be managed by GPs—ideally with ongoing support. So it is not just the front end; it is also the back end.

Senator FORSHAW—And that could be with other health professionals—psychologists or whatever. I have another question, and you may want to, if you could, provide me with some more detailed information on this. It is the specific issue of the role of family history of mental illness in early detection. We know that so many other chronic illnesses can be detected early if there is regular screening, whether it for breast cancer, colon cancer or whatever the complaint is. That obviously is probably a lot easier for most people than it is if there is a history of mental illness—depression or schizophrenia—in a family. People do not say: ‘Hang on, I’d better put my hand up. I may not be feeling that I’ve got an illness, but there is the potential for it.’ But I have heard evidence that there are genetic factors involved and family history can play a part. You might want to make a comment about that. I think people would run a mile away from some sort of national screening system and I am not suggesting that, but do you know what I am getting at? There is no doubt that it can run in families.

Prof. Yung—We certainly would not advocate a national screening system.

Senator FORSHAW—I am not suggesting you would, and I do not want anybody to misinterpret my remarks, but, at the same time, I understand there has been research work done over many years looking for genetic factors.

Prof. McGorry—Perhaps I could say something first and then get Alison to talk about this, because her work is very relevant to this. We know, from the latest issue of *Archives of General Psychiatry*, that in fact one in two people across the whole of the lifespan will develop a mental health problem at some point. It is just like physical health problems. You are going to get it at some point; there is a fifty-fifty chance of anyone developing an episode of depression or mental health problem or disorder. In that case the broad family history may not be that much use, but certainly, like any other set of illnesses, genetic vulnerability does play a part, but there are gene-environment interactions.

Senator FORSHAW—I am talking about where there have been one or two members with intensive—

Prof. Yung—Certainly we know from research that people with a family history of a mental disorder—plus other problems with living and psychiatric symptoms—are certainly at increased

risk of developing a full-blown mental disorder. It is not just a family history of mental illness plus someone feels off for a day or so; it has really got to be the signs of emerging mental disorder. They are the things that it is important that people in all levels of the health system are aware of. Asking about a family history should be routine in general practice. If a young person comes along and they have dropped out of school and they are socially withdrawn and they are feeling depressed, do not just treat that at face value; if they have got a family history of schizophrenia or severe depression, then maybe they are the sort of person who does need to be monitored more closely. I am not saying put antidepressants in the water supply. To have that index of suspicion—

Senator FORSHAW—I know you are not saying that. You have got to be careful that you do not actually entrench an idea in somebody's mind that there may actually be no ultimate concern about.

Prof. Yung—It is important to not give the message: 'You're doomed. You're going to get mental illness because your mother has got it.' It is important to, firstly, give the message that you may be at increased risk and, secondly, if you are at increased risk then we can monitor you. We can monitor you with monthly appointments with a GP or a counsellor and, if things get worse, refer you on. There is a chance that it can be prevented through early treatment, and that is what we are on about here: early treatment and prevention of ongoing and serious mental disturbance.

Dr Chanen—There are different levels of prevention. What you are referring to is a whole-of-population approach that might be used, which is called universal prevention. Then there is selective prevention, which is where you target people who have a risk factor but have no other problems.

Senator FORSHAW—Which is what we do in a whole range of other medical—

Dr Chanen—Those approaches have largely been unsuccessful thus far. The best evidence is for what is called indicated prevention, which is the kind of prevention that Professor Yung is referring to, where they have both a family history, or other risk factor, and emerging signs of a disorder. You intervene prior to them achieving a full-blown case of a disorder. That is the approach that ORYGEN uses across the board with all disorders.

Dr Lubman—I have a comment about other markers of later mental illness. One predictive factor that has come through in the literature in terms of marking the onset of later mental disorder is early problematic substance use. We know that a substantial proportion of young people who have problems with drugs and alcohol at a very early age will develop more entrenched morbidity in both substance use and mental health problems. One of the problems with the dichotomisation of the system in terms of mental health and substance use, where the substance use philosophy is really the only treatment model, is that it is just about reducing substance use. It really is not addressing the underlying psychological dysfunction that leads to ongoing mental health problems later on. What we have been trying to do at ORYGEN to address that issue is to work much more closely with the local drug and alcohol services. We have embedded mental health clinicians within their services so that we can start to address some of the underlying mental health issues within that population so as to prevent the

progression of the disorder and reduce the need for referral to a tertiary service. We will be able to intervene at a much earlier stage.

Senator WEBBER—I am aware of the fact that we are running fairly late, and I am anxious to hear from some of the young people too, so I will try and keep this as brief as I can. First, I want to congratulate you on the service you provide. It seems to be one of the few genuinely multidisciplinary, patient-centred treatment programs that we have come across, although this is an early stage in the journey for us. I have two questions. One picks up on the point that was just made before. My concern is that we have these silos. We have drug and alcohol, we have mental health and we have disability. You are targeting an age group that seems to fall through the cracks. What concerns me is the way they fall through. People can be at risk of being shunted from one to the other and never treated as a whole as a patient. I welcome your comments on that. Also, how much of your time do you spend chasing the money to deliver the holistic service rather than focusing on delivering it? I am really worried about those 1,200 young people every year that are not getting to see you.

Prof. McGorry—You are right about that first point about the silos. That is an absolute bugbear of the system at the moment. I am sure you have heard lots of stories about this. Any rehabilitation resources that are provided now are split off, in Victoria, into something called PDRSS, psychiatric disability rehabilitation and support services. They are run by NGOs, which in many ways is a good thing because it creates a different sort of culture. But it is a different system of care to the public mental health system. It is a silo problem. Drug and alcohol is the worst problem that we have. In the past, 20 years ago, drug and alcohol services were run completely integrated with mental health services, certainly in the two states I have worked in, New South Wales and Victoria. They have been separated off into two separate systems of care. At the bureaucratic level, we have a state director of mental health and we have a state director of drug and alcohol. On the ground, they are separate service systems and separate cultures now. It makes absolutely no sense for it to be like that. They are the same kinds of problems and, quite often, it is the same people with different thresholds of mental health or drug and alcohol problems. If you were to recommend that that be addressed seriously, the territoriality would probably defeat it. But if it were about patient care, you would bring those systems together tomorrow under the same leadership and the same principles of service provision. That is one thing you could say.

Dr Chanen—The other silo that you have not mentioned is that of the justice system, particularly the juvenile justice system. It has extraordinarily high rates of mental health problems. It tends to get neglected among all the other silos. I think that should be included.

Ms Albiston—The other set of silos, if you like, is the disability employment agencies and vocational agencies that come under a totally different government department. We have done a lot of work with them in terms of trying to move them towards our clients and to prepare our clients for involvement with the services that they provide. But it is quite difficult because everyone is working within their own limitations and their own mandate.

Prof. McGorry—What we have basically argued for in our submission is, at the enhanced primary care level, that all of these professionals are located in the same venue in the community. In our system, Parkville, where you were this morning, is established as a youth precinct—I think the state health minister is considering this very favourably—so vocational

recovery services, drug and alcohol services, and our services will all be co-located in the future. That is what we are hoping, but it is a slow process. That is the logical thing.

Regarding the second point about how much effort it is, I have spent the last two years doing everything I can think of to try to get our state government to address the resourcing issue. We have measured everything. Alison's study, the Grey Zone study, measured this. She followed up the patients that were turned away, and showed that they did very badly even though they were initially less severe than the patients that we took in. This has fallen completely on deaf ears. The most that we can actually extract is a commitment to extend the early psychosis model slowly across the state. That is a step forward, and you will probably hear about that later on today, but it could be done now. We could be supported better.

We need to be supported not just as a direct service provider but as an engine room for further reform. You can see the research resources we have at our disposal; they will not be there forever. They have already been sitting around for about the last three years underutilised because we have not got the infrastructure to partner properly with these research dollars. We have a program grant from NHMRC beginning this year which is totally focused on this youth mental health agenda. We seem to be able to convince our research colleagues and the NHMRC of the value of this approach. We cannot convince state and federal governments. Although the federal government, I must say, is starting to look at youth mental health more seriously. It just needs to keep on growing.

I sound like I am complaining, but I still think Australia has the innovation capacity in mental health, as it has in many other areas. We have already, not just in our areas but in other areas of mental health, taught the rest of the world how to do things. We could do it a lot more effectively if we got proper support—political and community support. I think the community is ahead of the bureaucracies and the politicians at the moment.

CHAIR—We will have to finish there. We have hardly had a chance to talk with you about your research program, which is a great pity, but we have two very important sessions coming up. We do need to move on; we are already an hour late. Thank you again for your efforts in making the submission, for your ongoing work and for presenting to us today, and also for having us at ORYGEN.

[12.50 pm]

BROWN, Mr Eric Kahotea, Platform Team Member, ORYGEN Youth Health

DIXON, Mr Christopher, Platform Team Member, ORYGEN Youth Health

FRIEDEL, Miss Emily Jane, Platform Team Member, ORYGEN Youth Health

GELMI, Miss Fran, Platform Team Member, ORYGEN Youth Health

MARTIN, Mr Christopher Edward, Platform Team Member, ORYGEN Youth Health

TOBIAS, Ms Jolan Lara, Platform Team Member, ORYGEN Youth Health

CHAIR—Welcome. You have a lodged with the committee a submission which we have numbered 280. Do you wish to make any changes to that document at this stage?

Ms Tobias—No.

CHAIR—Ms Tobias, I invite you to make an opening statement, then we will move to any of you who wish to speak and then we will go to questions.

Ms Tobias—Basically I would like to thank you for inviting us today. I will hand over to Chris now.

Mr Dixon—Hi. We are the platform team and we are going to tell you a little about ourselves, what we do and how we think mental health services should be set up for young people. We are young people between the ages of 16 and 30. We are past or present clients of ORYGEN Youth Health. We have all had experience of a serious mental illness issue at some stage, and we are passionate about making mental health services better for young people.

Mr Martin—We got involved because we have had a positive experience with ORYGEN. Many of us had had some very negative experiences in other services before we came to ORYGEN. We want to help make ORYGEN services even better, and we want other mental health services to learn how to provide appropriate services to young people.

Miss Gelmi—I am going to tell you a bit about what we like about coming to ORYGEN. Aside from one-on-one therapy, we really like the group programs that the service runs, because they are educational; social; confidence building; therapeutic; good for both emotional and physical health; helpful for future work and study, which are both very important, especially for young people; and, lastly, they are a lot of fun. Also, most of the ORYGEN staff really care about and are sensitive to the needs of young people. The approach of the service is quite different from that of many other mental health services. It is clear that their philosophy is not, 'Here; take your pill and get out the door.' Lastly, it is a service specifically for young people so that they can make peer connections and get the right kind of help that they as young people need.

Miss Friedel—I will let you know a bit about what we do. When I first got involved with platform, I expected that it would be pretty tokenistic but, as this at least shows, I was wrong. We provide peer support, and we help current clients with what they are going through. We provide a newsletter, which is run by clients for clients. We help develop initiatives within ORYGEN—for example, a client feedback process—participate in staff interview panels and assist with the preparation of published materials for clients. We participate in internal ORYGEN committees—for example, the quality committee and the health arts committee. We run youth participation workshops for other mental health services so that they can learn how to set up something like we have. We give information talks at schools and to graduate classes of health students, and we meet with politicians. We came up with the ORYGEN name as well, so there is a sense of ownership there for us.

Mr Brown—How has it helped us as a platform team? What it has done for us? We have got a lot out of being part of the platform team. We have got new skills, including public speaking, as Emily just mentioned. We have participated in planning and running workshops, meetings, interview panels et cetera. We have been to conferences. It has helped in rebuilding our confidence. Experts in mental health want to attend workshops run by us, and politicians are interested in what we have to say. When we meet with ORYGEN staff, they are generally interested in what we have to say and they listen.

It helps us with our work and study. We have been able to get involved at a commitment level that suits us. We get plenty of responsibility. We have therefore gained an impressive amount of experience that helps us when we are applying for jobs or getting back into our studies. We have had the chance to give something back to the service. We feel like we are making a difference and are part of the community. We also enjoy the opportunity to socialise in a supportive environment and we get to make new friends.

Ms Tobias—We recommend that all young people who need a mental health service should be able to access services that are specifically for young people, no matter where they live. All mental health services should have group programs and do more than just prescribe medicine. Social, vocational and emotional goals are crucial to psychiatric recovery. We recommend that young people should be involved in the design and delivery of mental health services for young people. This can be done, and we have shown that it is possible. In conclusion, we hope that the Senate Select Committee on Mental Health helps young people in Australia to access better mental health services. Thanks for listening. We are happy to answer any questions.

CHAIR—Thank you, and congratulations on being part of this initiative. It is obviously very practical, as well as worth while for you as individuals. Let me start by asking you to contrast the services that you have received through ORYGEN and your experiences coming into an emergency department in a general hospital. Which if any of you have been collected by a police paddy van and carted off somewhere? Can you tell us about what that is like and why it doesn't work with young people?

Ms Tobias—I will start with what I said earlier this morning about the differences about my first admission to ORYGEN. I was not put in a high-dependency ward. I was just sat down and spoken to. They tried to get me to think a bit and calm down, as I was fairly agitated. They said, 'Maybe you should take a Valium. Take this tablet; it'll help you settle.' I was really spoken to like a human.

My first admission to an adult mental health service was while I was still under ORYGEN's care but they had no beds. I wanted to go home, and the team were happy for me to go home, but unfortunately the emergency department decided that I was under their care then. They shackled my hands and feet. I got out of that and said, 'Look, I want to go home. The team are saying I can go home, and my mum is at home.' They strapped me back down on the bed, put me in a full body harness and transported me to the adult mental health service that was going to babysit me until ORYGEN had a spare bed. They put me straight into a high-dependency ward and stuck a needle in my bum. During the three days that I spent there, they locked me out of the toilet, tried to give me the wrong medication and would not listen to my treating doctor at ORYGEN because I was apparently under their care there. And there were several other things. They kept giving me IMs and saying, 'This is the way we do it here,' when I was not even agitated. I was just sitting on a chair, and they said, 'You've got to get up now and come in here and have this.' So it was quite different.

Mr Dixon—I have had a couple of experiences with police. The first one was when my brother was ill. The doctors said to me and my brother that he needed to go to hospital. He was not going to go, so they brought the police in. He walked out with the police and with the doctor, rather than being dragged or anything.

I have had an experience where I did not want to leave the room because I was quite ill at the time. The CAT team had been there for several hours trying to get me out because I was in quite an acute state. They could not leave me. They tried to get the police. The police came. I told them, 'I've got to go,' and they said, 'Yep'. I said, 'Give me five minutes and I'll go in the ambulance. Is that all right?' They came back five minutes later and I said, 'Yep, I've got to go,' so I went in the ambulance. So there is an element there that is good. They do work effectively if they talk to you.

I did have an incident where one of my friends was ill. He had a very acute episode within five or 10 minutes. I rang up the CAT team and they said that they would ring back. Then he got worse. He was unsafe to me and to himself and so I called the police. They came within 15 minutes. He was outside with them and they called the CAT team. Apparently if you call the police and it is quite a serious situation then the CAT team has to act. The ambulance came out and took me and him to the hospital. At the emergency ward we were told to wait half an hour in the waiting room. I spent the whole trip to the hospital, which was about 40 minutes, and the half-hour at the hospital talking to him, calming him down and doing breathing exercises. As soon as they saw he was doing that they thought he did not need to get admitted. They did not see the critical side of him. He was actually taken home by his parents in the end. That is the experience that I have had.

CHAIR—Does anybody else want to share anything like that?

Miss Friedel—My biggest problem with emergency wards at hospitals is that sometimes they just do not know what to do with you. They do not know who to refer you on to. They do not know where to get you help. They just say, 'Go out and find a private psychiatrist', which is really difficult in itself. You often have a two-month waiting period before you can get into one, which is completely ridiculous if you are in a really acute state. They just do not have knowledge. I saw several GPs before I chanced upon a doctor in St Vincent's who knew where

to send me. GPs just hand you your prescription for Zoloft or whatever and you are out the door. You have got 10 minutes of their time. They do not really know what to do with you either.

Senator SCULLION—Do you think you could help the emergency departments understand? Do you think if a team like yours was there that you could really be part of that process of helping calm people down because you understand it and you have been through it whereas other people have not and maybe do not understand? Do you think you could be a part of that process? I have already heard from Jolan this morning that there are some environments where there are a lot of people telling people what to do. Outside of that, let us say we could actually create a place where people could triage through the emergency department to somewhere else in the hospital. We have talked about that with other people. If there were that sort of environment, do you think a team like yours, people who have come through this process, would be useful?

Miss Friedel—I think we could be. It would depend on how acute someone is and what sort of care they need. Obviously we are not clinical and we cannot help with any of that, but if someone just needs somewhere to sit and have a chat with a cup of tea or something for a while, it could be useful.

Senator SCULLION—Do you think it is something you might want to do?

Mr Dixon—The emergency department actually have a psych triage person but I think part of the problem is that they are normally busy on calls or other things. It could take two to three hours before they actually get to see you. All we could do is interact with them on a lower level or train somebody in the different ideas or about different stresses that are happening.

Ms Tobias—There is a similar thing that we are doing at the moment at ORYGEN, which is a peer support program. Looking at a crisis situation, it would be on a very individual basis and would depend on whether that would be helpful or just another person in your face when you are not really sure what is going on. It possibly could be or possibly could not be. The peer support program at ORYGEN, which is sort of—

Mr Dixon—It is for in-patients.

Miss Friedel—Yes, it is for in-patients but it is starting to be for outpatients as well. It is past that crisis point, where you can share what you have been through and similar experiences and so on.

Senator SCULLION—What is the process of the peer support program and what is your role in it?

Miss Friedel—At this point in time, past or current clients who have decided to become peer workers go to the in-patient unit, and it is just a matter of being there and trying to make the ward a better environment for the people who are there, because often the nursing staff do not have time to sit and play a game of cards or a game of basketball and do those sorts of things, which make a huge difference. Since the group programs and the peer support visits have started, the incidence of violence on the ward has actually dramatically decreased.

We do not necessarily talk to people very often about the experience, but there is a shared experience and an understanding of it can be enough. People know that you are there because you actually care about who they are and what they are going through, instead of asking them every five minutes about their delusions and so on. That you are going there in your own time is really important to people—that you are actually volunteering your time because you care enough to go in there and try to make it better for them.

We are in the process of opening a drop-in room on site at Parkville so we can buddy with people who come across from the in-patient ward before they have to start doing things in the outpatient ward, which can be a bit daunting after you have been in such a secure environment. We also want to have resources there that are not just mental health specific but are general youth type activities, because they are things that can be quite hard to find unless you know where to look. We want to set up that drop-in room so people can use it as a way of getting access to peer workers and so on.

Senator FORSHAW—We all know that one of the big tasks about dealing with mental illness is educating the community and everybody that it is an illness—removing the stigmas and getting people to understand that it could happen to anybody and so on. I am interested in your experiences and the ideas you may have particularly about getting young people to understand—or to be exposed to—the idea that mental illness is out there and it could happen to any of us.

When you were at school was there any sort of education or programs for students along these lines? We now have programs for sex education and about the danger of drugs. I am trying to get a feel for what you think and how young people—your peers—could appreciate this illness better and be able to cope with it, not if it affects them but in terms of understanding that they may actually have that sort of experience themselves.

Mr Dixon—I think people like us or people who have done mental health first aid could talk to 15-year-olds and 16-year-olds when they are first experimenting with different kinds of substances about the reality that they can contribute to being unwell. That is one avenue that we could target. But I did not know anything about it until I was ill and then I found out what it was. When my brother was ill, I did not want to know anything about it. I wanted to just totally block it out. I think people do that as well.

Senator FORSHAW—That is why I am asking the question. If the first time people come to know about it is when they either experience it or another member of the family does—we are all about trying to get early prevention and early detection and a better understanding—then is there something we could recommend through the education system, for instance, that might assist in that way.

Mr Brown—There is a mental health promotion team with ORYGEN.

Senator FORSHAW—I noticed that it was said in your submission that you talk to students, but obviously you are only going to be capturing a very small group.

Miss Friedel—I did not have any mental health specific stuff. Maybe they give you a bit in psychology, but that is more about dissecting it than how to deal with it. I think a big problem with school age children is that when something happens to a friend they have no idea what to

do—they do not know how to help them. At the schools that we have spoken at, and at the big open day we had at ORYGEN where a whole heap of schoolkids came along, there has been a general consensus that there is not much information about it in schools.

Senator FORSHAW—What about the teachers and the school counsellors? Do you feel that there needs to be a lot more done to alert teachers and maybe counsellors? Do we need more of them or are they not sufficiently resourced to pick up the signs that some students are having difficulties and need assistance?

Ms Tobias—Definitely. Also, we recently spoke to several schoolkids, and there is a confidentiality issue about approaching school counsellors and everyone knowing your business. A solution probably would be to run something broadly in schools, like they do with drug and sex education—not to say, ‘You’ve got a problem and you have to go and see someone about it.’ Peers of schoolkids with mental illness would be aware of how problems present and know a little bit about mental health so they could look after each other or know if something was wrong. That is a really good way to get information across.

Senator HUMPHRIES—I would be very interested to know the specific mental illnesses that people who go through the youth program have been diagnosed with. I do not want to ask individually, because that is not our business to know. Might I suggest that a piece of paper be passed down the table and then someone read a randomised list of those illnesses so that we understand the range of those illnesses.

Ms Tobias—Are you talking about us and others at the service or us specifically?

Senator HUMPHRIES—I am trying to get a picture of what the illnesses are. You might not know what the diagnoses are of the people that come through the program. Are you told those things?

Miss Friedel—Yes. We know pretty much—

Ms Tobias—We know what we are diagnosed with, but as far as what other people have, unless they tell us, we do not know.

Senator HUMPHRIES—In that case, getting an idea of what your illnesses are would be helpful, but I do not want to ask you individually. Perhaps if you pass a piece of paper down the table and write it down, someone can read it out at the end so that, without saying that you have this or you have that, we will have an idea. Before you answer that question, I also wanted to ask what the incidence of involvement in alcohol or drug problems associated with those illnesses has been.

Ms Albiston—Some of these young people have certainly experienced the first onset of a psychotic disorder. Depression is probably the other one. Some of them would have been related to or occurred at the same time as some substance use. If you want to ask questions about those particular areas, I think that would be fine.

Ms Tobias—I am quite happy to speak to that.

Senator FORSHAW—Those illnesses would include bipolar and manic—

Ms Albiston—Yes, bipolar disorder and schizophrenia.

Senator HUMPHRIES—So the full range of mental illnesses that you might find in the community are represented on this program. Is that the case?

Ms Albiston—The major disorders—yes, probably.

Senator HUMPHRIES—Would it be reasonable to say that roughly 50 per cent of the people in the program have had a drug and alcohol issue as well?

Ms Albiston—I think the current estimates are about 70 per cent.

Senator HUMPHRIES—Not necessarily among this group.

Ms Albiston—From all of the young people who come to the service it is estimated at around 60 to 70 per cent.

Senator HUMPHRIES—Thank you. I am sorry if I appear to be prying by not being specific. I want to know if there are particular young people for whom this program does not work. Have there been peers of yours who have come into the program and have left it because for some reason or other it does not work for them?

Ms Friedel—Do you mean the platform team or ORYGEN?

Senator HUMPHRIES—I mean the people who come into ORYGEN in the youth program—the ones that you deal with and assist.

Ms Friedel—Often we do not see people for a long period of time. We might only see them when they are actually on the in-patient ward.

Ms Tobias—To give you some perspective, the visits on the ward have been running for maybe a year and a half now and we have only just in the last couple of months started the drop-in room and started to work out what stuff we need there. If it had been running for two years we would probably have more of an idea. We do see people on the ward, but we only have two visits a week on the ward, between six people. You might see someone on the ward and then you might run into them again in a couple of months, so it is not as if you have regular contact. It is not as if we are buddied up one-on-one with someone. We just go in there and see them.

Senator HUMPHRIES—So you do not see people regularly enough to know whether they are staying in the program or not?

Ms Tobias—No.

Ms Friedel—No, and if they go, we do not know why.

Senator HUMPHRIES—Is it difficult for people to get to those places where they might access, say, a drop-in centre, or the in-patient ward at Footscray? Do you find people might not come to them because they are too far away and they do not have access to transport?

Ms Friedel—As far as going from the in-patient unit at Footscray over to the outpatient unit at Parkville, the transport is pretty good. There is a woman who runs the groups program there and there is a guy who is basically there to do activities with the patients, and take them on outings or across to Parkville if they have an appointment. We are working with them so that, when we have our drop-in room open, they will bring people across. The transport is not that much of an issue for things like that but I know that for a lot of people it takes an hour and a half to get to Parkville for appointments. That is a massive amount of time.

Ms Tobias—I think there are transport issues with people getting to outpatients. I think one of the issues with the outpatient and in-patient locations being separate is that they are quite isolated. When both of them were on the same site there used to be a lot of mixing and a lot more informal peer support happening because people who came to the outpatient service for an appointment would also go into the in-patients and visit some people that they knew. Now they are separate and, if you go to the ward in the in-patient unit for the very first time then you are discharged and you go to your outpatient appointment, you will never have been there before. It is quite isolating, a bit daunting and another thing you have to overcome to get there and to start joining group programs.

Senator WEBBER—I want to thank all of you for bothering to come along and share some of your experiences with us. It is a pretty brave thing to actually front up to something like this. It is easy for me; I just ask questions. But for you to actually tell us—and therefore tell anyone who wants to access what we are doing—about your experiences is a tremendous thing. It was a great opportunity for us to visit the program today. I want to pursue two issues: I want you to expand a bit more on (1) how much you think the group work is important for young people in assisting them to deal with their mental illness on an ongoing basis and (2) how important you think it is to include the carers and families that support them on that journey to recovery. I want to get your views on the programs and support that are offered for them too.

Miss Gelmi—I think that the group programs are very important because they help with such a wide range of things. Often when people are afflicted by a mental illness, they tend to isolate themselves—as well as other people isolating them—because of the stigma that is attached to mental illness. You do not trust other people. You do not feel comfortable. It is very helpful to you to start integrating into a social aspect again with people who you know understand what you are going through, if not specifically at least broadly, and to be in a supportive environment. I think it also helps you discover new interests, because a lot of the time you tend to feel that things are purposeless or maybe you do not like anything. So just being given a chance to try out new things, with support, is really good. You might find that there are a lot of things out there that you are good at and that you like, and that is really important for building your confidence. So I think they are really good.

Ms Tobias—Just on that point about the group programs, when I first started there I could not even make my breakfast. I could not watch TV for two seconds. I was really unwell. The group programs put simple structure back into your life. They are little steps that you can build on and keep building on—for instance, ‘Okay, I’ll watch telly for a minute.’ I went to a group program

today. There are six people there that I remain in contact with. We are really close; we are like family. We have seen each other at our extremes, and we support each other and look out for each other. It is a really important thing to be able to have someone who has gone through similar experiences to yours and who knows what you are about when you are not feeling so good at times. Without the group programs and the social interaction—sometimes on the ward you are not in the right place or mind to be social—those connections would possibly not happen.

Also, with the platform team, I think to be able to give a little back to the service for the care and treatment that has been given to us is really important. We are the people who know how the service works for us. If you have spent so much time there being unwell, you know it really well and you know what is good and what is bad about it. To have your opinion valued and to have input into it I think works both ways—for my self-confidence or self-worth or whatever and for the service of other people.

Mr Dixon—I think one of the key things that we need to focus on is independence. The whole process is about becoming independent again. You need the social network that you get at a youth service. You have peers that you can talk to. Parents learn to give their children independence. You learn all the cooking skills, emotional skills, physical skills and social skills to rebuild yourself. I think that is the key thing that we need to focus on. That is the kind of help we want to aim for.

Ms Friedel—I will reiterate that, when the group programs are on the ward, the incidence of violent outbursts decreases. So, even when people are in acute care and may not necessarily be taking in that much of what is going on, the activity is really important in making that experience in an in-patient unit better. It can be really awful for some people and, if that is what they remember about their care or about going to an in-patient unit, that is when they avoid getting help. It is important that the whole social thing is really valued.

Senator WEBBER—Just briefly, what about the support that the program offers to parents or carers or other members of your family? Is it important from your perspective that they are also included and that they are told what to expect and how they can perhaps assist you?

Miss Friedel—I come from a small country town, so my parents had a great deal of trouble finding any help for me. It was only when I was living on my own in the city and ended up going to hospitals a few times that they started to feel like they were getting help. There are problems with isolation. They never found any parent groups. I think they were probably more traumatised by my mental illness than I was in the long run. I think my mum especially was yearning for someone to talk to. In the same way that mental illness patients yearn to feel like they are not alone and that what they are going through is being experienced by others, I think families definitely need that too.

Ms Tobias—I think my mum would have benefited a lot from the carer's program, although she got heaps of support and information from ORYGEN through the whole process. I did not mind that she was involved in the process. It was support for her as well in how she was dealing with what was going on with me. With regard to the issue of confidentiality, even if the person does not want their family involved in what is going on with them, I think the family still has some right to get support for how they deal with it so they can deal with it in an appropriate way.

Senator MOORE—I will only ask you one question, because there is so much we could talk about. One of the terms of reference—and I know you have read them all—is about the issue of stigma. A few of you have mentioned that in the comments you have made. Can you tell me what the stigma of mental illness means to you and how you are working with that?

Mr Dixon—I was living with four other people when I was diagnosed with my first episode of psychosis. They found out about two weeks later when my case manager contacted them. They came and visited me and said, ‘We don’t want to live with you any more.’ That stigma crossed that off. I think it is also a way of finding out who your true friends are. You just move on and rebuild.

Mr Brown—I agree. For me it was totally the same.

Senator MOORE—What about work? Have any of you had any questions when you are looking for jobs or looking to go back into study?

Miss Friedel—The question ‘Do you have any forms of mental illness?’ is often on the forms. We got told at one stage by the Mental Health Legal Centre—I am not quite sure who said it—that you should not actually answer that question because you might be discriminated against. The other end of that spectrum is, if you go into a job-searching agency or whatever else, they do not ask you if you have special needs like that because, if you present normally and are not on crutches or in a wheelchair, they do not really know what to do with you. They do not know if there is anything wrong with you. I think people are often very shy about asking those sorts of questions. People will tell you that, when they are in recovery, going back to full-time work is often a real dilemma because they will get cut off from the pension and then they will not be able to get back on it if they find that they cannot cope with full-time work. Going back to work triggers a huge fear of not knowing what will happen if one relapses or cannot cope. There is a feeling that one is going to fail. There needs to be some way of being introduced back into the work force gently. I know there are places like the Work Supply Company who do that sort of stuff, but I would never have known about those places unless I had gone to ORYGEN. If I had not gone to ORYGEN, I would not have known how to access those.

Ms Tobias—I think that Centrelink is a whole other issue in itself. It definitely does not work for me. I do the best I can at the moment, which is like slowly stacking building blocks. There are requirements—for example, if you work more than X amount of hours, you are meant to look for full-time work. There is a big jump between the two different things. It is a nightmare. I am fairly well now but, if I go back to full-time work and it stresses me out and I start to slide back, I have to be really unwell before I can go back onto some government benefits. From the point of not being able to watch telly for one second to how I am now has taken me 4½ years. I do not want to spend another 4½ years rebuilding again.

In terms of filling in that box, one of the places that I work for casually knows about my mental illness. I did fill in the box, and I actually got work through someone who knew me outside of work. It has helped me a lot. They are aware of what is going on for me. There has not really been an instance, but I know that if something were to come up—if I were to say, ‘I can’t take this shift’—they would be really supportive and understanding. But you are playing with fire a little bit.

CHAIR—We are hopelessly over time. Thank you very much for coming before the committee today. We very much appreciate it. If there is any last thing you desperately need to tell us, now is the time.

Ms Tobias—I want to finish the story that Pat was telling before about the young guy who was on the emergency ward and ended up in shackles. He actually ended up in seclusion, and one of the reasons he rang the CAT team for help was that he had had such a traumatic time in seclusion previously. He had a huge fear of it and he did not want to go into seclusion. The whole night that he ended up in seclusion, all he wanted to do was to talk to somebody, but he still ended up on his own with his mind going at a hundred miles an hour. I thought it was important to add that.

CHAIR—Thank you again.

[1.36 pm]

VINE, Dr Ruth Geraldine, Director, Mental Health, Department of Human Services, Victoria

CHAIR—Welcome. Dr Vine, you have lodged with the committee a submission which we have numbered 445. Are there any amendments or additions to that document at this stage?

Dr Vine—No.

CHAIR—Before I ask you to make a brief opening statement, I remind you of the standing orders whereby an officer of a department of the Commonwealth or a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or a minister. That is as much a reminder for us as it is for you. I invite you to make a brief opening statement at the conclusion of which the committee will go to questions.

Dr Vine—Firstly, the terms of reference of your inquiry are very broad. Victoria aimed to do two main things in our submission. Firstly, we wished to demonstrate that it is the task of government to provide a solid framework for the delivery of mental health services. By that I mean a framework that provides services not only across the age span—from child to youth to adult to the aged—but also across the span of severity of illness through early intervention to community based services and to bed based services and more intensive services. It is the view of the Victorian government that that framework is in place, that it is a strong framework and that indeed it is in line with the national mental health policy.

The second main area of our submission contains comment on some of the constraints placed on Victorian mental health service provision by the broader health issues and services, which include of course federally funded services. In particular, we draw attention to the difficulty that some of our population have at times in accessing private psychiatrists because of the inequities of distribution of private psychiatrists and also the different systems of work that exist between public mental health services and Commonwealth funded private psychiatrists. We also refer to some of the constraints on general practice as well as to some of the efforts that we have put in place over recent years to try to address some of these gaps or fragmentations, including our work with general practice through the primary mental health teams and our work with the support sector and homeless services through the psychiatric disability rehabilitation and support services and also through drug and alcohol services with our dual diagnosis teams. So my emphasis is on the fact that that strong framework, which is there and is something to be very proud of, nonetheless faces some challenges that are perhaps fairly universal. Among those of course are work force issues, not just as to availability but also as to professional mix distribution, some of the other support services needed—including accommodation and access to primary care—disability support and so on. That is it, I think. Ask away.

CHAIR—Thank you.

Senator HUMPHRIES—First of all, your submission is from the Victorian Minister for Health but you are in the Department of Human Services—what is the relationship between these two departments?

Dr Vine—The Minister for Health is the minister responsible for the mental health portfolio, in which I work.

Senator HUMPHRIES—And that is not a different department to the department of health?

Dr Vine—No—the Department of Human Services in Victoria includes health, disability, housing and community care.

Senator HUMPHRIES—I see: it is an umbrella department. There are a whole range of criticisms which have been raised before this committee by a series of witnesses over a number of days that are directly or implicitly critical of the department and I would like you to respond to some of those. You have sat through today's evidence, I think, and heard a great deal of what has been said, and shortly I will invite you to comment specifically on anything you have heard that you feel needs to be rebutted or put in a different context. Previously we have heard evidence of serious abuse of the mentally ill, particularly in the public hospital sector but also in stand-alone mental institutions in this state. These are abuses which go beyond what you might call simply the excessive use of force in dealing with people who are receiving involuntary treatment, in cases that range from rape through to fairly serious assault of people in mental institutions. What is the record of the state with respect to those sorts of cases?

Dr Vine—Firstly, I cannot comment on a specific incident—that is not within my capacity at the moment.

Senator HUMPHRIES—I am not asking you to do that.

Dr Vine—Secondly, you mentioned abuses that occurred in institutions and I think it is very important to make sure that my comments are about our current systems of delivery which, apart from the Thomas Embling Hospital, which is one of our finer services, are co-located mainstream services in line with national mental health policy.

Thirdly, I would not condone any type of abuse. Within mental health services, and particularly within public mental health services, when the targeted group is that with the most severe spectrum of illness, who are often those who are most severely impacted by their illness—by that I mean they suffer a loss of insight or a failure to recognise that they need treatment—it is important that we do have mental health legislation that encompasses involuntary treatment and that includes within it provision for intrusive and coercive actions such as seclusion and restraint but does so with very strict checks and balances and very strict supervision and reporting requirements. So I accept what you have said but I feel confident that in Victoria there are very close and strict processes around monitoring and preventing such instances.

Senator HUMPHRIES—We have asked for specific examples of the kinds of abuses which have been suggested to us and we are yet to receive a detailed list of those. Perhaps we should, when that information is provided to the committee, forward it to the department or the minister

and ask for specific comment on the tenor or flavour of those criticisms or comments. Certainly, there are some comments about quite serious cases of human rights abuses within state government run facilities, but they also go to the whole question of excessive and inappropriate use of force in respect of the treatment of people who have a degree of insight into their circumstances. You heard some of that already today, such as a person fronting up to the emergency department at the hospital recognising and complaining of their mental illness but then being shackled and forcibly sedated. Are there many complaints against the public health system in Victoria of that nature that are presently being dealt with by some kind of complaints process or by litigation?

Dr Vine—My answer to that will have to be limited because the major health mechanisms within Victoria are independent from the Department of Human Services. The Health Services Commissioner and the ombudsman are independent and separate and I cannot comment on whether there are complaints or procedures before them. I am not aware of litigation but, again, in a mainstreamed environment the litigation, if it occurred, would probably involve the health service. It would not be something that I could answer.

Senator HUMPHRIES—If there was a complaint made to you, do you have a commissioner for health complaints in the state?

Dr Vine—There is the Office of the Chief Psychiatrist and the Chief Psychiatrist, who is a receiver of complaints. The Chief Psychiatrist has a statutory responsibility to monitor seclusion and restraint and certainly does receive complaints. Some of those complaints relate to instances of seclusion and less often instances of restraint, which are comparatively uncommon—they are most common in aged care services among people with dementia and behavioural disturbances. The Chief Psychiatrist would investigate those complaints. I am not aware of specific instances under investigation currently.

Senator HUMPHRIES—When there are complaints to that office, is the department notified?

Dr Vine—The Office of the Chief Psychiatrist is within the department and within the mental health branch.

Senator HUMPHRIES—Could I ask you then to take on notice the question of how many complaints of that nature—to do with inappropriate treatment of the mentally ill in public institutions—are currently in front of the Chief Psychiatrist at the moment?

Dr Vine—You can, and I will take that on notice. I would also add that the Health Services Commissioner, individual health services and, in relation to government services, the ombudsman would probably also handle those complaints.

Senator HUMPHRIES—Can I ask that question then of the stats that you would keep within any area of the department of health?

Dr Vine—Certainly.

Senator HUMPHRIES—Before we leave this area, what specifically has been said by offices such as the ombudsman or other agencies in Victoria monitoring human rights about the record of the public health system in Victoria with respect to treatment of the mentally ill? Has this area been criticised by any of those agencies?

Dr Vine—To my recollection, not in relation to instances, say, of seclusion. I think in many ways the major complaint levelled against public mental health services has been around issues of access. Certainly the concerns around different levels of in-patient service provision in different areas has been an issue, as has at times people having to wait for access to a bed, say, in the emergency department. I am aware, for instance, that the public advocate has raised concerns about access to services and at times raised concerns about some of the amenities, particularly of one of our older facilities but not in relation to instances of seclusion or the statutory areas that are monitored.

Senator HUMPHRIES—Can I move a little bit away from that to a related area, and that is the question of policy of public health services in Victoria with respect to the involvement of consumers—if I can use that term; it is a term that is used by a number of advocacy groups—of mental health services. We heard a great deal of evidence yesterday, including from psychiatrists, suggesting that the model work in Victoria and probably elsewhere in Australia at the moment is wrong in that it emphasises far too much the decisions made by clinicians in which consumers themselves, even with a large degree of insight into the state of their ill health, had very little involvement, as a rule. There was very limited capacity for involvement by those consumers in the decisions affecting them, particularly as far as treatment and restraint was concerned. If the psychiatrists themselves, who are the drivers of the mental health system, presumably, admit that the model is badly wrong, what recognition is there of that within the department of health and what processes have been initiated to respond to that impulse?

Dr Vine—You have made a number of points, and I will try to cover them. The first thing I would say is that I cannot comment on how many psychiatrists may have made those comments to you, but I would say that—and it is something I regret—the majority of psychiatrists in Victoria probably work within private practice and so could not be seen to be the drivers of public mental health policy. They are a very valuable resource, they treat very ill patients and I value their work, but they perhaps treat people in a different manner—and often people with very different diagnoses.

Senator HUMPHRIES—This was the peak body of psychiatrists, the Royal Australian and New Zealand College of Psychiatrists.

Dr Vine—It is a fine college, and I am a member of it, but still the majority of its members work in private practice. The majority of them work in the inner metropolitan area and provide that private practice. They could not be said to be the drivers of public mental health policy. The second thing I would say in answer to your question is that the engagement of consumers and indeed of carers is one of the core planks of Victorian mental health policy. One of the challenges for public mental health policy is to strike a balance, and we have to strike lots of balances. One balance is between the issues of safety and autonomy, another is between the interests of the community and the interests of the individual, and another is between the individual's immediate safety and their longer term safety. That is why we have mental health legislation—to try to strike that balance and to try to take into account the different interests.

In terms of consumer representation, the way that Victoria has chosen to do this is through a number of layers. Firstly, there is funding to advocacy bodies. I am sure you have had a submission from the Victorian Mental Illness Awareness Council and probably from the Mental Health Legal Centre, which are both funded to provide advocacy and to support people with a mental illness. Secondly, we fund consumers within individual organisations. I think we are the only state in Australia that has this throughout our system—that is, consumer consultants employed within mental health services to promote consumers' rights and to promote engagement. We are starting to employ carer consultants as well. That is a more recent initiative.

Thirdly, we have tried to provide that balance within the legislation. Some recent amendments to the Mental Health Act that came in in December mandate that a person on an involuntary treatment order, whether they be an in-patient or in the community, has to have a treatment plan and the consumer has to be, insofar as they possibly can be, involved with and engaged in the development of that treatment plan. Wherever the consumer provides consent, a carer also has to be involved with and engaged in that treatment plan.

I accept that in mental health there are often times when a patient does not feel they are being heard. Having worked in clinical practice for a number of years, I am aware that at times we do not spend as much time as we should. But within legislation and policy—and, I think, within education and training—we have endeavoured as best we can to have the consumer voice heard. I should add that we also fund a consumer academic and a carer academic to try to make sure that that perception, that voice, is included in teaching and in research.

Senator HUMPHRIES—I invite you to read some of the testimonies and submissions—

Dr Vine—I have read the testimonies.

Senator HUMPHRIES—which are very critical of the lack of that consumer voice. I would like to ask questions of you about the resourcing of mental health and the reason that there is not enough recognition of the need in a whole range of areas, but, to be fair, that is a question that I really ought to put to the minister. It is worth recording that, once again in this sort of setting, we do not have the minister here to ask these questions of. That is the person to whom these questions should be directed. Equivalent committees of the Senate have had the same problem in recent years. On a slightly different matter, is the department of health prepared, in principle, to purchase some mental health services where there are deficiencies in the public sector from the private sector?

Dr Vine—That is a matter for government policy and it is not a question I can answer. I think the minister has made it very clear that expanding mental health services and trying to provide publicly provided services in all areas has been one of the priorities of this government. But in relation to purchasing in the private sector, it is not something I can answer.

Senator HUMPHRIES—Okay.

Dr Vine—I would be happy to discuss funding to the extent that I can, if you would like me to make some comment on the resourcing of the public mental health system.

Senator HUMPHRIES—I will let you do that. I acknowledge that Victoria seems to be doing better at funding mental health than most of the other states, but there is obviously strong evidence before us that the level of need is nowhere near being met. Do you want to comment on that?

Dr Vine—It harks back to my original comments that the level of need should not be seen as just reliant on public funding. Public funding is directed towards those most vulnerable, those most in need, those who may require treatment under the protection of the Mental Health Act. The recognition that this area has been under increasing demand and does require expanding services is shown in the growth of the mental health budget that has occurred. I hope my figures are right here, but we have had increasing additional growth funds every year for the last five years at least. In the 2005-06 budget we have had significant increases as well towards the capital expansion—that is, the underlying amenities for mental health with both new and expanded services in a number of areas.

The other thing that mental health funding has endeavoured to do is to cover its base funding. It has to cover its bed based and community based funding, but it also is a very important thing that changes and expands practice. Professor McGorry talked about the early psychosis centres and certainly it is the desire of this government to expand that so that, wherever you live in Victoria, you have access to a level of early psychosis. We have not got there yet, but we are incrementally expanding those services across the state. We are also directing services to other areas of recognition in changing demands, such as the growth of behavioural disturbance in primary schoolkids and trying to get in some services to that end as well.

Senator HUMPHRIES—Do you want to specifically comment on any of the evidence you heard this morning from ORYGEN?

Dr Vine—Clearly I heard only a section of that. What I heard emphasised what a good service it was, and I am very pleased that it is something that has been developed in Victoria. It is something that we try to take the kernel of to enable that intensive assessment, particularly some of the underlying principles of engagement and engagement with family and carers, to be extended across the state. It is something that has to be done incrementally. I would also say what Professor McGorry and his team were talking about with youth—that is, it is a very important section of the community, but it is not the only section of the community. Again, it is very important for governments to make sure they are also providing services across the adult and aged and young sections. The ORYGEN Research Centre does fine work, as do the government funded components, the community and bed based services. They are a very important part of our service delivery.

Senator HUMPHRIES—I have got other questions, but I will let others go first and, if there is time at the end, I will come back to you.

CHAIR—I want to pick up on your point about there being others apart from youths. Obviously there are, but do you not accept that the prevalence of mental health problems and disorders is with that group aged from late teens through to mid-20s?

Dr Vine—I think this is a very difficult question. If you had a proponent of infant psychiatry here they would say, ‘The best time to get in and do preventive work would be in the zero to

three years age bracket,' and many people with expertise in child and adolescent mental health would say, 'We can pick the people who are going to have a disturbed schooling and that is going to have a negative impact on their entire life' when they first turn up at primary school. What is true is that certain diagnostic categories, particularly schizophrenia and bipolar affective disorder, tend to have their emergence around that time. But many others can emerge later. I think we are increasingly recognising the prevalence of depression in children much younger than 15, and certainly schizophrenia does not only present during that time—you can have first episode psychoses right up to your mid-40s. So it would be very unwise to think that they had a corner on that initiation. It is a very important phase of life and there are very important emerging illnesses, and we are quite right to focus on that. I think that is why this government has invested particular targeted funds in the area of early psychosis and its onset. But it is not the only area.

CHAIR—But your submission and those of other state governments—and this is no doubt something to do with the National Mental Health Strategy—indicate that there is a focus on the clinical treatment of the seriously psychotically ill. What informs that judgment about where you devote the majority of resources and funding?

Dr Vine—I think that is informed by, in part, the evidence available to us—that is the research evidence, the prevalence and the epidemiological evidence. In part, governments have to respond to emerging issues and demands, and change some of their funding balance and practice accordingly. At the present time, of its public mental health funding, Victoria puts—and my apology for some of these figures not being completely to the nth decimal degree—around nine per cent into child and adolescent funds, probably 60 to 70 per cent into adult and youth and around 20 per cent into aged. But across that there is also a split between other categories—we would put about 40 per cent into community services, somewhere between 40 and 50 per cent into bed based services and a significant percentage into the non-government support services. So how does government decide where to place its funds? It is often trying to make sure that that spread occurs in a reasonable way based on the demands of patterns of population change, of prevalence of illness and of different changing treatment modalities, and on the things that are in your face.

CHAIR—This committee has heard in the last couple of days quite a lot of criticism—and no doubt we will receive this in other states as well, I am not trying to single Victoria out—of where the Victorian state government focuses on funding for the seriously ill. In fact, ORYGEN told us this morning that the model it has produced is a result of extensive research. It is a research institute and Victoria is to be proud of that. But also the forensic institute told us that the work they do on research and developing new models is taken up by countries overseas or by other states, but is largely ignored in this state. Can I ask you again, perhaps, to give us some rationale for the way in which both models and funding decisions are made through the research. You referred to it; you said you use it. Is it possible for us to have those references, because as I said what we have been told today is that mental health in this country is getting it wrong—it is not listening to the research.

Dr Vine—I am not going to cite journal articles to you, I am afraid. If you wish me to, I will have to take that one on notice; I cannot rattle them off.

CHAIR—That is fine.

Dr Vine—But let me give you some examples. I think there has been a reasonable body of evidence—and I think Professor McGorry's group has been at the forefront of this—saying that it is worth while to give people who are having an emerging psychosis a more intensive provision of service to reduce subsequent hospitalisation. Maybe it is not quite so clear, but it may be improving subsequent functional outcomes. So that is, if you like, an example of using that finding to think, 'Okay, we will ensure that a portion of new mental health money is not just put into the spread of the system, but that it actually targets that group.'

You used a forensic example; and Professor Mullen does fine research. Some of his research is to do with extensive linkage studies trying to compare populations over a long time, and certainly some of his findings have been very important in service development. For instance, he highlights that in terms of risk and relapse probably substance use is the No. 1 thing that predicts future outcomes. He has said that if we had more assertive and engaging treatment in the community we would be less likely to have relapses and returns to both offending and illness. Again I think that supports us continuing to build up our community services and trying to work out some intensive models. Some of our newer initiatives have been to think of where we can engage people who are otherwise difficult to engage, such as at homeless shelters and drop-in centres. We are trying to put forward a more joined-up service that encompasses substance use and mental illness in those particular populations, recognising that you probably get your 'best buy' there in being able to engage with those particularly vulnerable groups. Those are some examples.

CHAIR—Does that mean the government has plans to progressively roll-out youth mental health services such as ORYGEN provides? We have been told today that it would not take a great deal more money now that the model and the research are there for this service to be extended beyond the western suburbs of Melbourne to the eastern suburbs of Melbourne and to other country areas. Is there a plan?

Dr Vine—Clearly the government has many areas of need and priority and I cannot address those. While you say it would not take very much money, I think it does need to be put in the context of the overall state budget, being about \$700 million. This year we had \$30 million in growth funds. That has been distributed in a number of ways, but clearly it was distributed across Victoria and across the age range, and so would not be able to answer Professor McGorry's desire for a service that expands the numbers of people receiving treatment in only a particular age group.

CHAIR—Let me ask you the question another way: where does a 20-year-old with a depressive illness, episodes of self-harm and complicated substance abuse and personality problems get help in the public mental health system in Victoria?

Dr Vine—The question itself demonstrates an assumption that the public mental health system and the state government are the only responsible funders. A number of 20-year-olds with personality disorders and substance abuse problems will receive treatment within the private sector. That will be problematic—

CHAIR—Is that their only option?

Dr Vine—It is not their only option; it is a very limited option in the country. But it should not be thought that public mental health services only see those who present with schizophrenia or bipolar affective disorder. Victorian public mental health services treat about 56,000 people a year across the three main age groups. Of those, again, I cannot give you the immediate breakdown. Certainly, people with psychoses figure strongly in that, but people with personality disorders, depression and substance use problems would also be very, very common. Depending on the person's need for treatment and the severity of their presentation they would get their treatment at their area based mental health service.

CHAIR—But that is not right, is it? Area mental health services, hospitals and even services like ORYGEN are not able to see people who do not have a psychotic illness. Do you want to disabuse the committee of that impression?

Dr Vine—Absolutely. That is a complete falsehood.

CHAIR—Apart from telling us that private psychiatrists can do this work, where does such a person go? If we happen upon a person of that description—and we have been told there are many—where do they go in the public system in Victoria?

Dr Vine—They are able to ring, present or go via their general practitioner—I would hope they go via their general practitioner, who is the primary care component. If their need for treatment is there, they will receive treatment within the public mental health sector.

CHAIR—Can you indicate where?

Dr Vine—In west Melbourne the inner west community mental health team operates from a clinic in Mount Alexander Road, and the Royal Melbourne Hospital is just a hop, step and a jump up the road.

CHAIR—So, if someone with that description presents to either of those, they will be able to be dealt with today, tomorrow? What sort of service would be available to them?

Dr Vine—They would certainly get an assessment today. I understand you have probably heard many complaints of people not receiving the treatment they believed they should have received. You have probably also heard some complaints of people receiving a treatment they did not believe they needed. Mental health is like that; it is a challenging area. But if someone presented today with a serious depressive illness complicated by substance abuse or perhaps by suicidal ideation, they would certainly receive an assessment, and they may well receive an urgent appointment. If they needed admission, I would hope they would be admitted. But it would depend on a clinical judgment of the severity of the presentation and the need for treatment, not on a diagnosis. Certainly, they would not be excluded on the basis of substance abuse. Probably 50 to 80 per cent of our in-patients suffer from comorbid substance abuse, so they are clearly not being excluded.

CHAIR—Would the people who present to ORYGEN with those kinds of diagnoses—the 1,200 or so out of every 2,000 each year who are turned away from that service—be accommodated in the area mental health services or in the other two places you describe?

Dr Vine—It is true that public mental health services are targeted to those with the most severe needs and the most urgent needs and who cannot be managed in the broader primary care sector. I am certainly not suggesting that public mental health services cover everybody who presents with a mental illness or a mental disorder. Clearly we share that with the general practice, and the recognition of the importance of that has been shown by the Australian government in their Better Outcomes in Mental Health training and by the Victorian government in developing primary mental health teams. I am sure that sometimes those presentations are complicated and involve or need more than one system. I am not trying to get out of anything here; I am just saying that that service is available for those who are assessed as requiring that service, and there are about 56,000 of them a year in Victoria.

CHAIR—So the 15 per cent of GPs Australia wide—and the percentage may be a little higher in Victoria—

Dr Vine—I think it is 19 per cent in Victoria.

CHAIR—who have had the 20 hours training in mental health services under the Better Outcomes in Mental Health project will cope easily with a 20-year-old with depressive illness episodes of self-harm et cetera?

Dr Vine—I am sure they will do their best. I am sure they will also do their best with the person who presents with cardiac disease, diabetes, chest infection and an adverse drug reaction.

CHAIR—At least, those people know that if they go to the hospital they will get treatment. Why is it that in in-patient services in Victoria women are housed together with men? Why is it that the Deer Park women's hospital has no forensic facility for those with mental illness? What happens to women who are there? Can you give me a response to those questions?

Dr Vine—I certainly will. I might start with the last question first, because it is the simplest to answer. Mental health and general health services in prisons in Victoria are the responsibility of the Department of Justice, so I will not comment on facilities within the Dame Phyllis Frost Centre at Deer Park. Within our forensic hospital, the Thomas Embling Hospital, there is a female-only unit. The reason there is a female-only unit there was in recognition not only of the need but also of the fact that women prisoners often present with very different mental health problems from their male counterparts.

CHAIR—That unit is always full? Is that correct?

Dr Vine—All of our in-patient units are always full. They are efficiently—

CHAIR—How many beds are there for women?

Dr Vine—It may be 15, but I think it is 12. They are very efficiently used. It is also in recognition that a very high proportion of women prisoners have been victims as well as perpetrators of offences.

CHAIR—Eighty per cent.

Dr Vine—Yes. It is a very needy population. When I started my training in psychiatry, I worked out of Mont Park. Mont Park had M wards and F wards. They were at different ends of the grounds and the hospital ran very institutional programs. I guess part of the move towards mainstreaming was a decision to normalise people's environments. It was certainly to open wards and to say that in-patient units were episodic; they were not for prolonged times. There has always been criticism that that has gone too far and that lengths of stay are now too short. But part of the idea—and this is in line with general health—was that there did not need to be separately provided male and female wards.

CHAIR—How normal is it for men and women who are totally unrelated to one another to be in the same ward?

Dr Vine—It is pretty frequent in general hospitals as well.

CHAIR—People in general hospitals, I would argue, are a little more in control of their circumstances, although I think it is a problem there as well.

Dr Vine—Having said that, there is another thing that we have done in the design of units. Clearly, you cannot put up all your buildings in one day and tear them all down in one day; this is a progressive service. So a current design of an in-patient unit enables separate corridors. They are all single rooms with ensuite bathrooms. It would be a mistake in a publicly provided system not to be able to use a service that is funded. So, if a bed is required, you would not say: 'I'm sorry. You cannot have that. That's a girl's bed.' Our beds are for the population. Nonetheless, the generic design for wards is such that units can now be managed so that the sleeping arrangements, the bedrooms, are more or less in separate areas of the ward and, as I said, with single rooms and ensuites. I cannot say that that is the case everywhere, and I cannot say, particularly in the context of fairly sustained demand, that sometimes there might be more men than women on a ward and so there would be a degree of mixing. But I think to go back to having completely separate units is certainly not part of current policy.

CHAIR—And separating young people from older people?

Dr Vine—We run separate child and adolescent in-patient services from adult, from aged. Again, there are often pros and cons to various arrangements. One of the issues is that, in order to run an in-patient unit and provide a program, you have to have a certain number of beds. Victoria did have a phase where it constructed in country areas, for instance, very, very small adolescent units. They just did not work, because the person became isolated. If only one or two people are in an area, it is not conducive to interaction and activity. So, although we do try and separate out those groups, those are the broad groupings. We do not look beyond that.

Senator FORSHAW—I want to pick up on two areas with respect to, firstly, the role of the private sector in acute care hospitals and, secondly, the profession. We were told earlier this week, on Monday I think, by private hospital representatives that there is a critical shortage of public hospital beds for seriously mentally ill patients, or consumers, and that the private sector is in a position to take this up. There are certain barriers such as whether people have health insurance coverage, and legislative barriers.

With regard to the profession, we were told, for instance, by a number of representatives that private psychiatrists could have waiting lists of anything up to 12 months for new patients. Again, there is the issue of whether people can access those private services because of location. For example, you will probably hear from other senators from other states that outside the metropolitan areas there are no or very few psychiatric services. There is also the issue of not having private health coverage.

Another part of this debate, if you like, is the role of psychologists vis-a-vis psychiatrists. I get the impression they feel they are underutilised. One of the measures that have occurred recently has been to create a Medicare item number for psychology.

I am interested in getting you to expand on the comments in the submission about whether the Victorian government sees that there could be recommendations coming out of this inquiry about how we might address some of these issues by utilising the private sector more. Maybe that is not a desirable thing from a policy position; I do not know. I wonder if you could expand on that. I note you say in the submission that only public hospitals are able to admit involuntary clients in Victoria. You might want to take that question on notice.

Dr Vine—I will do my best to answer it. In our submission we certainly have emphasised that there is a misfit between the distribution, accountability measures and capping levels in the Commonwealth or health insurance funded private psychiatrist sector and the public funded mental health services. Senator Allison raised questions about where a person would go to receive treatment. A public mental health service certainly has some level of discretion in where they set a threshold but they do not have a discretion in whether, having made the decision that the person requires treatment, that person receives such treatment, whereas of course an individual psychiatrist has individual discretion about whether he or she accepts a patient, how long they treat that patient and how often they see that patient. Clearly that has an impact on the capacity of that system.

It is certainly our view that there is capacity for the state governments and the Australian government to work together around some of the training, support and availability issues within the primary care sector. Some of the Medicare items and Better Outcomes in Mental Health touch on that. There is also certainly a desire on our part to feel that there is capacity to improve the distribution and perhaps make adjustments to the incentive of private psychiatrists to perhaps take on more new people or to work more in more shared care arrangements or whatever. There is capacity to improve the spread of that system. I would hope that state and federal governments could work together to do that.

You mentioned psychologists. Public mental health systems have long had multidisciplinary teams. All of our services would employ a mix of psychiatrists, medical officers or registrars, psychologists, social workers, OTs and, predominantly, nurses. In common with just about the rest of Australia, I think, we also have areas of work force shortage and some difficulty at times recruiting the desired mix. I am sure the view of the psychologists is that they are underutilised because they do not have access to the same sort of Medicare rebates, but again that is a fee for service and may well have the same difficulties in that the person chooses which person they see for how long to provide which treatment rather than necessarily addressing areas of need. I think health work force must be a major challenge at all levels of government. I would hope that the different levels of government can work together to try to address that because it is a big issue.

Senator FORSHAW—Mr Schneider from the Australian Health Insurance Association told us that something like 43 per cent of mental health services are provided by the private hospital sector. Are you aware if that is an accurate statement? Also—and I hope I am quoting their submission correctly; I have not got it in front of me—they say that it is just not at the soft end and that they are covering a full range of acute mental illness conditions. I was surprised but that is what they claimed.

Dr Vine—There are a number of responses to be made. Firstly, as to their saying it is 43 per cent, I would need to get more detail as to which number that is. Victoria has about 2,000 public mental health beds. I do not know the total number of private beds. Our length of stay tends to be much shorter than that for the private system.

Senator FORSHAW—I think he was also talking about extended stay and daily treatment as well.

Senator HUMPHRIES—Much of their treatments were day treatments, I think he said.

Dr Vine—I do not know. All I can tell you is that we have 56,000 people and we do about 17,000 in-patient admissions a year. To say that private psychiatry does not see the pointy end is not fair because I think many private psychiatrists, particularly those providing more intensive treatments, see people with very severe disabilities and very severe illnesses but they tend to be of a different nature and manifestation than those managed in the public sector. Those managed in the public sector tend to be those cases where the impact of the illness is felt not just by the person but also by the community, which is part of the reason for involuntary treatment.

Senator FORSHAW—I do not think they were saying that overall private psychiatrists only see the pointy end. This was more about services provided within the private hospital sector. They are involved in the private health insurance side of it.

Dr Vine—There are frequent criticisms levelled at private psychiatry that it sees the worried well, but I would not support those.

Senator FORSHAW—I have one other issue to raise and you might take this question on notice. You have made some comments regarding information and education for families and carers. I am interested in what is being done in the general community. You have referred to the fact that you are a partner in beyondblue. I can understand that. You say VicHealth has recently released its second mental health promotion plan. I would be interested in getting some detail about what the whole of the state government is doing about educating, informing and promoting recognition of mental illness in the community. We had young people here earlier. Clearly, there should be opportunities through the school education system to promote this, and I am sure there are things being done. Please take that on notice and give us a picture of what is being done to promote understanding and destigmatisation of mental illness, because we are doing a lot of work in many other areas of health but I am not so sure that we are picking this one up as much as we should be.

Dr Vine—I am aware that your time is getting short so I will take that on notice, because I could probably talk for 15 minutes on it.

Senator WEBBER—I will try to be as quick as I can. When we first embarked on this process, Victoria was held up to us as a model of much better practice to that in my home state of Western Australia. I have some issues I will pursue with it when we get there. Dr Vine, you and I have not met before, so I was a little intrigued when I read your submission. It says:

These terms of reference have been influenced by interest groups with specific agendas without appropriate consideration of Commonwealth/State relationships and responsibilities.

I must admit that, as a member of the Senate that passed a motion that was negotiated across all parties I found that pretty offensive. I was a little taken aback by your imputation of the motivation of our work. Then there is the following comment, which I would like you to respond to:

Consequently, the inquiry risks setting unrealistic expectations about what can be delivered by a publicly funded specialist system of care.

What do you mean by that?

Dr Vine—Firstly, naturally, I apologise if I caused you any distress; nonetheless, I think the terms of reference were broad, and I think they were in response to issues raised by a number of groups. Maybe they were not; maybe they emerged fully formed. One of the dilemmas for health, and maybe particularly mental health, is that sometimes mental health is referred to as everybody's business and that mental health should be whole of government because other areas are so important for our mental health. These include education and issues of managing people with mental illness in prisons and accommodation and so on. So I guess the concern is that it is still perhaps most important—and the most important role of public mental health services, as narrowly defined—to provide treatment and care to those people who suffer from the most severe illnesses and have the most severe disadvantages. It is part of life, but there is a danger that that focus is often on people who are least able to advocate and lobby. There are many other areas where you could reasonably invest. So it was about that maintenance of effort, I guess. But, as I said, I apologise for any insult or distress.

Senator WEBBER—Thank you for that. I will now move onto something a little more positive. One of the programs that we have heard about in Victoria is around the dual diagnosis work that is being done. One of my concerns is that we have these silos of treatments. You have drug and alcohol, mental health and disability. As you have raised today, we also have justice. People get shunted from one to the other and fall through the cracks. They are no-one's overall responsibility to be made well again. Could you expand a bit on the work that the government is doing on dual diagnosis? With them all being in the Department of Human Services, does that make it better? What mechanisms do you have to make sure they are not shunted from one to other but treated as a whole human being?

Dr Vine—It is a very real issue, particularly in any system that is under stress and pressure. The natural response of that system is to bunker down a bit. In recognition of that, some years ago the government invested in dual diagnosis. The idea of that was really to provide education and training across those two sectors and some expertise around particularly difficult patients. More importantly, as time has passed and perhaps the importance and prevalence of substance use in our patients has become clearer and more obvious, I would expect mental health

practitioners to have a pretty clear idea about assessment of substance use and about lower level treatment and referral for others. I think this is a very real issue.

Those two sections separated for very good reasons: ideological, work, autonomy and legislative reasons. It has meant that for a group of people—not everybody—there was that separation. I can only say that I have a very close working relationship with my counterpart in the Department of Human Services. This year we are again expanding our effort, by way of education and in the work force, in that crossover. I think it would also be fair to say that this government has had a particularly strong emphasis on joined up government initiatives. It is trying to say that we have to recognise that you cannot just look after mental health; you have to look after other bits.

Senator WEBBER—In other evidence we have received so far, a couple of witnesses have referred to their disappointment with the National Mental Health Strategy. People have said they think it has fallen over. The first one was good, the second one was okay and now it has fallen over. From the Victorian government's perspective where are we at—has it fallen over?

Dr Vine—This comes back to your first point. The first plan was very clear. It was about structural change and system change in terms of where hospitals were, but it was accused of excluding many people who did not fall at the serious mental illness end. The second one tried to address that by promoting some prevention and early intervention partnerships. The third one was accused of trying to be all things to all people and therefore not addressing the issues. I think that is what Victoria has endeavoured not to do—that is to say, we have the framework and are going to keep the framework—our core services are solid—but we will add to that and address particular deficiencies.

Victoria has been fortunate because it has in some senses always been a bit ahead of the pack in how well it did that structural change at the beginning, but the structural change that then had to follow spread into early intervention and joined up services and so forth and to research and evaluation and information services. We are making good efforts at that but I think we have a long way to go.

Senator MOORE—Dr Vine, we do not have any time at all but I want to put two things on notice. I share Senator Webber's concerns because my view of the role of the Senate is to ask these questions and then, if people have disagreements through the process, they work them through. The common element from just about every person who gave evidence is that they do not give a damn where the funding comes from. It can be state, federal or from their aunt. They do not care as long as they get it. We have a purpose to serve by going through the process. Firstly, I will put on notice that I want some information on the CAT teams because every state operates them slightly differently. People were very concerned about the accessibility of CAT teams, the timeliness of response and exactly how they operated. So, for our information, I would like to know the basis of the CAT team operations in Victoria—how many are there and what are their roles? Secondly, quite a few people made a consistent comparison between Australia and New Zealand—

Dr Vine—They do not have a federated system of states.

Senator MOORE—Absolutely. I would like some information back from you or your department about your view of the role of the commission in New Zealand. Certainly, the federated system is a very important area but there is also the idea of a national voice, a national place where people who have issues about mental health can turn. I know that your department have read every single submission and they can see where it comes from but there has been a lot of interest in whether a similar kind of commission role, with the variations of our government structure, would operate effectively in Australia. I know that in your submission you did not have a chance to respond to something like that but I would like your comments. You can put that on notice.

Dr Vine—It would also be very interesting to get the comments of the director of mental health in New Zealand. The commission has served a very useful purpose but it is also something else that has to be funded, resourced, given information to and all those things. I am sure that many people making submissions to this inquiry do not give a damn where the funding comes from but, unfortunately, I think governments do give a damn—and so they should. They have great responsibilities in relation to that funding. I am very happy to take your question about the operation of CAT teams on notice. We have many different models even within the state. I think people would miss them if they were not there. Overall, people think they have been a positive. Certainly the expectation at times, particularly from police, ambulance and even the coroner sometimes, that they are an emergency service able to drop everything and that they are resourced to do that is clearly not correct. The understanding of their function needs to be realistic.

CHAIR—Thank you very much for appearing and for being patient while we kept you waiting for so long. We very much appreciate that. If we can seek your indulgence further, there are some other questions that we were not able to get around to asking you which were about structure and so forth. If you are of a mind to answer them, we will put them on notice.

Dr Vine—Do you want written answers?

CHAIR—Yes, if you can manage that.

Dr Vine—I am very happy to do whatever most suits the committee. I am aware that there is a difference between a written answer and a verbal answer. I am happy to respond by teleconference or whatever.

CHAIR—We will put that in our suite of possibilities. We were not able to see anywhere near the number of people who made submissions in Victoria. It may be that we decide to pick up on, particularly, the state government and others at a future date. But we will come back to you with that.

Committee adjourned at 2.40 pm