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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Reference: Mental Health

TUESDAY, 27 SEPTEMBER 2005

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SENATE

SELECT COMMITTEE ON MENTAL HEALTH

Thursday, 27 September 2005

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

Senators in attendance: Senators Allison, Moore and Troeth

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WITNESSES

Committee met at 9.05 am

HARLEY, Mr John Maxwell, Public Advocate, Office of the Public Advocate, South Australia

FARR, Ms Margaret, Assistant Public Advocate, Office of the Public Advocate, South Australia

CHAIR (Senator Allison)—I call the committee to order and welcome everybody here today. This is the 13th hearing of the Senate Select Committee on Mental Health. The inquiry was referred to the committee by the Senate on 8 March 2005. Witnesses are reminded of the notes they received relating to parliamentary privilege and the protection of official witnesses. Further copies are available from the secretariat. Witnesses are also reminded that the giving of false or misleading evidence to the committee may constitute a contempt of the Senate. The committee prefers all evidence to be given in public but under the Senate’s resolutions witnesses have the right to request to be heard in private or in camera sessions. It is important that witnesses give the committee notice if they intend to give evidence in camera.

You have lodged submission No. 268 with the committee. Do you wish to make any amendments or alterations to that document at this stage?

Mr Harley—No, we do not.

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

Mr Harley—I will not go over what is in our submission. I want to highlight three things that perhaps have not been underlined as much as I would like. Australia has sometimes been called a human rights wolf in sheep’s clothing. We tend to pontificate to other countries, particularly our Asian neighbours, when we consider that they are infringing people’s human rights. Our record is far from good. I have often felt that we are sometimes rather hypocritical in the criticism that we heap on some of our neighbours. The three areas that I want to concentrate on are people with mental illnesses, prisoners and detainees.

Mental health is the poor relation of all health services. From my knowledge in South Australia and what I read about Australia in general, while government seem to be full of rhetoric about what should be done about mental health and what they are doing, their record falls very short of fulfilling their obligations to people with mental illnesses. People with mental illnesses have a right to services, a right to be looked after by the community. It is not a privilege; it is a right. What is a right worth if you cannot enforce that right? There is no provision in any of the states or the Commonwealth, although there is provision in the ACT where there has been some endeavour to protect people’s human rights. People with mental illnesses are in a deprived situation in many instances. The cases we get are the serious cases. We see how these people suffer and how their lives are being destroyed through lack of proper care by the state.

The other group includes prisoners with mental illnesses. I refer you to page 15 of my submission where I have detailed the way in which prisoners are treated or not treated when they have mental illnesses. One of the failures of the mental health system is that, because patients are not being properly treated and cared for, they finish up in the prison system. So whilst we might have closed mental health institutions or asylums, all we have done is move patients into the prison system. It is there that they languish; it is there that they do not receive proper treatment. They are discharged back into the community upon release and there are inadequate services for them when they get out of prison. And so the cycle continues.

The third group includes detainees. I refer you to page 10 of my submission. I first became involved with detainees some two or three years ago, when a young man of 18 was sent to Glenside Hospital suffering from very severe post-traumatic stress disorder and depression. That was my first experience of trying to deal with the department of immigration. I rather wish that I had never had the experience. My complaints went unheeded. I am very pleased that the recent Palmer report has been made public and that people are now acknowledging the very extreme circumstances under which detainees have been kept both at Woomera and now at Baxter.

The practice has been for the government to deny that anything was wrong. On *Lateline* I heard Minister Ruddock, when he was the minister for immigration, deny that the average Australian accepted that depression was accepted by them as an illness. He was denying that there was anything wrong with some of the detainees. I now have about nine or 10 detainees under my guardianship. They are extremely ill. Glenside has opened up a ward to accommodate them. If they get visas then, after their health improves a bit, they will be discharged into the community. But, once they get a visa, the Commonwealth government ceases to have any responsibility for them. They are being released into the community with inadequate support services to maintain them and to help them improve their circumstances.

I have requested that the Commonwealth government accept responsibility for that. I have suggested that these people will, in due course, be able to sue the Commonwealth government for negligence for the way in which they have received medical treatment whilst in Baxter. If the Commonwealth government continue to deny any responsibility for these people, in due course, if damages are sought, there will be further damages payable due to the fact that, when the government had the opportunity to assist them—under their common law duty to assist them—they denied that support. I hope that, in due course, the Commonwealth might again see that they need to accept responsibility for what they have done to the extremely ill people whom we have had to deal with.

CHAIR—Mr Harley, could I invite you to expand on your last points a little more? Is your role to advise those detainees who are now out in the community about legal action—and, if so, have you done so?

Mr Harley—No, that is not my role. I am a guardian. I am guardian for Cornelia Rau. I have been appointed an administrator for the purposes of instituting legal proceedings in her case, but not with respect to the other detainees. They will take their own advice on that. My role as guardian is to make health care and lifestyle decisions.

CHAIR—So detainees are not in the same position as Cornelia Rau in this respect?

Mr Harley—They are, except that they do not have an administrator appointed to take proceedings on their behalf. They would have to institute those proceedings themselves.

CHAIR—What steps would have to be taken to appoint you as the administrator in order that you could do that?

Mr Harley—It is just an application to the guardianship board.

Senator MOORE—By them?

Mr Harley—Yes, or their caseworker if they have a caseworker.

Senator MOORE—So someone working with them could make that application?

Mr Harley—The legislation says anyone with a proper interest.

CHAIR—Is it your view that your office ought to be able to advocate for detainees in detention?

Mr Harley—Yes. I have no right of entry into the detention centres. We believe that, if the Commonwealth government are being honest about their desire to ensure that the conditions are appropriate for detainees, we should have a role in inspecting the premises and ascertaining the degree of care that is occurring there. It is obvious from the extract of the judgment of Justice Finn that is attached to my submission what the state of the care was in the case of ‘S’. The Commonwealth government fought that case all the way in the High Court to prevent that man from being brought down to Adelaide for medical attention. In the end, after they had fought it, he was so sick that, before the judgment was actually handed down, he was sent to Adelaide. They wasted the court’s time and everyone else’s time fighting that and he finished up so ill that they had to send him to Adelaide anyway. So the judgment was handed down but no order was made because, by that time, he was in hospital.

CHAIR—What legislative or other changes would need to be made to give you that advocacy role for detainees?

Mr Harley—I can advocate for all people with a mental incapacity and it does not matter where they are. It is just that I do not have a right to enter the detention centre. That could be given to my office by DIMIA.

CHAIR—So it is not a matter that would need a memorandum of understanding between the Commonwealth and the state?

Mr Harley—No.

CHAIR—Could you provide the committee with a bit more documentation about the problems you have with Centrelink with regard to your authority, which you refer to in your submission? It might be useful for the committee to be able to take this up with the Commonwealth department in a week or so.

Mr Harley—It is a systemic problem throughout Australia. Since I wrote that section of the report I have had a meeting with Mary Kosiak, the state director of Centrelink. I feel that we are starting to talk on the same level and that the problems are not as acute as they have been. But I remember that I did write and complain. Three cases were referred to me where Centrelink would not recognise the authority of the manager appointed under the Aged and Infirm Persons Property Act in this state. In two other cases, I think, they would not recognise administration orders. Ultimately, Centrelink say it is their decision as to whether or not they pay a Centrelink benefit to somebody. While there might be an order that says that all the protected person's pension be paid to a particular person, like a public trustee, the parent or someone like that—it is a state order not a Commonwealth order—ultimately it is Centrelink's decision as to whether or not they are prepared to recognise it.

CHAIR—If I could come back to detainees and visas: you say that there are no services for people once they are discharged. Are they limited in the sorts of services they can access any more than other individuals? Is this the group that is not able to access Medicare, for instance?

Mr Harley—No, they get all those benefits but the packages to keep them in the community are not just benefits that would be paid for under Medicare. There can be other, quite expensive, services that they should be getting as part of their therapy. Generally in the community there is a paucity of them and I know of one particular case of UnitingCare Wesley paying for these services themselves out of their own pocket.

Senator TROETH—I would like to take you back to your comments on those people held within correction systems while they are awaiting mental health assistance. Obviously, we have heard in other hearings that prison is not an appropriate facility for those people, especially if they have lengthy waits for assessment. In South Australia, or other places to your knowledge, what alternatives are available? If there are not any, what is your view on what alternatives should be put in place?

Mr Harley—James Nash is the facility where they should be placed. James Nash now, although it is not that old—I think it is only about 25 years old—is dated and rather than being a hospital-type facility it is very much a prison-like facility. In any event, it is too small.

Senator TROETH—I think you said that the number of beds has been reduced. Is that so?

Mr Harley—Yes. One of the problems with it is that there are people there who, instead of moving on into other things, are being kept there. So prisoners who are suffering from a mental illness cannot be treated there. There were two cases referred to me two weeks ago, of two Aboriginal men who have brain damage as a result of substance abuse. They are being dealt with by the courts and have been found to be unable to plea. They are being held in the Port Augusta prison and have been for months because there is no place for them. In effect they have been found by the courts to be innocent by virtue of their mental incapacity, yet they are kept with other prisoners and without proper treatment.

Senator TROETH—So James Nash is a secure treatment hospital with how many beds at the moment?

Mr Harley—I am not sure. There would be 30 beds there, but I would suggest the problem is that 22 of them have permanent residents.

Senator TROETH—So that is a logjam that is not clearing?

Mr Harley—Yes, there is no turnover. There is a ward at Glenside called Grove Closed that some people have been moved to. But, generally, the secure health facilities in South Australia are quite inadequate and inappropriate.

Senator TROETH—But in your view it is that type of facility, a secure hospital type facility, with a suitable number of beds that would be the best?

Mr Harley—Yes, with a step-down facility. The problem is that a whole lot of hysteria is whipped up by politicians and the media over Glenside Hospital, which is the general psychological hospital, suggesting that we are all going to be murdered in our beds as a result of these people escaping. So sometimes the steps being taken to get people moved into the community on a less restrictive basis are sabotaged by the public hysteria that is whipped up when we try to get these people rehabilitated and back into the community.

Senator TROETH—You have also talked about the Exceptional Needs Program as an example of a very successful holistic regime. Would you like to give us some details about that program?

Mr Harley—Perhaps Margaret would like to talk about that.

Ms Farr—The Exceptional Needs Program is funded by the state government to assist in the development of integrated service models for people who fall between the gaps, who do not neatly fit with mental health or with disability. Essentially, the Exceptional Needs Program find what we would call a lead agency to provide care coordination for a client, and that lead agency also coordinates other service providers to ensure that all of the problems that the client might have are met. So in one case you might have mental health as the lead agency, the client may not in fact have a recognised treatable mental illness but that service is seen as the most appropriate to provide the expertise in the coordination of services.

We may have people living in the community in a house and starting off with 24-hour care but that care can be withdrawn gradually as the person learns more skills. We have just talked about forensic services. Certainly we had one client under guardianship who was the subject of a lot of publicity prior to his release into the community because of his history of sex offending. That young man went through the Exceptional Needs Program and is living on his own with fairly minimal direct care support but still with mental health case management to fix the problems that occur from time to time in the community.

Senator TROETH—How many people would be on that program at any one time?

Ms Farr—It would be a very small number of people, I would say—around 20. Obviously, in the short term, it is an expensive model of care. But I had a client who spent six years in Glenside prior to coming into the community on a 20-hour or 18-hour care model per day initially. The savings to the community in the long term are there, I am sure, if we do the work. These people are typically people who had major problems as children. They have been in the care of the minister. They have been abused and have not in some cases learned actually how to make decisions and how to look after themselves. So some of the program is about parenting and learning to mature.

Senator TROETH—With that sort of program, with different agencies being lead agencies, it would be possible for that to be replicated in other states, from what you are saying. It is a coordination program.

Ms Farr—And with the funding, obviously. There is a bucket of money and a panel called the management assessment panel looks at the needs of the client and determines whether extra funding is justified on top of what services are already being put in.

Senator MOORE—How long has that program been going?

Ms Farr—The management assessment panel has been around since the middle of 1970.

Senator MOORE—That is the standard program, but what about this Exceptional Needs Program?

Ms Farr—The Exceptional Needs Program has been there for 10 years.

Senator MOORE—The state government refer to it in their submission as well and we have not heard that particular term. Many of these terms are used in various ways across the various jurisdictions, but that is one that I do not think we have heard anywhere else.

Mr Harley—Victoria has special legislation dealing with exceptional needs clients.

Senator MOORE—It is all slightly different terminology.

Mr Harley—There is a philosophical problem that some public advocates have. Often the legal framework in which we provide these services is facilitated by my being appointed their guardian and then giving directions and ordering certain things to happen. The philosophical problem is that we are supposed to be their advocate, so, on the one hand, we are imposing directions on how they behave and what services they need to accept but, on the other hand, we are supposed to be advocating for their rights.

Senator MOORE—Yes, there is a dichotomy. On that point, certainly we have heard evidence now from your counterparts in most other jurisdictions and the issues you have raised are similar in most places. Is there a mechanism for all of the public advocates to get together and talk about things, prioritise and try and use your amalgamated knowledge to enforce change?

Mr Harley—Yes, there is a body called the Australian Guardianship and Administration Committee that meets twice a year for one day. It includes all of the public advocates, all of the presidents of the tribunals and all of the public trustees throughout the Commonwealth.

Senator MOORE—Have the issues that you have talked about in your paper come up at those meetings?

Mr Harley—Yes.

Senator MOORE—What has the organisation done with this amalgamation of such good knowledge?

Mr Harley—We do not have any funding to run it—

Senator MOORE—There is no funding to run your amalgamated body?

Mr Harley—Yes. Consequently, at the moment we are relying on the hospitality of the Victorian Public Advocate, who is the chair. His office really runs the secretariat, if you like. Most of the participants just say that they would not be authorised to use their state moneys on a national body. Most of the offices of the public advocate in particular are fairly cash-strapped. We are not one of the most popular avenues to spend money on. Why would a government fund generously a body that, if properly funded, would be a thorn in their side?

Senator MOORE—I have one more question leading on from that. In the state government's submission they have talked about the various things that they have introduced recently in this area. One of the things they have introduced is a commissioner position, which is to look at complaints and the whole process.

Mr Harley—I think it is called commissioner for health and community complaints.

Senator MOORE—I would have thought that would be a thorn in the side type position as well. You are working in this area and seeing cases that show the worst aspects of process, and one of your roles is education in policy. How do you fit that into the state government model? They are all state government models that we are working with. Also, with the various things that this government has said they have done with memoranda of understanding, changing and consultation, where does your office fit, with all the issues you have raised in your paper, in getting that information through to the people who determine the policies?

Mr Harley—I report annually to parliament, and parliament and the government read it, I hope. But I do maintain a correspondence with ministers and departmental officials with respect to matters that come to my attention that I think need urgent attention. They are often individual cases that have a systemic aspect to them. Although we have a mandate for individual advocacy, we do not have the funds to provide it to people, and there are non-government organisations that provide it.

Senator MOORE—Do you refer on in those cases?

Mr Harley—Yes. We used to have an education officer and an information officer that did a lot of the work but, because of the number of guardianships that we have, we have had to use those officers in further guardianship positions. Our capacity for community education and general information has been severely inhibited as a result.

Senator MOORE—That is a resources issue.

Mr Harley—Yes.

Ms Farr—The other thing, John, is that you spend a lot of time on legislative reform reviews and inquiries, and I guess that is the area where we feed back as much as possible. The office would like to spend more time systematically gathering information that comes across our desk through our individual guardianship advocacy work and our investigative processes, but there are obviously recurrent themes that come up. We write them in the annual report and wherever possible bring them up through those other committee processes.

CHAIR—Could I ask you about the physical restraints that you mention in your submission in accident and emergency departments and also, from memory, in psychiatric sections of hospitals, presumably Glenside and other places. Are any of the people that you are the advocate for subjected to what might be described as inhumane treatment or no treatment, confinement or physical restraints?

Mr Harley—I cannot recall any case where somebody under our guardianship has been subject to physical restraint. Usually, if the person is in the A&E department of a hospital, there probably is not a guardian. They are probably being kept there while they are waiting for a bed in the psychiatric ward or waiting for assessment. Sometimes it might be because they have another health condition as well as a mental illness—a physical illness. They may need to be in the renal ward or something like that and, because of their behaviour, they may need to be physically restrained. The ombudsman has had a report on the restraint of patients as a result of the number of cases that have been occurring. It certainly is something that causes us concern—that people with mental illnesses need to be physically restrained in that way, simply because of a lack of suitable resources to place them.

CHAIR—Does this happen in prisons in South Australia —where patients are not able to be received into James Nash House?

Mr Harley—I have not been informed of any of those cases.

Ms Farr—We have certainly had some clients under guardianship who are placed in protective care in prison—which essentially means isolation—for their own protection. Rather than being a physical restraint, it is an environmental restraint, which I guess potentially has other consequences.

CHAIR—Are you involved at all in the new forensic facility that is being planned at the present time? Were you consulted in its design or involved in any way?

Mr Harley—I was originally and then I did not hear anything. A couple of meetings were cancelled and I have not heard anything since. So I have no idea what stage that has got to. I know that something was planned, because I was anxious to ensure, in particular, that there was a facility that was physically separated, to accommodate people with brain damage, neurological disorders or intellectual disabilities. They really do not mix well with the group that have other mental illnesses. In fact, people with those conditions are often kept in prison in isolation for their own safety, because the other prisoners can be violent towards them. That has been one topic that I have been very concerned about.

CHAIR—We will follow that up with the state government later this afternoon. I will finish on a question about tendering out. You have been fairly scathing about the business of tendering out non-government services and you have suggested that the lack of expertise is a problem for people with mental illness. Would you like to expand on that? Was it ever any different? Is there a new system of tendering out which is making the situation worse?

Mr Harley—No, it is just what we have observed. When people do not have a permanent job, you tend to have a turnover of staff as people look for permanent employment, so you do not get the continuity of staff and the development of people with greater experience in that area. I have made that clear in my submission.

CHAIR—Would it be fair to assume that this has come about as a result of national competition policy that infects every level of government?

Mr Harley—I think they call it ‘contestability’ or some such thing.

CHAIR—Finally, are you an advocate of a bill of rights?

Mr Harley—Yes. My history is that for 30 years I was a legal practitioner in private practice in the ‘big end of town’, as the Americans like to call it, and issues of human rights were really not high on my agenda. My agenda was mainly to see how many billable units I could complete in a week. But then, after I was involved in some of my work, I could see that in cases involving such people as refugees, prisoners and people with mental illnesses there is no avenue to seek redress. I have seen cases in England since the adoption of their Human Rights Act and in America, where they have the Americans with Disabilities Act, where people do have a remedy if the government have got certain policies but their actions are not consistent with those policies. Our only remedy is through the ballot box. For people who are so disempowered, which all of these people are, that is not worth very much. There is nothing ‘sexy’ about being a refugee or being mentally ill or being a prisoner—there are no votes in that. Governments do not get back into power on the basis of their policies with respect to those people. So those people are left without any remedy whatsoever. This country is the only English common-law country in the world that does not have any legislation to protect human rights, and it is high time that we did.

CHAIR—We will finish on that point. Mr Harley and Ms Farr, thank you very much for your attendance and for your submission.

[9.48 am]

HERBERT, Mr Royce Lincoln, President, Australian Guidance and Counselling Association, South Australia

BROWN, Ms Elizabeth Mary, President, Australian Guidance and Counselling Association, South Australia

BOUCHER, Ms Susan Pamela, Chief Executive Officer, Australian Principals Associations Professional Development Council Inc

ZOELLNER, Mr Don, Chair, MindMatters National Reference Committee

CHAIR—Welcome. You have lodged with the committee submissions which we have numbered 413 and 120 respectively. Do you wish to make any amendments or alterations to those documents at this stage?

Mr Herbert—No.

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

Mr Herbert—I would like to start out by saying—perhaps to simplify your job here this morning, in terms of the submission I drafted on behalf of the Australian Guidance and Counselling Association—that there are a number of items in the terms of reference for the inquiry that I addressed the submission to. There are two main ones to do with our submission. One is reference (f), which has to do with the special needs of children and adolescents. The other is reference (h), which has to do with the adequacy of education in destigmatising mental illness. My comments will relate to those areas.

One of the reasons I focused on those areas was simply because of the developing weight of evidence connecting early antisocial behaviour and internalising behaviours with later mental health problems in life as adults. The submission I wrote referred to the work of Margot Prior and her colleagues in Melbourne on the recent Australian Temperament Project, in which they followed children from birth to 18 years of age. That is one example, and there seems to be more and more evidence accumulating in the literature to support those kinds of suspicions that you would naturally have that the troubled and troubling children of today become troubled adults later on in life.

I have a copy of this year’s first edition of our journal, the *Australian Journal of Guidance and Counselling*, here. The lead article is titled *Problem behaviour and associated risk factors in young children*. It is based on the work of Andrew Martin and colleagues in Sydney. It refers to preschool children and the signs of later problems that are shown very early in life. You might find, if you get a chance to look at this, that the introduction gives a good brief overview of a lot of the evidence that supports these concerns. So that is part of why I wrote that submission—because the children of today obviously become the adults of tomorrow.

I mainly want to restrict my remarks to school age children. The reason for that is that I am here representing the Australian Guidance and Counselling Association, and our membership is made up of men and women who work in roles in educational institutions around Australia. The job titles of those people would be such things as guidance officer, school counsellor and school psychologist. We have 1,100 members nationally, and these members support schools in promoting the mental health and wellbeing of their students.

Our members tend to have roles in schools where there is a concern that the mainstream curriculum is not meeting the needs of students. So we tend to get involved more with those students who do not seem to be served so well by schools. As a consequence, our members get involved a lot with students at risk of leaving school early. In that group would be quite a number of students who would have high support needs in the area of mental health, so that is also how the association relates to this inquiry.

Members of the association, by virtue of their practice and their training, become quite experienced at working with troubled students, their families and the community connections there. So, in that sense, I think I can represent the AGCA as having a significant role to play in this field. That is not to deny all of the other submissions that you have to go through, including that of the Public Advocate, who appeared before us. But most of my focus is on children and youth. I would like to influence the Senate inquiry because I am presuming you will have some input into public policy about whatever the future mental health strategy and suicide prevention strategies and the like in Australia become and that some funding will be allocated towards prevention and early intervention for children, youth and their families. Naturally, our focus is on the schooling sector.

What might you do for children and youth? Schools already do an awful lot. Far and away the majority of students who go through schools come out from their journey from infancy to adulthood as better people. They are more skilled, more competent and more capable. But schools are not perfect. In different ways, they could be doing a lot more to help the future generations of Australia to build their resilience and to be able to cope with the slings and arrows of misfortune in life as adults.

Probably the main idea that I would like to push across to this committee is that mental health promotion and illness prevention need to be firmly embedded in the curriculum of schools. That is probably the main way of getting something seriously taught day in and day out in schools. Just by way of example: my wife is a secondary English teacher and works in a private Catholic school here in Adelaide. She became involved with the MindMatters state based office in South Australia and did a unit of work on bullying and harassment in her Year 9 classroom. She said that, after the students had done four or five weeks of that unit of work and had covered it fairly thoroughly, she could still turn her back on them and they would be passing notes to each other to basically harass each other. She said that this kind of thing does not happen with some of the basics of English that she teaches, because they are revisited. Things like capitals and full stops are revisited day in and day out, right through the life of the student in a school. But something like bullying or harassment tends to be more a piecemeal, one-off kind of subject that might not be revisited again for several years.

I think the fabric of schools needs to have this mental health promotion and illness prevention built right in. There are probably some societies in the world where people are quite happy to talk about it and, as my colleagues might talk about later, where MindMatters and MindMatters Plus appear to be working. There are a lot of different factors involved but it has a lot to do with the mental health literacy that is being promoted amongst the staff at the school that they are prepared to talk about these things and, therefore, identify these things and, therefore, endeavour to deal with these things in the school context.

Some other examples of what might be developed include lots of programs that provide targeted intervention for students at greater risk of developing mental health problems. That would include identifiable population groups such as children in poverty, children with developmental delay, Aboriginal and Torres Strait Islander groups and so on. You are probably hearing about plenty of population groups over the course of this inquiry.

Schools and their communities need systems of case management for the really challenging students. There does need to be good communication between the school personnel and the mental health professionals in the community around them to provide a better service, a better framework of care, for those special individuals in schools.

School policies and practices, I guess, need looking at forever. They are organic things. You have to tend to them; you cannot just feed them once and forget them. Policies in particular, like school discipline policies, need a framework and an attitude that supports troubled students to be educated, not punished. Also along those lines is early intervention. That would be greatly enhanced where, as I said earlier, schools have direct links with community agencies such as GPs and other mental health agencies. School systems need to recognise the latent mental health needs of students, because at this stage only some of the school systems across Australia recognise emotional and behavioural disturbances. Others, like my home state here in South Australia, do have some provisions but they are not aimed at students with recognisable disorders like that. Here the main provision tends to be in a negotiated education plan, which captures a number of students—and some of them would have mental health concerns—but it is imperfectly done.

I am also here, as I said, to represent the Australian Guidance and Counselling Association in order to develop and promote these and other mental health options in the school context. It is best that you have some people with training in both psychology and education, which are our members. And where our members are based in schools they are more likely to be involved in leading the mental health promotion and prevention in terms of individual and group activities in schools. So I think basically these people should be valued if you are sincere about mental health promotion, prevention and early intervention in schools.

Ms Boucher—First of all, I would like to thank the committee for giving the Australian Principals Association Professional Development Council the opportunity to make this presentation. I thought it would be appropriate to give you a bit of background to APAPDC. We are owned by the four peak principals associations in Australia—the Australian Secondary Principals Association, the Association of Principals of Catholic Secondary Schools of Australia, the Association of Heads of Independent Schools of Australia and the Australian Primary Principals Association. Those four peak associations and their affiliated associations represent, pretty well, all 10,000 schools in Australia. I think at the last census it was recorded as 9,600, but we work on about 10,000.

We are responsible for providing effective and appropriate professional development to school leaders and those aspiring to school leadership and, obviously, supporting school leaders in the work that they do in the school. I want to focus very much on the fact that we work across boundaries. Often the boundaries of being a Catholic or independent or government primary or secondary school leader or school prevent people getting together. We work across the boundaries and the school leaders we work with do a lot of work together, whether they are Catholic, independent or government, whether they are primary or secondary.

Our focus today, though, is on MindMatters and the work that APAPDC has done in the period 2000-05 with the mental health promotion program called MindMatters. This program is funded by the Department of Health and Ageing. We started from a very small base—a resource kit, basically. Knowing that a resource kit going out to schools was not going to be appropriate and would probably sit and prop open the door of the principal’s office or hide in the library somewhere and not be used, we felt very strongly that there was a need for a professional development strategy, led by school leaders and leadership teams in schools, and the role of counsellors and guidance officers is very critical to that as well.

MindMatters is fundamentally a mental health promotion strategy. It is about focusing on the larger population of students within the school but is also based on a whole school change approach. So it is not just about what is being taught in the classroom; it is actually about how the school is operated, the culture and the ethos of the school, the curriculum that is delivered, the methodologies that teachers apply within the school and the relationships between the school and the community—both the parent community and the wider local community, including Indigenous communities.

We believe we have a very significant record over the last five years in being able to conduct such a professional development activity. This is a program for secondary school enrolled students—and our record to date is that we have worked with 85 per cent of secondary schools. We have also run professional development activities for over 56,000 participants. In the main, these participants have been school based. They have not all been teachers. There have been support staff, school leaders and parents. It is quite a significant strategy. We also pay special attention to the work that we need to do in Aboriginal and Torres Strait Islander communities.

As I said, MindMatters is a mental health promotion project. If appropriate, I would like to present the committee with some resources regarding the project. I have a small folder—not to overwhelm you. The blue flyer in the folder indicates the whole of the MindMatters strategy, including MindMatters Plus, which Royce referred to a moment ago, the work that MindMatters does and the way in which we are structured. The resource kit, which is in the top left-hand corner, gives you an overview of the extent to which the project covers work in schools and focuses on health promotion rather than working only with students at risk or students with high support needs.

I want to draw your attention to the World Health Organisation triangle, which is just underneath that first glossy folder. I think it is really important that we acknowledge who we are working with. We are working with the top two-thirds of that inverted triangle. The top half is the focus on whole school change, of all students in the school. As you see, as it comes down to the pointy end it starts to represent students who indicate some sorts of risk factors, and then the very at-risk students who would need additional support and intervention outside the school. We are really working with the top two-thirds of that inverted triangle to encourage a level of prevention, rather than acting after the crisis has hit. Our focus is on the connectedness of young people in the school community.

It is education and health working together. This is not a project that is operating just in schools. It is an indication that the work that we do is across health and education and, while it is sited in a school, we cannot do this alone. Much of our work has been focused on the training and support of school teachers and school leaders in developing their own mental health literacy to be able to operate within the classroom and within the school, and on the building of resilience in young people as they move through the years of secondary schooling. Our work also helps teachers and schools to identify and support young people who are at risk and may require additional support, whether it is within the school or outside it. But there is the question of how the school actually works with that.

We believe that we can now say that mental health is no longer seen as the domain of mental health professionals alone. Teachers and others in schools are accepting their roles in working in this area. While we have a long way to go, there is a real sense of moving forward. Our evaluation—and we are a very strongly evaluated project—indicates that there are some very strong outcomes from the project. We are supporting schools, students and teachers as they work towards building the levels of health and wellbeing in young people. In closing, I would like to refer you to this poster. I think this says a lot about what we are on about: that every teacher is a teacher for wellbeing in a school. It is not just the pastoral care teacher or one or two counsellors who is part of it, but every teacher—whether they teach mathematics, science, English or physical education.

In conclusion, we believe that we have been able to achieve some very significant outcomes in mental health promotion. We also believe that we have just scratched the surface in the five years. Bringing about change in a school is really a three- to five-year strategy. For some of the schools it was about starting to ask, ‘What is mental health promotion?’ and ‘What is mental health literacy?’ and coming to grips with that for the teachers, let alone implementing it in the classroom or the wider community. We have also been able to identify that it is not just about secondary schools; early childhood and primary schools are really important. We are starting to talk with the Department of Health and Ageing about moving that forward, which is quite exciting news. We have learnt a lot from this project, for example in the work we do with Aboriginal and Torres Strait Islander communities, about the development of relationships and the significance of taking time to work with the community as it focuses on its own health and wellbeing—as a community as well as in the school setting.

I want to leave you with the message that school leaders are leading in this area. They are not doing everything, but they are taking on a responsibility to lead here. In my final statement I would like to say that APAPDC, through the MindMatters project and the work of school leaders, have been able to play a small part in the National Mental Health Strategy and we certainly look forward to working further in this direction. We think there is so much more to do and the work in the schools is very rewarding. It is seen as a positive way of approaching the whole issue of mental health and mental illness.

CHAIR—According to this *MindMatters Plus* document, the evaluation is taking place now with ACER and La Trobe University.

Ms Boucher—That is correct.

CHAIR—When do you expect to have that finished?

Ms Boucher—At the end of this year. In fact, the evaluation subcommittee met yesterday. There were some presentations of the early findings of the project. Royce is the chair of the MindMatters Plus committee. He might want to make a comment on that as well. Right through the project, since the beginning of 2000, everything we have done has been quite heavily evaluated. In the general MindMatters project we have had 16 case study schools. The work that is coming out of that indicates that, where you have good professional development strategies in place, where you have a whole-school approach and the leader is very much a part of the process and where it is established not just in the classroom but right across the school, there are certainly much better and more significant outcomes to the work that we are doing.

CHAIR—In case we do not notice it in the press or we forget to ask you about that evaluation, will you send it to us when it is finished?

Ms Boucher—Certainly. We would be very pleased to.

Mr Herbert—I would like to add to what Susan said. It is a commendation to the Department of Health and Ageing that, when they established the MindMatters suite of projects, they built evaluation very much into it. In a sense, it is groundbreaking because they are not, perhaps, the classical experimental control or randomised control type studies. That is not real life; real life is a lot different from that. They have been developing ways, using program logic analyses, to look at all the different parts of the MindMatters suite, which includes the MindMatters program, in the first instance, which Susan has spoken about. It is health promotion and prevention program materials for professional development for secondary schools universally.

Out of that, the department realised that students with high support needs needed something extra, so they invented something they called MindMatters Plus, which was a demonstration project aimed at building the capacity of secondary schools to better support those students and their families in the community. Also out of that grew the MindMatters Plus GP project, which was to develop pathways of care through the Divisions of General Practice, because I guess the most readily accessible form of primary health care out there is a GP. About 90 per cent of Australians see their GP at least once a year, so it is a good avenue for making a starting point. Other parts of the suite include Families Matter and so on. All of them are being evaluated, and I think it is a credit to the Department of Health and Ageing for putting that in.

CHAIR—Let us hope the evaluation, if it is a positive one, ensures the ongoing nature of the program, which it often does. Your inverted triangle indicates that 20 to 30 per cent of students need additional help in school such as psychosocial interventions in problems and that three to 12 per cent need professional treatment. That is a very large percentage of the school population. Can you comment on the insistence we are seeing at both state and federal level for literacy testing and numeracy testing and so on? To what extent does that run counter to the idea of being concerned about students with these sorts of issues? I presume that these are the same students who will get caught up in the problems of literacy and numeracy.

Mr Herbert—Statistically.

CHAIR—Would either of you like to comment on that general approach that we are seeing.

Mr Zoellner—The numbers of students indicate, for example, the prevalence of bullying. That is reasonably widely known. That gets into that upper middle group.

CHAIR—So bullies would be in the group of students needing additional help in schools?

Mr Zoellner—Yes.

Ms Boucher—And they might not need it for the whole of their five years. It might be for a short period of time. It might be for a crisis they are going through or a depressive illness that they are experiencing for a certain amount of time.

Mr Zoellner—To get back to your point about literacy: as luck would have it, I came across an article that has just been published on the Longitudinal Survey on Australian Youth. You may be aware of that survey. It goes back to 1995, when it began following over 13,000 year 9 students. Some of the latest data released from ACER indicates that what determines a student’s success in school is their relationship and connectedness with the school, which is what MindMatters is all about. It is about changing the way you do business. An interesting thing that has just been published in the *Preventablepus Review* suggests that it is not linked to literacy levels, to your academic outcome. It says that you do not have to be a good academic to be well connected at school. Without seeing the details of that, what we have found anecdotally from MindMatters would suggest that there are multiple ways of connection. If you have only one or two units of measurement in connectedness, then that is not going to work. We do know that. By all means, literacy and numeracy are important, but you need a number of other activities to be taking place in a school for students to connect to it.

CHAIR—So you are saying there is not a connection.

Mr Zoellner—That study is certainly suggesting that it is not a strong connection.

Ms Brown—If we look at the research on students with disabilities and highlight, say, students with dyslexia or Asperger’s, we find that those particular students are at high risk of depression and anxiety because they know what the other students can do and they identify with them and want to do it. If students with dyslexia have good sporting ability or good ways of coping with the fact that they can do one thing but they find difficulties with something else, then their general resilience and optimism can be quite enhanced.

I work in one of the northern suburbs schools. We have been looking at early intervention. We have been really looking at the students coming in at kindergarten—that is, four-year-olds—and the high overlap between play skills and communications skills as a predictor for successful inclusions. If you cannot talk to somebody, it is very difficult to get friends. We have done some work with an occupational therapist, looking at measuring play entry skills, teaching play skills and teaching communication skills to really ensure that young children coming into kindergarten are learning to play and to be included so that when they move into the schooling sector they are able to network within the social rules of school and the school behaviours and are able engage in a lot of the learning tasks. You hope that those early interventions and the smaller class sizes now in a lot of disadvantaged schools are going to enhance those relationships.

Research has said that if you get the relationships and the learning happening then the behaviour problems further on in the schooling are significantly reduced. Certainly, there is an overlap in some children with learning and behavioural difficulties. That does not necessarily mean that because you have one you have the other. As a school counsellor and a school psychologist, looking at the behaviour issues and trying to unpack what is behind them might really help to target some intervention. Is it as a result of bullying or learning difficulties or something that is happening outside school? Is it a grief and loss issue? Once you know what it is then you can target the particular programs.

MindMatters is a secondary school based program. There are some interventions going on in primary schools, such as Program Achieve and some of the social skills programs. Schools are increasingly wanting to put them in place. You hope that that will become a universal strategy that is going to lessen the number of students that you have to work with at an individual level, say, in secondary school.

Mr Zoellner—One of the things that MindMatters does is to offer a framework to schools to make some good evidence based decisions about what works. When we first moved into this area there was an almost national outcry of: ‘Let’s do something about youth suicide.’ So there were lots of ‘somethings’ being done, some of which were good, most of which were mediocre and some of which were downright dangerous. MindMatters gives schools a framework by which they can evaluate what types of interventions they want to put into the schools. One of the things that is clear is that, particularly in youth suicide but in mental illness generally, the most dangerous thing is a well-meaning amateur who gets their advice from *Home and Away*.

CHAIR—What sort of advice did you discover that was dangerous? Give us some examples.

Mr Zoellner—A teacher would find out that an individual student may be considering suiciding and the teacher thinks that they can handle it, that they have the skills to sit down and talk to the student about suicide, or they teach about suicide in an out-of-context manner. You would have people, particularly external, high-profile people under the guise of role modelling, wanting to come in and have the same sorts of discussions. We have learnt a lot through the evaluations as they have gone through but also by looking at the National Drug Strategy.

While MindMatters has not been tied up closely with it, we have worked in parallel. So, for example, there was some clear evidence that came out that some programs that were seemingly widely supported, such as the drug abuse resistance education, had quite a negative correlation with the intended outcome of reducing drug use among students. Drug use actually increases if you go through the program. There were a number of things like that. MindMatters focuses your ability to evaluate what you need for your school community, because you are looking at the whole school community and the way the school operates, as opposed to saying, ‘Here’s a dose or an inoculation.’

Ms Boucher—It also supports teachers in being teachers of wellbeing, but it does not expect them to turn into student counsellors. So there is a pathway identified clearly within the school where, if they have concerns about a particular young person, they can work through that. There is a sense that they do not have to come up with the solutions. They can assist in identifying and recognising some behaviours but do not need to be able to fix the problems.

Senator TROETH—Who actually handles the MindMatters program within a school? Is it a designated teacher or the school counsellor?

Ms Boucher—Where it works best is where there is a team of people within the school. It would include somebody from the executive of the leadership team, whether it is the principal, the deputy or somebody senior; a student counsellor or a guidance person within the school community; a school nurse if there is one—in New South Wales the school nurse is very strongly linked; and, of course, teachers who are working in classrooms with students. We also encourage parents to play a role and in some places there is student participation and a student voice. So it is not done to kids; it is part of a program that the young people have a voice in and make a contribution to and where they can certainly take a leadership role in the work of the whole school.

CHAIR—I am interested in Ms Boucher's comment that there is a clear linkage between staff mental health and student health and wellbeing. As part of this process, are you discovering teachers with mental illnesses?

Ms Boucher—When we started with MindMatters and working with teachers on professional development, one of the things that became very clear almost immediately was that you cannot deal with changing the mental health of young people without recognising that teachers and the school environment can be a contributing factor. So we found that some of the teachers who came to the professional development would indicate that they either might have a mental illness, were going through a depressive stage or were just struggling with things. That is why in Staff Matters we look at the health and wellbeing of the school community—the teachers, the ancillary support staff and the parent community—as being part of it. It is not just for children; it is for everybody in the school community.

CHAIR—I visited a little primary school in country Victoria which put in place a very successful antibullying program some years ago, and they said the most surprising outcome from it was that it changed the behaviour of teachers. Is that your experience too?

Ms Boucher—Yes, the evaluation is showing that. The students are reporting bullying more often in schools. They are also reporting that the school is acknowledging and doing something about the reported bullying, so the correlation is there. Then teachers are recognising that they are noticing more bullying in the classroom and are able to do something about it. That is in the evaluation.

CHAIR—What about noticing bullying in their own teaching style, in their own behaviour?

Ms Boucher—That in itself is part of the business of talking about the methodology they are using, how they are working with young people and how they are working with their colleagues. You cannot ignore that when you start to talk about MindMatters. Their methodology is very much in their face, basically.

Ms Brown—Certainly if you have a student voice, which is part of what you would have in a school, the students will comment on it. We have had evidence from some schools where students have brought it up and said, 'That sounds like a put-down,' and they will either confront the teacher—not always that individual person but one of the other staff members—and ask what they can do about it. If you are having class meetings, that is certainly one of the things that they will raise.

CHAIR—That is an excellent development.

Ms Brown—The younger the child the more likely they are to tell you, too.

Ms Boucher—One of the things that we found with MindMatters is that in the early stages when schools start to focus on MindMatters, and bullying in particular, the reporting of bullying goes up quite significantly. There was a concern about what was going on, but in fact it is about people recognising bullying and being able to report on it—

CHAIR—And name it.

Ms Boucher—and for the school and teachers to then do something about it, and then that drops off again. Royce’s story before was really about the business of getting the whole school to focus on it and not just talking about bullying in classrooms.

Mr Herbert—As everyone becomes more literate, they do intervene earlier. I will give you a very simple example. When little Johnny at the back of the room is running his hand up and down the back of the dress of Mary, who is seated in front of him, and ultimately she gets so upset she swerves around and screams at him and wops him one just as the teacher turns around from the board, Mary then ends up in trouble. If the teacher is more alert and aware of these things and notices that Johnny is doing these sorts of things in the first instance, they can often support Johnny to do the right thing by moving into his line of sight, his space, without having to say anything and disrupting the rest of the class. Johnny then chooses to do the right thing and desist from doing the wrong thing.

CHAIR—With 36 Johnnies it can be a little more difficult!

Mr Herbert—Yes, it is a challenge. Some of you were teachers in the past.

CHAIR—That is right. It jumps out at you, doesn’t it?

Senator MOORE—We need to get more information about MindMatters—how it works and what the funding program is. The only thing that is worrying me is the tendency for really good things to be funded for a while and then expected to be taken over and be self-sufficient. That scares me, I have to admit. In the evidence you have given us today, the future history as well as the past has to be taken into account. So I am going to put that on record and find out from the department what their plans are.

The other thing is training colleges for teachers. Senator Allison raised a point about the mental health of teachers, which is very important in this process. We have heard before on a couple of other committees that there are so many expectations of people in education in terms of their awareness and capabilities that just loading on more information for would-be teachers is a difficulty. In terms of the training of teachers, what kind of information is around about these issues? For would-be teachers to make the decision to become counsellors in that area, what extra do they have to do, and so on?

Ms Boucher—The Hunter Institute of Mental Health—

CHAIR—That is Newcastle based, is it?

Mr Herbert—That is right.

Ms Boucher—It runs a program called Response Ability—Royce referred to it earlier—that is focused on preparing young people for teaching. It is very closely linked to MindMatters, so that the language that they use prior to going out to teaching is very similar to when they come into the classrooms and work with other teachers. The issue is always about how much time you can get into the courses. The Hunter institute works very hard to work across educational faculties across Australia through the universities to get as much time as possible. It is always an ongoing challenge, given that universities have a right to determine what their programs are going to look like.

There are some very good materials there—certainly, where it is working well. I think it has also been a bit like when we first started MindMatters. People were saying, ‘What is this thing?’ But it has got to the stage where it now has very high recognition and is seen as a very useful vehicle for operating within a school setting without it being another top-down thing that has to be added to the curriculum or to the work that teachers have to do. It is a framework rather than the business of another thing you have to teach.

Senator MOORE—Is it still peculiar to secondary schools at this stage?

Ms Boucher—Yes.

Mr Zoellner—One of the things we have been insistent upon from the beginning is that we try to use, wherever possible, the existing health and education infrastructure. Instead of creating something new and separate, we work inside what we have. Essentially, if you look at the cost per student it is a soft drink and a packet of chips—although, probably in these healthy days it should be a falafel and an orange juice.

Senator MOORE—That is another element that teachers are now supposed to be involved in.

Mr Zoellner—If we get this right, many of the so-called issues around discipline disappear because you understand the dynamic that is happening. We do not have an advertising budget, for example. But the punters are knocking down the doors to get access to this material, particularly out in the primary schools, because the word out there among the profession is that it makes their life better in the long term. The word is out there that it is working, because 56,000 people cannot be wrong. It is a huge program. It is probably the biggest educational professional development program in Australian history.

Ms Brown—Here in South Australia a framework is being developed at the moment, which is out for consultation, which is the Learner Wellbeing Framework. It talks about the model that MindMatters is based on, but it is the whole school: how you are addressing the relationships, the curriculum, the liaison with your community and the support agencies that you use in trying to bring in the wellbeing framework. That will go from child care right through to the end of schooling. MindMatters will be one of those programs. There is also the drugs strategy—the

'Let's be active' or 'Let's go' or one of those policies. In some sense it does not matter where you start from with your strategy, because at the end of the day most of them are looking at the same issues: how you ensure that your young people in school are safe, know that they belong, are learning, achieving and being challenged. It is all of those sorts of things. Hopefully, these other programs will fit into the framework that is being developed across DECS. I agree that we do need to keep it as a high priority.

Ms Boucher—We do have a large number of primary schools. Whilst the funding is for secondary schools, it is amazing how teachers can access professional development that is not for them. We have had a lot of very resourceful primary schools that have bought the resource kit and participated in the professional development. That is why we are now moving forward to encourage the primary school strategy for mental health promotion.

Senator TROETH—Is that a part of your ongoing discussions with the Department of Health and Ageing?

Ms Boucher—Yes, it is. We have just been invited to seek further funding for the next few years for the secondary component as well, so they are not going to let one slide. The senator's point about making sure it is sustainable in schools and then the funding disappearing and losing its way is valid. We believe very much that it has to be a connection between health and education working together and that the opportunity cannot be missed. We have to keep funding it and we have to keep moving forward with it.

Senator MOORE—How much money are we talking about?

Ms Boucher—The total suite of projects for five years—including Families Matter, MindMatters and MindMatters Plus—was $8.3 million.

Senator MOORE—Over five years?

Ms Boucher—Over five years.

Senator MOORE—To when?

Ms Boucher—To the end of this year.

Senator MOORE—And you have actually been invited to ask for more money?

Ms Boucher—Yes.

Mr Zoellner—Probably one of the key things—and I was hoping that Senator Scullion would be here—

Senator MOORE—Yes, we were too!

Mr Zoellner—is that this is a national rollout, and so the focus on regional and remote areas has not been diminished because of location. In the Northern Territory, for example, which is probably among the most difficult, every school that has a secondary age component has had access to and been through significant training with MindMatters. And that has been repeated. The 15 per cent of schools that we have not touched has been an issue of self-selection by the school, generally, or maybe a feeling that they do not need what is on offer just now. It has not been a lack of resources or skills. This is a national program.

Senator TROETH—Is there any common factor among that 15 per cent? Are they large or small? Are they country or city?

Mr Zoellner—I do not think so.

Senator TROETH—Just across the board.

Ms Boucher—It is self-selection, really. Many of them may already have programs in place. They certainly have access to, and do have, the MindMatters resource kit, because that was made available for free to every secondary school in Australia. Certainly there are teachers with a great deal of expertise in this area.

Mr Zoellner—We are also getting reports anecdotally that, even though you may train teacher X in school Y, if they move or when they move they drag some knowledge of this process with them.

Senator TROETH—Portable skills.

Ms Boucher—And quite often the resource kit as well!

Senator TROETH—In the bag! That is a very encouraging and positive development, particularly at the coalface where we need to assist every citizen to grow up a healthy, happy individual. So I do congratulate you on that; that is tremendous.

Senator MOORE—I would like to ask one more question. We are always running short of the time; that is one of the horrors of this job. We have heard evidence in other places from very inspirational young people who have come to us with different hats. In Victoria they come from ORYGEN, and in the ACT there was a group of people who have had various personal experiences with mental health issues and who are now running programs where they visit schools and talk about their experiences, hoping to link in that way. Does MindMatters link in with that? These people did not come to us under the heading of MindMatters; they came in through different avenues. In a school using the MindMatters guide and process, would the invitations to those groups to come in and talk be under the MindMatters umbrella?

Ms Boucher—It might well be that the group coordinating MindMatters in the school would see this as a very valuable addition to the program, so I would say yes without having first-hand experience of it. Our two national coordinators would probably be able to give you a whole range of examples of where that is happening.

Senator MOORE—Can we get that from the national coordinators? We are trying to look at how things are working across the whole country, and we are getting these pockets of knowledge and experience. These people were very inspirational and interesting, but I just want to know how it works.

Ms Boucher—We have just produced a DVD called Community Matters. It focuses on diversity in schools and the issues that young people in schools deal with. It certainly looks at Aboriginal and Torres Strait Islander communities, both remote and metropolitan, and there is a beautiful example of a very inspirational young person who has really been struggling within the school around her own health. She is a self-harmer. It talks about how the school has been able to assist her, and that in itself is very inspirational for other schools to view. It is a training DVD for teachers; it is not used for young people in schools. But the idea of sharing those stories is very important. We could certainly provide you with examples of that and we would be happy to provide you with the DVD too, which really does give some very useful, down-to-earth, straightforward stories about what schools can do now, rather than always requiring lots more money to come into the school community.

Mr Zoellner—Lots of the good news stuff is shared on the web site. When we monitor the real hits on the web site—not by someone who has got there by accident but by somebody who goes in and has a look around—we can see the spikes of activity after a national activity or after particular training. Particularly, people are looking at resources and what else is happening out there. One thing we know from this is that schools love to hear what other schools are doing. They love this purposeful gossip. The other interesting thing from analysing the statistics is that the bulk of the hits are after 5 pm, so teachers are doing this literally in their own time.

CHAIR—They do most things in their own time.

Mr Zoellner—Yet another one!

CHAIR—I will finish on a question that goes to what an ideal model for a secondary school is. Should there be a school counsellor or a nurse? What is preferable? Should a certain percentage of the teachers have been through this professional development process? Should the principal always have been through it? What does the connection with the parent community look like in a school that gets it right? Can you spell out what a good model might be?

Ms Boucher—I think you have just described the model perfectly. It does require all of those elements working together. We have not talked about the Families Matter strategy, but that is part of MindMatters and is managed by the peak parent organisations. The connections between what is going on in the school and the close relationship with parents and the community is so important. It is probably the hardest area to work into, in secondary schools in particular, but it really is critical. We believe that the leadership of the school have to take a lead in this. They have to be part of the training and they have to be able to ensure they can support the leadership team who are working in the MindMatters area so that, when there are blockages, when there are other issues going on, they can support them and move them forward. I believe that every teacher in the school should be trained in this program, not just the 15 or 20 per cent of teachers who go out. It should be done as close as possible to school. More of our work is now being done in the school, which of course is very expensive because of the—

CHAIR—How much more money do you need?

Ms Boucher—We have not done the sums on that.

CHAIR—Now is your chance.

Ms Boucher—We need $14 million! We are in the business of pulling all that together and ensuring that it is long term. It is not something that you come into, inject some good ideas into and then walk away from. It is a long-term commitment. There is a community of teachers across Australia who share their practices. We had a very successful conference earlier this year in Sydney where schools were sharing their stories. Well over 500 teachers paid to come to the conference, and they were very enthusiastic about and very excited by what they were hearing. That is what I would like to see.

Mr Herbert—I can only reinforce what Susan has just said: the greater the number of teachers in a school, including guidance counsellors and so on, the better the momentum is in the school for doing that. We are really after a generational change, so that the generation of Australians in 30 years time needs less Prozac.

Mr Zoellner—It is a long-term commitment because, if you think about it, five years—from 2000 to 2005—in South Australia is just one student's journey through school if they have stayed to year 12. We are talking about, as Royce has pointed out, generational change. It is a long-term commitment. One of the reasons why the leadership team is important and why the principals got involved with this is that the worst thing that can happen to you as a principal is to have a student die in your school, particularly if they commit suicide. We knew that a short program, a quick fix, would not work. Our commitment to this has been unwavering. The school principal who says, 'I don't have time to do this,' is quite misled, because if you do not have time to do this you have a hell of a lot less time to deal with picking up the pieces in your school after a death. We would be looking to the Commonwealth to maintain its effort in this area over the longer term. Being sensible about it, another five years of about the same level of funding—you can always use more—would be a fantastic outcome for Australia's schools.

Ms Brown—Going back to your earlier point about the role of the teacher education authorities, sure there is a part for that, but I think the maturity of a teacher in growing into the role is what is happening in the school with the children you are working with and having staff that can mentor and support you. That is probably going to sustain you a lot longer in terms of teacher change, particularly if it is in a school where it is happening. I think you will get more growth. I am not saying that universities should not be doing it but, given that they have to cover a huge amount of content, it is really in the practice of teaching, and so I think using the mentor system in schools is really the best way forward.

CHAIR—Some would say that you do not learn to teach until you get on the job anyway.

Mr Herbert—Can I table this? I referred to it earlier. There are copies for the committee.

CHAIR—Is it the wish of the committee that the document be tabled? There being no objection, it is so ordered.

Mr Herbert—I am really only referring to the first article about problem behaviour and really only the introduction. I am not trying to give you a lot of reading, but I am trying to give you some evidence for arguing with people elsewhere about why we should spend money on children and youth for mental health promotion in Australia.

CHAIR—Thank you very much for your submission and for coming. It is very reassuring and gratifying to know that the Commonwealth program is achieving so well and that your efforts are also bringing rewards. Thank you very much for letting us know about it.

Proceedings suspended from 10.44 am to 11.03 am

CARSON, Mrs Ruth Mary, Carer Representative, Strategic Planning Group for Private Psychiatric Services, National Network of Private Psychiatric Sector Consumers and Carers

McMAHON, Ms Janne Christine, Independent Chair, National Network of Private Psychiatric Sector Consumers and Carers

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

Ms McMahon—I am a consumer as well as the chair of the national network.

CHAIR—You have lodged with the committee a submission, which we have numbered 189. Do you have any amendments or additions to that document at this stage?

Ms McMahon—We have some additional information here that we would like to make available to the committee to substantiate the recommendations that we have made.

CHAIR—Is it the wish of the committee that that information be tabled? There being no objection, it is so ordered. I now invite you to make a brief opening statement, after which we will go to questions.

Ms McMahon—We would like to thank the committee for the opportunity to appear before you today. In this opening statement I am speaking on behalf of my colleague Ruth. I think it is important to state that I have been a consumer of mental health services in the private sector since the late eighties, and I struggle with mental illness every day. Ruth’s experience has been in caring for someone close to her who has used mental health services for a major mental illness.

We represent Australians who contribute to health funds and others who receive their treatment and care for mental illness delivered within private sector settings, including psychiatrists in private practice. We are the authoritative voice for consumers and carers concerning the policy and practices of provider and funder organisations in private mental health. We are funded by the Australian Medical Association, the Royal Australian and New Zealand College of Psychiatrists, beyondblue, the Australian Private Hospitals Association and the Australian Health Insurance Association. You will note that, despite three formal requests—all of which were declined—we are not funded by the Australian government.

Whilst there is a sustainable and affordable private health sector, the reliance on publicly provided services remains as it is. There are a number of issues around the provision, and particularly the funding, of mental health services—including legislation—that are problematic. If left unchanged, we believe that they will in time impact on the whole of health. Last week we appeared before the House of Representatives Standing Committee on Health and Ageing, which is inquiring into health funding, and we raised a number of issues regarding our concerns for legislative change and also the practices of some health funds.

In our submission we have made eight recommendations that we believe need to be taken further. It is interesting to note that, whilst the national network is raising these issues, several span both private and public mental health sectors. If there are any areas that this committee has the power to change, the following would make a fundamental, positive difference to those people most disempowered in our community and those who care for them. Our recommendation 2 is that, with regard to the carer allowance, changes should be made immediately to alter the criteria for eligibility of carers of someone with a mental illness and the manifestly inadequate amount paid, which is currently just $92.40 per fortnight.

Recommendation 3 is that the guidelines that determine the benefits—as outlined within these guidelines—paid by health funds to private psychiatric hospitals for care across the continuum should be strengthened, including legislative change, to make compliance for both private hospitals and health funds mandatory. Recommendation 4 is that immediate change should be made to the Pharmaceutical Benefits Schedule to enable psychiatrists in private practice to prescribe atypical antipsychotic medication for treatment of disorders other than schizophrenia and bipolar 1. Recommendation 8 is that the eight state and territory mental health acts should be replaced by one national mental health act as a matter of urgency and that impediments should be removed, such as those that prevent involuntary admissions to appropriate settings in the private sector.

We have given you some extra information which highlights some of the areas regarding those recommendations and some of the data and statistics for private sector settings. There is also a research article on low-dose atypical antipsychotic medications. The third bit of information concerns the carer allowance and the eligibility questions that are asked. They certainly have more of an emphasis on the physical disabilities and the aged than on mental illness.

We welcome the opportunity of raising issues with you today that concern people directly involved in the receipt of mental health services and those that care for them in private sector settings. I think it is important to say that our submission may appear somewhat fragmented. That is because our members have had direct input in writing portions of that submission. So it is coming directly from users of the system such as me and from the carers of people in the system such as Ruth. Thank you for giving us the opportunity to appear before you today.

CHAIR—Thank you for your submissions. It is always good to have a set of clear recommendations for the committee, if I can say that. Can you expand a bit on recommendation 4 that you make—that the PBS should enable psychiatrists to prescribe atypical antipsychotic medication? Can you explain why you make that recommendation?

Ms McMahon—At the present time, psychiatrists in private practice with the Health Insurance Commission and the pharmaceutical benefits schedules are precluded and prevented from giving atypical antipsychotic medication other than Zyprexa to people who have disorders other than schizophrenia and bipolar 1. Some of the mood disorders, when you have depression with hallucinations or delusions, and some of the anxiety disorders and personality disorders that have a bit of a psychosis component only need a very small dose of atypical antipsychotic medication to augment the existing medication that people are on. Currently—and this is a bureaucratic decision based on cost—psychiatrists in private practice are precluded from administering and writing prescriptions for those medications. They can do it in the public sector hospitals.

We feel it is discriminatory against the private sector. It prevents psychiatrists from really delivering good practice. Some psychiatrists will perjure themselves and give a diagnosis of schizophrenia so that they can give them the best possible treatment available with regard to medication. That is an extremely important point that we raise. If nothing else comes out of this committee that we can present, that is really high on our list of recommendations. I think it highlights the difficulties of psychiatrists in private practice.

CHAIR—You also call for the National Standards for Mental Health Services to be reviewed. What are the current problems with standards? Is it a state-by-state matter?

Ms McMahon—The National Standards for Mental Health Services are basically guidelines for mental health services for delivering care and the services around that care. They were written for the public sector. There are many that do not apply to people like me in the private sector. There is an urgent need to review them. They were written, I think, in 1996 or 1997. Supported accommodation is one of the standards that is mentioned. That clearly does not apply to private sector services. No hospital provides supported accommodation. People who require that from private sector services have to obtain that in the public sector.

So it really is important to look at the standards which have been identified as best care standards and at the appropriation of them to the types of care that can be funded and offered in the private sector. We are a very complex, legislated sector. Health funds are precluded from paying for services that could be delivered in the community, for example, because the definition of ‘payment’ for people to receive those services in the community is that they must be an admitted in-patient. The health funds, under the legislation which binds them, cannot offer or pay for services offered to someone who might be in a preventive health situation. So it is about areas such as support, rehabilitation and dealing with social isolation, loneliness and those sorts of issues. The hospitals do not provide them because they cannot be funded under legislation, which really ties the hands of the health funds considerably.

Mrs Carson—It actually goes to the heart of the notion of continuum of care because, without the possibility of being able to incorporate rehabilitation, recovery is sitting very carefully with carers who obviously get no support in that way. Unless that issue is dealt with, that burden remains on the carers. Otherwise, they go through into the public health sector. Many of the people in the private sector may do so, but it means they actually do not have any choice at all about rehabilitation in the private health sector.

CHAIR—Is it possible to give the committee an example of where you or someone else as a carer might have taken advantage of changes such as you suggest?

Mrs Carson—I can certainly give an example of a young person who was discharged after a severe psychotic incident. Apparently it should have been able to be managed but, in an ordinary situation, because there is no case management and because there is no external support, the fact of the discharge after the psychotic incident did not mean that that person was well. In fact, it is a continuing and constantly emerging problem that comes and can emerge at any time. The thing that had to happen there—and which did happen because of the parent’s familiarity with the public sector—was that it was possible to tap into and be fairly assertive about what was then required. But many people just do not know, and nor do they want to have that as their only choice.

Senator TROETH—I would like to ask you about the issue of privacy. We have had quite a deal of evidence to suggest that carers, often for privacy reasons, are being left out of the loop when it comes to treatment regimes for consumers, and they also have difficulty obtaining any information on the consumers they care for—particularly parents of adult consumers. What is your view on that? Are the same problems encountered in the private sector?

Mrs Carson—There are problems encountered in the private sector. They are exactly the same: the definition of privacy and what is not allowed to be said. My view, and the view of many of my co-carers, is that that is often used as an excuse when it really is not valid at all. Secondly, the private providers are actually receiving our money to pay for young people—very often aged under 25. So you are financially supporting them, often for their education and certainly for the psychiatric help that they require, and you are still excluded. If you want an example of that, which you have not asked for—

Senator TROETH—I am now asking for it.

Mrs Carson—I was involved with a psychiatrist through my daughter, and was told that the psychiatrist was not used to discussing matters relating to my daughter with her parents. That is a very difficult thing to overcome, because in a sense it does not allow you to participate effectively in what is a caring program—there is actually a continuing treatment program as well—and that is really a very tough call.

Senator TROETH—Have others consumers encountered the same problem, to your knowledge?

Mrs Carson—Absolutely, yes. I know it is unwise to give a personal experience, but it was the one that was immediately valid and meaningful to me.

Senator TROETH—I can understand that.

Mrs Carson—What was the second part of your question?

Senator TROETH—That was on your views on the issue of privacy. Again, in some of the evidence that we have encountered from people who are undergoing mental health treatment, they say that they feel the need to keep their affairs private, but sometimes that crosses over to it being a symptom of their illness. We have also heard of tragic consequences which have occurred because carers and relatives were not informed.

Mrs Carson—That is exactly right. I think that the carers feel that their behaviour and their demands are interpreted as part of the cause of the problem as well and that, if a carer wishes to be more assertive about their rights and their privacy, they are less well defended. The carers can make observations and they can be passed on to the consumers, but it does not actually work the other way around.

Senator TROETH—Ms McMahon, do you have a view on privacy?

Ms McMahon—It is interesting, isn't it? I come from the opposite perspective and I think of my particular circumstances. Clearly, there are a great many things that I would not want my husband to know about in terms of my treatment and my care. The privacy guidelines came out in 2001, I believe. I think they were drafted with very little understanding of the complexities of the mental health system. I was part of a coalition group that put together a privacy kit to aid and assist practitioners and hospital service providers in addressing that very specific issue. We made a number of recommendations to the Privacy Commissioner at that time, but I think that mental illness is very misunderstood and that the complexities and the difficulties of it are very misunderstood.

Senator TROETH—Do you think the guidelines have got it about right? Would you like to see more stringent guidelines or would you like to see a relaxation of the guidelines?

Ms McMahon—I think the guidelines are adequate. We spent a lot of time looking at the very specific issue of confidentiality for partners or parents with young ones, and I think the guidelines are adequate.

CHAIR—On that subject, I notice that the submission from the Public Advocate says that some time ago he participated in a mental health working party whose objective it was to produce a balanced set of guidelines on the issue. Were you involved in that working party?

Ms McMahon—No. Was that the Public Advocate in South Australia?

CHAIR—Yes.

Ms McMahon—We worked with the Australian Medical Association, the private hospitals, the health funds and the college of psychiatrists in putting that together. A national approach was put together for the Privacy Commissioner—it was not a state approach.

Mrs Carson—I think the privacy stuff is quite adequate as well. One of the problems comes in its interpretation and practice, and that very frequently, particularly in something like psychiatry, it depends on what perspective the psychiatrists are coming from or the professionals are coming from. They do not necessarily want to explore with consumers, like my friend here, what it is that makes them say that they do not want this information passed on. It requires a degree of confrontation, if you like, or a pursuit of something—although frequently they do not have the time, the willingness or the wish to go down that path when it is easier to say, ‘It’s all right; this is private, secret—don’t worry about it.’ I think there is a strong component of professionals’ attitudes towards that sort of thing that sees it as a way to obstruct communication rather than a way of developing communication and being able to explore the issues that may be partly at the root of some of the problems of the illnesses that are being presented.

Senator MOORE—Your submission actually raises the issue of not having your voices heard, and it has taken a while to have this particular area considered in terms of the process. I get the impression that it is getting better, given the fact that your organisation has been funded by a number of key groups. Have you a sense that people are beginning to listen to you as people who use and need the private sector?

Ms McMahon—In the areas that Ruth and I work in, I do not believe that, in any way, shape or form or by any manner or means, it is a tokenistic representation or inclusion. We are part of key decision-making processes. I think our views, our thoughts and our experiences are very much taken on board.

We do, however, operate within a commercial environment. Hospitals need to make a profit. The health funds—some of which are not for profit and some of which are for profit—need to at least be sustainable. So it does impact on how much we are included in, for example, hospital service delivery. I think the private sector still has a long way to go in embracing consumer participation and carer participation in the frontline delivery of services. I think we are getting there, but I think we are well behind our colleagues in the public sector, and I think that that is more difficult.

With regard to the National Mental Health Strategy and the documents that came out under that strategy and the continuing plans—the first plan, the second plan and now the third plan, but certainly the first and second—we were lucky to get a dot point that referred to the private sector. People are acutely unwell. I have had seven or eight acute admissions since the late eighties. People are acutely unwell in the private sector. We want to put paid, once and for all, to the concept that the private sector only treats the ‘worried well’. That is not so, and the information I have given you shows just how unwell and sick people really are in the private sector. This concept that we are all employed, that we all work—

Senator MOORE—Or are independently wealthy.

Ms McMahon—and that carers can work because the people they are caring for are not really that sick is not correct. We have data now from 2004 to squash that emphatically. I think that is something that needs to be noted. I think that the national standards of mental health services were entirely public sector focused. With regard to rights and responsibilities, if you look closely at that document you will see a number of those things are just not applicable to private sector services. They talk about community care, for example. We are struggling to have community care in the private sector. There are only 12 of 46 hospitals with psychiatric beds that offer a community service.

Senator MOORE—That is nationally?

Ms McMahon—That is nationally. What happens? People have an acute admission, they leave the hospital, the door closes behind them and there is no support in the community for the majority of people. So without support people become unwell again. It is a cycle.

Mrs Carson—I think it is partly the structure that Janne has just described that accounts for why there is more difficulty getting consumer and carer participation in policy and development. In the public sector there are community medical centres that become the focus of continuing care. When a person comes out of a psychiatric hospital there is no such environment. So it is like a one-off experience. You have been dealt with in a crisis and then you are gone and that is it. There is no continuing service to keep the carers focused in one place to work together to provide an environment in which it is good to participate.

Senator MOORE—Do you find that people are actually using both kinds of care simply because there is no option? Your example pointed out that people are treated through the private sector but then something happens and there is nowhere to go. Do you find that people are being treated and bounced between both sectors?

Ms McMahon—As a rule, no.

Senator MOORE—You wait until you can get into the private area.

Ms McMahon—People in the public sector cannot get into services because it is overburdened and underresourced. You have heard graphic examples of that; I know because I have looked at some of the transcripts. So for someone who is treated as a hospital in-patient admission in a private hospital to then to go into community care offered by the public sector is just not an option.

Mrs Carson—It is difficult.

Ms McMahon—Very difficult, if not impossible.

Mrs Carson—The other thing is there is very little communication, if you like, between what you might experience in the public sector, because that is where you are transferred, and the private psychiatrist. That is a source of some tension.

Ms McMahon—Very often treatment regimes are altered and medication is altered, and that is not conveyed back to the psychiatrists in private practice. A lot of people see psychiatrists in private practice to get that continuity of service provider. In the public sector, as you know, they rotate approximately every six months. So to obtain that in-depth care—the psychotherapy, the psychological interventions—people opt to see a psychiatrist in private practice, but they need hospital care or community care through the public sector. The communication and the gap is quite wide between the two. As for being able to have in-patient care in the private sector and then access community services in the public sector, as I said before it is nigh on impossible.

Senator MOORE—I have one last question about your statement about Centrelink. We have heard considerable discussion over the last few months about the adequacy of the payments, and that is an ongoing discussion. I am interested in your statement that you believe that carers of people with mental health issues are not supported through the system as effectively as they should be. I know you have given us the splendid Centrelink form, which goes on for pages and pages. For the record, can you point out why you think it is more difficult for someone who is caring for someone with mental illness to actually get their case heard through Centrelink?

Ms McMahon—I enclosed those applications just so that you could see the questions that are asked. They talk about bladder control and about being able to eat, dress and do up buttons—difficulties with those sorts of things. It does talk about psychiatric care but—

Senator MOORE—It is one section.

Ms McMahon—That is right. But I am sure that it has to be focused towards dementia rather than other disorders, and people have to be unwell for six months, as I understand it. If you look at those questions, they are clearly focused towards the aged. They are particularly focused towards physical disability and they are really not geared towards psychiatric disability or mental illness.

Senator MOORE—What would your suggestion be in terms of working within the system? How would you change it?

Ms McMahon—I would like to see the criteria for eligibility changed to be more inclusive of the understanding of what the difficulties and the complexities are with regard to mental illness. Mental illness is chronic and people can be very unwell. There are times when people do not get out of bed—cannot get out bed—and need to be assisted with showering, clothing and those types of things. But then that episode seems to pass a bit. The acuteness of the episode passes a bit. But we are talking about people with chronic mental illness. Ruth will be able to talk on behalf of carers, but carers still have to be there 24 hours a day, seven days a week.

Mrs Carson—You have too many situations where you really cannot leave a person because it is so unpredictable what is likely to happen. So you are in a situation of having to protect them. You have to watch for the risk to the person and to the public—very frequently, in some cases. Firstly, my experience of the carers allowance application is that so much appears to depend on the interpretation that Centrelink chooses to put upon it and what their knowledge of it is. Secondly, as Janne has described in something else, when the general practitioners are filling it in they very frequently lie in order to slant the application to allow it to be possible. And it actually does matter if you have a description of schizophrenia, as opposed to borderline personality disorder or something. It is a category that affects how you are treated later, and it is very difficult to shed.

Ms McMahon—The recommendation we would make is that the form be reviewed immediately to make the eligibility criteria broader to incorporate and capture mental illness for people who may be young adults, not necessarily into the senior years.

Senator MOORE—So that one page on behaviour needs to be expanded in some way?

Ms McMahon—Yes.

Mrs Carson—Or a special section on psychiatric illness or psychiatric disability, instead of it being incorporated into the rest.

Senator MOORE—So it is not one-size-fits-all.

Ms McMahon—It needs to be a standalone thing. I would not have thought that would have been too difficult.

CHAIR—You fall short of making a recommendation with regard to the use of police and you call for the integration of ambulance and police services. The committee has found quite an institutionalised involvement of the police in mental health situations. Do you accept that that is necessary to any extent, or is there a model that would better serve people with mental illness than the one that is currently out there?

Mrs Carson—I do not think the police should be involved at all. I really feel that very strongly.

Ms McMahon—Yes, we feel very strongly about that.

Mrs Carson—There should be a system that does not involve them. You can argue that it is unfair to them anyway. It is not to do with their training; it is not what they went into the job for. They are in there for control—for law and order—and that is what they apply to a person who is severely ill. I do not think they should be involved. Some ambulance people have real difficulties in that they do not see that mental illness is a priority. If you can go to a heart attack, you go to that rather than to something else. But obviously that is a more appropriate thing. I would prefer to see wider availability of crisis teams, actually.

CHAIR—I thank you both very much for coming and appearing before us today and for your submissions. You have been really helpful to us.

Mrs Carson—Thank you very much for your time.

[11.36 am]

FEAR, Mr Graeme, Coordinator, New South Wales State Council, Advisory Committee for the Care of People with Mental Illness, St Vincent de Paul Society

HARRIS, Sister Myree, President, New South Wales State Council Advisory Committee for the Care of People with Mental Illness, St Vincent de Paul Society

BICKNELL, Mr Peter Ernest, Chief Executive Officer, UnitingCare Wesley Port Adelaide; and Representative, UnitingCare Australia

HATFIELD DODDS, Ms Lin, National Director, UnitingCare Australia

WATERS, Mr Mark, Manager, Employment Access, UnitingCare Wesley Port Adelaide; and Representative, UnitingCare Australia

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

Mr Fear—I am the coordinator for mental health issues for the St Vincent de Paul Society of New South Wales, and I am on the St Vincent de Paul national advisory committee on mental health issues.

Sister Harris—I am the president of the state advisory committee for the care of people with mental illness for St Vincent de Paul. My position was not listed accurately on the program. The state president would not be very happy if I claimed to be the state president.

CHAIR—We will correct the record

Sister Harris—I am also on the national committee.

CHAIR—You have lodged with the committee submissions Nos 291 and 478 respectively. Are there any changes or additions that you want to make to those documents at this stage?

Ms Hatfield Dodds—I will just say that ours can be read in conjunction with the submission from UnitingCare New South Wales/Australian Capital Territory.

CHAIR—I ask you to make brief opening statements, after which we will proceed to questions.

Ms Hatfield Dodds—Thank you for the opportunity to speak with you this morning. UnitingCare is one of the largest non-government providers of community services in Australia, with over 400 agencies providing services to children, young people and families, people with disabilities and older Australians in urban, rural and remote communities.

Peter Bicknell is the CEO of UnitingCare Wesley Port Adelaide, which is a large community service organisation with a significant specialty delivering community mental health services covering supported accommodation, housing, lifestyle and employment support. The agency supports people in supported residential facilities and boarding houses, as well as homeless youth. Over the last two years the agency has been involved particularly in supporting ex-Baxter asylum seekers exiting Glenside psychiatric hospital here in Adelaide. Mark Waters is the manager of the employment access services at UnitingCare Wesley Port Adelaide. Employment access provides both open and supported employment, particularly to job seekers across South Australia who have mental illness. It works with some 450 job seekers at any time.

We welcome the opportunity to speak with you about improving opportunities and supports for people living with mental health issues in the community. This morning we want to highlight three key issues in particular. The first is that of employment and participation in our communities for people living with mental illness. Under that there are probably two subissues. Firstly, we believe there are insufficient employment services and supports on the ground. Secondly, we believe the recently announced federal welfare reform changes will make not just the gaining but the maintaining of long-term employment more difficult for people living with mental illness.

The second key issue is the issue of the serious levels of unmet need in the community, both in the government and non-government sectors and in clinical and non-clinical services. We would say that that is true despite the National Mental Health Strategy. There is an illustration from the South Australian experience: the recent crisis in the emergency departments of South Australian hospitals is indicative of the need for significantly increased assertive services for people with mental illness within their communities. The South Australian government response of allocating some $25 million in one-off payments to non-government agencies leaves uncertainty and a significant ongoing gap in services.

The third key issue is that of addressing community attitudes and acceptance of people with mental illness in communities. Our experience right across the country is that stigma is still a significant issue and a barrier for people living with mental illness—and for their families. It really is a primary barrier to successful mental health outcomes, and it is one of the key things we need to address. We believe that the National Mental Health Strategy needs to be reoriented towards a primary mental health care approach, moving away from a predominantly medical model of support to a holistic model of support addressing all the social determinants.

We think that all levels of government, the community and the private sector really need to come together and work together to ensure that there is improvement in people’s mental health across the country. This kind of improvement will require the delivery of services first to those who need them most and as close as possible to their homes. We urge the federal government to take up the challenge and provide leadership to the states and territories and to other civil society stakeholders, to enable a concerted attack on the consequences of mental illness that result in missed opportunity, exclusion and diminished quality of life outcomes for real people in real communities.

We think a Commonwealth-state agreement would be a useful tool for the full implementation of the strategy and would ensure a better balance of resource allocation between medical, other health and the community sectors. Well resourced early intervention is also urgently required to reduce the prevalence of mental health issues in children, young people and their families. We also support the development of a national consumer strategy to enhance the rights of people living with mental health difficulties and disorders. We hope such a strategy would increase the engagement of these people and their caregivers in policy development, service planning, implementation and review processes.

We really need to build a mental health and wellbeing system that increases people's health and economic and social capital. Such a decent life system must include prevention, treatment, care and ongoing support and must focus on the aspects of daily life that affect people's sense of belonging and participation in their community—that is, where people live, how they learn and are educated, the work opportunities available to them, the health care available to them, the level of income they are able to obtain, their mobility and the extent of their relationship networks. In seeking a decent life for all we are driven by our belief that strong and healthy communities are those in which each person belongs, contributes and is valued and by our long experience in delivering community services in Australia.

Mr Fear—Thank you for the opportunity to be here. We have made many recommendations, some that are probably not politically attractive and some that would be considered too costly to implement. However, we believe that they all have great merit and are necessary if we are to have a system of best practice. Our observation is the same as that of many others in the field, from clinicians to community support field workers: the situation is getting worse and the only conclusion is that the National Mental Health Strategy is simply not working.

We have reached a crisis situation. There is fragmentation and a lack of communication between services, governments and the non-government providers, and there are legislative barriers. There are matters which can only be dealt with by a nationally coordinated approach. As a nation, we have proven that we can do that sort of thing, particularly when it comes to natural disasters. We now have our own home-grown, man-made disaster. Action would come about if a national state of emergency was declared. Only then would the vital communication and coordination that is necessary take place. The buck passing must stop. The blame game must cease if we are to go forward in a meaningful way. Just last week on *Four Corners* this problem was highlighted by comments from federal and state politicians. It also demonstrated—to us, anyway—that separate ministries on mental health at all levels of government would be a major step forward.

I understand that the federal government is currently committing millions of dollars to investigating issues relating to suicide across the nation. There needs to be a similar investment in, and commitment to, mental health. This would automatically follow a declaration of a state of emergency as a first step. The current drift away from easily-located, community-based services is tragic. It is understandably cost effective but it is counterproductive.

The focus on hospital-based acute care is similarly understandable. However, it means that social, recreational and living skills and vocational and pre-employment training issues are grossly neglected. The shared-care initiative for GPs to be the primary contact for the mentally ill in the community cannot work for many, if not most, because of time and financial issues. We do not in any way suggest a return to the pre Richmond days but the lack of true asylums, safe havens or secure retreats for the mentally ill is proving to be counterproductive. Psychiatric wards in hospitals are not safe havens.

Christopher Pyne, the parliamentary secretary to the health minister, said on *Four Corners* last week that we do not need an emergency summit as we have regular health ministers' meetings. Mental health is not a key issue on the agendas of those meetings. The main focus will be on how to reduce hospital waiting lists, which are embarrassing to government. The fact that we have a crisis on our hands and the National Mental Health Strategy has not worked for so many who have a mental illness leads one to the conclusion that the current system of regular meetings of health ministers is not effective enough. We need much more. We need a declaration of a national state of emergency, with all the powers that come with such a declaration, to override all the systems in place that so often set up the mentally ill to fail.

Sister Harris—I would like to expand on a couple of our recommendations. Firstly, I would like to comment on recommendation 8, on page 12. That had to do with the accommodation and support crisis. I was speaking on the basis of 15 years experience. I live in a small community house with people with mental illness—and I have done so for that period of time. In that period, something like 45 people have moved through our community. We buried one, who had lung cancer, last week. We become their family in lots of cases because families have abandoned them. I receive, in my position as president of the advisory committee, phone calls from all over the state from families desperate to find accommodation for their relatives.

In 2003 I had a Churchill fellowship to go overseas and look at models of dual diagnosis treatment and rehabilitation. In the course of that I found that one of the models that are really working overseas is the assertive community treatment team model. That is where you have a team with a capped case load which can provide intensive, flexible support in all areas of people's lives. It can help them sustain tenancies. It is a holistic approach. It is not based on the medical model.

The only application of that I have seen in New South Wales is the MAT team, the mobile assertive treatment team. I believe the ACT team model, which was originated at the Robert Drake centre in the New Hampshire-Dartmouth Psychiatric Research Centre, is a very good model and it could be applied. It could help people sustain tenancy and stay in their houses or flats. An example of that, which I saw in Manchester, New Hampshire, which is a really good model that we could apply here, was where you had a treatment team like that. They had 600 people with a dual diagnosis whom they were treating in the community. There was a residential component, Gemini House. It is a 16-bed place where people can stay for up to a year. Toward the end of the year they move into a flat up the top and start to prepare to go back into independent living. When they go back into the community, they are supported by the same team. The team support them in the community, in the residential component and back in the community. That is a model that could be used to support people with mental illness.

There is a model that is really working in New South Wales. I do not know if it is in other states. It is a pilot model, the Housing Accommodation and Support Initiative, called HASI. It came in at the end of the program. I was lucky enough to be able to give Matthew Carney some ideas of where to go to look at things for that program. I thought that that was a model that could be applied. Unfortunately it is only a pilot, but it is doing the same kind of thing that the ACT teams were doing overseas. It is helping people who have not been able to sustain tenancies stay in their places, giving them all the support they need.

Another model that we came up with through our committee and a coalition called CASA that we set up is what we call mental health community care packages, based on the CACPs for seniors. The ACAT teams told me that they are besieged by families of people with mental illness who want access to the CACPs so that they can get a brokerage of services to help their family members survive in the community. I believe that something like that could happen. We did send a recommendation to Kay Patterson, and she sent it back to the state but it never went any further. I followed it up, but it got lost.

I would like to expand on recommendation 3 on page 10 with regard to dual diagnosis. I would like at the end of this to submit my Churchill fellowship report, which details all the findings that I came up with. The most important thing is that dual diagnosis of mental illness and substance abuse is a massive problem. The estimates are that 30 to 50 per cent of people with mental illness have a dual diagnosis. We are not taking it seriously. It is being taken much more seriously in Canada, America and England—where I went. As a basic thing, we need national best practice guidelines, which they have. America had a SAMHSA report to congress. We need to be able to find out where the programs are. Our states do not talk to each other; we do not even talk to each other within the states. If someone needed access to a program, they would not have a clue where to go. Canada has a national program inventory—I found it very easy to find programs right across the country—and a provision of integrated services.

What is happening in America is very interesting. There are 15 American states as well as three Canadian provinces that are integrating their mental health and drug and alcohol systems at state level. They are using a consultancy called ZiaLogic, developed by Ken Minkoff and Christie Cline. It is a five-year process. I sat in on this in places throughout the States. They are then providing what SAMHSA in the States says is the best approach, which is integrated treatment, rather than parallel or sequential treatment. New Hampshire-Dartmouth has a tool kit available showing how you can use or apply integrated treatment. We need to investigate this and do something about it. In Great Britain and Canada they are also doing a lot of crosstraining. We are currently not doing either of those things adequately.

There are also specific, targeted programs, the most exciting of which I saw at a place out of Regina—Pilot Butte—called Ranch Ehrlo. It is a program for youth. Most of them turned out to be indigenous—the most disturbed youth from across Canada, many of whom have dual diagnosis. It is a non-government approach that has been going for 40 years, treating the most disturbed children from the entire country. We could use that, instead of having DOCS put such children in motels with carers, as happens in New South Wales. I saw harm minimisation programs for multiple diagnosis people, again using the ACT model and residential and group home programs.

The final thing I would like to talk about is recommendation 13 and the Compeer program. Graeme talked about the lack of social supports in the community. We have set up the Compeer program in New South Wales through St Vincent de Paul. We affiliated in 1995 with the Compeer program, which originated in Rochester, New Hampshire, in America. It is a program that matches volunteers one-to-one with people with mental illness, for friendship. The initial commitment is an hour a week for a year. Most of them continue on. We now have friendships that go back to 1995. We currently have 150 volunteers, six programs in New South Wales, two more coming, and one in Melbourne, and we are trying to promote a national initiative. This is something which helps break down social isolation, and I believe it can enhance people's lives immeasurably.

CHAIR—Can I raise a matter to do with tendering that was in the Public Advocate's submission. The Public Advocate argues that the state and federal insistence on contestability is in fact reducing the expertise within non-government sectors for service provision. Do you agree with that? Is this a problem that you encounter? Is the short-term nature of contracts and funding arrangements having an impact on your staffing?

Mr Bicknell—I think it is. UnitingCare Wesley at Port Adelaide currently has 13 different contracts with the state government for mental health services. In fact it has more than that if you include the support given to people in supported residential facilities. One of the difficulties is that over a long period of time there have been a lot of pilot programs et cetera. Here in South Australia there has been a big effort to try to bring those together. People you will hear from later on this afternoon have been active in trying to bring some of those together.

For example, the state government has recently made a one-off allocation of $25 million to mental health, and that creates the difficulty that John Harley was referring to. If you are not sure that that money is going to be ongoing—and say you spend it over three years but you do not know for sure that it is going to continue—you have a real difficulty with staffing and you have almost a moral issue about engaging clients when you cannot be sure that, if you take someone who is seriously ill and whom you know you will need to work with for several years, you will be able to provide an ongoing service. That sort of threat both to staffing and to client engagement is actually contradictory to the security that we want to build into this, because we need to build up a strong work force. In fact, where we work we have a strong work force. We have something like 90 community support workers working for us, and they have been there for a long time. Many of them are taking long service leave now, but that is an exception, and it requires us to juggle, manage and manoeuvre things around a bit more than is a fair thing.

CHAIR—But there is a dilemma, is there not? Particularly in mental health services, a strong non-government sector delivering services seems to be a good model. We do not want to stop innovative practice. We need to keep learning. What is the way forward? How do you get this right?

Mr Bicknell—Just designating the money from the beginning as being a one-off is certainly counterproductive. I think the agreements should be for at least three years and that they should be subject to renewal upon proper evaluation, and then reorientation, if that is required, or else funding should cease. But under those circumstances you would expect 85 per cent to continue. People can then plan, engage with their clients and develop their staff, and develop their programs with confidence. I think discontinuity is more of an issue than the tendering itself. One of the dilemmas with tendering, of course, is that if there is too much emphasis on competition, a heavy application of competition policy rather than an emphasis on encouraging collaborative tendering, you end up with a field that is very suspicious of each other, whereas you really want people to work together, to share ideas and databases and to train together. Sometimes, if competition is inappropriately overemphasised, it can be contradictory to the collaborative nature—

CHAIR—Can I press you? Is it being overemphasised in your view?

Mr Bicknell—I think it is being overemphasised.

CHAIR—Mr Fear and Sister Harris, is that your view too?

Mr Fear—We do not get involved in mental health tendering at all in the St Vincent de Paul Society, but I agree with the comments from UnitingCare. Our recommendation No. 7 on page 11 is to put an end to the pilot funding that happens so often. As UnitingCare have said, it is very difficult to get support from both the organisation and the staff on a long-term basis when they know their funding is generally short term.

I will give you a very good example of what can happen. In the mid-nineties we built a residential aged care facility for homeless men in New South Wales. We operate the Matthew Talbot Hostel in Sydney and we accommodate about 1,000 homeless people a night in New South Wales. With the Better Cities report back in the late eighties, it was determined that there were many men in homeless persons emergency services that would in fact qualify for Commonwealth residential aged care. As a result of this, there was system of grants and we ended up building this hostel.

The issue is that—and this has been supported and well researched—70 per cent of the people in all homeless persons facilities in Sydney have diagnosed mental illness. When they become old and frail—and bear in mind that we had people in the Talbot who had lived there for eight years; and it was an emergency service—they qualify for Commonwealth residential aged care, but they have mental illness. You need the type of staff that can cope with that situation. Your general personal care assistant cannot do that.

In the end, to cut the story short, we managed, with great difficulty, to negotiate with New South Wales Health for a top-up fund, which is most unusual for a Commonwealth-funded residential aged care facility. They gave us $150,000, which enabled us to employ two psychiatric nurses in the facility. That worked extremely well until the two-year commitment from New South Wales Health ran out. Then they basically said, ‘No, we are not going to renew it.’ So we got to the stage where we had to threaten to change our entry and exit criteria, and we had to make all sorts of innuendos at the end of the day to get the funding. It has now been renewed for three years. It was a full submission. It is a very difficult thing to actually cope with just that short-term funding.

CHAIR—Presumably Winteringham hostels in Victoria—

Mr Fear—Yes, we know them.

CHAIR—negotiated the same top up, did they?

Mr Fear—I do not know.

Sister Harris—It might be about a bit of a shift in terms of thinking from the state perspective—moving from thinking about funding projects to thinking about funding or resourcing partnerships. It is a different thing, so you can get your innovation through learning and innovative organisations rather than moving the resource pot around. The reality is that the staff on the ground often move from organisation to organisation, but the discontinuity for people accessing services and the distress caused is quite severe.

Mr Bicknell—I would agree with that too. We have a number of very successful partnership type arrangements with area health services, particularly in our social and recreational facilities—we have a couple of social and recreational areas in New South Wales, and one in particular at Sutherland. We have a very good relationship there and the area health service provides transport, occupational therapists et cetera. It works extremely well. That partnership model can be very good.

Senator MOORE—Much of the evidence both of the organisations have given was given to the poverty committee—

Sister Harris—Yes, much the same.

Senator MOORE—with the same issues and the same themes. It is very disappointing. Because of time, I would just like to take up your issues on the dual diagnosis, Sister Harris. Senator Webber from Western Australia has mentioned that. She is not able to be with us today. In terms of the options you raised, where have you taken those proposals? You have done the Churchill Fellowship, as I know Ms Hatfield Dodds has. It is the same overall field. So you have done that and brought back all of this knowledge. You have looked at an issue that everyone has identified. The issue of dual diagnosis is a critical issue and every state is struggling with it. There are pilot projects going on. What do you do now?

Sister Harris—I accept every opportunity and every invitation to speak to anyone who wants to sit and listen to me. I have talked to mental health conferences and drug and alcohol conferences. I addressed a mental health team at a hospital. I joined the Mental Health Coordinating Council, which has a drug and alcohol mental health thing going. We are trying to present a combined approach. I have contacted DOCS. I have contacted the deputy director-general, whom I happen to know personally, fortunately, because I could not get through any other way, and suggested the Ranch Ehrlo approach to looking after the most difficult clients. It is a much better option than motel rooms. I have written an article for *Disparity*. I write articles through St Vincent de Paul. I work through our coalition, CASA. I pester governments. I basically do everything I can to make myself a complete nuisance and keep talking about it, because I believe that we have to do something about this issue. For some unknown reason, it is not being taken seriously. If anyone would like to invite me to do anything, I am very happy to do it because there is a lot of information that can be passed on. I have handed out about 400 copies of my report. St Vincent de Paul keeps paying for the photocopying.

Senator MOORE—The key point there was ‘some unknown reason’. When you have actually finally faced the people who make the decisions in this, what is the reaction? Why are they not prepared to take it up? We have evidence that there is a project in South Australia for women. It is looking at dual diagnosis and it is a special one. They have mentioned it in their submission. So there are pockets of activity going on. Do you know what the barrier is?

Sister Harris—I think it is the competition between mental health and drug and alcohol systems. I think that could be it. There is competition between the two systems. For some reason, although they were once united, they have separated. I think there is a great need for the systems to be integrated. Perhaps it takes an act of will on the part of the government to do that. There is competition for funding. I think that, until we break that down, we will not be able to solve that issue.

Senator MOORE—So it is about minding your own turf?

Sister Harris—I think it is, as well as a scarcity of funding.

Senator TROETH—I would like to ask both groups about consumer rights and also carer rights. We have heard on the one hand from consumers, particularly involuntary patients, who have said that their basic human rights are not being respected. But we have also heard from carers who have advised us that they cannot obtain the information they need about the people they care for to enable them to better care for them. I ask both groups: what views have been expressed to you about the people with whom you interact about their rights? How do we balance out this issue of privacy?

Mr Bicknell—At UnitingCare Wesley, Port Adelaide, we employ two consumer advocates. We work hard to ensure that consumers are very involved in everything, particularly in their basic care plans. I think that is the most fundamental involvement. Often things happen to people rather than the people being involved.

We also have agreements in all of our work that people sign up to, which describe early in the piece who it is that we should be sharing information with and about what. With rare exceptions, carers and other important support workers are included in that, particularly if that is agreed to at a time when a person is essentially well. So we try and develop these working agreements, which we call care plans—in employment they would be called employment plans or something like that. We discuss those sorts of issues, particularly at engagement and then at other times when we are reviewing it and they are well.

In combination with that we have consumers on panels and carers on many panels—not necessarily all panels—and we seek to overcome that. I do think the privacy legislation is a very serious impediment to care. You often get quite serious nonsense with people not acting in the best interest of a client but acting in the best interest of protecting their professional ground, particularly being careful that they are not open to accusations.

Senator TROETH—So they are guarding the letter of the law.

Mr Bicknell—Yes. If they said that their prime responsibility was to act in the best interest of the client, I think they would see things differently than if they felt their prime responsibility was ensuring that they or their organisation did not get sued or criticised. Often the threat of an ombudsman or somebody criticising you is more powerful than what really might happen. I am not sure that too many people are actually getting sued in the end, but it is the threat hanging over them that people are afraid of. I think too many people are using that in a protective way and a way of avoiding scrutiny or dialogue.

Mr Fear—From our perspective, we made a recommendation to change the privacy legislation—

Senator TROETH—I note that.

Mr Fear—to enable medical welfare to be more effective. How do you change it? I do not know. All I can do is relate our experiences out there. Our biggest involvement with people with mental illness is in the community, because of our home visitation program. As a matter of fact, since this submission, we have put a survey out to all of our conferences in Australia. We have not got Western Australia’s back, but of the 664 responses we have got from the other states, 77.5 per cent of them answered yes to the question: do you encounter people who you believe have a mental illness in your home visitations? We also have about 600 stores across the country. In many of those, we have interview rooms where interviews with welfare people occur. Again, to our survey question, 31 per cent of those who responded answered yes to: do you encounter people that you believe have a mental illness at these interviews? In other words, we end up with a lot of them.

We end up dealing with a lot of people in the community who have some sort of mental health problem. So often our people say: ‘It would be important for us to know what their problem is and what medication they are on and what the side-effects are that we are likely to see. What sort of information can we gather that would tell us that they are having another episode?’ But so often they say that when they talk to the clinician they close up shop under the Privacy Act. It makes it difficult. It makes it very difficult for us because, so often, we are the people at the end of the line. We find so many people have alienated families and friends. In the end, Vinnies is there at the end of the line.

CHAIR—Perhaps they are alienated because their family does not understand what is going on.

Mr Fear—That is right. That is true. Our people often say to me, ‘We’re having great difficulty because we just do not have enough information and we would like more.’ We are not clinicians; we do not pretend to be and we do not want to be. We would like to be more a broker of services. But, so often, you need more information to become an effective broker too.

Mr Waters—In providing mental health services, we have to engage very much with the consumers. My knowledge of the mental health system is that it is very much consumer driven. There are a lot of consumer advocates there, and we ignore their message at our peril. Engaging with our consumers only enriches our services. It actually helps us to work more effectively. I was listening to the discussion with the private carers and consumers network, and that sort of tension—push, pull—of carers and consumers is constantly there. But, as we have brought carers into our services to dialogue with us, as well as the consumer being an integral part of the support team and the treatment plan, the carer is also an integral part of the support team. That can only add value if you can get over those hurdles of the privacy issues.

Senator TROETH—There was another question I wanted to ask St Vincent’s. You referred in your submission to establishing some asylums for people who have continual mental illness episodes and are unable to live successfully in the community. I take it that that would encompass some of the people who I think you said had been in an acute facility for eight years.

Mr Fear—Yes, in some way. We are talking about a long-term residential aged care facility there. It is really interesting: just last week I was visiting a client of ours in the St John of God hospital at North Richmond—a very good establishment. This fellow suffered severe trauma in Libya about 25 years ago and has never spoken about it. He is suffering from post-traumatic stress and has had it episodically since then. There are issues that he has not spoken about—he has spoken about part of it. When I was talking to him the other day, he opened up about a whole new range of issues that he said he had not spoken about for such a long time. By the way, he tried to commit suicide two months ago and ended up in a psychiatric ward at Penrith hospital then got to St John of God. Because he was an involuntary patient he self-discharged, had another go and is back again.

He said: ‘The group situations are really working well with me. The important thing for me is that I know—they have told me—that when I leave here, if I ever have a problem, I can just ring them up. If I feel I have got to come back in for a week or two weeks, I can just come.’ It is that sort of place that people can go back to. Our experience is that people who are unwell with a mental illness often know they are unwell. It is just like us when we hurt physically—we know we have got to go to the doctor. They know their condition, many of them, and will go for treatment. They will go for that time to get right again. But there is just nothing out there in the field to any great extent.

Senator TROETH—Would your vision for those facilities differ from long-term psychiatric care in purpose-built hospitals, or is that the same thing?

Mr Fear—That is more of an acute service. I am talking about ones that are not so acute and are episodic in nature, where people can generally, with assistance and support, live pretty well back in the community, but every now and again they need to go back in—but not into a full-blown acute care psychiatric situation. That is not a safe haven.

Ms Hatfield Dodds—It is developing a continuum of care. We talk about this all the time in aged care. It is enabling people to come into the system at the point when they need the support and all the treatment and then providing them with the support to go back out into the community. We know from our experience in UnitingCare—and all of us know as human beings—that we would all prefer to be at home in our own communities rather than in an institution.

CHAIR—The committee met with members of the New Zealand Mental Health Commission here, and a number of people have pointed to that model and said it is a good one. Sister Harris, maybe you know a bit about the New Zealand system. Perhaps one of our recommendations ought to be to have not just a council of mental health ministers but a body which actually monitors the mental health strategy and is somewhat at arm’s length from government. What would you say about that?

Sister Harris—We gave evidence to the New South Wales inquiry into mental health services. Our chief recommendation was that there be an office of mental health located in the Premier’s Department, separate from the department of health. In our present submission we are saying that this should exist at federal level also. It means that you separate mental health funding and organisation from health in general so that funding cannot get siphoned off into something more interesting or more embarrassing to the government. It should be quarantined so that we actually know that mental health services and funding are provided from the funding that is given. I still believe that is a very good model. I am sorry, I do not know the New Zealand model adequately, but it sounds like there needs to be a separate system. Maybe we need a minister for mental health at the federal level and a minister for mental health at the state level. We need separate conferences. The idea of health ministers' conferences talking about mental health issues—

CHAIR—Or not talking about them.

Sister Harris—It is a bit fanciful, isn't it! At what stage would that be? It would probably be item 15 on the agenda, the one they do not get to. It needs to have a separate significance of its own.

Ms Hatfield Dodds—We are not across the New Zealand model, but we are strong supporters of a independent entity of some sort.

Senator MOORE—Mr Waters, I felt it would be inappropriate to wrap this up unless we had some comment on the particular issue of employment, because your submission did touch on it and there are significant changes in federal legislation coming up. I think that for the record it would be useful, because of your experience in working specifically with employment issues, for you to have a chance to say something.

Mr Waters—Our position is simple: providing people who experience mental health issues with work or meaningful activity towards work actually helps to keep them well. It helps them to stay well and improves their mental health. We see that, as resources are put into employment programs, people with psychiatric disability are the group that is least accessed and the hardest to work with. The Department of Employment and Workplace Relations research has said that this group needs some special attention. Most of the resources in the employment area tend to go towards people with intellectual or physical disability. This is an area that needs to have some real attention.

In our work, as we look at welfare reform, the issue of finding people work is certainly one that we face. But our work focuses mainly on keeping them in work. It is actually about long-term post-placement support. The welfare reform moves actually may bring people more to focus on the front end rather than on the long-term support end. The episodic nature of mental health issues is such that you do need to provide some longer term supports to be able to work through the cycles that people are experiencing in facing the stress of work. Already we have had clients approaching us who, despite their paranoia, are saying that pressure is being placed upon them to change their status in the system. It seems that undue stress is being placed upon them with the impending reforms.

Senator MOORE—That is changing from the pension process to the concept of going into the work force?

Mr Waters—Precisely. That may or may not happen. That may not be a real thing. But they are experiencing that sort of pressure. They are getting messages through Centrelink that they are going to need to present in a different way or there will be a different obligation placed upon them or their income support will be taken away. They are concerned about it and they are reflecting that through our services currently. They are very real issues. We certainly see that we can do more in this area. We are currently capped at a certain level. We would be able to provide more services if more resources were made available.

We also see that there is a need for a very strong, rigorous assessment instrument because some of our clientele would present one week for assessment and they would be deemed capable of working 15 to 29 hours. In a couple of weeks time, they would be deemed capable of working about three. Those sorts of issues are not going to be picked up in a 1½-hour assessment through the comprehensive assessment system.

Senator MOORE—And your suggestions?

Mr Waters—At the assessment level there is certainly a need for standardisation and making sure that there is very strong training around mental health issues in the assessment and probably being able to view people over a period of time rather than in one hit. In the long-term placement area as well as the uncapped places, which are the 15- to 29-hour places which are about to be released, it is about being able to work out where people best fit and to work with them effectively in the long term. I think the 15- to 29-hour cohort could benefit from two years. In some instances, we have worked with people for three to four years before they have stabilised to the point where they do not need so much of our support. We would like to see sufficient time given to be able to see the episodic nature of their illness worked through as they maintain work in the workplace.

Senator MOORE—Is that message being relayed to the government?

Ms Hatfield Dodds—Yes, it is.

Mr Waters—Yes.

Ms Hatfield Dodds—This is in the context that our experience is that people do want to work and we believe a better approach is to think of the supports we can offer people, the opportunities we can give them to attack the barriers standing in their way, rather than assuming that we need a compliance based process.

Senator MOORE—And it is long-term support.

Ms Hatfield Dodds—Yes.

Mr Fear—May I just support that comment? So many of the people that we deal with actually want to work. They want to go out there and they want to do things. They wake up so often every day with nowhere to go, nothing to do and no-one to see. They want to get out there and participate in the community. They want to do things. They want to belong. They want to interact socially. They want to have friends. They want to work. They want to go to the footy. They want to do all those things. But there are just so many barriers to them doing those things; it is really sad.

Mr Bicknell—One of the frustrations for me has been being told by federal officials that supported employment is about employment only and that the fact that it might have kept someone out of hospital is a state issue. So it is part of the pressure to say it has to be 15 hours.

We do have many people who are quite unwell and who cope with serious levels of medication, to the extent that their effectiveness as workers is not high. Their productivity is marginal. Where we work, we help those people work in cooperatives, in which they are the owners of the cooperatives. That works extremely well and that could be duplicated or replicated many times.

But there is quite an attitude in the Commonwealth that, if it is not moving them on to further work but it is sustaining people in the community, through the fact that we monitor them two or three times a week—when they come in, we can tell when they are down or their medication needs reviewing or their wellbeing is changing—then that ought to be funded by the state and not by the feds. It is really unfortunate. It goes back to the Commonwealth-state disability agreement some 15 years ago, or whenever it was, when those things were moved from largely state to the Commonwealth and accommodation was moved to the state. But those programs, we find, are very, very important in sustaining people. You cannot just give them a house and even some support if you do not find them the sort of activity that Graeme was talking about. And employment is the best activity that they can do because that gives them status and dignity—all of that—as well as keeping them in good contact with people who are monitoring their wellbeing.

CHAIR—So the people you describe would be in trouble with the new arrangements, as you understand it?

Mr Bicknell—They are more at risk with the new arrangements because the push to actually move them on to employment in the wide world—into open employment—is much stronger. The threat is that, if they take that challenge and fail, they will be off their pension. That has serious implications, particularly for their medication and all sorts of other things like that. Some of these people have heaps of medical bills and pharmaceutical bills.

Ms Hatfield Dodds—It is not just a national-state issue. I have had multiple conversations this year with ministers and senior bureaucrats at the federal level where people say, ‘That’s not my portfolio,’ or, ‘This department does not cover that.’ Clearly we understand that in the sector, but our issue is that we come with a person centred approach. My personal view is that governments and departments are actually there to assist communities, families and individuals. So it is about finding ways of creating systems that can cut across those barriers.

Senator TROETH—It is like a silo mentality?

Ms Hatfield Dodds—It is, yes.

Mr Bicknell—And it is very difficult. We have programs like Mark is managing that were once all funded by one department—

Ms Hatfield Dodds—Yes.

Mr Bicknell—and continuity was encouraged. Now we have two departments with different rules for things like helping funding. We try to fund all the programs—as Mark said, there are about 450 people at any one time in this program. There used to be pretty natural continuity. Now it is much more at risk.

Ms Hatfield Dodds—Again, in those larger agencies and larger organisations that are person centred you can cross-subsidise. But if you are smaller you actually cannot do it, and at the moment a lot of the sector is still small enough to make it prohibitive.

Mr Fear—Just before you finish, may I ask you one question? Did any of you see the *Four Corners* program? I just think it is interesting. We closely monitored the media in New South Wales after that and there was nothing—absolutely nothing. So you face a battle; we face a battle. I call once again for a state of emergency to be declared because that is the way these issues that we have all been talking about can be cut across. That is the only way I can see, anyway.

CHAIR—That is an appropriate point at which to finish, I think. I am sure it is the wish of the committee that that be tabled; it is so ordered. Thank you very much for your submissions and for appearing today.

Proceedings suspended from 12.31 pm to 1.26 pm

O’HANLON, Ms Anne, Project Coordinator, Research and Evaluation, Auseinet

PARHAM, Ms Jennie Ann, Project Manager, Auseinet

RICKWOOD, Associate Professor Debra, Consultant, Auseinet

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

Prof. Rickwood—I am an associate professor in psychology at the University of Canberra but I do a lot of work with Auseinet, so I have been invited to be part of their submission today.

CHAIR—The committee has your submission, which we have numbered 441. Are there any amendments or alterations to that document at this stage?

Ms Parham—There are no alterations, but we would like to add something.

CHAIR—We would like you to make a brief opening statement, after which we will go to questions.

Ms Parham—Thank you for inviting us here today. In this opening statement we would like to highlight the importance of mental health promotion, prevention of mental disorders and early intervention as a key platform in the mental health agenda; Auseinet’s role in facilitating the implementation of promotion, prevention and early intervention—which for everyone’s benefit we have shortened to PPEI, as otherwise it is a bit of a mouthful; and the importance of continued investment in this area. The National Action Plan for PPEI was developed to provide direction for implementing promotion, prevention and early intervention under the second national mental health plan, and it also has currency under the current mental health plan.

Australia’s approach is consistent with international trends and leads the way in mental health policy development internationally. Recently I was overseas on a study trip and I spoke at a conference in the UK. It was clear from the feedback that we received that Australia is about 10 years ahead in policy in this area. I think that is in part due to the significant investment that the Australian government has made in national initiatives such as ours, MindMatters, the media and mental health initiative beyondblue and the Better Outcomes for Mental Health initiative. From a promotion and prevention perspective, the challenge is now for implementation, particularly at the state and territory and local levels.

Today we want to stress the importance of keeping promotion and prevention on the agenda. Even though it is a key priority area in the current mental health plan, there is constant tension in the mental health service system between the treatment and promotion and prevention approaches. We believe it is not an either/or scenario; they are both important. But we are here today to demonstrate why the promotion and prevention approach is equally important. It is important for a number of reasons and probably many of these you have heard before, but I just want to state them again.

The burden of mental health problems and mental disorders is high and rising. Close to one in five people in Australia is affected by mental illness or mental disorder. The direct cost of mental disorders in Australia now exceeds $2 billion every year. Australia has one of the highest suicide rates in the developed countries. Increasing evidence demonstrates the contribution of mental health problems to physical illnesses such as cardiovascular disease, diabetes and obesity. It is widely recognised and understood that treatment interventions alone cannot reduce the burden of mental disorders and that there is compelling evidence now that promotion, prevention and early intervention approaches will significantly reduce the burden. This is crucial if we are to stem the tide. At the end of the day, reducing human suffering and enhancing quality of life has to be a goal we would all agree with trying to achieve.

What do we mean by mental health promotion, prevention and early intervention? I am not here to give you a lecture, but I think it is really important to define what we mean by these terms because there is a lot of misinterpretation and misunderstanding of these terms. So, in simple terms, what we mean when we say mental health promotion is any activity designed to maximise health and wellbeing. That is at the social, emotional, physical and spiritual levels. It is about developing and maintaining resilience. Mental health is not just about the absence of mental illness. In fact, you can have good mental health and still have a mental illness.

Prevention, on the other hand, is aimed at preventing the onset of a mental illness or mental disorder. Some of the strategies are the same as mental health promotion, but others include the early identification of mental health problems and targeted interventions with those known to have high risk factors. Early intervention can be either early identification of symptoms with a view to preventing the development of a disorder or early treatment to reduce the impact. Fundamental to implementing such approaches is an understanding of the factors that influence mental health, and these factors are either the social determinants—such as social connectedness, economic participation and freedom from discrimination—or risk and protective factors, which are the things that either enhance and increase the likelihood of developing a mental disorder or the things that actually reduce that.

This approach is much broader in focus than the medical model that dominates the current mental health service system. It involves exploring the interface between the person and their environment and the relationships within that. This approach is consistent with the recovery approach that is also highlighted in the mental health plan. In our view, recovery oriented services are really health-promoting services for people with a mental illness or mental disorder.

So implementing this kind of approach to mental health services requires a level of service reorientation, particularly for early intervention and recovery, and an attitudinal shift. Auseinet has been funded by the Australian government as a national initiative to support the implementation of these approaches. Our role has been to educate and raise awareness about PPEI and what it means for mental health, provide up-to-date information and resources, make the evidence base accessible and understandable, build capacity for implementation, facilitate the sharing of learning and practice and develop a network to disseminate information. To date, most of the jurisdictions have developed policy to support the implementation and are investing in a range of initiatives. However, progress is variable. Significant initiatives are occurring within the consumer care and NGO sectors, in general practice, in education and with Aboriginal and Torres Strait Islander communities.

What do we think are the really important next steps and what do we want to see happen? We would like to see the momentum for PPEI continue. Everyone acknowledges the importance of it, but there is still a long way to go in implementation. It needs to be embedded in a sustainable way in the mental health reform agenda and jurisdictions need to be made accountable for expenditure on promotion and prevention. We believe that continued investment needs to be made in the following areas. In the kind of role that Auseinet is playing, there is a need to have a national body that provides leadership coordination and advocacy. There is a lot of influencing still to be done within a whole range of sectors to assist them in understanding their role in mental health promotion and prevention.

It also includes ensuring that initiatives are linked and partnerships are established, thereby minimising duplication. Work force development initiatives are critical, particularly in relation to general practice, primary care and the NGO sector. There must be development of a promotion and prevention scorecard for jurisdictions to report on their progress in implementing PPEI, and the service delivery system must be addressed to start to deal with the issue of these competing tensions. There is quite a gap between the specialist service and primary care sectors and there is a need to address another level of service in order for there to be acceptable referral pathways for early identification and early recognition. So, as the saying goes, prevention is better than cure. If we can reduce the suffering from mental illness through prevention and build resilience in children from birth, then I think we have a greater chance of building a healthier society that we would all feel more comfortable living in.

CHAIR—Do either of you wish to add anything?

Ms O’Hanlon—No.

CHAIR—You said at the outset that Australia was 10 years ahead in policy, yet we hear pretty much a doom and gloom scenario as we move around the country, particularly about prevention and early intervention. Why do you think it is that we have forward thinking policy? Who developed it and why is it slow in being taken up?

Ms Parham—In Scotland they did a review of all of the international policy in the area of promotion, prevention and early intervention and their view was that Australia was far and away ahead and leading the way. As I said in my opening statement, I think the Australian government has invested a lot in national initiatives that are really trying to move forward with a lot of the promotion and prevention thinking. The lag in the system is at the state and territory and local levels. As you are aware, we have a federated system and just because there is a national policy and approach does not necessarily mean automatically that states and territories will pick it up.

A lot of Auseinet’s work in the last couple of years has been to engage the states and territories and to assist them. We have even provided funding for them to assist in building the infrastructure that will help progress this, assisting them to develop plans and commit dollars for implementation and set up coordination mechanisms, because we felt that more money just for projects was going to go into a vacuum. We needed to start to put infrastructure in at a bureaucratic level to begin to make things happen. It is getting there. I think most states and territories now do have plans, but the issue is the commitment of dollars to make that happen. There is a plethora of activities and projects, but generally it is still based on champions. We do not have it bedded in the system yet, so there is still a lot more work to be done in that respect.

CHAIR—The Victorian state government told the committee that, in their view—and I think this is a general comment; it does not really reflect the actual circumstances—the Commonwealth was responsible for primary health care in mental health as in other areas and that the role of the states was to look after people who were very sick. Do you strike that sort of bureaucratic barrier as you go around the states? Is that the sort of thinking that needs to be broken down and, if so, how do we do it? Should there be some structural change to the way mental health services are funded?

Ms Parham—I think there are a number of issues. Where the rubber hits the road for the mental health sector—and I guess when I say 'the mental health sector' I am referring to the specialist mental health service system; when we talk about mental health from a PPEI perspective it is much broader than that—is that they are very much at the treatment end of things. So, when we start to talk about promotion and prevention with them, they start to think about the very broadest mental health promotion, which they link to campaigns like health promotion, which are around taking people out of the hospital situation. That is where I think it needs reframing and attitudinal shift because there is a lot of work that can be done around mental health promotion that can actually occur in in-patient facilities and in a service delivery system.

Recovery is a good example of that, as is early intervention. Recovery is a way of working with people with a mental illness that is around an equitable and collaborative relationship between the providers and the person with the mental illness. I think a lot of the work in promotion and prevention is about establishing collaborative relationships. There is a responsibility there for mental health services, but those working in the service system are just one component of it. Where they can engage with this is in the area of relapse prevention in terms of recovery and rehabilitation. I think there is still a lot of work that can be done there that would really fit with this.

CHAIR—The committee was in Shepparton on Friday and met with a group that had formed a collaborative relationship between the mental illness awareness foundation and the area mental health services to provide supported accommodation, which seemed to make a lot of sense to us, I think—but they are hardly cutting-edge, innovative ideas, as ideas go. Is that the sort of thing that your organisation facilitates and, if so, can you describe how you bring those groups together to say, 'Wouldn't it be sensible if you sat down and did this together'?

Ms Parham—We do do that. We certainly promote collaborative relationships. We probably do not drill down right to the local level. Because we are a small organisation, so to speak, we work with state and territory governments and we work as much as we can with area health services. We also have a number of programs. We have a major consumer and carer and NGO program, a program for Aboriginal and Torres Strait Islanders and a major program in general practice.

In all of those areas, we are working in collaboration with the key peak bodies. In our NGO program, we have been very much working with the sector around how they can both drive the PPEI approach within their sector and work with mental health services to do that. We are also doing that with the mental health sector. So, in every avenue that we are working in, we are really trying to help people with the skills as well.

Our focus is very much on implementation and on practical tools. For example, at the moment in the area of relapse prevention we are developing a whole part of our web site which is providing people with tools, with case studies and with access to what has worked and what has not worked, which will enable some of this to happen. In the area of supported accommodation, that is never going to work just by itself; it involves collaboration between the NGO and the mental health system because people need to be supported clinically. So all of the case studies that we will be providing for people will show them what has worked and what has not and how they can go about doing it.

As you say, supported accommodation might not necessarily seem like rocket science but the problem is that it has not been happening. It just has not. In all of those kinds of settings of everyday life where you would hope that people could be supported in terms of employment and housing, it has been incredibly variable and it has not been happening in a lot of places in Australia.

Prof. Rickwood—Where it does happen and where there are collaborative and integrated relationships, it happens because there are some champions, some key people who, through their own relationships, put those types of services together. But it is not pushed by the system or supported by the system, so those collaborative relationships can break down if one of the key players has moved on because the system supports are not there. It seems to be people’s goodwill that builds up what seem like very logical arrangements, but they are not sustained.

CHAIR—This morning we had a lot of complaints—and we have heard this in every state we have been in—that money is often available for short-term projects. The state government here has made a commitment of $25 million over one year, but it is a one-off. What do you do with one-off money when people with mental illness often have mental illness for the rest of their lives, even if they learn to live with it or—to use your word—recover? Is that something you warn against? Do you advise governments that this is not a sensible way to go?

Ms Parham—As I was saying earlier, this is one of the things we have been trying to do with the promotion and prevention agenda. As I said, we had a small amount of money and we wanted to give some enhancements to each of the states and territories. Rather than them spending it on just another promotion and prevention project, that is why we were keen to say, ‘Is there state policy consistent with the national policy? Is there a coordination mechanism to bring various sectors together to begin to coordinate the effort?’ Without those kinds of things it would not matter how many projects you had. So, even though initially they all wanted to come up with just another project, with a bit of persuasion and understanding they all engaged with recognising, ‘Yes, we need to do this.’ But then that brought out a whole lot of other issues like: ‘Well, we’re then going to have to have money to implement the plan.’ That is what we are gradually pushing away at. It is quite hard work, but we are pushing away at that because we have seen the impact of short-term project funding and its unsustainability. Unless you have things actually bedded down in what I would call bureaucratic capacity, then really they are not sustainable and we are just going to be back to square one.

I want to pick up on your earlier point, when you referred to the tension between state and federal governments and the kinds of services they fund. I think there is a tension between how the states fund their services and their work force compared to the Australian government’s investment, particularly in general practice. But I think there is some innovation that is required.

There are some examples. In Victoria they have developed—and I am not sure, but I think this is in the process of being evaluated—what they call primary care partnerships. So they have the specialist services and general practice and then they have primary care, which is trying to begin to provide that other level of service. If we are really serious about early intervention, we cannot have services that then are referring into a specialist system that has a three-month waiting list. There is a level of service reorientation that has to occur.

One of the major problems I see in progressing the promotion and prevention agenda is that we have a seriously underfunded treatment end of the services. When we talk about promotion and prevention, it is not that people do not think it is important but they think, ‘The tail is wagging the dog over here and the squeaky door is shouting the loudest.’ So I really think there are a number of things that need to happen: the service reorientation, the work force development and the attitudinal shift, and also addressing the level of service that needs to be provided. I think the Australian government has to be praised for its work in general practice and the Better Outcomes initiative. Even though it may not be perfect, it is really starting to provide an opportunity for general practitioners to do that. But we are just about to embark on a whole upskilling project with GPs. If we are going to ask them to identify early, they need a service system in which to refer; otherwise, you wonder about the ethics of it all.

CHAIR—Are you talking about psychologists, the allied health sector or psychiatrists?

Ms Parham—Not necessarily everyone who is identified early has to go immediately to a psychiatrist but they do need to be able to go where they will be given the service they need. At that point it might be some counselling or some skill building, probably by trained people. Essentially, in the main that is probably going to be psychologists and others. So there does need to be that availability because at the moment in most specialist mental health services you are lucky if you can see them if you have a florid psychosis, let alone if it is early identification. We need to be serious about early identification in mental health. If someone had breast cancer, they would not be waiting three months to do something about it. So, if we are serious about wanting to identify mental illness early and get early intervention on the agenda, we really have to do something about the service system that supports it.

Senator TROETH—You say what you do is about implementation. In your opinion, does the existing framework at the federal and state levels provide sufficient basis for the implementation of the National Mental Health Strategy? In an ideal world—if everything worked together and people were in jobs for a long time—would it work?

Ms Parham—I think it has the potential to work, yes.

Senator TROETH—So we do not need to add any further layers or any further incentives to make it work? What is there should work, if everything worked together?

Ms Parham—I think it needs some enhancement, definitely. As I said earlier, I think we need to think about tiers of services in mental health. With the current system, the federal government is dealing with their work force, which they pay for, which is general practitioners. I think they are aiming to try to do something through Better Outcomes. But I think at the state level they need to be thinking more about what the levels of service are that are required, which is not just about specialist mental health services.

Senator TROETH—In your view, is the Better Outcomes program geared so that GPs can take a more active role in mental health care? We have heard that GPs are naturally the first port of call for most people but, given the workload that most of them have, is it realistic to expect them to be able to not only refer people on but also deal with it in the first instance?

Ms Parham—I think the way Better Outcomes is structured at the moment is certainly giving them the opportunity to do a better assessment and some brief intervention where it is necessary. It is giving them the time and the payment to do that, which has not been there in the past. I think that structure has been incredibly useful, and I think that can be expanded and developed further. But, without that, mental health issues cannot be dealt with in a normal 15-minute session. In the past GPs have not had the structure, the payment or the Medicare benefits to do that appropriately. Many might say they still do not, even under Better Outcomes, but at least it is a start and I think it has at least begun to provide a basis to develop further. For example, we are just about to develop some training for general practitioners around promotion and prevention, which we hope to link into the Better Outcomes approach, which provides a whole new structure that GPs are already involved in. That gives a platform for things to happen on that we have not had before. Anne might want to say something.

Ms O'Hanlon—I think Better Outcomes is a realistic response to the fact that most people do go to see a GP if they are experiencing mental health problems. We are trying to train GPs to at least be able to identify and respond, either themselves if they have adequate training or by referring on, so it is a sensible approach. But, from our point of view, we would also be encouraging that other people become the first point of contact. It does not always have to be the GP. Most people do not get any help. I am sure you have heard this before: most people seek no help but those who do will go and see their GP. There are a lot of GPs who are really passionate about mental health issues, but even those who are passionate often do not have the capacity, either in terms of time or in their own perceived level of skill, to deal with the problem. We did a scoping study, which we published in 2004, and we did some focus groups with GPs. We selected some who were very passionate about and actively involved in mental health and we counterbalanced that with another group who were not uninterested in mental health but who were not active in it.

Senator TROETH—They had other priorities.

Ms O'Hanlon—But the responses were really similar between the two groups. They all acknowledged that promotion, prevention and early intervention approaches to mental health are really critical, and they know that because they see it every day in their practice. But a lot of them expressed that they were too scared to go there. They used phrases like, 'We didn't want to lift the lid,' or, 'We didn't want to overturn the stone,' or whatever the expression is. So they acknowledge it, but they do not feel that they are adequately skilled. I think Better Outcomes is really moving to address that for those GPs who want to be involved in that system. But it is really important in tandem to be encouraging people and informing people, basically, that there are other places that you can go to seek help for mental health problems.

Senator TROETH—Such as?

Ms O'Hanlon—Community health centres. There is also the whole area of schools. There is a lot of work being done in schools for teachers and ancillary staff.

Senator TROETH—Yes, we heard about this this morning, which was very encouraging.

Ms O'Hanlon—That is right. But, of course, they also have the same issue the GP has: having identified a problem, where do they refer to?

Senator TROETH—Where do they go, yes.

Ms O'Hanlon—It is not really adequate to overburden GPs, but we have to acknowledge the reality that, at present, they are the main point of contact.

Prof. Rickwood—But they are probably not necessarily always the best point of contact and you would not want to put all your eggs in that basket. Young people particularly are less likely to go to the GP and would want to have alternative pathways. I think this is where there is a need for more flexible funding arrangements and where there are some problems with federal government funding for GPs and, for example, schools, which get state based funding. To be able to provide a coherent set of pathways, the funding needs to support those flexible pathways. These issues are not unique to mental health. The National Chronic Disease Strategy comes out very strongly in having funding mechanisms that can fund primary health care arrangements where you have a whole system of community and specialist and primary care providers set up to suit a particular community area. But there are some significant challenges. We do not have the models to be able to fund those types of flexible arrangements at the moment, and that would take many conversations between the federal government and the states about how they are built.

Senator MOORE—We heard this morning from St Vincent de Paul about their interest in having specialised agencies within government on mental health issues. I found it really interesting that they felt that in the discussion between health ministers, which is the current model for Commonwealth-state relations on health issues, mental health may not be prioritised efficiently. I want to ask for your opinion on that. Also, can I find out more about Auseinet? Your opening paragraph says that it is a national initiative funded and administered through the Department of Health and Ageing. Is it on term funding? Is it over a period of time? Is it part of the public sector? How does it all work?

Ms Parham—I can probably answer the second part and then we can go back to the first part of your question. Auseinet is funded through project funding. We are basically a project funded through the National Mental Health Strategy and the National Suicide Prevention Strategy. Auseinet actually began in about 1997 and it was initially funded to be an early intervention network for young people. I was not involved in it then. Since then it has had two more cycles of funding.

Senator MOORE—Are these three-year cycles?

Ms Parham—Roughly, yes. I came on board with the second lot of funding. By that stage the national action plan had been developed, so our role has largely been to support the implementation of the national action plan for promotion and prevention and the Life Framework. Our money comes through both of those strategies and the contract is with the Department of Health and Ageing and Flinders. So Flinders University auspices the project but it is nationally funded,

Senator MOORE—You are located at Flinders?

Ms Parham—We are located at Flinders uni and the money comes from the department.

Senator MOORE—It just was not clear.

Ms Parham—That is how it works.

Senator MOORE—What about the issue of prioritisation within health? The current model of federal-state government discussions about health is the COAG process, where the ministers all get together and work things out in a grown-up way. There is a concern that mental health would not be in the top three priorities. Your whole role at Auseinet is to establish collaborative approaches?

Ms Parham—And it is also to try to establish whole-of-government approaches. This particular area of work involves suicide. Suicide prevention is interesting because state based suicide prevention strategies have moved to more of whole-of-government approach.

Senator MOORE—They have, yes.

Ms Parham—If you are really going to be serious about doing this work, action plans for PPEI require shared responsibility with other government departments and other sectors. I would think that it is really important to establish mechanisms with other government departments and to look at the mental health impact of other areas. Debra might want to comment on this, having just been involved in the chronic disease strategy.

Senator MOORE—There is a whole paragraph on your project in the submission.

Prof. Rickwood—I have some other insight, I suppose, because I have just been engaged as the consultant writer for the National Chronic Disease Strategy. In that, they quite deliberately did not include mental health as one of the chronic diseases, even though it is one of the national health priority areas and for many people it has a chronic course. It is included as a comorbidity but it is not considered in its own right, which I think is an interesting reflection on where mental health sits in the health agenda. From being involved in that strategy, I see that everything in that strategy applies to mental health problems as well. They are the same issues, but mental health is not prioritised there. Some of that is due to mental health’s own ambit. I am not sure what I think about this, but the mental health sector very often say, ‘Oh, we’re different; we’re different.’ Mental health certainly does need to be prioritised. But to some extent I wonder about the synergies in having a separate, parallel but not aligned agenda with something as strong, for example, as the National Chronic Disease Strategy.

Senator MOORE—I am interested in your perspective, given the research you have done on chronic disease. When people talk about ‘mental health’ so many things are lumped into that definition. I feel as though it is difficult to actually include everything under the term ‘mental health’. We have things like schizophrenia and those quite clearly defined things. From your point of view as a researcher and looking at the process, can you talk about mental health as one string?

Prof. Rickwood—Mental health and mental illness are completely different things. The work that we did on relapse prevention quite deliberately took a more focused approach. This was about taking the promotion, prevention and early intervention agenda but applying it specifically in the context of people who have been seriously affected by mental illness. I think that has had value for some people who have not understood the PPEI agenda from that perspective. This provides a platform and a link for how you get from serious mental illness back to mental health promotion.

Senator MOORE—And to this concept of wellbeing, the term which is now being used so often—where the whole person is well.

Ms Parham—I think there has been a bit of a misnomer. If you look at mental health services, they are largely mental illness services and they are around diagnosing and treating people with a mental disorder or mental illness. When we talk about mental health we are not even talking about mental illness, and so mental health is not just the responsibility of the treatment end of things in the mental health system. It is really about trying to create a shared responsibility across a whole range. Where you really want to have an impact on people’s wellbeing is in the early years. The further upstream you can work, the better. You really want to be getting in early with parents. It is not even necessarily a health issue at that point, whereas once it gets to the treatment end of things we are largely remedial. You can hardly say you are preventing an illness if it has actually happened. We can still work on mental health promotion and we can do the work that Debra is talking about around relapse prevention in order to have an impact on the course of illness on a person’s quality of life. But, if we are very serious about trying to build resilience, then what we have to do is try to get that shared responsibility across a range of sectors and settings.

CHAIR—On relapse prevention, could you confirm for the committee evidence we heard in Sydney that suggested that the average number of times a person typically presents at an emergency department in a year is around 65? Is that an area of your study?

Prof. Rickwood—I am not aware of that information. I suppose that would be possible for somebody who has a chronically relapsing condition, but it would be unusual, you would hope. It would certainly show that it is a system that is not working because that shows a complete revolving door where people are being sent home—

CHAIR—The argument goes that they are there for two days and—

Prof. Rickwood—They have not been put on a road of wellness and there have been no community supports put in place to maintain their wellbeing while they are in the community.

Ms Parham—As you were saying earlier, Debra, if you take the relapse prevention work seriously, it requires a flexible system for people to start to manage their own illness and be aware of their early warning signs. Many people often know what it is they need but it is not necessarily available. It is hard enough at the moment for people to get the appropriate treatment when it is a crisis situation, let alone when it is almost in a preventive framework where people need the care they believe they need at a particular time because they know it will aid their wellbeing. That is what is not happening in the system in Australia. People with a mental illness, the consumers, feel very disempowered by that. On the one hand we are talking about them taking more control over their illness and being able to work with it but on the other hand we are not providing a flexible service system that actually allows them to do that appropriately.

CHAIR—What percentage of mental illness is seriously preventable? What difference could we make? Could we reduce the number of admissions to hospital by half? Do we know? Is it possible to predict it? How much of the work you do on prevention is guesswork?

Prof. Rickwood—I do not know that anybody has been able to put any numbers on how much is preventable. It is not really possible to study that in a way where you can say, ‘We’ve prevented this much mental illness.’

CHAIR—That is always the problem with prevention programs.

Prof. Rickwood—Yes. However, I think we can get some understanding from the other end of the spectrum—from the number of people who have already been diagnosed with mental illness for whom we can prevent a relapse. It is quite clear that, with even minimal service support, two-thirds of people should not have to relapse, yet these are people who have been seriously affected by mental illness, by psychosis. The only evidence is comparative evidence about the rates of different types of mental illnesses—evidence about their prevalence and incidence.

Ms Parham—Also, the work that has been developed around the indicators of mental health might in time be able to provide a far better assessment of the level of mental health in a population than we have had before.

Prof. Rickwood—There are some small-scale studies, some of which are in the WHO document, and even some randomised control studies where, for example, they have been able to put small-scale prevention programs in place in schools and then been able to show how many young people who were in the program went on to develop depression or anxiety and how many did in a comparison group. That certainly gives some numbers on how these programs can prevent the incidence.

CHAIR—Would you mind naming that report for the Hansard record?

Prof. Rickwood—This is the WHO report titled *Prevention of mental disorders: effective interventions and policy options*. They have increasingly been pulling together these smaller scale studies of prevention interventions and looking at their evidence base, which is building. But, in terms of what these approaches have prevented in a population group, I think it is pretty much—

CHAIR—I think it was an unfair question.

Ms O’Hanlon—I will just add to that really quickly. In the Australian context, there was the national survey of mental health that was published in 1997 and I believe that there will be a follow-up done to that. That is going to give some indication of the impact of current policies, including the promotion, prevention and early intervention policy. You cannot attribute all changes to these policies, but I think it will at least be a marker to see whether there has been a shift in the 10-year period in Australia.

Ms Parham—The research is longitudinal. A lot of the prevention work has begun recently, so it is going to take a while before the outcomes of that will be noticed. Also, if I can just put a plug in here, I think this area needs different research paradigms. The randomised control trial type work does not always work as the most preferred research paradigm to provide those kinds of outcomes. So there needs to be innovation in the research that is being done.

Senator TROETH—So where would you like to see that happening?

Ms Parham—I think we would like to be promoting that there are other models of doing research. There is more outcome oriented research, and there is action research. There are other research models that can also highlight promising practice. You cannot always control for all of the factors in this area, particularly when you are looking at population based research or when you are looking at an intervention or a program. I think a good example of an epidemiological study at the moment is the work that is happening in Western Australia on the Aboriginal child health survey, where they have surveyed every single Aboriginal child in WA. What comes out of that work over five or six years will have a huge impact on the kinds of interventions that can be made. That has required a significant amount of investment and time, but it is things of that scale that will actually be useful in the long term, rather than always using randomised controlled trials of interventions.

CHAIR—Thank you very much for that. It has been very enlightening.

Ms Parham—We would like to table some policy documents, if we can.

CHAIR—Is it the wish of the committee that they be tabled? There being no objection, it is so ordered.

Ms Parham—They are the National Action Plan for Promotion, Prevention and Early Intervention; the Life Framework, which is the national—

CHAIR—I have just been reminded by the secretariat that we do already have that in evidence, so that will relieve them of the need to take it back to Canberra. But give us the other documents.

Ms Parham—There is a little bit about Auseinet, since someone asked about Auseinet; the three recent World Health Organisation reports on promotion, prevention and case studies; and the relapse prevention discussion paper.

Prof. Rickwood—On which there is some other work that is still awaiting release. We have updated the discussion paper as a result of considerable national consultation and we have developed a framework. We are in the process of trying to put together an implementation plan, which should be done within a month or so. The national mental health working group have asked us to do that. But this is the original document.

CHAIR—Excellent. Thank you very much for your time and for your submissions.

[2.11 pm]

ANAF, Dr Gil, Immediate Past President, National Association of Practising Psychiatrists

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

Dr Anaf—I am here as a private practitioner, but I am also here in the capacity of Immediate Past President of the National Association of Practising Psychiatrists, who let me speak on their behalf on these particular issues.

CHAIR—You have lodged with the committee a submission which we have numbered 265. I understand you will also speak to submission No. 203 which, as you say, was submitted by the National Association of Practising Psychiatrists. Are there any amendments, alterations or additions to those documents at this stage?

Dr Anaf—No, not at the moment.

CHAIR—I invite you to make a brief opening statement, after which the committee will ask you questions.

Dr Anaf—I would like to thank the committee for inviting me to speak. I trust that the submissions, particularly my private submission, have been read. My submission is quite succinct, I hope, but the NAPP submission is quite extensive and, I suspect, quite difficult to get one’s head around, which is why I asked if I could be invited to speak. I would like to highlight a quite important area from the clinician’s point of view, which is the complete oversight of psychotherapeutic services in the whole debate and discussion of mental health treatment, primarily—not so much in prevention. I think that psychotherapy as a treatment tool—and its most intense form, psychoanalysis—has really been completely dismissed as an issue to the detriment of the community and to the detriment of the training of psychiatrists as well. So that is really the guts of my submission.

CHAIR—Which I found intriguing. I think you are going to have to tell us a bit more. Who says psychoanalysis is out? Has it suddenly become unfashionable, or is this as a result of people spending lengthy periods of time on the couch and getting nowhere? Do you argue that it has a preventive element to it or that it is actually meeting its objectives? I think you might need to tell us.

Dr Anaf—Perhaps I can put it in a broader context in order to answer the question. The kinds of psychotherapy and psychoanalysis that I am talking about are highly specific techniques for treating patients with particular kinds of mental illness. Those mental illnesses are quite broad and the idea is that psychotherapy addresses the personality component that underlies the illness. For example, someone might have a major depressive disorder or a generalised anxiety disorder. But in taking the history as a clinician what you often find is the way the patient has lived their life, their experiences and the kinds of adaptive mechanisms they have adopted to try and get over their illness haves actually led them to perpetuate the illness, and so the symptoms just recur in a kind of a vicious cycle.

The kinds of patients that we deal with in the psychotherapeutic community are often the kinds of patients who have come, having tried briefer treatments, having tried medication, having tried cognitive strategies, having tried counselling, having tried self-help groups. In the end, because of the bad press that psychoanalysis occasionally gets and the increasingly low emphasis on psychotherapy in general, people tend to forget that it is available as a treatment option. So they go to their GP and, if they are lucky, in desperation the GP will say, ‘Why don’t you go and talk to an analyst or a psychotherapist,’ which then actually addresses the personality component of their illness.

With or without medication, they can then start to actually function and remain in the community, remain in their jobs, remain in their families. All of that actually has a cost offset for the community. You often do not need hospitalisations and you do not need fancy medications for too long. The community benefits from the productivity gains of that. So what we are talking about is psychotherapy as a treatment option. It is something you need to be specifically trained for but is different from general counselling or the kinds of advice you might get from a friend over the back fence, if I can put it like that.

CHAIR—How is it different from cognitive therapy or from the sort of therapy that a psychologist might provide?

Dr Anaf—The techniques are quite different, the aims are quite different and the underlying assumptions are quite different. In essence, cognitive strategies really are aimed at identifying and clarifying the kinds of thought processes that are said to lead you to have certain symptoms. For example, I can be afraid of walking across the main street and being run over by a car, and that fear could be so intense that I could have a panic attack. In a cognitive approach, I would be asked to identify what the anxiety is, what is triggering it and then to challenge that by telling myself, for example, ‘Well I know that doesn’t happen. If I’m careful it won’t happen. I know I’m quite safe and I just have to be careful and cross at the lights.’

In a psychotherapeutic strategy, it may be more appropriate for somebody who has repeated episodes of panic in that setting to go into their background and say, ‘Look, why have you got this particular symptom in the context of your life story?’ It might turn out in the history, for example, that there were traumatic instances with their family, say, when they were caught up in a riot on the main streets in some kind of civil disturbance—I am just exaggerating now. The point of the assumption there is that the past experience leads to certain strategies to fend off anxiety. Often that is forgotten and it is just the symptom that remains many years later.

So in a way the difference is that in psychotherapy you delve into the past quite a lot. In cognitive strategies, you tend not to do that as much because you are focused on challenging the thought at that moment. The point we make is that for many people who are quite chronically disturbed that does not work and they need that psychotherapeutic intervention.

CHAIR—So the restriction on MBS item 319 was for the kinds of people who can receive psychotherapy or psychoanalysis, the sorts of disorders that qualified, and the number of sessions that could be provided? Is that correct?

Dr Anaf—Yes.

CHAIR—And that happened in, did you say, 1996 or 1997?

Dr Anaf—In 1996 the newly elected Howard government brought that in—without consultation, as far as I am aware. They actually wanted to stop all psychotherapy other than one session a week. In the face of our protests, there was a compromise reached from their point of view—it was no compromise from our point of view—that certain diagnostic groups, people with certain illnesses, could come up to three times a week, which was their limit of 160 sessions a year. But our objection to that was that it invaded their privacy in having to divulge what their problem was by virtue of the item number you had to use.

Secondly, and maybe more importantly, that group of patients is not necessarily best treated being seen three times a week. For example, people who have been chronically abused, traumatised, suffered chronic illnesses, and who are trying to remain in the community and function, often need to be seen up to four or five times a week in order that all of these problems—which by delving into the past come up quite intensely—be worked through and overcome and for them to come to a more realistic understanding of where they stand in their present life, as opposed to reliving their past life, if I can put it like that.

CHAIR—And there was no evidence at the time of psychiatrists rorting the system.

Dr Anaf—That was the claim put forward and there was the famous Dr 747 jumbo-jet psychiatrist who was named as such by Dr Wooldridge. There was a claim that the psychiatrist saw somebody 747 times in one year. We pressed, under an FOI order, to find out more detail about that. As far as we could ascertain there was no evidence of malpractice, no-one was ever prosecuted, no-one was ever named, no-one was ever brought to account, no-one was ever deregistered for malpractice. So, as far as we know, it was a contrivance in order to bring about a policy that was preplanned, which was to cut psychotherapeutic services on the basis they are too labour intensive, they are too costly, there are no cost offsets and people do not need them anyway because we have these quick cognitive strategies. So, in essence, there was no evidence of rorting.

CHAIR—Are others pressing for this change, or is this something the psychiatrists alone are concerned about?

Dr Anaf—Can you clarify what change you are referring to?

CHAIR—Who are the champions for this change? We have had many consumer groups, for instance, make submissions and appear before us and this issue has not come up with them. Would you expect it to? Who else ought to know about this and be in agreement with you?

Dr Anaf—If you are talking about the reduction in services under MBS 319—that kind of change—I think the whole community should be alarmed at it, because basically what is happening is that a particular group of quite ill patients is being denied adequate treatment at the intensity which is required for it to work. In journal articles I read about psychiatric policy making, there is increasing emphasis on quick turnover, efficiencies and doing away with funding treatments that need a long period of time for efficacy or a frequent number of sessions. So there is a policy trend towards short quick-term treatments. I think the whole patient population should be alarmed at this kind of development, which has in fact been going on for eight years—it is not a new thing. But efforts to bring it to the attention of the government have singularly failed.

Senator MOORE—On that point, it would be that, if patients still required the kinds of services you described, they could still have them, provided they were prepared to pay privately. Is that right?

Dr Anaf—Yes, which in essence means they cannot have it.

Senator MOORE—Is it prohibitively expensive?

Dr Anaf—Yes. Under the Medicare restrictions, you can have only three sessions a week, which leaves you, if you are very ill, two sessions a week—

Senator MOORE—If you need the four to five sessions you were talking about, what kind of cost would that be?

Dr Anaf—If someone charges the schedule fee, for example, as I do, you are looking at an average person having to pay $148.50 times two, which is something like $300 each week.

Senator MOORE—Which would become very, very expensive.

Dr Anaf—It is prohibitive; it is like having a mortgage.

Senator MOORE—I was also fascinated by that statement in your submission. In terms of the kinds of therapy that you provide, are there enough of you in the country to provide the services that the community needs? This is more of your practising psychotherapists.

Dr Anaf—That goes to the other part of my submission, the private submission, which is that the maybe unintended effect of these policies is to lessen the attraction that this kind of work has for younger psychiatrists. So what in effect is going to happen is that people are not going to see it as being worth while in training because it is going to be done away with. Fewer of these people will be available to treat patients. The expertise will be lost when people who are disgruntled, say in my generation, retire earlier rather than later because they cannot get acknowledgment or recognition for the work they have trained to do. So you are going to get a kind of escalating vicious circle where there will not be enough people in the end. And there are not enough people now because, even in the psychiatric training curriculum, because of the way policy is going, there is more attention being paid to cognitive strategies and less attention being paid to psychotherapeutic strategies, when in reality at the clinical coalface you actually need a range of treatments. You cannot adopt a one-size-fits-all approach.

Every patient needs something different or a combination of different things and, if you cannot provide that because your training has been limited or because government options say you cannot provide it, and the patients are not going to ask for it because they think it has all gone anyway, you are really creating a dilemma. In the not too distant future you are going to have not too many people doing this kind of work, and that will rebound on the community.

Senator MOORE—Is this following an international trend? Your paper does not draw a comparison. Is this particular bias—and that is the way you describe it—something that is international as well as peculiarly Australian?

Dr Anaf—I think it is. There is an international trend away from psychoanalysis. I am not quite sure, but there must be many complex factors behind that. Time is an issue. I think anti-intellectualism is an issue. The value in actually spending time understanding one’s problems has to do with all sorts of cultural factors, and then there is also the issue of money. Funding is always a problem all over the world. There are countries that actually fund unlimited sessions of psychoanalysis—for example, Belgium and Holland, and Germany to a limited degree. And America is increasingly providing research that interestingly shows that, if you provide unlimited funding—and they did a study on a war veterans’ association—for unlimited sessions for psychotherapy, they actually reduced their health bills quite considerably. There is research to back that up. So, in essence, it is a penny-wise, pound-foolish approach to cut services.

Senator MOORE—Is it a bit of a fashion?

Dr Anaf—Psychoanalysis has never really been fashionable, except in Woody Allen movies.

Senator MOORE—It is very fashionable in them!

Dr Anaf—Yes, it is, and he has had made a lot of money out of it. But I think there is a public image that psychoanalysis has as taking a long time and dealing essentially with people who are disparagingly called the ‘worried well’—people who are between tennis sets. I have to tell you as a clinician that that just is not the kind of patient I see. The kind of patient I see who benefits from analysis is often traumatised, sexually abused, physically abused, divorced and sick—as in physically sick and then recovered, but carrying the scars of that kind of illness and experience. There is a range of traumatic experiences people have—early bereavement, early separations, loss of parents and dislocation of country, which is increasingly a problem. Those kinds of patients are the ones we tend to see as a psychoanalytic group, and a psychotherapeutic group would not be much different. So it is important to understand that people, when they talk about the worried well, that kind of person just does not exist really. If they are worried and they are well, they do not come to psychoanalysis or psychotherapy.

Senator MOORE—Your submission also talked about your concerns about the Better Outcomes process and the focus of that particular tool in the servicing smorgasbord. Just for the record, would you care to make a comment about how you view the Better Outcomes process?

Dr Anaf—I have particular views about general practitioners being asked, or forced in a way, to treat mentally ill patients. In saying that, I want to have it on the record that I support the idea of upskilling GPs. I support the idea of them being more broadly trained. I support the idea of them having more of an interest in mental health issues. None of that is a bad thing in my view. But I think if it becomes a de facto way of rationing, whereby people are expected to go and see GPs for their mental health diagnosis or mental illness diagnosis and accept the treatment that GPs quite rightly give out as a first option as the only treatment. But GPs may be made to feel that referring on is burdening the community by adding to costs—that, if you refer to specialists, costs are going to increase and therefore you should not do it, it is a bad thing. I have to say it actually has been my experience in a couple of cases that this has happened. People have not come to me on the basis of the GP saying, ‘Look, you’ve had the treatment and there’s nothing else for you,’ which actually was not correct. If it becomes a de facto way of rationing then I think we are in big trouble. GPs, if they are upskilled—if they are trained and taught—to the point of saying, ‘Look, this is what you can do; this is what you are able to do. For anything after that you need a specialist’ then I have no objection. If it becomes a policy way of rationing, I very strongly object to that because I have already had the experience of that.

Senator MOORE—And were the incidents you raise from GPs who had been through the specialist training to have Better Outcomes endorsement?

Dr Anaf—Yes. The person I just referred to, as far as I know, had been through that kind of training. Another case that I was made aware of was a general practitioner who had been through the training modules and had kept on trying to treat the patient—with some success, I have to say. It is not that the patient was no better at all. They were better but they just needed a lot more of a different kind of treatment and they were there for eight years. One has to wonder then about the kind of strategy and policy that says to the GPs, ‘We’ll upskill you,’ if the result is going to be that specialists do not exist after that because the GPs are saying, ‘We can do everything.’ GPs do not have the time for that. They do not have the expertise for that and they should not be expected to do that either because I think it is an unfair burden on them.

Senator TROETH—Is psychotherapy suitable for all mental illness?

Dr Anaf—No, it is not. It is like any other treatment. There is training involved in how to apply it. You apply it to particular groups. Part of the training is to identify which groups will and will not respond. So you apply it like any other treatment where you have an expectation it will work for certain criteria. Having said that though, everyone who has a mental illness has a personality and everyone can benefit from their psychiatrist or psychologist or whoever having a psychodynamic—which is the psychotherapy jargon for understanding the personality issues. If you understand someone’s psychodynamic reasonably, you have a much better chance of increasing the rapport with that patient and improving the outcome of that intervention, even if it is not psychotherapy.

Senator TROETH—Given that there are MBS restrictions on the services, who can access psychotherapy services? Is it people with enough money or those in a particular category?

Dr Anaf—At the moment anyone can access psychotherapy services—anyone at all who goes to a GP, gets a referral and goes on to a psychiatrist. The problem is the criteria under which you can access intensive psychotherapy, really. Many patients will do very well with cognitive strategies—there is no question about that—and they do not need psychotherapeutic intervention. The group that fails that approach needs psychotherapeutic intervention. Of the people in that group that needs psychotherapy, a large proportion will benefit from psychotherapy once a week. There is a group of people, however, who I suppose are the psychiatric equivalent of intensive care patients, who will need very intensive treatment for quite a long time—and they are the patients that I talked about earlier who have quite traumatic pasts. That group is there in any medical specialty, whether it is cardiac specialties or whatever. Those patients are going to need a long time. They are the ones who are limited because they can have only 160 sessions a year under current arrangements, but only if they fall into certain criteria. So, if you have a patient who does not neatly fit those diagnostic criteria, they cannot legitimately access that treatment.

The other component of the criteria is that you have to have a particular score on what is called a general assessment of functioning scale. What that means is that you have to rate that person’s functioning socially, occupationally and at home and say, ‘You have a very low level of functioning in one of these areas; therefore you can have 160 sessions.’ That is a problem, because not all patients neatly fit those criteria or that kind of scale. If they do not, what do you do? For example, it is not unheard of for analysts to be seeing quite high ranking public servants, for example, all over Australia. Those people might refuse to use item 319 on the basis that their privacy will be breached and they do not know how they are going to fit the criteria anyway, but they know they need treatment because of quite severe issues. So a lot of this kind of treatment is in effect in the end what can be paid for. What the public can access and how easy it is really is the issue. Those who can afford to pay do pay, but that is not the point.

Senator TROETH—Is it covered by private medical insurance?

Dr Anaf—No. It is all discretionary spending.

Senator TROETH—So it would literally come down to who could afford to pay.

Dr Anaf—Yes, and that is really the injustice of it.

Senator TROETH—Do you think this is curtailing or inhibiting the uptake of psychotherapy training among medical graduates, if they know there is the restriction of 319?

Dr Anaf—There is no question about that.

Senator TROETH—I did note the affidavits from the psychiatrists.

Dr Anaf—Yes. We have a training program for psychoanalysis in Adelaide and many people have expressed interest but they are put off by the Medicare restrictions. They do not know what is going to happen in the future. They have already seen what has happened in the past. They see the way cognitive strategies are being promoted as the one-size-fits-all approach. There is no incentive really. My real concern is that people are not being trained; there are disincentives for training. What will we do in five or 10 years time when people like me who know how to do it retire? It is not going to be my problem. It is going to be the problem of the next generation of patients.

CHAIR—Do you accept that there should be some gatekeeper? Far be it from me to stand up for the Commonwealth on this issue, but do you accept that without any restriction whatsoever there is an opportunity for abuse of the system? If so, if you accept that, what sorts of caps or containments would you suggest?

Dr Anaf—I do not accept that, actually. I do not accept that for a specific reason. If we are talking about psychoanalysis, there is something like, in round figures, 100 psychoanalysts nationally—that is all. There are a limited number of patients you can see because every consultation is 50 minutes long in the internationally accepted standard. It is a time-limited thing, so you cannot abuse people because you cannot work that much. You physically cannot work that intensely all week and still remain reasonably grounded, if I can put it like that. So it is a self-limiting thing as far as psychoanalysis goes.

The next problem is that, if you say, ‘We cannot have psychoanalysis because everyone will start rorting the system, even though there are only 100 psychoanalysts,’ the rebound effect of that is that psychoanalysts are not there to train psychotherapists, who are the less intense specialists. If you are saying that psychotherapy is open to rorting and therefore needs some kind of gatekeeping service, then there are ways of providing that without Medicare restrictions and financial penalties that actually impinge on the patient rather than the practitioner. So the problem with Medicare item 319 at the moment is that it impinges on the patients. It is the patient who suffers; it is not the practitioner.

CHAIR—So if you had a cap on the number of consultations a psychiatrist could have but not on the number the patient can have, do you think that would work?

Dr Anaf—If you are going to have a cap on the number of consultations psychiatrists can have, you are limiting the way they can actually apply their training. I do not think that works.

CHAIR—You could divide up the number of hours in a week and say that 50, or some other figure, is reasonable.

Dr Anaf—One of my views on all of this is that we have gone a long way from trusting the medical profession to do a reasonable job and having peer review mechanisms in place to ensure quality control. The HIC already has powers to audit and to interview and to examine if there are cases of suspected or alleged rorting. The powers are there. I do not think Medicare item 319 restrictions have really achieved anything other than stopping people training and stopping patients coming.

Senator TROETH—And I think you were just saying that the hours which a psychotherapist could work would be self-limiting anyway, assuming that they wanted to retain any personality themselves.

Dr Anaf—That is right. If, as part of their registration, for example—which is increasingly I think in the pipeline—they are required to attend peer review controls and quality assurance programs, professional development programs and that kind of thing, I do not think rorting will be such a problem. I think it is actually a problem in the minds of policy makers more than in reality, because in reality the HIC can already deal with that as it stands.

Senator MOORE—Are you aware of any other medical services that have been curtailed in such a way?

Dr Anaf—No. We actually said at the beginning that this particular restriction was setting a precedent.

Senator MOORE—Obstetrics have been cut down to how many times you can visit your obstetrician.

CHAIR—I think there is a restriction per patient.

Dr Anaf—Is that right? It is a different area.

CHAIR—Thank you for drawing that to our attention, for your submissions and for appearing today.

Dr Anaf—Thank you very much.

[2.42 pm]

WATSON, Ms Sally, Executive Member, South Australian Branch, Australian Association for Infant Mental Health

FUDGE, Ms Elizabeth, Project Manager, Children of Parents with a Mental Illness, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

GARVIN, Ms Susan, Company Secretary, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

MASON, Ms Paola, Co-Founder, Children of Mentally Ill Consumers; and Member, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

ROBINSON, Mr Philip, PSM, Chair, Board of Directors, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

GLOVER, Anne, AO, State President, South Australian Branch, National Investment for the Early Years

CHAIR—Welcome. Is there anything you wish to add to the capacity in which you are appearing?

Ms Mason—I am here as an adult child of a parent with a mental illness.

CHAIR—The committee has your submissions, which we have numbered 83 and 301 respectively. Are there any amendments or additions to those documents that you want to provide us with at this point? If not, we will go to brief opening statements and then to questions.

Ms Watson—This information is just to back up some of the research.

CHAIR—Is it the wish of the committee that this document be tabled? As there is no objection, it is so ordered. Have you worked out amongst you who is making a brief opening statement?

Ms Glover—We have. Sally is starting.

Ms Watson—Thank you for the opportunity to speak to our submission. There are two points that we particularly want to make. We are interested in two areas, in the sense that the mental health of the primary caregiver, which is primarily the mother, has a huge impact on the mental health of the infant and so, at a number of levels, we see that it is very important that there are resources and attention given to the area. We know that it is much more difficult for a mother or a primary caregiver who has mental health issues—the relationship is compromised. We know that, when the relationship is compromised, there are then poorer outcomes for the child in the immediate future, but also in the longer term, in terms of education, mental health, employment and physical health. So the key point we want to make is that adult mental health really impacts on the infant's mental health, and the infant is our point of interest.

Ms Glover—I would like to support that. We know that investment in the early years in terms of the mother-child or the primary caregiver-child relationship has extraordinary benefits for the child, both in the present and later on. There is an enormous amount of evidence to support that. Really the essence for NIFTey and for the Association of Infant Mental Health is to ensure that prevention rather than treatment later on is a priority for the governments of Australia.

Mr Robinson—We would certainly support both those perspectives. In addition, I think from AICAFMHA's perspective, one of our concerns has been that most policy direction of government has been written from an adult psychiatric perspective. When you read various documents, like the second national mental health plan—and, in fact, when we did the third national mental health plan—the only time we got a consultation on young people was when I invited the committee to come to Adelaide to get some information on young people. If we look to the United States, the US Surgeon General, David Satcher, when he did his report in 1999, noted that adult criteria for illness can be difficult to apply to children and adolescents. In recognition of that, the United States convened a separate planning process for child mental health, and subsequently released a report from the Surgeon General's conference on children's mental health. Certainly, if you look to the United Kingdom, a similar thing has occurred with the Audit Commission there, where there has been a national report entitled *Children in mind: child and adolescent mental health services*.

From our perspective, we are very keen to look at the policy framework for child and adolescent mental health, including infants, as being unique. The other issue we want to focus on is that we believe that the majority of child and adolescent mental health problems can be dealt with in a community setting, starting from infancy and working onwards. Certainly our perspective is that most of the focus has been on looking from youth or from young adults or adults, rather than looking at it from infancy. So our perspective is to try to reorientate things from an early intervention perspective.

Ms Garvin—That opening statement covers all of us.

CHAIR—Excellent.

Mr Robinson—Paola, you might want to make a comment from an adult consumer's perspective.

Ms Mason—Being the adult child here, I might just explain that I started caring for my parent at a very early age. My mum became unwell when I was six. I can acknowledge that I really took on the primary caring role at the age of 11 and I have been caring for her ever since. So my life experience is, I suppose, quite unique here. I strongly support the all of life span, from birth right through, but there does seem to be this lack of understanding that the early years are so important. There is a concentration on the teen years. Not that I would ever want to take that away from the teens, but, having life experience here, I know that there are so many things that could have helped me and my family if support and education had been coming through earlier. So I strongly advocate for the work in mental health to actually start from an earlier age.

CHAIR—Ms Mason, was this your experience or not? We have heard from various submissions that someone might present with mental illness—whether it is in an emergency department of a hospital or to a psychiatrist or somewhere else—and no-one will bother to say, ‘And have you got small children somewhere or is there a great aunt that is depending on you?’ Is that common?

Ms Mason—It is extremely common. I just think it is ridiculous that we are in the year 2005 and it is still going on.

CHAIR—Does anyone else want to add to that? What ought to happen? Is it just a question of reminding psychiatrists to ask this question or, having asked it, do they then have to take on the responsibility of doing something about it? Is that the issue?

Ms Fudge—There are different levels of that. Some of the intake systems into mental health services do not have that question on their sheets. I am glad to say that that is changing across Australia—people are now listing on their intake sheets whether the person is pregnant or is a parent of a child under 18. But then, once that information has been taken on board, there is still often a lack of skill and knowledge about what people should do with that information and what other questions they should ask about the child’s safety and care, and not only just at that point of intake. Often when it is asked at the point of intake, there is no follow-up at a later time. For example, when a person appears with a first episode of psychosis or an early episode, there might be emergency systems that are put in place at that time, but they may not be there further on in the mental illness.

We know that mental illness is a cause of marital disruption and so further down track there might often be children living with a sole parent and that may not have been the case when they first presented, for example, or there might be extra pressures on the other parent or the other family members that are sort of cumulative. Lots of families can cope with one little crisis in isolation but not repeated situations with people with a chronic mental illness.

Mr Robinson—I guess the other thing that is worth commenting on is that the Australian government has actually funded AICAFMHA to produce a principles and actions document, which actually looks at key principles to do with children of parents with a mental illness, which covers that particular issue. We have been working with all of the various professional associations around Australia in respect to that. A good example would be the work we have done with the RANZCP, because a lot of the feedback we got from the various national reports that we have done was that psychiatrists only ever focused on the patient, on the person; they did not actually focus on the whole family. About six months ago, we got a statement through the RANZCP as a position statement to say that you should not just consider the individual that is in front of you with a mental illness; you actually should consider the whole context of the family. That is a very important step forward in terms of practice and how you change people’s views about working with these people.

CHAIR—It has also been said to the committee that we should stop referring to six-year-olds as being carers; that they have a right not to be carers until they are well and truly older than that. Do you agree with that, or is it just a question of semantics?

Ms Mason—I totally agree. I think that every child should have the right to be a child. Having had the burden of caring from a young age, I know that there are a lot of consequences that come from that which carry on into adulthood. I am a strong advocate for children having the right to be children. I think that they require a little caring because that adds a little bit of backbone to the character of a young person, but I would say that the overburden of caring is extremely questionable.

Ms Fudge—We had a debate at the recent THEMHS conference that you visited briefly between this issue about whether children of parents with mental illness should be classified as carers—and that was a very long and interesting debate and had a lot of comment. The fact is that children are caring for their parents. Whatever label we use, they are caring for their parents. So I guess we started from that base point. Even if they are not physically caring—making meals or whatever; and a lot of children are doing a lot of physical care—they are emotionally caring for their parents. They are worried about their parents. One aspect of the best thing we can do for these kids is to actually care for their parents' illnesses better—do a better job in mental health care for people who are parents—because these kids are caring. They are worrying about their parents while they are at school or they are emotionally worried about signs they see, changes they see, in their parents. So they are caring for their parents, no matter what the semantics are.

Ms Glover—And I think that, while they are caring for their parents, their own social and emotional health is at risk. We know that there is a direct link there between children's social and emotional health and their parents' health, particularly if they take on a carer role. We also have evidence that suggests quite strongly that, if children's social and emotional health is not right by the time they are six, seven and eight, they are at a direct risk of not being able to form intimate relationships when they are adults, holding jobs et cetera. So we have the evidence to show that it is really important that we ensure that children in families where the primary care giver is at risk or has mental ill-health are at significant risk themselves.

CHAIR—We talked earlier today about the issue of tendering of services. I come from the era in Victoria when everything in local government had to be tendered out, including maternal and child health services, which alarmed a few people like me. But it also identified big differences in the amount of support that was available. Even within one state in Australia, some services were described as Rolls Royce and others as bare bones. What is your knowledge about the diversity, shall we say, of maternal and child health services and supports? Is it adequate? Do you just represent South Australia? Can you talk from that perspective?

Ms Watson—The Association for Infant Mental Health is a national association, but I guess I feel comfortable speaking more from the South Australian perspective. The Universal Home Visiting Program is a good example of that early intervention. It is a universal program and I think that there has been a commitment to beginning and expanding that, and actually having the family home visiting, which is for families who have been identified as being at risk—not the highest of high risk, but the 90 per cent sort of thing.

CHAIR—So it did not go out to tender to the lowest bidder?

Ms Watson—No.

CHAIR—That is reassuring.

Ms Glover—There is a big nationwide difference in Australia between rural and urban services and the outreach services that are available, which is why NIFTey and a number of other organisations are talking about national services that are not tendered out, that are part of the social capital of the country. That includes things such as parent education courses for all parents, because one of the problems is that when parents have new babies there are a lot of things they need to talk about. If there is violence and abuse in the family or mental health disorders or disease, parents do need help; we know that. There are some programs that need to be taken on board as significant, and all families—Indigenous and non-Indigenous—need access to them. Whether or not they take them up is another issue, but they need access—they need access to counselling when they have young children.

Senator TROETH—If we did reprioritise and expand the budget for child and adolescent mental health, could I ask each of you to nominate where it should be spent as a matter of priority? Would it be home programs? Would it be school programs? We heard this morning from MindMatters, which was extremely encouraging in terms of what they are doing in schools. So where would you put the money?

Ms Watson—Where it is about putting money is in universal settings and settings that are nonstigmatised. I think that is where things like the Universal Home Visiting Program come in. It is a service that people are using anyway. A project that I am involved in uses child-care settings as an early intervention opportunity. People feel very positive about coming to child care, so it is nonstigmatised—as are schools and kindergartens. So it is using those universal settings that are nonstigmatised and are accessible and are in the community that is really important. I do not know whether it is about just the one place, because I think it is important that there are a number of access points for people within the community.

Mr Robinson—I think you have to put this in context. We know about the prevalence of mental health problems. Sawyers's work in 2000 indicated that about 14 per cent of the population of people aged four to 16 have a mental health problem. So we are talking about one in four or one in five young people with a difficulty. The next issue from that is that child and adolescent mental health services around the country get about seven per cent of the mental health dollars to service around 30 per cent of the population. So there is an underinvestment whichever way you cut up the cake in respect of child and adolescent mental health services.

I agree with the idea of providing them in holistic settings or whatever, but there is also the need to be able to support mainstream child and adolescent mental health services, because what most child and adolescent mental health services around the country have is community clinics. That is where most of the young people and children will go. If we do not have resources to be able to see them, then one of the big issues for child and adolescent mental health services, not only in Australia but around the world, is a long waiting list for services. If you look at the June 2005 issue of the *American Journal of Psychiatry*, an article in there says that the longer the delay between treatment and presentation, the worse the outcome will be. So I think that that remains a major issue.

We also need to look at systems of care. One of the examples I can give, coming from South Australia, is work that we have been doing at the Women's and Children's Hospital in Adelaide. With our in-patient services there, we aim to have a continuum of treatment whereby we take people from the in-patient treatment to a hospital-home transition program and then into community services. In the *Australian* recently there was a article which said that there were over 500 young people under 18 in New South Wales in adult facilities.

Senator TROETH—Yes, I saw that article.

Mr Robinson—In South Australia, with the system of care that we have instituted, I am the only person that can authorise people to go from the Boylan ward into another more intensive care environment. Over that same period we had only three young people transferred into an intensive care environment. That does not account for every young person, but that gives you some idea that there are some systems or services available that could have a benefit for all young people.

Senator TROETH—It is very alarming to think that there are that number of young people in totally unsuitable treatment areas, I would have thought.

Ms Glover—One priority is the changing social and demographic conditions for families. That means that we must ensure that families have better support when they have young children. So I would advocate training, particularly around maternal depression et cetera, for all early childhood care and development professionals—nurses, child-care workers, kindergarten directors, school teachers, hospital workers et cetera. I think it is absolutely imperative that we strengthen the support offered to people with young children.

Senator TROETH—Yes. Along the lines of which, could you give us some details about the Perry preschool program? Where is it active at the moment in Australia? Is it the sort of thing that could be easily replicated across the country?

Ms Glover—The Perry preschool program is an American program and it has not been replicated in Australia, because obviously context is different and culture is different, but pieces of it have been taken. It shows quite strongly that when you have a much more integrated service that supports families—whereby a parent or the primary care giver does not just dump a child in a service and leave the service and then pick the child up at 4 o’clock, 5 o’clock, 6 o’clock or whatever—then children’s health is much better, and obviously parent health is much better as well.

So a number of services throughout the nation are looking at integration—South Australia is currently looking at cross-government and cross-department services here—to ensure that when a child is in a centre that that centre actually works for the whole family. So there might be health and education and community and family services all visiting the centre and working together. People from that centre might be going out to visit parents in their homes or the primary care giver in their home. That is really important because it is often when the parent or the primary care giver is home alone that a lot of the difficulties occur for them. We see that in Indigenous communities. A young Indigenous child might be taken to the local child-care centre and then a very young mum might return home and actually be sitting on her veranda terribly depressed. We are not making strong enough links there between what is happening to the mum and what is happening when the child is at the centre. So home visiting et cetera are important.

Senator TROETH—Your submission also talked about targeted intensive programs for high-risk parents. How are high-risk parents identified?

Ms Watson—In terms of the process?

Senator TROETH—Yes.

Ms Watson—We would obviously look at the research to see what the risk factors are for a compromised relationship and outcomes for the children. We know that mental illness is obviously one of the high-risk factors, as are poverty, education, social support and those sorts of things. Each service, I guess, would have its own process for going through that and identifying what the risk factors are. Is that what are you asking about?

Senator TROETH—Yes: what are the factors which enable you to identify them? Do those high-risk parents—and obviously it is impossible to strike an average—know that they need some help? Are they keen to be involved in programs or is it not possible to get them involved in programs?

Ms Watson—There is no one answer to that.

Senator TROETH—No, there is not.

Ms Watson—But often families that have been identified as high risk have often had a history of being involved in agencies which have not always been very positive. So one of the really big keys to engaging parents is building up relationships, and that takes time. That means perhaps doing home visits, making sure the service is very accessible, out in the community and so on. So that process of engagement is really important. I made the point about a non-stigmatised setting, and that really is a big thing as well, because often families have had really negative experiences and, if they can feel positive about being involved in and receiving service from a particular agency, that goes a long way. That is where the universal services can play such an important role, because they overcome a fairly big barrier for engaging families.

Ms Glover—We do have some really innovative services in South Australia—and obviously throughout Australia—where high-risk parents are attracted to services because there is a relationship built up with a person or a group of people where they are not stigmatised et cetera. The evidence is there. And we do know the risk factors: people arriving late for antenatal stuff or who have an unwanted pregnancy et cetera. That is well documented, and so it is a matter of having enough funds and the political will to actually implement things. We know what is needed in terms of infant mental health, mothers’ health, maternity depression and the way we can support families through integrated services. It is having the resources to do that.

Senator TROETH—In some of the unfortunate cases that are in the media, I think one of the factors is sometimes that the parent or the parents did not have an ongoing relationship with one single caseworker—that they saw a variety of people—and that the problems were not picked up in time. You can never solve these problems automatically, but there was simply not the personal connection that you are talking about.

Ms Watson—That relationship is the key. It is the key to the child and mother relationship, and it is the key to the mother being engaged with the service as well through that particular person.

Senator MOORE—There are two things I want to follow up. One is that the committee was fortunate enough to visit ORYGEN in Victoria, which is Lyn’s home state, and we were bowled over by the positive environment there. They had a range of different professionals who were there and a very intensive process for young people. They were saying that they were getting requests for children as young as six at that particular centre, even though the kids we met were adolescents. The concern that was raised was that that model was only available in one health area in Victoria. We heard evidence that people were moving across the state to try to live there to access that service. The model that is there is highly publicised. Is there discussion about whether that process in that area is a good one to go with?

Mr Robinson—The issue we would comment on there is that that is run by an adult psychiatrist by the name of Pat McGorry—

Senator MOORE—He is the CEO. We met a bunch of people there.

Mr Robinson—He is the CEO of the whole thing. I guess what we would be saying is that, from what we understand, it is a very expensive service. Certainly, I would invite you to see the services we operate in South Australia. We believe that we have a comparable model of continuum of care with respect to not only our in-patient service but also hospital-home transition, adolescent services and an in-field campus. I illustrated the results earlier in terms of the numbers we have had in there, and it is a very cost-effective service. It has not received as much publicity as the ORYGEN model, but I would also indicate that, as we have indicated in our submission, one of the concerns that certainly AICAFMHA has had with respect to the model is that it started off from 16 to 25, it then went down to 12 to 25 and so on—I think that is what people are speaking about.

Our concern with that is the different developmental ages of people and what they actually need at a particular point in time. So the needs of a 12-year-old are certainly not the same as the needs of a 25-year-old. In terms of the way services are structured, the way we have structured our services has been to ensure that they are developmentally appropriate. So, if we have a 10-year-old, they receive the appropriate sort of milieu and environment for that service. If you look at some of the other literature on this, there is quite an international debate around what is the best way of actually doing this. I guess where we would be coming from is to say that, in general, what we aim to do is to try to have children treated as children and, where possible, we are actually able to achieve a good outcome before they need to enter into an adult psychiatric environment.

I guess the philosophy of AICAFMHA is to say that we need to try and have developmentally appropriate facilities and services to reduce the need to have people in an in-patient environment. A lot of the work that you are seeing in places like ORYGEN is focusing on very low prevalence disorders such as early psychosis. I guess where we would be coming from is to say that there is a network of services for child and adolescent mental health, which is in fact pretty much right around Australia. It involves a continuum of care, it involves community treatment and it involves early intervention, as we have talked about, along a continuum from prebirth onwards and then, where necessary as a last resort, we have in-patient admission. However, within that context we then have another process to ensure that those young people are orientated back into the community as quickly as possible.

Senator MOORE—Yes, all of the above, which is exactly what Professor McGorry was talking about when he spoke to us about the range of services that were available.

Mr Robinson—I guess what we are saying is that those services are not just at ORYGEN—they have been publicised at ORYGEN. I guess the child and adolescent mental health community around Australia would be saying that they have, in a number of these settings, a similar type of program. Certainly, as I said, we have a program like that in South Australia. It has happened that one program has been provided, if you like, with more focus than some of the other services. I think what I am suggesting is that it would be good for people to actually have a look at some of the other services that are provided.

Ms Garvin—Certainly, the ORYGEN model was established around treating early psychosis.

Senator MOORE—Yes.

Ms Garvin—I think through the publicising that has occurred there, there has been a lot of talk about early intervention. I guess from the AICAFMHA point of view we look at early intervention starting from early in the life span and even preconception, and following through a life span approach, as opposed to just looking at early intervention in the course of an illness. So there is a real difference there of taking an illness approach to a disorder and how you treat it, as opposed to saying, ‘Well, let’s have a look at the developmental spectrum and see if we can get the best outcome by intervening early in someone’s life and providing them, their family, their relationships and their community with the resources necessary to create those good outcomes.’ So something that we very strongly push is looking at what is already existing in the community: what CAM services are there that are working with other agencies in the community to create a circle of support around those families and those children to provide those outcomes.

Senator MOORE—The other discussion we have had where people have taken quite different views about the methodology was one we had in Perth. It was a discussion around the diagnosis of young people as young as five with behavioural issues, whether they were actually diagnosed with ADD and variants of that, and what treatments there were for that. There was quite a stimulating discussion between the people who felt that there needed to be medication involvement—promoting psychiatric discussion and treatment with medication—and the people who felt very strongly against that particular approach. Of course, there was no agreement; far from it. But, in terms of the process, has your organisation, which is looking at the whole issue of young people’s mental health, looked into that particular area? That is probably the most publicised aspect of young people’s mental health. If you have looked into it, what did you find?

Mr Robinson—When you say ‘looked into it’, there is quite a lot of research that is being done in this area. Part of it is a philosophical issue about what you are diagnosing. When you are diagnosing a five-year-old with a particular set of problems, our broad perspective would be to look at the child or infant within the context of their family and to look at the system. What can often happen is that there can be a projection in terms of saying, ‘Well, the problem resides within the child and therefore we will actually provide something to do with the child to make the child “better”,’ without then considering whether this a symptom of a broader constellation of issues that might be going on within the family. Our position would be that, in the first instance, a very thorough assessment needs to be undertaken not just of the child but of the whole child and family system to try to understand the meaning of that behaviour. That would be the first point we would want to make. On the issue of medication, there is quite a lot of published literature in respect to that issue which we could certainly refer you to.

Senator MOORE—We have it all!

Mr Robinson—I am sure you have. I think our general position would be that we would rather deal with the child in the context of the family and not be going down the road of medication in the first instance. We would not see that as being the most efficacious way to proceed. In the first instance, you really need to understand the meaning of the behaviour within the context of the family. Often what you will find is that there are significant problems going on within the family that could explain the child's behaviour.

CHAIR—Mr Robinson, I am not sure whether you are responsible for it or not, but there was criticism in your submission of our terms of reference being very adult focused. Could you explain where we went wrong? You say that the language of the terms of reference for this inquiry reflects this adult terminology. It did mention children.

Mr Robinson—I think we were talking about how there is a focus on what you do for consumers and carers. What our perspective has been is that you have children and families. So sometimes when you have those terms it is then hard to figure out how children or young people or families fit within that context.

Ms Garvin—Also, I think it is the case that it is certainly not just these terms of reference; it is something that is very familiar to us through mental health policy and the mental health plans—tend to be written very much from an adult perspective. So they talk about terms that are more to do with the adult mental health services.

CHAIR—So a six-year-old is not a consumer.

Ms Garvin—They are, and their family is the consumer.

Mr Robinson—I suppose it links with the research of Shatkin and Belfer in 2004 in which they ranked Australia on a scale from A to D in terms of mental health policy and Australia ended up with a B because it indicated that we did not actually have an action plan in respect of child and adolescent mental health. So internationally there has been some recognition of that issue. What we were really trying to say is that, because there is a lot of focus, and understandably, on adult psychiatric issues, you should not forget children. The other issue that links into that is that all the consumer advisory groups around Australia are adult focused. The Australian government funded us after our commentary on the third national mental health plan to develop a national youth mental health consumer participation strategy, which has not yet been published but has involved young people having their voices heard on these issues.

The message that we were trying to get across is that the voice of children and young people and how you seek their input is different. As you would be aware, we submitted to you a DVD of young people's views. The only reason we have not brought young people with us here today is because we felt that that would not be an appropriate environment for them in the first instance to talk to you. But we have been trying to work out how we can actually ensure that the voice of young people is actually heard in shaping policy directions.

Senator MOORE—How old are the young people? I know how old they were on the DVD, but what do you mean when you say ‘young people’?

Ms Garvin—Primarily, when we are talking about young people, we are talking about under-18s. So we tend to work quite a lot from the definitions in the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health. So we are talking about children aged five to 11, young people aged 12 to 17 and young adults aged from 18 to 25. So, in undertaking the National Youth Participation Strategy Project, we were primarily focusing on young people under 18 years of age, which is in a legal respect a completely different set of people to the young adults who are 18 and above. So there are a whole range of issues around consent, duty of care and the legalities of what you can do with these young people and how they can be involved that are different from young adults. That project certainly was able to give us a lot of insight into how they might be involved, what capacity they felt they had, where they would need extra support and where they thought information needed to be directed.

Mr Robinson—The issue we need to try to highlight is that the needs of children and adolescents are distinctly different from the needs of adults in terms of the sort of care and the issues that have come into the medical system. That is what the US report found. They initially did a similar thing in terms of what you have done here—an inquiry into mental health—but then they did a separate one into child and adolescent mental health. If you read, as you probably have, David Satcher’s work, it indicated that there needed to be a specific focus on what the needs were of children and adolescents. Our key premise is that we need the voice of children and the needs of children and adolescents to be understood within their context, because some of the service needs they have are different from those of adults.

Ms Watson—Obviously the infant’s voice is even more silent. What we know from our opening statements is that the mental health of the mother has a huge impact on the infant in those first few months. A randomised control study was done in the UK that showed that infants of mothers who had PND, even after intervention, were still quite severely affected—the relationship and the outcomes were still quite compromised. I think that the infant is very much absent in the thinking and we need to make sure that they are considered.

Ms Fudge—And there is early evidence about fathers with mental illnesses as well and the impact that has on their children. The evidence is nowhere near as extensive as that on the impact of maternal mental illness, but there certainly is increasing evidence about the impact of paternal mental illness.

CHAIR—In fact, you say that infants as young as three months can detect depression in their mothers. How is that known? How do you measure that?

Ms Glover—I am not sure; I did not do the study. But certainly there are things around the way a primary care giver holds a baby, and whether it is close or not close. There are a whole lot of things that we can tell from the time babies are born about the relationship between mother and baby.

Ms Watson—There is a particular procedure called the ‘still face’, where the mother is asked to keep a still face.

Senator TROETH—There was an article in the *Bulletin* about three weeks ago which detailed the effect on a baby of the mother holding another baby. The expression on the six-month-old child’s face was charted in a succession of still photographs which really did show the effect on them and the emotions that they were registering. So I am sure they would be able to pick up the fact that the mother was depressed.

Mr Robinson—She may not only have a still face; she may not be able to interact with the baby, pick the baby up when it is crying, make eye contact et cetera. We know from all the evidence about attachment that if you do not have that very strong bond to start with then you are going to have long-term difficulties. I did not do that submission, but from my experience they would be the sorts of things we would be observing, noting and trying to then work out how to develop in the relationship that we know is so critical in the first 12 months of life.

Ms Mason—And even with the older child—that is, say, six, 11 or 12—when you are faced with a chronically depressed mother, there are lots of issues that that six-, 11- or 12-year-old will also be contending with. It is about understanding why their parent is like that, why the parent is not attaching and being loving et cetera. I would really like to see that it is the whole-of-life span from yeah to when I go myself, because I will always be an adult child until my parent passes away. So there are issues that do need to be absolutely addressed prebirth and at birth, but I really would love to see more also done for the ones who are between six and about 15, because they miss out on a hell of a lot.

Mr Robinson—I guess that is where we were coming from in terms of your earlier question about the terms of reference or whatever. We have been trying to look at how we can have a voice in terms of infants—and you are quite right that that is another tough question. But, at the moment, in trying to even get a systematic approach whereby we can have meaningful dialogue with young people on what their needs are, there has been no support, except for what the government has given us now to try and do this study. But, in order to actually implement the outcomes of our study, there would need to be some investment.

AICAFMHA sits on the Mental Health Council of Australia, and adult mental health people are predominant on that council. There are two organisations that come from a child/adolescent perspective, but that is not even having young people there. It would be people like me representing young people. What we are trying to say is that young people need to have their own voice and, as we have done with consumer advisory groups for adults, we need to think through what the needs are for children and adolescents and how we can get them set up. That is really the thesis of the report that is now with the Australian government for hopefully some funding so that there is a mechanism across Australia to systematically get that input into policy and then into programs and services.

CHAIR—I think in a part of your NIFTey submission you draw attention to the fact that children under three who spend long hours in long day care that is not of the highest quality suffer high levels of stress throughout the day and that that is a big risk factor for children. What does that lead you to suggest by way of standards or improvements in child care? Could I just get you to expand on this risk factor?

Ms Glover—There is a national accreditation process for long day care, and I am sure most people are aware of that. I guess we were all seduced by the idea that young children could be in long day care, the care centres would be accredited and, therefore, there would be no significant negative impact on children. What the current research is showing us is that if a centre is rated as satisfactory there is still a potential negative impact on children. Centres have to be much more than satisfactory; they have to be high quality in order for there to be no stress.

That stress is measured by cortisol levels et cetera. Current research coming out of the eastern states is that many of the long day care centres are operating at a satisfactory level. We have given them a tick, and yet they can potentially impact negatively on children, and particularly on children’s emotional development. Of course, your emotional health and your social health are tied up with your ongoing development. So there is a big thing there because of the increasing number of children in child care. Parents are using long day care rather than family support because of changes in families. So we need to relook at the accreditation systems. We also need to make sure that the people working in those centres are well trained and well supported—that they can work with parents in ways that support parents but that they also get paid well for doing it. We know that child-care workers are currently the lowest paid group of workers in Australia.

CHAIR—So the committee should look at the report that you have referenced here on the morning to afternoon increases in cortisol concentrations for infants and toddlers in child care. Are there any other documents you would like to draw to our attention?

Ms Glover—There are a number of documents and I can provide information about them. Recently, some of you might have read Anne Manne’s comments in the *Australian* about how the person who hears your first word might be a carer and the person who hears your last word might be a carer—that is if you are in a child-care centre when you are young and you are in a home for the elderly when you are old. That is just an interesting flippant comment, but it says a lot about young children and how we need to make sure that the people who are responsible and who are becoming the primary care givers for very young children actually understand child development, understand the child and the family and understand maternal depression. They should be really well trained and well supported, and we should have enough of them. They should have access to a network of nurses, mental health therapists and the sorts of people we know we need to support our families and the community.

Ms Watson—I guess one of the concerns is the increasing privatisation of child care. That is a real risk in terms of compromising the relationship based programs in child care and whether they will be satisfactory—that they will meet accreditation standards but they will not be high quality. As I said, the research is saying that they have to be high quality.

CHAIR—Is it borne out in the research that private child-care centres were more likely to be satisfactory rather than excellent? Is that what the figures show?

Ms Watson—I am not sure if she did private versus public. I think it was just that being ‘satisfactory’ was not good enough. Given that private centres are often run as a business, they tend to think that if they are satisfactory then that is the criterion they need to meet. That is not to say that that is the case with all private centres, but I think that something that we need to be really very mindful of is that, with the increasing privatisation of the child-care industry, we need to make sure that we have high and not just satisfactory qualities of care.

CHAIR—Thank you very much for your submissions and for presenting to us today. We very much appreciate it.

Proceedings suspended from 3.30 pm to 3.47 pm

BRAYLEY, Dr John Quinton, Director, Mental Health, Department of Health, South Australia

DURRINGTON, Ms Learne, Executive Director, Mental Health, Central Northern Adelaide Health Service, Department of Health, South Australia

CHAIR—Welcome. The committee has your submission, which it has numbered 506. Are there any amendments or additions you wish to make to that document at this stage?

Dr Brayley—No, there are not.

CHAIR—I invite you to make a brief opening statement, after which we will go to questions. But first, thank you for being here during the day. It is always helpful, from our point of view, for you to hear what others have said to us and we will, as you would expect, no doubt be putting to you some of the things that were said. I have just been reminded that I should have said before we commence: I remind senators that under the Senate's procedures for the protection of witnesses, officers of state government departments should not be asked for opinions on matters of policy. If necessary, they must be given the opportunity to refer those matters to the appropriate minister.

Dr Brayley—To start with, I think we need to put mental health in the context of general health reform in South Australia and some of the social inclusion initiatives, and we need to go through some of the initiatives for new mental health services that have been put in place or will be put in place, including the review of mental health legislation for this state. First of all, for this presentation, Learne and I will go backwards and forwards in the respective areas.

The Generational Health Review was commissioned in 2002 and it has a focus on primary health care, correcting health inequities and looking at the social determinants of health. Addressing mental health and mental illness are priorities of the Generational Health Review. It has led to a change of governance of health services in South Australia. Mental health is part of that changing governance in that previously we had individual health units with their mental health services, and now we have health regions and mental health services now belong to the regional health services. In the city, that is the Central Northern Adelaide Health Service and it is the Southern Adelaide Health Service for adult and psychogeriatric services in the south. The Southern Adelaide Health Service also looks after child and adolescent mental health, and the Child, Youth and Women's Health Service looks after some state-wide young people's services and community services for young people as well.

Ms Durrington—Just to add to that—and I have heard mention of it today—on the issue of silos and fragmentation, the new regional structure for health services in South Australia enables us to develop structures that make better sense for our communities and for consumers of services. While it is early days, in effect the structure will enable us to make some significant reforms that will also help us provide services much closer to where communities are growing and developing. I say that by way of background.

One of the other critical developments in South Australia over the last few years has been the government's social inclusion agenda—and the witnesses today have been talking about the need for much better integration in terms of service delivery. The social inclusion objectives of this state provide a vehicle to recognise the relationship of mental health to a range of other topics. So in this state we are now seeing a lot of development around, for example, the relationship between homelessness and mental health, poverty and mental health, and school retention and mental health.

In itself, while that assists our mainstream services to recognise the mental health issues of their relevant constituencies, from a mental health perspective it also enables us to widen our brief to work with our community members in a more holistic way. So the social inclusion agenda has rolled out over the last couple of years and, in particular, the homelessness reference has been very important, particularly where we have seen congregations of people with a mental illness in the inner city who use our homelessness services. So it has been important to bring together services that make better sense for that population. Similarly, as you would have heard from Phil Robinson, around young people, the school retention agenda has been really important in recognising the role of education and schools in assisting young people to develop healthy lives. I say that because, for our mental health reform, we need to put it against this backdrop of social inclusion on the one hand and social exclusion on the other, and that has been a very important feature of our service system.

Dr Brayley—The next point to address is the management of emergency demand. Some years back the Brennan review of mental health services in South Australia was undertaken. They noted the need for more active leadership in the management of the front end of the services. They noticed a decline in fragmentation in mental health services over the previous 10 years in South Australia. Margaret Tobin was appointed to be the director of mental health services in this state and she initiated the emergency demand management policies—a series of seven policies that looked at the whole process of admission, risk assessment, transport, what you do when beds are full and contingency planning links with the community. These policies were launched in October 2003 and then subsequently implemented across South Australia. They have provided some more standardisation in the way emergency services, say, do triage on the telephone or do their initial assessment.

In addition, this year another emergency initiative has been a combined project with the South Australian Ambulance Service. The ambulance officers were being called out on calls where they felt that if a mental health worker was present they may not need to bring a patient back to a hospital and that they could have treatment there. So a project is about to start soon in the north and south of Adelaide whereby ambulance officers will receive support from mental health workers who will go to a patient's home and assist.

Ms Durrington—By way of background—and you heard mention of this earlier today—there has been an injection of $25 million into community agencies. Those funds have been provided to non-government agencies that provide disability support and psychosocial rehab, to agencies such as beyondblue for prevention and promotion activities, and also to organisations such as the Division of General Practice. I was listening to some commentary about the chronic disease framework that has been very critical here in terms of our GP relationship, and mental health in South Australia is one of our chronic disease management strategies. We have been able to assist to build capacity through that model. It is very early in terms of the process, but we will be looking at allied mental health staff being with GPs to assist GPs through shared care arrangements with mental health consumers. The other critical features of the $25 million have been funding to train peer workers to work in the mental health system and for carer training and development. But I could speak to that in more detail later if you would like more information.

Dr Brayley—A recent development has been an additional $5 million worth of recurrent funding for clinical mental health services. We have decided to run this out with a mental health care improvement initiative. Basically, the issue is that in our services we have good people working in the services but the systems often let them down. There is a need, as well as rolling out new services, to improve our systems. There is a recognised way of improving systems, and that involves basically giving the workers on the ground the time and tools to do the job in terms of redesigning systems. There are examples from the UK where there has been a modernisation of their health system that has set targets and has involved workers in changing how the system operates.

In South Australia we have had some good examples in general health, particularly in the way emergency departments operate, and we are going to be using this approach in our mental health services as well. In particular, we will be focusing on the processes so that we can try to ensure that people have options of care, other than just the emergency department, more readily available. There will be a specific focus on people, because we have to make sure that the jobs are designed so that people will want to stay in them, because recruitment and retention is a major issue for our mental health work force—at the current time it is medical, nursing and social work. And we need a policy base to underpin that work. We have it already with the emergency demand management policies, but that needs to be improved.

A specific area of focus is drug and alcohol and mental health comorbidity. We have a steering group of the CEOs of the health regions, the CEOs of the department and an implementation group of the mental health leaders. As well as that, Keith Evans, the leader of Drug and Alcohol Services South Australia, is on that implementation group. We are going to use mental health funds to employ drug and alcohol workers to actually operate within mental health services. It will start with six and then, in addition, Drug and Alcohol Services will be providing more training to mental health workers and another position to help coordinate the function of those drug and alcohol workers within the state. Then the care improvement initiative can look at our systems in terms of how we respond to people who have a mental health problem but also have a drug use problem—commonly marijuana or amphetamines—leading to relapse.

So the actual design will be worked out by the staff and by consumers. But the general principle is that mental health workers will be doing basic assessments and interventions for drug and alcohol problems, but they will have specialist drug and alcohol workers readily available to refer to and to seek assistance from. So this initiative of looking at the design of our current system is part of the roll-out of the new funds: Drug and Alcohol Services; some more supports for emergency; young people’s services—both telephone support and community support; and getting more community mental health workers in our emergency ASIS teams. They are some of the things that will be rolled out over the coming months.

Ms Durrington—As John has described, there are a lot of developments under way in South Australia at the moment, but critically there is also a capital program that is rolling out currently and over the next few years. This is the development of a range of new acute mental health services. The aim is to mainstream acute mental health services into our generic hospitals. The process has already started. But, before I describe that, I must say that what is critically important is developing new acute mental health services in our hospitals. That is also an opportunity to bring together a range of practice changes and new service models. It is not just about the bricks and mortar. So, building on what John was saying, it is an opportunity to look at what the model of care is and how we can provide services.

Currently, there are two new facilities well under way: one is the Margaret Tobin centre at the Flinders hospital and the other is a new aged care facility at the Repatriation General Hospital. Further to that, there are a range of new acute facilities over the next four to five years. Included in that is a new forensic facility—and you heard that mentioned earlier this morning—to replace James Nash House, so it is a new modern facility. The facility that is there is about 12 to 13 years old, but it is like any of these service delivery options: as we learn more there is new evidence about how to provide services. Our facilities become outmoded fairly quickly, and so a lot of time is taken up with design, but we know we have a very robust capital plan over the next five years.

Dr Brayley—The other activity this year has been the review of mental health legislation in South Australia. Our current 1993 act was up for review. Every few weeks we were running into problems with the act, particularly in looking after people in rural and remote areas, because the act required in-person assessments by medical practitioners and psychiatrists for the purpose of detention review. When the act was put in place, videoconferencing was not really considered as a mainstream way of providing clinical care in remote areas. This is an opportunity to have best practice legislation for South Australia.

There has been a review of mental health legislation conducted by Ian Bidmead. Comments have been received on this review and we are now at the stage of the government looking at what the new legislation will actually contain. It is likely to be very consistent with what is already in the review. There is a focus on rights, on looking at the function of the guardianship board, on appeal processes and basically on improving many areas of the act, both in the way that it is administered—for example, videoconferencing could be used in rural and remote areas—and so that people’s rights are more explicitly stated as part of the mental health legislation. I have copies of the review of the mental health legislation that I would like to table for the committee, because it will give you a good idea of how South Australian legislation will proceed.

CHAIR—Are those the thick documents that you are about to give us?

Dr Brayley—Yes!

CHAIR—Is it the wish of the committee that the documents be tabled? There being no objection, it is so ordered.

Ms Durrington—By no means finally, clearly there are a range of challenges in the work under way in mental health. Even though there has been a lot of developmental activity in the last few years, clearly what are before us are some challenges in our work force. The question is: how do we maintain, build and grow a work force that reflects the changing needs of our consumers and their carers? We know we need to plan for that, particularly in a state of this size.

So the question is: how do we keep a robust work force and a vibrant work force in mental health?

One of our other challenges, which I think is critically important, is that, in developing new community based services, the whole notion of partnership and working together in sharing care is a beginning point for us in South Australia. We have a fledgling non-government community support system and we are in the throes of building the relationship and the partnership in care—it is very early days. While we can build from the experiences of other states—and you heard Mr Bicknell talking this morning about how we progress this in a way that works for not only our community partners but also our specialist mental health service—it is early days in terms of partnership. It is a big cultural change to work together in sharing the carer and the individual. I do not think we can underestimate the philosophical change in mental health.

Again, there has been mention of the stigma in the community, and how we build community support of mental health reform is critically important. But also how we build a commitment to topics such as recovery and rehabilitation, how we build that into our system so it becomes part and parcel of practice, is also important. So again I think we have a long way to go in terms of those philosophical shifts. But, notwithstanding that, we do have a range of innovative strategies around mental health community care packages and supported accommodation. Our challenge in South Australia is having enough of those services to meet the demands of our community. But, again, we are building and it is building blocks over time.

Dr Brayley—In summary, the next steps are improving our systems—not just adding new bits but looking at our existing systems so the consumers are served well by them and the good people who are working in the systems are served well by the processes that they are a part of—working across government and non-government sectors and other providers and looking at community acceptance. That is a key element in many of the programs that are under way in terms of either getting people to present early to get treatment for their condition or to accept other people in the community who might have a mental health problem, and also working in prevention and promotion. That concludes our introductory comments.

CHAIR—Thank you very much. Can I start with this review of the mental health legislation? I have not had a chance to read it, so please forgive me if it is already there. But does it consider harmonising with other states?

Dr Brayley—There has been a close look at the legislation in other states. The key issue has been cross-border recognition. So if a person who is under a mental health order in this state were to go to Victoria or New South Wales, for example, that recognition is not in place at the moment. This legislation will commence that process of getting more widespread cross-border recognition. At the moment we are working with the Northern Territory and we have agreements almost in place to have cross-border recognition with the Northern Territory—which is particularly important for the APY lands so that people in South Australia can go to Alice Springs for their care—but we do not have other cross-border recognition in place at the moment.

However, the approach to the legislation is not necessarily the same as in other jurisdictions. It is trying to learn from them, but it has developed in its own particular way. For example, it still has psychiatrists rather than magistrates, say, responsible for detention reviews—it has been a practice in some states to have psychiatrists doing it; in other states magistrates do it.

CHAIR—Does it refer to the National Mental Health Strategy and the various plans?

Dr Brayley—Yes.

Ms Durrington—And, by intent, it is also about modernising the legislation, again given what we know today versus a few years ago. So it is recognising the changes in practice, the relationships between consumers and the centrality of consumers in the system. So it is modernising it up to today’s standard and within the context of all the national directions.

CHAIR—The committee has been told that mental health acts in other states tend to continue the focus on acute care as opposed to care more broadly in the community. Can you comment on what the forms are in this document with respect to that?

Dr Brayley—I think it would be fair to say that the legislation still has a focus on acute care, but it is not just acute care in hospitals; it is acute care in the community as well for people who may require treatment under a community treatment order. So it does grapple with that difficult situation where a person may need treatment against their will—and it is a very significant thing for anyone to have to be given medication, usually by injection, against their will. It grapples with balancing the rights, the health and the safety of individuals and the safety of others. It has tried to improve our system for community treatment orders, because with the old act it was actually easier for a medical practitioner to detain somebody in hospital than it was for them to start a community treatment order. That is an anomaly in terms of giving care in the least restrictive place. But it is focused on the needs of people who are unwell and who have mental illness and disability.

CHAIR—Can we come to the hot topic of the day, which is Glenside and beds? Can you tell the committee when Glenside will be closed, whether the beds that are currently at Glenside will be somewhere else? Will they be in the new Flinders hospital, in the new aged care facility or elsewhere again? What is the future for Glenside?

Dr Brayley—I think it is very important to note for South Australia, in following the National Mental Health Strategy, our policy is not so much to close Glenside as to provide community services, and to provide clinical services and support services along with them, and also to provide local care, whether it is hospital care in a local general hospital or in a local community centre. South Australia has been under criticism through successive national mental health reports for the amount of its budget that it has spent on stand-alone psychiatric hospital care that might otherwise be spent in the community, giving people the supports they require there or the opportunity for early intervention. With this in mind, facilities are moving off the Glenside Hospital site. As we speak, two brand new facilities are being constructed—Flinders Medical Centre, a new 40-bed facility; a psychogeriatric facility—

CHAIR—So the 40 beds are all for mental health services?

Dr Brayley—They are all for mental health services. They have been designed with staff and consumer consultation to be an effective unit but one that is homely and welcoming and that acknowledges that sometimes children will be coming in there to visit family members. So it is 40 beds for people with mental health problems. It replaces beds that are currently in a modified medical ward at the Flinders Medical Centre. But, in addition, there are beds on the Glenside site that will relocate to Flinders Medical Centre; so a ward will close at Glenside. Similarly, at the repatriation hospital, an acute psychogeriatric unit is being built and a ward will close at Glenside and be moved there. This is the process that we have under way of moving our acute—

CHAIR—Can I put the question another way? Is there to be a net in-patient facility loss overall from the current changes?

Dr Brayley—For acute beds the numbers will stay the same. There will be no change in—

CHAIR—The same as?

Dr Brayley—The same as they are now.

CHAIR—Has there not already been a downsizing of the number of beds at Glenside?

Dr Brayley—There has been a downsizing but over the years that has been more in the number of longer stay, extended care beds. So the number of acute beds has remained pretty much the same and there is no intention of reducing the number of those beds.

CHAIR—Can we go to the James Nash House proposed changes? The Public Advocate says that they are going from 30 to eight. What will the new forensic centre have by way of numbers?

Dr Brayley—At the moment there are actually 30 beds at James Nash House but there are another 10 beds on the Glenside campus.

CHAIR—So why would the Public Advocate say they have gone down to eight?

Dr Brayley—As I heard him this morning, I think he was referring to a problem that we have with our Criminal Law Consolidation Act which means that people who, because of mental impairment, are deemed to be essentially not guilty, but who need ongoing care because of a mental impairment defence, have been looked after in our forensic mental health beds. Quite often those people’s illnesses improve considerably but, because of the nature of the fact that their mental impairment has been proven, they continue to get care in a hospital bed and, because of that, even though clinically we would think that they may not need to be there, they stay in a forensic hospital bed and so that puts pressure on our bed numbers. As part of the review—

CHAIR—I am sorry but I do not understand you. Can you explain the 30 to eight problem?

Dr Brayley—I think the Public Advocate was referring to the 30 beds at James Nash House at the moment and, to his understanding, he thought that up to 22 of those patients were less acute—were less unwell.

CHAIR—These are the people who it is not appropriate to send back to prison because they have not been charged with anything.

Dr Brayley—Yes, they were found to have a mental impairment defence that has been—

CHAIR—What do you say to that problem of sending people to prison who have an obvious mental illness but who are not fit to plead?

Dr Brayley—We need to change the way that part of the Criminal Law Consolidation Act operates, and that will be part of the legislation review.

CHAIR—So this new forensic centre will have how many beds?

Dr Brayley—It will have 50 beds, which will be 10 more than the current.

CHAIR—So are there only 10 people who have been sent back to prison unfit to plead but nonetheless mentally ill?

Dr Brayley—The difference once the new legislation is in is that we expect that there will be changes in the way those people's treatment is supervised so that, if they are fit to have intensive community care, for example, they could receive it. The 50 beds are what we estimate will be required for the forensic population. It should also be noted that it was said this morning that the facility was about 25 years old—it was built in the mid-eighties—but there has been a significant change in the way forensic mental health care is delivered. It is more along the Thomas Embling facility model that you might be aware of in Victoria.

CHAIR—We went there last week.

Dr Brayley—That is what we are aspiring to in terms of improving the forensic facility at James Nash House.

CHAIR—Is it for women and men?

Ms Durrington—Yes, it is.

CHAIR—How many beds are there at present in the women's prison for those with a mental illness?

Ms Durrington—It is used on an as-needs basis rather than it being set aside by gender. At the moment they would reshape how people are cared for in the facility, dependent on who is in there.

CHAIR—How many of those beds would you expect to be taken up by women—50?

Ms Durrington—I cannot answer that.

Dr Brayley—I cannot tell you that. We can confirm that. When I visited James Nash House recently there were only a few women who were, say, admitted there.

CHAIR—What is the name of your women's prison?

Ms Durrington—Adelaide Women’s Prison.

CHAIR—That is straightforward! Is it the case that there are roughly 70 per cent of people in the prison who have had a mental illness or disorder in the previous 12 months—I think that is the normal measure? Would that be true of women in the Adelaide Women’s Prison too?

Ms Durrington—And there is national data that becomes available that does make statements about the presence of mental illness, and we would assume that the South Australian population would be no different to other states in terms of an episode or an ongoing mental illness.

CHAIR—And not much different from other states insofar as fewer specialist services for women too?

Ms Durrington—Yes.

CHAIR—Are women secluded? Are there special units for seclusion in the women’s prison?

Ms Durrington—I have been to the women’s prison and there are environments by which there is seclusion, yes, as I understand it.

CHAIR—How many women would be there, roughly?

Ms Durrington—That is a question for them. I could not answer that off the top of my head.

Senator TROETH—I know that my Senate colleagues will have other questions about Baxter, which we are visiting tomorrow. I would just like to ask you one. I do acknowledge that Baxter comes under the control of the Commonwealth Department of Immigration and Multicultural and Indigenous Affairs, but what arrangements are in place for the Baxter detainees to access the mental health services provided by the state government?

Dr Brayley—I will just mention in general that we do have a protocol that was signed off between the Department of Immigration and Multicultural and Indigenous Affairs and our Department of Health in June, but a formal memorandum of understanding is still yet to be signed. We have had a recent meeting with DIMIA, because one of the recommendations from the Palmer inquiry was that DIMIA consider having South Australian mental health services provide all of the specialist services to detainees, including in-reach into Baxter and in-patient services, but also community services and community follow-up as required. We had a preliminary meeting, possibly about two or three weeks ago—

Ms Durrington—And there is another one this week.

Dr Brayley—Yes.

Senator TROETH—So that is under active consideration or some consideration?

Dr Brayley—It is. In the interim, we are still discussing with them the pathways of care—the issues of responsibility and accountability—that were clearly highlighted in the Palmer report. Learne’s service actually looks after the in-patients who come down from Baxter.

Ms Durrington—The other thing, just by way of information, is that we are having active discussions with DIMIA; however, as you would be aware, they have a range of contractual arrangements which may preclude how that progresses—but we are in dialogue about how we can work to improve services. But, critically, there is a pathway into the mental health system through our Rural and Remote Mental Health Service, which is our first point of contact. Generally, that has been working fairly smoothly. We have refined that to the degree that we are advised much earlier and can provide consultant services if that is necessary, but it is an active, ongoing dialogue at the moment.

Senator TROETH—That is good. I would also like to ask you about your rural and remote work other than Baxter. You mention in your submission that you are making use of technology and increased rural networks. Could you give us some details of that? We have encountered a similar position in Port Hedland where obviously, with huge distances and a sparse population, there is a need to coordinate services better. Can you give us some idea of how the technology and the increased clinical network work here?

Ms Durrington—In particular, our Rural and Remote Mental Health Service, which is based out at Glenside, provides a consult and liaison service by using telemedicine. Largely, that is an interface with our psychiatry staff with a general practitioner on the care and treatment of an individual. To all intents and purposes, it aims to support a general practitioner caring for a person in their community and/or, if they need transporting to Adelaide for an in-patient stay, it assists with that process as well. There has been, over a number of years, a reasonable investment in telemedicine services across major country hospitals, and even to what we would call our urban fringe in terms of Gawler and surrounds to also assist those sites.

While I think our consultant service works very effectively, we are still building the confidence in the system to work for both the GPs and the consumers and their carers, and so that is ongoing, but we see that as an increasing service over time. In South Australia the Rural Doctors Work Force Agency has provided a range of mental health training for country GPs to assist, so we try to work in partnership to build on that.

Senator TROETH—What about those consumers who need to come to Adelaide for follow-up treatment? Is there any state government assistance for them to come to Adelaide and cover their costs?

Ms Durrington—It is called PATS—the Patient Assistance Transport Scheme. It is means tested, as I understand it.

Senator TROETH—So there is assistance.

Ms Durrington—Yes.

Senator TROETH—That is good. You mention that, instead of having silos as were referred to this morning, you have coordinated mental health care among the regions. Does each region have a comparable level of mental health professionals, I presume pro rata to the population of the regions?

Ms Durrington—In effect, what has occurred in South Australia, which I imagine has happened elsewhere, is that health units in their own right have grown. So it has been historical in terms of the spread and location of our staff. We are now beginning to look at how we have an equitable distribution of our staff and at the same time manage our staff's needs to relate to their current place of employment. So you can imagine that there are some recruitment challenges, particularly in the really outlying suburbs—how do we make those environments attractive to staff so that they want to move there and practise there? So there is a range of work under way around recruitment and retention so we can build capacity, particularly in the outlying suburbs. At the moment there is disparity, but then conversely no-one is overdone, but it is about what our current work force is and its location.

CHAIR—How many regions did you say there were to be?

Ms Durrington—There are two metropolitan regions—Southern Adelaide Health Service and Central Northern Adelaide Health Service. Then there is the women's and children's service, and then there is the country.

CHAIR—How many regions are there in the country?

Ms Durrington—In the country there are seven regions.

CHAIR—Are they all equal in terms of the population they serve?

Ms Durrington—No.

CHAIR—They are not equal in terms of the dollars that go into them either?

Ms Durrington—And there is a huge disparity in geography. When you go to Baxter tomorrow, you will see that the northern and far western region is probably half the size of New South Wales—very large geography.

Senator TROETH—And not much in terms of population.

Ms Durrington—Yes, that is right.

CHAIR—What would be the funding formula? How do you determine who gets what?

Ms Durrington—Dr Brayley can go into that, because I do not do that in the regions, but we have the Country Health office, which works closely with the other parts of the department in terms of funding distribution.

Dr Brayley—It occurs essentially through that office. The models of care in South Australia for rural mental health are affected by the fact that we have a city-state in the sense that we do not have any psychiatrists residing in the country. There are no specialist in-patient units. There have been a number of small capital works programs to improve interview areas et cetera in country hospitals so that mental health workers, GPs and visiting psychiatrists can do their work. But it is still the case that each of the areas have mental health teams which are evolving. They rely on visiting psychiatrists. The specialist care is provided in the city and people come to

Adelaide for that specialist in-patient care. The outpatient specialist psychiatric care is provided on a visiting basis.

CHAIR—So there is not a formula for funding?

Dr Brayley—There is a formula for funding for looking at the state as a whole. The positions in rural areas have developed over time, so sometimes there are positions attached with individual country towns; in other areas there are distinct teams that are servicing a region that have developed. The latest example would be with the new recurrent funds. Some of that funding will go to Country Health and it will be between the office of Country Health and the regional general managers of the country regions that decisions will be made about where those funds go.

Ms Durrington—But, for example, just to clarify further, an allocation of new funds is based on population and is weighted for rurality, distance and Indigenous communities. So it is a population based model currently, but clearly there have been historical decisions made that may not have been based on that type of information—but new funds that become available are now based on that.

CHAIR—New funds?

Ms Durrington—New funds. John just mentioned the there was a recent $5 million allocation. The country allocation was based on the population, which is close to about 500,000 people, and it is weighted—

CHAIR—So do you expect over time for the per capita funding for mental health services to match metro and rural in the future? Is that the aim?

Ms Durrington—We might find that in fact the cost per individual is in fact higher in the country given the delivery costs. So, for example, where we might fund a non-government agency in the city for a particular model of care, it will be more expensive in the country. So in fact it may look vaguely different, given transport, distance, single services rather than economies of scale. So in fact we might find that many of the models of care will in fact be more costly, so it might actually skew.

Senator TROETH—My other question is about infant, child, adolescent and family mental health. The previous presenters to you stated that—and these figures are Australia-wide—in terms of that population sector seven per cent of the mental health budget is spent on 30 per cent of the population. Would that be so for South Australia? Can I ask you to comment on the level of importance that you place on that early intervention issue with children?

Dr Brayley—There has been that criticism of the level of funding to that child and adolescent age group and the need for early intervention. With a number of illnesses, if there is early intervention in the teenage and young adult years, that can significantly improve the outcome. The planning that we have been doing recently with the Children, Youth and Women’s Health Service has been more focused on the emergency end and having emergency services—both telephone and potentially a new community service for the northern areas. But, through the $25 million, there are early intervention type programs. For example, there is one that funds infant mental health by giving GPs and other health workers support when they are dealing with mothers of infants and on the recognition of post-natal illness and depression and support for mothering skills. In addition, there are more counselling services provided as part of the Keeping Them Safe initiative in South Australia, which has been looking at child protection.

Senator TROETH—Yes, I have heard about that.

Dr Brayley—Some of those counsellors are working with our mental health services like CAMS. Others are working with child protection services or community health, both doing one-to-one work either in the two to 12 age group or the 12 to 18 age group, but they are doing some group work. Part of that mental health response is distinctly through mental health teams; some of it is through community health and child protection services.

Senator TROETH—So would that proportion that I stated be true for South Australia—seven per cent of the budget?

Dr Brayley—I would have to check the department’s figures.

Senator TROETH—Please let the committee known how that stacks up against your expenditure—thank you, that would be useful.

Senator MOORE—Does South Australia have a mental health plan?

Dr Brayley—The plans that we have been operating from have been the national plans and, in addition, there have been a range of specific strategies associated with the emergency demand management work.

Senator MOORE—The sorts of things you have in your submission.

Dr Brayley—Yes, that is right.

Senator MOORE—But you have not developed a document that is the South Australian mental health plan for 2005 to 2010, or something like that.

Dr Brayley—At the moment we do not have a public document of that nature.

Senator MOORE—In terms of priorities for mental health, your submission is chocker with actions and strategies and things like that. Is there a priority that you are working to?

Dr Brayley—One current big priority is making community mental health work, because people have been in the community without adequate support or clinical input. Another big priority is improving our emergency care and access to emergency care, because consumers and carers have been concerned about a lack of responsiveness and access to services. We also recognise the needs of specific population groups to develop, such as the dual-diagnosis area, that focus on being able to provide early intervention, either directly ourselves or through the services that we might be funding. For example, we are supporting access to allied health therapy counsellors through the Divisions of General Practice. So the pressing concerns have been at the acute and the emergency end, but the focus on early intervention and trying to prevent people needing those hospital services in the first place are there.

Ms Durrington—To summarise from the operational perspective, it is around the sustainability of community support services for people to build our relapse prevention approach, because again it is long term for the consumer that, if they do not relapse, they are going to get better and recover. It is also about building our relationships with the non-government providers who provide our psychosocial support, which has been a very small part of our system to date. That is critically important. That is what consumers want. It is the longer term care rather than the short treatment based model.

The other key issue for us, as John mentioned, is not only about emergency departments but about better capacity to prevent admission. We have just expanded our Hospital in the Home program, and there are a number of individuals who may require clinical care but they can do that at home, and we think that is also critically important. The evidence also says that, even though you might be ill, if you are cared for at home you will actually get better more quickly—it takes away the trauma of an acute admission. So it is expanding those options and building that capability.

Senator MOORE—One of the things that the committee is looking at is raising awareness of mental health in the community. It does seem to be that, when something goes wrong, it gets high media attention—it is spread all over the media. This morning the Public Advocate talked about what I think he called hysteria, when something goes wrong in terms of an escape or something like that. You have identified priorities there in terms of what the department is looking at. Is that well known in the community? Do you go out and try to involve people and tell them what your priorities are? You have obviously done consultations with them. That is in your submission. But do you then go out and say, ‘We as a department consider these to be our priorities’?

Ms Durrington—Yes.

Dr Brayley—I think we have done more in terms of mental health awareness and that we do need to do more about explaining our mental health reform agenda. It is clear that the level of community concern and lack of understanding about the needs of people with mental health problems is significant. We are addressing it through our health promotions branch in terms of education. However, fully explaining to the community what community mental health care is about and how it is provided, and the difference between that and older forms of care—the historical institutionalised care—is something that we need to do better.

In particular, because in this state, as in other states, there have been many examples of people who have been in the community without what we would recognise as a required level of both clinical and support service support—carers visiting and providing some supervision and giving people activities during the day so that they do not get bored and use drugs and then get in trouble—I think it is very understandable that members of the general population are aware of things that have gone wrong in those settings. There have been so many examples where people have been in the community without the care that they require. So we have a difficult message that we need to get across.

Ms Durrington—Related to what John is saying, we do work hard at trying to have what I would call the good news stories in the media, but again it is what is newsworthy. So often our publicity about what we are doing is on the back of another story, because that is only then that we can get attention—I am not saying we would want it that way—on what we are actually doing. It is an unfortunate sort of dichotomy that, in South Australia, when there is an incident in mental health, the first visual that anyone will see is the lovely old clock tower on Glenside campus, even though the incident may not have been there. That reiterates a message about Glenside rather than a different message. We do work actively with our media to try to get as many good news stories out there as we can to help demystify mental health, but again it is about what is newsworthy.

Senator MOORE—Your submission points out the new commissioner position that you are putting in and also the development of a charter of rights for consumers, which are both very new, aren’t they?

Ms Durrington—Very new.

Senator MOORE—Are they seen as positive stories? Are they seen as things that would attract attention?

Dr Brayley—I believe they should be. I think the issue of rights within the legislation is also significant, but we have not to my knowledge publicised them in a way that might attract that sort of attention. I guess there are a number of initiatives, and this new legislation will be something that we will need to tell people about. It gets back to the question of the importance of communicating the policy—whether the policy is about doing all of these positive things in terms of new services, reforming existing services and the capital program or whether it is seen as just being about closing Glenside. It is not just about closing Glenside. There will be service elements to replace Glenside when it eventually closes in, we estimate, around 2010, but I do not think the complexity and the sophistication of that message has been fully understood by the community.

CHAIR—Can I just go back to the memorandum of understanding? How long has it been since that was first drafted?

Dr Brayley—The memoranda of DIMIA?

CHAIR—On Baxter, yes.

Dr Brayley—I think it has been going most of this year.

Ms Durrington—Last year too, and even a bit of the year before, I think. It is a good period of time.

CHAIR—In the meantime, what services are being provided by the state government for mental health at Baxter?

Ms Durrington—As we responded earlier, we now have a clinical protocol which describes the pathway. So it assists at the Baxter end of the—

CHAIR—So services have continued as they previously did?

Ms Durrington—Absolutely.

CHAIR—So what difference does the protocol make?

Ms Durrington—The protocol clarifies the agreement between the states. It is a safeguard in terms of—

CHAIR—It does not make any difference; it just clarifies.

Ms Durrington—In good faith we have delivered services—that is what we should say.

CHAIR—What are they?

Ms Durrington—We largely provide a specialist mental health service. For example, at the moment we are providing care to a number of individuals which is an intensive specialist mental health service here in Adelaide. Those services usually are over an extended period of time—so a number of weeks.

CHAIR—So these are people out of Baxter that go to Glenside?

Ms Durrington—That is right.

CHAIR—What else? What is there in Baxter?

Ms Durrington—In Baxter at the moment the arrangements are as they have been to date. We provide a consultancy service as requested and required. We also can invite in, so to speak, our rural mental health staff from Port Augusta. Our community mental health staff can also attend Baxter as required.

CHAIR—If requested by the department of immigration?

Ms Durrington—If requested by the Baxter health staff. But let me say that the services in Baxter in very recent times have expanded considerably in terms of mental health service delivery and also mental health assessment of all individuals entering detention.

CHAIR—So do you conduct assessments of all those entering Baxter?

Ms Durrington—No. They conduct assessments, but they are baseline assessments.

CHAIR—They being?

Ms Durrington—The health service in Baxter, not us—not the state mental health service. It is a very recent initiative, but what it provides is a baseline. So, if an individual does have an illness that has yet to be identified, that will become apparent through the baseline assessment, whereas in the past that did not occur. That is very valuable information for us if we need to provide—

CHAIR—Does a psychiatrist do that for every new intake?

Ms Durrington—I think the mental health nursing staff do it.

CHAIR—A psychiatric nurse?

Ms Durrington—Yes. They have two mental health nurses on shift.

CHAIR—What percentage of the population at Baxter would have been assessed through that process?

Dr Brayley—I think you might need to ask the operators at Baxter about that. It certainly has been a view in South Australia that there is benefit in separating the provision of specialist mental health service from the actual operation of a detention facility—because theoretically you can get a potential conflict of interest between the correctional objective and the treatment or therapeutic objective—so that mental health care does not become an agent of control rather than an agent of treatment.

CHAIR—How is that being overcome?

Dr Brayley—That would be overcome if DIMIA were to follow the Palmer recommendation to have the South Australian government services provide the in-reach care in Baxter. At the moment we can be invited in there, but basically the care is provided by contractors of the operator.

CHAIR—Is this a sticking point in the MOU?

Dr Brayley—No, because the existing MOU started before Palmer’s recommendation. I think it would be fair to say the sticking points have been making sure that immigration law and mental health acts have all been very clear and compatible in terms of how they are administered. If DIMIA were to decide to proceed with the Palmer inquiry recommendation then the current MOU would be superseded because it would not be relevant.

CHAIR—What is the process of reaching that decision? Are you just waiting for DIMIA to let you know?

Dr Brayley—We anticipate from them that, by December, they will have a view about that and we have indicated our preparedness to take on that role.

CHAIR—And then you will spend another year and a half working out the details via an MOU!

Ms Durrington—And in the meantime we are working with them. We mentioned that there is another meeting this week about how we provide services, how we can actively be engaged in the provision of services, and so that work will go on.

CHAIR—Of existing services or new services?

Ms Durrington—Of existing services to improve our response and see what opportunities there are for us to be more actively involved, respecting their contractual issues and their own governance issues that they are operating within.

CHAIR—It sounds like a minefield.

Ms Durrington—It is a minefield but we have made progress.

Dr Brayley—And there is a common will there. At our last meeting, Dermot Casey, who previously had a significant role with national mental health strategies, is now a part of the section of DIMIA which is involved in the design of mental health care, so there is a sort of common language and common objectives that we are able to discuss with him.

CHAIR—Have you also expressed a view to the Commonwealth about the Public Advocate’s role? Have you suggested that the Public Advocate should have access to all of those detainees?

Dr Brayley—We have not expressed that view.

Ms Durrington—Not formally, no.

Dr Brayley—Our starting point has been that the people in Baxter should be receiving similar services to other people in South Australia, but obviously the department of immigration has a specific extra responsibility, because the people are detained, in terms of ensuring that those services are provided.

CHAIR—Is it nonetheless your view that the Public Advocate should have access to those people?

Dr Brayley—Indeed, just like anyone else in terms of protecting their rights.

CHAIR—In your submission you refer to the South Australian Department of Health’s policy on restraint and seclusion and you also discuss it on your web site under Emergency Demand Management Policy and Procedure series, titled ‘Restraint and Seclusion in Health Units’. Given the quite large amount of evidence that shows that seclusion is used as behaviour modification in Baxter in both the management unit and Red 1 compound, is that a concern or was it ever a concern for your department, and is that the subject of discussions with the management of Baxter?

Dr Brayley—Since I have taken on this role in the last three months it has not been subject to discussions with DIMIA or the operators. My immediate reaction to that is that, if a person is so unwell that seclusion is even being thought about, that would mean to me that they should have in-patient psychiatric care rather than still being in—

CHAIR—So they should be out of Baxter and in Glenside?

Dr Brayley—Yes.

CHAIR—If that is your view, how do you propose to progress the issue?

Dr Brayley—As you are highlighting it now, we will progress it in our meeting this week with DIMIA. We have seen their new flow diagrams for how mental health care will be provided within their part of the system at Baxter, but we need to specifically ask the question that you are asking in terms of where seclusion fits in and what they are doing regarding seclusion for mental health problems.

CHAIR—Can I just press you on this?

Dr Brayley—Yes.

CHAIR—Would you suggest to the department that it is no longer appropriate for seclusion practices and that those units ought to be closed down for the purpose they are currently being used for?

Dr Brayley—There are two elements. There is the general operation of Baxter and then there is how people with a mental health problem are looked after in Baxter. If seclusion is being used in Baxter for people with a mental health problem, then those people are in the wrong place. They should be in a psychiatric care setting. That would be our view. So it is fairly clear cut.

CHAIR—You cannot make it clearer than that. Thank you. Can I go on to the prison population? The Public Advocate was pretty critical and said in fact that services to prisoners had declined markedly over recent years. Can you advise whether you agree with that assessment of the situation and, if so, apart from the new forensic unit, what your department intends to do about that?

Dr Brayley—I would agree with the concerns the Public Advocate is reporting about the level of forensic mental health care, given the demand that you mentioned. He estimates seven per cent in women’s prison and 50 per cent or higher in the prison population generally. We know that our forensic psychiatrists, when they visit prisons, are extremely busy seeing many people very quickly in terms of assessment and treatment. There are elements that we need to improve within our existing systems, particularly how people with a mental health problem are followed up after they leave prison and how the forensic in-patient facility links up with general mental health facilities when people are discharged. We have some resources at the moment in terms of providing some ongoing community follow-up in addition for people who have gone through the mental impairment defence, but we need more resources for in-reach into prisons—basically, we need new resources to do that. We are looking at that at the moment in the metropolitan area. The issue of country prisons and their access to mental health workers, from local mental health teams, requires further planning as well.

Ms Durrington—There is an injection of funds to expand the in-reach service of forensic mental health nursing into the prison health service, but, as John says, there is much more work for us to do to expand the model. Expanding the capacity will help a lot but, as John has explained, given our psychiatry work force and the finite resource of psychiatrists in forensic as well, we are left with some work force challenges as well as the need to expand the service.

CHAIR—Do you expect the time frame within which prisoners on remand—that is the term we use in Victoria—who may be assessed to be unfit to plead will be shortened? Do you have an objective? Currently it is a very long time, isn't it? Is that going to be shortened any time soon? Are there any plans?

Ms Durrington—Just by way of introduction to this too, the new regional structure in health has provided for the prison health service to become part of the regional structure and to link to our primary care structure, which is quite new and innovative because it will enable us to make the prison health service more robust. Prior to the structural changes, it did not link into the system in a manner that helped build its capability and capacity. So I say that just as a beginning point. So now the prison health service being part of the primary care directorate will assist in terms of just the robustness of the service being delivered. Similarly, there has been extensive—

CHAIR—Does that mean you would push for GPs to service the prison population under the Medicare model?

Ms Durrington—No, I am not saying that. I am not running that particular program. But in effect the structural changes will assist in building up the resource base rather than it being an isolated service, as it was to date. The other thing that is probably important to mention is the work being done in terms of service modelling around the replacement of the James Nash facility. Secure rehab also includes forensic mental health policy and, by default, that flows on to what the service model will look like, what services we need and how we will build them. So, while I cannot answer your direct question about time frames, there is a major piece of work under way around that topic, of which that service is an integral stakeholder.

CHAIR—Is there some reason why the $25 million is a one-off injection of funds? Quite a lot of the evidence we have had here and in other states is that too much comes, whether it is just for this year or even over the next three years, and after that it disappears. Innovation and so forth then goes down the drain, and skilled staff become very demoralised by this short-term funding approach. Why $25 million in one year?

Dr Brayley—The $25 million was an opportunity that we had to have funding to boost—

CHAIR—Do you mean it was left over from the budget?

Dr Brayley—It was an opportunity that we would not say no to for two to three years of increased non-government services, because $14 million of it will go to that purpose, and then there is a whole range of other things that it is supporting. So it is one-off funding, but those elements that it is funding are very important and there is obviously going to be an ongoing need for those sorts of services.

CHAIR—So will you guarantee that there will not be a damaging effect of this—in terms of saying, 'Now you've got it, now you haven't'—on either patients or service deliverers, or on non-government organisations? How can that money be effectively spent, and does it have to be spent in one year or can it be spread over a longer period? What happens at the end of it?

Dr Brayley—The aim is two to three years. I think it is important to note that the work that will be done with that money fits into the more intensive psychosocial rehabilitation end, so it will be people who will have personal goals in their independence, such as accommodation, and some of them might even end up starting some sort of work or other community engagement. The benefits will be there for them to have an intensive period of community rehabilitation with goals during that period. It is possible that many of those people may require an ongoing level of support. The experience of our NGO providers is that the level of support is more intensive initially during the first six to 12 months, but in general, if all is going well, it then tapers off after that period of time. So I would expect that to happen with many of the people in this program.

We have the returning home program from Glenside. One of the things that the NGOs have reported there is that there is often quite an early improvement because, if people are in an institutionalised setting, they often go backwards because they have not had to do things for themselves. So it is reasonable that in this population we would see improvement, but many of them will need some sort of ongoing care, but it will not be at the same intensive levels.

CHAIR—In fact, the St Vincent de Paul Society suggested there was a bit of a hump that needed funding. Maybe this is it.

Ms Durrington—Yes.

Dr Brayley—There is a smaller amount of money that will provide lower level disability support care that will be linked up with the disability sector. A psychiatric options coordination service will be formed and that will run alongside other options.

CHAIR—It would be useful for us to have a breakdown of the $25 million, so far as you know what it is at the present time, if that is not too much trouble.

Ms Durrington—Yes.

Dr Brayley—We have all those details.

CHAIR—Just a couple of other short criticisms—I hope they are short. The Public Advocate was involved in setting guidelines on information and privacy but there is no sign of them yet. When are they expected?

Ms Durrington—We are getting this document printed as we speak, but it has also been provided to our consumer peak organisation for it to not redraft it necessarily, but to make it consumer friendly. That work is under way at the moment. We would expect to see that, and I understand his dilemma.

CHAIR—It is a long time coming.

Ms Durrington—Yes.

CHAIR—He criticises the fact that there is no community visitors scheme at Glenside. Is there going to be one?

Dr Brayley—We are working on developing a community visitors scheme. It is not specifically a part of the planned legislation at this stage, but it is the intent to have a community visitors scheme, linked up with similar schemes in the disability sector.

Ms Durrington—While it is not a community visitors scheme, we have invested in peer workers, peer advocates and carer supports. So we are hoping that the introduction of consumers and carers into our in-patient system will also help in terms of transparency and accountability, so that is another strategy that is under way at the moment.

CHAIR—You may want to take this next question on notice, because it will probably require greater reference to what the Public Advocate said in evidence this morning and that will not be available until the *Hansard* has been produced. He criticised the silo mentality. We would find it useful if you could give a response to some of those criticisms.

Dr Brayley—Yes.

CHAIR—And the short-term mentality of funding and the practice of tendering—everything must be contestable these days—and what that does to staff.

Ms Durrington—I must admit that we have been through a process in South Australia in the last 12 months to accredit, for want of a better word, mental health service providers in the community. It could be construed as competitive tendering but in fact it was not. It was about having a number of providers who could be accredited, which in fact makes it far more flexible than the models of the last decade. So we now have 11 providers on our books that we can invite, via expressions of interest rather than through the full tender process, to submit for funds. So in fact we have greater flexibility and we are pleased to now have 11 providers who are all accredited as mental health providers. So in fact it is quite a significant reform.

CHAIR—We hope it works.

Dr Brayley—With respect to the silo issue, I think this is part of the consumer and carer concerns about lack of service responsiveness in that you can have great people working in a team but if their job is defined by what that team does rather than by what the consumer needs then you have a problem. Part of modernisation and redesign of existing services is to look at that very issue, because it applies in general health just as much as it applies in mental health. You have each bit of the service and they can all be doing their job well, but if there are gaps or poor coordination between them or people just doing their bit well, it is only the consumers going through the whole lot who actually see the entire journey. So redesigning things to match the consumers' experience of their journey through the system rather than making the little silos better is part of what health service redesign is about.

Senator MOORE—In terms of the issues that Senator Allison has been raising, a lot of them came from the Public Advocate, as you know. I asked the same question of his office. The issues he has raised are obviously not new. How do you get that feedback from his office to the department and respond to or act on them? He told us that his report goes to parliament—hopefully they read it—and that kind of thing. But it seems to me that that kind of information must be more immediately shared.

Ms Durrington—Yes.

Senator MOORE—How does that work from the department to the advocate?

Ms Durrington—There are probably two answers. There is probably a department answer and then there is an operational answer.

Senator MOORE—I would like both.

Ms Durrington—We have a very good working relationship with John Harley. We share information around individual matters as well as what appear to be systemic matters. If he has a feeling he can see it as a system issue, we discuss what our response might be to that. We also actively engage him in planning and consultative processes. So it is a very effective and quite a good working relationship. We do not wait for his report to parliament to address the issues as they arise.

Senator MOORE—I think that is really important to have on the record, because otherwise it seems like there is one bit of government sitting waiting to hear things. It is important to have that on record.

Ms Durrington—By way of example, even though he has not had entry to Baxter, he has been very actively involved in that topic.

Senator MOORE—Yes, for many years.

Ms Durrington—Yes, and we are in regular dialogue about what we are doing, what it looks like and how it is working. He will advocate for those services. That works quite well.

Senator MOORE—You have been there three months, Dr Brayley?

Dr Brayley—Yes.

Senator MOORE—How long have you been in your position, Ms Durrington?

Ms Durrington—I started when John started.

Senator MOORE—So you are both new.

Ms Durrington—We are both relatively new, yes. But I was previously the deputy director in the Mental Health Unit.

ACTING CHAIR (Senator Troeth)—Thank you very much for your attendance today. I declare the Adelaide hearing closed.

Committee adjourned at 5.10 pm