REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

INQUIRY INTO MENTAL HEALTH ISSUES IN NEW SOUTH WALES

At Sydney on Thursday, 23 May 2002

PRESENT

The Hon. Dr B. P. V. Pezzutti (Chair)

The Hon. P. J. Breen
The Hon Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. D. F. Moppett

CHAIR: Ladies and gentlemen, welcome to the first hearing of the Select Committee on Mental Health. I would like to say from the beginning that there have been some 260 submissions, or a few more, and they are still coming in. That is probably the most submissions that I have received in any parliamentary inquiry that I have been on, and they range from stories about "my son and my daughter" right through to magistrates, the Police Association, to all of the non-Government organisations. Today we are setting the scene for what the major community organisations and some of the peak bodies see is actually happening on the ground.

Members of the media should be aware that Standing Order 252 of the Legislative Council states that any evidence given before the Committee or any documents presented to the Committee which have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person.

Accordingly, the Select Committee on Mental Health has resolved in this regard to authorise the media to broadcast sound and video excerpts of the public proceedings here today. The Committee's resolution conforms with the guidelines governing the broadcast of proceedings adopted by the Legislative Council. Copies of the guidelines have been circulated.

The Committee wishes to emphasise that when the public hearing commences only the members of the Committee hearing evidence and the witnesses appearing before them may be filmed or recorded. People in the public gallery are not considered to be part of the proceedings and therefore may not be included in sound and video broadcasts. Further, any person reporting the proceedings of the Committee is to be advised that as with the reporting of the proceedings of both houses of Parliament, you must take responsibility for what you publish and for what interpretation is placed on anything you say before the Committee.

OWEN ROGERS, Executive Officer, New South Wales State Council, Society of St Vincent de Paul, 1 West Street, Lewisham,

MYREE ANNE HARRIS, President, State Advisory Committee for the Care of People with Mental Illness, Society of St Vincent de Paul, 1 West Street, Lewisham, and

JUDITH MIRANDA BALL, Co-ordinator of the Compeer Program, Society of St Vincent de Paul, 1 West Street, Lewisham, sworn and examined:

CHAIR: Are you conversant with the terms of reference for the inquiry?

Mr ROGERS: I am.

CHAIR: There has been a submission put in by you. Do you wish that to be included as part of your sworn evidence today?

Mr ROGERS: Yes, please.

CHAIR: Are you conversant with the terms of reference for the inquiry?

Sr HARRIS: I am.

CHAIR: We have received two submissions from you. Would you like those to be included in your sworn evidence today, that is submission 75 and submission 172, as well as the submission *The Long Road to Recovery*?

Sr HARRIS: That is right, yes.

CHAIR: Are you conversant with the terms of reference of the inquiry?

Ms BALL: I am.

CHAIR: You have made a separate submission for the Compeer Program. I do not know what the number is, but would you like us to take that as part of your sworn evidence today?

Ms BALL: Yes.

CHAIR: If you should consider at any time during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request, and please be aware that the Legislative Council may overturn the Committee's decision and make the evidence public.

Would you like to make a statement before we commence?

Mr ROGERS: Good morning, Dr Pezzutti and honourable members of the panel and ladies and gentlemen. My name is Owen Rogers and I presently occupy the position of Executive Officer of the New South Wales State Council, Society of St Vincent de Paul. It is indeed a pleasure for us to be here today, but I must apologise for the absence of Mr Patrick O'Flynn, New South Wales State Council President, who has other commitments. As we have already heard, allow me to introduce Sister Myree Harris, who is a Josephite sister and currently acts in the role of President of the State Council Advisory Committee relating to people with mental illness, and to Judith Ball, who is a co-ordinator for the society's Compeer Program, a program which matches volunteers in friendship relationships with people experiencing mental health.

It is the intention for me to present a brief overview of the society in New South Wales, with particular reference to our involvement in mental health. Sister Myree Harris will then present on specific and related issues relating to mental illness and Judith Ball will speak on the society's Compeer Program and the success that this program currently enjoys. I shall then finish our presentation with a concluding statement.

Dr Pezzutti and members of the panel, the Society of St Vincent de Paul was founded in 1833 in Paris by Frederic Ozanam under the patronage of St Vincent de Paul. The principal work of the society is the provision of assistance to any person irrespective of colour, creed or race, and certainly without judgment. There are some 20,000 volunteers in the society in New South Wales and a total of 40,000 throughout Australia.

The core work of the society is home visitation, where society conferences, who are volunteers, they are parish based, visit people in their homes who require and seek our assistance. There are some 573 of these conferences in New South Wales who as volunteers make themselves available 365 days a year to provide aid to the so many disadvantaged people in our community. All together the society in New South Wales operates and administers some 114 special works relating to and dealing with care of the aged, homeless persons' facilities, youth care and support, family services, child care, self care units, and of course care of the mentally ill, and there are other special works like the Compeer Program, which Judith will talk about shortly.

Some of you may be familiar with the society's centres of charity or op shops which provide clothes and furniture free to families and people in need. There are 273 of these shops scattered throughout New South Wales. I make mention of these simply because interviews by people in need do take place at some of our centres. The structure of the society simply centres around the society's conferences, who are financially supported by the next level or link in the structure, and these are known as regional councils and those regional councils are likewise supported by the diocesan councils. The presidents of each of the 11 diocesan councils in New South Wales, together with appointed board members, constitute the State council, who are the legal entity and are known as the trustees of the New South Wales ACT State Council. While there is a link of support existing between conferences and the State council, I point out that the structure operates on a decentralised system model.

The State council endeavours to provide as much support as it can to conference work of home visitation and a quality of care to those in need. State council is responsible for the development of policy on a range of issues. As such, the State council has issued a number of social justice statements which examine the day-to-day lives of disadvantaged people through research and exploration of issues like poverty, homelessness and unemployment, and of course mental illness. The issues covered in each of the society's statements are initially identified by the St Vincent de Paul members through a network of the parish conferences and special works committees. By producing these social justice statements we are able to clarify concerns and play a constructive role in addressing specific issues.

Now, what are these social justice statements? In 1995 the society produced a statement dealing with mental health crisis, and these are available to the panel. This was a discussion paper which highlights the problems the society members were experiencing while trying to deal with the increased numbers of people with mental illness who are using our society's facilities. The following year, in 1996, the society issued a statement *Unmet Needs*, which was released as a result of a forum on the private for profit boarding houses in the Newcastle Hunter region which examined the unmet needs of boarding house residents in the Hunter region. The following year *Shifting the Deck Chairs* was issued. It was a paper which was compiled by a number of major associations, the Sydney City Mission, the Society of St Vincent de Paul, the Wesley Mission and the Haymarket Foundation, and this particular paper focused on homeless people with mental health problems in the inner city of Sydney. It was pointed out that there was clear evidence that the process of de-institutionalisation had led to an influx of people with a mental illness to our crisis refuges and our facilities. Again, that same group developed a paper in 1998, *Down and Out in Sydney*, which examined the prevalence of mental disorders and related disabilities in Sydney's inner city hostels and refuges for homeless people. It is interesting to note in that particular paper that the study showed that 75 percent of homeless people have at least one mental disorder. The development of these statements by the society demonstrates our commitment to advocating on behalf of these people living with a mental illness.

I mentioned earlier about the society's special works. The society currently administers and operates a number of facilities involving mental health, such as Manressa House, which is situated in Neutral Bay, and this was established in 1995 by the society to provide affordable secure accommodation for some poor people with mental illness. Its development resulted from a recognition by the northern suburbs region of a lack of suitable accommodation in that particular area. There were increasing requests for conferences to assist people with a mental illness and a house was made available at the lower market rental by the Neutral Bay Kirribilli parish for accommodation for people with mental illness. This particular Manressa House project by the society is managed by a Committee composed of a majority of society members with representatives from the parish, the society's State Council Advisory Committee and the New South Wales Health. The day-to-day support of residents is provided by a community health team and accommodation services with volunteers from the society conferences and the parish offering companionship and other assistance.

There is one other society special work, and that is the Mary McKillop Outreach at Lewisham, and this has been going for quite a number of years, but basically provides activities and support to boarding house residents in the inner west of Sydney. Living skills, training and recreational programs are administered there. Between 150 and 200 residents use that specific service each week. It was funded by the society since its foundation in 1992.

Finally, the society's Ted Bacon House, which is a joint venture between the society and Sutherland Mental Health Services, operates as a drop-in centre and it provides ongoing support and recreational opportunities to those people who suffer with depression and mental health.

In conclusion on my part I refer to the society's social justice statement on mental health, *A Long Road to Recovery* which was launched last year. It became clear that through the conference work of the home visitation the members were confronting increasing numbers of people who have become socially displaced, dislocated through mental disorders going unchecked, as such, that when our members deliver material assistance to households they usually discover the individuals who are isolated, whose only forms of interaction is the house call they receive from society conference members, and so the society statement *A Long Road to Recovery* was produced having had direct consultation with society members and forums held in a number of dioceses throughout New South Wales, including Lismore, Wollongong and Sydney. I would like just to read a few comments on some of the conference reports which came about through our consultation, and I am referring now to page 8. This will just take a minute.

> 75 percent of the people we help in Armidale have a mental disorder. They need someone to listen to them and help them sort out their essential priorities and to be helped to feel some worth in society. In Northbridge, Sydney, we regularly encounter young people on New Start. Some have reached to the point they can no longer support themselves in any way. They are generally affected by anxiety, though not necessarily clinical anxiety, and we estimate about 50 percent by depression. It seems a lot of people have been forced out of Sydney because of the high rents and have come to Katoomba. Many of them suffer from mental health problems.

In Yass a report:

> We have seen a steady increase in the number of people suffering from mental health problems requiring assistance. Invariably they have been found without any money, are in distress they are confused and completely disorientated. Some of these people have been found hundreds of kilometres away from the address on their identification.

And finally the last three:

> Most of the people we see in Parkes are suffering from depression and anxiety. Most of them also have an addiction. One of the biggest causes of poverty, particularly in this area, is mental illness and there are many people living by themselves who just cannot cope. It is as prevalent in Mosman as anywhere else in Sydney.

And finally:

> The Bowral conference attends to many people suffering from anxiety and depression. Often our assistance is sought as a last resort after stewing over their predicament and heightening their anxiety levels.

That concludes my input and I would now like to invite Sister Myree Harris to deliver her presentation.

Sr HARRIS: I am picking up now from page 5 of the report and looking at the main issues that came through from consultation with the 20,000 volunteers throughout the State. First of all, we have found that, as Owen has said, the number of people with mental illness who approach St Vincent de Paul has steadily risen. Many of these people lead lonely fragmented lives and receive little treatment and support for their mental illness. We encounter many people with mental illness in hostels and refuges for the homeless, not just Matthew Talbot but throughout the State. We find that the strict criteria for hospitalisation means that sufferers and carers are often left to deal with very difficult episodes on their own. The lack of acute care beds in hospitals has led to shorter stays, not long enough to stabilise people, so that they go back to their flats or bed-sitters or wherever they are - boarding houses - and they struggle to try and stabilise, and often fail to do so and go back around the cycle again. This is compounded by a lack of follow-up and counselling. Overall, the promise of an integrated, well-resourced community mental health service was simply not realised as a result of the Richmond changes.

Picking up the main issues, homelessness and mental illness, as Owen commented, from the report, Down and Out in Sydney, 75 percent of people on the streets or in insecure housing have some kind of mental disorder compared to 20 percent in the general population. 23 percent of men and 46 percent of women on the streets have schizophrenia, which is an extraordinary figure when you look at one percent in the general population having schizophrenia. 33 percent suffer from depression compared to six percent and 93 percent have experienced at least one major trauma, and we are talking about really major traumas. They have experienced murders, rapes, bashings, experienced them or seen other people, friends or relatives experience them. Some people have come from countries where they have been prisoners of war, they have been tortured - there are all kinds of backgrounds which lead people to be on the streets. There is a new report, Pathways into Homelessness, which is being done by the same team that did Down and Out in Sydney. It has been worked on over the past two years and will be released in July, but the preliminary findings say that the profile is the same except that drug use has increased.

We find that, in terms of homelessness, the dire lack of adequate mental health services to reach the floating population in the inner city means that we cannot tackle the cycle of homelessness or of mental illness among these people. Breaking the cycle of homelessness requires a high level of cooperation between government and non-government agencies - not just Health. In fact we find that only in a few instances has New South Wales Health been willing to be a partner in an integrated approach. It is probably the most unwilling participant we have found.

We find that mental health services are not available to our homeless services when they are needed. For instance, Vincentian Village in east Sydney often has situations where there are violent episodes or threatening things happening or people totally out of control in their meal room. They call the crisis centre and the crisis centre asks who is it? Oh, so and so, right, he's got a personality disorder, that's not our problem, we don't have to deal with that, or we don't have the resources anyway, and they don't come; or tell him to come down to our centre or tell the police to come and get him. There was one episode where the person in charge was bailed up in her office for well over an hour while someone with a knife rampaged around outside. She was totally at risk and there was no resource and no one came until the police arrived and I think it took the police at least 40 minutes to come.

We find that mental health teams and crisis teams are stretched to the limit. I talked to the boarding house team of central Sydney recently and they have a case load each of 60 people. In the inner west of Sydney where I know the teams fairly well they used to have a case load of around 50 and 60, but now they have had to drop a lot of their clients. The reason is Federal paperwork, this MHOAT thing, Mental Health Outcomes Assessment and Training paperwork that has to be done on every client every 13 weeks and it is taking so much time that they cannot attend to their client loads. From above they have been told to drop as many clients as they can, pass them on to GPs. General practitioners cannot follow up these people. In fact they have to be followed up actively and physically, you have to go and find them. They are not going to show up in doctors' surgeries. As a result, these people spiral back into the system of homelessness.

There is a big problem with dual diagnosis of mental illness and substance abuse. We have quoted the story of Annette in our report. Annette was a young woman who had anorexia and had anxiety and depression. She also developed a heroin addiction. She was constantly trying to get help but, as in the case of all these people who have this kind of dual diagnosis, the health services, mental health services and the drug and alcohol services work against each other. They do not work together. You try to get help from one and you are told you have to fix up the other condition first before they will treat you. So these people land on the streets and they die. Annette went to St Vincent's Hospital. Her weight had fallen to 29 kilos and she could not walk. She went to the emergency ward, was kept for one day and discharged because it might compromise her freedom otherwise and "we cannot be paternalistic", as one doctor said. That was a great help to Annette. Annette died on the streets of Kings Cross two weeks ago or so, very greatly mourned by her family, who loved her deeply and had tried consistently to help her, but her condition made her very difficult to reach and, despite everyone's best efforts, she died on the streets of a heroin overdose.

Something has to be done. There needs to be a circuit breaker and we have attempted to do that. We think that the whole issue of dual diagnosis is totally out of control. These people land in the gaols, on the streets, in the refuges, and they die. No one is helping them. St Vincent de Paul has put forward a proposal, which we will table, for a clinical trial of a residential treatment rehabilitation program for people with dual diagnosis of mental illness and substance abuse. We presented this to the Premier in January after a meeting with him in December and on the 13th of this month the Premier sent a letter saying that the first stage of this would go ahead. We requested that an expert committee be set up to work with a project officer for about a year and come up with a model acceptable to Australian conditions and then run a clinical trial of that. Something has to be done to stop people from dying.

CHAIR: So you have all of those people on board now, have you, the co-leaders and the planners?

Sr HARRIS: I have been told by the Premier that the list of people that I suggested has been assessed, Cabinet has looked at them. I was told by someone else that Beverley Raphael has looked at the list and has suggested some other people. I also contacted Cabinet and reiterated some key people whom I wanted on it. The Premier says that they are deciding the membership and they are contacting the expert people now, so I guess the composition will be announced shortly.

CHAIR: Who will run that trial?

Sr HARRIS: I do not know. We have asked for this committee to be set up under Premier's Department and Cabinet. I do not know.

CHAIR: So it will be the Premier's Department and Cabinet that will run the trial?

Sr HARRIS: I am hoping that that will be the case. It seems that we do have the Premier's support and that is a really good move. We may be able to do something about this intractable situation.

Personality disorder is also a huge issue. As I mentioned with the crisis teams, we cannot get help for people with personality disorder when they turn up in our crisis refuges. They are often the ones who cause the most difficulty because they also tend to take a cocktail of drugs, so it is another form of dual diagnosis but a more difficult one. In fact it is very hard to find out what they have taken. These people often become toxic and aggressive, abusive, violent and dangerous. They are the people who cause havoc in the psychiatric wards of hospitals throughout the State, the ones who are probably responsible for all the assaults of staff and other patients that have been reported. Something has to be done to help this group of people. The Health Department says in its 2000 guidelines that it is responsible for people with personality disorder. However, on the ground, this does not seem to happen, so there has to be a change there.

We perhaps need to keep in touch with what is happening throughout Australia and internationally in terms of the treatment of people with personality disorders, such as borderline personality disorder, and we need to look at what is happening in England in terms of the dual diagnosis of personality disorder and substance abuse. Tony Blair is getting very worried about this and is looking at, with the help of the national health scheme, changing the Mental Health Act to provide for some compulsory treatment of people of this kind with personality disorder who are dangerous and a threat to themselves or others. That is currently going through Parliament in Britain, it seems. Tony Blair was looking at setting up treatment rehabilitation units for this group of people. We need to follow what is going on there and find out if they are successful because we need to tackle this issue as well. This issue and the other kind of dual diagnosis, mental illness and substance abuse, is a major difficulty in the Aboriginal population also, so we need to look at that.

Rural issues are something that we need to look at where there are great problems. In general they are much more poorly served than the city, even though the city is not perfect in any way. There are something like three to four month waiting lists for psychiatrists and many major areas do not have resident or visiting psychiatrists. Once you have an appointment, it then can take three to four months to get another appointment. In the Hastings Valley, with a population of 87,000, the mental health staff cannot offer crisis service outside of Port Macquarie Base Hospital. They cannot offer continuing case management and no longer visit clients in homeless refuges. In Wagga Wagga, if you want a crisis team at the weekend your call is diverted to Melbourne.

CHAIR: Is that right?

Sr HARRIS: That happened to our volunteers, yes. There are no crisis teams available in most rural areas. In Mudgee, for instance, the St Vincent de Paul president was called out at midnight to look after a homeless mentally ill woman at the police station because they did not know who else to contact. The mental health team works Monday to Friday, 9 to 5 - or the one mental health nurse, I think it is.

CHAIR: Not on public holidays?

Sr HARRIS: No, and not at weekends and not in the evening. So there is nothing available in country areas and the country areas are often where you get itinerants, people who get on trains and go as far as a $3 ticket takes them: Lithgow, Nowra or Goulburn. They get off the train and wander around and go to the St Vincent de Paul refuges where often you have older volunteers who cannot deal appropriately with people who need specialised care and, as was mentioned before, often they have no identification, no idea of what kind of medication they are on. There does need to be some kind of database through the mental health system whereby you can print in a date of birth, a name, and find out what medication a person should be on, otherwise you spend a long time trying to determine that. Truckies drop people at Gundagai, that is another thing we found out, and these people then wander around trying to find some help somewhere. St Vincent de Paul and the Salvation Army, I guess, and other agencies are the ones who deal with itinerant mentally ill people who seem to have no links throughout the community and no resources.

We think there is a need for some kind of asylum, not the old psychiatric institution, but we need a longer stay in hospital or in some kind of therapeutic community outside of hospital, some kind of supported accommodation where people can get well enough. If you come out of hospital, you have got schizophrenia, you come out of hospital, you have just been stabilised and you go back to your flat, you are alone, there is no food, it is probably cold and dirty, your clothes have not been washed for weeks, no-one comes to see you, you just regress straight back into the cycle where you were.

CHAIR: And you are physically sick as well.

Sr HARRIS: Yes, that is right. So these people need to be given some stabilising so that they get their physical health back. I have had a situation for instance with someone who came out of the psychiatric unit into the house where I live with some people who have mental illness and she was incontinent. They had not noticed in two months in the Missenden unit that she was incontinent every night. I noticed the first night because I happened to find the bed clothes were wet. We got her to a GP, and the second treatment he tried, it worked, she stopped being incontinent. I did complain to the health system that surely they should have physical checks happening in their mental health units.

We need to be able to stabilise people physically as well as psychologically and we need to help them with their social and living skills so that they can then function and be integrated into society a bit.

CHAIR: What sort of length of time are you talking about?

Sr HARRIS: It is going to depend on people. It could mean a week in some kind of respite place; it could mean a month in a supported house where they get the help to get their living skills back together and get their health on track and get them to be able to resume their lives.

CHAIR: You say in your submission something up to two years is necessary.

Sr HARRIS: The American model I saw in Chicago where they had people who had been homeless and had a severe mental illness, either schizophrenia or bi-polar, and severe drug and alcohol use, they found that, yes, a residential treatment facility of up to two years, but then you were not just stopping the dual diagnosis. You were getting them to the point where they could start an autonomous life. They had their own room; they did cooking and cleaning; they helped with budgeting and shopping and cooking; they had to look after their own washing and clothes; they then went off into educational or vocational places and got a job before they left the facility; and then they have to be helped with housing and support. If you can do all that, you can break the cycle, but just treating them for six weeks and putting them out is not going to change anything.

One huge issue is the lack of psychosocial rehabilitation centres. We have got a few activity centres throughout the State which seem to be untargeted and unfocused and used by a few people, just to occupy their time basically. What we need is something like what we propose for the dual diagnosis. We actually need a committee of experts and people who find out what is happening throughout the world and get them to do some assessment of need, find out what the target groups are and then design specific, targeted, gradated facilities to meet the particular psychosocial needs of these people.

I was in Columbia, South Carolina, in 1995 and saw a very well integrated, gradated series of club houses that were set up by a very enlightened director of mental health there, starting with the young people who want vocational training, through to older people who need integrated social activities, right through to the elderly who need to be kept up with the newspapers and have gentle exercise. They had people bussed to these centres; they had meals provided; they checked that their laundry was okay; they were able to be helped in all areas of their life and that was a well serviced system. We have nothing like that here.

We have recommendations then and I will just go through them quickly because I am taking a bit long. New South Wales is the second lowest per capita spender on mental health in all States. We propose a two percent annual increase over the next five years, especially rural resources, staffing and training for GPs, health and community works; 24 hour crisis teams in all areas and more mental health team members; and psychiatrists. I do not know why it is so hard to get psychiatrists into the public system. Someone or some committee has to investigate why we cannot get and cannot keep psychiatrists in the public system. Marrickville, where I live, has not had a permanent full-time psychiatrist in the 12 years I have been in the area. It mainly works around six month rotations of the psychiatric registrar. There is no continuity of care. And that is in the city, so you can imagine what is happening in the country.

Our big recommendation is for an office of mental health separate to New South Wales Health, located as part of the Premier's Department and Cabinet. This is because mental health is different from mental illness. Mental illness requires medication. Mental health is integration back into the community as a fully functioning person. It is a holistic thing. We want experts from all Government departments and from non-Government agencies to be working together to plan a service delivery.

Why would we need this? For instance, homeless people are involving the SAAP services, which is DOCS. We need social support services that would involve health and NGOs. We need education and training which will involve a whole range. We need housing and support and that is going to involve those departments. And we need a program of psychosocial rehabilitation involving as many agencies as possible.

The Compeer Program that I found in America in 1995 and we set up here in 1996 has been going in the States for almost 30 years now. It is a program that Judith will now give a presentation on. It shows how we in the community can all help people with mental illness to be fully integrated into society by the provision of friendship. So Judith will go on and do that now.

CHAIR: There are other recommendations which are on page 20 of the report.

Sr HARRIS: Yes. I will come back and finish off the recommendations.

Ms BALL: As Myree said, Compeer is a special work of the society that was established in 1995 that addresses the social and emotional needs of adults with mental health problems by matching in one-to-one friendship relationships with volunteers from the community. Our volunteers spend an hour or two each week developing a relationship with their matched friend and just sharing ordinary social activities, like going for a coffee, going to the movies together, looking at the shops, and just developing a relationship is the key thing in the program.

Compeer, as Myree said, began about 30 years ago in New York, where in the early 70s many of the institutionalised psychiatric patients who were moved from hospitals to the community were not exactly thriving. They had the clinical support, but because of their poverty, low self-esteem, lack of social networks and because of the stigma and discrimination in the community, they were not really living as part of the community at all. They were physically in the community, but living very segregated and isolated lives and often because of that ended up back in hospital as a result. So something needed to be done to better meet people's whole of life needs, and so the Compeer Program was established and volunteers were recruited to provide companionship, build self-esteem and act as a bridge to community life.

The program was so simple and yet proved so successful, that it has been replicated all over the United States and around the world. There are now over 100 programs operating, including three in New South Wales, one in Sydney, one was established in Illawarra in 1999 and last year in Griffith. So we have three Compeer programs which all look at ways to support society.

The program in Sydney is one of the fastest growing Compeer programs worldwide. We currently have about 80 volunteers and fewer matches; those are 14. People who are referred to Compeer come from all sorts of backgrounds and have varying living situations and levels of functioning, but what they all have in common is that (1) they all have an identified mental health problem, (2) they have become socially isolated through their illness, and (3) they are receiving ongoing mental health treatment. It is important to emphasise that Compeer is an adjunct to therapy, not a replacement to clinical care. The referring health professional, the consumer and the volunteer are working together towards achieving the consumer's goals.

About 50 percent of the people referred to Compeer have schizophrenia. Others have bi-polar disorder, schizo-affective disorder, depression, anxiety or are recovering from an episode of psychosis. Currently, people referred to the program are in the age range from 19 to 90 but the majority are middle aged. Our volunteers are also diverse and come from various ethnic, religious and socio-economic backgrounds, and a significant number of our volunteers are themselves people who have come through mental health problems and are now well enough to be in a position to help others. Volunteers must complete a criminal history check at interviews, provide three referees and undergo a training course before being matched. So there is a very rigorous screening and training process. We also provide ongoing support for volunteers.

For someone who has been shunned and rejected most of their lives, to have someone simply take an interest in them and spend time with them out of choice, not because it is their job, can be enormously powerful. Just to give an example of that, we have a young woman in the program in her early 20s. She was living in the Eastern Suburbs and receiving mental health care from a psychiatrist. She had been on various medications. I understand she had also had ECT treatment. Nothing was working, and the reason why it was not working was that she was taking illegal drugs and had a chaotic lifestyle and a very bad family situation. Things just really were not working for her. It would be easy to see how that person might well have had a pretty short life because of her drug use, but she had the foresight to see that she needed to move away from the area where all her friends and families were drug users. She moved to another suburb of Sydney but, as you can imagine, living alone in a new suburb, with no friends, no family and no support, the likelihood of her succeeding was pretty low and luckily she was linked into the Compeer Program. She was hesitant to join. Her self-esteem was rock bottom. She could imagine nothing working for her. She had a schizo-affective disorder and an eating disorder. But a year later, she has been matched with her Compeer friend; she is now working part-time; she has been off drugs for well over a year and is doing very well and now has a circle of friends, a social life and, as I said, a part-time job. So for her Compeer has been a real link back into a successful life.

Results from Compeer's annual evaluation survey also demonstrate how effective the program is. For those for whom it was a goal, 92 percent of health professionals, volunteers and consumers reported an increase in the consumer's self-esteem as a result of participating in Compeer - 92 percent. 85 percent reported that they were more comfortable in social situations. Over 70 percent said the consumer was more independent in their living situation and 60 per cent said there was a reduction in hospitalisation. Over 50 percent said participation in the Compeer Program had helped them in achieving employment and training goals. Now, I think if a drug were responsible for such consistently positive results, it would be splashed all over the newspapers tomorrow, but there is no doubt that Compeer is very successfully achieving our aims of improving people's self-esteem and quality of life.

CHAIR: Very cheap too, much cheaper than drugs.

Ms BALL: Exactly.

CHAIR: It should be subsidised.

Sr HARRIS: That is a good idea.

Ms BALL: It is a really good point. At a cost of less than a thousand dollars a match, it is very cost-effective and easily pays for itself and reduces hospitalisation.

CHAIR: I presume you get lots of funding from the Government.

Ms BALL: No.

CHAIR: You do not?

Ms BALL: We have never received any recurrent funding from Government. We were able to get a $50,000 one-off grant from the Health Department two years ago, but other than that, the program has been entirely supported by the St Vincent de Paul Society and private donations.

The bad news, part two, is that we are nowhere near meeting the demand for the service. With only one and a half full-time equivalent staff and about 80 volunteers for the whole Sydney metropolitan area, we just cannot meet the demand. We are a tiny organisation spread incredibly thinly. Although the number of volunteers is increasing really quickly, the number of referrals we are receiving is increasing even more quickly. Last year, for example, we received 88 referrals and activated 29 new Compeer relationships, so it is only about a third of the people who are referred that we are actually able to help.

CHAIR: We might go back to Sister Harris at this stage because we are running out of time.

Ms BALL: Sure.

Sr HARRIS: I have very little to finish with really. As to our recommendations, with dual diagnosis something seems to be being done, which is great, so one of our recommendations has had positive action already. Greater resources for supported accommodation targeting homeless people with mental disorders is another recommendation. Currently the kind of high level support that you need to move out of the cycle of homelessness and mental illness is not there. Matthew Talbot has an outreach system. It has 60 beds in it and each person receives six hours' support per week. That is not enough for someone with serious mental illness. You need a lot more support to be able to develop your social skills and get yourself back into the community and live independently, so we need more. We need some funding for community education. The community does need to be better educated about mental illness, so that needs to be done fairly creatively. The Government needs to assist St Vincent de Paul in providing training and resource opportunities for members. We tried to do it through Compeer. We provide some good training for our volunteers and we offer that to the conferences, but we need to find more ways of doing it and to do it more assertively and we need some support in that. One of the ways that the Government is currently helping is by DOCS providing training for our volunteers in assisting in resettling homeless men. Now that is a positive move by a government department. We think that that kind of training for volunteers could be replicated by other government agencies.

In conclusion then, what I would like to say is that I think we need to have a positive approach. If we are just carping and critical and we condemn everything the Government is doing, they are just going to close down. There is sensory overload. You can only take so much of that, it all becomes too much and we become a lot of nuisances. I think the approach we have to take is, okay, there are great deficiencies, but we have some positive ideas because we are on the ground, we know the people. As with Compeer, we came up with something which is actively helping people in a way they have not been helped before. I think that the Government needs to be much more open to the ideas and projects and proposals of non-government agencies and also government departments need to work much more effectively together to pool resources and ideas and support each other. Rather than just criticising, let's come up with proposals and encourage Government to involve us as partners and to work effectively together.

CHAIR: Other serious, chronic, relapsing conditions, like diabetes, have that whole of government approach to the care of people with access to hospital at the drop of a hat and so on.

Sr HARRIS: That is right.

CHAIR: If that was replicated in mental health there really would not be a problem, would there?

Sr HARRIS: No, that is right.

CHAIR: And the dialysis and so on which goes with diabetes is very expensive. Mr Rogers, you were going to make a final point?

Mr ROGERS: Yes. It is quite clear that much remains to be done irrespective of the development of a national health plan and other attempts to better coordinate and provide services to those people who suffer mental illness.

Since the Human Rights and Equal Opportunity Commission under the direction of Brian Burdekin we could ask the question: What really has been done to significantly improve the lives of those identified by that inquiry as having special needs? These people are the homeless, the elderly, women, people with dual diagnosis, Aboriginal and Torres Strait Islander people and prisoners, amongst others. The answer to that question, the society believes, is precious little.

Whilst the society is not an organisation that actually specialises in the care of people with a mental disorder, we have had to become specialists by default. Our members are fortunate to offer real assistance to many who would otherwise be totally isolated, but we could do a lot more.

In the report we made a number of pledges and I would like to read them. The society pledges to provide all members with training in mental health issues on a regular basis. We are currently doing that through the Compeer program and other initiatives. The second initiative pledges to provide all members with a local resource booklet listing organisations to call for assistance. That is in the process of being developed. Thirdly, encourage the development at local level of programs such as Compeer, Manressa House and Sutherland which I spoke about, and that is continuing. The final two pledges: Investigate the establishment of a network of respite services, which we are currently doing through our advisory committee, and continue advocating for people with a mental disorder and their careers. That is ongoing through CASA, the coalition for appropriate support accommodation for people with disabilities.

That concludes our presentation.

CHAIR: Could I ask a question following on the letter from the Premier to you: Are you comfortable with the Government having carriage and control of this proposed series regarding dual diagnosis?

Sr HARRIS: Well, the people I have suggested as being members of that committee are experts in their fields. We have an expert in mental health and in dual diagnosis and, for instance, John Hoskin, who is a former president of the Country Psychiatrists' Association, was recommended as a member, and Professor Ian Webster who is a specialist in drug and alcohol and public health. We did also suggest Professor Helen Hermann who is currently in Manila working in the World Health Organisation. She has expressed interest. Rob Fitzgerald has expressed interest. We suggested those two as co-chairs. I do not know what the Government is doing about that. I have been told that I am on the committee and, since it was my idea along with Colin Robinson, I certainly will be pretty vocal and active.

CHAIR: Have you any idea of the time line for this?

Sr HARRIS: Well, we asked for a twelve month period for the committee to work and then to have a facility built and trialled.

CHAIR: You are talking about two trials here, two different trials?

Sr HARRIS: Yes. I think we are more likely to get the first one, mental illness and substance abuse, going first. I think we need to keep track of what is happening in Britain for the personality disorder and substance abuse one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have there been any trials comparing people to drugs? With PBS costs blowing out and this problem not being solved, and also the delivery of mental health services being a problem so that, even if you put someone on a drug, you then have to have someone I guess chasing around homeless haunts to find them to give them the drug, so in effect they are not really on the drug anyway because they are not having it delivered, have there been any trials which do that comparison? It seems to me that if, as you said, a drug did this, it would be headlines, cleverly marketed, there would be a huge amount of well-organised pressure put on the PBS and the tax payer would come up with the money, no sweat, but in this case where the system is unable to either lobby for that money to be redirected and prepare the treatments, because of course all the research is done by drug company protocols and so on and the community sector does not have those protocols, has there been an attempt to get this sort of comparative research, comparing those on Valium with Compeer, comparing costs, producing a paper and saying: We apply to the PBS that this should go off the PBS and we should go on?

Ms BALL: There have been those kinds of studies comparing therapeutic intervention, talking cures, with Prozac, for example, with not very conclusive results. I do not think a clear result has come through on that, the jury is still out, but I think the other thing to note is that Compeer is not a replacement for clinical treatment. They go hand in hand.

CHAIR: The thrust of your submission today has been that you need both the clinical side and support, the socialisation, employment, security, good health and so on.

Sr HARRIS: Yes. Also I think we do injustice to people with mental illness. We do have to ensure that they have access to the best drugs available for their condition and that is not always the case. There are people in country areas and in boarding houses, for instance, under GPs who will not trial new medications, who are still on old drugs with terrible side-effects - and on huge dosages of them - so people are not getting the care that they need.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The simple model is the drug versus the person, but if you then said, well, what is the risk weighted natural history of this disease? Where do they end up? They end up in gaol at $60,000 a year, or so many percent, and so many percent end up dead or whatever. The cost of that versus the cost of the program would allow you to put submissions. I mean it seems to me that dollars are the only thing--

CHAIR: That actually has been done in Chicago. It is in the submission. It says that it pays for itself in workers' compensation claims alone.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, I have gone through the submission, but it has not happened in Australia.

The Hon. AMANDA FAZIO: Sister Harris, you mentioned that the types of clients that your workers in St Vincent de Paul centres are having contact with range from 19 to 90.

Sr HARRIS: This is the Compeer program, yes.

The Hon. AMANDA FAZIO: I think you said that you have people who have had some terrible life experiences who come into your centres, including people who may have been prisoners of war, and I presume that you are getting people who have come to Australia on refugee programs who have been through some pretty horrific things in their home countries.

Sr HARRIS: Yes.

The Hon. AMANDA FAZIO: Have you noticed any other major trends in the sort of people who come into your centres for assistance who have mental health problems?

Sr HARRIS: Taking, say, Matthew Talbot, the big homeless refuges particularly and Vincentian Village, drop-in centres and things, the great change is in the age of the clients coming in. They are much younger, so we are getting younger people, particularly men, who often have very heavy drug use and have mental illness, so that is the greatest change. They are young, energetic, often aggressive, volatile and on a cocktail of drugs, and that makes it very difficult.

The Hon. AMANDA FAZIO: Is one form of mental health problem more predominant these days than others with some of the new people coming in?

Sr HARRIS: It is mainly schizophrenia, schizophrenia with bi-polar, and then drug use. Often you can get schizophrenia precipitated by drug use, say marijuana, that is one of the linkages, but they would not all be. We have not counted the number of those. That is the difference. That clientele contrasts greatly with the remaining older people with alcohol problems and they tend to be much more vulnerable then to the younger group, who are much more aggressive and tend to roll them for their money.

CHAIR: Are you aware of the level, as a percentage, of funding for mental health in New South Wales and for NGO support within that budget compared to other jurisdictions in Australia?

Sr HARRIS: We have some figures. This actually comes from the submission I think the Mental Health Co-ordinating Council is putting in. It says that New South Wales has a 1.3 percentage of total mental health expenditure spent on mental health by NGOs. 1.3 percent is the lowest of all States in Australia, and it has 1.6 per capita expenditure. It is a good deal below the national average of five.

CHAIR: Five?

Sr HARRIS: Five, yes.

CHAIR: How many dollars is that per head of population?

Sr HARRIS: I don't know, I am sorry. I haven't worked it out.

CHAIR: And then the level of community participation in the integration of mental health services?

Sr HARRIS: On paper it is fine. The documents say that they encourage partnerships and encourage NGOs to be part of it, but it tends to happen in a rather ad hoc way. That is my experience anyway. Beverley Raphael has rung me up recently and invited me to meet with her to talk about two projects that we will be working on together. I presume one is the dual diagnosis. I do not know what the other one is. I did write to the Federal Government about a proposal for what I call mental health community care packages. The reason people who are mentally ill cannot survive in their houses or flats or whatever is because they have not got the living skills, they cannot budget, they cannot shop and cook and pay their bills.

CHAIR: Like a disability care package?

Sr HARRIS: Yes. The aged care packages are available if your aged related disability is your predominant diagnosis, but if your primary diagnosis is mental illness, you are not eligible for those. So the aged care teams are being called in to assess all these people and have to keep refusing them. I talk to them a lot and they suggested that we come up with something different and I called it a mental health community care package. So I wrote to Kay Patterson suggesting it. She said she would have to do it in conjunction with the States. I presume she has written to Beverley Raphael. I hope they do it, because that could help people with mental illness to stay in their houses. You could procure the services for cooking and cleaning, like you do for aged people.

CHAIR: When the intellectually incapacitated were turfed out under the Richmond arrangements - there was a parliamentary inquiry in New South Wales recently on that - the State Government gave them a life-long guarantee of care.

Sr HARRIS: Really.

CHAIR: I do not know whether that exists for people with mental illness.

Sr HARRIS: I very much doubt it.

CHAIR: But there was a life-long guarantee of care by the State Government for the intellectually incapacitated that came from Peat Island and so on.

Sr HARRIS: I have not heard of anything similar for people with mental illness. In fact, they are often completely stranded. They do not have access to facilities run for people with intellectual disability for instance.

CHAIR: The other questions, which come from research being done by the Committee which I showed you before, you would not like to comment on quality control?

Sr HARRIS: I do not know anything about that.

CHAIR: Or the staffing levels, et cetera?

Sr HARRIS: I can talk about staffing levels. I think they are completely inadequate. Mental health teams certainly need more staffing crisis teams. We had a report that a Compeer client had to be hospitalised at Liverpool Base Hospital and her parents wrote the most horrendous statement of her experiences there. Now, the client/carer ratio in the locked ward was four clients per staff member. That is in a locked ward with dangerous people, dangerous in the sense that they are at risk of harming themselves or others.

CHAIR: Do any of the staff - and the Minister has not let the staff give submissions to the inquiry.

Sr HARRIS: Of course not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We don't see it that way.

Sr HARRIS: I know we don't, but you can understand, obviously there is information being withheld. It is only coming from those of us who have access to the system and can try and get some stories passed on or get information passed on. You would wonder what they are hiding that they will not allow the staff to testify. But I have heard that, yes, they have to go through the heads of department.

CHAIR: Do any of the staff come to you for help or for peer support if you like in terms of their own anxieties?

Sr HARRIS: Yes, they do and I have had conversations with people at fairly high levels too.

CHAIR: What sort of concerns do they express to you as community health workers?

Sr HARRIS: They express concern about, for instance, the kind of situation going on in the psychiatric units, where you have a huge mix of people, a very diverse mix. You have everything from young aggressive men who have personality disorder, substance abuse syndrome, who have become completely toxic. They cannot treat them except with extreme care because they can die if they give them the wrong drug. They don't know what they have been on. They are aggressive, violent and predatory. You have got them in a locked ward, often with young girls who have eating disorders or the first episode of psychosis and with elderly people with the first experiences of dementia, and these people are totally vulnerable to young, aggressive, predatory males. This has been an explosive situation throughout the State. It is still going on. This particular group, the personality disorder group, the substance abuse, are very hard to treat. They need long term treatment to stabilise. They need to be in their own facility. There should be somewhere in the State, or a few places, where people like that should be able to be treated. They should never be in a locked ward or any kind of fixed ward with other vulnerable people. I have had people talk to me in great distress about that.

CHAIR: There has been a proposal, which I think is a glimmer of hope, for bail hostels for people who are homeless. Have St Vincent de Paul been asked to tender for those sort of things?

Sr HARRIS: What are they?

CHAIR: Bail hostels, where the magistrate can bail you to a bail hostel if you have got no fixed abode and so on.

Sr HARRIS: It seems a good idea. I have not heard about it.

Mr ROGERS: We haven't heard anything in relation to that.

The Hon. PETER BREEN: It is being contemplated under the amendments to the Bail Act.

CHAIR: Yes, it is contemplated in the Bail Act. I am just wondering whether or not the department has gone out to tender or to expressions of interest of any sort.

Sr HARRIS: We haven't heard of any. We are meeting with the Department of Corrective Services on Monday to deal with their mental health branch to work on the issue of dual diagnosis.

CHAIR: We are meeting with them too.

Sr HARRIS: They are particularly interested in our submission. The Attorney-General's Department and the Department of Corrective Services are interested in looking at that. If you have such a facility, a treatment rehabilitation facility, it could be an alternative to gaol sentences.

The Hon. PETER BREEN: Are you referring to your submission?

Sr HARRIS: Our submission on dual diagnosis, yes, that one.

The Hon. AMANDA FAZIO: You mentioned about the toxic young males being putting into locked wards at hospitals. It has been put to me a while ago by somebody in the community that they felt it would be better to have gender segregated mental health facilities attached to the hospitals. Would you support that?

Sr HARRIS: I think I would, yes.

CHAIR: There is a submission number 259, which I have not read entirely, about women in mental health, which says there is a higher percentage of women in prison with mental illness than men in prison, but there are particularly women's issues which are specific and there is specific housing for mentally ill women, so there is certainly some logic to that.

The Hon. AMANDA FAZIO: It was more the case that the women patients tend to be more vulnerable.

Sr HARRIS: Yes, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I wonder what your opinion would be of the decriminalisation of drugs with a taxation placed on drugs that we were desiring to discourage and that money being used to fund treatment facilities. In other words, a change - as these are currently being supplied at relatively high cost and illegally, the profit is currently being used by criminal elements, and of course the criminal problems associated with the behaviours are significant and costly. If it is assumed that the drugs cannot be banned, then they would go into that sort of framework. What would your response be, for example with regard to the personality disorders in drug using males, which does seem to be in greatly increasing numbers?

Sr HARRIS: You mean to the decriminalisation?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Sr HARRIS: I have followed with interest the reports of heroin trials, for instance, in various countries where heroin is provided on prescription to people who are actually certified as addicts, and my totally personal response is I think it is a very good idea and should definitely be tried.

The Hon. PETER BREEN: Which countries are you referring to?

Sr HARRIS: Switzerland and a number of the European countries. We saw recently some four or five countries.

CHAIR: Some small trials were done in Switzerland, but they are not necessarily ongoing.

Sr HARRIS: No, but I think we need to follow what is going on to see what is happening, because at the moment the money is just going into the criminal underworld.

CHAIR: Is it personality disorders in drug abusing males or is it drug abusing males who have a personality disorder?

Sr HARRIS: I don't know which comes first.

CHAIR: Which comes first, the chicken or the egg, or is it both?

Sr HARRIS: It could be both I would say. In the case of Burdekin and probably before that, Burdekin talked about safe self-medication, that people with mental illness, and I presume personality disorder, often use drugs to start with as a self-medication to stop the symptoms, in the case of schizophrenia to stop the voices. That is why they smoke tobacco. It has been found that nicotine bonds with some of the receptor sites and gives them a clearer head. It could well be that that is how it starts, but then it spirals out of control and becomes an addiction. But with the personality disorder there are cocktails. They are on so many different things, they are using everything, amphetamines, speed, marijuana, heroin, and they just all interact.

CHAIR: It is just that some forensic patients have identified being perfectly normal, having their first joint and then having a schizophrenic type reaction.

Sr HARRIS: Yes, I know people who have had that.

CHAIR: So there is both, there are people who are normal who take the drugs and then develop a disorder, or people with a disorder who then use drugs which complicates the whole or exacerbates it.

Sr HARRIS: That is right, yes.

The Hon. AMANDA FAZIO: Just so that your last comments are not taken out of context, do you find this the case - that the use of marijuana by people who suffer from schizophrenia, they were going to become schizophrenic anyway, but it just brings it on as an earlier onset?

Sr HARRIS: The research at the moment seems to be saying that there is a predisposition to schizophrenia in a certain percentage of the population. There does seem to be an hereditary component and maybe various triggers in the environment set it off. It may never have developed or it may have been triggered by something else later.

CHAIR: Certainly, I have seen reports where people have taken marijuana, had this terrible reaction and never taken it again and never developed schizophrenia. So it is sort of a bit of both.

Sr HARRIS: Yes. LSD too. I know a man at the moment who had it triggered by LSD.

CHAIR: If there is anything that later you think you should have said when you get the Hansard, because you will get this for your own correction before we make it public, if there is anything you think you really need to say and did not -

Sr HARRIS: Okay. We have included the reports from CASA and Gesthemane, the boarding house situation.

CHAIR: We are going back to that on Wednesday next week. I wonder if you are available to come and sit in on that because there might be something that you might be able to add to it.

Sr HARRIS: Would I be able to contribute if I came in?

CHAIR: I would think so. We will check that.

Sr HARRIS: Just very quickly though, although the boarding house reform process has been very successful, it needs further funding to be completed. I just would like to put on record that there are still some boarding houses in the State where people are at risk.

CHAIR: There needs to be legislation.

Sr HARRIS: Yes, there needs to be a change in legislation to ensure that these places can be adequately monitored and the safety and care of residents ensured. That is not the case at the moment. I would like to make that very clear.

CHAIR: Were you consulted on the pre-Olympics proposed legislation on homelessness and the regulation of boarding houses?

Sr HARRIS: No, not the pre-Olympics one.

CHAIR: That was legislation drafted before the Olympics which did not see the light of day eventually, but you were not?

Sr HARRIS: No.

(The witnesses withdrew)

(Short adjournment)

RUPERT ELLIOTT, Medical Practitioner, St John of God Hospital, 177 Grose Vale Road, North Richmond;

PIETER JOZUA ROSSOUW, Program Consultant, Senior Clinical Psychologist, St John of God Hospital, Grantham Street, Burwood, and

MICHELLE JOY THOMPSON, Chief Executive Officer, St John of God Health Services, Grantham Street, Burwood, sworn and examined, and

ROBERT THEODORE BROOKS, Research Psychologist, St John of God Health Services, 177 Grose Vale Road, North Richmond, affirmed and examined:

CHAIR: Dr Elliott, in what capacity are you appearing before the Committee?

Dr ELLIOTT: I am appearing as a staff specialist psychiatrist who has experience working in both the State sector and the private sector and previous experience in general practice.

CHAIR: Are you conversant with the terms of reference of this inquiry?

Dr ELLIOTT: I have read the submission which we prepared, which I assume is based on the terms of reference.

CHAIR: Dr Brooks, are you conversant with the terms of reference of this inquiry?

Dr BROOKS: I am.

CHAIR: You have made a submission. Do you wish to include it as part of your sworn evidence?

Dr BROOKS: I do.

CHAIR: Dr Rossouw, are you conversant with the terms of reference of this inquiry?

Dr ROSSOUW: Yes, I am.

CHAIR: Ms Thompson, are you conversant with the terms of reference?

Ms THOMPSON: Yes, I am.

CHAIR: If you should consider at any stage during your evidence that, in the public interest, certain evidence or documents you may wish to present should be seen only by the Committee, the Committee would be willing to accede to your request, but be aware that the Legislative Council may overturn the Committee's decision and make the evidence public. What that means is that the Parliament could vote, but I do not think that has happened. Your wish is now to go in camera for your evidence?

Ms THOMPSON: Yes.

(Evidence continued in camera)

(Conclusion of evidence in camera)

(Public hearing resumed)

(The witnesses withdrew)

(Luncheon adjournment)

PETER GEORGE GATES, Business Consultant, 37 Brighton Street, Petersham, New South Wales Consumer Advisory Group, and

DOUGLAS JOHN HOLMES, Executive Officer, New South Wales Consumer Advisory Group, PO Box 1108, Rozelle, affirmed and examined:

CHAIR: Mr Gates, you are conversant with the terms of reference?

Mr GATES: Yes.

CHAIR: Will the submission that the advisory group has made be taken as part of your sworn evidence?

Mr GATES: Yes.

CHAIR: Mr Holmes, you are conversant with the terms of reference?

Mr HOLMES: Yes, I have read them.

CHAIR: The submission is going to be taken as part of your evidence.

Mr HOLMES: That is right.

CHAIR: If either of you should consider at any stage during your evidence that, in the public interest, certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request, but you should be aware that the Legislative Council, voting as a whole, can overturn the Committee's decision and make such evidence public.

Would you like to make any comments before we begin with questions?

Mr HOLMES: I have actually written something down.

CHAIR: Would that be additional to your submission?

Mr HOLMES: Yes.

CHAIR: Would you like to table that?

Mr HOLMES: Yes. This is the opening statement from the New South Wales Consumer Advisory Group. My name is Douglas Holmes. I am the executive officer with the New South Wales Consumer Advisory Group, Mental Health. My colleague, Peter Gates, is the consultant who helped New South Wales Consumer Advisory Group develop the submission for the Legislative Council Select Committee on Mental Health which was titled "A Time for Action".

New South Wales Consumer Advisory Group is an established group of mental health consumers and carers. We work in partnership with all organisations who have an interest in mental health services reform and policy development. CAG was first formed in 1994 as a mechanism for New South Wales to independently report on the implementation of the national mental health strategy and, in particular, the first National Mental Health Plan 1993-98. This was extended in 1998 to include feedback on the second National Mental Health Plan. New South Wales Consumer Advisory Group has a funding agreement with New South Wales Department of Health for administration purposes and is an incorporated association registered with the Department of Fair Trading.

The information presented in the submission was obtained from various sources, including a conference that CAG organised last November called Forging our Futures where we had over 200 consumers and carers attend. We actually held a forum during March this year to address the terms of reference and we had a Statewide phone-in that was widely advertised through our extensive networks and consultation by Mr Gates with our current and some past members.

In our submission CAG has identified many issues concerning consumers and carers across New South Wales and it includes 23 recommendations which were not prioritised by the main group. Of particular importance to us are recommendations 3, 10, 19 and 20. Recommendation 3: Consumers are the experts on issues affecting consumers. Recommendation 10: Quarantine budgets for mental health services. Recommendation 19 was about compliance with national standards. Recommendation 20 was that obligations and responsibilities be added to the national practice standards.

I brought several publications of the consumer advisory group along for members of the Committee, including our annual report, a contact card, information about Network New South Wales and a copy of the national standards book, one of the projects that we are actually currently developing.

CHAIR: Are you happy to table those?

Mr HOLMES: Yes.

CHAIR: Mr Gates, would you like to make any comments?

Mr GATES: No, my role here is as an adviser.

CHAIR: I must say that I am impressed that you went to that level of consultation and I must admit I did enjoy reading your submission. You are really addressing (a), (b) and (g), so would you like to make any comments further to what you have in this document or lead us through (a) and (b)?

Mr HOLMES: This is the first time that I have actually appeared at something like this and I am just a little unsure.

CHAIR: Well, although we have the written document in front of us, since you prepared it, it would be better if you could highlight those points that you would really like us to take notice of. You have done a very inclusive and very full submission, but there are obviously some bits that you would like us to particularly take note of, so if you would just highlight the bits you want to talk about because we have some time, and don't feel uncomfortable because we have not done this inquiry before either.

Mr HOLMES: Right. I would like to draw your attention to recommendation 1, which is about finding the balance. There are often problems between the medical and recovery model and what we are asking for is that some funds be made available to evaluate and do some research on the different sorts that are available in New South Wales.

CHAIR: So there is the medical recovery model and then, of course, the rehabilitation stuff that follows that, so you are talking about what we would otherwise call acute services?

Mr HOLMES: That is right, it is reliance mainly on the medication.

CHAIR: So that acute services really is the protective part of locking people up if you like or protecting them from harm by observation and whatever, but then there is the other bit that almost always goes with that, which is the use of psychotropic drugs or some form of medication?

Mr HOLMES: That is right.

CHAIR: And you would like to see more research about the effectiveness of the different forms of therapy in that regard?

Mr HOLMES: Yes.

CHAIR: Isn't that undertaken by the department? Don't they practice evidence based medicine in the department? Wouldn't the therapies and the way in which they go about things be evidence based or not?

Mr HOLMES: Yes, but what I think I am saying there is that there is a heavy reliance on the medical model, the imbalance of power with the doctors having a fair bit of say in the direction that this stuff goes.

CHAIR: In spite of the Mental Health Act, which gives them that power, you think that power should be to look at whether they should talk somebody through or let's hit them with the drugs, in other words psychotherapy versus the drugs, is that what you are saying? We have had other evidence like that, that's all.

Mr GATES: I think what the Consumer Advisory Group is saying that whilst the medical management of people with mental illness is important, there needs to be more emphasis on the community based care and the things that are not considered medical, employment, those sorts of things. So it is getting the recovery, if I can use -

CHAIR: 80 percent of the money is spent on hospitals, only 20 percent of the money spent on community care; let's get a balance and let's see what works better for the consumer?

Mr GATES: Yes, that is right.

CHAIR: And the carers of course?

Mr GATES: Yes.

CHAIR: That is reference number 1. Do you think that in spite of the Richmond report, which de-institutionalised, we have still got too much reliance on spending the money on the acute, lock them up, give them medical treatment, rather than what happens later? In other words, that there should be a better balance between the two?

Mr GATES: I think the issue for us is that because of the medical nature of the problem, that there is not that wider use of non-medical interventions, and that it is currently being addressed in policing issues and in other issues, and if we did more on the recovery side of it, we would actually need to spend lesson on the policing, et cetera.

CHAIR: Yes, I understand that. So as Dr Chesterfield-Evans pointed earlier, the bulk of the funding for mental health goes into these acute intervention, in hospital services, but very little is spent on the downhill side, keeping people well or helping them to make a full recovery after they are discharged from hospital?

Mr HOLMES: That is how it appears to us, yes.

CHAIR: That is really A; in spite of what Richmond has done in terms of de-institutionalisation, do you want to say anything more about reference A, the changes that have taken place since Richmond?

Mr HOLMES: Just from a personal observation, there has been a split between intellectual and mental health.

CHAIR: That was the result of the Richmond report; there was absolutely.

Mr HOLMES: Yes.

CHAIR: But there are still some people who are intellectually disabled who have got mental illness.

Mr HOLMES: That is right.

CHAIR: Otherwise called dual diagnosis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: About a third, I gather. Would you agree with that rough figure? It might even be 36 percent of the disabled are dual diagnosed, the intellectually disabled if you like?

Mr HOLMES: I am not sure of what the statistics are.

CHAIR: Certainly, the people who as a result of Richmond went into the community who were intellectually incapacitated or had that disability label rather than the mental health label, they got a life time guarantee of service from Government for their treatment in the community, whereas the mental health people of course did not. The disabled part seems to be reasonably well catered for, does it not?

Mr HOLMES: Well, the intellectual disabilities, but psychiatric disabilities are not.

CHAIR: No, the intellectual disabilities I am talking about.

Mr HOLMES: It does, yes.

CHAIR: They can get those care packages from the Commonwealth and a whole lot of things, but mental health is not covered in the same way.

Mr HOLMES: No, not from the psychiatric disability part of it.

CHAIR: Under the Richmond report, the intellectual part was looked after reasonably well and has over time gone along reasonably well for those people, but for the psychiatrically disabled that is not so. Do you want to say anything more about that?

Mr HOLMES: No.

CHAIR: What about B, "Impact of changes"? That covers your 4.2 and the accommodation point, doesn't it?

Mr HOLMES: Yes.

CHAIR: Would you like to tell us more about that?

Mr HOLMES: I am having a little bit of a mind blank at the moment.

CHAIR: That is all right. This is the impact of when they were de-institutionalised. A whole lot of things flowed from that; they had to have accommodation; they had to have ongoing treatment; they had to have their money looked after and a whole lot of things; and the view is that those things were not adequately catered for.

Mr HOLMES: Yes, I would agree with that. That comes across from a lot of people that we talk to.

CHAIR: You also raise in this issue of 4.2 that there is not access to the appropriate length of stay and acute facilities when they need it, they are more or less being discharged earlier.

Mr HOLMES: I think one of the problems with that is that one of the outcomes of the Department of Health gives is length of stay, how many days people actually stay in hospital for. Given that some of the medication may take ten or twelve days to actually kick in, and it takes a few days for someone who is acutely unwell to actually settle down and start responding to the medication, if they are using 12 days average, you have got to start wondering.

CHAIR: And even when they are no longer mentally ill, they are certainly not well, are they?

Mr HOLMES: No.

CHAIR: From a physical point of view?

Mr HOLMES: For some of us it actually takes a long time to get over it, yes.

CHAIR: So that that access to acute beds and an appropriate length of stay is a concern?

Mr HOLMES: Yes, it is.

CHAIR: And then the step back into the community, is there an issue there? In other words, when you come out of an acute facility, is there an issue about the continuing support?

Mr HOLMES: Having just spent two years working in the Greater Murray down in the rural remote areas there, one of the big problems we have is the way services are actually managed and the funds are actually - they use what words like "purchaser provider models". If you happen to be a consumer that lives in Griffith and is scheduled 200 kilometres down to Wagga and arrive at eight o'clock at night, and when you walk into accident and emergency, they deem you maybe five or six hours later not to be mentally unwell to actually get admitted into the acute unit, you can be -

CHAIR: Go home?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Go home at two o'clock in the morning?

Mr HOLMES: Two o'clock in the morning. I spent quite a lot of time trying to get the units to talk to each other. That was just a personal experience. I really do not know how you come overcome those sort of things, because you have got 17 health areas in New South Wales and there is nobody that you can go to ask where does all the money go to. If you really want to fix the problem, you need to have someone who is actually responsible for the budget.

CHAIR: Before Richmond, the mental health money was a separate budget completely and over time the budget for mental health has been split amongst the regions, not necessarily in a fair way, but in an historical base funded way, and it is very hard to see where that money - the Minister's nearly $105 million, we have had a number of submissions which wonder where the $105 million extra has gone but nobody has got any extra staff. That is an issue of accountability.

Mr HOLMES: For some people.

CHAIR: You are saying much the same thing, the accountability and the open way of working out where those mental health dollars actually go because they are not accounted separately any more.

Mr HOLMES: One of the other things, just while you are on that, I find difficult is that you have got someone like Professor Raphael assisting the Centre for Mental Health that is in some way responsible for the 4,700 mental health staff across New South Wales, but under the model that they work with in Greater Murray that I am very familiar with, she has no way of actually having any say of the way that the staff work. That came out of the policy. So it gets back to you really do not -

CHAIR: There is nobody responsible?

Mr HOLMES: You could generally say that, yes.

CHAIR: At head office Professor Raphael dictates policy and guidelines. The Area Health Services actually spend the money.

Mr HOLMES: In the majority of cases they do, yes. One of the things that has changed though is that some of the money that has been flowing through from the Commonwealth the Centre for Mental Health does have some sort of control over and they are actually writing into the area directors service agreements to actually do perform certain duties.

CHAIR: That is because their area directors have to actually respond to the Commonwealth on how the money is spent. Do you think that sort of tied arrangement is better?

Mr HOLMES: From the projects that I have seen that come under that funding, it seems to be more responsive and people are actually achieving more, especially within the health promotion area.

CHAIR: Are there any other impacts? In this one you have got the forensic alternative. That is one of the impacts, is it not, that there are more people ending up in front of the courts?

Mr HOLMES: Yes, and one of the things we are concerned about is that New South Wales does have a forensic hospital inside a gaol. It reinforces the stigma associated with having a mental illness, and I don't whether you have had the privilege of visiting there, but the conditions are not the best.

CHAIR: We are going to visit there, and I do take your point, as other submissions have argued, that once somebody is declared to be mentally ill, they should be in a mentally ill facility, not in a prison.

Mr HOLMES: That is right, yes.

CHAIR: And that is the argument you put here. In, say, Greater Murray, what would happen if somebody who was mentally ill commits a crime?

Mr HOLMES: Within a very short space of time they are admitted to Long Bay.

CHAIR: And when do they go back to Wagga?

Mr HOLMES: I don't know exactly how long it takes, but for some people it is years. It is a very slow process.

CHAIR: Is there any court diversion process at Wagga that you are aware of through your other associations, where somebody who is mentally ill gets diverted by the magistrate or the judiciary into mental health, rather than dealing with the so-called crime?

Mr HOLMES: That is one of the things we have been pushing for for some time, to actually have people with mental health assessment skills sit in on some of the cases, and I believe that there have been a number of trials started in the last few months. That has come out of quite a lot of talking and collective wisdom. Oftentimes, if a court became aware that someone did have a mental health problem, they would actually contact the service to come along and do assessments.

CHAIR: We have a submission which we are dealing with on Thursday of next week from forensic psychiatrists and there are a number of set-ups now in New South Wales that do precisely that.

Mr HOLMES: Yes, but it depends on how well a person knows their rights and whether they can actually speak up and ask for these things. It is not consistent and it is not common knowledge. That is part of the problem, the inconsistency with the way things are done.

CHAIR: I want to ask you some questions about carers having more say in the process when somebody for whom they are caring becomes ill.

The Hon. PETER BREEN: Do you have any direct experience of the Long Bay Correctional Centre with regard to people who are involved in crime and who appear to have some mental disability?

Mr HOLMES: No, I have not had the privilege of actually going into Long Bay, but several years ago I spent two and a half years running a group at Cessnock. I was living at Singleton at the time.

The Hon. PETER BREEN: Can you tell us what happened to people that went to gaol and who appeared to have a mental disability? I mean were they put in solitary confinement, for example; were they put in restraints of any sort?

Mr HOLMES: Well, I did not actually witness any of that.

The Hon. PETER BREEN: Did you hear about anything like that?

Mr HOLMES: Not in the time I was going there, no, I did not hear that.

The Hon. PETER BREEN: You mention in your submission at 4.4 on page 25 that the current practice at Long Bay with regard to people who have been found not guilty of crimes is that they are treated in a certain way which you say is contrary to the universal declaration of human rights. I am just curious about that. I would have thought that people who were found not guilty of crimes because of mental condition or insanity would be taken away to an appropriate mental institution and not kept in gaol. I am just wondering if you have any other experience?

Mr HOLMES: I have heard plenty of second-hand comments, but I have not actually witnessed it. I have had people relate stories to me of what you are saying. My understanding of Long Bay Gaol is that the prison is actually inside the gaol.

The Hon. PETER BREEN: The point I wanted to make, though, was that if a person is found not guilty they would not stay there, would they? If they are found not guilty of the crime on the basis of a mental condition, would they not be taken away to a mental institution outside the gaol?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I don't think so.

CHAIR: That is exactly what should happen and that is one of the issues that we will deal with probably more on Thursday, but there are certainly a large number of issues particularly concerned with this issue of the declaration of human rights.

The Hon. PETER BREEN: Yes, so you have no direct experience of the facility at Long Bay gaol?

Mr HOLMES: No, but what I have had experience with is when I was in the Hunter I actually used to go down to Morisset twice a week and run groups there and they spent quite a lot of money building a unit up there, about $38 million, and they had a number of cottages, six of them, where they actually had 50 people who were going to be there for life, never to be released, and then there were another 25 people, I think, and occasionally what would happen is that they would become unwell for a variety of reasons and go back into the maximum security unit, and that was very gaol-like.

CHAIR: The Committee is going to visit Long Bay and also go to Victoria or Queensland to see the difference - we have not decided whether it will be Victoria or Queensland - because it is a completely different way that they are dealt with.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I suggest Geelong.

Mr HOLMES: Just in relation to that, one of the things we actually did fight for and win against Hunter Health was exemptions for non-smoking in those cottages. This was going back to about 1996. They were actually trying to enforce the no smoking policy and we took that on as an issue and actually got exemptions.

The Hon. AMANDA FAZIO: Arthur is upset now.

Mr HOLMES: Well, you may very well be, but the reality is that we are talking about people with an illness--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: After 25 years, why would you stop now?

Mr HOLMES: Yes.

CHAIR: So you are arguing that mental health and related legislation must ensure that a person accused or convicted of criminal offences and in need of psychiatric treatment should be treated, but the alternative that Peter is putting to you is that, if they are not guilty by reason of mental illness, in other words they are not guilty because they are mentally ill, they should be treated in an appropriate environment, not a prison.

Mr HOLMES: Yes.

The Hon. PETER BREEN: They should be taken to a hospital or some other institution.

Mr HOLMES: That is right.

CHAIR: That hospital may look like a prison, but it is not under the control of Corrections Health, it is under the control of New South Wales Health.

Mr HOLMES: That is right. If you want to get right to the nitty-gritty, the reality is when you are in gaol - and that is where these people are - a lot of times the gaolers are the guys that are actually the nurses.

CHAIR: That is right.

Mr HOLMES: And they operate under a different set of guidelines to nurses.

The Hon. PETER BREEN: They are not trained for a start; they are not trained in psychiatric care.

Mr HOLMES: That is right.

CHAIR: But the gaols are also not sensitive to those other issues of socialisation and psychiatric rehabilitation, so to speak, which is an argument that others have put. Is that what happens at Cessnock, because that is fairly new, is it not?

Mr HOLMES: Well, it has been a few years since I was there, but--

CHAIR: It is not 100 years old.

Mr HOLMES: No.

CHAIR: The other issue is the boarding house issue. What is your view about that?

Mr HOLMES: I am trying to recall all the different people that we spoke to about these things. This particular issue came from Newcastle and it was more to do with the number of people that could actually be housed in boarding houses and basically with the arrangement at the moment people cannot meet their costs. That was a lot of the issue that was coming from some of the carers.

CHAIR: You mean the operators cannot?

Mr HOLMES: Yes.

CHAIR: And they are closing down, of course.

Mr HOLMES: Yes. Well, that is not the preferred option, but it was something that we needed to acknowledge that people were concerned about, and some of the difficulties. For argument's sake, if you want to get into a Department of Housing place in Waterloo, if that was where you preferred to live, I believe there is an eleven year waiting list.

CHAIR: The other issue is, if you go to a boarding house, your security of tenure and the control of the person who operates the boarding house can be a bit excessive and intimidating and they do not provide any other service apart from accommodation.

Mr HOLMES: That is right, and my friend over here might buck at this, but quite a lot of research has been done and I think in the vicinity of about 90 percent of people with a mental illness smoke.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would not dispute that for a minute. It is a fact.

Mr HOLMES: So if you are taking 80 or 90 percent of your budget, it does not really leave you with very much money for socialising. I think the Government needs a little bit of a pat on the back for what it has tried to do. They may have been motivated by the Olympics coming along, but they have actually tried to address some of those concerns.

The Hon. AMANDA FAZIO: Could I just ask, in relation to boarding houses, apart from issues like fire safety and those sorts of things, for some general comments on what you see as the quality of care or the lack of quality of care for residents?

Mr HOLMES: Lack of quality. Would you live there?

The Hon. AMANDA FAZIO: No, but I have heard that some boarding houses are acceptable and yet I know from my own local area we used to regularly try and get the local boarding house, which was used as a half-way house for people being de-institutionalised, inspected because of the lack of care and nutrition and all the rest of it for the residents there, but I thought your organisation might have a broader view of how these services operate across the State, or do you think that they are just all woeful?

Mr HOLMES: I will just give you an example. I was working for Richmond Fellowship, and we are talking about people with psychiatric disabilities, and through the work that was done with the boarding house team they had identified a number of people to be relocated. We picked one guy up from one of the boarding houses that was closed and, with having people that were supporting him and who had a really good understanding of mental illness, within the space of about four months a lot of the agitation and aggravation, and being able to actually get some input into stabilising with medication - he was just a different person. It was really amazing that this character had gone from - you know, it was just two different people, but I do not think you can just put a brush across and say that all boarding houses are the same. There are some rogues out there. We were really grateful when a couple of the big boarding houses in Newcastle were closed down.

CHAIR: Some of them burnt down, didn't they?

Mr HOLMES: Well, yes, it would have got rid of a lot of the cockroaches.

CHAIR: There was a big old sprawling place in Kyogle - I have forgotten the name of it - with 35 people in it and it was closed down by the Board of Fire Commissioners because of a change in the rules, but it was one of the places for the mentally ill and the community mental health team used to go out there every morning and hand out all the pills, and every afternoon and check them, and the psychiatrist used to visit twice a week. The woman who ran it was a local girl and mother of 20 and so on. They are certainly known to me, those sorts of places, but they are all closing. Most recently, one in Lismore with 16 residents looked like closing last week, I saw in the press, because they are simply going broke. With it closing there was a need to suddenly house 16 people. It is not easy.

Mr HOLMES: No, well, I know in the Hunter there was a group of about 35 people moved out of one in Mayfield that closed down and that created a lot of problems because there was not a lot of thought put into where people would actually go and who would look after them.

They are some of the positive changes that have actually come out since the Richmond report. It has taken time, but it is starting to become a little bit more coordinated and I do not think that the Government should actually relax the vigilance around that sort of stuff.

CHAIR: Are there any more questions about boarding houses at this stage? The shift of care from institutions to the family, this is a separate issue where suddenly somebody who has been cared for in an institution - I assume this goes to the issue of going from a big institution to home, but it is equally the problem, I would think, of going from acute care, where you have had a decompensation or a flare up of your illness and going home. What are you the issues that you recognised about that? In the submission you look carefully at the need for the carers to have good information, education and training about how to cope with their relatives. Are there any other issues?

Mr HOLMES: One of the blow-outs we see as a consumer and carer advisory group, one of the fundamental differences that consumers and carers have is the understanding that consumers have the right not to have others involved in their care. That creates an enormous amount of conflict at times, not only for the carers, but also for the mental health workers. One of the ways that we have tried to address that is to encourage services to get involved in developing what is called individual service plans or relaxed management plans, there is a whole range of names, but setting goals for what people want.

CHAIR: Is it making decisions when they are well?

Mr HOLMES: Yes. Unfortunately, a lot of times when people do become unwell, it sort of sneaks up on you. It only took 27 years to catch up with me. It is a shame that one of the carers could not actually have been here to talk more on that issue.

CHAIR: It has been suggested by some of the other submissions that somehow or other there should be legislation that gives the carer some sort of say, as you point out in your submission here about the Carers Act in the United Kingdom.

Mr HOLMES: That is right.

CHAIR: And in Victoria I think and in New Zealand, some say, and I think ARAFMI, many of the organisations and people associated with ARAFMI, have argued that they are the ones who personally know well the early signs of decompensation, yet they are not necessarily a part of the consideration that the people doing the treating have to or do in fact take any notice of.

Mr HOLMES: I think that is one of the suggestions we had in there, that when and if the Mental Health Act does get reviewed in New South Wales that that needs to be addressed in some way, but you get back to the rights of the consumer. I do not really know how you overcome that.

CHAIR: It is a big issue, is it not, where the person has a right under the current Act to be treated in the least restrictive circumstances? Just because you are unwell, does not mean you have got to be treated.

Mr HOLMES: No.

CHAIR: It is only if you are unwell and you have another couple of things go wrong, like you are a danger to yourself or to others. So you could be quite psychotic and wandering the streets, not causing any harm to yourself or anybody else, but that is not reason for forcing you to take treatment or being putting into hospital.

Mr HOLMES: That is right.

Mr GATES: There are issues that because of the ultimate fence around the consumer, there is no engagement of the carer at all, and there were a couple of instances reported through our process, where in one there was a suicide because the carer did not know they had been released from care and was now out in the community, and the processes are such that the service is not allowed to tell the carer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think then that there should be a carer or an advocate for every person sort of statutorily linked to someone who has mental illness or is classified as having a mental illness, so that in every case the obligation is on anybody in the treatment group to actually liaise with the carer? Assuming that carer and advocate are interchangeable, they may be the same person or may not, but there is a carer and advocate for every mental health person, and once you have established that statutorily, the discharging or moving organisation would have to liaise, so there would be at least somebody who was responsible, or do you think that would just be a way of passing the buck?

Mr HOLMES: I think part of the confusion for the carers is that people can be discharged from hospital into the care of a boarding house team and the boarding house owner, for argument sake, can get quite a lot of information and the carers are actually cut out of the loop. I do not know how it would happen, but there needs to be some consultation with the carers, and a lot of it revolves around getting the person to agree that they can talk to people in their family. The worker sometimes I find hides behind - they assume that the consumer does not want the family to know, and I think that is more to the point, that they do not actually --

The Hon. AMANDA FAZIO: I was just going to follow on from what Dr Chesterfield-Evans was asking. Rather than saying should every person who has a mental health problem have an advocate or a carer appointed to look after them, when they already have one, which in nine cases out of ten would be a family member, do you think it would better if they had -

CHAIR: But they don't.

The Hon. AMANDA FAZIO: But if they do have one, that person would be -

CHAIR: We have got a very good submission from the guardian, and people can have a guardian appointed, usually for property. That is the Protective Commissioner who looks after their property, and they can be a consent authority, but if you are an adult, you have got an adult child aged 18 or 19, the hospital cannot ask you for consent for surgery, unless you get appointed by the guardian as the person's guardian.

The Hon. AMANDA FAZIO: What I am saying is rather than have a system like that, do you think it would be better if a person who had a mental health problem had the right to designate somebody to be a carer, which does not exist under current legislation, so that that person would be advised and would be consulted about major decisions made in relation to the person with the mental health problem? So that if they have got a family member who has been looking after them, say they live at home and they have some sort of acute episode and they are placed into residential care or hospital care for a while, that that carer or family person is involved. Do you think that there should be some sort of legislative framework that would allow somebody to be designated by the person themselves as their carer?

Mr HOLMES: Just thinking about what you have said, there is currently training being rolled out across New South Wales called MHOAT, which is Mental Health Outcomes Assessment Training, and the idea behind that is that all the mental health staff have gone through a period of between 12 and 20 hours of training around assessment and the paperwork necessary when people first come into contact with the service and they have regular reviews. As part of that they will be encouraging people to identify who are what they call the "significant others". I think that in time might help to start to alleviate some of the problems, because if you go back to the Greater Murray, there were 11 silos that you would actually go to to receive services and none of them used to talk to each other, and as the health records become more unified across the State, some of these problems I believe will start to address themselves.

CHAIR: Can I ask you about one of the suggestions which was made this morning by Ms Ball that there be a registrar for each person who has a mental illness, where a professional - sort out the privacy issues later - a professional might access with an age and a birth date what medication they are on and what their past mental history has been?

Mr HOLMES: What would be the advantage in doing that?

CHAIR: They said that a lot of the people that they come into contact with are dropped off by a truck driver at Gundagai or I think they gave the example of getting on a train using a $3 fare and ending up at Goulburn, quite out of it, psychotic, with no identification on them, or having identification on them but no pills on them and not being able to give a reasonable history.

Mr HOLMES: I can feel the Australia card coming on here.

CHAIR: Some of the information will be on Medicare cards soon.

Mr HOLMES: We have had quite a lot of input into electronic health records and we believe that that will overcome some of the problems you are talking about, because in time as people start to trust the system and to realise that there are safeguards in there where they will not be abused, I think some of those things you are suggesting will be able to take place.

CHAIR: We have got the Privacy Commissioner coming to see us about some of these issues. The other thing of course is that if you get scheduled using the Mental Health Act and you are unwell, you become the property of the court. So the court gives consent. They become really your spokesperson and there is a mental health advocacy service who are meant to go to court in front of the magistrate to get that order, but after they have got that order, and it is a six months treatment order for example, it is the State that has the power to make sure you take the medication. Do you think the State should also have a duty of care to make sure that (a) you take the pills and you are carefully looked after in other ways apart from just making sure you take your pills? The duty of care issue that goes with that court ordered responsibility.

Mr HOLMES: So you are talking things like housing? That is one of the things that constantly comes up, we hear about people falling through the cracks all the time, and part of the trade-off is like the privacy stuff or whether people are going to be cared for sufficiently, but I know as I travelled down my path with mental illness, I really resented a lot of the intrusions into my life.

CHAIR: But if you are ill enough to get a treatment order that goes for six months, which is court ordered, and that is meant to be supervised by the department, shouldn't they equally pick up a duty of care, because they now own you in that regard because the court says they do?

Mr HOLMES: Yes.

CHAIR: Do you think they should equally have responsibility, not to provide you with accommodation, but to make sure you have it, whether it is with a carer or a family or whatever?

Mr HOLMES: I will have to think about that one.

CHAIR: That is not what I am suggesting we should do, but they are suggestions that others have made.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back to the question about an advocate? I still wasn't quite clear. It seems to me that whenever you were taking a medical record of anybody, you had a next of kin as one of the forms and records you kept.

Mr HOLMES: Yes, you would think so, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And it would seem that that should be the case in psychiatric diagnosis just as it is in physical ones, and then of course the question in discharge planning usually was from a medical perspective, people vary how much account they took of the next of kin's situation or they just dealt with the person themselves, but if there were a statutory situation of a carer or an advocate and this had to be recorded and there had to be some negotiation with them at the time of movement, would you support that as a compulsory or statutory obligation on the health system to do that? And, if so, who would be involved in collecting that and how would it be stored and how would it be distributed amongst the groups involved in the care, assuming there was a team approach?

Mr HOLMES: I think I would be reluctant to support that. I mean people can go to the Guardianship Act and a number of other places, they can get that now, if someone feels that that is what is needed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But guardianship usually deals with property.

CHAIR: No, that is the Protective Commissioner.

Mr HOLMES: What I am hearing is that, at that initial assessment when someone first comes in, you are asking for some sort of legislation to say that they must say who the next of kin is or who their advocate is. Some people do not actually want another person involved and that gets back to dignity and choice. One of the things that really concerns me is that, as I am hearing you, you are actually taking that option away from people to have a choice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am more concerned with putting the obligation on the people who are supposedly coordinating the care because people are coming in to psychiatric facilities, being assessed and being sent home, which is what you were talking about in Wagga Wagga or Griffith - I forget the example you used - and we have a number of submissions saying that relatives were scheduled or taken by the police or whatever to an assessment facility, they were released and sent home, whatever you want to call it, and they then had some horrific event and the family was not informed. That is the nature of a lot of our submissions.

Mr HOLMES: Yes, I would believe that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And people are coming from being homeless, making contact with a health facility and going back to being homeless and often their relatives would like to know, and often they are not competent to make the decision. If the obligation was the other way around, that the treating group or assessing group had an obligation to get help, if the position was that they had to deal with a carer or advocate and if they did not want to they had to justify not doing so, in other words the onus was turned the other way, because at the moment they may do that if they want to but they do not have to, all I am saying is - and I am looking at it from a legislative point of view because that is our job.

CHAIR: I may be able to help a little. My wife and I recently signed powers of attorney for one another, but that covers property only. We also got I think what is called an authority for continuing care. We also signed over, me for my wife but not my wife for me, for continuing care. Say I had a stroke, she could then make decisions about my continuing care and act on my behalf in other matters apart from property. That is available to people who are mentally ill now. Do many of them take that option that you know of where they give that power of decision-making in a prospective way, that if they are not in a position to make their own decision it goes to somebody else?

Mr HOLMES: Some of us have done that, but a lot of people actually come into crisis, that is how they discover that they have a mental illness, and maybe there needs to be some education around the power of attorney or whatever it is.

The Hon. PETER BREEN: Sometimes it is called a living will.

Mr HOLMES: Yes. We have problems using that particular term because--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It suggests you are on your way out.

Mr HOLMES: Yes, euthanasia stuff, so that is why we call it part of the individual service plan or the relapse management plan. Most people do not get to that until after they have had the crisis and that is the stuff I think you are struggling with, if people are not aware that these things exist.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The down side is the person who has a mental illness who would like it kept from their family, they can cope reasonably well and they have come in for help, and it is in fact an infringement of their civil liberties, but, on the other hand, if they are grossly psychotic or drug dependent and they are lost to their family who is looking for them, they come to a treatment facility, they cannot find out who their next of kin or carer is, there is no one to advocate an ongoing plan for them and the assessing person says, well, we haven't got beds here, nothing we can do about it, mate, get going, that is the down side. What I am asking you to do is balance the two and asking should we change the default, the standard practice, so that you justify doing the opposite? Do you understand what I mean?

Mr HOLMES: Yes, I do, but you really need to ask the person if that is what they want.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Assuming that they are not psychotic.

CHAIR: Well, they would then be able to make their own decisions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they are not psychotic they would, but it still may not be the best--

CHAIR: What worries some of the submitters to us is that sometimes the mental health service uses this, "the patient has to be free", to avoid caring.

Mr HOLMES: Yes. I think we should just wind it up there. We could argue about this particular point all day, but what I would say is the bottom line is that is you really need to ask the person if they want other people informed about where they are. It is that dignity and choice.

CHAIR: How do they give somebody the right to advocate for them? Say, for example, you really wanted Arthur Chesterfield-Evans to advocate for you. How do you do that? Take a person who is very depressed, not out of it psychotically but they are so tired and sick that they do not want to do it themselves and they want somebody to push for them to get certain care or housing or get something. How do they empower an advocate and make it legally empowering, apart from going through the steps that I have just discussed?

Mr HOLMES: I think that is part of the reason why I never became a lawyer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A lawyer assumes an adversarial model I think and that is often the worry. I suppose the reason why I am concerned about advocacy is because I have just done an inquiry with the disabled and sometimes their advocate is their carer, and obviously that is difficult if they are in a perpetual sort of childlike relationship, but the issue of who is the advocate and what is their status and indeed, in terms of people who have not got an advocate from their family, whether the Government should pay an advocate is a very vexed question in the disabled area. I think I can say that without fear of contradiction. So I suppose I am putting that scenario to you in terms of this inquiry.

CHAIR: The Government is funding individual advocates.

Mr HOLMES: If you are saying should people have access to independent advocates--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, I think they should, but it is a question of what status they would be given and how much is the treating doctor compelled to have an advocate and take notice of them; are they only to ask the person who has the mental illness is the advocate to be the carer, and what framework are we, as legislators, to set up to make the norm from which other models deviate? You have advocated that carers and advocates should have a better go, I mean that is the essence of your submission, is it not?

Mr HOLMES: Yes, it is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So I am just trying to elucidate the point a bit more.

Mr HOLMES: I am getting a little bit tired but--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure.

The Hon. AMANDA FAZIO: Mr Holmes, one thing I was interested in, partly because of another inquiry that I am sitting on that is running at the same time as this, is that in your submission on page 32 you have parents with a mental illness, who supports the children? I think that is a really interesting concept because we tend to focus too much on people who have mental health problems as being individuals or perhaps we do not look at them as having a role as a parent in a family unit so much, which is wrong because often if they do have a mental health problem and it is not managed it will contribute to a family breakdown, but you are saying here that you recognise the recommendation that parents with a mental illness have ongoing support needs and that facilities should be provided to enable them to access services and maintain family relationships. Have you got any specific sort of proposals in regard to that recommendation, what sort of services you would like to see? The other inquiry is into child group homes, the DOCS inquiry for want of its proper name, and that definitely is a case where children go into care when their parents are unable to cope for a range of reasons, one of them being mental health problems, so I would just like your comments on that.

Mr HOLMES: Well, one of the things that writing this submission has done for our group is actually identify a lot of issues that we need to go away and do quite a bit of work on. I do not have any particular models, but there is quite a bit of work being done in that area and I will be suggesting to my group that we actually develop some discussion papers around these recommendations. Part of that problem again is it gets back to that initial assessment when people come in for help. One of the comments we often hear a lot of the mental health workers saying, and surrounding the stuff with the MHOAT, is that they do not feel they are actually having face to face - they are actually not doing their work while doing all the paperwork. It is not only children, it also relates to pets, because a lot of times you get to a point where the only friend you have left is a dog, so what you are talking about here is parents with mental illness but it is that initial assessment stuff, it is much bigger than in like emergency departments.

The Hon. AMANDA FAZIO: It is the impact on a person's lifestyle as well.

Mr HOLMES: Yes.

CHAIR: I think we will have to wind up because we have gone over time a little. It is a very full submission that you have sent us and you have clearly identified just about every issue that everybody else went to little bits of and I congratulate you for that. If there is anything that you get in Hansard that you think (a) you would like to have corrected or (b) you would like to add to, or if you think you need to come back and see us again after the publicity that happens over the inquiry, please be in touch directly with us. The Hansard should get to you I would think in about a week's time, and if you could return it to us as quickly as possible because we would like to put it on to our web site so that people can see what is happening and that might foster a bit more debate in the community. If we have any further questions of you as a result of the inquiry or today's answers, would your organisation be happy to take them on board and perhaps respond to us at an appropriate time?

Mr HOLMES: Yes, we would.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I congratulate you as well: I think it is an excellent submission, very clear and very simple, really excellent.

(The witnesses withdrew)

(Short adjournment)

MARGARET ANNE SMITH, Lecturer, University of Western Sydney, President, Mental Health Association NSW Inc., 62 Victoria Road, Gladesville, and

GILLIAN CHURCH, Executive Director, Mental Health Association NSW Inc., 62 Victoria Road, Gladesville, affirmed and examined, and

LEONIE MARGARET MANNS, Chairperson, Mental Health Association NSW Inc., 2/29 Station Street, Petersham, sworn and examined:

CHAIR: Dr Smith, you are conversant with the terms of reference?

Dr SMITH: Yes, I am.

CHAIR: Would you like the submission made by the Mental Health Association to be included as part of your sworn evidence?

Dr SMITH: Yes, thank you.

CHAIR: Ms Church, are you conversant with the terms of reference?

Ms CHURCH: I am.

CHAIR: Ms Manns, are you conversant with the terms of reference?

Ms MANNS: I am.

CHAIR: I should warn all of you that if you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be happy to accede to your request. However, I should point out that you should be aware that the Legislative Council can overturn that decision and make that evidence public. Would you like to make an opening statement that deals with your submission?

Ms CHURCH: I would like to furnish you with just an opening and then pass on to my colleagues. First of all, a bit of background to the Mental Health Association. It was formed in 1932 as the Mental Hygiene Association. At the moment we are involved in, and have been for some time, the provision of mental health information. We have a mental health information telephone service and web site. We are involved in support groups, setting up support groups and training facilitators.

CHAIR: Are you an umbrella group for a large number of other organisations?

Ms CHURCH: No. We make it clear at this stage we are not the peak body for mental health. That is the Mental Health Co-ordinating Council, of which we are a member. We do in fact have two organisations under the umbrella of our incorporation, which are the Depression and Mood Disorders Association, of which Meg Smith is the president, and the Anxiety Disorders Alliance. They are the two organisations that we are responsible for as well.

In terms of mental health promotion activities, we organise Mental Health Week in New South Wales, we do Stress Less Day and recently we did a new initiative called Healthy Life Day, which was in April, and we also engage in advocacy in the broad sense.

The association, I think, is unique in mental health in that it represents the interests of consumers, carers and service providers and that includes mental health professionals and the general community. Those are our members. We advocate across the range of mental health illness and mental health issues. We are not a one issue group at all. We have a highly respected board of management, and of course I have two members of the board of management with me today, who are in their own right highly skilled consumer advocates for people with mental illness. So collectively I think we are well placed to know what is going on in the mental health sector as far as can be expected.

In our submission we stated quite clearly that we strongly support care in the community.

CHAIR: You are funded by the Northern Sydney Area Health Service?

Ms CHURCH: That is right, yes.

CHAIR: And by your members obviously as well?

Ms CHURCH: Yes, and fund raising activities, et cetera, as a registered charity.

We say quite clearly that we are strongly in support of care in the community, and I must say at this stage that we are implacably opposed to either reopening the old institutions or to building new ones. For example, there is a proposal in the air that has been put by the Opposition to build a new 400 bed hospital on the grounds of Rozelle. I am not sure if that is one building or several buildings. It does not matter to us. We are opposed to that in principle, and we can go into that later on in detail if you like, but just to say that it goes totally against State, national and international policies and trends in treating mental illness, and we regard it as a very retrograde step. We are concerned that it might achieve some popularity in the community and be seen as a simple solution to a problem of a shortage of beds. We will take it upon ourselves to inform people about the issues in relation to this if it comes to that.

A lot has been done to improve mental health care in New South Wales, but there is still a lot to do, and we would like to call upon the Select Committee to take a bipartisan approach to resolve any difficulties that we see in mental health services currently. In our submission you will see that we have included 26 recommendations, and we would like to draw your attention to the major four in particular. The first one is recommendation 5, which you can see on page 10 of the submission. I think that we do need increased funding in the mental health sector as a whole.

CHAIR: More importantly, I have underlined the word "transparency".

Ms CHURCH: Yes, that is the second part of that recommendation. In terms of the increased funding, which is on page 10, I have never met anybody who said there is enough funding in mental health. I think we can take it as read that more funding is needed and I just hope that there is the political will there to provide that funding on both sides or all sides of Parliament.

CHAIR: In that recommendation you also include on page 10 the idea of partnerships.

Ms CHURCH: Yes.

CHAIR: That is recommendation 4, but on page 10 I have underlined, in my reading of it all, "the whole of Government and non-Government responsibility", and the idea of partnerships is included in that.

Ms CHURCH: It is a separate recommendation but obviously, yes, those are two very important recommendations. Secondly, the whole of Government response, the problem is obviously just too big for mental health, for the Centre of Mental Health, for the Area Health Services. It has got to be a whole of Government response.

Thirdly, recommendation 11, there is a huge problem with the mental health workforce or lack of. The situation is critical in terms of attracting suitable people and training them. Those issues need to be addressed very quickly, like ten years ago probably.

Fourthly, there should be increased involvement of consumers and carers in service planning and delivery.

CHAIR: Which recommendation is that?

Ms CHURCH: Number 12 on page 14. There are many other ways to do business than what is happening at the moment. I believe that a lot of mental health workers are involved in work that could be done by people who have different kinds of skills, and we need to look at those innovatively and bring in of course consumers, carers and non-Government organisations to take on those roles.

So those are some of the important issues that we think we have covered in this submission.

CHAIR: I have also ticked "mental health and drug alcohol be combined at all levels".

Ms CHURCH: Yes.

CHAIR: Because they are included separately with a separate budget.

Ms CHURCH: They are.

CHAIR: And yet I think that is one of the keys, identifying across the board the DDs, the drug and alcohol, plus mental illness.

Ms CHURCH: Yes, and that is part of the whole of Government approach of course.

CHAIR: Of course, but, again, to bring them under the same umbrella, which is almost going back a step, is within the Mental Health Act, but for some reason they are treated quite separately.

Ms CHURCH: Yes. Well, it is just because there is such a high incidence of dual diagnosis and people get pounded from pillar to post and are not getting the right service.

CHAIR: Actually, the mental health people will not deal with you if you have got a drug problem. The drug problem people will not deal with you if you have got a mental health problem. So you absolutely go away because neither of them will handle you while you have got both.

Ms CHURCH: That is right, yes.

The Hon. PETER BREEN: Can I just clarify something about dual diagnosis?

CHAIR: Well, there are two types.

The Hon. PETER BREEN: I am a bit confused.

Ms CHURCH: There are two types.

The Hon. PETER BREEN: Can you tell us what your understanding of dual diagnosis is?

Ms CHURCH: In this context it is mental illness and drug and alcohol abuse, but also it can mean mental illness and intellectual disability, developmental disability.

CHAIR: The proper term that we are talking about is MI, mental illness -

Ms MANNS: And substance abuse.

CHAIR: MISA, which is what Sister Harris was talking about this morning, but it is often called dual diagnosis, is it not?

Ms CHURCH: Yes. It is always important I think to clarify what you mean when you say that.

CHAIR: So they are your major recommendations?

Ms CHURCH: Yes.

CHAIR: Would you like to expand further on your submission? Would you like to go through the terms of reference as they are?

Ms CHURCH: Could we take a slightly different tack?

CHAIR: Of course you can.

Ms CHURCH: Leonie Manns was scribbling - I was going to say madly, but I won't say that - since she has been here and she has got a few things that she is burning to say, so can we give her the opportunity to do that?

CHAIR: Yes, of course.

Ms MANNS: First of all, I wanted to congratulate the Parliament for the installation of amplifying microphones in this room. I think a number of times I have been called to give evidence here it has been a major complaint of mine. I hope that the next time I am giving evidence we also have a hearing loop installed.

CHAIR: This room has a hearing loop.

Ms MANNS: Well, thank you to the Parliament for doing this.

CHAIR: It was put in some years ago.

Ms MANNS: It didn't have it the very first time I gave evidence in this room, so I am very pleased.

Another general point I would like to make to the Select Committee and also to any media that are present is that the Mental Health Association and people with mental illness in New South Wales would like to hear the cessation of the term: The inquiry into the mentally ill. We are not actually inquiring into people with mental illness, we are inquiring into services for people with mental illness. I would like the Committee itself and members of the Committee to refer to people with mental illness and I would also like them to refer to people with disabilities, not the disabled.

CHAIR: Actually this is an inquiry into mental health.

Ms MANNS: That is exactly right.

CHAIR: And it is very important, we all need mental health.

Ms MANNS: We do indeed.

CHAIR: Even those of us who are not mentally ill.

Ms MANNS: No. I once heard somebody say that they were working very hard to cure mental health, so I begged them to stop. I just wanted to make those points of view and I think the more we hear on television, radio and in the press that we have an inquiry into the mentally ill is derogatory to people with mental illness in this State because we are not inquiring into those people.

CHAIR: No, we are not.

Ms MANNS: Thank you.

I was a member of the consumer advisory group for many years, so I have knowledge of their work. I think one of the major issues that they were raising was the issue around supported accommodation. I think this is something that Health really needs to take a few lessons from the disability sector on because Health does not know how to do it. Even a number of the non-government organisations within disability and within the mental health area are not so clear on how to provide supported accommodation services. It is absolutely critical that they do occur, but I do not believe that the health department needs to start getting back into the role of being landlords. I think that is a really dangerous thing for them to be doing and it probably needs to be with non-government organisations, but for those non-government organisations to be funded appropriately to provide a service because that is what does not happen, simply because there is no understanding of what it is.

CHAIR: You may not have been here earlier when I made the point that there was an inquiry by the Standing Committee on Social Issues into disability services and it was clear that the Minister, Ron Dyer at the time, signed a commitment of continuing care, lifetime care, for people who were de-Richmond who were disabled, which did not happen and perhaps should happen for people who are de-Richmond or Richmond if they are mentally ill.

Ms MANNS: That is quite right and I think that was a very big issue. Earlier you were talking about the dual diagnosis of people with an intellectual disability and people with a mental illness. I believe that the figures are around a third of people with an intellectual disability also have some form of mental health problem, so I think that is where those figures come from.

Our submission told the Select Committee that we did not believe that we needed to revisit the Richmond report, that that is something that happened 20 years ago. I think Dr Smith will probably elaborate a little bit on this, but I would have to say that, of people with mental illness only, I think around 260 people were released from hospital particularly in the Richmond era. I would presume that most of those people have died of old age by now. The association is quite clear on that.

CHAIR: It was only 20 years ago; they are still alive.

Ms MANNS: Quite a lot are, but quite a lot are not. I do not think they are the homeless population of Sydney, I think we need to be very clear on that. Most of the people went into boarding houses at the time or into other accommodation. Of course, some were lost.

I think the appropriate people to be answering questions on budget and the issue of where is the extra money that came in the last couple of years are the CEOs of the area health services. I do not think that we have anywhere near a transparent delivery of mental health services yet and I do not put the blame at any public servant or any politician or minister of either colour because I think in the last 10 years every health minister has tried to get that information and somehow they have not been able to do it.

CHAIR: They are all quarantined.

Ms MANNS: They quarantine it, but then they do not tell you what they spend it on. It is very hard for an area mental health service at a very local level to try and do a budget when no one tells them what the yearly budget is, so the CEO does not tell you actually what your budget is. The area directors of mental health in some areas - only a couple - actually hold their budget, but in some they do not even know what it is, so that is a major issue.

Mr Breen was asking questions around forensic issues and one of those major problems I think was that people who have been found not guilty due to mental illness or are unfit to plead due to mental illness - as Dr Pezzutti knows, there are many, many people in Long Bay under those conditions for many, many years. They are technically in hospital but because our hospital is within the grounds of a gaol they are in gaol and they are still under the care of Corrections Health, but also the Department of Corrections provide the security and the guards.

I think it was in 1994 when I first went to Long Bay gaol as an advocate for a young man who was suicidal, a young Aboriginal man in that hospital. He was on suicide watch at the time. The suicide watch consisted of him being in solitary confinement in a cell - they called it a room, but it was a cell - and on the floor was a mattress, a polystyrene cup and a bedpan. Sitting as close to him as Ms Church is to me was an armed guard and the nursing station was probably as far away as Dr Pezzutti. The nursing staff were trying to get that young man removed to a proper hospital such as Morisset. That was proving quite impossible and when I rang the health department at the time the question that was asked of me was: In what role was I asking the question? In what capacity was I visiting the gaol? My answer then and today is: Human being.

CHAIR: That goes to the issue we discussed before about the empowerment of an advocate or an advocacy service.

Ms MANNS: Yes, and I have been an advocate at Long Bay and at Emu Plains womens' prison and I am sure that if you wanted to look up my evidence to the forensic inquiry you would see that there is quite a lot more in that.

CHAIR: We will be making a study of the inquiry into the increase in prison population.

Ms MANNS: I think it is quite true that you should look at that and not just take the evidence because the people that will give evidence will be more the professionals in that area whereas a number of consumer groups gave evidence to you on that issue.

CHAIR: Yes. I was not on that inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was on that inquiry.

Ms MANNS: Yes. I think there is a really big issue around boarding houses because there is much confusion both within and out of government.

I just want to go back to the forensic issues. I think there is a responsibility for the public and the politicians to accept that the issues of law and order that they continually bring up within Parliament, within the press, on talk-back radio, are what feed the attitudes that we still have those draconian conditions in our forensic facilities and I really think that we need to separate them, and I do not single out any politician from any area.

The Hon. PETER BREEN: Can I just say in response to that that I am a regular visitor to Goulburn gaol and talking with the wardens and the prison officers in the gaol is very enlightening and when they tell you what they do with people who suffer from mental conditions it is frightening.

Ms MANNS: It is very frightening.

The Hon. PETER BREEN: So we are aware of what is happening.

Ms MANNS: I could give you an example of a place where I have seen it dealt with a lot better and that is the Italian solution. Within Italy, using the example of a regional mental health service, if they have a forensic patient and the person lives within that region, if the psychiatric team in that region are prepared to guarantee that they will provide the mental health service to that person, the person will be returned to their region and treated in the community by the mental health service. I recently visited Trieste and Trieste are very proud to say that they have no clients of their mental health services in gaol because they guarantee to provide the service for all of them, so I think that is something we might look at.

The Hon. PETER BREEN: We have a long way to go to catch up with Trieste.

Ms MANNS: We have indeed, but it is always an ambition to try.

CHAIR: As I said before, the Italians did this 10 years before Richmond, they realised it was never going to be cheaper, it was going to be more expensive and they put the money in.

Ms MANNS: That is quite right.

CHAIR: The design of Richmond was to return money to Treasury.

Ms MANNS: Yes.

CHAIR: The saving on closure of the institutions was to go to Treasury and some of it was to go to community mental health.

Ms MANNS: The big gain on that was on the closure of Riverside at Gladesville, across the road from Gladesville Hospital, where the director general at the time was cunning enough to get some comp money out of Treasury and that is what happened and I do not know if it ever actually got paid back.

CHAIR: Treasury also got the money from the sale of land.

Ms MANNS: That is right. I think we also have to be clear that the land that has been sold in New South Wales - certainly in recent days - is not land that is for mental health, it is basically the disability money. It is not the mental health money.

CHAIR: Yet.

Ms MANNS: Well, this will be a good thing, when we sell some of it.

I would have to declare that I am currently chair of the ministerial reference group on boarding house reform. I have been involved in boarding house reform for I think 12 years.

CHAIR: Which minister?

Ms MANNS: Minister Lo Po'.

CHAIR: So it is DOCS?

Ms MANNS: Well, it is disability because they are licensed boarding houses.

CHAIR: They are the licensed ones?

Ms MANNS: That is right, and that is what I was going to say: There needs to be a very clear differential between licensed boarding houses and lodging houses. Licensed boarding houses are really the only ones that we can do anything very much about in this sector.

CHAIR: So who has the responsibility for regulating the other ones?

Ms MANNS: I do not think anyone has it.

CHAIR: There was some legislation prepared before the Olympics.

Ms MANNS: Yes, but nothing has happened with that.

CHAIR: Who did that?

Ms MANNS: I think Housing or Planning. I could not be sure, Dr Pezzutti, I am sorry, but certainly my stated view - and I think most people who know me would say it is my view - is that licensed boarding houses are never a good option for people with disability or people with mental illness. I think that is something we need to be very clear about and it is interesting because I think they currently appear to be an acceptable model to some people working within the public sector and I am finding that quite frightening.

I think we also need to be aware that the boarding house reform money has been able to show what can be done in the area of supported accommodation in mental health. It has been interesting that it was handled by a different department, by the Department of Ageing, Disability and Home Care, and those mental health non-government organisations that have been involved in this have found it very enlightening and they have enjoyed it because they have actually been funded to provide the work and it is probably because that department has an understanding of what supported accommodation is.

CHAIR: They basically got a direction that the department would not do any of this.

Ms MANNS: That is right.

CHAIR: The department would set a standard and police the standard but they would not do it.

Ms MANNS: That is right.

CHAIR: Hannaford did that and I remember it vividly because it caused a lot of trouble.

Ms MANNS: I know, and I believe that was quite an appropriate thing to do.

We talk about advocacy, just raising the issue of how we might do that. A suggestion that I would make is that there could be an advocacy service, but I would see it as a consumer run service that would be linked with the mental health advocacy service and it could be a voluntary service. I have had over the years many talks with the director of that service and he would be quite happy to do it, but it is often very difficult.

The problems with CTOs, Dr Pezzutti, there are other things that people are supposed to do except give out the medication. The problem with the administration of community treatment orders, and I speak as a member of the Mental Health Review Tribunal, is that some area mental health services are finding that if you are not on a CTO, we are not going to treat you. So the CTO itself is becoming an instrument of treatment and I think this is something that we need to really address very clearly, and I do not have the answer to that, how we do that.

CHAIR: So you think the tribunal needs sometimes to force the Health Department to actually do the job, is that what you are saying?

Ms MANNS: Sometimes but I think sometimes the tribunal is complicit in - the tribunal is part of the system.

CHAIR: No, but if they actually give somebody a community treatment order, that requires an onus of care to the department.

Ms MANNS: Yes, I suppose that is right.

CHAIR: It is not just the drugs, there is an onus of care and that is given by a court or a tribunal to the department. If they do not give that CTO, then the department, as you say, will not -

Ms MANNS: That is right exactly, sometimes you may wish not to give the CTO, but you know the person may not get any treatment if you do not make a CTO.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is not the Health Department merely saying that they cannot cope with the load and so they are doing the ones that they have to do first, in other words it is priority, it is not just being objectionable or obstreperous?

Ms MANNS: I agree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is saying, "We can't cope. If you set those priorities, we will run with them".

Ms MANNS: I think there are two things. A lot of mental health workers, through no fault of their own, do not have very good understanding of the Mental Health Act, because nobody teaches them about it. So they do not actually have a really good understanding of the Mental Health Act. It is very hard to have an illness that is regulated by an Act of Parliament. That is quite a difficult thing to live with.

CHAIR: The institute is specifically funded a million dollars a year.

Ms MANNS: They are, but I do not know what happens, I just do not know, but there are many many people out there who do not understand the Mental Health Act enough, and the other issue I think is that many of the service providers and many of the Area Health Services are caught up with "the service can only be delivered in the way we have always done it". There are doctors and nurses and OTs and social workers, and if you are lucky psychologists. The association in our submission believes that there are other ways that you could deliver that. You could certainly use consumer and carer organisations as service providers, particularly in areas of case management, and I think that is certainly something that we do not do - well, we do not do it at all.

CHAIR: There was a trial at St Vincents - it used to be call Eastern Sydney Area Health Service - where they trialled having health, social worker, the housing and the DOCS community service people working together and they split the clients, 60 of them, into 15 each. So the housing person was responsible for these 15 and if the next door neighbour had a problem with one of the clients, she rang that person directly and she might have been the housing person, but she made sure the care got given. You do not need to be a mental health nurse to do that.

Ms MANNS: I think that is an issue that we then strike industrial problems with that. At some stage we are going to have to sit down with the unions and say, "Okay, it is not like we have mental health nurses. We are not overflowing with mental health nurses or social workers", whatever, and that there are other options, but the main objective of the whole thing is the consumer, the person with the mental illness, the second objective is their family and then the rest of the community and then the health workers. They are a bit way down the pecking order. I might be quiet now.

CHAIR: No, you are right. Dr Smith, have you got any comments you would like to make? Would you like to address the whole issue of forensics?

Dr SMITH: Yes. I sit on the Guardianship Tribunal and something like 15 percent of people with a mental illness are coming before the Guardianship Tribunal, and one of the issues that comes up a number of times is the whole issue of somebody who has got a mental illness, who has got themselves into some kind of trouble with the law, legal action is being taken and the person is not able to instruct a lawyer or get themselves any legal representation, so the Protective Commissioner or a guardian is asked to ensure that a person gets legal representation.

The other area that I can comment on is the issue of people with bi-polar disorder, and a number of people with bi-polar disorder get themselves into trouble with the law in the early stages of the illness, young people in particular.

CHAIR: And intermittently?

Dr SMITH: And intermittently, yes. The support has to be tailored, and I suppose the issue for us is you cannot put everybody under the one umbrella, you really do need to look at some specific issue. I guess from where I am sitting the guardianship legislation is often much more flexible in terms of enabling things to happen. The mental health legislation seems to be a lot more inflexible in terms of ensuring that things happen. Okay, you might make a CTO, you might say we are going to commit you, do this and all that kind of stuff. Okay, fine for the six months the person is under the CTO and what have you, but people are often really pissed off about it, so they are quite likely not to comply with things afterwards.

CHAIR: In terms of the forensics again, what about the trials that are going on with having a forensic team or people with forensic psychiatric experience, nurse, doctor, being in the court when some of these things were heard for diversion out of the court system?

Dr SMITH: I think that would be a really good idea, because I think that often lawyers representing a person may not know terribly much about mental illness. The people in the court themselves may not know terribly much about mental illness.

CHAIR: There are a number of trials.

Ms MANNS: The problem is that that program is being administered through corrections health out of Long Bay as usual.

CHAIR: It is a trial though.

Ms MANNS: It is a trial.

CHAIR: We have had evidence from the clinical psychiatrists about that. That will be dealt with next week. But I think this idea of drug court diversion and so on is very attractive.

Ms MANNS: I agree, but I think it might have been better to divert the program out of Long Bay. The person who is running it is running it out of Long Bay.

CHAIR: It is still controlled by the Minister for Health, not the Minister for Corrections, so there is a trial being done about that. Are you aware of the detail of that?

Dr SMITH: Not really, no.

Ms CHURCH: I think in nine courts it is happening.

CHAIR: We are going to get evidence about that, but that goes to some of the issues that you are talking about.

Ms MANNS: They will be nurses who are doing that program.

CHAIR: Some of them are psychiatrists, are they not?

Ms MANNS: I think they are mostly nurses.

CHAIR: They will have to make a judgment and a diagnosis. You keep going through these. I was interested in what you were saying about the forensics, advocacy for them.

Dr SMITH: I think it would be lovely for someone to sit down with a person and figure out exactly what the issues are. I guess one of the issues about advocacy is that it has often fallen to the families to do it, and they may not be the best people to actually do it. I agree with Ms Manns that maybe we need a consumer advocacy service or maybe we need a different kind of service to intervene, but the people we see through the support groups at the Mental Health Association who have come into trouble with the law, it has generally been at a magistrate court's level, driving offences, traffic fines, that kind of stuff.

Ms MANNS: Money.

Dr SMITH: Money, getting into debt, credit card, mobile phone bills and things like that. It is often only when things get to a real crisis, the person is thousands of dollars in debt, or they have got $40,000 in unpaid fines or something, that it actually gets to the point where maybe the Guardianship Tribunal gets involved in order to get something done about it.

CHAIR: Correct me if I am wrong, but if it is a matter before the tribunal, the person has to be represented.

Ms MANNS: No.

CHAIR: To get a CTO to get an order for compulsory -

Ms MANNS: The only places where you actually have to have representation are when an agency is requiring to have a person made a continuing patient or to have their temporary patient order extended or if there is an appeal in any way. Other than that, there are no resources. If they provided a lawyer for every CTO -

CHAIR: No, but if you go before the magistrate to get an order -

Ms MANNS: If you go before the magistrate, perhaps that may be so. If you go before the magistrate, they usually have a lawyer there, but certainly there is no compulsion to have a lawyer for a community treatment order.

CHAIR: I would like to challenge you a little bit. Ms Church, you said you did not want to see any new buildings built at all.

Ms CHURCH: No, no.

CHAIR: I wrote it down "any new buildings built anywhere".

Dr SMITH: Large institutions.

The Hon. AMANDA FAZIO: I wrote it down differently. I had "opposed to building new institutions".

Ms CHURCH: That is right.

CHAIR: You actually said, and I think you will find it in the Hansard, any new buildings anywhere.

Ms CHURCH: I will correct that in the Hansard.

CHAIR: There is a shortage of 850 acute beds identified by an inquiry done by the current Director of Mental Health, Beverley Raphael.

Dr SMITH: Yes, there is something like 800 beds needed across New South Wales.

Ms MANNS: Ms Church and I would both dispute that and we have disputed it with Ms Skinner.

CHAIR: I am just saying that this is what Beverley Raphael in her report to the Minister said, and I am aware that they are building inside Long Bay a 120 bedder.

Ms MANNS: That is correct. I think that is co-located.

CHAIR: Yes, inside/outside, but it still going to be inside/outside contiguous and part of Long Bay, and I think there are plans to do something at Goulburn as well. The one at Goulburn may well just simply be a renovation or a new building or better facilities, and the one at Long Bay may be much more sensitive in terms of its construction and its outlook and its architecture and what it does, rather than being just a box with white walls.

Dr SMITH: I think there is an issue between psychiatric beds within the prison system and psychiatric beds within the general community, if you like, and certainly I would have no objections to more psychiatric beds being built within the prison system because if people are in an institution, in Grafton gaol say, and they have a mental illness --

CHAIR: You cannot have it both ways. The human rights orders say that if you are mentally ill you should be in a hospital, not in a prison. That is what it says specifically. If you are mentally ill, whether you are guilty or not guilty, you should be in a hospital, not in prison, and it says that very specifically. So here you are, the Mental Health Association, telling us you have to have a mental health institution within a prison but not anywhere else - really extraordinary.

Ms CHURCH: I am not sure that we have said that we approve of the 135 bed hospital I believe in the grounds of Long Bay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought Dr Smith was saying she did approve of it.

CHAIR: I am not trying to divide and rule, but I am just saying there are issues involved here.

Ms MANNS: We have to say that the Association for Mental Health has not had a discussion around the forensic area. We have certainly had discussions around proposals building new mental health hospitals.

CHAIR: The idea with these 850 beds or 600 beds or 400 beds or 20 beds, however many beds there are that are needed to provide acute mental health services around the State somewhere, they are going to have to be built somewhere, and I know that Beverley Raphael has been running around the State promising, yes, we are going to start tomorrow on the 50 bed hospital at Lismore, and tomorrow we are going to do something else here, and the amount of money that has been promised to be spent is a large amount of dollars for acute care. Now I am saying that these are buildings that are going to be built somewhere.

Ms MANNS: I think, though, that we do not represent Beverley Raphael and I think we need to be really clear around that, and we do not represent the Government as well.

CHAIR: No.

Ms MANNS: We receive some funding from the Government, but we have always been an organisation that did not seek funding as shut-up money.

CHAIR: No, but is it better to build 50 twenty-bedders in every area health service which all look the same or have some which are specific, like some women only acute care areas and some children only?

Dr SMITH: People need to be close to their family and friends. One of the most destructive things about going into a psychiatric hospital is losing your links with the community. The two hospitalisations I have had have been hundreds of kilometres away from the people I knew and that causes great disruptions in people's lives. Modern medication does mean that people do not have to spend quite as long a period in hospital. If you are only going to spend a couple of weeks as against a couple of years in a hospital, then it should be close to your community networks, so yes, I would say that 50 units of 20 beds each is far more preferable to 400 beds in a capital city or a regional centre.

The Hon. AMANDA FAZIO: Could I ask you a few questions about accommodation and residential options. Do you support the idea that acute beds for people with mental health problems should only be attached to hospitals or do you believe that they can be built as small stand-alone facilities?

Dr SMITH: I think we might have different views about this. My personal view is that they should be attached to general hospitals.

Ms MANNS: That is my view.

Ms CHURCH: Mine too.

Dr SMITH: People with acute mental health problems often have other physical illnesses and one of the issues that came up in the inquiries into the big mental health institutions was that people often had other physical problems which were not being addressed. At Rozelle Hospital, which is probably not that far from Royal Prince Alfred Hospital, there were a number of instances where people had things like heart problems, things like diabetes and what have you, that were not being adequately looked after while the person was actually in the psychiatric hospital.

The Hon. AMANDA FAZIO: There was a question that Dr Pezzutti alluded to which is something that had been put to me by some community activists interested in mental health issues on the south coast, which was that they believe that because of the tendency for a lot of women suffering mental health problems to be more vulnerable at the time that their condition was acute they should not be placed into mental health units attached to hospitals that were mixed with male and female clients.

Dr SMITH: Yes, that is an issue that we have looked at. In fact Women in Mental Health commissioned a report a few years ago looking at sexual assault within psychiatric services and there is a high incidence of sexual assault within psychiatric services, particularly for young women in the manic phase of a manic depressive illness. It is an issue.

The Hon. AMANDA FAZIO: So do you support the segregation of those clients or closer supervision?

Dr SMITH: Well, closer supervision, but I guess the other issue has to be education and training of staff. One of the outcomes of our report into sexual assault in psychiatric services was that some of the better hospitals did actually start instituting a policy about, well, look, if you are ill enough to be in hospital and we are saying you cannot look after your affairs, then we also consider that you are not able to consent to sexual interaction either, therefore we are going to make sure that you are protected against sexual interaction, and that seemed to be a pretty sensible thing to do actually, but to back up that policy you also need more staffing.

Now one of the issues that I have against large institutions is that large institutions do not necessarily mean better care. In fact they often mean worse care. You can often be in a very large ward with, say, 25 other people, all of whom have different sorts of mental health disorders and what have you, and there may not be enough supervision to stop the patients hassling each other, so I guess the issue has to be the level of illness of the person and, frankly, if people are acutely ill they should be in a ward where there are very few patients and a high level of supervision by staff. Okay, as people become more well and more able to look after themselves, they are moving into rehabilitation wards and what have you, but unfortunately the large psychiatric hospitals like Rozelle, Gladesville and Macquarie were often - and probably still are - operating on a model that if you come from a certain geographical area you go into this particular ward, which means that a young person, say a young woman who is acutely ill with mania, may end up in a ward with older men, people with alcohol-related brain damage, people with schizophrenia, people with depression, a whole range of mental health problems.

CHAIR: That is exactly what is going to happen if you put 20 bed wards everywhere and the issue really is about women specific units and, more importantly, for kids. I mean currently kids to the age of 14 are in with 19 and 30 year old men acutely ill at St George Hospital, at Royal Prince Alfred Hospital, because there are only two places for kids in Sydney.

Ms CHURCH: Well, you asked us whether we prefer a large stand-alone hospital or 50 twenty-bed units. They were your figures.

CHAIR: I asked you whether you wanted 50 twenty-bed units all over the State or should there be some more specific types of twenty-bed units.

Ms CHURCH: But those are not the only options, are they?

CHAIR: No, but I asked the question.

Dr SMITH: In an ideal world, in Lismore, say, I would like to see a women only ward, a ward for children, a ward specifically for people in the acute phase of schizophrenia and a ward for people in the acute phase of mood disorder. Now if we have the resources and the money is made available to provide that, excellent.

CHAIR: So if it is only a 50 bed ward, which is what they are doing in Lismore right now, it would be easy to do that, would it not, to have sections of the ward which are quite separate?

Dr SMITH: Yes.

CHAIR: As well as the lock-up area, if you like.

Ms MANNS: I think a lot of it is in the way that you design it and I think the way the Department of Health, no matter who is running it, designs hospitals, they never ask people that use them very much.

CHAIR: Absolutely right.

Ms MANNS: They never ask the staff and they never ask the users of the service, the consumers or their families.

CHAIR: They ask the architects.

Ms MANNS: They ask the architects and they ask the accountants. I can remember when they were building the Missenden unit at Royal Prince Alfred and they brought consumers in at the very last minute and it was the consumers who discovered - we are actually the ones who picked up on it, and I think Gillian was there at the time too - that the way it was designed, when the fire alarm went off, everybody got locked in the locked ward and they all burnt to death.

Ms CHURCH: Another thing that we discovered was that there was no toilet for the acute unit.

Ms MANNS: That is right.

CHAIR: Because they had never asked a nurse.

Ms MANNS: That is exactly right, so I think there are those issues and I think the things that you are talking about, Dr Pezzutti, often are a matter of design. I still think that, going back to

Ms Fazio, the philosophy of the association for mental health is certainly not to have large stand-alone psychiatric hospitals on a campus that is designated a psychiatric campus. It is around attitude and it is around community attitude. If you say to someone: I am not feeling too good, I am going to hospital. Where are you going? Concord. You could be having anything done. If they say: Where are you going? Rozelle.

CHAIR: Well, we have to get over that and be interested in patients.

Ms MANNS: Well, we are not getting over it, and I mean I do not know how we do get over it, but by building those hospitals will not get us over it, it increases it.

CHAIR: I am not arguing for the 400 bed anything, okay, I am putting some propositions to you because we have to make some recommendations about this. Obviously if the department is helping with 850 more acute beds, and they are because that is the advice from just about every other submission--

Ms CHURCH: Well, I think we have disputed that.

CHAIR: But you are one group of people. I can tell you from the other 275--

Ms CHURCH: I have seen the report you are talking about and it was actually a draft and I dispute that it was actually presented to the minister.

CHAIR: They are always draft, but she is now the director, she wrote it, and as far as I can tell there are going to be some beds built. It might not be 850.

Ms CHURCH: And it was not about acute services, that document.

CHAIR: No, it was not, it was a mix of services.

Ms CHURCH: Yes.

CHAIR: It did not go to rehabilitation services.

Ms MANNS: No.

Ms CHURCH: No, it was mostly long stay.

Ms MANNS: It was about long stay and medium stay as well as some acute.

CHAIR: That is right. What Andrew Refshauge did when he was minister, which I thought was quite interesting, was put some mental health beds within the public hospitals and what you find now in Lismore is a mentally ill patient being admitted to the children's ward in the middle of the night, not to Richmond clinic - fascinating - in Lismore, for heaven's sake, where there is an acute psych hospital ward, but the idea was to try and rotate your general nurses through the mental health wards so that there was a cross-fertilisation of knowledge but, more importantly, to break down what was perceived to be an attitude, you know, the ward 22B at Townsville attitude, the culture of mental health, and somehow that is part of your concern about institutionalisation, as I understand it, and there are ways of going about it, but putting mentally ill patients into a general ward like you would put someone who had any other illness, I mean you do get some people with diabetes, asthma, heart failure, cancer, vascular disease in the same ward, male and female, nobody worries about that.

Dr SMITH: Providing you have the staff to be able to treat those people, that the person with asthma gets specific treatment for his asthma and the person with diabetes is going to get specific treatment for his diabetes. What we are arguing is that in a sort of general ward where people are coming from a geographic area they are not getting specific treatment. Now, okay, the Government has finally funded the Black Dog Institute of the mood disorders unit at Prince of Wales Hospital and we would applaud that because at least we now have at least one specialist unit within New South Wales.

CHAIR: They are not admitting patients to that. The institute is a policy direction area, it is not wards, not patients.

Dr SMITH: It will be once they have built the building.

The Hon. AMANDA FAZIO: Earlier you said your organisation supported the concept of the provision of supported accommodation to people with mental health problems. What models of supported accommodation would you see as being appropriate, because you said that licensed boarding houses was not necessarily much chop.

Ms MANNS: I think there are a number of models and I do think that we probably have to look a little bit at those models and have some understanding, as within the disability sector, that group homes are not the only answer. We constantly have the group home model. I do not think it is the only answer. Sometimes the support may be in a person's own home and it may be providing some support besides dropping in every morning with tablets and that is the only thing you do. I think it is around issues of different sorts of accommodation, but the trouble is, within the mental health sector, we are even yet to have a debate that is realistic because there are a number of NGOs which are providing supported accommodation and would be able to show you different models, but the historical funding to the non-government sector in mental health is so poor that there is very little opportunity to change the way we do things, so I suppose that is what I am saying. They have had numerous debates, even parliamentary inquiries into how you provide supported accommodation within the disability sector, but I do not think we have had a very educated discussion and consultation within the mental health sector and we would probably need to.

CHAIR: We were given two papers of de-institutionalisation into small group homes by 50 or 40 people in the Northern Sydney Area Health Service followed up for two years, where some of them died and some of them could not survive and went back into hospital and so on, but they were quite well-run studies which substantially did not show an awful lot of improvement necessarily in their mental illness but improvement in their quality of life certainly and improvement in their socialisation skills certainly.

Ms MANNS: That is right.

Dr SMITH: I think it depends on how much support. I mean I have seen an excellent--

CHAIR: This was a study done with Northern Sydney Area Health Service funded by the Commonwealth and the State Government and a range of people.

Ms MANNS: That is right.

Dr SMITH: I think the other thing that needs to be said about northern Sydney area is that in terms of the community it has probably got a lot more resources than other areas of the State. If you look at, say, western Sydney you are looking at an entirely different kind of scenario. Group homes work really well providing you have a reasonable level of support or services can in fact be brought in. I guess the issue I have about group homes is that sometimes there is not enough choice and I guess, from when I have been sitting on the Guardianship Tribunal, if you look at a person with an intellectual disability there is often a bit more choice in services than there is for a person who has a mental illness or is living with a mental health problem.

The other thing that needs to be said about accommodation is that people are going to need different kinds of accommodation, depending on how old or how young they are or what have you. Ironically, once people get to their late 50s and 60s and they have a mental illness and they start to latch into the older person's health care system, they are often a lot better off. The difficulties seem to be for people in their 30s and 40s who may not want to live with other people, particularly if they are not going to have any choice about the other people they live with. They find living with other people who also have mental health problems quite distressing or exacerbates their mental health problem, but if they live on their own in a housing unit they are not going to be able to get the level of support that they need to stay healthy.

CHAIR: How confronting is "Big Brother"?

Ms MANNS: It is only a big group home.

Ms CHURCH: Just to reinforce that point, I did a small amount of research a number of years ago with consumers. I conducted focus groups, asking them what kinds of supports and what kinds of accommodation they would see as optimal, and surprise, surprise, just like the rest of us, they want a range, they want a choice.

CHAIR: And there are enough people involved to provide that choice. There wouldn't be 150 choices, but even if there were, there are enough people involved with what Amanda is talking about to offer 150 choices, aren't there?

Dr SMITH: There is often a waiting list. Richmond Fellowship is probably one of the best places to find supported accommodation if you are a young person living with bi-polar disorder or schizophrenia, but they often have a waiting list. So it often means that a person has to wait some months before they can find a place.

CHAIR: If you are intellectually disabled, there would be no waiting list.

Ms MANNS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No.

CHAIR: Substantially that is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not what the disability inquiry said.

CHAIR: As I understand it, the Richmond people have been substantially housed?

Ms MANNS: Certainly that group has, Dr Pezzutti, but the population of people with intellectual disabilities is continuing to grow.

CHAIR: So are the mentally ill.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We need an inquiry to find out what the unmet needs are. It has not been quantified. I don't think you can make a statement like that.

Ms MANNS: I do not want to set up any one group against another group and "We are worse off than you are". I do not think it is about that. It is about service for the citizens of this State, and I think that is what we need to bear in mind, that people with mental illness are citizens of this State.

CHAIR: But this is a group of people who cannot really wait, can they? The alternative for them is homelessness. It doesn't mean they need more beds.

Ms MANNS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They need more beds in hospitals.

CHAIR: No, we are talking about Richmond, we are talking about accommodation for young people with bi-polar disorder. These are the sort of people who have to wait, whether they wait on the street or in gaol.

Ms MANNS: There are other options though that I think we do not look at. I think we do not look at the fact that under the SAPS scheme, women refuges hate taking women with mental illness, youth refuges do not want young people with mental health problems. Those again go back to attitudinal problems and I also think at some level the irresponsibility of the funding body, because the funding body I think has to take some responsibility about exclusion, particularly when it is the public purse.

Dr SMITH: Yes. One of the issues about youth refuges is training of the workers. We have a youth worker degree at the University of Western Sydney which was demanded by youth workers in youth refuges because they were appalled that they were working with young people with a range of pretty complex problems and they did not have the training. If you look at the positions vacant pages in the Herald, there are lots of jobs for youth workers, for shifts at youth refuges. They do not necessarily ask what your qualifications are.

The Hon. AMANDA FAZIO: How transitory do you think the accommodation and support needs of people with mental illness are? In fact somebody from the Compeer program this morning here was talking about people being able to be supported in their home or supported in independent living options.

Ms MANNS: That is right.

The Hon. AMANDA FAZIO: So we want to look at the accommodation needs of people with mental illness. Is it fair to assume that a certain percentage of those people can be streamed maybe from a kids' facility through the supported accommodation, through independent living?

Dr SMITH: If the work is done to work with the person while they are still in an institution, and particularly with the people I have worked with with bi-polar disorder, people are often discharged from hospital, go and stay somewhere pretty temporary, a cheap hotel, maybe a local refuge, maybe into a flat for a few weeks and what have you. It is uncomfortable, they are lonely, they are isolated and they move on. If, on the other hand, there is some work done with a person before they actually leave the hospital and follow-up is organised and the person is encouraged and supported while they are actually leaving the hospital and settling themselves down into some kind of accommodation, yes, it can actually work quite well.

Ms CHURCH: But generally speaking it should be the level of support that changes, not the accommodation.

Ms MANNS: That is right. It would only be in fairly severe cases I think that you have the step down type of accommodation.

CHAIR: Step down is not necessarily cheap.

Ms MANNS: No, I am not saying it is cheaper.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back to the issue of how many beds to be built. My view, to be blunt, is that we should not be pontificating until we have heard all the evidence.

CHAIR: That is right.

Ms MANNS: I think that is a point as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Pezzutti is right in the sense that the majority of submissions want more beds because the majority of people want more everything and they think that is a proxy for more money for mental health. If you ask John Laws' listeners, "Should there be more gaols to put people in", the answer is, "Yes, the more the merrier". You have taken a strong position against necessarily more beds being built, and my gut feeling from the people I have talked to who have studied this subject is that until you have built the community supports and supported accommodation to a high level, you probably do not even know how many beds you need. Until you know how many to keep out of institutions, you do not know how many institutions you need.

Ms MANNS: That is right, once you build the beds you fill them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Once you have built the beds, you have done your dough and the opportunity cost is paid.

Dr SMITH: One of the issues that is a problem with mental illness is that you do not know how many people are going to develop a mental illness. We say one in a hundred people have bi-polar disorder, three in a hundred people have schizophrenia, five in a hundred have severe depressive episodes, that type of thing.

CHAIR: But some of them are not disabled by it at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It doesn't mean they go to hospital.

Dr SMITH: Precisely, it doesn't mean they go to hospital.

CHAIR: Or they have got to take treatment for it.

Dr SMITH: Okay, so then maybe you are looking at what services do people actually need. One of the issues I have about people being admitted to hospital is that often hospital care is not what the person actually needs. Sure they might need medication, sure they might need some kind of interpersonal supervision during the day, sure they might need some help getting meals, sure they might need some help with being lonely or what have you, but you are not necessarily going to get those in hospital anyway. Hospital is an easy solution because everybody assumes that once you get the person into hospital, all your problems are going to be solved, and they are not.

CHAIR: That is an issue in your recommendation number 1. Recommendation number 1 has referred to the Richmond report as being "substantially implemented". Then you say, "Most people who are able to access treatment are treated in the community or in the general hospital setting". Of course, if they are able to access treatment, then they are going to be treated in one of those two places. Where else can you be treated? So the recommendation (a) is nonsense, but (b) how many people, in fact it should be "all" -

Ms CHURCH: Where is that?

CHAIR: This is on page 21 of your recommendations. That "most" should be "all" - "All people who are able to access treatment are treated in the community or a general hospital", because there is nowhere else they can be treated.

Ms CHURCH: That is not our recommendation. It is the Richmond report's recommendation.

Ms MANNS: We are commenting upon the Richmond report's recommendation.

CHAIR: I am sorry. That is why I was surprised by that recommendation at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not their recommendation.

Ms CHURCH: No, it is a comment on the recommendation in the Richmond report.

CHAIR: Where is your recommendation number 1?

Ms CHURCH: At the beginning. You are looking Appendix 1.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Page 4.

CHAIR: Page 7.

Ms MANNS: We will look at page 7.

CHAIR: "The changes that have taken place since the adoption of the Richmond report". It says that it is time to move on. The trouble is that the very same people ended up in institutions in the days before Richmond, because after all, New South Wales had a very enlightened, for its time in the 1890s, types of treatment of the mentally ill.

The Hon. AMANDA FAZIO: Is that the last time we had a good treatment system?

CHAIR: No. At the time, and we have been through various changes, and we have had to have royal commissions, like just about every other nation in the world.

Ms MANNS: Yes.

CHAIR: We then followed basically what was happening in Italy and other experiments, and Richmond came along, as quite a young man, and you now say it is time to move on. Well, a lot of people are saying that for the same reasons that people were put into institutions in the past, namely the need for long-term care while they got better. We had the representatives of St Vincent de Paul saying today that sometimes you need a dual diagnosis.

Ms MANNS: That is extremely rare.

CHAIR: If 20 percent of the population in New South Wales at any one time have a mental illness or are mentally ill, treated or not treated, then we are talking big numbers, we are talking about one million people in New South Wales minimum over the age of 18, because there are five million voters. There are seven million people in New South Wales. So we are talking big numbers. So even if a small number of those big numbers need it, then you are talking again still big numbers. Some people talk about the need to get well, both mentally and physically - this is the physical/mental thing - then there is the need for socialisation and the need for employability and employment. They are the four aims when you are looking at mental wellness, it includes sociability and employment, and it means being physically well as well as mentally not ill if you like. For some people to get well after their first decompensation with schizophrenia or first decompensation with a bi-polar disorder of various sorts, they have obviously decompensated over a short period of time and they are often quite unwell physically and they are quite jangled. The drugs don't kick in in a minute or the ECT does not happen tomorrow. So they are there for at least two or three weeks, usually six weeks. What happens after that? They are certainly not well enough to go straight back to work as a hairdresser, so what happens after that? What some people are recommending is a longer period where they can actually get themselves on their feet. Many parents have said this statement, that their son was in a long stay care arrangement for 18 months after the first decompensation and that set him up for life.

Dr SMITH: Yes.

Ms MANNS: That may well be -

CHAIR: What is your attitude? They are the people you deal with all the time. You deal with parents and relatives. They are the sort of things that people are writing. Are they wrong or right?

Dr SMITH: They are both, and again the issue is we need to look at the individual. Sure, yes, 18 months care, if you have an episode of -

CHAIR: I am not talking about in a big institution, but we need some places like this.

Dr SMITH: One of the things that people talk about in the mood disorder groups is the days when Rozelle Hospital actually had day programs, and they were wonderful. You could go home at night time, providing you lived in the local area, and you were actually able to spend your time during the day doing something that felt comfortable and productive and what have you.

One of the issues that we have with people that come along to our support groups is that they do not relate to the living skill centres that have been set up by our staff. A lot of the better functioning people say, "Well, they're all schizos there" or "People there are pretty burnt out" or something like that. There are levels within groups of people who have mental health problems. If you are a young person who has been reasonably high functioning and you have just had an acute episode, you are not going to relate to somebody who is in their 50s and has a longstanding illness.

It comes down to more choice I guess, and if there is only one living skills program and it is dominated by middle aged men with schizophrenia, you are not going to get young women with bi-polar disorder coming along to it. They are just not going to relate to it at all. That is one of the issues. One of the problems that we have with our support groups is that people often want to come along to our support groups because it is something to do during the day. It is a pleasant kind of social experience where you can talk about similar issues with people who are like yourself. The problem we have is that we do not have resources to set up enough of them. I suppose that is where the partnerships come in. The only way we are going to get to set up more support groups, say, is to work in partnership with mental health services and other community organisations that have clients that they want to refer on.

CHAIR: What about the club house movement?

Dr SMITH: The club house movement I think works really well again for maybe younger people with fairly acute severe mental illnesses. I do not think personally that it works terribly well for people with bi-polar disorder because often people with bi-polar disorder become reasonably well between episodes and are able to resume employment or go back to study or what have you. Ironically, I work at a university and I have noticed a lot of young people coming through who have recovered from an acute episode of mental illness and are now coming back to university. It has been changes to disability policies and EEO and affirmative action and anti-discrimination stuff that has made that possible for a lot of young people. That is not going to be possible for some people with schizophrenia and that is where maybe the club house model does actually work.

Ms MANNS: I think the club house model too is specifically around issues of employment. It is based around the work ordered day and I think that is also limiting in a way because it is only one model and it is about work for some people, different sorts of work. I mean I think we need to expand on it. The club house model is fine for one group, but it is not the be all and the catch all.

I also wanted to go back a little bit. Dr Pezzutti was talking about the Richmond report and that we have not solved the issues. We are not saying that we have solved those issues, but what the association said in the submission was that another inquiry that actually puts the failure of a previous inquiry into its terms of reference appears fairly limiting because we are already limiting ourselves to look at something that we do not think worked so many years ago or was not carried far enough. There certainly need to be far reaching inquiries into how we deliver mental health services in this State.

CHAIR: Just so that I do not get confused, what is appendix 1?

Ms CHURCH: That is our response to the Richmond report. We did not put it into the body of our submission, we put it as an appendix.

CHAIR: So reference (a) of the inquiry is really what appendix 1 is about?

Ms CHURCH: Yes, that is right, term of reference (a).

CHAIR: Surely you should have said all people are able to access treatment. How many people are unable to access treatment? In other words, what is the unmet need and how, with people not being able to access the treatment that they need--

Ms CHURCH: We would have to look at the recommendation.

Ms MANNS: I think what we meant to say, Dr Pezzutti, was what I was just saying to you: The association was very clear in its discussions as a group that we felt that an inquiry that was taking as one of its terms of reference the failure of a previous inquiry was already limiting itself.

CHAIR: I see. Well, no, the inquiry is really as a result of the fact that Richmond is now 20 years old.

Ms MANNS: Yes, but we felt fairly strongly about not wanting to go into the changes that have taken place since Richmond because they are numerous, but then some people on the board wished us--

CHAIR: Some of them are not the result of Richmond, some of them are just simply things that happened.

Ms MANNS: Exactly, and there have been a lot of other inquiries, as we said. I think Australia - and New South Wales as well - needs to take some credit that we have done some things right.

CHAIR: I do not doubt that.

Ms MANNS: Not everything is bad.

CHAIR: The Mental Health Act reflects that. The change to the Mental Health Act changed that too.

Ms CHURCH: Yes.

CHAIR: But to the extent that we are now operating in a de-institutionalised society, are we now providing the same level of services for the people for their mental illness and for their ongoing day to day living is the question.

Ms MANNS: I think we are probably still treating the same number of people and I think the people that we are treating are getting, for the most part, good care. However, I think budgetary constrictions - and I think that is quite societal, you know, we are not really thinking very clearly as a civil society today and if we were there would be very few problems within such areas as disability and mental health.

CHAIR: Don't you think it is interesting because there are so many of us who have got it, but it is one thing that we just seem to be able to deny. It seems really odd that we can deny red China, I mean in policy and in spending terms that we seem to have this ability, in the community at large, to say, oh, it's over there or let's keep it out of sight.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But we deny reality all the time.

Ms MANNS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have been amazed since I have been in Parliament how much people deny reality.

Ms MANNS: We know a good hospital where denial of reality can be treated.

Dr SMITH: One of the frustrations I have found working in the mental health area is that people have an acute episode of illness, they think it is never going to happen to them and often the reaction is that, as long as I find a good doctor, you know, can find the sort of magic pill that is going to cure my illness, not have to tell anybody else about it, when I go into hospital it is going to be something like Chelmsford which is so innocuous no one is ever going to know why I went into Chelmsford, I just went in there for a rest, and, okay, it turned out to be bad news for some of those people, but anyway--

CHAIR: I had a nervous breakdown, but the mechanic came along, they changed the tyre, put a new spark plug in and I'm right again.

Dr SMITH: That is right, yes, and as long as I can keep up my private health insurance I can keep my good psychiatrist and all that sort of stuff. Of all the people I have seen over the years, okay, in the mood disorders area but also through the mental health association, only a small fraction of them have ever got involved in advocacy for mental health, action at the level of actually speaking out publicly, and I cannot see that changing, quite frankly, because there is still stigma and still discrimination.

CHAIR: Why is there a stigma against, say, Northside Clinic being able to admit patients compulsorily?

Dr SMITH: People with depression do not see themselves as having a mental illness.

CHAIR: No, I mean people who have to be scheduled. Why can't they be scheduled to a private hospital?

Ms MANNS: I do not have a problem with that, but I think many of the other clients at the Northside Clinic are the ones that would be having the problem with it. That is why they are going to the Northside Clinic.

CHAIR: Say the St John of God organisation decided that it was going to run a private psych clinic for scheduled patients. I mean this is a problem for Port Macquarie and it is a problem for Hawkesbury Hospital. They cannot compulsorily admit because they are private hospitals. There is a change of Act needed.

Ms CHURCH: It is not because they are private hospitals but because they have not been gazetted, and they could be if the clients--

CHAIR: Well, they cannot be gazetted, we are told by the previous minister, Andrew Refshauge - and I think he is right, he was not mucking around with this one - because of the Act.

Ms MANNS: I think that is quite correct. I also think that there are a lot of issues around that, Dr Pezzutti, and one of them is that some people choose treatment in a private hospital specifically for that reason, that they will not have to mix with people who have been scheduled.

CHAIR: Yes, but the Government actually stops them. For example, if my son became acutely mentally ill and I had to struggle through the public system and they throw him out in 12 days when he is just vaguely getting well and I have the option of going to a private clinic where I can see my own psychiatrist who might have been looking after him outside, but he does not have access--

Ms MANNS: It works in the private hospitals too, you know, unless you go to the one that your doctor goes to, you cannot bring your own in.

CHAIR: No, but in the public hospital, say my doctor does not go to North Shore public, for example, but goes to the Northside Clinic. He cannot be scheduled to the Northside Clinic. It is a first-class institution.

Ms MANNS: I agree.

CHAIR: I do not know whether they want to do it or do not want to do it, but the fact is that they are precluded by legislation from even trying to do it.

Ms MANNS: I agree.

CHAIR: Now we have emergency departments in the private sector now, we have all sorts of things happening in the private sector now. Why is involuntary psych care - voluntary psych care is all over the place, but involuntary psych care, absolutely no.

Ms MANNS: I have no philosophical problems against it.
CHAIR: I just don't know why it is.

Ms MANNS: I don't know why.

CHAIR: Is it because of Chelmsford, because we had to legislate because of that?

Ms MANNS: I would say that would be hanging over a lot of politicians' heads. I don't know who would like to bite the bullet and say because it does become - the greater the number, I would say, of schedule hospitals and gazetted agencies, the more difficult they are to regulate, police and all of those sorts, and the next thing is we have another Chelmsford.

CHAIR: Well, like the day surgery centres. You can set standards, which you then have to live with yourself, of course, which is a problem. The other thing I am interested in is why are there no psych beds that are accredited in New South Wales under the ACHS?

Ms MANNS: I thought some of them were. I think Rozelle is.

Ms CHURCH: Yes. North Shore?

Ms MANNS: No, North Shore is not accredited at all I don't think.

CHAIR: The whole hospital, no, I know that, that is a problem, but that is basically an OH&S problem. North Shore has an OH&S problem.

Ms MANNS: They certainly are part of the accreditation system, mental health, psychiatric departments, and a lot of work has been done at a Commonwealth level and with ACHS to bring the method of accreditation in line with the national mental health standards, so it is coming on quite well and they are using consumer surveyors.

CHAIR: Somebody has made the point in one of the submissions that they are not accredited.

Ms MANNS: Well, I do not think that is right.

CHAIR: It is because there is not an accreditation process which is appropriate to judge them.

Ms MANNS: No, there is and it is happening. I do not think that is right, I think they are being accredited.

CHAIR: Is there anything else you would like to say?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I would like to confess that I am the one who put Richmond in the terms of reference.

Ms MANNS: I knew that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought I was doing good.

Ms CHURCH: You meant well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I meant well, and I notice you wanted an international mid-term review of the second National Mental Health Plan for Australia 2001. Well, it is submission 226 from the Commonwealth Department of Health, it is part of that, so you will be delighted to hear that that has been taken care of. As you come from the Northern Sydney Area Health Service, we have heard of the Curtis report this morning. Do you agree with the Curtis report and is it typical of health services in New South Wales, although it only relates to northern Sydney, doesn't it?

Ms MANNS: I can answer that on a personal level, I would not be prepared to answer on behalf of the association. I think there are some problems with the Curtis report. I think a lot of people have embraced it because Laurie Curtis is a wonderful woman, she came from America and she is very consumer focused, and that is very good. However, I think once you look further into the Curtis report there are some problems of implementation and I think you would need to really look very closely at it.

The other issue around northern Sydney, Northern Sydney Area Health Service actually looks like it funds a lot of NGOs, but you have to realise that it funds us, ARAFMI, Schizophrenia Fellowship, all those NGOs that are different sorts of NGOs. There are very few accommodation services and those sorts of things in Northern Sydney and I think in that report you were talking about they were actually talking about health department accommodation services for the most part. There are a couple of church accommodations.

CHAIR: Yes, I mean New South Wales' funding of NGOs is legendarily bad.

Ms MANNS: Yes. I have suggested in Northern Sydney often that they really need to think a little bit more clearly about how they are funding their NGOs.

CHAIR: Do you think they are frightened to fund the NGOs because the NGOs with money are more dangerous than NGOs without money?

Ms MANNS: Well, probably.

CHAIR: Other States get, say, five percent of mental health funding for work of NGOs, which does include drug and alcohol treatment and all sorts of things, but for some reason New South Wales is 1.3 percent of funds, and our funding is pretty low anyway, so it is a big issue.

Ms MANNS: It is an issue we have raised for a long time.

Dr SMITH: And we initiated some of the non-government programs and I think it is one of my personal bones of contention that we have actually initiated some fairly innovative programs in New South Wales but we did not get the funding, but in Western Australia and Victoria they got funding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: For ones that we invented, you mean?

Dr SMITH: Yes.

CHAIR: We have the brain power in New South Wales.

Ms MANNS: We have the brain power, we have the innovation and we have the dedication, but we have not had the money and we have not had the money for a long time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I just come back to Curtis again.

Ms MANNS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have said it has implementation problems.

Ms MANNS: That is only personal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that was the official response too?

Ms MANNS: Was it? I don't know. I do not have anything officially to do with Northern Sydney.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I see, but it has funded the umbrella bodies in the whole State, which is kind of generous of it.

Ms MANNS: Well, it is not actually. When we had the deregulation, I suppose, of the NGO system throughout New South Wales Health, decentralised or whatever we called it, the area health services became responsible for those organisations that were in their geographical area, so we just happened to be in Northern Sydney, as did Schizophrenia Fellowship, ARAFMI--

Dr SMITH: Yes, because Northern Sydney, of course, encompasses all the old campuses of the big psychiatric institutions, so it is convenient for them.

Ms MANNS: We all have free accommodation in those places.

CHAIR: Well, thank you very much indeed, it has been worthwhile and I am sorry if I was a little confrontational, but it is really the only way to draw some of the things out.

You will get your transcript within the next week. If there is anything there that you would like to add to, if you think your answer was not long enough or you have thought of something smarter to say, or there is something you think in a question that we asked that missed the point or something, would you please drop us a note?

Ms MANNS: Yes.

CHAIR: We will be having other inquiries and it may be that we will want to talk to you again. If you would return those to us, we will make those public, they will go on to our web site so that people can see what you are saying and that will inform them, as we get further and further down the tree, so that people can say, well, I won't say that because everybody has said that and I agree with that, in other words it adds weight to it, but it gives them an idea of perhaps broader thinking, because of the nature of your organisation, of the things you have looked at in some detail.

(The witnesses withdrew)

(The Committee adjourned at 4.35 p.m.)