REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

INQUIRY INTO MENTAL HEALTH ISSUES IN NEW SOUTH WALES

At Sydney on Friday, 31 May 2002

The Committee met at 9.30 a.m.

PRESENT

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

The Hon. Dr A. Chesterfield-Evans
The Hon. J. Hatzistergos

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IAN WILLIAM WEBSTER, Medical Practitioner, 3 Grosvenor Road, Lindfield, affirmed and examined:

CHAIR: You are conversant with the terms of reference of the inquiry?

Professor WEBSTER: Yes.

CHAIR: You made a submission which is numbered 193. Do you wish this submission to be included as part of your sworn evidence?

Professor WEBSTER: Yes, I do.

CHAIR: Should you 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 may overturn the Committee's decision and make that evidence public.

Professor WEBSTER: Yes.

CHAIR: I wonder if you could speak to your submission and then we might ask you some questions.

Professor WEBSTER: Thank you. I appreciate the opportunity enormously to make presentation to you today and also to have made a written submission. My written submissions addressed four areas and I am going to concentrate today in my discussions with you on the problems of substance use as it relates to mental illness, but in my written submission I dealt with the homeless mentally ill, the combination of mental health and substance use disorders and I wanted to present to you the idea that mental health is a public health problem and that we need to have a broad frame of reference in thinking about mental health in those terms. I also wanted to speak to you about the role of the media in mental health and in suicide, but perhaps I can do that on another occasion if we are dealing primarily with drugs and alcohol.

CHAIR: If we could start with drugs and alcohol, and you might just let the Committee know of some of your current appointments?

Professor WEBSTER: I am emeritus professor at the University of New South Wales; I chair the National Advisory Council on Suicide Prevention for the Commonwealth Government; I am President of the Alcohol and Other Drugs Council of Australia; I chair the Alcohol Education and Rehabilitation Foundation which is a newly established independent foundation established by Parliament; I am chair of the expert advisory group on drugs arising out of the Drug Summit in New South Wales; I am co-chair of the Mental Health Implementation Group with the Department of Health and I have just recently been invited by the Premier to co-chair with Professor Beverley Raphael a whole of government response to the problem of combined substance use and mental health disorders.

CHAIR: Thank you, that just puts it in context, and I know that you are appearing today in your private capacity, but that gives us a certain focus on your expertise in this area. Can we go to the area of substance abuse first, but we certainly want to hear your views on other areas.

Professor WEBSTER: Perhaps I ought to give some context as to why I felt I wanted to come to speak to you. For many years I have been a professor of public health and community medicine where drugs and alcohol have been key public health issues and, as I say, mental health I think is a public health issue too and should be dealt with in that way.

During my time in Sydney I have run a clinic for homeless people at the Matthew Talbot Hostel and that started before the Richmond report and I was caring for patients during the period of time of the Richmond report and subsequently. I suppose at the time of the Richmond report and

those events I felt, like lots of medical people, that the closure of hospital based beds, institutional beds, was probably a bad thing. I do not think that any longer. I rapidly came to the conclusion that, as that affected mentally ill people at the time, it probably had little bearing on the transfer of mentally ill patients to the community and I have seen the predicament of mentally ill homeless people as one which is what I describe as a pincer movement. They are the most vulnerable people in our society, the severely mentally ill, and by many of the processes which government and communities adopt they get squeezed out into the situation of homelessness. What is particularly notable about that is that it is predominantly men who are homeless mentally ill. There are mentally ill homeless women but, for the most part, it is men.

The sorts of things I think which lead to them ending up in that environment goes back to one of the central points in my submission, that when people have mental illness and a substance use problem or mental illness and any other problem the likelihood that they will get that dealt with satisfactorily falls exponentially with the number of problems that they have. If you have one human problem in our system you have probably got, let's say, a 60 percent chance of having it picked up. If you have two, that starts to fall exponentially because people categorise the responses that they make. The mental health system will only see the mentally ill; the drug and alcohol system in the past would only see people with drug and alcohol problems; the surgeons at the hospital were reluctant to have a mentally ill patient in their bed for the operation of a hernia and many of the eligibility and targeting that we adopt in government programs effectively excludes the people with most needs. So my view about the prevalence of mental illness amongst the homeless is that they are there because many of the government programs and eligibility criteria for many of the things like housing, access to welfare benefits, access to medical care indeed, access to other rehabilitation programs and the like, get closed down because they have often got combined disorders. I see it as more a social, community and, rather than a problem of the mental health services, a problem of many elements of government, and perhaps that is the starting point I take.

If I might now take up the drug and alcohol area specifically, the first thing is that drug and alcohol problems are extraordinarily common, very important and very prevalent in our society, and it is only very recently - about three years ago - that in Australia we have been able to document in our community the extent to which there are people in the community with substance use problems and mental health problems. That was the national survey of well-being and in that was documented the proportions of people actually in the community who have combined either mental health or substance use problems or different sorts of mental health problems, anxiety and depression. In my submission I table those figures, and they are probably known to you, but it is much more prevalent and much more common than people appreciate.

The second thing is that by the time people start running into trouble and present to a mental health unit or present to a drug and alcohol program, or indeed are in trouble with the law or with the prison system, the prevalence of these problems multiplies and in the drug and alcohol service, broadly speaking, we estimate that between 30 percent and 80 percent of people who are in treatment for drug and alcohol problems have an underlying mental health problem, and that is probably conservative, but it depends. When you look at people in the methadone program the vast majority of them have had depression and anxiety, suicidal behaviour and many other things and, conversely, when you look at the people who come in to contact with mental health services, they too have very high rates of substance use problems. It is a question of how you define that. If you were to define smoking you would find about 90 percent of them had a substance use problem, but, if you take young people apparently who get admitted or get taken in in an acute stage of a psychiatric problem, almost every one of them is using a substance of some kind. Commonly it is cannabis but it may be other substances, so the overlap between those things is enormous.

The skills required to deal with drug and alcohol problems span two defined areas of medicine. At one end it is mental health where drug and alcohol problems may be causative, consequential or complicating the mental illness and at the other end is physical health where substance use, tobacco or alcohol damage the human body and, of course, of recent times, we realise they can spread infection with HIV AIDS and we have both of those compartments pretty well developed, but the drug and alcohol area has not been very well developed at all and there is a tendency to say that people with drug and alcohol problems are difficult people, unpleasant people,

and we do not want to deal with them, but actually the skill requirement and the service requirements span both mental health and the physical health side. Just thinking about physical health for one moment, one of the outstanding characteristics of people with long-term mental illness is that their physical health problems are commonly neglected, they get poor attention.

The Hon. JOHN HATZISTERGOS: What sort of problems are we talking about?

Professor WEBSTER: Physical health problems, chronic lung problems, bronchitis, high rates of neglected liver disease.

CHAIR: Hepatitis C.

Professor WEBSTER: Hepatitis C. They have very high levels of risk behaviour, and of course amongst the homeless there is virtually not one person who has normal health, in fact it would be the rarity of about one percent, I would say.

CHAIR: How many of these people might have a consequential or a preceding head injury as well?

Professor WEBSTER: Certainly in the homeless scene, a high proportion, but in the drug and alcohol field and the mental health field generally it is a bit hard to discern. There is evidence, for example, that people who take overdoses actually get mental impairment as a result of that and one area I wanted to highlight, which I have not highlighted in my submission, is that there is a whole area of people with alcohol related brain damage who nobody is interested in providing responses to. I mean the mental health system excludes them; the aged care system excludes them; they often have behavioural disorders which are difficult to manage and unpleasant and they get really excluded.

Going back to Mr Hatzistergos's question, I would just like to say that Western Australia is extraordinarily well set up to study what happens to people in the health system. They have a data linkage system which links all hospital data and all health data and they did a study of people with mental illness. You probably have had access to this, but it showed that the death rates of people with mental illness were four times that of the population, or a figure of that order, and the life expectancy of people with chronic mental illness is 40-odd years, equivalent to that of the Aboriginal population, and that is because they get poor access to general medical services, another reason having neglected physical health problems; they smoke; they are often exposed to drugs; they have other high risk behaviours, as you mentioned, hepatitis C, and it has been a very much neglected area. I would argue that probably the best people to engage with that holistic problem or aspect is the process at the primary care level with general practitioners. I mean the mental health people are not good at doing physical examinations and I suppose, on the other side, people are not that good at doing mental health assessments.

I have talked about the problems of clinical services. I just want to make another point: There is a common belief amongst doctors and everybody that addiction treatment is pretty ineffective and that is simply not true. There is a report in the Lancet of some years ago - and I think I quote it in my submission, but I certainly have some tables here - that the treatment of addiction is as effective as the management of diabetes, high blood pressure and asthma. In diseases like asthma we accept that people relapse, we accept that they do not follow their treatment plans, but if it happens in the drug and alcohol area we say the person has failed and we ought to kick them out of the program. If you take diabetes as an example, the extent to which people follow their foot care, diet and insulin use and so on, the compliance rates are quite poor. In fact this publication said that compliance with the medication regime was less than 50 percent in people with diabetes and the compliance with diet and foot care was less than 30 percent and the relapse rate in diabetes was 30 to 50 percent.

CHAIR: But we do not turn them away when they relapse?

Professor WEBSTER: No, that is regarded as part of the normal, that is chronic relapsing conditions, which mental illnesses are.

CHAIR: And even if you stick to your program, whether it is asthma or diabetes, stick rigidly to it, you are still going to have relapses of that condition.

Professor WEBSTER: Yes. I have some figures here that with alcohol the success is of the order of 50 percent, 40 to 70 percent; in managing opiate dependence, about 60 percent, that is a range of 50 to 80 percent of cocaine and nicotine, and yet the general impression is it is hopeless and this probably happens in mental health systems. I think in a way they are not as optimistic about managing mental health problems as they ought to be, so I am just trying to indicate that there is a sense of nihilism and defeatism and discrimination against people who have substance use problems, particularly if they are mentally ill, which is unreasonable in terms of achieving better outcomes.

I just want to make two other comments and then I will retreat a bit on this initial introduction. One of the dilemmas being faced in hospitals and environments where people present with acute illness is how to manage the acutely disturbed person, the person who is psychotic, and there has in the past been the tendency to say, well, I am not prepared to look after that person unless you fix up their mental problem first or, if they have entered the drug and alcohol system, I am not prepared to look after that person unless their psychosis is managed. Clearly those things have to be better managed together. Hospital systems have to be better organised so that it happens. I know in hospitals when people deteriorate in the mental health unit they have to be carted across the medical unit to get some decent care and vice versa. There should be much better holistic care of people who are admitted with mental illness with their physical health problems.

Getting back to the acute case, the key thing in managing those people is safety. The key thing is to get hold of the psychosis first, and we do have effective medications and ways of treating acute psychosis which again often people do not appreciate, so that a person who presents very disordered, perhaps drug using has to be treated as if it is a medical emergency, just as we would treat an asthma attack presenting at the emergency department as a medical emergency. There is a tendency to set the mentally ill aside and leave them and not respond to them. There are effective ways of managing acute psychosis. There are guidelines which the Department of Health has developed for emergency departments to manage them. In fact they are fantastic little handbooks which all doctors should carry around. We just have to treat this much more up-front and seriously as a primary response of the health system rather than setting it aside.

My final comment is that there is discussion in the drug and alcohol field about how you approach these complicated problems like drug using people and, in the mental health area, people who are acting out. I think the notion of harm reduction, which is trying to contain the problem, not necessarily get rid of it, a sensible medical approach of trying to reduce the set of harms or limit the harms that these people are exposed to, because the judgment of mentally ill people is often poor and their risk taking behaviour high, is a fundamental and very important idea in managing people who have particularly complex behavioural disorders.

CHAIR: The separation of mental health and drugs, according to my reading of a document from the department, happened in the 1970s.

Professor WEBSTER: Yes.

CHAIR: Why was that done in the 1970s, because you would have been around then.

Professor WEBSTER: Yes. Well, it was a combination of two things I think, and this has not happened in other countries, incidentally. In the United Kingdom they are run together, but even there it is strange that even the psychiatrists tend to have difficult relationships. It happened for two reasons. First of all, I think the mental health system people were realising that there were people inappropriately located with brain damage and long-term drug and alcohol problems and they were not being managed well, but within medicine the drive to become interested in drug and alcohol was led by gastroenterologists, people who were investigating the liver. The first drug and alcohol clinic in Australia I think was established in Melbourne at St Vincent's Hospital and in fact Jim Rankin, who was in this State, was one of the first doctors to go and work in it.

CHAIR: He is now working in Lismore, I think.

Professor WEBSTER: That is right, and he was one of the first doctors to run a drug and alcohol clinic in Australia. There was one at St Vincent's Hospital here in Sydney run by a chap called Bill Hennessey, but they were essentially gastroenterologists interested in liver disease and the effect of alcohol on the liver and in medicine generally there was not much public discussion about drugs and alcohol. If you look through the medical journals of that time there is hardly an article about it, and I might mention in parentheses that the non-government organisations of that day were often led by doctors, the noblesse oblige. Weary Dunlop was a member of the non-government drug and alcohol unit in Victoria. I am president of the Alcohol and Other Drugs Council of Australia, but William Refshauge was involved in its forerunners and Nan Waddy, who was a quite famous psychiatrist and still on the Mental Health Tribunal in New South Wales, was president of that organisation. They were doctors and people who said that there were bigger issues about drug and alcohol that needed to be addressed socially and in the community. George Wilson was another one, as a general physician at St George Hospital. So drug and alcohol tended to be driven by a medical paradigm and, to some extent, it has even been taken more down that track with the HIV AIDS epidemic and the spread of those things and I think we have to build better bridges between that physical health orientation of drug and alcohol and the mental health because, after all, it is the mind that goes wrong in addictive behaviours and it is the mind that is the problem, of course, with mental illness, and it is very often to describe or differentiate the particular characteristics, particularly in community settings, it is very difficult to separate the feelings and beliefs and views of the world that a substance using person has from someone with a mental illness in a community setting where they are quite florid, say, depressions or schizophrenia.

CHAIR: If people who have a drug problem or a mental illness problem or a combination of both were looked after by the same, or say it came under mental health for organisational purposes, do they require the same sort of rehabilitation and the same sort of general medical care? In other words, is it possible to put them together without detriment to either service?

Professor WEBSTER: Well, there are some very similar principles in both. I do think it would be possible, but you need to think it through fairly carefully. Burdekin, in his review on mental illness, has a whole chapter on the problems of substance use and mental illness and he makes it very clear that the sort of ideological dynamic of both are very different - I hope they are changing. In mental illness there was much more the case management proactive follow-up. In the drug and alcohol field I am embarrassed to say that people could decide to treat or not to treat a person for a whole set of reasons. One would be they are not prepared to accept our particular approach, abstinence or whatever it may be, and it is their motivation which is the key problem.

I think that, both in mental health at present and in the drug and alcohol system, the way we assess people for admission into these systems is worrisome. To get into a detoxification unit is certainly, wherever it is, even in the organisations I work in where I would have tried to have managed it differently, still requires people to ring and ring, day after day, to find out whether there is a bed. Those organisations then insist that they quite independently assess the need for detoxification, despite the fact that an expert may already have decided that, and the same unfortunately happens I think in the mental health system. A general practitioner who can be well-knowledgable or a physician - myself, I have had this experience - who realises the person needs to be followed up by a mental health team sometimes feels humiliated by the fact that they insist on reassessing the person again before they will even decide to accept the person.

The Hon. JOHN HATZISTERGOS: Just on that issue, I was troubled during the period of the drug summit, I went to a number of rehabilitation facilities where they were telling me that people were being referred, this is a constant picture I got from Sydney, the people were taken in or being referred in for treatment and just totally lacked motivation, they may have been prompted by a conflict with the law or there was some other precipitator, independent of their own desires to go for some form of treatment; money and resources were put towards trying to address the individual's problem and it was just a total failure.

The factor that came across to me as the reason for that failure was a lack of motivation in

the individual. This was particularly noticeable with young people, particularly young people who commenced with substance abuse and had a whole series of other problems you mentioned. How do we address that motivational problem?

Professor WEBSTER: You are absolutely right.

The Hon. JOHN HATZISTERGOS: We are wasting resources, and not only wasting resources, but we are denying other people the opportunity to access those resource who may genuinely want to get treatment?

Professor WEBSTER: Yes.

The Hon. JOHN HATZISTERGOS: If there is a scarcity as you say in resources, why should not the rehabilitation people be able to make their own assessment of individuals to see if they are suitable for the treatment or not?

Professor WEBSTER: I think probably inappropriate people were being referred to those places. You are absolutely right, motivation is a key point of change in dependence, as it is with many medical conditions to overcome, whether it is managing diabetes. You can look at managing dependence as a sort of right angle - on one axis we might have degrees of motivation and on the other axis degrees of dependence. A highly dependent person who is poorly motivated is going to have to have, if we are going to change that person, a tremendous amount of input into them.

In the drug and alcohol field that person might be the sort of person who would go on a methadone program. You are substituting the dependence on street heroin with a prescribed medication and then you can work with their motivation which develops over time. To become dependent does not happen like that. It takes years to become a dependent person for the most part, and it takes years to come out the other end. If you think that people in general can be rehabilitated quickly, it does happen, but it is a rare phenomenon. I say to people, "You have this problem of dependence. You have the problems in your life. You have the medical problems, but you have to become a different person. And how you are going to become a different person? You have to relearn a whole lot of things".

The Hon. JOHN HATZISTERGOS: It is not only the physical dependence, it is the mental dependence as well. They are stuck in lifestyles that they are reluctant to disengage themselves from.

Professor WEBSTER: That is true. To discuss motivation is quite a big topic. You mentioned people being sent by the courts, in fact the courts are probably the most powerful motivators for change. The drug court program in New South Wales I think will prove to be effective.

The Hon. JOHN HATZISTERGOS: They carefully screen who they take in. They do not take every one in. I have enough people tell me that they complain they can not get their clients in because they are assessed and found unsuitable.

Professor WEBSTER: The people who are being taken into the drug court program are the most difficult. They are screened to take the most difficult. If you took the easier ones, the likelihood of success would be better. They are screened but they are screened because the Parliament or the legislators decided if we are to prove that this works, we will select the hardest group. In your right mind you would not have chosen that if you were trying to reach the largest benefit.

Coercion is a very effective change motivator, and being a doctor and belonging to medicine, many of us feel very uncomfortable about coercive treatment. Out of the drug summit and seeing some of these things I believe it is effective.

CHAIR: It is a choice thing, the person in the drug court has a choice, you go to gaol or you do this diversion. You are right about the most serious case because the dropout rate is quite high,

which is what you would expect, but the success rate of those who go through it has been surprisingly good.

Professor WEBSTER: Yes.

The Hon. JOHN HATZISTERGOS: What about young people, is it effective?

Professor WEBSTER: Coercion?

The Hon. JOHN HATZISTERGOS: Yes.

Professor WEBSTER: Can I take a step back. In dealing with addiction the idea that suddenly something happens at a point in time is not true. What happens with addiction is what we call a process of change. Tobacco smoking is probably the simplest one to take in the first instance. There are people smoking cigarettes who would not even think about changing, but after a while there are events that might take place, advertisements or they have observed what is happening around them, people getting ill. We describe people as becoming precontemplators; they are people who may be contemplating changing. Then an event will change in their lives or they have been exposed to a doctor or developed an illness and they become what is termed in this language a contemplator, they are contemplating change. Then they may change. They will stop smoking or stop using a substance, and then there is a period after that which is the maintenance of abstinence where there is a risk of relapse.

Now, each stage of that requires a different level of input. Each stage of that is to do with motivation of one sort other another. Public advertisements, campaigns that, say, the Commonwealth Government is running about illicit drug use, may shift some people along that line a bit, but it is often not until you have personalised the problem to the person that they may be really motivated to change.

Then having changed, smoking is a good example, maintaining abstinence is a hard job, that requires effort too. Now, in young people I do not think there is any clear answer for me but I think that for a start the question would be whether the type of drug problem that is being considered is a problem that requires intense treatment or not. If it does require intense treatment, yes, I think coercive factors would be important but we do not have any capacity to do that. You can not force young people into treatment.

CHAIR: On the young people, an issue that has come to us, a young person with schizophrenia, and they take marijuana or amphetamines, they become, as other people have described, toxic, violent and dangerous. Now, that is a group where the taking of the drug is not just a matter of dependence or whatever. Because of their pre-existing condition, this becomes a much more dicey situation for them, as well as the community at large, and that is the area that the forensic people drew us into yesterday. Myree Harris has talked to us about a number of people. John is asking the right question about young people but particularly the young person who has an illness.

Professor WEBSTER: I absolutely agree with you. The young person with schizophrenia is using substances to moderate the way they feel. They often use substances to make themselves not appear mentally ill because being a drug using person is less stigmatising than being mad. They are in a peer group where the ability to control their risk behaviour, because of the underlying mental illness, is not high. It is a very difficult problem. I would say that the key strategy, without being a psychiatrist, is limiting the harm that occurs to that person, harm reduction approaches, and trying to influence the risk behaviour and limiting their exposure to it in some way.

Whether that involves coercive treatment and mental health treatment in a contained environment is something I think would need closer thinking about and addressing, but I think there certainly are arguments that with young people out of control with drug use, as we do when they offend against the law, that there may be some arguments for coercive rehabilitation of some kind.

The Hon. JOHN HATZISTERGOS: Would you agree that younger people are less

motivated towards treatment?

Professor WEBSTER: Yes.

CHAIR: I did my CPA trip on drugs to Sweden, Switzerland and Washington DC, States with seven million population like New South Wales. The thing that struck me about Sweden and Switzerland is the ready access to long term care. In Sweden it is not uncommon to get 18 months for drugs and alcohol, but just for drugs in Switzerland. These acute rehabilitation services, which are extraordinary, have 1,700 beds for long term rehabilitation for drug and alcohol in Sweden. We do not have those facilities here, so that is why the Hon. John Hatzistergos is concerned about the limited access and often they are run by NGOs who have a particular treatment set, which limits again whether you match with them, rather than your needing a service.

Professor WEBSTER: Exclusivity, there are virtually no publicly run rehabilitation services.

CHAIR: The one that I know best is the one at Binaburra called the Buttery, which asked people to sign up for 12 months minimum, where they are looking at six months at the Buttery and six months of supported accommodation later. They have been given more funding by the Commonwealth, and then again by the State as a result of the drug summit. Their results seem to be very good, but I think it is the only one in the country.

Professor WEBSTER: There are lots of residential programs.

CHAIR: I mean the country rural.

Professor WEBSTER: It is difficult to compare countries. Sweden has a long history of a different relationship to alcohol than Australia has. At one time in Sweden you had to sign books to get alcohol and they were very prohibitionist.

CHAIR: It is very expensive still.

Professor WEBSTER: Going into the European community has changed it. They have a slightly different history of the controls of alcohol than our country. You are right in terms of their approach to rehabilitation. They have a strong coercive system for young people with drug and alcohol problems. The evidence is that rehabilitation programs will only work if people stay in them. There is success if people have stayed in for three months and have shown some change by the end of 12 months. The longer they stay too, the better they do. There is no question that that works but only a very small proportion of people stay.

The Hon. JOHN HATZISTERGOS: At what point do we those forms of judgments? The issue that precipitated this discussion was what I detected was a complaint that many of these places, notwithstanding an assessment which may have been made by a general practitioner or some other medical person, they end up, after some considerable effort, being assessed by a rehabilitation centre.

Professor WEBSTER: Yes.

The Hon. JOHN HATZISTERGOS: And the rehabilitation centre then, notwithstanding the earlier assessments, decides it is going to do its own assessment. Am I correct in saying that you were critical of the fact that that centre would need to make further assessments?

CHAIR: I was referring to detoxification centres and some rehabilitation centres.

The Hon. JOHN HATZISTERGOS: What I am putting to you is in light of what we have been discussing, do you not understand or accept that there may be a reason, particularly in terms of limited resources, why the centres would be taking that approach?

Professor WEBSTER: They will do it for their own terms, but they also may do it for

ideological reasons. They may have a religious view about how people should be treated and will only accept people who fit our paradigm. I think it is a very dangerous ethical position.

The Hon. JOHN HATZISTERGOS: Some would.

Professor WEBSTER: And do.

The Hon. JOHN HATZISTERGOS: The public ones do not.

Professor WEBSTER: There are virtually no public ones. Let me make another point. I do not think you should put all your cards in residential programs because for the most part they are relatively ineffective. The most effective way to manage people with an addiction is in the community, with a good doctor, counselling, appropriate support and psychology. I think one of you mentioned before, there are virtually no work based programs for any of these people. I have actually just been appointed to a Commonwealth committee for the PSP, Personal Support Program, and the Commonwealth Government is allocating money. They have identified something like 50,000 people who are on welfare benefits because they have a substance use problem or a mental health problem. The most common reason for a woman getting a disability pension is being mentally ill. The second most common reason for a male getting an invalid pension is being mentally ill. For all those people there are virtually no employment programs. There are also virtually no support programs. The Commonwealth Government is trying to provide some support for them.

We have got to be much more realistic about what we offer people to re-engage them in community life. For the most part we offer nothing and some of the programs that we have are not well linked with productive outcomes. Two days ago I visited the Charles O'Neal House in Sydney, which is linked with Matthew Talbot Hostel. They have four floors where people live in for a year. These are homeless people, who for the most part have dual diagnosis. While I was there I saw a computer class operating. There were 12 computers, 12 homeless men sitting behind the computers being taught by a TAFE person to use a computer. The first course in that week was archaeology. They were getting teaching lessons from the Sydney Grammar School. There was a Professor of philosophy from Sydney University running a course on philosophy. I heard they were discussing Kerkergard, and there was an another Professor who was giving them anger management courses. What was so good about that was that it was in an accommodation environment, tolerating people with significant mental disorders and substance use disorders. They had been selected in various ways, but they were getting fair dinkum teaching programs by qualified teachers, not by half baked people like me who might have a good view of what they wanted to learn, and the homeless people had, in part, determined their program. Now some of them were graduating. What was good about that, it was really hard nosed, skill orientated, hard skill orientated and some of it very work directed, computer skills being one.

CHAIR: If we go back to the drug issue, Lidcombe used to be a place for homeless men and that used to be a scene for people who had mental illness, often plus a physical disability, neurological disability.

Professor WEBSTER: Yes, there were wards that did accommodate people like that.

CHAIR: I got out an old document from the Department of Health in 1991 and it said that there were 11,700 residents in care in the mental hospitals that were around in those days in 1951. By 1975 we were down to 7,400 and our population had gone up by 30 per cent. The number of years that they stayed in those institutions had dropped from 1.48 years to four months.

Then by the time you get to 1986, which is when they included the disabled as well as intellectually disabled, you were down to 5,000 people, you halved it, and the length of stay was two months. By the time you get to 1991, when you took out the disabled, that took out 2,500 of them. You were down to 2,200 mentally ill people in institutions. This was also, by that stage, some general hospital beds as well as the big institutions, and the length of stay was .024 of a year. As I understand it, that was with a population of five million. We have doubled our population almost.

With the move to general hospital care that should have picked up some of the concerns you had about mental illness plus physical illness and tapping into a local community, has that been successful? Moving from the old days, these would have been mostly schedule hospitals.

Professor WEBSTER: You have put your finger on an important idea, one of the most important things that has happened in mental health, being the establishment of mental health units within the general hospital. I think much more could be made of them because if you go into a general hospital you will still find the mental health unit tends to be segregated from the rest, one way or the other. In some of the hospitals I have worked at I have been very concerned to try and see that the professor of medicine showed some interest in the mental health unit, and even in fact the professor of surgery, because they are part of their organisation. It has often been very difficult to do that. In principle it is been a very important progressive change but in practice there is still segregation.

The second complication of that, which would not argue against the value of the change, is I think it has provided a different set of pressures on emergency departments because emergency departments have become the funnel for almost everything that gets into a public hospital or health system. That means the mentally ill go through the emergency department, which were designed for the walking wounded and ones that come in horizontally. While in one way that could be argued as a good thing. I do not think we are dealing with it very well at all. I think it has led to perhaps some of the conflict that you hear about in emergency departments and we ought to have other ways of accessing the mental hospital beds in the general hospital system.

In talking about institutional care, the fundamental problem for many people with a chronic mental illness and a drug and alcohol problem is accommodation. If you look at homeless families in Melbourne, and there have been studies on this, those families are commonly single-headed and commonly the mother has a mental illness or a drug and alcohol problem. They move around. They cannot find accommodation. It is not until you can stabilise a person with mental illness in an environment where you can engage with them, that you can help him. In rural areas that is important too.

CHAIR: I accept the evidence about homelessness and the access to care, that is important. If we are to deal with the drug and alcohol problem, given you say if they are mentally ill and have a drug and alcohol problem they are going to be a long term rehabilitation or management process, we therefore need to be looking perhaps - I ask the question, I do not know the answer - should we be looking at medium term beds rather than trying to put these people into our acute beds and therefore what people say is silting up the acute beds?

Professor WEBSTER: You are quite right. I think that many of these things could be managed in better community settings with better relationships and better accommodation. I think there is something in what you said that is important. I think what has happened in our whole health system, we have polarised it to highly technical intense hospital care and a community response.

In the old days, although we probably do not want to return to that, we had convalescent hospitals. In Melbourne at St Vincent's Hospital, across the road there is a house, it is quite a big house, which has beds in it and homeless mentally ill people who get acutely sick can be admitted to that place and not admitted to the hospital and get home based medical care in that environment, and they do very well. They do not have to get admitted to hospital. The sick mentally ill person who has long established mental illness and particularly if they are poor and homeless, they need care in the first instance, place, bed, food.

CHAIR: The sort of thing I would get if I had a nasty flu and my wife would look after me?

Professor WEBSTER: They do not have that.

CHAIR: In Lismore now Jim Rankin has this wonderful detoxification unit which is separate from the hospital, across the road and down the road a bit, a beautiful building. It is for detoxification rather than anything else. It is run by community based GPs, as well as himself. That is

separate from the Richmond Clinic, which is attached to the hospital, down the bottom of the hill, in the hospital itself. It occurs to me that this movement to general hospital care meant that when they are doing a discharge from a general hospital you have your community health staff get contacted and you have a discharge plan. From a mental hospital they get a mental health discharge plan, which does not necessarily take account of the positive advantage of having these people in a community based hospital. How do we overcome that?

Professor WEBSTER: I absolute he agree with you. The other thing I expect you will be looking into is the way records are dealt with. I am embarrassed to say that the drug and alcohol unit I work in has separate notes as well as the hospital notes.

CHAIR: This is the one at Fairfield?

Professor WEBSTER: No, this is the one at Liverpool Hospital.

CHAIR: The new one at Fairfield is now open?

Professor WEBSTER: That is a detoxification unit.

CHAIR: Is that integrated into the hospital, Bossley Park?

Professor WEBSTER: No.

CHAIR: Why not?

Professor WEBSTER: It ought to be. It is a very good question. It is the problem of intake that I was alluding to before. Why do all these systems have to set up their own intake system? Why is there not a general acceptable level of assessment of a person which I accept from you or you accept from somebody else, instead of putting people through the process again?

CHAIR: Generally hospitals run out patient clinics. The detoxification and drug and alcohol services at Bossley Park and certainly the Lismore one have much the same process, and were set up under the same process. They have inpatient and outpatient care. Why are they separated in terms of accountability and funding? Why are they not part of the hospital?

Professor WEBSTER: There are not many hospitals run outpatient clinics in drug and alcohol.

CHAIR: They run outpatient clinics?

Professor WEBSTER: Yes. It goes to the culture of medicine. It goes to the notion of "I own groups of patients".

CHAIR: "I own beds"?

Professor WEBSTER: "I own beds, I own the record. We deal with mental health problems and they are special and particular and we do not want to expose those to people". The privacy people support that idea, but I must say I do not. I think the duty is in the opposite direction. We should be communicating, and have very open communication about problems of people.

The child health review each year reports on the deaths of children. Quite a lot of the deaths of those children are drug using and sometimes mentally ill parents which the people looking after the mother have not been aware of, or conversely the child, have not been aware of the fact that the mother or the father is mentally ill. There is a duty of care I think to know that a woman with a mental illness has dependent children. We ought to be concerned, if we are engaging with the mother, about the welfare of those children. If we are running a methadone clinic for young women we ought to be concerned about whether children are getting immunised and whether they are at risk or not. That means the record systems have to be much more communicating and open.

CHAIR: Does that mean we need better managers? The expertise is out there, the knowledge is out there. It is a matter of a manager drawing this together, whether it is a medical manager, probably doctors are not particularly good managers, some might be. It is a matter of a clear direction from the Centre for Mental Health, for example, but you see Beverly Raphael does not have vision of, necessarily, drug and alcohol programs.

Professor WEBSTER: That is right.

CHAIR: Should the Centre for Mental Health bring those two together?

Professor WEBSTER: I think the Centre for Mental Health would be very good at that. Even that is a paradox, we require a Centre for Mental Health when we have a health system. One of the difficulties has been the mental health programs have been run independently of the general health programs. There are advantages to that.

CHAIR: I think Professor Raphael says the Centre for Mental Health is a change agent. I do not think she sees it as a management agent. It does not have control over the Area Health Service budgets, which many people have argued they should have. She has no control over the mental health budgets in the various areas or how they are spent, but I think she sees the Centre of Mental Health as the change agent.

Professor WEBSTER: I am sure she does and I think it is a pretty effective change agent too.

CHAIR: If she also had in the Centre for Mental Health drug and alcohol, would that be effectively a good thing to do? I simply do not know.

Professor WEBSTER: I would say yes to that. I will probably get eaten for saying it though.

CHAIR: Everybody has struggled with it, the Mental Health Review Tribunal, the forensic advocates, the people from the prison service. At least in prison you get a combined service. We heard from Dr Matthews that at least in the prison you can get both.

Professor WEBSTER: I think there is some debate about that. I have a son who is a psychologist in the prison service and he is concerned that in the general prison population it is hard to get a mental health assessment, which is distinct from the forensic side of things.

CHAIR: The concern, of course, is once they leave the hospital or leave the prison.

Professor WEBSTER: Even in the prison I think they have difficulty.

CHAIR: I have read your document and it is just outstanding, especially about suicide. We are going to deal with suicide separately because we have to try, as members, to use some logic as to what the issues are and, whilst many of the issues you raised of drugs, alcohol, mental health, homelessness, relate to social connectedness--

Professor WEBSTER: Yes.

CHAIR: And I know the Commonwealth and States are all working together on many of these issues, but it all comes down to a whole of government approach, as you say. I think - and I've seen much better evidence as we go through - sure, there is disconnect, but I can see a real attempt to try with housing, for example, terribly cooperative under Gabriel Kibble, but the support for that is dollars. Everyone is talking about dollars for supported accommodation, which of course the whole process depends upon.

Professor WEBSTER: I think that is right and I agree with the sense of what you are

saying. The other element I would like to emphasise is the focus on developing primary care to a greater extent. That is where people can be managed as whole persons well and it is the point at which the social welfare and the community sector and the NGOs and specialist services ought to come together. General practitioners are a real focus of that and I think the changes in general practice over the last 10 years have been remarkably positive. I mean there are divisions of general practice, as you know, that have special mental health programs.

CHAIR: That is a relatively new process again.

Professor WEBSTER: Yes.

CHAIR: But we have done very well with smoking in this country.

Professor WEBSTER: Yes, we have.

CHAIR: We are probably the best in the world.

Professor WEBSTER: We are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would dispute that; we are not the best in the world.

CHAIR: If we are not the best in the world, we are very close. The figures published recently say that we are very close. Over a long period of time, with public health input, we have done something to one of the great scourges, but for the most part, in my view, given that we have done well in smoking, we have not done so well, although we have done well in preventing AIDS with interventions for drugs and other co-morbidities, for the treatment of drugs, obviously illicit drugs, and where we in the past would have been right up there with mental health in this State, New South Wales, I get the impression that we seem to be falling behind.

Professor WEBSTER: It is a very difficult judgment to make. I met the chair of the National Mental Health Council recently with one of the ministers, the health minister, and the view being expressed - and it was a rather private view - was that New South Wales was doing better, certainly in adherence to the standards which had been set at a national level, so it is a hard call to make, but I think Australia has been remarkably progressive in health promotion and social change. We have reduced coronary heart disease rates ahead of other countries; we reduced tuberculosis ahead of other countries and I think we are doing better in a broad sense with drugs than other countries. We have certainly done very well with smoking. Alcohol is still a huge problem in our community, but it is declining in its use, and the deaths due to it. I think mental health ought to be approached again with that broad public perspective, promoting mental health, looking at risk situations, which we can discuss on another occasion possibly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are a couple of points I would like to ask arising from your submission: The religious nature and the effect that has on service delivery is a fairly sensitive issue, because most of the groups delivering services are religious.

Professor WEBSTER: Yes. Well, yesterday I had a discussion with Reverend Tim Costello about homelessness in Melbourne and there is a book published about the response of Melbourne as a city to homelessness which describes the change since the founding of the colony as to how homelessness has been dealt with in that city. One of the characteristics of Australia is that governments have had virtually no role in responding to homelessness until fairly recently when the Commonwealth developed the SAPP program and they have funded some NGOs to an extent, so it has been left to the charities and the churches. That book describes the history of the churches' response to homelessness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which book is that?

Professor WEBSTER: It is called Going Bad and in it is the city's response to

homelessness. It is written by Alan Jordan. It was based on a thesis that he did, the first sociological thesis at La Trobe University where he studied the life stories of 1,000 homeless men and examined the deaths of homeless men back in 1974 and also followed up young people in foster institutions.

The Hon. JOHN HATZISTERGOS: What was the conclusion, that Melbourne was not doing as well as it could do?

Professor WEBSTER: Well, my conclusion from what I have just said so far is that governments have virtually been non-engaged in the response to homelessness until fairly recently.

The Hon. JOHN HATZISTERGOS: And what was the outcome?

Professor WEBSTER: Very poor.

The Hon. JOHN HATZISTERGOS: Because of the religious--

Professor WEBSTER: No, I have not dealt with the religious question yet. The religious side of things is that we have had different religious groups respond and some of them have responded in quite different ways, and you can make your own judgments but I think some have responded in better ways than others. Essentially it was left to the churches and the charities to deal with homelessness.

The problem in the drug and alcohol field is that there are sort of ideological moral beliefs about the nature of substance use where the drug itself, the use of the drug becomes the moral question, and that leads to people making value judgments about the people who use it, whereas you can take other moral positions about drugs and substance use. The moral position might be that you want to see the least harm done to the greatest number of people, which would be essentially a public health matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are talking, in a sense, about Brian Waters' view of drugs perhaps or the Alcoholics Anonymous view of alcohol as a disease almost. In a sense, that touches the moral component. To what extent does that actually impact on the services delivered and the way in which people are screened?

Professor WEBSTER: I should make comment about Brian Waters. Brian does hold strong views about certain aspects, but he chairs a national council of which I am a member and essentially that council supports the national government policies, so I think his position of not being supportive of things like needle syringe exchange programs and many other so-called harm minimisation approaches is a wrong public perception, but nevertheless it is a perception. It does influence.

Much of the response to alcohol and drug problems was based on the idea that abstinence was the most important way of dealing with alcohol problems, and that also has been applied to drug use generally, but it is very rarely practised now in Australia. Even the organisations that started off with that as their framework now accept that harm reduction is the way that they should go. Odyssey House, which would have been founded on the idea of a residential community becoming totally drug free, accepts the treatment of people within its environment, it actually runs residential rehabilitation programs for people on methadone, so most people who have been managers and proponents of the abstinence idea of years ago now recognise that that is alienating for many people and that their philosophical view can still fit within the broad sort of public health framework that we adopt, but to hold wholly to a particular philosophical view has a potential also to create harm.

I have to deal with other countries, I visit Brunei and Indonesia and have contact with people in Bangladesh and places where the religious view and cultural views of drugs are very different from Australia. In the Moslem countries drinking alcohol is against their religion. They see the gateway drugs as tobacco and alcohol, which I must say I do too, but commonly people talk about cannabis being the gateway drug. I mean to those countries it is alcohol and tobacco.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This may be the case in Brunei or wherever, but in Australia do you think that people are excluded from treatment because of the religious proclivities, beliefs or whatever about drugs of the people who are, in essence, subcontracted by the State to run facilities?

Professor WEBSTER: No, I do not think they would be excluded for religious beliefs. I think they might be excluded because the people felt they did not fit their program or what they were offering.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that happens in a lot of programs, secular or non-secular.

Professor WEBSTER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We only deal with this type of person, only women of this age or other criteria.

Professor WEBSTER: Yes, or people who will conform to an abstinence regime or whatever it might be, so I do not think that religion influences the selection, in my judgment, my experience, of people in treatment programs, whoever runs it. I am not aware of it anyhow.

CHAIR: Certainly the Salvation Army is absolutely non-discriminatory.

Professor WEBSTER: St Vincent de Paul is absolutely non-discriminatory too. The great thing about a place like Matthew Talbot Hostel is that you do not have to prove who you are, you do not have to have any defined problem, you have just got to be needing care, and there is no coercion of a religious kind there, it is just that that organisation believes implicitly that its response is a charitable one in the broad sense of that word.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could I ask you about emergency departments which in effect is where the systems crash. Anybody who is between specialties has difficulties. If you have a liver disease and an ear problem the two departments always say you fix the other and we will do it. There are always territorial wars.

Professor WEBSTER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The difference, it seems to me, in emergency departments is that you have an ear, nose and throat problem, you call the ENT registrar and he or she comes and fixes it. If you have a mental health problem you call the mental health staff and they may or may not come and, if they do, they are not integrated, they look scruffy and everyone else wears a white coat, just to put it in simple terms. Is the problem that there is not enough mental health associated with the emergency department in terms of the percentage of people there with mental health problems and the disruptiveness of them? The resources of their specialty to fix that are not there, so in a sense they are administratively not there as well as any other differences they might have.

Professor WEBSTER: I absolutely agree with you. I think we have got to really improve the point of engagement with mental illness at the front line and in emergency departments probably - I have not visited many--

CHAIR: Recently there has been a trial of more general use of triage mental health nurses in the emergency department.

Professor WEBSTER: Yes, and that has been a great step forward, that has been a very important and positive idea, but I agree with the general line that is being taken. I mean I visited the emergency department very often at Liverpool, I do not now, but over the last ten years, and I would be called down there because there was a problem with someone who was acting out because they were drug using and the staff, I must say, were excellent, the good humour with which they handled

incredible situations, unbelievable, in the emergency department, but to handle this sort of problem you would have to scurry around and find a room where there was nobody else, perhaps sit on the corner of a bed and try and talk down somebody who was angry or out of their mind or resentful and making a terrific fuss, and those problems were handled very well given the environment, but the environment was inappropriate, I think.

(The witness withdrew)

(Short adjournment)

KATHERINE JEAN LENNANE, Psychiatrist, 10 Wharf Road, Birchgrove, sworn and examined:

CHAIR: In what capacity are you appearing before the Committee?

Dr LENNANE: I am appearing, I believe, as President of Friends of Callan Park, but I wear a number of hats.

CHAIR: Are you conversant with the terms of reference?

Dr LENNANE: Yes.

CHAIR: Would you like the submission you have made, number 181, to be taken as part of your sworn evidence?

Dr LENNANE: Yes.

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 heard or seen only by the Committee, the Committee would be willing to accede to your request.

Dr LENNANE: I have noted in the actual submission that there is an annexure which the person wrote specifically be available only to the Committee and the person not be identified. That is the experiences of an ex-staff member.

CHAIR: Is that the entire document?

Dr LENNANE: No, just that one annexure.

CHAIR: You should be aware that the Legislative Council may overturn the Committee's decision and make the evidence public. There is a fair bit in this submission that you have made to us which goes to a range of issues, but my knowledge of you is that you ran a major drug and alcohol rehabilitation program, did you not?

Dr LENNANE: Yes, I did. It was not just rehabilitation, it covered the whole spectrum of drug and alcohol services from detoxification through to the rehabilitation of people with mild, moderate to severe alcohol-related brain damage.

CHAIR: So these were people who had a physical illness plus substance abuse?

Dr LENNANE: No, people with other mental problems in the form of brain damage caused by their drinking plus often other psychiatric diagnoses.

CHAIR: So you were dealing with the dual diagnosis.

Dr LENNANE: Dual, treble.

CHAIR: Where was that being run?

Dr LENNANE: That was at Rozelle Hospital.

CHAIR: How many beds did you have?

Dr LENNANE: We had 100 beds of which I would say about 20 remain.

CHAIR: What was the unit called?

Dr LENNANE: It was just called Drug and Alcohol Services, Rozelle Hospital, and at that time Rozelle Hospital was really quite a centre of excellence, if you like, of drug and alcohol treatment because on the campus was the CEIDA, that is the Centre for Education and Information on Drug and Alcohol, which is a statewide resource that has subsequently been shifted, and there was the Psycho-Pharmacology Unit of Sydney University and then, of course, the rest of the hospital was available with expertise and facilities for people needing more intensive treatment of a psychiatric problem.

CHAIR: Where did you get your funding from for that service?

Dr LENNANE: From State Government.

CHAIR: When did you first start working there?

Dr LENNANE: I started in 1976 and then I took over the Drug and Alcohol Service in 1980 and was there until I was sacked in 1990.

CHAIR: So where did the funding come from for that?

Dr LENNANE: There were various bits of funding. Some of it was a one-off drug and alcohol thing that happened around 1980. That was under the Wran government. Then some of it was just the general mental health services funding which at that time was centrally administered and the drug and alcohol, as far as I recall, was part of that funding because at that time a lot, if not most, of the drug and alcohol funding was contained within mental health.

CHAIR: We have some other writing by the department that indicates that in the 1970s the drug and alcohol was split from mental health.

Dr LENNANE: That is not my recollection.

CHAIR: How long ago do you think it was that they were separated?

Dr LENNANE: It was a progressive process and it would have started with that grant from the Wran government, a lot of which went to general hospitals and general hospital units setting up drug and alcohol services.

CHAIR: Was it a major initiative by the Neville Wran government in 1980 to establish drug and alcohol services across the State?

Dr LENNANE: That is right, including in general hospitals where, up until that point, they had been lacking because they had tended to be concentrated within psychiatric hospitals and the push was to get them into general hospitals, which is something I agree with in general terms, that obviously we needed drug and alcohol services in general hospitals, very much so, and still do, but part of that then became getting right out of psychiatric services, completely separated from them, and that, in my view and I think most people's view, has been a disaster.

CHAIR: So have any of the general hospitals now still got their drug and alcohol services?

Dr LENNANE: Not many.

CHAIR: So that initiative of the 1980s is now pretty well--

Dr LENNANE: Most of it is defunct. Those services have mostly died. For example, the detoxification unit at Royal Prince Alfred Hospital, which was known as Basement 82, was set up with that money and that ran very successfully until it was suddenly closed by Central Sydney Area Health Service last year.

CHAIR: In Neville Wran's day, that was when we had a Health Commission and there were direct budgets. They were not controlled by area health services.

Dr LENNANE: No, the area health services came in mid-1989.

CHAIR: They came in before that, Barry Unsworth had them in first.

Dr LENNANE: No, they had regions and then they split up again into areas, but the regions did not actually have control of the money. The big change was giving the areas direct control of the mental health and drug and alcohol budget, and that was in 1989.

CHAIR: That is right, and since then the areas decided what services they offered and so on.

Dr LENNANE: Yes.

CHAIR: So that is the history of having them together, and then at the same time in 1980 we were also seeing more mental health beds being opened in general hospitals, were we not?

Dr LENNANE: Yes, we were starting to. It was a process that had started some time before, but yes, it began to accelerate.

CHAIR: Then Richmond came along in 1983.

Dr LENNANE: Yes.

CHAIR: Whilst we will talk about that in general terms later, if we could, from a drug and alcohol service point of view, what was the impact of subsequent policies following Richmond which may not have been related to Richmond that saw drug and alcohol seemingly separated from mental health and seemingly separated from our general hospitals? Has drug and alcohol--

Dr LENNANE: Did that impact on it?

CHAIR: Yes.

Dr LENNANE: It has impacted very, very severely. One of my major concerns as a psychiatrist is what has happened to mental health services, which in my view is quite appalling, but I have to say that what has happened to drug and alcohol services is even worse. There is a slight difference though in that drug and alcohol services in the 1980s were relatively good. If you had a drug and alcohol problem you could get into the detoxification unit easily at the time when you needed to and wherever you needed to, wherever you happened to be you could access a detoxification unit.

CHAIR: Where were they?

Dr LENNANE: They were all around, like in Sydney, for example, you had Langton Clinic, which has subsequently closed as an inpatient facility; you had Gorman House that was set up at St Vincent's Hospital and that is still there, one of the few; you had Basement 82; you had the McKinnon Unit.

CHAIR: Still there?

Dr LENNANE: No, Basement 82 has gone, just closed. Supposedly the beds went to join McKinnon Unit at Rozelle Hospital, but they did not or, you know, they never appeared, they are still on the road somewhere, and then you had, in the northern area, the unit attached to Royal North Shore, which is still there but it is smaller than it was. So, overall, in the Sydney region there has been a cut of, I would say, 70 per cent in the number of available beds.

CHAIR: Has that been picked up in terms of moving that to treatment services in the community?

Dr LENNANE: No, there are no staff, very few staff and there is the odd staff member in community health centres but they do not have the back up. They do have supposedly some staff that can offer various things including supposedly home detoxification, but of course that only works if you actually have a home, and many of these people do not.

Generally speaking, my practice I have reduced very greatly, but I am still dealing with people who need detoxification from time to time and the idea is that you have to telephone to see if there is a bed - there never is - and then the person needing detoxification has to phone every morning at eight o'clock until a bed comes up. Now, for a highly motivated person who has a home and who is not at death's door that may work and they eventually get in, but there are a number of cases where people have died waiting to get in, and of course a lot of people lose their motivation.

CHAIR: There are some new places. The one out at Bossley Park, in part of the Fairfield hospital, and the facility at Liverpool which I think the professor mentioned this morning. There is certainly a new one in Lismore.

Dr LENNANE: A new detoxification unit?

CHAIR: Drug and alcohol unit.

Dr LENNANE: I do not know about that. I do not know what beds are available there. I know what I am dealing with around the Sydney area, and that is very grim.

CHAIR: If somebody had a dual diagnosis of mental illness and also had substance abuse - was it MISA Mental Illness Substance Abuse, the term we are going to use?

Dr LENNANE: Not MICA, Mentally Ill Chemical Abuser? It does not matter.

CHAIR: If somebody has that and for various reasons they either want service or they need service because they are a forensic patient or whatever, where would they access those services in New South Wales?

Dr LENNANE: You can not actually access services; that is one of the problems. What tends to happen to these people is that they are not welcome in drug and alcohol facilities because they are too disturbed or need other care that is not available there, and they are not welcome in psychiatric units because of the alcohol and other drug problem.

I have a case in point, if I could mention that, a patient of mine. I see the mother of two sons. I see the mother because she is depressed, and no wonder, she has two sons with a dual diagnosis. They are both severely ill. One son is at last in a long stay bed at Macquarie Hospital but it took a long time before he got there. They have the misfortune to live in the eastern suburbs where there are virtually no services of a longer kind, there are literally no long stay psychiatric beds.

The younger son the Prince of Wales Hospital was adamantly refusing to treat in any way, although he had documented diagnoses, multiple diagnoses, not just two, one of them was schizophrenia and the other was preliminary, and because he drank so much and was always around the town drunk and disorderly and obviously dishevelled and disturbed, they had refused consistently to treat him at all, inpatient or outpatient, anywhere. Then, at my suggestion, the mother spoke to a journalist at the Sydney Morning Herald who did a story on it and miraculously, suddenly, this man became recognisably ill and was admitted and was treated for his psychosis as well as his drinking. He is now back home. He is not psychotic any more, because he is on medication. He has always been fairly compliant with medication, and he is not drinking. Now, his family had gone through about ten years of absolute hell trying to get treatment for this guy and could not until they got help from the press.

CHAIR: If he is mentally ill, does that not mean he at least gets compulsory admission or goes before the magistrate and so on?

Dr LENNANE: No, because what happened was when he became very disturbed and the police were called, the police, who thought he was mentally ill and should be in hospital, would take him to the hospital and then the hospital would look at him and say, "He is drunk" and send him home.

CHAIR: Yesterday in the forensic forum we talked about the large rise in the number of people for whom section 24 is used to take them to a hospital for assessment, pick them up and use section 24. There has been a drop off in the number of people who eventually get a section 22 schedule, or the old schedule 2, coming from medical practitioners, but many more coming from the police, and we were told yesterday by Dr Matthews from the prisons health that there has been a fairly decent rise in the number of associated drug and alcohol plus mental illness amongst the schedule 2s these days. That is rising and they are more violent and more toxic and so on.

Dr LENNANE: Yes.

CHAIR: The two things it could be due to - there could be many more - one is that there is more drug taking, I think they identified marijuana and amphetamines as the two. Heroin does not seem to be a problem in this regard.

Dr LENNANE: Not so much, if you are organised enough to get the heroin, you cannot be so terribly psychiatrically ill.

CHAIR: Even so, they do not cause the same problem. They seem to be quiet in the corner. The other problem could be these people seem to be going around and around because of the failure of community mental health to be assertive.

Dr LENNANE: Exactly.

CHAIR: I wonder if you are aware of the contribution that either of those might make. It is quite a dramatic rise. The number of section 24s has gone up from 1,000 in 1996 to 2,500 in the year 2000 and still rising.

Dr LENNANE: I think both those things are factors, that there is an increase in the number of people using these drugs, particularly people who are mentally ill and not functioning all that well anyway, and then the treatment just is not available. What happens when you get such a shortage of beds and services, as we now have, is that everybody is only too happy, because they are all overworked and overstressed, they are so happy to be able to say, "You do not fit in this basket, you are not in my basket, you have to go off over there." So people get the run around.

CHAIR: If they are not sick, and they go there under section 24, the Police Association's evidence is that they have to take them back to the cells.

Dr LENNANE: Yes.

CHAIR: If they think they are disturbed enough to take off, they cannot release them, so they end up in the cells going through the criminal justice system.

Dr LENNANE: That is right.

CHAIR: They may then be picked up in the criminal justice system as being mentally ill.

Dr LENNANE: If they are lucky they will.

CHAIR: They call liaison services. Certainly the evidence is that the trials of that have been pretty good.

Dr LENNANE: It does not pick everybody, and, likewise, you can easily get into gaol without being diagnosed. The police really are currently being used as de facto travelling psychiatric units because they are landed often with taking people not just to a particular unit but around the State looking for a bed. You are aware, are you, of the web site that now has listed all the beds in New South Wales?

CHAIR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Psychiatric web site?

Dr LENNANE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How recent is that?

Dr LENNANE: Quite recent, a few weeks. That was because of threatened industrial action by the medical officers, particularly out in western Sydney, because of the amount of time that it was taking them to ring.

CHAIR: We have had evidence of two hour phone calls.

Dr LENNANE: Multiple phone calls. The Health Department's answer to that is to set up this web site and I have had a couple of printouts from it which I guess I could deidentify and give them to the committee.

CHAIR: You can give them to us and we can deidentify them. Would you like to table them?

Dr LENNANE: As long as they will be deidentified.

CHAIR: Can you photocopy them deidentified now before Dr Lennane then tables them.

The Hon. JOHN HATZISTERGOS: What do they show?

Dr LENNANE: They show very few beds anywhere in the State, very few available beds, and particularly almost no acute beds or secure beds. There are sometimes beds that are general adult beds but, of course, you may have your patient in Campbelltown and the bed may be available in Gosford. I am told that is what is happening; people are actually being trucked around, as far as from Sutherland to Gosford was the last one I heard about.

CHAIR: Certainly we have plenty of people saying that in the stories about their son, their daughter and so on. The Police Association is saying that they are often done in the back of a paddy wagon.

Dr LENNANE: That is right. Someone arrives at a unit where there are no beds, and when there are no beds, that means that everyone there must be very, very ill because people, as I am sure you have heard, these days get discharged in a state of illness that would have got them admitted ten years ago and should have them remaining in hospital for another several weeks. They get discharged like that and a lot of them die as a result.

If your unit is full and they are too ill, even by today's standards, to be discharged you cannot admit this other person. So the paddy wagon is used as a de facto accident and emergency room and you sedate the person in the paddy wagon and you leave them there until something happens, you find a bed somewhere and you can get them transported there or whatever.

CHAIR: Since we have got down that track a little bit, some of the evidence we had yesterday from Dr Barclay, or the corrections health, was the issue that many of the acute units are being "silted up" with people who have long term psychiatric illnesses who can not be dealt with outside a strong supportive or contained area.

Dr LENNANE: That is right.

CHAIR: So the people who need acute admission who might have a relapse of schizophrenia or manic depression or whatever, who may only need to be in for a week or so, simply cannot get in?

Dr LENNANE: That is absolutely correct. I do not know of any figures on how many acute beds we are short of, because, if we did have the longer stay beds, maybe in many areas there would be enough acute beds. In the eastern suburbs, for example, there is just nothing, so at any time you have at least five of their 30 beds taken up by people who are long term. The Health Department document shows a shortfall of 850 or something non-acute beds throughout the State.

CHAIR: Are they non-acute? I thought they were a mixture.

Dr LENNANE: Purely non-acute.

CHAIR: What is the shortage of acute?

Dr LENNANE: We do not know because they have not done that work. If you just look at the figures that they give and they say, "We have 2,000 beds in New South Wales with a population of eight million odd", that is only 0.25 beds per thousand, which is exceedingly low, and that is half what they have got in Italy, where they as you know run a very, very intensive deinstitutionalising, get people out into the community, campaign.

CHAIR: They do a different thing according to other evidence we have had. They knew it would be more expensive.

Dr LENNANE: Yes. I think this is where the whole thing went terribly wrong in this country, and particularly in this State, that at the same time as we had the deinstitutionalising push we gave the money to the health areas and each area CEO was under enormous pressure, on a performance based contract, to appear to be doing fine, even though they were not getting enough money. So the temptation to pinch the money from mental health I think was just overwhelming as a soft option and that is what has happened.

I think part of our submission was what has happened to services in central Sydney. We have reasonably good figures for staffing in central Sydney, owing partly to figures provided by the now Governor Marie Bashir when she was head of Mental Health Services there, and that shows a very clear decline of about 60 percent of mental health staff.

CHAIR: I have a publication here from 1991 that says central Sydney had seven community mental health teams, including mobile treatment teams and community rehabilitation teams, five child and family mental health teams, three live-in skill centres, four extended hour or crisis teams and one group home and hostel and two psychogeriatric teams. That was in 1991. What have we got now?

Dr LENNANE: About half that, less than half. The area has got bigger because it acquired some extra geographical areas and services, I forget what year that was, but there are only four community health centres, three extended hours teams.

CHAIR: Community and family, child and family?

Dr LENNANE: There is only one as far as I know.

CHAIR: They had one psychiatric hospital, one general hospital unit, one CNA, that is Child and Adolescent Residential Unit.

Dr LENNANE: That was Rivendell.

CHAIR: They have still got that?

Dr LENNANE: They did not have that when they moved to Concord. Then they acquired the area that contains Concord. That is incorrect for the present day, because Concord Hospital was not in the central Sydney area in 1991.

CHAIR: Rivendell was. That land is owned by Royal Prince Alfred Hospital, it is not owned by Concord.

Dr LENNANE: Okay, that is Rivendell, that was owned. Concord Hospital had two acute psychiatric admission units but they have both been closed.

CHAIR: So what was the function of the drug and alcohol unit at Rozelle when it had 100 beds?

Dr LENNANE: When it had 100 beds 20 of those were at the McKinnon Unit, which was a detoxification facility that admitted people for short term detoxification, and that had about 1,200 admissions a year.

CHAIR: How long would they be admitted for?

Dr LENNANE: Seven to ten days. And then we had two units for the rehabilitation of people with alcohol related brain damage, and that was a stay of about three months, and then there were two halfway houses associated with that. That was a total of ten beds, which were two cottages of five beds each, where people lived independently on their way out of rehabilitation units.

CHAIR: How long would they stay for?

Dr LENNANE: About three months. Then there was one unit for people with very severe alcohol related brain damage, people with Korsakow's Syndrome, often complicated by other things; people who cannot remember, if they come into the room and go out again, they would not remember being here, they have no short term memory at all, they need around the clock care.

CHAIR: How many beds was that?

Dr LENNANE: Thirty beds.

CHAIR: That was long term?

Dr LENNANE: Yes.

CHAIR: How long?

Dr LENNANE: Indefinite, but there was quite a turnover. We would have had about 20 admissions a year to that unit.

CHAIR: With the 30 beds?

Dr LENNANE: Yes.

CHAIR: Some would have died?

Dr LENNANE: Some would have stayed on.

CHAIR: Some would have died?

Dr LENNANE: One or two, yes.

CHAIR: Of those people, how many people would have had a mental illness?

Dr LENNANE: Quite a high proportion, about 50 per cent.

CHAIR: So they have been accessing psychiatric care while they were in that ward?

Dr LENNANE: Because it was in a psychiatric hospital, the staff were trained psychiatric nurses, the medical staff were trainee or trained psychiatrists, they got it all in one package.

CHAIR: I see. Is it possible to recreate it? The big difficulty which we seem to have is, as you said, if you are mentally ill and you have a drug problem the mental health people will not take you until you get your drugs fixed up, and the other way around. Is it time we put it back in the same box?

Dr LENNANE: I think it is high time, because this really amounts to fragmenting patients. You are trying to pretend that the patient has two separate problems, whereas in fact they are two interacting, or three or four interacting problems in the one person and it is the one person who needs to be dealt with, and that one person would be among the least able to navigate a complex system to access care when some of it is here and some of it is there. If you are wanting to service that kind of patient, you have to have it all in that kind of package.

CHAIR: What is left there out at Rozelle?

Dr LENNANE: There is no alcohol brain damage facility whatsoever. That has all gone.

CHAIR: Where have those patients gone?

Dr LENNANE: Some of them are dead, quite a number.

CHAIR: Have they been replaced by new people who have the same illness?

Dr LENNANE: No.

CHAIR: What I mean is --

Dr LENNANE: Where are they going?

CHAIR: What is the epidemiology of alcohol brain damage?

Dr LENNANE: The epidemiology is probably declining because of two things. One is that consumption of alcohol in the adult population has declined fairly steadily over the last ten years and the other thing is that thiamine, vitamin B1, was added to bread, in flour, about seven or eight years ago and that would have reduced the incidence of some types of alcohol related brain damage. I believe the incidence has declined. However, I do not believe it is anywhere near zero. These people would mostly be clogging up the system in other places. They would be in gaol; they would be in the St Vincent De Paul kind of homeless circuit; they would be on the streets and so on.

CHAIR: What is left out at Rozelle? There is a 20 bed unit?

Dr LENNANE: No, there is not a 20 bed unit. The McKinnon Unit has been shrunk. I am not clear how many beds it has at the moment. There were 20 beds at Basement 82, which was

supposed to go to McKinnon. McKinnon had ten beds. McKinnon, as far as I know, despite the closure of those 20 beds at RPS, still has, I do not know, ten beds, maybe 12 or 13.

CHAIR: This is for detoxification?

Dr LENNANE: This is for acute detoxification.

CHAIR: Is not some of the detoxification being done in the home?

Dr LENNANE: Some of it is. As I say that is difficult because (a) a lot of people may not have a home and (b) not everybody can be safely detoxified at home.

CHAIR: Alcohol, is that an easy thing to detoxify at home?

Dr LENNANE: It can be, it depends. Alcohol detoxification is potentially highly dangerous because people can go into the DTs and they can have seizures, both of those being potentially dangerous conditions with a potentially significant mortality, but if there is adequate supervision, if the person is not physically ill as well, they can be adequately monitored at home, and if they are not sick to start with that could be okay.

CHAIR: This could be done by the Area Health Service with community health teams or drug and alcohol teams?

Dr LENNANE: There is a team operating from Canterbury Hospital that theoretically is doing that. I have tried to access it for a couple of patients and there seem to be so many difficulties that it just has not happened.

CHAIR: What of the other beds, the other 90 beds or so, 80 beds or so, the long term beds, while there is a diminishing need you do not know where those people are, the three month period in the cottages, the rehabilitation?

Dr LENNANE: Those people, I suspect, are just sliding down the social scale and would be ending up in trouble or homeless.

CHAIR: Does not central Sydney have a drug rehabilitation service?

Dr LENNANE: They do have, they have Palm Court. I forget how many beds that is. I think it is about 15. It is rehabilitation. I do not know whether this is policy or whether it has just happened, it is mainly for drugs other than alcohol.

CHAIR: That seems to be a huge issue. There are fifteen beds there, but do they have also community mental health or drug and alcohol workers who support people in the community?

Dr LENNANE: No.

CHAIR: I just ask. I simply do not know these things.

Dr LENNANE: Every now and then you lose something like - there was a very good halfway house kind of hostel thing that we used a lot that was not run directly by the Health Department, it was indirectly involved with the Department of Housing in Camperdown, called Camperdown Lodge. That was a 20 bed facility that did very, very well for quite a lot of guys. It was men only, recovering from alcohol problems and most of them had alcohol related brain damage and/or some other psychiatric illness. That was closed when the owners decided to sell. It was during the Olympics. They wanted to make it into an Olympic facility. What I was trying to say is that of the 17 guys in there when it closed, three were dead within six months.

CHAIR: What about the NGOs, do they run any of these either detoxification,

rehabilitation units, et cetera?

Dr LENNANE: Yes, they do. The Salvation Army run William Booth, which is a significant facility. They run a dual diagnosis facility up in the Hunter region, but that is as far as I know the only one in New South Wales.

CHAIR: That does detoxification and rehabilitation?

Dr LENNANE: Well, they do not actually detoxify but they do the treatment of both conditions on the one campus. I might say not your ideal staff training and so on.

The Hon. JOHN HATZISTERGOS: In terms of the inpatient services, you have indicated to us where the cuts or transfers are taking place. Do you know about any of these new facilities that have been proposed by the department?

Dr LENNANE: The facilities at Concord?

The Hon. JOHN HATZISTERGOS: Well, we are told that there is a proposal to put in this year, for example, 20 at Taree; 17 at Coffs Harbour; 10 at Tamworth; 25 at Tweed.

Dr LENNANE: I am told by people on the ground up there that these units are not in fact operational and I think that is something that the Committee needs to look at. These were set up I think in good faith, the buildings, as I understand, are there and I am told the buildings are very nice, but they have not got the staff, so they have not got patients, so the thing is not working and, while that is the case, the area, it seems, gets to keep the money.

The Hon. JOHN HATZISTERGOS: We are told there are also some facilities in progress. I do not know in what state they are, but perhaps you might enlighten us: 20 at Liverpool; 20 at Blue Mountains, 50 at Wyong and 10 at Kempsey. Do you know about any of those?

Dr LENNANE: Well, they are in progress, but they are not operational, as far as I know.

CHAIR: What about the 10 at Campbelltown? That is meant to be a children's unit.

Dr LENNANE: That is for children and adolescents, yes, and I understand from the horse's mouth there that they have not been able to open it properly because they cannot get the staff, and I am sure you have been told about staffing issues.

CHAIR: Yes. This would be the third unit in New South Wales that dealt with children, I understand, and adolescents.

Dr LENNANE: Yes, but it is not currently operational or, if it is, it is on the basis of maybe one patient because of lack of staff. The money is there; the facility is there, the facility I am told is beautiful.

CHAIR: Well, I know the one at Tweed is there because I saw it physically myself and I am aware that its opening is to be staged. In other words, I think 15 beds this year, 20 next year and so on, because it has been built for the long haul, so I do not expect every one of those beds to be opened tomorrow. I heard the member for Coffs Harbour saying the other evening in the House how the one in Coffs Harbour is not fully occupied. What you are saying is that they get the money, but they do not spend it?

Dr LENNANE: They do not spend it on that.

The Hon. JOHN HATZISTERGOS: Because they cannot get the staff or they do not try?

Dr LENNANE: Well, I suspect a bit of both. There is certainly a real staff problem, as you

know, particularly nurses. It is just very, very difficult. Mind you, that was foreseeable and nobody did anything. There is also a big temptation, they have that pocket of money that they can hang on to at least until 1st July and I suspect the temptation is too much.

The Hon. JOHN HATZISTERGOS: Isn't the money quarantined, or not?

Dr LENNANE: The money theoretically has been quarantined all the time and that has not stopped them.

The Hon. JOHN HATZISTERGOS: What happens if they do not spend it?

Dr LENNANE: Well, they do spend it, but they do not spend it on mental health and they disguise that in the accounts. One of my hats is Whistleblowers Australia and we have information from auditors within the health system who say this can be done and it is done. You can hide it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have to look at that at estimates.

CHAIR: Every minister that I know - Hannaford, Collins, Refshauge, everybody - says it is quarantined and everyone has gone to extraordinary lengths to make sure it is, but the evidence that I have seen too from the submissions is that it is still being filched.

Dr LENNANE: Yes. I can probably get you a couple of auditors to talk to you anonymously if you wish.

The Hon. JOHN HATZISTERGOS: We can go into a confidential session, if we need to, to hear from them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be helpful. The Commonwealth submission suggested that there has not been much spending in the community based centres in New South Wales by national standards. You have talked about bed numbers, but the bed numbers in New South Wales are not hugely different from the national average, not hugely different from the Victorian ones, and I note in the Government's submission to us in reply to the terms of reference that they are claiming that the number of full-time equivalent jobs has still risen in New South Wales in mental health staffing. Is this a fast and loose definition, would you say?

Dr LENNANE: I would say it must be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They quote the budget papers, which I thought was an interesting thing for the Department of Health to quote, in the sense that one would have thought they would quote their own figures.

Dr LENNANE: Well, the trouble is, if they quote their own figures, I am sure they would say otherwise. Our information about central Sydney is that it has a 60 percent reduction in staffing over 10 years. That comes from their annual reports, but it is difficult extracting that information and it is quite a bit of work for someone to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Weren't mental health facilities very much concentrated in central Sydney, not many in the regions? How much of that is just being shifted to other area health services?

Dr LENNANE: Well, part of that no doubt was the resource reallocation formula or whatever they were calling it, but that should have been a decrease of maybe 20 percent and we have 60 percent, and I personally have always greatly objected to that resource reallocation formula because, as you know, and I am sure you have evidence to that effect--

CHAIR: There isn't one.

Dr LENNANE: There was.

CHAIR: There is not one for mental health. The RDF does not apply to mental health, I can tell you that now because we have had that from another inquiry.

Dr LENNANE: Okay.

CHAIR: They are working on the process of having an RDF and all governments since 1980-something have been trying to move money into general hospitals and into areas of need - I have papers here from 1991 and 1995 and the current minister is doing the same thing with building things at Liverpool and moving mental health money to where people are - but there is no formula.

Dr LENNANE: Well, that is good, but the problem with mental health, as I am sure you know from other evidence, is that there tends to be an inner city drift, so that people with both mental health problems and alcohol and other drug problems tend to drift towards the inner city centres and so you have an historical conglomeration or accumulation of people in the inner city.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was interested really in the relocation to community services. I do not think anyone is disputing that the beds have been cut--

Dr LENNANE: Massively.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the beds are obviously very intensive in terms of staffing needs, you presumably get a lot of community services for the price of a bed.

Dr LENNANE: No, you do not actually get all that many. The problem with community services is that they are scattered. If you have a centralised service you have the convenience and you do not have travel time and that kind of thing. When you get people in the community trying to follow patients up, half of the attempts to even see the patient are unsuccessful because they are out or they are not letting staff in or something like that, so it is not as favourable a cost exchange as you might think. The real problem, of course, has been that some of these services that were put in the community have since disappeared. There were things that were held up by David Richmond at the time of the Richmond report as models of where we should be going, services that were established in the community - Ellamatta Lodge in northern Sydney and Louisa Lawson House somewhere in the east - and both of those have been closed. They were closed years ago and nothing was put in their place.

The Hon. JOHN HATZISTERGOS: There is an international trend towards decline in inpatient services and there has been for some time.

Dr LENNANE: Yes, there has, and part of that is justified by better drugs and better treatment, but a lot of it is not. There are all sorts of beds. There are beds in a fully staffed operational psychiatric facility down to some kind of community living accommodation where you might have mental health staff visiting once a week and through all grades of intensity from there. That is where Victoria has done an awful lot better than New South Wales: They have far more community accommodation, supervised community type accommodation.

The Hon. JOHN HATZISTERGOS: It just seems to me that the problem may have arisen where there has been this trend and it has been happening, as you say, for some time.

Dr LENNANE: Yes.

The Hon. JOHN HATZISTERGOS: Both here and overseas.

Dr LENNANE: Yes, worldwide.

The Hon. JOHN HATZISTERGOS: Years and years ago it was just, well, this is a place where they ought to go, put them there and forget them, but now that has changed, it may not be the

most appropriate method of treating people with mental illness, so those methods have changed, but the interesting thing that I have seen in terms particularly of the Health Department's submission is that the number of involuntary admissions into mental health institutions, particularly the number of police presentations under section 24, have grown rapidly.

Dr LENNANE: That is right.

The Hon. JOHN HATZISTERGOS: Particularly in the last five years, or a bit beyond that actually. It really appears to have started in the middle of 1995 and it has gone up very steeply and, for one reason or another, the facilities have not been sufficient to be able to cope with that increase. Is that right?

Dr LENNANE: Well, yes, but it is circular.

The Hon. JOHN HATZISTERGOS: It is a circular problem.

Dr LENNANE: It is a circular problem. If you do not have enough beds then people get chucked out too soon and they are disturbed and they come back again, the police bring them back and so on, so you are going around and around in circles doing nobody any good.

CHAIR: But there has also been this drugs thing.

Dr LENNANE: Yes, the drugs in addition, yes, and they have added a complicating factor that made everything more difficult, that made it more dangerous. I would hate now to have to work in an acute unit. They are really most unpleasant places to work.

The Hon. JOHN HATZISTERGOS: That is why we have difficulty attracting staff.

Dr LENNANE: Exactly, because people are there for such a short time, they are all completely crazy while they are there, they are difficult, they are violent, the risk of assault is very high - that is whether you are a patient or staff - and sexual assault, of course, is rampant in these units. People are not in long enough to establish a therapeutic relationship with them and so you just see people at their worst and one of the great pleasures of practising any kind of medicine is seeing people get better. You see someone come in in a complete mess, difficult, violent, hardly a human being, and then three or four weeks later you see this nice person that was underneath all the time, but that sort of reward has gone because the person has been discharged long before they get to that stage these days. It is a really very unpleasant, very dangerous, very difficult environment, and I think that is one of the worst aspects of the lack of beds. The other, of course, is the number of deaths that are occurring and that is something that I would really like to say something about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I was going to ask you about that. What can you say about deaths while under the care of the Health Department?

Dr LENNANE: Yes, let us be quite clear, that is deaths while you are in hospital or while you should be in hospital, you were there and you absconded, or when you have been discharged and you are still theoretically receiving care, you are going to be seeing someone in a week or two--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or you are presumably working in hospital.

Dr LENNANE: Working in hospital?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, have there not been some staff deaths?

Dr LENNANE: Yes, sure, or patient deaths, yes, but anyway, you die while under the care of the system, and the Health Department I think has been engaging in what to my mind is a criminal cover-up of the number of deaths that have been happening. As the system has got more and more

chaotic and difficult, more and more people are dying. We have some figures that fell off the back of a truck, and I do not know if you have these from the Health Department, the Mental Health Quality Portfolio dated February 2002. That has two figures for suicides in 1999 and 2000 and they were 177 and 166 respectively, that is people dying while under the care of the department.

CHAIR: Is that in a hospital or on a CTO or something like that?

Dr LENNANE: Well, whatever, but under care, they are a patient, they are a client of the service at the time, and the ratio of hospital to outpatient deaths is probably about three to five.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hospital to outpatients, three to five?

Dr LENNANE: Something like that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Where are these figures coming from?

Dr LENNANE: Well, that figure is from the one publication that the Health Department has done, which is in our submission, the client mortality or whatever. It was a paper that they published in 1995.

CHAIR: That was 1995?

Dr LENNANE: Yes.

CHAIR: But we have not seen anything since then?

Dr LENNANE: No, we have not, and we have been trying. The Sydney Morning Herald has tried under freedom of information and the National Association of Practising Psychiatrists has tried under freedom of information to get the figures and the only updated figures, as I say, that we have are these two for those two years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What were they again?

Dr LENNANE: 177 for 1999 and 166 for 2000. This document is dated February 2002, so obviously they could have included the figures for 2001. They did not and I would suspect that that is because 2001 was even higher.

CHAIR: That is interesting against the background where, generally speaking, suicide rates are dropping, except for older men.

Dr LENNANE: Yes.

CHAIR: The latest report we had from the Commonwealth for the year 2000 was that the figures had actually turned around and they are dropping in the general community.

Dr LENNANE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is the name of that report?

Dr LENNANE: You are welcome to a copy. We got it after we sent the submission. There are only three pages of interest in it, most of it is just rubbish. There is one page about violence and one about suicide and one about sexual assault within the system, which are more frank than usual, but don't bother reading the rest of it.

CHAIR: Would you like to include that as part of your evidence?

Dr LENNANE: Yes, sure.

CHAIR: Would you move that they be made public?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I move such.

(Motion by the Honourable Dr Arthur Chesterfield-Evans agreed to.)

Dr LENNANE: The paper that the Health Department published, and it published it very low key in 1995, had the suicide figures for just over three years, 1992 to 1995, and they pooled those figures, so you could not see what the trend was. I am quite sure that the trend was upwards, as we have seen, but the average for those three years was 80 per year and we now have more than double that and they will not release the figures.

CHAIR: The other problem is, according to the Mental Health Review Tribunal, there were 52 forensic patients in 1991. There are now 400-odd.

Dr LENNANE: Yes.

CHAIR: So there has been a change in the level of lawlessness amongst people who are mentally ill.

Dr LENNANE: Yes, of course.

CHAIR: Or there are more people who are being not treated for mental illness and therefore they are going through the criminal justice system.

Dr LENNANE: Well, both those, but the big issue is that they have not been able to get treatment and I have heard of so many cases where there has been a homicide - this is the other issue - and you had a submission the other day--

CHAIR: We had Dr Barclay in here, but we did not talk to him about homicides.

Dr LENNANE: No, the National Association of Practising Psychiatrists. Part of NAPP's submission was the suggestion of setting up a psychiatric deaths committee that would monitor these deaths - that is both suicides and homicide - with a view to just tracking how the services are going because, if you had good services, homicide by someone with a known mental illness should be extremely rare. It should be really, really rare, and so should suicide by a person who has known mental illness while in a hospital. That should be exceedingly rare. It used to be exceedingly rare before 10 years ago, but now it is common. You have people walking out of the Missenden Unit, two or three a year walking out of the unit supposedly in secure conditions and often going off a bridge or under a train or hanging themselves or whatever.

CHAIR: They were doing it inside the unit as well.

Dr LENNANE: Inside the unit because the conditions are so chaotic and so unsafe, because of the speed with which people are being turned over.

CHAIR: But I mean actually physically inside a bed inside a unit.

Dr LENNANE: Yes, inside a bed. In one case, and I am in communication with the mother, two of her three children were lost to suicide within the last three years. The first one was under the care of the community mental health team at the time he suicided. The second one was actually in Missenden Unit. She had been seen by the magistrate, given a six week order and that same day she was moved without her mother's knowledge from the secure part of the Missenden Unit, a locked part, to an insecure part. That same night she disappeared and she was seen at The Gap and her shoes were found. She has never been found.

CHAIR: There was also the case at Manly where the kid hanged himself inside his room.

Dr LENNANE: Yes, but that sort of thing, as I say, should be rare. It used to be rare and now it is common and it is common because the whole thing is chaotic.

CHAIR: Do you think we focus too much on the failures in the system rather than on successes, in the community at large rather than you and me?

Dr LENNANE: No, I think we do not focus enough on the failures myself because it is by our failures that we learn. You can always have a success, you know, that is all fine, and it may depend on the individual. Likewise, the failure may depend on individual problems, but that is how we learn. You make a mistake, you see what you did wrong and you avoid doing that next time, but I do think that it is terribly important if we have a psychiatric deaths committee, and that has to be independent obviously because the Health Department has just been in the business of completely locking things up, it has to be independent and I think it has to report directly to Parliament.

CHAIR: The death under anaesthesia committee?

Dr LENNANE: That kind of thing, or the maternal deaths committee. If you look at the maternal deaths committee, there was big publicity because maternal deaths had increased from say 30 to 37, or something like that, and instant action. Everybody says, "Right, something is going wrong. Let's do something." Here we have with the suicide deaths, I believe it is not just a doubling since 1995, I believe it has quintupled since 1990, five times at least. I believe there are a thousand people dead over the last ten years. Most of them would have been young and most of them could have had reasonable lives. Many of them had schizophrenia but they could have had quite reasonable lives. They are dead and they would not have been dead if there had been adequate services available.

As you know from the deaths under anaesthesia committee, it is very important to avoid a blame culture. You are not looking for a scapegoat. You are looking for answers as to how to avoid this the next time. What went wrong and how do we avoid it?

CHAIR: Do we take enough notice of the things that are successful and learn from them, programs either here in Australia, or in a local area, or internationally?

Dr LENNANE: Well, I think we tend to learn too much from them. The problem with mental health is that it is very complex, as I am sure you are now painfully aware. It is not homogenous, and it would be like looking at a successful program, say for treating throat cancer, and then you extrapolate that to cover the whole of medicine and surgery. That is the kind of thing that happens in psychiatry. You get a successful program that is very successful in a particular setting for a particular group of people at a particular time, and you say, "Right, if we have ten of those we are going to be able to cut out all this."

CHAIR: There have been massive improvements in the quality of pharmaceuticals.

Dr LENNANE: Massive.

CHAIR: From say before the war, which I do not have the figure for, 1955 through to now, we have gone down in the number of beds that are in long term care by a massive number.

Dr LENNANE: Yes.

CHAIR: While there might be some problems, just the introduction of lithium and thoropropozine, and since then the newer drugs, we have step rise changes in the dependency and support and the ability to live independently. I know that should not change what we do for individuals who cannot be managed or will not be managed, or whatever, but there have been some significant problems where drugs have allayed the community's fear of mental illness?

Dr LENNANE: Question mark. I think one of the issues that I have is that there is probably actually a lot more to fear from people with mental illness than there was ten years ago because of the lack of facilities, lack of treatment. The chances of running into a problem of severe violence is probably higher than it used to be. That is an issue and, there is a whole frustrating thing about that, that it is completely unnecessary because we do have so much better drugs. If we were providing the treatment there would be much less risk to people with mental illness, who are usually a danger to themselves rather than others, and also less risk to everybody.

CHAIR: The obvious question is are we relying too much on drugs and too little on personal community services?

Dr LENNANE: I think that is a big issue, that you think that you give people a drug and they will be right. There is a lot more to it than that. I have found throughout my career that the biggest protection against suicide is the human bridge, if there is someone out there that the person who is considering suicide knows cares and they can contact. That is just not there most of the time for most people these days.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that is partly the reason for the increase in the suicide rate, the change to more drug treatments?

Dr LENNANE: Not change to drug treatments but change to relying on drug treatments and forgetting about the human factor. The other big issue about the drug treatments I think is that we are not getting anything like the amount of benefit we should be getting from them because of the chaos in the admission units, because the average length of stay is now so short, and that is all that it can be because there are people queuing at the door to get into the vacant bed. You have great pressure to shut people up and calm them down quickly. Psychiatric drugs do not work that fast. They do not work in five to seven days. So if you pump people full of drugs, which is what tends to happen in the acute units, in an attempt to get them manageable enough to discharge them in a week's time, you are going to be giving them a lot of unnecessary side effects because the doses are too high and too many drugs are given where one would probably do if you had longer to play with, and that is a very, very unfortunate side effect for a lot of people with schizophrenia, for example, who are going to need very long term medication, putting them right off the idea of drugs ever. Whereas if you had more time to manage them in the hospital, get them suited on the drug, something they could live with, that suits me, yes, my thinking is clearer and things are going better, then you have someone who is set up for life and they may never need to come back again.

CHAIR: Anecdotally, I have a relative who died in a house fire just last week who had been admitted to the local general hospital on a schedule some time before following a suicide attempt.

Dr LENNANE: Right.

CHAIR: And having come out of that she looked like she was getting disorganised again some years later. The mental health team said, yes, they would rearrange her admission. She was desperately concerned about this admission. We do not know why she burnt her house down and died but it was thought by the relatives that she was very worried about going back into hospital. To what extent is admission to hospital such a frightful thing that it would cause somebody to do that or even think it?

Dr LENNANE: I think again the chaos that I have spoken about, I think being in an inpatient unit at the moment is very unpleasant for both patients and staff because everybody there is so crazy. Also, of course, as part of an illness, particularly a depressive illness, you can get desperately concerned about things that are not really of concern. That may have been a factor, but it really is very difficult to get treatment now for people who have a quiet psychiatric illness, if you like, because the experience of admission is very distressing for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask you about personality

disorders? I am getting the impression, certainly yesterday, that personality disorders are not quite mental illnesses.

Dr LENNANE: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are not treatable by drugs and they are not very well treated in other ways, is that right, recalcitrant?

Dr LENNANE: Depending on the type of personality disorder, they are difficult to treat, and they cannot be given a magic drug because there is not one, but, again, the human bridge is very, very important for that particular group and if they can have established a regular human contact with a counsellor, psychiatrists, whatever, that is one of the most important things that can be done for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are important for the forensic service, are they also important in the deaths under mental health treatment?

Dr LENNANE: Yes, they would be, although tend not to be admitted. That is one of the reasons given for refusing admission, that someone has a personality disorder rather than a psychiatric illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are the ones people take and put in gaol, where the human bridge is shaky?

Dr LENNANE: The human bridge tends to wear an unpleasant face in gaol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there more personality disorders than there were?

Dr LENNANE: I think there may well be because it is related- it is partly genetic it would appear, but it is also related to neglect and abuse in childhood and I think there has been rather more of that of recent times.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, if the problem of mental illness in gaols is a serious problem, presuming we are able to improve the treatment of treatable illness in the psychoses and drug and alcohol area, there may be a residual group of personality disorders?

Dr LENNANE: They are a difficult group. Every country in the world struggles with this problem but they actually do quite well, sometimes astonishingly well, with a long term psychotherapeutic approach that is on practical lines, not Freudian type, practical support.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it more preventable if you improve kindergarten services or something like that?

Dr LENNANE: If you could improve Department of Community Services you might do well there but that is where a lot of the personality disorders come from, from failures.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the area of child support?

Dr LENNANE: Yes.

CHAIR: Before we conclude, if you find that we have misunderstood any of your questions or that there are some answers you would like to extend or there is some information, like this information that came to you, that you would like to have included with your evidence, we would be happy to receive it.

You will get your Hansard for today sent to you, because it will go onto the web uncorrected when it is done by Hansard, and then we will put your suggested corrections in, so it becomes a

corrected version. We may need to see you again for some other purpose associated with your submission. Would you be happy to assist us with those matters?

Dr LENNANE: Yes, of course.

(The witness withdrew)

(The Committee adjourned at 12.30 p.m.)