REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

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At Sydney on Thursday 30 May 2002

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. Dr Brian Pezzutti (Chair)

The Hon Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. John Hatzistergos
The Hon. Peter Breen

CHAIR: This morning the Committee resumes to deal broadly with the issue of mental illness and interaction with police and prisons system. I am very pleased to welcome Dr William Barclay, AM.

WILLIAM ARTHUR BARCLAY, Psychiatrist, 24 Fernhill Avenue, Epping, sworn and examined:

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

Dr BARCLAY: Yes, I am.

CHAIR: You made a submission to us. Are you happy for the Committee to take that as part of your evidence?

Dr BARCLAY: Yes.

CHAIR: If any stage during your evidence you believe that, in the public interest, certain evidence or documents and may wish to present to the Committee should be seen or heard only by the Committee, the Committee will be willing to accede to your request, but you should be aware that the Legislative Council may overturn the Committee's decision and may make the evidence public. Would you like to make some broad remarks? You have been in the system for a long time and you have advised governments for many years. I see from your record that you were on the planning committee of the Westmead Hospital in 1973, so you have been in the business of planning and delivery of services for a long time. Will you give the Committee a summary position of the speech you gave recently?

Dr BARCLAY: As I said on that occasion, the mental health service faces a shortage of acute beds and that has been developing over many years. Part of the acute situation that exists in virtually all of the admission centres is now due to the very substantial increase in the number of people, particularly young people, using and abusing mind-altering drugs. This has resulted in a very big increase in admissions to acute psychiatric units of persons with what is called drug-induced psychosis. That may cover a number of things: In some cases, you get acute psychotic states directly from the use and abuse of drugs, but in many cases the people already have an underlying mental illness or mental disorder whose condition is aggravated by the use of those drugs. These people are frequently young, very disturbed and are often extremely aggressive. They place a heavy burden on the beds in acute units but also on the staff in managing them.

One of the problems that occurs because of the acute psychotic state is that it often masks the underlying less obvious mental disorder—frequently a schizophrenic illness—and that illness may go unrecognised during the short period that patients stay in hospital. As I stated in my submission, a number of people who come into acute admission units have complex needs. Some of them will be brain damaged and will have psychotic manifestations, either of a separate illness or of brain damage. They are very hard to place and they often occupy beds for a significant period. There may only be one or two of them in the unit but if you have a smaller unit and a shortage of beds, they make quite a difference. The average length of stay in acute psychiatric unit is really too low for first-class quality clinical practice.

The people in such units are rushed off their feet and they are working under very high pressure. There are other factors that make that work difficult. Just looking at the straight question of a patient, patients are often being discharged at a relatively early stage of their illness. That is not always a bad thing, provided that what they go to is prompt, effective, clinical care in the community—in their home or in an outpatient clinic with regular and frequent skilled follow-up. There are a number of issues about how community mental health services and crisis intervention services and treatment of the home services are structured and managed. Two of the things that put the inpatient units under stress—and they will all say this—are the shortage of nurses and the shortage of doctors.

Mental health nursing is facing a fairly steady decline in recruits. The nurses who come out of the university training courses are nowhere near adequately enough prepared to go into acute mental health services. They get a very small component of mental health training and are often

overwhelmed by what they come into in an acute admission unit and there is a very high wastage rate. Up until recently there has been no significant amount of training provided in the first year of service for those nurses. There have been orientation courses but I was given to understand, as recently as during the past two weeks, that the department has made funds available to provide training courses for graduate nurses who are coming into mental health services. For example, I know that in the Illawarra a four-week training program is provided for first-year nurses who are coming into mental health services after university graduation. I do not know how widespread the program is but my impression is that it is very much left to the areas to plan and implement the training courses.

It is my belief, and I know that this is shared by a nursing colleague of mine with whom I have been working, Professor Ted White, that such training needs to be formalised, regular and thorough so that nurses are well prepared for the work that they are going into, which is something they simply will not have experienced to any significant extent in their university training. The shortage of nurses causes problems, particularly in the acute units, because they are often forced to make up the numbers by using club nurses who come in from private nursing clubs. They try to get trained and experienced psychiatric staff all the time from those clubs, but that is variable. It is not terribly different in many of the acute medical and surgical units, I might say. Having been in hospital a number of times over the past few years, I know how frequently patients are nursed by a private club nurse who just comes in for the day or a few days and then disappears. The shortage of nurses really breaks up continuity in the quality of care in acute services.

There is a shortage of doctors. Recruitment in psychiatry in Australia and in other parts of the world is falling and there are many reasons for that. Although it was indicated several years ago that there would be support at the highest levels, which meant Commonwealth and State governments, to improve psychiatric recruitment, that has not been achieved. New South Wales—and I know that this is true of Victoria also—is unable to fill its quota of registrars to take up training each year. That is going to lead to problems further down the line about whether we have enough psychiatrists. It raises all sorts questions about what sort of work psychiatrists should be doing. Also, the proportion of the total number of psychiatrists working in the public sector has been falling steadily since about the late seventies or early eighties whereas at the time when I was still in the service—my last year was 1976—we were able to say reasonably confidently that approximately 50 per cent of qualified psychiatrists worked in the public sector.

The recent Australian workforce survey showed that that is down to about 38 per cent and it continues to decline. Part of the reason for that is that the psychiatrists find the work they have to do and the way they have to work in the acute admissions services, which makes the heaviest demand for staff, so unattractive that they leave. They go into private practice. They may well come back and provide treatment on a sessional basis, but the service is facing a shortage of psychiatrists and it is particularly marked outside the metropolitan area where it is very difficult to recruit psychiatrists. You have to have enough acute beds to enable you to treat your patients for an adequate period so that the average length of stay for most of these units is above six days. When I first started reviewing mental health services about three years ago, I found that some of them have an average length of stay of about six days. Most of them manage to get up to about 11 or 12 days, sometimes by the provision of additional beds and sometimes by better diversion programs into community care.

But even that is questionable. Nobody knows what the ideal average length of stay is. Certainly, when you are down below 14 days, many of your patients are being discharged into community care at a very early stage of their illness and sometimes they are relatively unwell. That will not be easily or quickly solved. So it means that you have to pay a lot of attention to having a really efficient, quick response, high-quality community mental health service that picks up the patient as soon as he or she is discharged. So you have to have a good discharge planning program.

I have found in the reviews that I have done that in most cases that has been lacking. In one or two places it was excellent. It was usually excellent because someone was given the specific job of organising the discharge planning and following through each patient to see that they got an early appointment and were followed through. But then when you get to acute care it means that you have to have a variety of services that are able to respond quickly to requests for assistance if people ring up and say, "My son has become ill again." If there is an acute crisis you have to be able to get someone to see them promptly and deal with the issue. But you also have to have a system that is able to take in patients—I do not mean as an in-patient—and see them promptly in the community health

service within a day or two of their discharge from hospital and then maybe see them two or three times in the next few weeks.

That was certainly my policy when I was in private practice for all patients that I discharged from hospital. But, of course, we were keeping them in two or three weeks, so they were much less ill when they went out. But you made a follow-up appointment for that patient within the next few days and then early in the following week—perhaps twice in the second week. So by the third or fourth week you would probably be able to cut down those appointments to weekly. But that is the sort of responsiveness that you need to have, particularly when you are discharging patients after a short period of stay when they have had an acute mental illness or a mental disorder.

CHAIR: What happens if you do not?

Dr BARCLAY: Patients may not comply with their medication and compliance with taking medication is one of the most important things for those people who have a severe biological depression or an acute psychosis. But even without that they may break down. They find the stress of perhaps being unsupported, being at home or even being on their own too much. Quite often they come seeking early readmission. It is not uncommon to have people coming back within a few days and saying, "I need to come back into hospital again." And, of course, there are risks. It heightens the risk of dangerous behaviour, of either self-harm or of harming someone else. That is very much part of the risk management of people who are potentially suicidal.

The Hon. AMANDA FAZIO: When you were talking earlier about drug-induced psychosis and these episodes being brought about by mind-altering drugs, do you include alcohol in that?

Dr BARCLAY: Yes, I do. You certainly can get quite severe disorders when a patient is in alcohol withdrawal. The abuse of alcohol in itself is not going to cause a psychotic state, but if it is heavy abuse of alcohol it certainly has a very adverse effect on people who have an underlying mental disorder, particularly if they are depressed. They get more depressed. If they are schizophrenic they are already having trouble coping with life. If they are bombing themselves out on alcohol they are much less able to cope. So we are certainly including alcohol, but we are more particularly talking about the use of marijuana and amphetamine-like drugs.

The Hon. AMANDA FAZIO: There is a real trend now for prescribing people those sorts of serotonin boosters to try to keep them stabilised or whatever. But do you think that that masks some of their problems so that when they do have an episode it is were worse than it would otherwise have been?

Dr BARCLAY: That is not a simple question because you have to identify the reason why the drug is being prescribed. In our push to get people to appreciate the significance of depression in our community we have tended to just use the phrase "depression". But depression covers a wide spectrum of low mood—everything from sadness right through to the biological depression that is part of either a unipolar or bipolar manic depressive disorder. If you are talking about that latter end of the spectrum it is simply a fact that some people need to be on an antidepressant drug for long periods of time and perhaps even for the whole of their lives and it can be very effective in preventing them from having recurrent episodes of very severe depression, which can be life-threatening.

But if you are talking about the other end of the spectrum, with not the biological type of depression but more a depression that is reactive to life circumstances of a whole variety of kinds—what perhaps in the past might have been called a neurotic depression, but we do not use that term these days—it may be very questionable whether those people need any antidepressant drug at all. They are the group of people who are often best managed by psychological or psychosocial treatments, particularly cognitive behavioural therapy, which has a well-proven record of being effective in the management of such people. So the answer to your question is yes and no. It depends very much on which category of person you are talking about.

You would not want to put someone who is just sad or bereaved, or who is having difficult life circumstances, or who may be even chronically unhappy on any antidepressant drug and leave them on it. You might not even want to put them on it at all if you can find other methods of handling

their problem. That is a very important area where the public mental health system has a marked shortage of people to administer the psychosocial treatments. I mentioned that in my paper.

The Hon. AMANDA FAZIO: The third question that I have relates to the articles that you attached to your submission, which talk about the difficulties in recruiting and retaining psychiatrists. I was just wondering whether you had any helpful suggestions as to how that problem might be overcome?

Dr BARCLAY: I have been talking about a lot about this, particularly to people from the Centre for Mental Health and to some of my colleagues. Somehow we have to demonstrate to young medical graduates who might have an interest in psychiatry that psychiatry these days has a scientific base and that it can be a scientific discipline. We have to provide those who enter psychiatric training with experiences that are professionally rewarding. Recently I have been told that three registrars have approached their supervisor of training and said that they wanted to give up their psychiatric training because it was not what they thought psychiatry would be like. What they meant was, "We thought psychiatry was going to give us an opportunity to spend some time with people, to do thorough assessments and then be engaged in some sort of process of ongoing treatment of that person."

Instead what they find is that, because there is a desperate need for doctors in the admission centres, they get thrown into the pool—often very much at the deep end—there is a heavy turnover of patients and a high demand is placed on them for quick assessments, and there is very little opportunity for them to follow through those assessments with ongoing treatment of patients. What happens in the public sector is almost totally unlike what happens in the private sector. What has happened is that even if you manage to get them through their training, many of them leave to go into a combination of private and public practice because they can get what they want in the private sector, which is the ongoing relationship with patients and treating them and time to do thorough assessments.

So we have to somehow re-establish the view of psychiatry as a scientific discipline. We have to provide role models that young people or young trainees can look at and say, "That guy knows his business; he is competent; he has a scientific base to what he is doing; he is someone that I could aspire to be, or a position like that." We have to accept that we will not again, for a long time or if at all, be able to attract many psychiatrists to staff specialist positions on a full-time permanent basis in the service. When I joined the service I envisaged really spending my life there. I did spend 20 years there and I enjoyed every minute of it. I do not know whether I would enjoy it now. But I saw it as a very rewarding, valuable career.

The reasons why I left are quite complex. But that feeling is not there any more. We may just have to accept that people do not want to work as staff specialists on a full-time basis. A few do, but nowhere near the number we had prior to that. We have to look at forming partnerships with the private sector, as has been done with the Coffs Harbour program and as is developing with the Wagga Wagga program. I have been asked in the near future to visit Albury, to talk with doctors there and to look at how we can re-establish the relationship between the public and private sector there.

The Hon. JOHN HATZISTERGOS: One of the suggestions we had was visiting medical officers [VMOs].

Dr BARCLAY: Yes, that is exactly what I am talking about. That is what I mean. The major impediment to that, as the area chief executive officer sees it, is the cost. They do cost, on an hourly basis, twice as much as a full-time staff specialist. On the other hand, you get a lot of work out of them. The guys who go to Coffs Harbour get there at about 9.30 a.m. and they pretty well see patients all day. They go to the wards and they discuss patients. They have very high productivity.

CHAIR: That is a fly-in, fly-out service?

Dr BARCLAY: A fly-in, fly-out service. That is not the ideal. What you would like to have is private psychiatrists working in Coffs Harbour who worked as VMOs at the hospital. I do not regard the fly-in, fly-out service as an ideal service by any means, but it is a way of getting the quality of psychiatric care that you need. So it is a variety of things.

CHAIR: That is what is happening at Wagga Wagga.

Dr BARCLAY: Yes.

CHAIR: It is happening at Broken Hill and at Dubbo substantially. Tamworth and Lismore have their own VMO locals, plus staffers.

Dr BARCLAY: Yes. In Lismore, Harry Freeman has virtually phased himself out of practice and the other man is getting on in years.

CHAIR: They have three more though.

Dr BARCLAY: That is good. The ideal is to be able to attract doctors to an area who are prepared to work in a rural practice. There was an article recently, I think in the Australian Medical Journal, about why general practitioners stay in the country, in rural areas, and why physicians do not. It is hard to attract specialists to country centres.

CHAIR: We received a submission from the Superintendent, Mental Health Service, Northern Sydney Area Health Service. The issue there involved the consultant who used to be employed as a VMO to support community nurses and others. The consulted worked out plans for some of the patients with whom he was presented. That position has been abolished and no-one has been reappointed. That happened recently. That involves a VMO appointment as a consultant. I note that your argument, based on the articles you present, is that the real need is to see a psychiatrist as a consultant, rather than necessarily the caregiver.

Dr BARCLAY: Yes. I think that has to be developed more. The main reason for getting rid of those people is to save the cost of employment. There is a tremendous reluctance on the part of the areas to employ VMOs because they regard them as too expensive. But you cannot effectively replace them with anyone. It is extraordinarily valuable to have experienced doctors, who have established their careers and are consultants in the true sense of the word, to provide supervision to the registrars and meet with the nursing staff.

One of the things I was trained in when I was in the United States was what is called mental health consultancy. That is where a consultant comes in and does not actually see any patients but sees the people who are seeing the patients.

CHAIR: That would aid us with retention of our nurses, particularly our young doctors?

Dr BARCLAY: Yes, it is invaluable in that regard.

CHAIR: Even in community mental health, there is a need to be able to talk to someone who has experience and knowledge and whom you can rely upon in a confidential manner when you feel you are not coping?

Dr BARCLAY: I agree totally.

CHAIR: In your submission you say that there has been a reduction in long-term supported accommodation. That must drive the silting up of the acute care system?

Dr BARCLAY: Yes, it does. Somehow we seem to have missed the boat. It is not rocket science to know what you need in terms of supported accommodation in the community. You need a range of facilities with varying degrees of supervision and support. It starts with the open rehabilitation ward on the campus of a hospital, whether it be a mental hospital or—

CHAIR: Are there any of those left?

Dr BARCLAY: Yes, at Morisset. But I know that the area director would like to close them down. Sometimes they are in good standard accommodation wards that have been renovated. And then you work your way through the cottages and villas on the periphery of a hospital, as you will find in Wharf Road at Rozelle and at Cumberland Hospital, just outside the hospital but with some degree of nursing supervision, right through to independent living, which may or may not be supported.

There is a series of grades, all of which recognise that patients with serious mental illness, particularly schizophrenia, plateau off at various levels of disability and need varying levels of support in their community-based or hospital-based accommodation. We just do not seem to have picked up that ball and run with it; we have not really put the money into it.

CHAIR: In 1998 you were called in by Collins to provide advice. At that time de-institutionalisation was stopped until we caught up a little, because we were discharging people at a rapid rate without providing accommodation.

Dr BARCLAY: Yes.

CHAIR: Sister Myree Harris, a witness who gave evidence yesterday and who worked in the area for many years, said that during that period of time people moved out into the community without support and this caused a lot of the troubles in the Maroubra area and so on. Perhaps we need to have a little pause until we catch up. Otherwise, the silting up that is occurring in acute services will cause a lot of problems in terms of both recruitment and the care they receive.

Dr BARCLAY: There is not much to pause. I am not quite sure what you mean by that. Certainly I would not want to see the rehabilitation beds at Morisset closed; I would like to see more effective use made of them. I would not want to see any of the rehabilitation beds that currently exist closed, but there are not that many.

The real problem is that what we have is an acute service that is turning people over very quickly and there are very limited facilities for those people to go to, if they need them, after discharge. There is nothing much to pause. What we need is to get to work providing that range of sheltered accommodation in the community that we know is needed.

CHAIR: Richmond was not meant to be a cheaper service; it was meant to be a better service.

Dr BARCLAY: Yes.

CHAIR: I was extremely interested to read your final comments. You said that the closure of asylums and the move to community-based care is still a fragile plant and needs protection.

Dr BARCLAY: Yes. When people look at the problem, they say we went too far, we closed all the mental hospital beds—and we certainly did close a lot. When I started in 1957 there were 13,000 patients in mental hospitals in New South Wales. That did include the developmentally disabled.

CHAIR: There are still 2,500 patients—?

Dr BARCLAY: Yes. We are down to about 6,000 now, or even fewer.

CHAIR: Are there 3,500 mentally ill patients still in institutions?

Dr BARCLAY: That would include the acute beds. It is very hard to tell; you would really have to do a census. It would include the acute beds, and we have increased those very substantially in number. People look at the situation and say, "We should reopen the asylums, the mental hospitals." I do not think that is the answer. What we have to do is simply implement what we know works. I was seeing these things in the United States in 1964 and 1965. There is nothing new about what we know works. It is having the will and the finance to provide it.

I think we are in a much better position now than we were in 1998 when there was very strong community resistance to the opening of group homes. You might well get some local resistance, but generally speaking the concept of placing people into suitable accommodation in the community is now much less contentious then it was 13 or 14 years ago.

CHAIR: We have evidence that even in the 1960s the Hunter area was producing this de-institutionalisation at a rapid rate before the Richmond report.

Dr BARCLAY: Yes, it was happening before then.

CHAIR: They had better group homes then, but they now seem to be losing them.

Dr BARCLAY: Yes. Once again, often there has not been the understanding in area health services about the importance of these facilities for extended care mental health patients; there has not been the sympathy for them. The management of many of the group homes has been passed over to voluntary organisations. I know that one organisation in the Illawarra region wants to get out of the business because it says it cannot afford to continue to provide 24-hour care because it is too expensive. I know of another group home that the area health chief executive officer proposed to close because he saw it as too expensive. Often the will has not been there to provide these services because of the cost. As well as the capital cost, you will easily understand that they have an ongoing maintenance cost, but they also have a staff cost.

CHAIR: According to the witnesses who gave evidence yesterday, the housing cost does not seem to be an issue. The Department of Housing seems to be able to provide housing very effectively. And, of course, NGO funding is not what it could be.

Dr BARCLAY: Absolutely.

CHAIR: Compared with an acute bed, it must be cheaper?

Dr BARCLAY: Much cheaper.

CHAIR: It would mean that you would not need to build more beds?

Dr BARCLAY: Yes.

CHAIR: You raise the difficulty of communicating with carers, and the need to develop a partnership between professionals and carers in order to improve the quality of care provided. Could you elaborate on that?

Dr BARCLAY: I think it would be fair to say that a substantial number of mental health staff have not fully adopted the concept of consumer participation in the processes of care. This is particularly true where they feel run off their feet or overwhelmed by what they are coping with in acute admission wards. They see having to deal with relatives and other carers as simply adding to their burden. I think that in years past psychiatrists had been guilty of that as well.

A lot of work has gone into trying to develop better relationships with consumers and carer organisations, but most of those people, particularly the one I know as ARAFMI, feel that they do not get the responsiveness from the mental health system that they need when they are faced with problems.

CHAIR: But the professionals are not in any way required to take any notice of carers?

Dr BARCLAY: No.

CHAIR: The people who have made submissions to the Committee have said when they recognise an early symptom people take notice of them, and that they have a place at the table in terms of the Mental Health Act.

Dr BARCLAY: Yes. I would have to think about how that could be done. The week before last I asked a very senior nurse if there was one single thing you could have to improve the quality of your service, both inpatient and outpatient, what would it be. She said leadership. I think that is where it lies.

I do not think you can force people to like doing something. You have to make them feel that this is important and that setting aside time to speak to carers and respond to their requirements is just as much part of their duty as seeing the patient. You have to build that into the system so that when

you make an appointment for a patient to be seen at the community mental health centre, you set aside a period of time to see the carers as well. You have to ensure that you have somebody who is responsible for providing the liaison with the various community organisations that are playing an important role.

I know the Illawarra better than most, because I chair the integrated care committee down there and I have reviewed the service. The Wollongong Youth Accommodation Service manages a lot of very disturbed young people. The service needs someone to liaise with it constantly, to ensure that when a young person is disturbed and needs psychiatric care they get it, so that they do not get bounced around when they approach the system.

The integrated care project has put extra money into ARAFMI to provide the organisation with a full-time administrative officer and extra counselling services. But the organisation needs a person who knows ARAFMI and knows the people. As I say in my paper, partnerships depend on personal contact—in other words, spending time in the other person's office. I have been in situations where staff have been criticised for being out of the office, when what they were doing was establishing those partnerships. This concept has not been fully grasped by the public mental health service.

CHAIR: You talked about the Illawarra Area Health Service. Clearly, in the document provided to us by the department, the Illawarra spends $150,000 out of its $20 million budget for mental health on NGOs.

Dr BARCLAY: Yes.

CHAIR: That has to tell you something about how the Illawarra Area Health Service values this sort of communication and partnership—$150,000 is just peanuts, compared to say Northern Rivers, which has a $13 million budget, spending $1.2 million.

Dr BARCLAY: In fairness to them, I think they value it more now. You may not know about the integrated care project.

CHAIR: We are getting the people up from Wollongong.

Dr BARCLAY: Yes. The integrated care project is jointly funded by the Commonwealth Government and the State Government through the Illawarra Area Health Service. What the Commonwealth did was look at the Illawarra, which is very short of private psychiatrists, and they grossed up the Medicare payments to what the Illawarra would spend to the national average. So, the short version is the Commonwealth put in $1.1 million a year of unspent Medicare rebates for psychiatry, and the State matched that. The project has an independent managing committee which I chair, and which has service representatives, consumer representatives, private psychiatry representatives and general practitioner representatives, and we are funding 13 partnership projects including NGOs, so we are spending $2.2 million a year very nicely, and we cannot spend all the money at the moment.

CHAIR: You talked about leadership but you also talked about having somewhere where the buck stops, so the Centre for Mental Health has policy direction. It depends upon the way in which the 17 areas decide to interpret that and who is in charge of that money and who is in charge of allocating those resources. Is it time that we had a separate mental health budget again? We are now told by the Minister that there are three clusters for the State—northern, southern and western.

Dr BARCLAY: Yes.

CHAIR: Is it about time we took the area health services on? A lot of people are saying we want open, accountable, discussable, clear, transparent mental health funding, and where the money goes and where it does not go.

Dr BARCLAY: I am sure Professor Raphael would appreciate assistance. A constant problem has been to do just that, be able to identify the budget and identify where all the money has gone. The short answer is yes.

CHAIR: Is this a matter of leadership? You talk about leadership at the community level, leadership at the institutional level, but we are talking about what happened in mental health. It is all very well to say we should do this and that and we have this program and that program. That is the problem, we have too many little programs—but leadership.

Dr BARCLAY: One answer is yes but the area system, I understand, has virtually been enshrined in legislation. The area chief executive officers are very powerful in their areas. I know that Professor Raphael has had great difficulty in ensuring that the area mental health budget is all those things you said—quarantined, open and—

CHAIR: The national plan, 1992, said quarantined. The first thing it said was quarantine, and we are still not seeing it.

Dr BARCLAY: That is true. We are getting there but it has been a hard row to hoe.

CHAIR: Ten years to get quarantining and clear accountability of mental health funding—I cannot tell you how unsavoury that sounds. I am not blaming you but it seems to me to say we are getting there or that Professor Raphael is concerned about it—I know the Ministers have tried. Refshauge tried, Phillips tried and I am sure that Craig Knowles is trying, but somebody has to bite the bullet and do it.

Dr BARCLAY: I do not think I should comment on that. I look back to the time with great pleasure when I controlled the budget for mental health.

CHAIR: Is that not what is needed, that the area chief psychiatric officer, whether he is a doctor or an administrator, has to be in control of the budget?

Dr BARCLAY: Yes, without doubt.

The Hon. JOHN HATZISTERGOS: I want to go back a little bit to the issue of visiting medical officers [VMOs] and the cost of that. We have been given some information that the cost of the VMOs is $152.95 an hour.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: And the staff specialists—

Dr BARCLAY: About $83, I think, or something.

The Hon. JOHN HATZISTERGOS: It is up to $83—from $62 to $83.

Dr BARCLAY: Yes. It depends on their seniority.

The Hon. JOHN HATZISTERGOS: I am particularly interested in the suggestion we have before us that the decline in staff specialists in hospitals is really a nationwide phenomenon.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: How are we comparing with other States? Are you aware, or not?

Dr BARCLAY: No, not precisely. I know it is similar, because a few years back, before I retired from private practice, and the year or so after that, I was consulted by people from Victoria with medical negligence cases against psychiatric hospitals. I became aware after discussion with those people, particularly with the relatives of the young people who had been disadvantaged in hospital—in one case a suicide and in another severe brain damage—that the situation was pretty much the same as it is in New South Wales. I do not think it is anywhere near as bad in Western Australia and I think South Australian is fairly well off. It is the two big States that have the biggest problems.

The Hon. JOHN HATZISTERGOS: But there is a particular problem in rural areas.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: And I think what Health is now doing in at least one area, I think New England, is flying in visiting medical officers.

Dr BARCLAY: Yes. I do not know about New England. I certainly know Coffs Harbour and Wagga Wagga, but they may be doing it in New England too now.

The Hon. JOHN HATZISTERGOS: That is partly because of lack of staff specialists?

Dr BARCLAY: Yes.

CHAIR: The staff specialists' cost, it says $83 there, but that is not the real cost. Lots of on-costs are associated with that. There are times when they are away, they have holidays, which the VMOs do not.

The Hon. JOHN HATZISTERGOS: No, that is included. The $83.85 includes leave and other on-costs. It says it in the submission.

Dr BARCLAY: I would not know.

The Hon. JOHN HATZISTERGOS: The base rate is $62.06 but it goes to $83.85.

Dr BARCLAY: I would not know what they have included in that.

The Hon. JOHN HATZISTERGOS: It does not matter. There is a big difference between that rate and the VMO rate.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: In the Health submission we are told there are some specific programs to support the development of a psychiatric workforce in rural and remote regions and growth regions?

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: In partnership with the College of Psychiatrists.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: Are you familiar with those programs and what impact or success they are having?

Dr BARCLAY: I am not sure what they are referring to. I know, for example, Dr Jim Greenwood went to Tamworth for some period of time and was seeking to build up the service there. He has left the service now but he was flying up several days a week from Sydney. After he left there may have been established a fly-in service. Tele-psychiatry is being developed and it is very valuable, but you cannot run an acute admission ward with tele-psychiatry. If you take a place like Coffs Harbour, when I did a review of Coffs Harbour the only qualified psychiatrist they had was an overseas-licensed practitioner who was licensed to work in an area of need.

CHAIR: Under supervision?

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: Can I ask you a question about carers and consumer participation, which you have also made reference to.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: We are told in the Health submission that there are at least two examples—Northern Rivers Mental Health Service Council and the Western Sydney Area Health Service Community Consultative Committee—as types of structures that have been developed at the local level to provide for participation by carers and consumers.

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: Are you aware of how successful they are?

Dr BARCLAY: Not those. I know that some of them are very unsuccessful and I gather that some of them are quite successful. You really need to talk to the people involved. I know of one where the chairman said he was going to resign because it did not seem to be achieving anything.

The Hon. JOHN HATZISTERGOS: It depends on the ability of the participants?

Dr BARCLAY: It depends on the ability of the participants. It depends on the willingness of the area to mobilise resources, to involve them in the processes.

The Hon. JOHN HATZISTERGOS: Are you aware of how many area health services have structures of this nature?

Dr BARCLAY: No.

CHAIR: They are all meant to, under contract with the chief executive officers, but I think we would have to ask the health people about that.

Dr BARCLAY: Yes, you would have to.

CHAIR: We have some submissions from some of these health councils.

The Hon. JOHN HATZISTERGOS: I know, but it is just that the budget has allocated money towards all this.

Dr BARCLAY: And most of them now have someone who is called the consumer initiatives officer or consumer relations officer in the area office. Just how successful that is I really do not know.

The Hon. JOHN HATZISTERGOS: There have been some successes and pluses with those councils?

Dr BARCLAY: Yes.

The Hon. JOHN HATZISTERGOS: Are you able to demonstrate or tell us what some of those successes might be?

Dr BARCLAY: No. The only contact I have had with them is that when I review a mental health service I invite the consumers to come and be interviewed and I hear what they say. I go to an ARAFMI meeting or to a consumer meeting when I am there. I do not think that on the whole they think an enormous amount is being achieved. But it is improving. I went to a meeting last Friday in the Illawarra, which was a presentation of projects that we have running down there. A number of consumers attended. I know them personally now, and they certainly felt that things were improving but they still had points to make. They were very much the points you have made.

CHAIR: It is early days of that initiative.

Dr BARCLAY: Yes.

CHAIR: One area that has been of constant concern is the treatment of adolescents and young people. It has been the subject of recommendations by Richmond, by your report in 1988 and by Burdekin in 1992.

Dr BARCLAY: Yes.

CHAIR: And by just about everybody who sent us a submission, from kids aged 14 or 15, to adults.

Dr BARCLAY: Yes.

CHAIR: We have two units in Sydney to deal with children.

Dr BARCLAY: I know that Dr Ken Nunn, who is a psychiatrist at Westmead Children's Hospital, is currently working about three days a week, I think, in the Centre for Mental Health establishing several programs to improve child and adolescent services. He is working, first of all, on the development of tele-psychiatry for rural areas; on acute response teams in areas to deal with children and young adults who have acute psychiatric illness; and on modules of four-bed units that can be added to existing services to accommodate adolescent and young adults. So certainly the awareness is there. You would be quite right to say that for 20 years very little or nothing much has been done. There was an excellent program on the Central Coast, the Yippie program. It was first class. I keep proselytising. Does it get axed, I do not know. It is an excellent program. I do not know of any others. There are some early psychosis intervention programs. I know the one at Hornsby is excellent and it sees mostly young adults. The Illawarra early psychosis program takes adolescents and young adults. It is a very good program but it is very patchy.

CHAIR: What happens to young people who are caught up in the Minda Juvenile Justice Centre? Where do they go?

Dr BARCLAY: If they are lucky they might get into Rivendell.

CHAIR: Does Rivendell have secure units?

Dr BARCLAY: No, they are not secure. I do not think there would be anything.

CHAIR: What about kids who are young forensics, if you like?

Dr BARCLAY: I do not think there would be anything.

CHAIR: Where do they go?

Dr BARCLAY: They would stay where they are and get psychiatric consultation, I would imagine.

CHAIR: But if they are forensic they are meant to be getting mental treatment, not be imprisoned.

Dr BARCLAY: What else can I say but yes.

CHAIR: From what I have read it seems to be wrong when a child aged 15 who is mentally ill, and not guilty by reason of mental illness, is in Minda.

Dr BARCLAY: I know there is a serious problem because I confronted that occasionally when I was doing medico legal work. I knew that having perhaps succeeded in such a defence, there was virtually nowhere else for the young person to go.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your point was that there had to be more private-public partnerships; you had three psychiatry registrars who had resigned because it was not the sort of work they expected.

Dr BARCLAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did not actually say but your implication was that no-one could seriously be expected to work when there was no ongoing continuity of patient care.

Dr BARCLAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely to simply say, "It is all too hard. We can't ever keep staff psychiatrists. No-one would want to work in this sort of unit permanently", they would have to do some other work to keep them sane, if you want to put it bluntly. Surely, if the thing worked before, if there were proper community support services so that the admission ward was not where the psychiatry registrars was working, and if a sufficient salary could be negotiated—presumably people will work for less money than $152 per hour if the work is satisfying—

Dr BARCLAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely the psychiatric services could be maintained, such that staff specialists could be retained and psychiatric registrars could be trained without resigning. Are you not simply saying that the thing is hopeless and the best you can hope for is a private-public partnership where the private sector keeps them sane and the public system has them in acute bedlam?

Dr BARCLAY: I am not saying that. Yes, I agree that things can probably be improved. It will not happen tomorrow. I am not just talking about the flying psychiatrists; I am talking about a willingness to accept the model that prevails throughout the whole of Australia, which is that hospital services are staffed by a combination of staff specialists and visiting medical officers [VMOs]. It recognises that the visiting medical officers have an important contribution to make to the quality of care. It used to be that the mental health service had no visiting medical officers—virtually none. When I was in the system that was the way it was done.

Now the doctors have changed in their attitude towards the sort of careers they want. Many of them want to work in the public sector but they do not want to work there on a full-time basis. I have sat on a number of selection committees for young people applying for psychiatric jobs, and I have done some selection committees for the forensic mental health service. You say to them, "Doctor, you have applied for this job. How much time do you want to work in it? Full time?" "Oh, no." What are you looking for? The answer may be three-fifths, two-fifths or half time. What will you do with the other part of the time? I want to have some private practice and I want to do some medico legal work, academic work or research. They want a varied career.

That is the way it mostly works in America. Very few American hospitals have full-time staff specialists. People build up careers on a public and private basis. They may work in as many as three different centres doing different sorts of work. That is what the young graduates want these days. I am just saying that that needs to be recognised and utilised. That is not to say that we cannot make the job more attractive but the way you make it more attractive for the young registrars is to have those VMOs coming in and supervising them and available to provide them with their expertise and to act as role models. You also need to give those young registrars the opportunity to work in a different sort of psychiatry. One of the big problems is that because of very low staff numbers and because of how busy the acute admission centres are, it is very rare for a registrar to work in a community mental health clinic where he might be able to engage in seeing patients on a continuous basis.

What you generally get is that the career medical officer works in the community mental health works and sees the patients, and the registrar is flat out in the acute admission ward. The career of one young registrar who I know personally and who was going to give up psychiatry was saved by us arranging transport for her to a rehabilitation unit. Now she says, "Now I can see a bit of what psychiatry should be like, I can spend some time talking to the patients and getting somewhere with a feeling of continuous treatment." So I am not as negative or as realistic as you make out. I think in terms of the day-to-day management of the service in its current situation, those partnerships are

necessary. But I have always advocated, even when I was in the service and running it, that we should have visiting medical officers.

When I resigned from the service in 1976 the first thing I did was get myself a job as a visiting consulted at Macquarie Hospital, North Ryde. I went there one day a week for the next 13 years and I loved it. I supervised registrars, I lectured to the nurses, I saw patients in consultation and I was on random call. If they had an emergency I handled their medico legal problems. They would ring me and ask me to see so and so, and I would say yes, of course. That is the sort of partnership I am talking about. At the moment, to staff our rural services we just have to hire the guys at considerable expense to do all the work because there is no-one else to do it. I agree that we have to look at how we might attract three psychiatrists, which is the minimum. They are the critical mass.

Mostly if you drop below three psychiatrists in a country town the other two will go very shortly because there is too much demand on them. But if you can attract three guys together—I would even consider things like leasing them rooms at favourable rates, setting them up in practice, seeing that they get some of the benefits that the guys in the public sector get of a pool for conference travel and so on. There are a number of ways that we might be able to make the work more attractive, but the most important thing is to provide that degree of personal satisfaction about actually being able to treat patients. In some of the documents I submitted to you I recognise that we may also have to change the role of the psychiatrist away from doing less individual treatment and more working as a true consultant. That will take time.

CHAIR: We do not have time to go into it, but you recommend the increased use of psychologists, occupational therapists and other allied health services, and that stands in your document.

Dr BARCLAY: Absolutely. It is the way we have to go.

The Hon. PETER BREEN: I have one question and you may not be willing to answer it. In your conclusion you said that there are people who would like to see the prisons grow even larger to incarcerate the mentally ill and mentally disordered you do not wish to treat. Are you able, or do you wish, to identify those people who have that attitude?

Dr BARCLAY: No. All I can say is that in going around talking to people I hear people saying, "We have gone too far in moving the seriously mentally ill out into the community. They really should be locked up." It is an experience I certainly had when I was doing forensic work and medico legal work, even amongst psychiatrists. They believe that if someone has a serious mental illness and has committed even relatively minor crimes they should be locked up. I will say this: It is not an uncommon attitude amongst some groups of psychiatric nurses. Recently I had occasion to advise Rozelle hospital and its area board on a WorkCover case, which no doubt you will know about. The hospital was faced with the problem of handling one very aggressive, violent young man. The attitude I encountered amongst many of the staff was that people like this should not be in a mental hospital; they should be in the forensic unit at Long Bay.

So it is not an uncommon attitude, and maybe in some cases they are right. But the only reason they would finish up in such a unit was the lack of alternative facilities within the mental health system. In my submission I talk about the need for secure long-term beds within the mental health system for people who are very aggressive but whose so-called criminal acts are comparatively minor but are very distressing to people. Yes, they may need to be detained somewhere while they receive effective treatment, and Clozaril is producing some remarkable results. But you have to contain them while you treat them.

CHAIR: I understand that the Government is planning 15 beds for non-forensic patients at Long Bay.

The Hon. JOHN HATZISTERGOS: There is a plan but I think it is about 120.

CHAIR: But 15 of those beds are identified as non-forensic beds within the same facility but with high security.

Dr BARCLAY: Yes. I was pleased to see that at long last there is what I think is a comprehensive plan for forensic mental health services.

The Hon. JOHN HATZISTERGOS: For the Long Bay security unit.

Dr BARCLAY: Yes, it includes Long Bay and forensic diagnostic and assessment units and containment beds within the mental health system, rather than all within the wards at Long Bay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you comment on whether personality disorders are mental illnesses and what can be done?

CHAIR: We will spend a day on personality disorders, if I get my wish, on Wednesday. Are personality disorders something that you have particular expertise and interest in? Can we get you back if you are available?

Dr BARCLAY: I would not describe myself as necessarily an expert on personality disorders but I did treat a number of patients with severe personality disorders in my private practice and I would have a view about the matter.

(The witness withdrew)

RICHARD JOHN MATTHEWS, Medical Practitioner and Chief Executive Officer of Corrections New South Wales, 269 Darlinghurst Road, Darlinghurst, sworn and examined:

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

Dr MATTHEWS: Yes.

CHAIR: In what capacity do you appear before this Committee?

Dr MATTHEWS: As the chief executive officer of Corrections Health. I still do a small amount of clinical work at St Vincents Hospital.

CHAIR: Are you aware of the contents of the submission on forensics of the Department of Health to this Committee?

Dr MATTHEWS: I am, and much of the content in relation to Corrections was supplied by us to them.

CHAIR: Can the Committee take the material in the submission on Corrections as part of your sworn evidence?

Dr MATTHEWS: Yes, you could.

CHAIR: If you should consider at any stage during the 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. Please be aware, however, that the Legislative Council may overturn the Committee's decision and make that evidence public.

Dr MATTHEWS: I have a short presentation, if that is acceptable to the Committee?

CHAIR: Yes, that would be helpful.

Dr MATTHEWS: I apologise on behalf of Professor Penny who is chairing our very important research seminar. He asked me to convey his apologies. We know from the evidence given earlier in the week that the Committee is planning to visit the Long Bay Hospital. Provided that is not on a Wednesday which is sacrosanct for patients, he would be very happy to meet with the Committee at that time. I should say at the outset I am not a psychiatrist. My background is 21 years in general practice in Darlinghurst and 17 years in drug and alcohol work at St Vincents Hospital.

CHAIR: And you say you have no experience in psychiatry?

Dr MATTHEWS: Lots of experience with patients with mental disorders. My task today is to try to give this Committee the facts in relation to Corrections and who goes into Corrections, and to point out where there are no facts and where there is supposition and anecdote. Firstly, I apologise to Dr Arthur Chesterfield-Evans who has already seen some of this presentation when I appeared before another Committee.

Inmate population is just under 8,000 and it has been more than 8,000. At the time of the Richmond report it was about one-third of that. The Attorney General is projecting another 1,000 increase in the next couple of years. It is important to understand the difference between the census figure and the throughput. There are about 15,000-16,000 people who walk through the front door each year. Changes to the Bail Act: we think that the number of people who walk through the front door is going to increase quite considerably.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: An increase of 8,700 next year?

Dr MATTHEWS: There is a natural increase. The figures of the Attorney General's Department, which have been accepted by the Government, for an increase in the census population of 800 and an increase in the throughput of about 5,500.

CHAIR: As a result of the Bail Act?

Dr MATTHEWS: Yes.

CHAIR: I presume, therefore, you can project enormous increases in the funding to Corrections Health, because these people have got mental illness, in terms of assessment?

Dr MATTHEWS: Yes. They are projections, and I should point out that nobody really knows the effects of these changes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were these presented to the Parliament when the Bail Act was going through?

The Hon. PETER BREEN: Yes, they were.

Dr MATTHEWS: Various people produce figures and I think the Government accepted the figures of the Attorney General's Department. They are a matter of public record.

CHAIR: One hundred and forty thousand?

Dr MATTHEWS: About 90,000 of those are escorts out to court. It is important to understand the system is court-driven. About 90,000 of those movements are people going out to court for the day and coming back, the remainder are movements from institution to institution. There is a big churn factor. That is the number of occasions at reception and the way it has increased since 1995-96. It is an interesting 2000-01, there is some evidence from Dr Weatherburn that crime decreased significantly during the Olympics.

The Hon. AMANDA FAZIO: This is the general prison population?

Dr MATTHEWS: This is the total, I will come to the mental illness in a moment. We expect that we will see the trend line restored in 2001-02. If, on the other hand, you look at the number of individuals as opposed to the number of occasions at reception, you can see that the number of people coming to gaol is not changing all that much—the same people coming more often.

CHAIR: It is recidivism?

Dr MATTHEWS: Indeed. There are some misconceptions about how long people stay in prison. Not everyone is there for life. Of the roughly 16,000 annual receptions, about 70 per cent come on remand and 30 per cent are sentenced; of the total, 27 per cent remain with us for less than eight days; another 17 per cent between eight and 30 days, so almost half the total is there for less than one month; 56 per cent remain longer than 30 days—

CHAIR: Half the people on remand stay there longer than 30 days?

The Hon. PETER BREEN: Some would be sentenced.

Dr MATTHEWS: Some would be sentenced, some proceed from remand to sentence—

CHAIR: What is the average length of stay of somebody on remand? A person would not get a sentence of 30 days?

Dr MATTHEWS: Average is actually quite misleading. If I could draw a curve it would go like that, so that very large numbers one week, two weeks, four weeks and very small numbers occasionally for very serious offences with very complicated trials, up to two years, but that is quite rare.

CHAIR: But large numbers on remand for 30 days?

Dr MATTHEWS: Yes.

CHAIR: I am saying that half of them are staying for more than 30 days?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it correct that half of them who get sentenced, having been on remand, do not get a further custodial sentence? In other words, half of them are either innocent or their sentence was less time than the remand?

Dr MATTHEWS: It is, in fact, more than half. The percentage who are sentenced and proceed to sentence is only about 20 per cent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that because they have already served longer than they would have been convicted?

Dr MATTHEWS: The magistrate says, "I sentence you to 30 days. You have done 30 days, so off you go."

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is tough luck if they have been on remand for 60 days?

CHAIR: It means they have got 30 days. I asked the question because I know that on the North Coast a lot of the mentally ill people used to spend six weeks in Grafton, and would get dragged back for another six weeks with no psych opinion and the magistrate would throw his hands up and say, "You have got to go. I can't keep you more than three months without a psych opinion." He would let them go and they would be back again next week.

Dr MATTHEWS: I have got good news for you on Grafton. From the point of view of rehabilitation generally, of those who walk through the front door only about 10 per cent stay more than six months. In a moment I will present the deficit from which these people suffer. Just to show that our funding has been increased, that presentation shows our budget as it has been for the past eight years and it shows a reasonable recognition that our services are important. Next year we will be over $50 million. To give you a picture of who comes through the front door: about 17 per cent Aboriginal and Torres Strait Islander and 23 per cent have a language other than English. You can see the unemployment figures. A really important feature is that 50 per cent of both sexes did not get as far as the School Certificate. The national norm is about 75 per cent of people get through to year 12.

CHAIR: How many are intellectually disabled?

Dr MATTHEWS: I have got some figures on that. The EDOCC score is a Bureau of Statistics score of education, occupation and other factors which informs the resource distribution formula [RDF]. The average is 1,000 across the State.

CHAIR: You are outside the resource distribution?

Dr MATTHEWS: We are.

CHAIR: So is mental health?

Dr MATTHEWS: You are correct, I am trying to put our service into perspective.

The Hon. AMANDA FAZIO: Let us do the presentation first.

Dr MATTHEWS: An area health service like North Shore has an RDF of about 1,120. The lowest of the others is Far West which is about 890, and the inmate population as a whole is 790. The lowest local government area in the State, if you do it on local government areas, also has an EDOCC of 890. Hardly surprisingly, we are dealing with a group that has a significant socio-economic deficit before we start to look at their health deficit. As part of our research—and some of this is being presented this morning—we did a national mental health interview on 754 male and 169 receptions, that is, people walking through the door. This includes a SIDY which is a World Health Organisation tool. Three positive screeners for psychosis gets you sent to the psychiatrist. You can see that 11 per cent of males, 14 per cent of females had three positive screeners. About 7 per cent of the total were

confirmed as having, and it is important to say because these figures have been misquoted, that is a 12-months prevalence of psychosis. It does not mean—and we will drill down, I have not done it yet—that the person is actually psychotic at the time. These are preliminary figures from our survey and some people have misquoted them and said that 7 per cent of people who walk through the front door are psychotic; that is not the case—12 months prevalence. You can see major depression is quite high. Bipolar disorder, not surprisingly, is also quite high. Significant numbers have had contact with public—

CHAIR: Is that 0.1 per cent?

Dr MATTHEWS: In the males that figure is artificially low. The reason for that is that a lot of people who are manic, were just too ill to be brought to the clinic and interviewed. With the female figures, I think we just about got 170 consecutives. With the male figures, with the vast numbers, it was logistically not possible to do that so I think it is fair to say there is a bit of under reporting there. This Committee is the first group to see these figures, I only got them yesterday from Dr Butler, but when you look at those who screen positive and those who were negative by offence-type, there is not any statistically significant difference between the two groups. In fact, if you look at homicides, out of those 1,000 people, that is, 3.2 per cent or 30 homicides, there was 2:1 by the non-psychotic as against the psychotic. So I think we lay to rest some of the myths in relation to mental illness and the types of offences that they commit. It would appear on this preliminary data—and again we are going to drill down further—that there is no statistical significance in the difference.

I stress that the researchers are not going to be too happy with me because this is very preliminary data. We are just working with Professor Andrews at St Vincents Hospital to clean it, code it and make sure that it is right.

The Hon. JOHN HATZISTERGOS: Where do these figures come from?

Dr MATTHEWS: They come from taking the individuals that we interviewed and linking those individuals to their most serious offence.

The Hon. JOHN HATZISTERGOS: Is it all individuals or do you just take a sample?

Dr MATTHEWS: No, it is the 854 males and 169 females that we screened which was a random process.

CHAIR: That is a fairly representative sample?

The Hon. JOHN HATZISTERGOS: It is for men, but we need a few more women.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is inpatient screening?

Dr MATTHEWS: This is reception. These are people on reception, marching through the front door.

CHAIR: There are 20,000 people walking through the front door and they are screened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you screen 800 out of 20,000, or whatever it is?

Dr MATTHEWS: We did this survey on that number, yes. We do a reception assessment on all of them that takes about 40-50 minutes. The nurses type it on their laptops so that it can be fed into another computer.

The Hon. JOHN HATZISTERGOS: When you form these statistics do you add the males and females together?

Dr MATTHEWS: This is not separated out for sex as yet. This is the total. That kind of spread is pretty much the normal spread for most serious offences, in percentage terms.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So this says that people diagnosed by your screening tools with psychiatric illness do not commit more crimes?

Dr MATTHEWS: I am saying they commit the same spread of crimes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They commit the same number of crimes. There is really no statistical difference in those figures. They do not commit more or less crimes than people who are not screened as having psychiatric illness?

Dr MATTHEWS: No, it does not say that. We may be able to say that subsequently, but at this stage I can say that when people who screen positive for psychosis commit crimes, they commit roughly the same spread of crimes as do people who screen negative for psychosis. Do you see the difference?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought that is what I said.

CHAIR: It is not what you said.

The Hon. JOHN HATZISTERGOS: I thought you were trying to demonstrate that, for example, people who screen negative would be twice as likely to commit homicide as are those who screen positive.

Dr MATTHEWS: Correct. Homicide is probably the only area where there is a statistically difference, but there may not be sufficient numbers to give you power to say that difference is a real difference, because we are talking about 30 homicides, and that may not be a sufficient number to have confidence there is a real difference rather than an aberration.

CHAIR: I am astonished by the figures that show that those who screened positive to psychosis in the past 12 months are organised enough to do a robbery. But perhaps that is why they get picked up, because they are not sufficiently organised to do a robbery properly.

Dr MATTHEWS: Most people who commit robberies—which is dealt with in the next lot of figures—I think are not organised, because they are desperate. To me, the person who is dependent on an illicit drug and needs money is more likely to commit a desperate crime—a visible crime, an easy-to-catch crime—than the professional who sits at home and calmly works out how to commit the crime. I suspect that most of our customers commit desperate crime.

Mental Health Outcome Assessment Tool and Training (Minister for Health-OAT)

This again is new, and again the Committee is first to see it, and again it is very preliminary. You have probably had some evidence about the mental health outcome assessment tool [MHOAT] that is being introduced by the department. Not surprisingly, everyone in a mental health bed in a hospital is receiving active treatment, as one would expect. When we come to Mulawa, on a snapshot of a day there are 285 inmates, with 145 registered as patients. To be registered as a mental health patient on admission or on assessment you must be receiving psychotropic medication. But many of those people are quite stable on their medication because it includes antidepressants. Some 28.5 per cent, or 80 of those 280, are patients receiving active treatment from our mental health team, the mental health nurses and the psychiatrist. We have final figures for a couple of the gaols at Long Bay, 17 per cent and 8 per cent. The data is not complete for the main reception gaol for men. We have started to get them in from Goulburn but we do not have all the numbers as yet.

CHAIR: But that is not in Long Bay hospital.

Dr MATTHEWS: Long Bay hospital is at the top.

CHAIR: Yes, and 100 per cent of them are treated.

Dr MATTHEWS: Yes.

CHAIR: But that is the 50-bed hospital. What about the other people in Long Bay who screen positive?

Dr MATTHEWS: The Metropolitan Medical Transit Centre [MMTC] and the Metropolitan Special Purpose Centre [MSPC] are both at Long Bay. You can see from the slide that in one of those gaols 17 per cent are receiving active treatment, and in the other one 8 per cent are receiving active treatment.

CHAIR: Are those percentages of the people who should be receiving active treatment, or of the total number of people?

Dr MATTHEWS: We believe we are pretty good at picking up major mental illness. Most of the people are known to us. I think if we have a gap, it is probably more in the area of anxiety disorders, post-traumatic stress disorders and so on.

CHAIR: Are you saying that everyone who needs treatment and goes to the Silverwater Remand Centre gets that treatment?

Dr MATTHEWS: "Everybody" is a big call. Some people who come there are very quietly psychotic.

CHAIR: But they are getting the appropriate treatment. Are you saying that everybody who goes into the remand centre at Silverwater—which we have evidence about—gets appropriate treatment?

Dr MATTHEWS: What I am prepared to say is that every single one of them gets a very comprehensive reception screening when they come in, but very many of them have been there before so we know their history and we continue their treatment. We make some new diagnoses. The vast majority are being seen and are receiving treatment.

The Hon. JOHN HATZISTERGOS: Is that at Silverwater?

Dr MATTHEWS: The MRRC is the main male reception gaol. Firstly, my data is not complete. The second thing is that you see 900 beds, but there is a 200-person turnover every single day of the week. So, when I say that everybody is getting adequate treatment, I do not think we can say that about any area of health. But in the case of major mental illness I think we are doing a reasonable job. Dr Barclay raised the workforce and the VMO issue, and we scribbled away on an envelope at the back of the room. Of our $45 million budget we spend about $1.8 million, or $35,000 a week, on VMO psychiatrists. Plus we have some staff specialists, six registrars, those in training at the hospital, and senior registrars at those other places.

The Hon. JOHN HATZISTERGOS: Why is there a big disparity in the number of beds compared to the number of registered patients—except at Long Bay, where there seem to be more patients than beds?

Dr MATTHEWS: I am sorry about the confusion. The hospital figures are slightly different. They look at the monthly throughput. So, during the month of May, 110 patients went through those 89 beds in the hospital, because of discharges. Of course, all of those were registered as patients because they were all admitted to a mental health bed and are all receiving active treatment. I think you must view the inpatients slightly different from the others that we really see as outpatients. The number of beds is the capacity of the gaol. Not all of the gaols are full all of the time. Most of them are, of course.

The Hon. JOHN HATZISTERGOS: Every cell that has a bed is regarded as a bed for them?

Dr MATTHEWS: The Department of Corrective Services uses the term "beds", but that term does not mean what it means in health. The best way to view a gaol is as a small town with a wall around it.

The Hon. JOHN HATZISTERGOS: That is basically the capacity of the gaol?

Dr MATTHEWS: It is the capacity of the gaol.

CHAIR: To elucidate further on the remand centre, for example, there might be 2,000 people going through that centre, but only 200 patients are registered.

Dr MATTHEWS: For the remand centre we have only done the special mental health area at this stage, and that is why I say the data is incomplete. The MHOAT has just been introduced. We have finished the training. I will have the throughput data shortly.

CHAIR: It could mean that for those 100 you have screened 2,000 in a week.

Dr MATTHEWS: Yes.

CHAIR: Say 2,000 in 10 days or thereabouts. But you end up with 100 registered patients?

Dr MATTHEWS: Yes. We have only actually mhoated the ones sent to pod 16, which is our mental health unit.

CHAIR: But that does not have a capacity of 900 beds.

Dr MATTHEWS: No. It has a capacity of about 30.

CHAIR: Yes, and that is always exceeded, as I understand it.

Dr MATTHEWS: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The figure missing is the number of separations.

Dr MATTHEWS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, with those 900 you might have had 10,000 separations, and therefore the 100 is a much smaller percentage.

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not a percentage of 900, it is a percentage of 10,000, or whatever the rate of separations is.

Dr MATTHEWS: I should not have put it in because it is not complete. But it was on the slide.

CHAIR: If it goes out as a slide, no-one will understand it.

The Hon. JOHN HATZISTERGOS: I still do not understand it.

CHAIR: Nobody is going to understand that slide.

The Hon. JOHN HATZISTERGOS: Are some of these people being treated as inpatients and some as outpatients?

Dr MATTHEWS: Only those on the top line, at Long Bay hospital, are inpatients. Everyone else is an outpatient.

The Hon. JOHN HATZISTERGOS: Then what is the point of giving us the number of beds? Does that just tell us the capacity of the gaol?

Dr MATTHEWS: That is right. Well, the gaol has cells with beds.

CHAIR: The one that would tell us the numbers is the turnover, and that is what you have to assess. That is your workload and what you do.

Dr MATTHEWS: Yes.

CHAIR: Of those people, there are 100 patients whom you identify as needing treatment. It is then a matter of whether you treat them. At Silverwater it is 200 a day, and that is perhaps 1,000 in a week—through a 900-bed facility.

Dr MATTHEWS: I suspect that is correct, and I will have that data in another two or three weeks.

CHAIR: But in a week you are only treating 100 of them, and they might be 100 different patients or the same 100 patients. But they are getting, or not getting, treatment. That is what the third line is about.

Dr MATTHEWS: Yes. About 6,000 people go through that centre a year.

The Hon. JOHN HATZISTERGOS: Which one?

Dr MATTHEWS: The MRCC. That is, 6,000 receptions. There are more transfers that go through, but there are about 6,000 fresh receptions. If we accept that 7 per cent will have psychosis plus other forms of mental illness, we will wind up with about 600 registered patients, some of whom will then move on to the hospital and also be recorded there.

CHAIR: Of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How does that 7 per cent compare with Jonathan Carne's figures from the courts? Didn't he do a survey there and produce a report? If so, has that seen the light of day yet?

Dr MATTHEWS: Yes. Jonathan's was a very good report. He was responsible for the psychiatric services in the two pilot programs. It was tabled at Beverley's committee on forensic health, it has gone to DCS and it has gone to the Victorians, who asked for it.

CHAIR: Has it been released publicly and made available for everyone in New South Wales to read?

Dr MATTHEWS: Yes. It is available if anyone wants it. I am happy to table it here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would like to see it.

Dr MATTHEWS: That is no problem.

CHAIR: Thank you.

Dr MATTHEWS: That report shows, as does some of the other data that I am about to show you, that the court diversion program actually works.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you talk about its figures in relation to these? Are they comparable? You were using one screening instrument previously, and I think he has used a different methodology, but you could be expected to come to similar conclusions.

Dr MATTHEWS: The conclusions are similar, and they are similar to the overseas findings. We are now finding that from the seven courts in which we are now operating, if you look at the custodial throughput, about 10 per cent are being referred, and two-thirds of those—that is, 7 per cent—are being found to have mental illness and are being dealt with by the court liaison service. So the figures are remarkably consistent. I will come to those figures from the seven courts in a moment.

When I when overseas, 7 per cent was the figure that was quoted in Glasco, Germany and New Zealand. It seems to be pretty consistent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they all using the same screening tool?

Dr MATTHEWS: Some are doing it simply on diagnosis. Remember, the screening tool screens more than the diagnosis. That is normal with a screening tool. The 11 per cent of males and 14 per cent of females who have screened positive are all referred, and the result is 7 per cent of the total.

The Hon. PETER BREEN: I do not follow the 7 per cent. What are you referring to—7 per cent of what?

Dr MATTHEWS: Some 7 per cent of those who present to the criminal justice system have a 12-month prevalence of some form of psychotic illness.

CHAIR: They have been psychotic at some stage in the previous 12 months. Is that what you mean?

Dr MATTHEWS: Yes.

Head Injuries 2001 HIS

I will have to update this slide. In this inmate health survey we included a screening instrument for intellectual disability. It is called the Hayes ability screening instrument. I have got there that 20 per cent screened positive; it was actually 26 per cent. With your approval, I will amend there slide to give the Committee accurate information. All of the 26 per cent who screened positive were referred to qualified psychologists, who administered an instrument called the WAIS, which measures an IQ according to the Wechsler adult intelligence scale. About 25 per cent are below 75; that is, 25 per cent of those who screen positive.

CHAIR: So a quarter of those who screened positive are below 75?

Dr MATTHEWS: Yes. Another significant percentage, about 25 to 30 per cent, were between 75 and 85.

CHAIR: So 50 per cent are below 85?

Dr MATTHEWS: Fifty per cent of those who screen positive.

CHAIR: So that is 10 per cent of people who come into the prison system.

Dr MATTHEWS: It is 10 per cent of those we screen, yes.

CHAIR: Do you selectively screen, or do you screen all?

Dr MATTHEWS: It was a random screen.

CHAIR: Of the people presenting to the corrections system, 10 per cent would have an IQ of less than 85?

Dr MATTHEWS: As administered by the Wechsler Adult Intelligence Scale [WAIS], yes. What we have found is that there is a very big correlation between those people who were at the lower level and recurrent head injury. Those of us who have worked in the field have seen this over the years. This is a group who age quickly. I have 40-year-old patients who I feel are much older than I, and I am 52. There is a combination of lifestyle, drug use and recurrent trauma. A significant number of those people who were in the lower IQ bands gave a history of multiple occasions of trauma resulting in loss of consciousness. There is evidence, but again we need to do a lot more work, of cumulative deficit in this group. I think that is really important. We want to do a research study on it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It means that they have been bashed up, does it?

Dr MATTHEWS: A lot of them have been in motor vehicle accidents—25 per cent. People who use drugs tend to wander across the road and they get knocked over a lot, but a lot of it is trauma—that is, trauma caused by being hit by a person or an object, but not necessarily bashed up. There are bashers and bashees, and sometimes the bashers come to grief.

CHAIR: That correlation is so good that it almost excludes people who are under the age of 18 and who are intellectually disabled. Is that 25 per cent of the figure above? Is this a hierarchy? Twenty per cent of those screened are positive and of that 20 per cent, more than 25 per cent had had a head injury, or is it that of the people you screen, or those who come through the prison system?

Dr MATTHEWS: I apologise for the confusion. I put this together fairly quickly yesterday. It means that 25 per cent of those who went on and were in the lower IQ band as a result of the WAISE had significant head injury.

CHAIR: So 2.5 per cent of the people who present to the prison system have had multiple head injuries.

Dr MATTHEWS: Yes.

CHAIR: We can get at it that way. You screen them all and 10 per cent of those have an IQ of less than 85, and 2.5 per cent have had head injuries. That puts it in a way that we can understand it.

Dr MATTHEWS: This slide, "NMHI—Drug & Alcohol", refers to drug use on reception and involves the same group. Again, this looks at 12 months prevalence and is not necessarily current. It looks at dependence and abuse and it does not include use without abuse.

CHAIR: So it is abuse over a 12-month period.

Dr MATTHEWS: Or dependence over a 12-month period. Where you see those two percentages, one is dependence and one is abuse. You can see that of that sample, 100 per cent of the women have either been dependent on or have been abusing opioids in the 12 months prior to reception, and that is also the case for about 99 per cent of the males.

CHAIR: Can I have an idea of what you call "dependence"?

Dr MATTHEWS: Alcohol is probably a good way of helping people to understand. If we all have a glass or two of wine with the evening meal, that is use. If we have more than the standard four drinks a day or we go to the pub on Friday night and have 12 schooners, that is abuse. In terms of opioids, it is a little bit more difficult to define, but the tool has a way of doing it. If I have been to a party once or twice in the past year and have snorted some cocaine, that would be use, and not abuse. If, on the other hand, I was doing that every day and missing time from work and my social functioning was disintegrating, that would be abuse or dependence.

The Hon. JOHN HATZISTERGOS: And dependence?

Dr MATTHEWS: Dependence usually is when the drugs ceases and you show physical signs of withdrawal.

CHAIR: That can happen on a daily basis for some people.

Dr MATTHEWS: Yes.

CHAIR: They will tell you that they depend upon it because, if they do not have it, something will happen to them.

Dr MATTHEWS: Yes.

CHAIR: Some people who even abuse the opioids do not get those symptoms, do they?

Dr MATTHEWS: That is right.

The Hon. JOHN HATZISTERGOS: That does not tell us what is physical dependence, does it?

Dr MATTHEWS: The term "mental" or "psychological dependence" is very difficult one. As we get down to the molecular level with this, as we are starting to, we look at receptors. We see molecular changes in receptors rather than some psychological dependence on a drug. It is a term that I do not really like to use. I think abuse is easy to define; it is something that is doing damage.

CHAIR: I understand what you are saying.

Dr MATTHEWS: Ninety per cent of the women who were abusing are dependent on amphetamines and for men it was a little less. The typical person who arrives, particularly the woman, is a polydrug user. The most concerning figure to me in relation to this inquiry is the figure for amphetamines and cannabis. As a drug and alcohol doctor, I can say that it is one of the big drivers. There has been a big change in patterns of use. The experts tell me that there has been no increase in the prevalence of schizophrenia, but I believe that the use of these drugs means that a lot of people who used to be stable are now having more frequent, more severe and more treatment-resistant exacerbations of their illness because of the use of these drugs.

CHAIR: We have had that consistent evidence from a number of people.

The Hon. JOHN HATZISTERGOS: Users of amphetamines and cannabis are polydrug users?

Dr MATTHEWS: Amphetamines in particular, cocaine to a great extent, and heavy marijuana use. There is no question that, in the susceptible, it tips them over the edge. As far as I am aware, as yet there is no evidence that these drugs cause an underlying psychosis. It may be that they do; it may be that further study will show some changes in the brain. There is starting to be some evidence related to amphetamines and some measurable change on the pulsed eddy current [PEC] scanners and more sophisticated equipment these days, but I think that the jury is still a little bit out. You would expect an increase in the prevalence.

CHAIR: Some people might take cannabis and that sort of explodes their first bout of schizophrenia. They may never ever display that again after the cannabis has worn off in a day or so.

Dr MATTHEWS: That is correct.

CHAIR: Or they may, at a later stage, have their first bout without cannabis.

Dr MATTHEWS: That is right. We get a very frequent diagnosis of drug-induced psychosis. The psychiatrists say that if a person has a long period without drug use, we will probably know whether it is underlying. The problem is that they never have a long period without drug use so you never get to find out whether they would have it without drug use.

CHAIR: But you do. Some evidence that we have been given indicates that when they first had their three joints of marijuana, they went over the edge and stayed that way for a day or so, then they never did it again. The evidence was of siblings, with one sibling who takes it and with another sibling who does not.

Dr MATTHEWS: Using alcohol as an example, many people will describe their first occasion of drinking as being the first time that they ever felt normal. People who have mental disorders are often very unhappy with the way the world is because of their altered perceptions, et cetera. A lot of this is self-medication. It is extremely difficult to get people with psychosis off marijuana. They like it; it makes them feel better. There is an element of self-medication. Many people self-medicate depression with alcohol, so it is very difficult to disentangle. I think it is one of the most significant causes of the increase in the number of people who are before the courts.

Generally it is causing an awful lot of chaos in the system and I do not know that we have an answer to it.

CHAIR: For how long has this trend been around—the past 10 years in particular, five years or three years?

Dr MATTHEWS: Until relatively recently, amphetamines were the problem of long-distance truck drivers. Small amounts were for oral use when partying. We have had an explosion in the use of analogues such as ecstasy. Some evidence has been presented by Don Weatherburn that during the so-called heroin drought, those who were heavy injectors of heroin tended to switch to injecting amphetamines and cocaine. Those who were lighter users of heroin tended to switch to much heavier marijuana consumption. In some senses, a heroin drought is bad news.

CHAIR: The reason I ask you this is that on the graph of the mental health departments, the report shows from 1996 that there has been a rapid climb in the number of section 24 admissions, that is, police admissions. Somebody is obviously acting out and somebody else rings the cops. The cops pick them up and take them off, and they do a section 24 because they are obviously psychotic or whatever. Has that increased since 1996 because of drug abuse, or not?

Dr MATTHEWS: I think that certainly a significant factor in that would be marijuana.

CHAIR: The other question related to that is whether or not that is occurring because people are not getting properly treated in the community. I will come to that later. In terms of what you are seeing, these come into your system, do they not?

Dr MATTHEWS: Indeed, because people who use amphetamines are like people who use alcohol—they are often violent. Heroin addicts, when they have their heroin, cause no problem. It is only when they do not have it that they cause a problem. The amphetamines and alcohol are the reverse—people cause a problem when they have them. This slide, "Inmate Census 1999", may or may not be of interest because it shows where customers come from by way of area health service. It shows south east Sydney, south west Sydney, central Sydney and across. The yellow bar is the absolute number and the dark bar is the rate per hundred thousand. There is an absolute number for south west Sydney and the highest rate is Macquarie, mid west and far west—places like that. It reflects overrepresentation of indigenous people.

CHAIR: As well as unemployment and all sorts of things.

Dr MATTHEWS: Of course, south east Sydney, which is an affluent area, has a relatively high rate and that is associated with homelessness in the part of the area in which I live, Darlinghurst-Kings Cross. That is where customers come from. The next slide, "The challenge of continuity of care", shows why we have difficulty in providing continuity of care. It is because we have very large numbers and the majority of them are for a very short stay. There are lots of movements. The three main groups—the mentally ill, the drug dependent and the Aboriginal and Torres Strait Islander Commission [ATSIC]—are mobile in the community. They are hooked up to a variable degree with area health services, private medical services and Aboriginal medical services.

Because they are committing crime, family support tends to be less. Many of them exhibit challenging behaviours. There is lots of stigma attached to incarceration and because of activities, lifestyle and socioeconomic status, they have had poor access to health services. It is this inverse care law—people with the greatest need for health services access them the least, and that is true in most part is of the western world. It is not unique to New South Wales. The next slide is "Target Group for Forensic Mental Health Services". I want to talk about forensic mental health services because it has been topical. Our area health service probably has the greatest body of expertise in both psychiatric and mental health nursing in this area for obvious reasons. This is the group who will be caught up in what is at the moment a draft but what will be the final Statewide forensic mental health plan.

Those who appear before the courts and who are unfit are people with a serious mental illness or are those who are a danger and they are referred by the courts for psychiatric assessment and/or treatment, inpatient or outpatient. They are selective high-risk offenders and this is mostly after release. A lot of sex offenders fall into this group and need some continual supervision after release.

There are those who require being transferred to hospital and those who require specialist treatment services while in prison. There are, if you like, four arms to forensic mental health—inpatient services in forensic hospitals, correctional mental health, court liaison and community liaison.

CHAIR: Can you go back and go through each of those groups and tell me what you do with them? Begin with people who appear before the courts and who are found unfit or insane.

Dr MATTHEWS: This is a group of people who are either unfit to plead or who are not guilty by reason of insanity.

CHAIR: What happens to them?

Dr MATTHEWS: At the moment they all commence their journey in the Long Bay prison hospital. They then have a pathway, subject to recommendation to the Mental Health Review Tribunal and the approval of the Minister for Health, out to medium secure units at Bunya and Kestrel, minimum secure units, and community release.

CHAIR: Under the law and under various covenants these people should be treated by a mental health service rather than by a prison service. Is that correct?

Dr MATTHEWS: Yes.

CHAIR: Are they?

Dr MATTHEWS: Corrections Health Services, which provides health services at Long Bay, is part of the Department of Health. It is true that, at the moment, the Long Bay prison hospital is a curious hybrid. It is both a schedule 2 hospital and a maximum security prison. With the plan, that will change.

CHAIR: I accept that. Let us assume that the hospital is, for some reason, virtually outside the walls of the prison. It is not a prison; it is a hospital. Does it offer the sorts of services that an acute ward in a general hospital would offer?

Dr MATTHEWS: In relation to the staffing level of nurses and psychiatrists, yes, it does.

CHAIR: Does it provide those other services which are important in rehabilitation programs and so on?

Dr MATTHEWS: There is a progression from the acute admission ward to an intermediate ward and then to a ward, which is the long-term rehabilitation ward. That provides a rehabilitative service. The aim with that first group—

CHAIR: If we took that building from where it is now at Long Bay, and we plopped it next to the Royal Prince Alfred Hospital, it would look like the Missenden centre?

Dr MATTHEWS: No. If you asked me whether the physical amenities were all that I would like, the answer would be no.

CHAIR: It is not a particularly old building. Was it not built in 1987 or 1988?

Dr MATTHEWS: It was opened in 1987.

CHAIR: That is right. We are told that people who are at risk to themselves—for example, a person on suicide watch—sit in a little cell with a prison officer next to them. That would not happen in a public hospital.

Dr MATTHEWS: The vast majority of people—not all—who are suicidal are not these patients with a major mental illness. They are people who are in a situational crisis. They are extremely unhappy about being in gaol or they are withdrawing from drugs. The majority of people in

the correctional centres on that so-called suicide watch are not suffering from a major mental illness. They are extremely unhappy people.

CHAIR: So these people should be in a hospital, not in a prison?

Dr MATTHEWS: They are. Should the hospital be outside the prison system? Yes, it will be.

CHAIR: The next group is people who are a danger to others?

Dr MATTHEWS: Yes. This group of people have not been before the criminal justice system but they are considered to be extremely dangerous. At the moment they are accommodated in the Kestrel unit at Morisset.

CHAIR: So we should not find these people in our prison system either?

Dr MATTHEWS: No. You should not find anyone in the prison system who has not been charged. But there is a group around the State—

CHAIR: You can have a serious mental illness but, at the time that you committed the crime, you could be perfectly sane?

Dr MATTHEWS: Absolutely.

CHAIR: You can still find those people in our prison system, but you will not find them in our prison hospital?

Dr MATTHEWS: Let me think that one through. I think the group that you are talking about are what are called transferees—people who have been sentenced for a crime or who are on remand and who have a psychotic episode. They are—bed being available—transferred into the hospital for treatment—

CHAIR: So once somebody becomes seriously mentally ill—whether or not that was the cause of his or her problem—that person requires and deserves to be treated in the same way as anybody else would be treated?

Dr MATTHEWS: Yes.

CHAIR: Whether or not they are inside or outside the system. If you have a serious mental illness you are going to be in a hospital. You might still be under guard because you are a prisoner, you might not be guilty by reason of mental illness, or for any other reason. Access to mental health services should be the same, whether you are inside or outside a prison.

Dr MATTHEWS: Absolutely. There is a group of people who come before the courts—and this is the whole business of the Court Liaison Service—who require assessment. The magistrate is concerned about their mental health. The majority of those people can be assessed in the community. But there is a group of people who are so ill that they require admission to a hospital for assessment. Our figures are starting to show that about 10 per cent of those people are referred. So that is the function of the Court Liaison Service.

CHAIR: So they can be compulsorily admitted under bail conditions. Is that right?

Dr MATTHEWS: The magistrates can order that they be taken to hospital and assessed under section 33.

CHAIR: It is a bit tricky for police. They have to take them off to court, sit there while they are being assessed under section 33 and they then have to bring them back to court because they are not patients and they are not part of the Corrections Health Services; they are still part of the community?

Dr MATTHEWS: That is right. The whole aim of the Court Liaison Service is to make those section 33 referrals appropriate and preceded by a telephone call from health to health so that the outcome is more likely to be the desired one. So you reduce the number, make them appropriate, and you have a much better chance of getting them in. The next slide shows offenders with serious mental illness—the group to whom you are referring. An existing sentenced inmate has a psychotic episode. If they require compulsory treatment they should be referred to hospital which, at the moment, is Long Bay. There are many people in prison who are receiving voluntary treatment and who are quite stable with their mental illness, as you can see from our number of registered patients.

CHAIR: As there are in the community.

Dr MATTHEWS: Absolutely. The last group is those people who are in the prison system who require assessment and treatment under so-called correctional psychiatry. So these are all our target groups under the plan. We all agree that we require a secure forensic service hospital run by health outside the prison environment. We also require on-site mental health liaison services in the court to divert people from the criminal justice system. We also require a systematic assessment of all new receptions to pick up those who have been missed. We need multidisciplinary teams within the correctional centres. We also need a liaison service provided by the experts to all the other area health services to assist them with their difficult patients. The next slide shows something similar.

CHAIR: Is the secure forensic hospital run by health outside the prison environment? An idea came up when we dealt recently with changes to the Bail Act. You said that that would increase your population throughput. Was there a suggestion about providing a bail hostel arrangement? Is the issue of giving bail or arranging for a community assessment a problem particularly for the homeless?

Dr MATTHEWS: That can be a problem, yes.

CHAIR: The Attorney General came up with the idea of establishing bail hostels?

Dr MATTHEWS: Bail hostels have been trialled overseas.

CHAIR: The idea of bail hostels was raised when we dealt with changes to the Bail Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was this information taken from the draft plan of forensic services in New South Wales?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that plan available?

Dr MATTHEWS: That is a question for Professor Raphael.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a draft plan that is awaiting submissions. If that is the case, surely everyone would want to put in a submission.

Dr MATTHEWS: Yes. As I said earlier, the plan does not belong to me; it belongs to the department. We are contributing to it, so I would prefer it if questions about its availability were directed to the department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought you might know, as you probably had an input into it and you will be affected by its output.

Dr MATTHEWS: It is out for consultation with all the mental health professionals. Our psychiatrists are available for consultation. Whether it is at the stage of development where it is out for public comment may be the next step. As I said, that is a question for the department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it anticipated that there will be a separate forensic service? Apparently New South Wales lacks such a service and other States and jurisdictions do not lack those sorts of services?

Dr MATTHEWS: There will be a statewide directorate with a statewide director for forensic mental health, yes.

CHAIR: That is the proposal in the plan?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will it be part of Corrections Health Services?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that Dr Carolyn Quadrio and Jonathan Carne have resigned. Have any other psychiatrists resigned?

Dr MATTHEWS: The turnover of staff in the health system generally runs at 5 or 6 per cent a year. So a number of psychiatrists have left. Carolyn really retired but Jonathan resigned. Others have left and others have come. We just recruited Professor David Greenberg, who I believe is the foremost academic psychiatrist in Australia, to head the Court Liaison Service. People come and people go.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you had Dr Quadrio running it. Now you have someone much less qualified, is that right?

Dr MATTHEWS: We have an Acting Director of Mental Health. The reason for that is that we are in an interim phase of having this statewide director. I need to determine the final structure and reporting lines, but the statewide director will have overall responsibility. Professor Greenberg will run court and community liaison. There will be a medical superintendent in the hospital and then there will be someone else managing and running the correctional component. But the statewide director will have responsibility for all four sections. Until this time we have had only the correctional component. We are just putting the other parts of the system into place.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that psychiatry is certainly not in crisis? You would think that, even though there was a significant number of resignations, it was routine turnover and not a serious problem. There is not a problem in the delivery of psychiatric services?

Dr MATTHEWS: As I said, we remunerate VMO psychiatrists to the tune of $35,000 a week. I would not call that a crisis. We have recruited a number of new psychiatrists recently.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly from my work on the Select Committee on the Increase in Prisoner Population, I am aware—as inmates told us—that inmates are waiting long times to obtain any sort of psychiatric service.

Dr MATTHEWS: In some places that is true. Under the system they are triaged by mental health nurses. I am a patient sort of a fellow. I have been working with Professor Penny now for 10 years. It is my view, and it is his view, that we are 10 years into a 20-year plan to improve health services for people in custody and in contact with the criminal justice system in New South Wales.

CHAIR: We are a long way from Richmond, which occurred 20 years ago. Richmond mentioned that as one of the four target areas that required fixing up. If you are 10 years into your 20-year plan, you started off 10 years too late, did you not, given that the impetus was there in 1987? We seem to have lost quite a bit of time. In 1993 Burdekin said that we had to do something. We are five years away from having a new building outside the prison walls.

Dr MATTHEWS: No, I do not think that is the case.

CHAIR: Are we closer than five years?

Dr MATTHEWS: I hope so.

CHAIR: That has not yet appeared in the budget line items.

Dr MATTHEWS: I am not privy to what will be in the budget papers next Tuesday night.

CHAIR: Even if it involves design and construct it cannot be less than three years.

Dr MATTHEWS: That is correct. That would appear to be right.

CHAIR: If it is the usual public service planning process it cannot be less than five years. That is how long it took to build Coffs Harbour.

Dr MATTHEWS: Because the existing forensic hospital will be on degazetted land at Long Bay—therefore the "not in my back yard" factor comes into it—it is not a high-tech hospital. It does not have intensive care units, et cetera. There is no reason why the time frame cannot be—

CHAIR: It is high security.

Dr MATTHEWS: That is true. It has a perimeter wall equal to a maximum security gaol. Most of that wall is there. What is inside will come down.

CHAIR: At Long Bay you deal with general health as well. A lot of the surgical stuff still goes to Prince Henry and Prince of Wales hospitals, does it not?

Dr MATTHEWS: There is a secure unit at Prince of Wales with seven beds.

CHAIR: Are mentally ill patients housed with general patients?

Dr MATTHEWS: They are in separate wards.

CHAIR: Do you find that a substantial number of the general patients also have mental illness? We are told that in public hospitals the proportion is 30 per cent.

Dr MATTHEWS: It does happen that people with mental illness get hernias They come in to ward B, and then go to Prince of Wales Hospital and have their hernia operated on. The majority, but not all, of self-harm is around situational crisis and not a major mental illness. There are two hospitals to be filled at Long Bay. One—and the Department of Corrective Services has the money for this—will be a new prison hospital for sick inmates.

CHAIR: It will be inside the walls?

Dr MATTHEWS: Yes. Then there will be a 135-bed forensic hospital, which will be on degazetted land, so it will be a hospital adjacent to a correctional centre. I understand that there are concerns about that and there are arguments both ways.

CHAIR: I personally do not care where it is, as long as it is not owned by a prison and it is not guarded by prison officers.

Dr MATTHEWS: The plan is that it will be a health-run institution, degazetted, with no legal right for prison officers to be there.

CHAIR: Offering multiple use by people who are not prisoners but who are forensic in other ways. I think that is an enormous step forward.

Dr MATTHEWS: It is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am worried about the cultural spill over the wall.

CHAIR: The facility will have brand-new staff?

Dr MATTHEWS: Not only that. There will be the opportunity to rotate staff, so that people who work in the correctional institutions as doctors and nurses will have the opportunity to work in a hospital where there is a hospital culture which they take back.

CHAIR: That is only if you put brand-new staff into the new facility—in other words, not one person from the existing facility?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This assumes that the cultural transmission will only go one way. I would be concerned about it going the other way.

Dr MATTHEWS: It will be my job, if I am in the chair, to make sure that it does not.

CHAIR: Will you have visiting staff there, or permanent staff?

Dr MATTHEWS: In terms of psychiatrists, the majority will be VMOs. There will be registrars in training, of course, and they tend to be permanent.

I would like to take mild exception. We have some very dedicated, very good staff out there. I am a little distressed that you say that not one should go into the new hospital.

CHAIR: If you want to start off a new, state-of-the-art service of excellence in New South Wales, you cannot start with pre-existing practices.

Dr MATTHEWS: I agree with that entirely.

CHAIR: In every individual, you will have good practices and not so good practices. We have had good submissions about the caring staff at Long Bay ward A. There is no doubt about that.

Dr MATTHEWS: I can assure you that that will happen. You can be assured that there will be a health culture. The next slide lists the physical components, which are: custody, court diversion, assessment units for a further diversion on further assessment, and for that group that needs to remain insecure custody there is a pathway to either the hospital or the correctional centre, whichever is appropriate.

CHAIR: Where do the patients who are diverted go? They are not sick enough to go to the hospital, they are not schedulable, but they are unwell.

Dr MATTHEWS: The majority of them are known to community mental health teams.

CHAIR: But where do they go? They are often picked up by the police and taken away because they are causing a fuss, under section 24 they are taken to the hospital, the hospital says they are not sick enough to be admitted, so they are taken away and charged. Once they are charged, they go before the magistrate, and the magistrate says they are mentally ill and sends them off to community mental health. They then go out of the court and off into the street again.

Dr MATTHEWS: We are trying to do a little more than that, by making arrangements for community mental health to go to them. If you are asking whether there should be more supported accommodation, I would agree with you 100 per cent.

The court liaison service was first started in the Hunter and has been operating there for some years. We have two pilots in Parramatta and Central, and we have received funding to expand that to the other five courts. They are now all operational. We are just recruiting to Parramatta because the nurse who was there moved to Liverpool. That funding also enabled us to employ Professor Greenberg from Western Australia to set up this service. I have to tell you, it is an appointment I am very pleased about.

CHAIR: The slide does not have Kempsey and Port Macquarie on it.

Dr MATTHEWS: Kempsey is run by Mid North Coast Area Health Service, not by us. The statewide service will involve networking with the other three, which are the Hunter, the Mid North Coast and the Illawarra. Next financial year there will be funding for five more. So we will be expanding to probably three or four more country centres. The decision on where they will be will be taken in conjunction with the Chief Magistrate.

The next slide shows the outputs for three weeks in May. These are the aggregated data for the courts. I have with me the individual court data. For the week 1 to 7 May, there were 306 people in custody. This does not include people who walk in off the street to appear before the courts. You can see that the rate of referral is running at about 10, 11 or 13 per cent. There are a small number of referrals in relation to people who are not in custody. We are seeing this as a diversionary program, but if legal aid says, "I have got someone here whom we would like the nurse to see," we see them.

I apologise for the slide being slightly confusing as to the outcomes. First there are the section 32-33 transfers, which are now made by the magistrate on the advice of the nurse and the psychiatrist on the phone. The next line shows those who are successfully diverted to community treatment. In the last line, custodial diversions should not really be called diversions. I am going to get them to change their system. These are people who—usually because of the nature of the offence—cannot be given bail, but they are assessed in the court and they are linked to treatment services inside. In other words, then nurse contacts people and says, "Joe Bloggs is coming. These are the problems we have assessed," and they are linked to services inside. I am going to put them on a separate line. They are really custodial transfers; they are not strictly diversions. The total numbers of diversions out of gaol in those first three weeks are 11, 10 and 15.

CHAIR: In other words, before they get to gaol you know that someone who has a mental illness and has been assessed is on the way—rather than having to wait for them to be assessed when they get there in perhaps two or three days time—so that their treatment can continue if it is needed?

Dr MATTHEWS: That is right. And many of those will be awaiting a psychiatric report. In relation to these courts we have introduced a system where initially we have guaranteed to reduce the turnaround to four weeks, and we aim to ultimately reduce it to two weeks.

CHAIR: The Mid North Coast Area Health Service sent us a submission setting out its outcomes, some of which extend over the first year. The service speaks about decreased reoffending behaviour, as indicated in the absence of breaches of section 12 bonds; improved community safety through earlier assessment and intervention aimed at decreasing the risk of reoffending due to untreated mental illness; identification of drug-related crimes and referrals to detoxification and rehabilitation services; the decreased risk of deaths in custody due to suicide as a consequence of earlier interventions; increased support of clients, carers and staff; and collaboration between the community, government agencies, carers and stakeholders.

I would see this as a very positive step forward—by an area health service of its own initiative, because the community got together and said, "We have to do something about this." To what extent are your liaison services plugged into the local council, local non-government organisations, the police, drug and alcohol services, mental health services, and so on?

Dr MATTHEWS: They are meeting with all those groups to do that.

CHAIR: But do they all own it?

Dr MATTHEWS: Yes, they do.

CHAIR: Or do you own it?

Dr MATTHEWS: We employ the staff, but everyone works together. There has to be an excellent relationship between the area health service that provides the community service, the non-government organisations, the police, and all the people who have been consulted. They are all very happy to have it and to have it expanded. Many of those laudable claims of the Mid North Coast Area Health Service we need to prove—

CHAIR: What I read to you were outcomes.

Dr MATTHEWS: How can you prove a reduction in deaths in custody?

CHAIR: The area health service has provided the figures.

Dr MATTHEWS: I do not doubt it. However, the best way to prove it is to do a research trial and look at rearrest rates. That way, you will have some real proof. That is what we intend to do. I do not doubt that it will happen. Do not get me wrong: I think this is one of the best initiatives across the State that we have seen for some time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With regard to referrals for people who are outside custody, does that mean people who are on bail but are referred by the court liaison scheme?

Dr MATTHEWS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If from 1 to 7 May there were four people with mental illness referred from outside, that means that there were 30 people referred who had been in custody. An awful lot of mentally ill people must have been in custody before?

Dr MATTHEWS: To be fair, this is an initiative that is aimed at people in custody, to get them out where appropriate.

CHAIR: All of these people are in custody, are they not?

Dr MATTHEWS: Where you see the third row, 4, 2 and 4, they are people who are on bail and have appeared before the court. Probably legal aid has said to our nurse, "Can you see them?" and we have seen them. But we are not aiming for that group, because if you look at the throughputs for those courts with all matters, it would be in the thousands.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, if they were on bail and they were already attending community mental health support services, they would not be referred because they would already be in that system?

Dr MATTHEWS: They ought to be seen in the community. Very often these people are represented by legal aid. They only meet the solicitor on the day, and the solicitor forms a view that this person may have a problem. If there is a resource just around the corner, they will grab it—you cannot blame them for that. The problem may not have been recognised until that day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if it had been recognised, they would not appear in those figures?

Dr MATTHEWS: That is right. The service is not targeted at that group. The next slide is a quote by Oscar Wilde. I always finish with Oscar Wilde.

CHAIR: A lot of people start with Oscar Wilde.

Dr MATTHEWS: For me, the significance is that he was incarcerated for something that is no longer a crime. He was locked up for 23 hours a day, and he slept on bare boards. That is the end of my presentation.

CHAIR: Do have a copy of the department's submission?

Dr MATTHEWS: No, I do not.

CHAIR: I cannot share it with you, unfortunately. The number of police presentations, the section 24s, has risen sharply from 1,000 to 2,500 per annum between 1996 and 2000. That is a huge jump in four years. Some of that, I now understand from your evidence, is a sharp rise in the use of amphetamines, and it may have been kicked forward because of the drought, although the drought

does not appear in these figures just yet. How much is that due to the failure of the assertive community-based services in keeping people in the community mentally well and a failure of the acute services to pick them up early enough?

Dr MATTHEWS: I cannot really answer that question, because I do not believe that the data are available.

CHAIR: When there is a section 24, when the cops turn up with somebody, they must give a reason for them being picked up. They can get an assessment to confirm they are mentally ill or not mentally ill, otherwise they cannot be held. Those section 24s do not go to the prison system necessarily, they go to a hospital?

Dr MATTHEWS: That is correct.

CHAIR: Some of them, if they are not mentally ill, not section 24s, end up in gaol because if they are not mentally ill or not mentally ill enough—which is the evidence—they get carted off to the cops' cells, where they get charged, bailed and appear.

Dr MATTHEWS: Yes. The only way to answer your question, I think, would be if the data were collected to see who was presenting on a section 24 and look at their previous history, had they dropped out of treatment—

CHAIR: That is what I want to know.

Dr MATTHEWS: I do not think anyone knows.

CHAIR: Surely, if you are going to design a service—this is all part of the forensic system and I know you are in Corrections Health and you are that part of the corrections system, but if you are going to have a forensic mental health service, this is the sort of thing that needs to be found out, because this is what drives people going to your forensic prison or keeps them out of it. It stops the cops from spending all that time.

Dr MATTHEWS: The data, I agree with you, are absolutely critical. We are a data-driven service now under Ron Penny, and that is why we have spent nearly $500,000 on an inmate health survey.

CHAIR: That is just your little cosy bit. The outside bit, which is what drives the cops' workload, has increased twofold in the numbers of people they have to spend six damned hours with waiting for the psychiatric registrar to assess. If they are the only two cops in Dubbo they have to wait with someone to be assessed only to be told that they are not sick enough to be admitted and we are full tonight anyway, take him back to the cells and charge him, and they go through that system. You assess the person later as mentally ill. That is what we need to know.

Dr MATTHEWS: Yes.

CHAIR: The next thing is the proportion of involuntary patients admitted by medical practitioners and police. There seems to have been a big increase in the number of section 22s. In other words, those who are brought in by the police off the street as opposed to a medical practitioner being called. Is that due to the drugs or a failure of community mental health?

Dr MATTHEWS: I think the drugs are a factor.

CHAIR: I accept that. That is to your knowledge, because you know that those people turn up in prison and you know that has been the cause of problems.

Dr MATTHEWS: Yes.

CHAIR: Involuntary admissions per year is quietly rising from 4,000 to 6,000 in 1996, and suddenly in 2000 it is 10,000. It has gone up by more than half in 10 years, but particularly in the past

four years. Again, something must have happened in the past four years that has driven those three things—involuntary admissions for various reasons.

Dr MATTHEWS: I think there are multiple factors. For mine, the change and increase in drug use is probably the predominant factor. That is my impression, and I do not have data to support it.

CHAIR: There is a figure at the top of page 18 of the report. It does not have a year on it but it is patients in acute wards requiring other forms of care. In other words, this is people who are admitted under the Mental Health Act, I assume, who need other forms of care. In other words, they are pretty sick as well as needing protection, containment and other care. Is it your experience that when they come to the liaison service or the prison system, that they are sick as well as being mentally ill?

Dr MATTHEWS: Yes, and a lot of that again is about drug use. It is almost unknown—and I worked in the community too—to see someone with a major mental illness who is not abusing something, either licit or illicit.

CHAIR: How can we persist, with the Drug and Alcohol Authority there and the mental illness authority there and between them this enormous gulf in policy, funding, co-ordination, ownership and direction?

Dr MATTHEWS: You are talking to a bloke who spends almost all his budget on mental health and drug and alcohol and we have them pretty well together.

CHAIR: You are prisons health.

Dr MATTHEWS: Corrections Health.

CHAIR: In the Northern Rivers Area Health Service you do not.

Dr MATTHEWS: Of course, we do not have to provide coronary artery bypass and renal dialysis and all the other things that are competing. We do not have to treat people with prostatic cancer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think Brian is saying that drug and alcohol and mental health are separate.

CHAIR: I am saying they are separate. Most area health services have completely different directorships for this and for that. At the head office they are not even combined. Beverley Raphael does not have control over the direction of drug and alcohol. She has direction over mental health. Mental health does not have direction over drug and alcohol.

Dr MATTHEWS: It is unfortunate, in my view, as a drug and alcohol doctor, that there is not a drug and alcohol specialty that is recognised. I do not know that all drug and alcohol has to sit in mental health. Drug and alcohol is a problem that severely affects other parts of the body apart from the brain. My personal view—

CHAIR: So does mental illness.

Dr MATTHEWS: Sure, but my personal view is that treatment of drug and alcohol abuse and dependence ought to be a specialty in its own right. Not everyone would agree with me.

CHAIR: Given that the impact of drug and alcohol in particular is towards mental illness and the effect of mental illness on people who take drugs and vice versa—they used to be together in the 1970s and in some States they are still together, but in New South Wales we split them in 1970 and since then if you have a mental illness problem they cannot deal with you until you get that mental illness fixed. If you have a drug problem, we are not going to deal with your mental illness until you get that drug problem under control, and they are falling through the cracks. We have a huge amount of evidence that that is the case.

On the other hand, you get them in a contained situation in prisons health and you are able, because of the constrained situation, to deal with both at the same time. And this is where your problems come from. This is the evidence that you are giving us today, that a lot of your increase in population in the prisons are drug alcohol and mental health related.

Dr MATTHEWS: Certainly drug and alcohol, but the mental health question is a very interesting one.

CHAIR: Combined, is what you are saying?

Dr MATTHEWS: Yes.

CHAIR: I am talking about sections 22, 23 and 33 admissions. These are substantially mental illnesses and you are saying that a lot of that increase since 1996 in those sorts of people is to do with drugs. Surely, if we are having a huge spike, and this is a big spike according to the department's own figures, would it be sensible, in your view, to put them together?

Dr MATTHEWS: It would certainly be a good idea to have specialist programs for people with co-morbidity but there are other groups as well. The indigenous people have very specific problems with drug dependence and drug abuse which involve an even broader range of drugs, like petrol and glue and things. I would not like to see them fall through the cracks either.

CHAIR: You are not saying anything different from what Richmond said, what Barclay said and what Burdekin said about the need for the Mental Health Service to have a drug and alcohol arm. All of them said it and everybody is still saying it. When are we going to see it? What can you do from your side—you are the end product—to say to the front end what are you going to do about it to stop us being overloaded with these 10,000 prisoners?

Dr MATTHEWS: We are the end and we are also the beginning, because many of these people access treatment services for the first time with us, and they start on the journey of treatment with us. It is a difficult question for me to answer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I noticed the figure of 250 per cent, and I was not sure what question I should ask about that.

Dr MATTHEWS: Two hundred and fifty per cent what?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The 250 per cent increase since 1995 of police bringing mental health people in. There are two things I would say, perhaps getting the other view from Brian's, as to the need for drug and alcohol and mental health services to go together. If we take an analogy in the area of mental health and intellectual disability, the disabled have lobbied and fought very hard to get intellectual disability under DOCS rather than Health, and now the ones that have both problems are falling between the stools but the ones that presumably do not are better off, we would hope. Is there a danger that the same thing will happen in mental health? There must be a lot of drug and alcohol users who do not have mental health problems, and you would bring them into a net that was too wide?

Dr MATTHEWS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is your opinion on that? That is the opposite view from Brian's.

Dr MATTHEWS: Indeed. I am probably biased because I have come from general practice into drug and alcohol. I think it should be a specialty on its own with a very strong mental health component and very strong partnership with mental health but also with general medicine—gastroenterology, liver disease. Sixty-six per cent of the women and 40 per cent of the men are hepatitis C positive, and that applies to the mentally ill and the non-mentally ill. There needs to be a very strong public health and primary health focus too. The fact that they are old men and women at 40 means that they need very strong general health care. I see people working together as a team.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My last question you might not want to answer. Presumably a lot of this is decriminalisation of people who are drug users, and that is why your police presentations and your numbers are going up. Would you support the decriminalisation in some sort of staged fashion of drugs and use and abuse? You do not have to answer that if you do not want to.

Dr MATTHEWS: What I would say is that Spain and Portugal have decriminalised personal possession of all drugs and that we should take a very close look and see what happens there. There are arguments for and against. I have a personal view but I do not think I should be putting that forward here. It is happening in other places and we should take a very close look and see what the results are.

CHAIR: So we should certainly look at Portugal and Spain and see whether their admission rates for psychiatric reasons are going up?

Dr MATTHEWS: Also I think to see what happens to crime, which is also terribly important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that being well documented in those jurisdictions?

Dr MATTHEWS: It has only just happened in the past few months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably though, if someone has taken a step that radical they will hopefully have figures from which they can draw some conclusion in a relatively short time, will they not?

Dr MATTHEWS: I would hope so.

CHAIR: It may reduce the crime—

The Hon. JOHN HATZISTERGOS: Are you only talking about possession?

Dr MATTHEWS: Yes.

CHAIR: It may reduce the crime but I am talking about your services today—Corrections Health and forensic services. If you are telling me that a 2½ times increase from 1996 to 2000 was substantially due to marijuana and amphetamines, we will find out whether or not it is also due to poor community mental health. It is one or the other. That is the section 24s. If you do not think that is going to increase, I would be very surprised. These are not due to crimes, other than people picked up who the cops think are mad.

Dr MATTHEWS: It is more complex than that.

CHAIR: This is section 24s.

Dr MATTHEWS: Yes, but I think we are seeing an increase in amphetamine use and marijuana use because there is not enough heroin to go round. I have been doing this for 20 years. If you sit there and say they are all here on the table—the heroin, the speed, the coke, the alcohol, the pills, the marijuana—which one are you going to pick up, the vast majority will say the heroin.

CHAIR: So what we are seeing could simply be a default mechanism as things get rarer, more expensive, unavailable, et cetera? So, as we see more and more people getting pinged for importing heroin, as the Commonwealth and States get more successful—amphetamines get produced here in little laboratories, do they not?

Dr MATTHEWS: It is a potentially perverse outcome, shall we say.

CHAIR: How do you plan for that?

Dr MATTHEWS: Me?

CHAIR: You have been going to the Minister for your prisons health budget, $50 million. You are not part of the RDF process but you are part of the consideration he has to make with you and the kids hospital and a couple of others. You are one of the major expenditures apart from the kids hospital that he has that are outside the RDF.

Dr MATTHEWS: Yes, and the ambulance.

CHAIR: But within that does he tell you how much mental health money you will get? If he has told you, that is an area where you can say, "Here is a steep curve. We have to match that one."

Dr MATTHEWS: Like all area health services, we have specific mental health money from the Centre for Mental Health and from the Commonwealth. We report on that specifically for certain programs but we spend far more than that specific money on mental health. Last year I think it was about $13.5 million. The specific special project money is probably about $2 million or $3 million.

CHAIR: Do you account for that? In your line items do you get allocated a certain amount for mental health?

Dr MATTHEWS: Yes.

CHAIR: It is $2.4 million or something like that—I have forgotten what it is. Is it $2.9 million?

Dr MATTHEWS: Specific mental health funding?

CHAIR: Yes. Whatever it is, you account for that. If I went to your place tomorrow you could say, "Here is what we spent on mental health and this is how we spent it."

Dr MATTHEWS: Yes. It is in the annual report. As I said, that specific money is for specific programs.

CHAIR: I accept that the money comes to you. Does the Minister say, "Here is your budget for corrections health this year"?

Dr MATTHEWS: Yes.

CHAIR: And there are lots of ways you can spend it. Are you able to move the money in and out?

Dr MATTHEWS: Yes.

CHAIR: As long as there are no big movements. If there are big movements the Minister or the department will want to know: "Here is how I spent it, Minister. and I had to pinch money from here, which the department knew about, to augment here."

Dr MATTHEWS: Yes and when I report according to programs. It is hard. When you employ a nurse to do a reception assessment tonight and she sees 20 people who have a plethora of problems you cannot dissect that out. But I do report to the department, and it is in the annual report, according to programs, and one of the programs I report under is mental health. From memory, it is about $13.5 million or $14 million—it may be more. I would have to check. We also report Aboriginal health.

CHAIR: Separately? Is some of that mental health money?

Dr MATTHEWS: Some of the services which are specifically Aboriginal health are mental health as well.

CHAIR: Some of the prevention money you use.

Dr MATTHEWS: Health promotion money, yes.

CHAIR: That is mental health too?

Dr MATTHEWS: As I said, at the end of the day it is very hard—

CHAIR: This is what constantly amazes me. I am sure that Health spends more money on mental health than the $500 million it writes down. Even the Minister is saying that he spends only $500 million. I cannot believe that that is all that is being spent, knowing that in our emergency departments money is spent on mental health and in our public hospitals acute in-patient care there is mental health money. I think it is underestimated. I do not think that is all they are spending.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Minister would love to hear all this.

CHAIR: I do not care. I want to be fair. I want accrual accounting. I want to know what it actually costs to run a mental health service. It is no good saying, "Let's do it" and then they say, "We have found that we are spending $600 million today because we had not been counting this. So here is a big boost for mental health." I would like to know what we are spending today and make that accountable and open so that the community sees it. Even for things like housing, the Government is spending large amounts of money on housing people who have a mental illness. All they account for is some of the money they give, some of it is through DADHC for long-term support. It is not called mental health money; it is called disability money but it is support for people who need long-term disability care.

Dr MATTHEWS: I would argue that the majority of money that the Government spends on housing for the mentally ill is through the Department of Housing.

CHAIR: That is exactly right but it is not identified as mental health money.

Dr MATTHEWS: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But then they are still people, are they not? They are not just mental people.

CHAIR: I know that but I want to see what is spent on mental health. Given de-institutionalisation, we should be able to see what it is really costing so that we can see each year whether the housing money is dropping, whether the disability support is dropping or rising, and whether the money going to corrections which is used for mental health is rising or falling. The community should be able to see what is being spent and where it is being spent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But these are not Richard's areas of expertise.

CHAIR: In his small area.

Dr MATTHEWS: I have one small plea. Reporting requirements can become so onerous that you then do not have any time to do anything.

CHAIR: That is the next question. What about clerical and other support? The Minister makes great play about what percentage of staff are now face-to-face workers as if it is a huge thing. All of this money is not being spent on bureaucrats; this money is being spent on front-line workers. However, the bureaucrats, telephone operators and non-face to face clinical operators are equally important, particularly for an area like this, are they not?

Dr MATTHEWS: Absolutely. If I do not have a very good payroll department, and if people do not get paid every second Thursday, that has an enormous effect on the delivery of clinical

care. So all those support parts, the human resources, the occupational health and safety, they are all critical in the delivery of clinical care.

CHAIR: They are the ones who are being squeezed to keep the number of nurses up. Do you not think so?

Dr MATTHEWS: All I will say is that finding the right balance is extremely difficult. That is probably the best way I can put it. We do the best we can.

CHAIR: Thank you for your evidence. We may need to see you again later in the inquiry. For example, we may have some recommendations that we want to toss out to you to see whether they are feasible, sensible and not ridiculous.

Dr MATTHEWS: That is fine. If you want to visit Long Bay—

CHAIR: We will have to be in touch with you directly about a time to visit. We intend to go to you and then go to Victoria or Queensland.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we look at Jonathan Carne's report and the draft forensic plan?

CHAIR: He cannot give us a draft forensic plan.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you communicate that we would like it?

Dr MATTHEWS: I will communicate that.

CHAIR: And the Carne report. Jonathan Carne gave evidence yesterday and he is not aware that it is a public document.

Dr MATTHEWS: Yes. It is an excellent report.

(The witness withdrew)

(Luncheon adjournment)

OLAV BRIAN NIELSSEN, Psychiatrist, and Chairman, Forensic Section, New South Wales Branch, Royal Australian and New Zealand College of Psychiatrists, of 62 Beresford Road, Bellevue Hill, sworn and examined:

CHAIR: In what capacity do you appear before the Committee?

Dr NIELSSEN: I am appearing as the current Chairman of the forensic section of the New South Wales branch of the Royal Australian New Zealand College of Psychiatrists. I specialise in forensic psychiatry.

CHAIR: Do you want your submission, number 22, to be taken as part of your sworn evidence?

Dr NIELSSEN: Yes.

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. I should warn you that the Legislative Council may overturn the Committee's decision and make the evidence public.

Dr NIELSSEN: I introduce myself as someone who has worked in the area of forensic psychiatry for the past 10 years as a visiting psychiatrist at the prison hospital and the Corrections Health Service. Prior to that I worked and trained at St Vincents Hospital where I had some exposure to acute psychiatry, so that is my personal perspective. The forensic section has a great interest in mental health services as a whole because the Corrections Health Service picks up the failures of the mental health service as a whole. Many of the people we are looking after in gaol are there because they could not get care for one reason or another in the community. We also have a serious problem in returning people from custody to care, and that problem is getting both community mental health services and community hospitals to take people who have been in custody. Again it seems to be a resource issue as much as a stigmatisation issue, but stigmatisation is definitely there.

There is an historical perspective, and probably the most quoted author is Penrose. The Penrose hypothesis of 1939 is that the fewer community hospital beds you have got the more people you will have in gaol. That held true in Europe in the 1930s and there has been some truth in it in western countries in the past 20 years with de-institutionalisation. It is my view that the gaols are in some ways vast psychiatric hospitals. There is plenty of data to show that there is a lot of mentally ill people in gaol, and more so than there were 20 years ago.

CHAIR: From one bedlam to another?

Dr NIELSSEN: Yes, exactly.

The Hon. PETER BREEN: Do you have the statistics?

Dr NIELSSEN: I have just completed a study that was based on interviews. All the studies that are based on structured questionnaires I think have no validity. In New South Wales, 6 per cent have psychotic illness, based on doing specialist interviews with people who came up on screening interview and were referred in other ways in a recent inmate survey. That is 12 times the community rate found using the same methodology, so it is very high, and that is just acute mental illness: it is not brain damage, epilepsy, severe personality disorder and many other disorders.

CHAIR: Do you know from where they came before they went to prison?

Dr NIELSSEN: Yes, I would like to do that study to try to establish whether the people who were de-institutionalised came to the new institutions. I have an approval from the Research and Ethics Committee to look at the sample from the homeless 500 that was studied by Neil Buhrich that has been published extensively to look at their criminal records. I might have that answer in a few months.

CHAIR: They are now separate by 20 years so many of the people who would have been de-institutionalised have died, but there will be the people who in the past would have been institutionalised who are now aged 23 or 24 who are going to the prison system. It would be a very difficult study.

Dr NIELSSEN: Of course the gaols are recruiting a new population of mentally ill but it might just show if the homeless 500 group, whose hospital admissions go back to the 1950s, if they came in to gaol after leaving hospital. As far as the Richmond report is concerned, I feel sorry for Dr Richmond for being so much maligned, as he really opened the door after the horse had bolted, because de-institutionalisation had already occurred. In my submission I said that he gave impetus to the false prophets who led the health planners to believe that they could reduce the hospital bed numbers as much as they have. Because the clear problem is we need a few more acute beds and more supervised long-term places. They need not be hospitals because this group is often very stable. After de-institutionalisation the voluntary agencies—Matthew Talbot, Swanton Lodge, Edgar Eager Lodge and so on—became the chronic wards. Increased resourcing for some better version of the chronic wards, if you like, supervised boarding horses, would be one of the desirable outcomes. That would help the clients who become forensic patients as well.

The Hon. PETER BREEN: When you talk about forensic patients do you mean patients suffering from mental illness?

Dr NIELSSEN: Yes, I am using a general term meaning mentally ill people or mentally disordered people who have come before the courts, not the forensic patient category that has been made by law.

CHAIR: People who have been before the courts?

Dr NIELSSEN: Yes, I am just talking about mentally disordered offenders generally. The people known to mental health services who then go before the courts for whatever reason.

CHAIR: The end result is some of them do become declared forensics?

Dr NIELSSEN: Yes. I was really going to talk a little bit about the perception of the reduction in available services. I do not mean to criticise Community Services, as we are talking prior to the inquiry about the difficulties they face. They have got far more difficult patients and I believe that the increased abuse of amphetamines in particular has made existing mentally ill people more difficult to manage: they are more acute than they were.

CHAIR: Are they more violent and aggressive?

Dr NIELSSEN: Yes, often and have more episodes because they relapse when they have amphetamines whereas they might not have relapsed otherwise. However, in hearing about staff numbers—and this has been borne out—money has leaked away from mental health that should not have leaked away. There does need to be a firmer commitment to resources for community mental health and community hospitals.

CHAIR: Do you guess that or do you know that?

Dr NIELSSEN: I am just basing it on St Vincents Hospital and the number of staff they have in the Darlinghurst community centre. I cannot give you the figures but it has not increased.

CHAIR: The department has claimed that the number of the work force has dropped for inpatient services from 3,882 in 1993 to 3,862, so it is about level. But the number of people in the community has grown for ambulatory mental health services from 1,200 to 2,700, and for community residential services from 240 to 376. That gives a rise in the number of work force from 5,300 to 6,900.

Dr NIELSSEN: Again I was only basing it on the one unit which already had a big increase in the 1980s so perhaps that was why it did not represent the whole State. However, I have had the experience in the prison hospital of having difficulty getting a community health centre to appoint a

case manager for somebody who could be released on a community treatment order. They say, "We don't have a case manager. We are closing our books for taking new patients." Therefore, they are not able to arrange that follow up.

CHAIR: So it could be that as the numbers have increased the workload has not increased sufficiently to meet what you see as the demand?

Dr NIELSSEN: Yes. Again, I am not in a position to talk about the management of services—for example, the morale, the productivity, whether everything has been tried, or whether there has been assertive case management. I am in a position to say that as someone who gets to audit the written notes—because of doing assessments for the courts, for example, and having written notes of, for example, homicide in hospitals, and I saw one for the defence and one for the prosecution—the shortcomings in the management of many patients are obvious, in retrospect. It is also obvious, over time, which are the better managed areas, perhaps because they are more middle-class, particularly Sutherland and Hornsby, which are really good. They still have catastrophes, but probably not as many because of the better management. Some of those that probably have more difficult populations do not seem to have the same assertive follow-up and assertive case management.

CHAIR: You said there were homicides by these people. Was that in or out of prison?

Dr NIELSSEN: I would use the example of the two homicides in psychiatric hospitals in the last 18 months. One was in Kempsey and one was in Mandala at Gosford. I got to have a look at all of their inpatient notes because they were part of the prosecution brief.

CHAIR: I did not intend to pursue that because I figure that would be too identifying where matters might come before the Coroner and so on.

Dr NIELSSEN: They have been dealt with. But I do not want to point to specific matters. It is really to do with management and co-ordination of services. Of course, there will be an increase in civil actions as a consequence of inadequate care—not that one can predict catastrophic events because, thankfully, they are relatively rare. But, when you look at them retrospectively, one can see a manifest failure to provide an adequate standard of assessment or care.

CHAIR: Was that the case with the Central Sydney Area Health Service, and the fine of WorkCover? A number of people were injured.

Dr NIELSSEN: WorkCover is one. But even the patients are suing over the consequences of inadequate care. Forensic patients found not guilty on the ground of mental illness are suing the agency for not looking after them.

CHAIR: But they have an absolute right to be treated under the mental health plan of 1991.

Dr NIELSSEN: Once they have come to the attention of services, yes.

The Hon. PETER BREEN: It will not be so easy for them once the Civil Liability Bill is passed.

CHAIR: You say in your submission that the court liaison service is limited in its ability to arrange transfers from custody to care because of the lack of services, and that there is no service to assess or treat the mentally ill under the supervision of Probation and Parole. Would you like to talk to us about that?

Dr NIELSSEN: Yes. That would be an easy service to set up. It will be necessary if the changes proposed to the Mental Health (Criminal Procedures) Act come through. I hope they do. Section 32 and 33, which apply to the local court, will require supervision by Probation and Parole, and they will need some kind of mental health backup. It would not need to be huge. It is my submission that, for instance, a co-ordinated statewide forensic health service, with outpatients, could be created without any additional resources, just by co-ordinating the existing resources and filling in a couple of gaps, mainly by the use of an inexpensive outpatient service.

CHAIR: We heard from Dr Matthews that there is a draft plan that might effect that change.

Dr NIELSSEN: I am pleased to hear that. It has been a while coming.

CHAIR: It has not been signed off. We do not know what is in it, but we are told that a draft plan is before Dr Raphael, and I presume it will be before the Minister after that. So it may well come into being. These people have absolute rights to certain treatments under the Mental Health Statement of Rights and Responsibilities, which was signed off in 1991. Under the various other provisions those who are mentally ill have a right to be treated as mentally ill, whether they are guilty or not guilty of an offence, and whether they are in the community or a mental hospital or a prison hospital. To what extent do you think people who have mental illness of the forensic type get the mental care that they would get elsewhere if they were not of the forensic type?

Dr NIELSSEN: It is a complex question because in some cases they are getting better care because it is the only care they get. Also, on the whole, they are not using drugs, and that is good for their physical and mental health. But the prison hospital is now substandard. I understand that is to be replaced. It is not a good therapeutic environment. We know that 6 per cent of those in gaol are mentally ill or have related psychoses. Those places are counter-therapeutic; they make people worse. Stress could induce episodes of mental illness, and they are definitely preyed upon. I have lost count of the number of mentally ill people who at their first presentation to health services have a broken jaw, just because they are so socially inept and vulnerable in gaol. So, in answer to the question, it is not the best place to look after them. They are not looked after all that well in the mainstream gaol.

CHAIR: The issue of forensic care has then raised in most recent reports by Richmond, then Barclay in 1988, then Burdekin in 1993. This has been identified as a special area of need. To date, there does not seem to have been a great deal of change in spite of the rising incidence. The Committee had evidence today that Dr Matthews is pinching money from his general budget to put into mental health, so there obviously is a commitment to this issue by Dr Matthews and his board. Is there a reason why forensic care is not being better resourced?

Dr NIELSSEN: Resources are not my area. However, resources have improved significantly. I think the budget was about $12 million and it is now about $30 million. I would attribute much of the improvement to the motivation of the people taken into the service over the past decade. Part of the problem is that the gaols are not set up to look after mentally ill people. There are not many quiet areas where people are kept stable. The buildings are not designed to look after the mentally ill

CHAIR: What about the story we hear about the reception centre and people being put into stripped-down cells rather than into wards for care?

Dr NIELSSEN: When I started, the prison hospital used to have a thousand admissions. You could always get a bed there in a short time. The last time I looked at the board only four beds did not have forensic patients in them. So only four beds were available to look after the 20,000 receptions, when some hundreds really should be in an acute psychiatric hospital. That is one of the reasons. They used to come to the prison hospital, but now they have to be looked after in a pod in the MRRC. But every gaol that is receiving patients has this problem of acutely psychotic receptions.

CHAIR: So do they get looked after at Grafton, Goulburn and so on?

Dr NIELSSEN: That is right. Every gaol has a quite large psychiatric burden.

The Hon. PETER BREEN: The problem is that there are no actual facilities, is it not?

The Hon. JOHN HATZISTERGOS: Are we talking about forensic patients?

Dr NIELSSEN: No. I am talking about mentally ill people.

CHAIR: Well, they are forensics, because they are in the prison system and they are mentally ill. They are not declared forensics, as under the Mental Health Act, but they are forensics

given the definition that Dr Nielssen is talking about. How do they get treated in Goulburn, Grafton, Junee and so on?

Dr NIELSSEN: I went to Goulburn recently. There is a quite nice clinic there, and they have a protection area with a developmentally delayed area. The mentally ill mostly get cells with less opportunity to hang oneself, which means less facilities and less privileges.

The Hon. PETER BREEN: Are our people having bad psychotic episodes handcuffed?

Dr NIELSSEN: Restraint is not used very much in the gaol. It can be used, but it is really only used for people who tried to exsanguinate themselves—bleed themselves to death.

The Hon. PETER BREEN: Anecdotally, in Goulburn gaol for example, it is suggested that people who have a psychotic episode are handcuffed, the handcuffs are tied to their waist strap, a stack hat is put on their head so that they will not injure themselves, and they are put in their cells until they get over it. Is that very common?

Dr NIELSSEN: When I was on call I never ordered or permitted that. I think Goulburn has a developmentally delayed unit where they may have had to resort to that kind of thing.

The Hon. PETER BREEN: The figures given to us this morning, from Goulburn for example, suggested that in May 36 registered patients, out of 618 beds, suffered from psychiatric disorders in one form or another. It seemed to me that that figure was extraordinarily low.

Dr NIELSSEN: Yes. They are probably the more acute disorders, I guess, but as you can see, it is a pretty big burden of health care on the correctional system.

The Hon. PETER BREEN: Yes.

CHAIR: Do they have a visiting psychiatrist at Goulburn gaol?

Dr NIELSSEN: They have eight hours per fortnight, I think, and it is nowhere near enough for there.

CHAIR: So what happens between the fortnights?

Dr NIELSSEN: Of course, there are nurses in two shifts. There are a lot of nurses there and some of them have mental health expertise.

CHAIR: So the eight hours per fortnight can be emergency call-back and so on, I assume?

Dr NIELSSEN: No I do not think so. It is a clinic that is done during a whole day each fortnight.

The Hon. JOHN HATZISTERGOS: We have been told that there are visiting medical officers [VMOs].

Dr NIELSSEN: Yes, that is right.

The Hon. JOHN HATZISTERGOS: Is that what you are talking about?

Dr NIELSSEN: No. I am talking about the psychiatrist, Dr McGrath, who goes to Goulburn in particular.

CHAIR: But are there visiting medical officers other than that?

Dr NIELSSEN: Yes.

CHAIR: There are general practitioners, obviously, but are there visiting psychiatrists?

Dr NIELSSEN: No. There is on-call and there is a teleconferencing facility to Goulburn, Bathurst and Grafton. That was the great hope of the Corrections Health Service when we hooked them all up but, of course, you have to have someone at the other end. If there is no-one at the other end, the facility does not make any difference.

The Hon. JOHN HATZISTERGOS: We were told that approximately $32,000 a week is spent on VMOs.

CHAIR: That is across the system.

Dr NIELSSEN: Right. There are 35 gaols .

The Hon. JOHN HATZISTERGOS: It is a fair bit of money.

Dr NIELSSEN: It is, yes.

CHAIR: It is $1,000 per gaol per week. It is 1.2 per cent of the budget. That is what they said.

Dr NIELSSEN: Right. That is not a lot.

CHAIR: But it is still a significant amount. You were saying that there is nobody at the other end.

The Hon. JOHN HATZISTERGOS: We are only talking about medical officers.

CHAIR: We are talking only about visiting medical officers, too, not just staffers.

Dr NIELSSEN: There is almost no staff. There are no staff psychiatrists. Very few staff psychiatrists have stayed for very long. They have been there from time to time.

The Hon. JOHN HATZISTERGOS: That is not true, either, according to this report. It certainly is true that there has been a decline.

CHAIR: He is talking only about the gaols.

The Hon. JOHN HATZISTERGOS: Yes, I know.

CHAIR: The ones at the reception centre are all VMOs and Long Bay is the only other inpatient facility.

The Hon. JOHN HATZISTERGOS: VMOs charge around $152.95 an hour, so I think that $32,000 a week is a fair bit of VMO input at a fairly high rate.

Dr NIELSSEN: Yes.

CHAIR: But there is no staff.

The Hon. JOHN HATZISTERGOS: We are told that staff specialist numbers are in decline to about 38 per cent of the total number of psychiatrists.

Dr NIELSSEN: I would be surprised if it is that much. There are only two that I know of, and one is an administrator—or the other one was the one who left, and that was Dr Quadrio.

The Hon. JOHN HATZISTERGOS: Where are you talking about—which hospital?

CHAIR: He is only talking about the forensics, which is the remand centre, Long Bay and places like that. There are 30 gaols and there are only VMOs in those gaols. Prisons health does not have any staff specialists any more.

The Hon. JOHN HATZISTERGOS: Okay.

CHAIR: You were talking about videoconferencing. You said that there is nobody at the other end. Does that mean that there is no psychiatrist at the other end, or there is no prisoner at the other end?

Dr NIELSSEN: No, there is no psychiatrist at the other end. That is the point. If you are going to provide an extra clinic, you have got to have a psychiatrist ,say, in Sydney for example, who is going to provide it.

CHAIR: So they have not been able to set it up because they have not got people at the Sydney end?

Dr NIELSSEN: Effectively, yes.

CHAIR: Is that because people are not comfortable using the service or because there simply is not anybody who has been attracted to do it?

Dr NIELSSEN: Put it this way: You are talking about having an on-call and someone to cover the times in between. You have got to have someone who is available to cover those times in between so it has never worked as an emergency service. From time to time motivated people have done clinics but I do not think that those clinics have ever turned into a fixed arrangement, which is what they really want.

CHAIR: But the gaols such as Goulburn would have a visiting medical officer, such as a doctor from the community who would come to do all sorts of things like fixing cut fingers and so on.

Dr NIELSSEN: Yes.

CHAIR: They would also assist the nurses in writing prescriptions and whatever under the guidance of the visiting medical officers. Is that the way it works?

Dr NIELSSEN: Yes. They do help a little bit and, as you say, mainly with medication. They have a pretty big burden themselves.

CHAIR: The videoconferencing would help with that gap when the visiting medical officer specialist is not there and the general practitioner might want some expert opinion about where to proceed now. They have got a care plan.

Dr NIELSSEN: Yes.

CHAIR: But if the patient does not conform to the care plan that day and they want some advice and some direction, the videoconference would be suitable for that, would it not?

Dr NIELSSEN: Not if you needed to see the patient. The phone would cover for most doctor to doctor or nurse to doctor consultations or things of that kind. My colleague Jeremy O'Dea goes to Grafton once a month and has, in between, provided two hours of videoconferencing where he is actually seeing the patient and that has worked pretty well, so he is able to increase the frequency, for example, of emergency assessments and initiations of treatment.

CHAIR: That would certainly cut down on the cost of travel, which is a big part of the visits to Coffs Harbour and to Wagga Wagga.

Dr NIELSSEN: Yes.

CHAIR: Yesterday, Dr Carne stated:

> In my experience New South Wales is in breach of the Burdekin report, it is in breach of the Mental Health Act, it is in breach of United Nations Resolution 46/119 and it is in breach of the United Nations standard minimal rules for prisoners. In my opinion New South Wales is acting illegally and in breach of international covenants.

Is that putting it a bit too high, or is that about right?

Dr NIELSSEN: Technically speaking, he is correct. Bearing in mind the conditions under which the mentally ill are housed—in the safe cells with perhaps crash helmets, without the recourse of being transferred to hospital for more intensive care such as 24-hour observation, with the staff in many gaols clocking off at a certain hour and with being kept in a safe cell—that is a cruel and unusual punishment, I think. For 23 hours a day you are in a cell with no television and is no stimulation.

CHAIR: Would that happen in one of our general hospitals or in one of our psychiatric hospitals?

Dr NIELSSEN: Well, there are different rules covering the use of seclusion, and usually it is only short term for more acute people, with constant observation and regular human contact. The lack of proper hospital facilities for the acutely mentally ill in all of the gaols means that they have to be looked after in the only safe environment available, which is the strip cells.

The Hon. PETER BREEN: Also it could be said that the prison officers do not have any training to do anything else except lock them away.

Dr NIELSSEN: Yes. That is one of the reasons that it is so anti-therapeutic, really—it is just a security mentality. There are considerations of how you can manage people better.

The Hon. JOHN HATZISTERGOS: How could one improve it?

Dr NIELSSEN: I think you need to create some kind of therapeutic areas in each gaol, which I think some of the gaols are trying to do, and look for officers who are interested in the therapeutic care of people.

The Hon. JOHN HATZISTERGOS: That does not tell me much. What does one physically do?

Dr NIELSSEN: I think that physically you could start by purpose building some areas where humane care could be provided through being able to give contact and through being able to let people out of their cells. Then you staff them with people who are interested in providing that humane care and not just in locking them up.

The Hon. JOHN HATZISTERGOS: But they are very difficult people.

Dr NIELSSEN: Yes, but that is what we have to do. That is what other countries do and it is what other States do.

The Hon. JOHN HATZISTERGOS: Tell me about that. Tell me what they actually do. What is the physical environment like? How does one recruit these people who are very interested in these very ill other people?

Dr NIELSSEN: I can probably start with the therapeutic units at the gaol that I provide a clinic to, the metropolitan special purpose centre [MSPC]. They have the Kevin Waller Unit which houses approximately 12 inmates and that is meant to deal with people who have severe personality disorders, who tend to self-mutilate, and who are self-defeating in various ways, and they are often aggressive. That is 12 for 8,000 prisoners whereas in Holland the number of beds for people with severe personality disorders in that system, which is also about 8,000 for a population of 15 million—that is Holland's gaol population for 15 million—is 600. We are offering 12 for an equivalent number of prisoners whereas they are offering 600.

If I take us to Britain, which is highly equivalent, a lot of our prison officers are ex-British Army types and they are terrific because they are mature and they are turn-the-other-cheek types of blokes. Britain's therapeutic gaols seem to recruit a mature and therapy-minded officer officer from the general officers ranks. I am thinking of Grendon Underwood, which is a fantastic gaol for sex offenders and a group-therapy based gaol for larger numbers of prisoners, not just 12 but 200. I think

we probably need more therapeutic units of different kinds. We just have too few. We have a violence prevention program but it is only for a small number and we have acute care units which are only for stopping people from committing suicide. We probably need a lot more and better facilities for them.

The Hon. JOHN HATZISTERGOS: Are there any interstate examples that you want to draw our attention to?

Dr NIELSSEN: I think the interstate examples that are in every other State forensic patients are removed from gaols to hospitals. Certainly I know that that is the case in South Australia, in Victoria and in Queensland. Once you are scheduled as a forensic patient and you are transferred into a health front facility. You might have an officer on the gate to check on warrants and so forth, but the personnel inside are all health personnel. New South Wales is the odd one out in Australia and throughout the OECD by doing it all inside gaol.

The Hon. JOHN HATZISTERGOS: That is what you want to change?

Dr NIELSSEN: I think that is where Dr Carne is telling the truth, yes. We should be having a health-run mental health service. But, even so, there will be people who will have to be looked after within gaols. They need purpose-run facilities of the kind I mentioned—properly designed and properly staffed.

CHAIR: There is a distinction between someone who is mentally ill in the sense of being scheduled and someone who has a mental illness and who happens to be in prison, is there not?

Dr NIELSSEN: Yes. Obviously, some have to be looked after in gaol. You cannot transfer the whole lot.

CHAIR: No.

Dr NIELSSEN: Also, some of them deserve to be in gaol. I do not mean to say that they are all vulnerable. There is a sliding scale of responsibility. Some are just totally disabled but others are quite responsible.

CHAIR: What about the 10 per cent who go in with IQs of less than 85? Of the reception people who come through—I think there are 20,000 a year—Dr Matthews said that about 10 per cent have IQs of less than 85.

Dr NIELSSEN: I disagree with those figures. Because of the way IQ is measured, there is a cultural bias towards people who have had formal education in an IQ test.

CHAIR: I notice that two per cent of those who go through the prison system do not have any formal education whatsoever.

Dr NIELSSEN: I am actually always amazed at the literacy and subcultural general knowledge of prisoners, you see. I apply my own IQ test which is to ask if they know how many grams there are in an ounce, how many years you can get at a Local Court, for under 25s, the size of Subaru engines and for over 25s the size of Holden V8s. Then there will be football and other general knowledge, such as crime stories and so on. If you use the subcultural IQ test, they do not seem to be quite so dim. I am also amazed at how well they can read and write, considering the figures you get. Twenty per cent are supposed to be retarded, according to Professor Hayes, but I do not find that. You are looking at an undereducated and underprivileged group of people.

CHAIR: But it is only two per cent who have not been to school, though. He did make the comment that the vast majority had been to school until aged 15, and he added the proviso of the Wechsler test.

Dr NIELSSEN: Yes, that is the Wechsler adult intelligent scale [WAIS].

CHAIR: There are shortcomings with that test, as you clearly point out. You say that that 10 per cent figure is a little bit of an overestimate?

Dr NIELSSEN: Yes, I think so. They have got subcultural skills. A lot of them have had a bit of education in institutions, in juvenile justice and in gaol.

CHAIR: We will come to juvenile justice. What about kids who are mentally ill? In the juvenile justice system, what access is there for them to mental health care in a mental hospital?

Dr NIELSSEN: I do not know much about it. Formal mental illness, such as schizophrenia and manic depression, are much less common the younger you are. It is rare amongst children and it is less common amongst teenagers. The most common onset of schizophrenia is in the first five years of adult life. So it is less common. They have visiting psychiatrists. Overall, the facilities are nice. I have seen a couple of people with schizophrenia at Kariong.

CHAIR: Are they are still in prison?

Dr NIELSSEN: They are still in the juvenile justice centres, which are generally better physically.

The Hon. PETER BREEN: Some of the juvenile justice centres have been closed. Is that right?

Dr NIELSSEN: I am not sure about that. That is not my area. I do reports from time to time.

CHAIR: The one at Tamworth was closed and reopened as an adult prison.

The Hon. PETER BREEN: I am wondering whether there is the same shortage of beds in juvenile institutions as there are in adult institutions?

Dr NIELSSEN: I do not know actually. I know the psychiatrists who do the clinics there—Dr Walker, Dr Adler and Dr Weaver. They are some of the psychiatrists who perform at those clinics. So they do have mental health services.

CHAIR: What about a dual diagnosis—drugs and alcohol and mental illness. Can you tell us a bit about that and what number of people are affected? There seems to be a rising number of people who are declared to be forensic by the Mental Health Review Tribunal.

Dr NIELSSEN: It is universal. Almost all the mentally ill in gaol have some kind of drug and alcohol problem. The problem is amphetamines. Last year amphetamines overtook heroin as the most common drug taken by people entering gaols. We know that amphetamines exacerbate existing mental illnesses. We do not know whether it causes mental illness, but we know that it makes someone with an existing mental illness worse. It makes those patients a lot more difficult to manage.

The Hon. JOHN HATZISTERGOS: Is that because of the heroin drought?

Dr NIELSSEN: I think it is a combination. The heroin population is already ageing. It is just social changes and availability of amphetamines.

CHAIR: So what access is there? Let us say, for example, that someone who is in prison has been diagnosed as having a mental illness which is exacerbated by drug taking. In other words, they have both problems. They are pretty easy to handle in the prison service but when they get outside what access is there to rehabilitation services?

Dr NIELSSEN: Again, it is an identified need. The access is not that great. There are some terrific programs like the Endeavour Program which is run by the Salvation Army. I think that that has about 80 beds, but that is a long-term rehabilitation service for dual diagnosis. I think that every psychiatrist in any setting is conscious of the problems of substance abuse. You need special facilities for people with dual diagnosis. You need closer supervision, if you like. You need to be able to check on their drug use, through urine drug screens or whatever new technology becomes available, and you need to sanction them if they are not adhering to a commitment to stay off drugs. We know that it makes them worse, and we know that it causes them to reoffend.

CHAIR: The rehabilitation service of which I am most aware is the Buttery up on the North Coast. That services asks people, on entry, to sign up for a year. There is detoxification first, then they come in and they sign up for a year. That is consistent with a year at Binna Burra, which is near Bangalow. Then they go to live in some sort of community house, supported accommodation, or partly supervised accommodation in Byron Bay. If people coming out of prison are to receive that sort of support to get fully rehabilitated, they need long-term supported accommodation-type rehabilitation programs. There do not seem to be a lot of those around.

Dr NIELSSEN: I have never had any trouble getting people into short-term rehabilitation but, of course, staying is usually voluntary. They are not locked away in any way, which is how it should be. There are enough rehabilitation beds. Perhaps there could be some more purpose-run centres for dual diagnosis because they do need some psychiatric input. You need to be managing their psychiatric disorders properly. It will also need to be metropolitan because not a lot of psychiatrists are living in the country. Most of the long-term rehabilitation services are rural based.

CHAIR: We heard about another issue yesterday. The police pick up someone in the street, for various reasons. Using section 24 the police take that person to St Vincent's Hospital, St George, or whatever. We were told yesterday that quite often the registrar says, "We would really like to schedule this person, but we do not have a bed." Or the registrar might say, "If we have to take this person we will have to discharge somebody." Registrars spend a long time on the phone while the police are sitting outside. The police are then asked to cart someone off to Nepean. How often does that happen? Is that an uncommon scenario, or does that happen regularly?

Dr NIELSSEN: It has been a while since I worked in that kind of service. I have been teaching registrars for the last 10 years and they all tell me that that is the bane of their life. It is great if a you have a bed to admit someone. If you are full and you get someone in who needs to be admitted you have to do the responsible thing and find a bed. That is very hard. I noticed it particularly in relation to section 33 transfers from court to hospitals. That occurs at the end of a court day.

CHAIR: At 4.30 p.m.

Dr NIELSSEN: Exactly. Most discharges from hospitals occur first thing in the morning, so there is never a bed. Transfers of people under those conditions hardly ever happen.

The Hon. PETER BREEN: Presumably they go back to court?

Dr NIELSSEN: They go back to court and they go into custody.

CHAIR: That is exactly the point. They go back to court. Yesterday Dr Carne said that the magistrates are then pressured into finding that these people are not mentally ill so they have to go back to cells rather than have the court go through the hassle of finding a bed.

Dr NIELSSEN: That is right. The court does not have the skills do to do that. The Court Liaison Service sometimes rings up and smooths the way. They probably need to change the legislation. That is in train anyway to make transfer elective.

CHAIR: We have not seen that legislation.

Dr NIELSSEN: They are hoping to make some amendments to the Mental Health (Criminal Procedure) Act.

CHAIR: When is that supposed to occur?

Dr NIELSSEN: I thought that it was in the spring session of Parliament.

CHAIR: That would occur after consultation with some stakeholders?

Dr NIELSSEN: No, I do not think so. I have been involved in a committee that has been looking at it. It covers fitness for trial and it also covers Local Court provisions for the mentally ill.

CHAIR: Have you had discussions about the provision of bail hostels for court diversion?

Dr NIELSSEN: Yes, not for the mentally ill but for other people. I have heard that they have been helpful. I have a colleague in Birmingham, who I saw a couple of weeks ago, who is running a mentally ill bail hostel which is very successful. It would be a welcome initiative. If you look at the WorkCover problems of providing formal hospital-type care, you are looking for any non-government or less labour intensive-type facilities that might help.

CHAIR: We were told this morning—something that surprised me although it was in the impact statement when the bill was introduced—that it is expected that the number of people who are held on bail will increase from 15,000 to 24,000. That is because of the changes to the Bail Act. If you have been before the courts a number of times there is a presumption against bail.

Dr NIELSSEN: Yes.

The Hon. JOHN HATZISTERGOS: No. It is removing the presumption in favour of bail.

CHAIR: That is right.

The Hon. JOHN HATZISTERGOS: For a certain category of offenders.

CHAIR: The magistrate still has to make a judgment on the same principles, does he not?

The Hon. JOHN HATZISTERGOS: He does, but there is no presumption in favour of bail. It is a mutual position. It is neither in favour nor against. The magistrate then has to exercise his discretion.

CHAIR: If it is expected that that number will go up dramatically as a result of changes to the Bail Act—I do not think that it will make such a difference—people who are homeless and who do not have somewhere to go will be able to go to these bail hostels. That would help a lot of homeless and mentally ill people. Have there been any discussions about that issue as far as you are aware?

Dr NIELSSEN: No, I have not heard of any. It is a terrific idea. I would love to be involved if anyone is going to put up the money to buy a building or start the service. The mentally ill will be the people who will be refused bail. They already are refused bail, but they will be refused bail more and more because they are repeat minor offenders. They are inept and they cannot be relied upon to stick to bail conditions.

CHAIR: If the Attorney General expects this number to increase dramatically you think that would occur in particular in the area of the mentally ill?

Dr NIELSSEN: They will be more affected than other people.

CHAIR: So more mentally ill people will be going to gaol?

Dr NIELSSEN: I have noticed even now with existing bail provisions that they have trouble making bail, particularly for, say, breaches of apprehended violence orders. That is a common scenario. Family members are the people who would have to put up bail, yet they are scared of them. It also requires some social skills to organise it in other ways—skills which the mentally ill often lack.

CHAIR: Do you think that the Centre for Mental Health should have more organisational control rather than just policy control over area health services?

Dr NIELSSEN: I thought they already were strongly in control.

CHAIR: They are not in control of the budgets. That is the evidence that we have. Area health services still have control of their own budgets. The Centre for Mental Health can give them

grants for special purposes but, generally speaking, they still have to account for the mental health budget that goes to the areas. Those budgets are meant to be quarantined and so on. Do you think that the Centre for Mental Health could play a better role in backing up policy, or do you think the area health services are fairly responsible?

Dr NIELSSEN: I am not an expert in it. I have heard—and it is only gossip—that mental health funds are not quarantined and they tend to leak away. If they stopped that from happening, if it is happening, that would be a good thing.

CHAIR: If there is anything that you think we have misunderstood or that you would like to clarify, please let us know. At some stage later in the inquiry we might pass on some recommendations to you to determine whether or not they are good or bad ideas, worthy of support or practical. Would you be happy to do that?

Dr NIELSSEN: Yes, thank you.

(The witness withdrew)

ROBERT JOHN WHEELER, Solicitor, Mental Health Advocacy Service, 74-76 Burwood Road, Burwood, and

NIHAL HANIFE DANIS, Solicitor, Mental Health Advocacy Service, 74-76 Burwood Road, Burwood, affirmed and examined:

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

Mr WHEELER: Yes, I am.

Ms DANIS: Yes, I am.

CHAIR: Your submission was received by the Committee on 22 April. Would you like that submission to form part of your sworn evidence?

Mr WHEELER: Yes.

CHAIR: Ms Danis, are you aware of the submission made by Mr Wheeler?

Ms DANIS: Yes, I am.

CHAIR: If either of you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request. However, the Legislative Council may overturn the Committee's decision and make the evidence public. Would you like to speak to your submission and outline your concerns with regard to the terms of reference?

Mr WHEELER: The matters I have raised in the submission are all critical of the system and point out matters that I believe are defects. Hopefully, as a result of this inquiry, those defects might be improved. In doing that, it was not my intention to indicate that I think that the overall mental health system, particularly those who are working within it, provides poor service on every occasion.

I think a lot of the elements of the design of the system are good, particularly the focus on providing community treatment where possible and on providing acute hospital care in a range of community hospitals rather than simply stand-alone psychiatric facilities. It provides more widespread access than in the institutions that were largely city based. I think it is much less stigmatising for people to perhaps have an admission to Hornsby Hospital or Sutherland Hospital than hospitals that are clearly identified as psychiatric hospitals, such as Cumberland and Rozelle.

There is frequently an issue about the lack of placements in link care and beds at a number of levels, but when those beds have been made available, on the whole the treatment that is provided is both professional and compassionate. Similarly with community health services. Again, there is frequently a problem with getting people a case manager, but where there is a case manager involved they go to considerable efforts to maintain their clients out of the hospital system and follow them up quite assertively on many occasions.

Many of the people working in the community I have seen go beyond the scope of their day-to-day client care jobs to do things like organise after-hours education for their clients and the relatives of their clients. The criticism I want to make relates to the lack of facilities at each of those stages a lot of the time, rather than about the people working in those facilities.

CHAIR: Your service is identified in the Act as the Advocacy Service, is it not?

Mr WHEELER: That is correct.

CHAIR: So you would have frequent contact with patients, and you would be a person that patients would see as someone they could complain to if they think there is a problem?

Mr WHEELER: Certainly to a large extent, that is true.

CHAIR: So you would be in a position to have some passionate and dispassionate view of the services that are offered, which you have just spoken about?

Mr WHEELER: I think so, yes.

CHAIR: And you get that feedback from your agents around the State?

Mr WHEELER: That is correct. I wish to speak a little more about what the Advocacy Service does, as opposed to the rest of the Legal Aid Commission. We are responsible for providing representation to the patients at all the magistrates hearings that take place throughout the State. That is through a combination of our in-house solicitors, other legal aid solicitors at regional offices, and also through solicitors and barristers in private practice who act on assignment to go to the hospitals.

CHAIR: How is the service funded?

Mr WHEELER: It is part of the Legal Aid Commission.

CHAIR: So it is funded by the Attorney General's Department?

Mr WHEELER: Yes.

The Hon. PETER BREEN: The Federal Attorney-General's Department?

Mr WHEELER: No. As I understand it, the NSW Government is funding it now. The Legal Aid Commission was a result of a merger of a number of State bodies plus the Australian Legal Aid Office. I understand that under the current Federal Government the merger has split, so we are now State Government-funded. We receive some funding from the Law Society through the management of trust accounts, and the Federal Government contracts to the Legal Aid Commission for the services it wants us to provide. But the majority of the funding comes from the State Government through the Attorney General's Department, as I understand it.

CHAIR: All the services would be funded by the State Government, is that right?

Mr WHEELER: Yes.

CHAIR: Would a repatriation person be funded by the Commonwealth, or still funded by you?

Mr WHEELER: They would still be funded by us. There is not that separation. In the documents that we complete, there is a box you tick as to whether a person is a former member of the defence forces. At some point that may be included in the statistics and readjusted. But we go out and provide representation for these people.

CHAIR: What does the service cost?

Mr WHEELER: It is about $1.2 million a year.

CHAIR: How many magistrates hearings are there?

Mr WHEELER: For the combination of the magistrates and all the mental health review tribunal hearings, the statistics I have indicate 16,000 occasions of service. I looked at that before coming here today because that is the figure I have quoted, and it seems very high.

CHAIR: It could be the same person a number of times?

Mr WHEELER: It could be the same person. Quite frequently someone going before a magistrate will have a number of adjournments, rather than an order being made, and each

representation is counted. We provide a telephone service as well as a face-to-face advisory service at the office. I think it takes into account the telephone advisory service as well.

CHAIR: Do you contract that service to local solicitors in smaller towns such as Grafton and Lismore, or do you have an agent there?

Mr WHEELER: There is not a psychiatric hospital at Grafton. There is a Legal Aid Commission office at Lismore. There is a psychiatric hospital at Goulburn, and there are about three solicitors on the roster who go out on each occasion.

CHAIR: With the establishment of the new beds, such as at Taree, Coffs Harbour and Tweed Heads, would you have a legal officer in those towns?

Mr WHEELER: Taree is the most recent one. We have started providing services to them in the last month or six weeks. We have arranged a roster of local private practitioners to go to the Taree Base Hospital. Coffs Harbour has been up and running for quite a few years now.

CHAIR: What about Tweed Heads, which is new?

Mr WHEELER: We have not done anything with Tweed Heads yet. When Coffs Harbour was set up, there was not a Legal Aid Commission office and we had a very large roster of private practitioners at Coffs Harbour. There has been a Legal Aid Commission office up there for something like four or five years. Most of the representation is done in-house, but if the office is not able to provide service local practitioners are used as well.

CHAIR: What about Kempsey and Port Macquarie?

Mr WHEELER: There are no hearings at Kempsey or Port Macquarie.

CHAIR: But, generally speaking, you provide a service in the major towns or you have arrangements made?

Mr WHEELER: Yes. Under the Mental Health Act we are required to make arrangements for everybody going before the magistrates. We have been doing that since the current Mental Health Act came into force in 1990. The service itself was originally set up in 1986. Prior to that we did not cover every magistrate's hearing but we covered it if we could.

CHAIR: How many magistrates hearings would there be in one year?

Mr WHEELER: Thousands. It would be about 100 a week, statewide. It would be about 5,000 a year.

CHAIR: You get caught up in the argument about whether a person is mentally ill?

Mr WHEELER: Yes.

CHAIR: That dictates whether the person ends up in the gaol system or the health system?

Mr WHEELER: Not really. At the point that that argument is taking place, it dictates whether they remain in the health system or they walk out the door and go back to whatever they had in place before. The issue about whether they remain in the gaol system or the health system is something I did want to address particularly. If someone fronts up at the Local Court and appears to the magistrate to be mentally ill, under section 33 of the Mental Health (Criminal Procedure) Act the magistrate has the discretion to refer them to the hospital for assessment and admission.

If the hospital finds the person to be mentally ill, they are admitted, they go before the magistrate at the hospital, and the magistrate may adjourn the matter or make an order detaining the person. The magistrate may make an order releasing the person on a community treatment order, or may discharge the person. The decision about whether they stay in hospital or go back to court is

made before the magistrate sees the person at hospital; it is made during the assessment process at the time of the person's arrival at the hospital.

CHAIR: The magistrate orders the assessment, the assessment is done, and if the person is to be admitted as an involuntary patient there is a separate hearing for that?

Mr WHEELER: At the hospital, yes.

CHAIR: Each year there are 5,000 referrals?

Mr WHEELER: Not all from the court. They are the hearings that take place at hospitals.

CHAIR: I am referring to section 33 referrals. You have to go to those, and you have to go to the ones at the hospital. But they are not section 33 referrals, are they?

Mr WHEELER: No. We do not appear at the Local Court at the time that the section 33 referral is made. That appearance is done by the duty solicitors appearing at each of the Local Courts. We only appear at the hearings at the hospitals.

CHAIR: Each year there are 5,000 of those referrals?

Mr WHEELER: Approximately, yes. At Rozelle hospital, there are about 20 a week, and something similar at Newcastle.

CHAIR: There has been an increase in the number of section 24 referrals by police to the health system, quite a drop in the number of section 22 referrals by general practitioners as a result of police intervention, and a higher incidence of section 22 referrals. Can you tell us whether there has been a change in those numbers in the last two or three years?

Mr WHEELER: The numbers have increased. I think the increase is 8 or 9 per cent a year, and that has been pretty steady.

CHAIR: Is that since 1996 or before 1996?

Mr WHEELER: I think that has been fairly consistent since 1990 or something like that.

CHAIR: Is it possible for the Committee to see what the numbers are?

Mr WHEELER: I could produce what I am able to, yes.

CHAIR: We have graphs from the department in relation to section 24 and section 22 referrals, which show a major change since 1996. Do you see any correlation there.

Mr WHEELER: We do not keep the statistics of section 22 or section 24 referrals. But I could produce some figures, such as our system is capable of producing, of the actual numbers of hearings.

CHAIR: Would you like to go through the submission? You have already identified a few problems. The first is the integration of mental health services involving community participation.

Mr WHEELER: The first issue I have talked about here, and I think it is fairly clear from Dr Nielssen's evidence earlier that this is not new, is that we identified a problem with people after a period in prison being linked back with mental health services. There seems to be a lack of a formal structure to do that so frequently if they have not been identified in prison as being mentally ill, and even if they have, the link up between the community health centres and the prison does not seem to take place on any sort of regular basis. Sometimes it works well if somebody gets transferred across, even if they are serving a term of imprisonment, to become a forensic patient. The system allows a forensic patient in the last six months of their sentence to be reclassified as what is called a continued treatment patient. Those people then can make that next step on to a community treatment order [CTO]. So, if somebody is actually identified, whilst serving a term of imprisonment, as being

mentally ill and is made a formal forensic patient by that transfer process, they may pick up some ongoing supervision in the community. But I think that is a fairly small proportion of people who get admitted to prison with a mental illness.

CHAIR: Before somebody gets a CTO, does your organisation get involved in representing them?

Mr WHEELER: Yes, generally. There are two paths by which somebody might be placed on a CTO. One is at the magistrate's hearing, and we appear in all of those. The other is after a period in hospital. If the magistrate makes an order detaining somebody in hospital as a temporary patient, prior to the expiration of that order he can be brought before the Mental Health Review Tribunal and the Mental Health Review Tribunal can discharge the patient on a community treatment order.

CHAIR: And you have to represent them there too?

Mr WHEELER: No, we do not at that point.

CHAIR: So you think there is a bit of a problem because they go out and if there is no treatment order they go back in again?

Mr WHEELER: Yes. And I do not think there necessarily needs to be an order with every person but if there is not even a link up with the community health centre, I or a case manager will follow them up. I did make some inquiries with the Corrections Health Service about whether it tries to make that link up, and the advice I was given was that they often do but they are often not very successful in arranging it.

CHAIR: So you have a couple of examples there that are fairly florid examples.

Mr WHEELER: They are, and I think they are examples of a specific problem that maybe does not arise all that frequently, where somebody is not even released at the end of their sentence but has been released from court, and there has not necessarily been an understanding from the Department of Corrective Services or Corrections Health that they are about to be released.

CHAIR: But there must be some spectacular successes as well as spectacular failures? Dr Nielssen just said that this is sometimes the only place where some of the mentally ill have ever had a chance to be properly treated.

Mr WHEELER: I think there are and I think the ones where there are spectacular successes are generally those who have been identified as forensic patients. The route to be a forensic patient is either a not guilty by reason of mental illness finding, a limited guilt finding at a special hearing or, while serving a period of imprisonment, being transferred across to the hospital system, which normally is the prison hospital first of all, for a period, which is often up to the balance of the term of imprisonment. For those people, frequently the first part of the path is to the prison hospital. The next step for most of them is to the Bunya unit at Cumberland Hospital or the Kestrel unit at Morisset Hospital, which are both referred to as medium-secure units. That is a relative term. They are certainly very secure, perhaps not to professional security-type eyes. The treatment may go for some period and then normally if the person continues to progress well, they will be transferred to cottage-type accommodation in grounds of one of the hospitals, Rozelle or Macquarie—Goulburn also provides some of that type of accommodation—and ultimately transferred to living in the community, either independently with supervision from the Community Health Centre or some sort of supervised community accommodation first time.

CHAIR: They could in fact serve the bulk—if it is a 10-year term—six years in the community?

Mr WHEELER: They could, although generally if they actually got a sentence they are not going to get out that early in the sentence. The Attorney General also has a right to object to release on the basis that the person has served insufficient time in custody.

CHAIR: So has the Government.

Mr WHEELER: Yes. I guess the Mental Health Review Tribunal and the Government and the Attorney General take the view that if somebody has a long period as a sentence, then they are not going to recommend that conditional release early in the piece. It does not seem to happen very frequently. Where you can get that, with the system acting very humanely, is if somebody has been found not guilty by reason of mental illness, where there is no fixed term. If they respond well to treatment and particularly if their illness is not further complicated by drug abuse, the system can work very well. A while ago I acted for a lady who is not mentioned in this submission who was found not guilty by reason of mental illness of having killed one of her children in fairly tragic circumstances. Fortunately she was never in prison. She was taken to Rozelle Hospital initially and then Cumberland Hospital and then found not guilty by reason of mental illness. She was returned to Cumberland Hospital and in fairly short time was transferred into one of the cottages. She spent—I cannot remember exactly—about three or four years under supervision in the cottages and was ultimately transferred to Department of Housing accommodation, I think—certainly rental accommodation. After a number of years follow-up by the community health centre she has now been unconditionally released.

CHAIR: We often get the examples of the stunning failures. That is an example of a great success. You have a patient alive at the end of the day who is enjoying life, having got past her guilt and self-harm and all that stuff.

Mr WHEELER: Absolutely.

CHAIR: So you have a lack of statewide forensic medical service?

Mr WHEELER: Yes. The difficulty I see with that is the co-ordination between each of those steps. Referrals to each step along the way are generally made by solicitors working with our service. Corrections Health has decided to a large extent that it is not really appropriate but normally a referral from somebody in the Long Bay prison hospital to Rozelle or Macquarie or Cumberland will be put together by Miss Danis or one of her colleagues.

CHAIR: So you are advocates for moving from what is an inappropriate therapeutic area to a more appropriate therapeutic area?

Mr WHEELER: Absolutely, yes.

CHAIR: You do that in a proactive way on behalf of what are really your clients?

Ms DANIS: Yes, that is what we do.

CHAIR: But it does not seem to be initiated from the other side?

Mr WHEELER: Not very much.

Ms DANIS: These days it is becoming more so, hospitals are making referrals.

CHAIR: A section of the Act allows the doctor at the hospital to go to the department and say move him or her.

Ms DANIS: It does not get acted on very much.

CHAIR: No, it does not. That is the point. If they were more proactive they could do that themselves.

Mr WHEELER: Yes. I would have to check the section you are referring to. There is certainly a provision that allows for transfer between hospitals of temporary patients and continued treatment patients, which are the civilly detained patients. The normal path for transfer from prison hospital to a community hospital and from a community hospital to a more secure ward and from that to the community generally is done and intended to be done on the recommendation of the Mental Health Review Tribunal. There is provision for the—

CHAIR: But you kick this process off a bit?

Mr WHEELER: Yes.

CHAIR: Is that because you visit or because you think he or she has been there long enough? It is a big problem for the women, is it not?

Ms DANIS: Of getting out of—

CHAIR: No, of mental illness plus admission to hospital. There is a higher percentage of women who are forensic than men of the people who go to prison?

Mr WHEELER: I do not think that is right. The vast majority of forensic patients are men.

CHAIR: Are they?

Ms DANIS: Yes.

CHAIR: Did they not say this morning that of the people who had psychosis in the previous 12 months, women were a higher percentage?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, a higher percentage of women had psychosis than men had psychosis, but there is still a lot more men than women.

CHAIR: In prison yes, but percentagewise.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The women percentage, you are right, it was higher than the men percentage.

Ms DANIS: Is someone saying that they present in a more acute state?

CHAIR: Yes.

Ms DANIS: That may well be.

CHAIR: No, sorry, within the previous 12 months.

The Hon. AMANDA FAZIO: Who exhibited that behaviour within the previous 12 months.

CHAIR: That is right. So there were more women who had a mental illness in the 12 months before they go into prison than men, as a percentage. That is what he said this morning.

Mr WHEELER: That may be so but I do not think we have the knowledge to answer that. What we said is that there are far more male forensic patients than female forensic patients.

CHAIR: Yes. But how do you work it out? Do you visit?

Ms DANIS: We do. We visit every forensic patient as soon as they become forensic. If they are found not guilty by reason of mental illness, they generally end up at Long Bay prison hospital. If they are lucky enough they might end up in a community hospital, and we visit them at the community hospital. We take instructions. As soon as they are finished with their trial we will contact them. If Legal Aid has represented them we will have some referral from them or the hospital will let us know that there is a new forensic patient who needs representation, and we just know when people come into the system.

CHAIR: You say you take instructions. We have some evidence that says they do not even know how to make the bed, let alone give instructions about their ongoing care. What sort of instructions do you get?

Ms DANIS: That is not entirely true. By the time we get to see some of these people they are reported to be better functioning than the majority of the population in prison. I saw a chap this week who is in Rozelle Hospital, some 16 months after the offence occurred. He has been undergoing treatment for all of that time. He is now as well as he is going to be for the rest of his life. He was perfectly okay to be able to instruct me.

CHAIR: Do you take any notice of relatives?

Ms DANIS: Yes, we do.

Mr WHEELER: Yes. There are a number of issues with that. The patients are our clients, the relatives are not our clients. Sometimes relatives are very supportive and wish to assist in providing care and accommodation, and sometimes they are exactly the opposite.

CHAIR: Like relatives all over the world.

Mr WHEELER: I think that is right. Essentially, if our client is instructing us that they wish to progress through the system to somewhere less secure or to commission a release, or whatever, and the relatives are opposing that, it is not for us to temper our instructions. It is certainly something that the tribunal is required to take into account, and I believe it maintains a victim's register.

The Hon. AMANDA FAZIO: We have had put to us that it might be better for people if there was a capacity for them to nominate a family member or some other person to be a carer or advocate, somebody to look out for their best interests during their, hopefully, progression through the system and going back out to live in the community.

CHAIR: That was in circumstances where the person was at a stage where they could not make a decision themselves.

The Hon. AMANDA FAZIO: There are two aspects to that that I would like to get your comments on: whether you think that would be a good system and how it might come about without impinging on the personal liberties of the person with the mental health problem and, secondly, how it operates within your system now. Whether the client of your service has to nominate somebody or whether you will talk to family members without the okay of the client of your service?

Mr WHEELER: Generally, we would not be talking to family members without the approval of the client. If there is approval of the client, and the family and the client appear to have the same sorts of desires and interests, then we certainly get assistance from relatives, and quite frequently, in arranging, particularly further down the track, release-type plans. The final stage of finding accommodation outside the hospital system is probably the hardest one. I do not see how that system of taking some direction from the relatives could be put in place, certainly over the objection of the client. Maybe if the client was unable to give instructions, then an informal arrangement may be successful.

CHAIR: Would it be helpful sometimes to have not a living will but a continuing care arrangement. I have just signed one to give my wife power over me if I am incapacitated. Such arrangements are not uncommon. The document does not have living will in it but that is what people use for their living wills. Will it help mentally ill people who will obviously decompensate from time to time, if they had this continuing—what is it called?

Mr WHEELER: Enduring guardianship.

CHAIR: Will it help if they had enduring guardianship? The document says, "If I am unable to make the decision myself, then [this person] should make the decision." It costs nothing.

Mr WHEELER: I think that would be useful for people's treatment as they decompensate. I do not see how that sort of provision could be put in place before dealing with the criminal justice system.

CHAIR: No, but it could help people who have problems with the criminal justice system. It could help when they decompensate and when their relatives turn up at the hospital and say, "Treat him." Currently, they are totally able to be ignored.

Ms DANIS: If such a document had any power or any force in being able perhaps to allow people to get that assistance, it may work for those who are out in the community and who may go back into their cycle of decompensation.

CHAIR: Sure, but it is not necessarily while ever you are there.

Mr WHEELER: No, it is a change in legal concept. At the moment we have a system which says if you are over this bar and you are a mentally ill person, you can be treated against your wishes. That is defined in terms of symptoms and consequence. If you are not, you can walk. It may be possible for someone to say, "If I give a direction while I am well that I am prepared to accept involuntary treatment even though I don't fit within the definition of mentally ill person". You still need to get some sort of external assessment as to whether the person has deteriorated to the stage where the decision-making responsibility goes to someone else.

CHAIR: We have talked about you going to see them and access to the least restricted circumstances. If you go in there and say that a person should be in the Bunya unit or the Kestrels unit at Morissette, what do you do if they say, "No, sorry, all full"?

Ms DANIS: They end up staying at Long Bay.

CHAIR: Is that not in breach of the Act?

Ms DANIS: It is for me. I do not think it is appropriate for a lot of these people.

CHAIR: No, I asked whether it is in breach of the Act that they are held in such secure circumstances when they do not need to be in such secure and restrictive circumstances.

Ms DANIS: I am not sure whether it is in breach. Certainly, it is against the aim of the Act.

Mr WHEELER: It is perhaps in breach of the objects that say that the intention of the Act is the person—

CHAIR: Have you ever taken an action on behalf of one of your clients to force the issue?

Ms DANIS: We have forced the issue before the tribunal. We have not taken it to the Supreme Court.

CHAIR: Have you thought of doing so?

Ms DANIS: All the time.

CHAIR: What stops you? We have evidence from Dr Carne, who said that they are in breach of the Burdekin report, the Mental Health Act, the United Nations resolution and the United Nations standards of minimal rules for prisoners. In Dr Carne's opinion, New South Wales is acting illegally and is in breach of international covenants, the Mental Health Act and the Burdekin report. That is what he said yesterday.

Mr WHEELER: It is difficult to determine whether those things provide a remedy or not. Certainly, we did seek advice in relation to the international covenant with one particular client which in the end did not progress anywhere. But, no, we have not done that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could the advice be that in fact the Corrections is being a good samaritan in the absence of an available bed?

CHAIR: I am talking about forensic patients who are in ward A at Long Bay who, in everyone's opinion, should be in the Kestrel unit or in a lower security, better physical facility with

more access to education, rehabilitation, all sorts of things. It is the judgment of everyone that the person should go to the Kestrel unit but it is full. You must then comply with the resources provided by the department. You have not actually pushed the envelope to say why you think there should be more resources. Page three of your submission is all about long waits in inappropriate places, those sorts of things. Do you think that as you covered by the Act you should be pushing it a bit harder?

Mr WHEELER: It is not that we have not looked at it. We have not been convinced that there has been a remedy available. I am certainly not suggesting that that is a sufficient reason for not getting further advise and for not pushing it. I think that our own resource issues perhaps come into it as well. The work that is involved in trying to do what we are required to do in terms of providing representation to each of the people going before magistrates' hearings and each of the people going before the tribunal, in the end has become our principal priority. A lot of the time I think we have attempted to work with the tribunal as well to try to get around practical problems, to try to look at alternatives.

CHAIR: It goes further. The commission's solicitors are invariably told that there is a chronic undersupply of cottage accommodation. So when the Mental Health Review Team says that the person should move out of the Kestrel unit and into a cottage, what do you do when you are told that there are no beds? The commission has a hearing and recommends that the patient is now ready for a cottage or a further step out into the community from a cottage—that is the recommendation of the Mental Health Review Tribunal—it is signed off by the Minister, the Minister goes to the Government and Governor in Council and it is signed off by the Governor, what do you do when you are told that the patients cannot be moved because there are no beds available?

Mr WHEELER: It does not really get to that point because you do not get the recommendation from the tribunal and the sign off from the Minister.

CHAIR: So the tribunal actually has a look to see whether the resources are available—do not make a decision about the patient's welfare but make the decision with a clear eye on what is available.

The Hon. AMANDA FAZIO: Is that not a question better asked of the Mental Health Review Tribunal?

CHAIR: We will, but these people do talks.

Ms DANIS: Not really. We make referrals to hospitals, which then make assessments. Depending on the assessment, we put the matter of a person's transfer to a particular place before the tribunal. It takes some period of time for the approval to come through and by then, if the tribunal has made the recommendation for that transfer, then the hospital looks at being prepared for that person eventually to come into their care and somewhere along the way it will provide a bed for that person.

CHAIR: But the Act states that someone should be treated in the least restrictive environment. You are the advocate, and the person is then assessed as to whether they could be handled in such an environment. Someone might say, "I've got a bed and therefore I might be able to take him". Do you see the difference?

Ms DANIS: The assessment is usually about whether or not the person can go to a particular facility. It is not about where else they can go; it is about whether they can go to that facility.

The Hon. AMANDA FAZIO: If the particular facility is not available, presumably you have some sort of follow-up resubmit system where you will keep pursuing the best outcome for that client of yours.

Ms DANIS: You try every other facility that can take them on, and you go from a medium security unit to a lower security unit. You look at the appropriateness or otherwise of that person being assessed or being referred to a number of organisations that might be able to assist.

The Hon. AMANDA FAZIO: Is it the case that the bed not being available immediately in the first facility named is not the end of the matter as far as you are concerned?

Ms DANIS: No, it is not the end of the matter but it may be that at some stage there simply is not anything available for them.

CHAIR: Quality control is the next section. Your submission states, "Poor quality service at early assessment". Can you tell us a bit about that?

Mr WHEELER: Again particularly it relates to a number of forensic patients and the examples I have given there relate to forensic patients where there has been concern generally expressed from relatives about the person's mental state deteriorating. There has been some approach made to either a hospital or community health centre, and for whatever reason the hospital or committee health centre has not acted sufficiently assertively to arrange for involuntary treatment. In the past there have been some very bad outcomes. We have quoted a couple of cases in our submission.

CHAIR: The paragraph on page 4 of your submission commencing with the words "The *Mental Health Act 1990*" supports what I was arguing before about the commission's role. The paragraph states:

> … the intention of Parliament set out in section 4 that patients are not to be involuntarily treated or detained unless the requirements of the Act are clearly satisfied. The person must be a mentally ill person as defined in section 9: that is, the person must be suffering from mental illness and, owing to that illness, there must be reasonable grounds for believing that care, treatment or control of the person is necessary to protect the person or others from serious harm.

Your concern is that unless they get a proper assessment and that assessment is accurate, you cannot make those judgments about their need for care.

Mr WHEELER: That is true. What I am attempting to do in quoting that section at that point is saying that it is a difficult predictive decision at the time, that there are those cases where there has been contact with the mental health services. Mental health services are directed by the Act to conduct their functions and exercise their discretions to have the minimum impact on people's civil liberties but nonetheless provide effective service. I am not saying that every time anyone expresses concern about the mental state of somebody the involuntary detention process should automatically kick in.

CHAIR: Are you saying that if there is a delay in the assessment of a person, that can delay their access to care? In other words, if someone rings up and says that their aunt, brother, sister or cousin has gone off the deep end and the mental health team said that it cannot come today or no-one is answering, you take them to the public hospital and they say there is no mental health bed available, come back next Thursday. Is that the sort of thing you are talking about?

Mr WHEELER: Perhaps, but what I was really trying to say was that even when that assessment takes place it is a difficult decision. It is a difficult assessment process where on one hand there are relatives expressing concern about the person, saying that the person's behaviour is unusual or bizarre and that the person needs care. One some occasions there is pressure and a desire to say, "Yes, that is the case. They should be scheduled. They should be detained. They should be brought before the magistrate and start that process." At the same time the Act is directing us to start the process only if no less restrictive alternative is available and we are satisfied about the requirements in the Act, such as the presence of symptoms. Perhaps it is more difficult to assess that there is this real risk of serious harm.

The Hon. AMANDA FAZIO: In case studies 3 and 4 it would seem that family members contacted health services and said that they thought the person's behaviour was bizarre and was building up to another acute incident or whatever. The comments and concerns of the families do not seem to have been given enough weight by the health services, given that family members would probably more familiar with the person. Do you find in other cases that the concerns of the family and carers about the onset of some sort of psychotic attack or whatever are ignored because the health services do not recognise the value of the family and carers knowledge?

Mr WHEELER: That is frequently reported to us second hand because I suppose we are not normally involved at that point. It is certainly very commonly the complaint that we hear from other family members that "We are this person's family. We know him very well. We know the early signs of when he is starting to deteriorate and we report these things to wherever he is being treated and we are ignored."

CHAIR: Case study number five states:

> … a client of one of the Legal Aid Commission's regional offices, was mentally ill and in a local general hospital following an attempted suicide. The nursing staff identified a high risk of further suicide attempts, and contacted the regional psychiatric unit. There were no beds available.

In other words they could not do the close observations. The case study continues:

> By the time a bed was available and the patient was transported, she had jumped from a window in the general hospital and sustained serious injuries.

Does that happen a lot or just occasionally?

Mr WHEELER: I do not think that sort of thing happens a lot, but it happens. I have not got the figures to say how frequently that sort of thing happens, I am sorry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is hard to get.

CHAIR: We have been trying to find out how many people have suicided in care but for some reason the department is not keen to provide the Committee with that information. The information that is provided in this document does go to some of those matters. Professor Raphael explains that it is difficult to compare those numbers with previous numbers because of different methodologies. Unfortunately on reading the document it is hard to understand what the different methodologies are, and how many mentally ill people have committed suicide, and how many have committed suicide whilst under care.

The Hon. AMANDA FAZIO: In case study number six the person is in a catch-22 situation. There is obviously a problem with his mental condition, the police took him into custody, he was not charged and the hospital knew he had not been charged. That occurred and then he ended up with no care and did not receive inpatient treatment in a hospital. Do cases like a catch-22 situation occur very often? Could there be a better synchronisation or meshing together of services so that these people do not slip through the gaps?

Mr WHEELER: That case study was provided to us by one of the regional offices, and perhaps is slightly different to what we see in Sydney. It illustrates perhaps that one of the effects of the movement of services from large stand-alone psychiatric hospitals into community-based hospitals that have psych units is that those hospitals are perhaps less equipped to deal with very difficult and violent patients. In the old days Rozelle, Cumberland or places like that had intensive psychiatric care units or something of a similar name which were well staffed and frequently staffed by large male nurses. That sort of service is not always available to Hornsby, Manly or Lismore or wherever. There is a reluctance sometimes by those general hospital units to actually have people because they say that they are not equipped to provide that sort of service. Staff do not like getting assaulted, and I do not blame them for that.

I think the solution is what seemed to me, at least, to be in place when the move away from the big psychiatric hospitals to the community based units started. There appeared to be a formal arrangement whereby those units could actually arrange more appropriate care for the patients if they could not provide it themselves. For instance, if the behaviour of somebody at Sutherland, I think that was one, was such that it was too difficult for Sutherland to provide care then they had an arrangement where the person could be quickly admitted to the intensive psychiatric care unit at Rozelle. I think those arrangements are technically still in place but certainly it has been related to me that they are difficult to make because it depends very much on who you know on the staff and whether those other hospitals are prepared to accept those types of referrals.

CHAIR: From reading that case study and the submission from the Police Association it seems that the police are very caring. The Police Association was meant to be here today but it could not come because of its conference that it holds every two years. The police try very hard to get care for the people they pick up, they cart them off under section 22, ring you up because the mental health people will not come and they ask what are you going to do about the person. They seem to be the meat in the sandwich, the lowest common denominator through which people will eventually pass.

Mr WHEELER: On the whole the police are quite caring. Over the past few years—I am not sure exactly whether it be five, eight or 10—they have certainly recognised that they are going to remain having that role within the mental health system. The police have put into their recruits training scheme a course that tries to provide some basic education about mental illness. The police have worked with the health department to try to establish a protocol.

CHAIR: They have a substantial memorandum of understanding. the Police Association says that Health does not live up to its part of it.

Ms DANIS: On occasions the police have spoken to me about not wanting to charge somebody. They have taken somebody to hospital and about two or three hours later they find out that the hospital will not admit them. They then have no choice but to charge the person because they have spent the past eight or 12 hours restraining the person and they have to somehow account for what they have been doing. They have discussed with me their regret for having to charge someone like that who in their view would be better treated in the hospital without having to go into the criminal justice system. That certainly occurs often enough for them to be concerned when they think people who need treatment and care are not getting it, so they have to then turn to the criminal justice system.

The Hon. AMANDA FAZIO: When you have had those sorts of discussions with the police have they also expressed concern about the risk of the person harming themselves or being in danger of harming others or harming property? Is that also a consideration?

Ms DANIS: Yes, they are concerned because they think that the person should be in treatment and care but because the hospital eventually says "No, the person is not mentally ill." or acutely ill or whatever their reasoning is, the police then have to take them into their care because they are concerned that they may become worse and do more than what they had initially been picked up for. Yes, those concerns are there.

CHAIR: Is it a problem that only a magistrate can use section 33 of the Mental Health (Criminal Procedure) Act but local courts, that is, the judiciary, cannot? Is it a glitch in the system?

Mr WHEELER: It is a diversion from the criminal justice system. It is a discretion and part of what goes into that is the seriousness of the offence by which the person is brought before the court. I think normally matters that cannot be dealt with by a magistrate probably would not normally be dealt with under section 33 and that some more formal type of resolution would be looked at.

CHAIR: They would be kept on remand, waiting for a District Court Judge to come to Lismore before a decision could be made about whether they are mentally ill.

Mr WHEELER: I suppose they could.

CHAIR: That is extraordinary. Is that a practical issue?

Mr WHEELER: They are not prevented from applying for bail. I suppose it is not the point that we are involved in all that often, which is why I am trying to think it through. Frequently we have seen people who have subsequently become our forensic patients—they are not guilty by reason of mental illness—who are commonly remanded and get some initial treatment in the prison hospital and maybe perhaps get bail after their condition has stabilised, and they find out later that they perhaps might have been able to get sent to a civilian hospital.

CHAIR: If they are charged with murder, which cannot be dealt with by the magistrate, for how long are they locked up before they can be declared mentally ill and get carted off to a hospital rather than to the prison?

Mr WHEELER: Most people charged with murder do not get bail.

CHAIR: No.

Mr WHEELER: It would be mostly until such time as they have had their trial. Following that they would actually still be, even if they were not guilty by reason of mental illness, returned to the prison hospital.

CHAIR: While they are waiting for the hearing by the District Court Judge as to whether they are not guilty by reason of mental illness, what happens to them in the meanwhile?

Ms DANIS: They would probably be in one of the wards in Long Bay prison hospital unless they have been successful in being able to get into community psychiatric hospital on bail.

CHAIR: On the recommendation of the medical officer in charge making a direct approach to the chief medical officer?

Mr WHEELER: Normally if they are bail refused they will be transferees so there will be the two reports come through to go to the chief medical officer, which is a transfer from a prison to a hospital. In fact, that is normally from a prison to the prison hospital and they will be detained in the Long Bay prison hospital pending their hearing. They get reviewed by the Mental Health Review Tribunal during that time but it is unusual that a recommendation other than remain in the hospital until the legal process is completed.

CHAIR: You also raised the lack of supported accommodation, the lack of hospital and community placements for forensics and the lack of supported services in the community for these patients. What sort of formal recommendation have you made to government about those matters?

Mr WHEELER: I do not know that we have.

Ms DANIS: No, I do not know that we have.

CHAIR: Are you just wringing your hands or have you written to the Department of Health and said that it is a real problem for your clients? Does the Advocacy Service have a responsibility under the Act? Are you mentioned in the Act?

Mr WHEELER: No, we are not mentioned in the Act. I think the Act implies our existence when it makes reference to people going before magistrate hearings shall be represented unless they choose not to be, and where it makes reference to forensic patients being represented unless they choose not to be.

CHAIR: Is there a regulation that says that?

Mr WHEELER: No.

CHAIR: It is almost a contracted service?

Mr WHEELER: I think that the commission understands that it is the body that is expected to provide that service, being the Legal Aid body in New South Wales.

CHAIR: Your organisation has never taken up what you have noted and brought to our attention with Corrections Health or the Department of Health?

Mr WHEELER: Not in a formal submission type sense, no.

Ms DANIS: We tend to run our concerns through the Mental Health Review Tribunal.

CHAIR: The Committee will be seeing them at some stage. You make the point on the last page of the submission, "For patients with a dual diagnosis of drug addiction and mental illness, there

appears to be little assistance for the drug addiction while the patient is in hospital, and when patients are discharged from hospital it is into hit and miss arrangements with drug rehabilitation services."

Mr WHEELER: I think that is right, and I cannot add much to that statement.

CHAIR: You then say, "There is a high level of violence from mentally ill patients, often as a result of drug taking." So here you see a recipe for this to happen, you can see the disaster happening before your eyes, and you know it is going to happen again because it happened last week and the week before that, yet you have not brought this to the attention of the department. Is that because you figure the department knows about it?

Mr WHEELER: I think the department well knows about it. In individual cases where a forensic patient has that sort of history, we do what we can to try to arrange a discharge plan that involves drug and alcohol counselling as well. We think the department has a responsibility to assist with the arranging of that plan.

CHAIR: As advocates for your clients, you push pretty hard, but you can only get what you are given. Is that the case?

Mr WHEELER: We try to put forward something that we think has a reasonable chance of success.

The Hon. AMANDA FAZIO: Are the discharge plans that you prepare for clients of your service drawn up in co-operation with any other agencies?

Ms DANIS: We do not actually prepare discharge plans for them. We make requests, assessments and referrals for that assessment, then seek supporting reports for that plan to take place, and we present that before the tribunal.

The Hon. AMANDA FAZIO: If the Mental Health Review Tribunal agrees that the person should be discharged into some sort of community housing option, or whatever, do you then liaise with the providers of that service to fit the patient in, or is the patient just handed over to the community housing service?

Ms DANIS: It depends where they are. The liaising takes place between wherever they are going to go and wherever they are. So, if somebody is at the Bunya unit and we suggest that they should go into a community at Morisset, then the hospital and the primary nurses and any other persons involved with that person will liaise with the organisation that we suggest the person should go to. But, before we suggest that, we will contact the organisation and say, "This is the person we have. What do you say about this person coming into your care?" They will come down and see and assess the person on a one-to-one basis, and ask for background material, which we provide. That is the process involved.

The Hon. AMANDA FAZIO: So your role is more one of facilitating assessment for these other services?

Ms DANIS: Yes, I guess so.

CHAIR: So that if there is a plan, you make sure they get it? This is only forensics we are talking about, isn't it?

Ms DANIS: Yes.

CHAIR: We have a lot of evidence from other solicitors who represent people in the courts. I am aware that there is a court diversion process that goes something like, "You will go and see the mental health team next week, won't you?" To that the person will probably say, "Yes." But they then often have to be give a few bob to get them home. We note from a number of submissions that the solicitor will give them say $20 to get home.

The Hon. AMANDA FAZIO: That is in this submission, I think.

Mr WHEELER: Yes. We certainly have done that. One of those cases where the solicitor gave the person $20 related to one of my clients. I gave him $20 because we had just walked out the back of the court and he had no money and nowhere to go. It is a little bit different with a forensic patient for whom we are arranging a transfer from Bunya to Endeavour, for instance. But the process is that after we obtain reports from Endeavour, along with whatever else we need, such as a follow-up from the community health team, and before we put them before the tribunal, the tribunal will produce a quite detailed recommendation. It will contain conditions on which the person was released and so on.

CHAIR: I used to sign them.

Mr WHEELER: The step after you sign them is a Governor's order basically.

CHAIR: They are most detailed.

Mr WHEELER: Yes. That order will then be sent to a number of places, but certainly to where the person is at the moment. I am not sure how the person is physically transferred, whether in a taxi or whatever. But they do not seem to get lost between Bunya and the community housing service.

CHAIR: But you do find that people you represent are discharged by the court and have nowhere to go.

Ms DANIS: We hear of those.

CHAIR: You have even given an instance of that.

Mr WHEELER: I have. There are two things about that. Although we have done that, that is not what we normally do as part of the functions of the Mental Health Advocacy Service. The submission gives two examples. In one, I did the person's committal hearing because he had been an ongoing client of the service and I knew him, because he was at Morisset at the time. The other referred to in the submission related to one of the Legal Aid Commission criminal law solicitors. The preparation of this submission was based mostly on my observations and those of other people. The commission was circulated saying that these are a number of the terms of reference that I think the commission could reasonably comment on and, "Does anybody want to make a submission about these things? What are your experiences?" So the submission is intended to be wider than just my experience.

CHAIR: I understand that. A copy of the transcript of your evidence will be sent to you. We will put it onto our website uncorrected. We would rely upon you to make what corrections you think are necessary to the transcript. If you think that we have misunderstood one another, that questions we have asked are a bit off the track, or your answer has not been as full as you would like, please let us know. If there are any other questions that arise from the evidence given by other people, we would appreciate your response to those questions, or your opinion or explanation. It may be that we will need to get back to you later in the inquiry for two purposes: possibly to see you again; and, secondly, if we make some recommendations, for you to check that those recommendations are sensible, reasonable and achievable. We would like your comments upon those so that we do not end up with a report or recommendation that is frankly silly, because that would do everybody a disservice. Thank you very much for your submission, for appearing before the Committee today and for the good work that you do.

(The witnesses withdrew)

JONATHON MONTALT CARNE, Psychiatrist, Level 4, 9-13 Bronte Road, Bondi Junction, on former affirmation, further examined:

CHAIR: Dr Carne, could you tell us a bit more about your concerns about forensic patients?

Dr CARNE: My recollection is that we were talking about revolving doors and my experience leaving me with the feeling that the whole of the mental health service in New South Wales is basically a giant revolving door with a lot of corridors going off it, with the mentally ill coming into hospital briefly, being discharged too soon and becoming homeless. Without a home they do not get access to mental health services because, as you know, mental health services and community health services are based on location. So these persons become itinerant. Petty crime is committed either to get food or to support drug dependence, either because they are not on medications and they start using substances illicitly to ameliorate their symptoms, or some of the medications have horrible side effects and they smoke marijuana or take alcohol or other drugs to ameliorate the side-effects.

CHAIR: Or they lose them or run out of them.

Dr CARNE: They lose them or they run out of them, but you can hardly look after yourself very well if you remain psychotic because you have been discharged from hospital after two weeks in hospital instead of six weeks. Then you might be picked up by the police. The police might take you into the local hospital. Because the local hospitals have a tradition of pedantically interpreting the Mental Health Act, they will say, "Look, this person is a little bit disorganised and they are a little bit psychotic but"—as I have seen in letter after letter after letter—"is not actually mentally ill under the Mental Health Act because this person is not a danger to themselves or to others." So it is back in the police van and back to the Local Court. When the person comes before the Local Court, the person, to everyone in the court, is quite clearly mentally ill, but the Local Court sends them back under section 32 or section 33 to the same hospital or a different hospital.

The hospital is full, so there is a reassessment by another junior registrar or even by a non-psychiatric trainee. The person goes back to court and into gaol where the only alternative is that if they are not put into gaol, the police will object to bail because the person will never turn up to court again because they are too disorganised. The magistrate under the Bail Act is forced to reject bail and the person ends up in prison where they are faced with the grossly inadequate psychiatric services that have been the subject of the first part of my written submission to the Committee.

CHAIR: Is that the remand centre?

Dr CARNE: The remand centre is the first place that they go to. In these days in New South Wales, if you are remanded in custody you may go to the Metropolitan Remand and Reception Centre [MRRC]. Parklea has been turned into a remand gaol and the old Parramatta centre has been reopened again after being closed because there are so many prisoners. Then you might get to see a mental health nurse. You probably will because, even though there are large numbers of mentally ill people in gaol, the mental health nurse will see you. You might have to wait a week or two to be seen by a psychiatrist. The mental health nurse cannot prescribe medications because nurses cannot prescribe medications except in certain circumstances such as withdrawal from drugs. You may get medications if your case seems to be so urgent that they will get a psychiatrist on the phone.

A person in such circumstances may quite likely be put into what is called a safe cell, which is a cage with a concrete floor, a concrete bed and a lavatory in public view, where they will be monitored so that they do not kill themselves. In my personal opinion, that seems to be the main priority of the Department of Corrective Services. They are interested in making sure that they do not get a coronial case on their hands. So this goes on, and the patients may be quite mentally unwell.

CHAIR: But they provide a custodial service.

Dr CARNE: What you mean by "a custodial service"? There are prison officers there. The people are locked in a cage. They cannot kill themselves.

CHAIR: They are in custody.

Dr CARNE: They are in custody, yes. If you were mentally ill, would you like to be locked in a cage with a concrete floor and a public lavatory?

CHAIR: No, but they do what they can do, and what they can do is make sure that the person stays alive to live another day.

Dr CARNE: You say they do what they can do, but I find the service, as I have said in my suspicion, is in breach. You know what I have said. I do not have to repeat it, do I?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have been quoting it today.

Dr CARNE: I think it is appalling.

CHAIR: What can a prison officer do?

Dr CARNE: What should a prison officer do? The people should not be in the prison in the first place. It should not be up to the prison officer to do this. People with a mental illness should be offered, not only simply humanely but by law under the Mental Health Act and by virtue of the Burdekin report and the United Nations minimum standard for the treatment of prisoners, mental health care, just like you and I can get if we are mentally ill and we walk into a local doctor's surgery or we walk into our community health centre, but they do not get it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Systematically, can you give us what happens in gaol and what should happen, and clearly distinguish the two?

Dr CARNE: Okay.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think you have partly answered that, but let us just do it systematically.

Dr CARNE: Okay. Let us assume that unfortunately somebody with a mental illness has been remanded in custody.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would call that a system failure for a start, would you not?

Dr CARNE: It is a system failure. It is quite clear as well that people with a mental illness might come before the courts and might not want to admit that they are mentally ill, nor might the mental illness be obvious. You cannot expect a legal system to act as a screening system for the mentally ill. It is inevitable that some mentally ill people will come to gaol, because that happens. There is nothing wrong with that happening provided that the service exists in the gaol to detect mental illness and treat it in exactly the same way as it would be detected and treated if the person was not in gaol. You cannot expect better than the community service, but you can expect a reasonably equivalent standard. So when a person either is mentally ill or becomes mentally ill, what then happens is that they are often detected by nursing staff because their behaviour is bizarre, or for some other reason.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does everyone get screened when they go to hospital by nursing staff?

Dr CARNE: I am sorry, I have not been fair on the system. There is a screening system. Everyone gets screened by a nurse when they come in and the nurse's job is to identify whether they have mental illness by asking them whether there is a history of mental illness and by trying to observe whether there are signs of mental illness. That screening system is a very good screening system. That is one of the best systems that they have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that new?

Dr CARNE: It has always existed but it has been improved and I think it is very impressive. I do not think you can fault the screening system.

CHAIR: They know who is there and who is mentally ill.

Dr CARNE: They know some of the people who are there and who are mentally ill. The screening system is only based on a nurse. Remember that 400 people are admitted to a prison system every week. Sometimes a truck will turn up at the MRRC at 10 o'clock or eight o'clock at night and they will be screening people until midnight. The staff are exhausted and the prisoners want to get to bed, so the prisoners may not actually identify themselves as mentally ill. They may not trust the prison system because they may be paranoid and they may not admit anything at all; they may just keep quiet. While it is an excellent screening system, it is by no means perfect

A mentally ill person can be identified by the screening system or by the prison officers who are largely not a bad bunch. If they identify someone as being mentally ill, usually there will be an officer who will identify that the person is mentally ill because they have been trained to do so—not trained to identify mental illness, but trained to be aware that it could exist and they identify that to the medical staff. They also do that because they do not want a death in custody. They do not want someone hanging themselves.

The person will then see a nurse who will re-screen them, if you like. They will go through a more sophisticated psychiatric assessment process and if the nurse feels that they have a mental illness, they will refer those people to seek a psychiatrist. This is the first bottleneck because, firstly, they may not get to be screened or reviewed by the nurse immediately, depending on the workload and the time of day and whether it is a weekend or not. The nurses are on duty just about all the time. They may not get to see a psychiatrist because of the shortage of psychiatrists who are working in gaols. If they do get to see a psychiatrist, then the psychiatrist will prescribe some medications. But in terms of any other treatment, it is just about non-existent.

For example, if a person was acutely mentally ill, the normal course of events if they are really unwell is to admit them to a psychiatric hospital. In gaol, as you have learned, there are 90 beds at Long Bay prison hospital's psychiatric wards A, C and D, and they are usually full. There is a waiting list of anything between 20 and 40 prisoners. It is impossible to be admitted into Long Bay if you are acutely ill in much the same way as it is often impossible for people to be admitted to any psychiatric unit in the community because there is such a shortage of beds. If there is a fear for the person's safety or a fear that the person might commit suicide, they are put in what is called a safe cell. As I have said, I a safe cell is a concrete cage. Safe cells have been criticised by the Royal College of Psychiatrists, as I pointed out in my submission, which has stated that they should never be used.

If I was looking after a patient who was suicidal, I would never put them in isolation because it makes the depression worse. What a person who is depressed and suicidal needs is support and another human being. They need to be in a tranquil, warm environment, not a hostile, concrete, isolated environment. Putting someone in a safe cell is absolutely the last thing that one should do if you want to treat them. It will stop them from hanging themselves, but it may only temporise their course. If you are really disturbed and distressed, you will be in a safe cell for a few days. It might appear that you get better and you go to the main part of the gaol then, and then there is nothing to stop you from harming yourself. Often it merely puts off the moment. Secondly, many inmates know what safe cells are like and they find them abhorrent. They will not admit to being depressed or suicidal. I have had prisoner after prisoner saying, "Look, if I tell you how I feel, you will not put me in a safe cell, will you?" They know what it is like.

You are asking me what the course of action is. The mentally ill prisoner will be looked after in a normal cell in the normal prison and they will not be in an environment that is more conducive to recovery. They will get medications but how frequently they get the medications reviewed depends on the workload of the psychiatrists. Psychiatrists are usually overworked and so it depends on the workload of the nurses. They certainly do not get the standard of care that is obtainable in a well-run community health centre.

If they are very disturbed, to the extent that they are mentally ill under the Mental Health Act, psychiatrists will write a schedule 3 on them and attempt to make them a forensic patient. That still does not guarantee a bed in Long Bay hospital because there is such a shortage of beds in Long Bay

hospital. Many forensic patients, who are still waiting to be transferred into Long Bay hospital, are in safe cells or in the general population of the gaol. I am sure that Olav Nielssen described exactly the same situation.

CHAIR: So schedule 3 is written by two psychiatrists?

Dr CARNE: Two psychiatrists have to write it. Schedule 3 is the one that transfers people from a prison to a prison hospital. I could pull out the Mental Health Act to determine that for you.

CHAIR: Even if they write that the prison hospital can still say, "No way."

Dr CARNE: Exactly. If there are no beds there is nowhere to put them. It is not that the prison hospital is being obstructive; it is just that it does not have the beds. So they remain waiting for a bed. That is what happens now. The other thing is that some defendants at Local Court—and I can talk from personal experience—are remanded in custody for a psychiatric report for their case. It is the case—different meaning of the word case—that in some cases they will wait longer for a psychiatric report to be prepared than they would have been sentenced. So this is a gross breach of their civil rights.

CHAIR: It is less than two months.

Dr CARNE: It takes four, five or six weeks. I cannot tell you how long; you can get that data from Corrections Health Services. Many lawyers have told me that they wait longer for a report than they would be sentenced. That is why we set up the court diversion program. There are lots of other reasons, such as it is just, ethical and right to have a court diversion program, but one of the concrete reasons was that we were trying to cut down the length of time that people were waiting on remand for psychiatric reports. So that is what happens. I have taken you through the whole system, as it occurs. We do not have a State forensic psychiatric service, which is one of the great deficits.

Last time I was talking to you I referred to the shortage of beds, acute beds, rehabilitation beds, drug and alcohol services, and the relative shortage of drug and alcohol rehabilitation programs which accept a person on psychiatric medications. We talked about the shortage of psychiatric rehabilitation beds where somebody who has had an acute episode is not well enough to go and live in a Housing Commission house; is not a quite well enough to go and live in a group home; but who needs to live in the equivalent of the Rozelle cottages and the Macquarie Hospital cottages. There are not enough of them.

Let us talk now about the forensic service. A State forensic psychiatric service consists of entities. It has three divisions. It is run by senior forensic psychiatrists who have experience in psychiatry, dealing with psychiatrically ill offenders, and who have some knowledge or a degree in law, criminology, or something like that. The three components of the service, as well as the general administration, are a series of secure hospitals. Psychiatric care is available at the same standard as is available in a good community psychiatric hospital, but they have secure perimeters so that the individuals in them cannot escape.

It consists of a second component which is a court diversion program where every court has psychiatric staff attached so that mentally ill defendants are immediately identified, psychiatric assessment is arranged and, if assessment cannot adequately be carried out there and then, they can immediately be transferred to a bed in a secure hospital where, if a longer assessment—as is often the case—is needed, that can be done by the forensic psychiatrists in the secure hospital.

The last component is a community forensic psychiatric service which gives support to the normal community mental health services to deal with the more difficult to manage mentally ill ex-offenders, or people with a mental illness who have come out of the prison system but who, because of their dual mental health drug problem, dual mental health developmental disability problem, or dual mental health personality disorder, cannot be followed up as simply as the general population of mentally ill. So specially trained forensic psychiatric nursing staff and social workers work in the community alongside the community health centres to give extra care to the mentally ill ex-offender, or mentally ill offender, who might otherwise not comply with treatment and who might present difficult problems that the general run of psychiatric nurses will not have been trained to deal with.

Those are the three components of a State forensic psychiatric service. They exist in Queensland, Victoria, South Australia, Western Australia, New Zealand, Canada the United Kingdom, Denmark and Holland. However, they do not exist in New South Wales. It is a gross deficit in the psychiatric services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that there is a draft forensic mental services plan. Are you aware of that?

Dr CARNE: I am aware of it too. In fact, it is here somewhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that it has not been publicly released, but it is being discussed by people with an interest in this area?

Dr CARNE: Yes. I used to work for Corrections Health Services as both a visiting consultant and as a staff specialist. I was involved with the committees meeting at the health department which were dealing with these things. I subsequently resigned and I am now no longer a party to these discussions, so I cannot tell you, since my resignation in August last year, where we are with that process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We will endeavour to get that document. We have not got it yet.

Dr CARNE: I have it here somewhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What do you know about the document, if anything?

Dr CARNE: Let me see whether I can find it. I will then be able to refer to it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably you have an earlier draft. There may be a later draft to which you have not been a party.

Dr CARNE: I do not think that I have got it. I know the document that you are referring to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this in the pipeline? Are we about to get a State forensic service?

Dr CARNE: Are you asking me to predict the future? I cannot predict what will happen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You may know about the dynamics of the department.

Dr CARNE: When I first joined there was not a State forensic mental health plan.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that that is something that is coming?

Dr CARNE: By the time I left—and this is not my responsibility by any means—there was a plan that was a working document. I thought I had an old draft of it here, but I do not. But certainly I have seen a plan for a State forensic service. I understand that there is a plan to set one up.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With a little push from this Committee and a little publicity perhaps that will be set up in future.

Dr CARNE: Absolutely. I have one serious reservation about the plan that I saw, which was that it was to be under the joint management of Corrections Health Services and the Department of Health. I think that is unprecedented and ridiculous.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is Corrections Health Services not under the Department of Health?

Dr CARNE: Corrections Health Services is a statutory body that works as though it were an area health service, but it is not exactly. You had before you the chairman of the board of Corrections Health Services, Ron Penny.

CHAIR: No, we had the chief executive officer.

Dr CARNE: I am sure that he would have been able to describe to you exactly his relationship with the health department, what his responsibilities are, how they are divested downwards, how it is funded, and how the decisions are made.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We did not pursue that issue thoroughly.

Dr CARNE: That is very important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding was—I established this fact in the Select Committee on the Increase in the Prisoner Population, which is why I did not explore the issue—that Corrections Health Services was effectively under the Department of Health. That was terrific because it was thus independent of the Department of Corrective Services. That was my understanding.

Dr CARNE: My experience is that Corrections Health Services works closely with the Department of Health. I have found it difficult to work out exactly how the funding arrangements work. For example, when I was working for Corrections Health Services, I was involved in the establishment of the court diversion trial program, at the end of which we assessed it as being successful. I wrote a budget submission, as a staff member of Corrections Health Services, to Treasury for funding to get the service extended around the rest of Sydney.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which is what has happened.

Dr CARNE: That is what happened, on my budget submission. I do not quite know the route that that funding application followed, nor the route through which the funds came back. My personal objection, and this is not in relation to personalities; it is my personal opinion and it is not necessarily the opinion of the National Association of Practising Psychiatrists, is that it is unprecedented that a prison medical service, which is essentially the general practice service for a gaol—it looks after the coughs, the colds, the cuts, the bruises, all those things—should run a psychiatric service.

Let me put this scenario to you. If you became mentally ill, or if you needed a heart transplant or a coronary artery bypass graft, would you be happy if your general practitioner was doing the operation or your general practitioner was looking after you in a psychiatric ward? You would not. You would want specialist care. Yet the plan as I learned about it last year was that the State forensic service would be under the joint management of the Department of Health and Corrections Health Services. That is unprecedented and wrong. Corrections Health Services is far too close to the Department of Corrective Services. The custodial mentality rubs off.

In order to have an ethical, just and effective forensic mental health service it has to be completely independent from the Department of Corrective Services and it has to be run directly from a directorate in the health department. That is how they are run in other States and countries.

CHAIR: Given that it is an area health service—

Dr CARNE: De facto.

CHAIR: It has a board of management like every other area health service, it has a chief executive officer and it is paid for by health, as I understand it. So if it looks like a duck, waddles like a duck and quacks like a duck, is it not a duck?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Under unusual circumstances if it did not have co-operation from the Department of Corrective Services it could not work. If it chose not to help prisoners who came to it, if it was not scheduled and it was not given space, protection and so on from anybody who was violent or whatever, it would cease to function. So, presumably, it has to have a working relationship?

Dr CARNE: What are we talking about? What has to have a working relationship?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Corrections Health Services has to have a working relationship with the Department of Corrective Services. It cannot function in opposition to it.

Dr CARNE: Unquestionably. The service that is offering general practice service to prisoners has to be wherever the prisoners are. I have no objection to that. I think Corrections Health Services does an excellent job in looking after the general practice needs of prisoners. I have no criticism of that whatsoever. I have worked with the general practitioners who are well-motivated, hard-working and committed. That is not the issue. The issue is that the current plan—and this is present experience—is that Corrections Health Services also runs a psychiatric service, and it does that hopelessly. Visiting neurologists, cardiologists and physicians go to the gaols. None of them work for the Corrections Health Services; they all come either from private practice or from the local area health services. The psychiatrists are employed or contracted as VMOs by Corrections Health Services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a one-off?

Dr CARNE: It is a one-off. So they run psychiatry. But they do not run neurology, cardiology, hepatology, iridology or astrology.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if they take the psychiatrist's word about the diagnosis and presumably the psychiatrist's advice on treatment, is this a big deal?

Dr CARNE: It is an enormous deal because they do not. They know that Corrections Health Services is run by the hospital. There are not enough beds for mentally ill people. Corrections Health Services runs the psychiatric services to the cell blocks and it goes along with the idea that it is okay to put someone in a safe cell in breach of all the international and national standards.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you mean that, if you have a heart attack, you would go to the Prince of Wales Hospital?

Dr CARNE: If you have a heart attack you would go to the Prince of Wales Hospital. If you have a kidney stone you would go to the Prince of Wales Hospital. If you have a mental breakdown you get locked in a concrete cage.

CHAIR: Prior to 1990 Prisons Health used to be owned and operated by Corrections Health Services.

Dr CARNE: I joined Corrections Health Services—the staff and psychiatrists—in 1994. So I have no experience of what happened before then.

CHAIR: I remember the fights that went on between various Ministers and departments about ownership. Moving Prisons Health into the Department of Health rather than into prisons resulted in a huge fight.

Dr CARNE: And it should be in health; not in prisons.

CHAIR: I thought it was. The fact that they are colocated within the prison is simply a matter of geography. What is important is who owns it, who directs it, who sets the standards and who pays for it.

Dr CARNE: In terms of general health, it has to be within prisons. You must have the prisoners' general medical service inside gaol. In essence, a forensic psychiatric service needs to be outside the gaol, except for that part of the forensic psychiatric service that has the role of identifying newly identified mentally ill people and checking whether or not they are mentally ill. For that purpose, one needs a Long Bay psychiatric hospital.

Someone who, for the first time, presents in gaol with a mental illness can be taken out of cell blocks, out of the general prison, and assessed and monitored in a prison hospital. If it becomes clear that they have a mental illness that should legitimately lead them to be diverted to a forensic service, that can be done, because there are other conditions that do not require that.

For example, as you are well aware, illegal drugs circulate widely in the gaols. Somebody could have had a bad dose of amphetamines, or a bit too much marijuana to smoke, or taken a bit too much heroin. They could have a transient drug-induced condition that would resolve and would not require them to be passed into the forensic service. Or, following sentencing for example, they may become acutely distressed by the fact that they are going to be in gaol for a long period of time.

They need to be transiently managed in a psychiatric service. They may spend a week in Long Bay hospital, get better, and return to the main gaol system. That part of the psychiatric service must be inside the gaol. But there must be a wide channel so that individuals who are clearly mentally ill and should not be in gaol are then moved into the State forensic service facilities: the medium-security hospital, the high-security hospital, or wherever else.

The Mental Health Act allows that to be done. It is only not going to because there are not the beds. That is what I meant by saying that the current service is in breach of the Mental Health Act. It is acting illegally because it is not doing what the Mental Health Act allows it to do, and it is not doing that because there are not the beds or services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When I first met you, you were with the Select Committee on the Increase in Prisoner Population and you were looking at diversionary programs in Central Local Court, and you produced a report from that.

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This morning we heard evidence that 11 per cent of people in gaols are picked up by the three screening tools, and that 7 per cent of people have a significant psychiatric injury, which is pretty much a world standard. Did your report confirm that percentage?

Dr CARNE: You are referring to a report with which I am familiar, which was a psychiatric sample survey of a large proportion of prisoners to assess their a level of psychiatric illness. That report showed a 7 to 11 per cent level of psychotic illness—the general community has a level of about 1 to 1.5 per cent—and about a 20 to 25 per cent prevalence of depressive illness. As you know, about half the prisoners have had some contact with psychiatric services. About 70 per cent of those prisoners had a significant drug problem. That is the survey of gaol mental health.

My report looked at the prevalence of mental illness in people coming before the Central Local Court diversion program. So we are looking at different populations. I will quote from the report. The prisoner health survey, which I simply reviewed, showed the prevalence that we spoke about. Firstly, each year about 5,000 matters go through Central Local Court. If you look at court statistics, it is difficult to distinguish how many people there are, as opposed to matters. Obviously, there are more matters than there are people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely a database can provide that information?

Dr CARNE: It is very difficult to get that sort of information out of the Chief Magistrate's office. They can talk about matters, but they cannot talk about numbers of people. The Chief Magistrate's office has been extremely co-operative and helpful in setting this up, and they have been very supportive. They tried to get this data. In any event, say 4,000 people go through Central Local

Court each year, 250 were referred to us, and about 90 per cent had a psychiatric illness. It is quite extraordinary that lawyers and magistrates were picking up illness so accurately.

The Hon. AMANDA FAZIO: Would those results be a little skewed because of the concentration of homeless and mentally ill people being mainly in the city?

Dr CARNE: Absolutely. Obviously, each court has a population that reflects the socio-demographics of that catchment area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say 90 per cent of the people were referred to you?

Dr CARNE: 90 per cent of the people referred to us had a mental illness.

CHAIR: So 10 per cent were not?

Dr CARNE: Yes.

CHAIR: Of the people who were not referred to you, how many did they miss?

Dr CARNE: That is the question I was going to ask you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you screen all of them?

Dr CARNE: No, we did not. We only had people referred to us who were identified as having a mental illness and needing some sort of diversionary alternative presented to the magistrate. If someone did not look to be mentally ill, they were not referred to us. My question is: What proportion of the people who were not identified as mentally ill by court staff, who are not trained in identifying mental illness, were in fact mentally ill?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the percentage is so high, surely it is likely that some were missed?

Dr CARNE: Absolutely. When you look at any screening system, you look at the detection rate. You look at false positives and false negatives. We had a very low false negative rate, only 10 per cent. So what proportion of people were not picked up?

CHAIR: These were not aided by a court liaison nurse?

Dr CARNE: They were not the people who were referred to the court liaison nurse.

The Hon. AMANDA FAZIO: Who were the people doing the referring?

Dr CARNE: Primarily, legal aid and Aboriginal legal aid lawyers; and secondly, the officers in the cells, who were very good. We ran in-service training sessions—

CHAIR: It is like the packing room pick of the Archibald Prize?

Dr CARNE: Yes, absolutely. They learnt how to identify a good painting, and they were interested in doing it. The extraordinary thing is that lots of staff in the health system actually want to do better. The prison officers, once they got to know us and John Pryor, who was the nurse there and is an extraordinarily good psychiatric nurse, would ring him up and say, "John, I think Joe Blow is coming in this morning. I think he is mentally ill. Can you come down and see him?" The Salvation Army people would identify them, and a magistrate would sometimes identify them. But sometimes private lawyers work in the court, and they are not as sensitive to these issues as the legal aid lawyers are. The magistrate would say, "Look, this person is mentally ill. Don't you think you should get them to see John?" The lawyer would say, "John who?" They did not know that the court diversion program, which was a pilot research study, could have been set up in the court. In answer to your question, those are the sources of referral. I have the data here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could we have a copy of that report?

Dr CARNE: It was submitted to the Corrections Health Service; I gave it to them as an employee of theirs. I do not know whether I can give it to you. I would be delighted to give it to you, but—

CHAIR: Dr Matthews undertook to provide it to us, and I think that is probably the safest way to do it. If you provided it, you would be protected—

Dr CARNE: Am I protected by parliamentary privilege in what I say here?

CHAIR: Absolutely. However, if you name a person, in fairness we must allow that person the right of reply so they can give their side of the story. So we need to be a little careful.

Dr CARNE: That is why I have intentionally not mentioned anyone by name, except to compliment them.

CHAIR: Unless there is a reason for doing so, which you think is in the public interest.

Dr CARNE: I think the issues here are not personalities and individuals but principles and policies. From the data we received there were a lot of interesting facts. These are people who are referred by the court as needing psychiatric treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The figure is about 250 in 5,000?

Dr CARNE: About 250 referrals out of about 5,000 matters. About half of them told us that they had never had psychiatric treatment before. Yet, when we assessed then we found that almost half had schizophrenia, almost a quarter had a substance dependence problem without schizophrenia, about 11 had some sort of brain damage, and a few had a developmental disability or mental retardation. About 60 of the people with schizophrenia had both schizophrenia and a substance abuse problem.

If you classify a substance abuse problem as a mental illness—as I do, because it is—then more than 90 per cent of the people had a mental illness. If you say that a substance abuse problem is not a mental illness—psychiatrists would never agree with you on that—then we would have to say that about 60 per cent of the people had a mental illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is about 3 per cent, because you have 5 per cent being referred to you?

Dr CARNE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You take away 10 per cent on the basis that they were not mentally ill, and you are then talking about 40 per cent of 90 per cent of 5 per cent, is that right?

Dr CARNE: Yes.

CHAIR: I can tell you that they are missing half. These surveys of people coming into the prison system show a figure of 6 per cent.

Dr CARNE: Exactly. But it is actually probably more than 6 per cent; it is probably closer to 10 per cent.

CHAIR: So the magistrate can pick the more florid ones?

Dr CARNE: The magistrates are very supportive of court diversion. I cannot speak for them; you have to talk to them.

CHAIR: But they picked 90 out of 5,000?

Dr CARNE: They picked 250 out of 5,000, which is 5 per cent.

CHAIR: But they missed about 90?

Dr CARNE: Exactly. And who would be surprised? It is not their job to identify mental illness.

CHAIR: That is why you had to set up the court liaison service?

Dr CARNE: Exactly.

CHAIR: What was the result of the introduction of the court liaison service?

Dr CARNE: We made recommendations for diversionary treatment for the people who came to us. The magistrates diverted and treated about half the people in respect of whom we made a recommendation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They knocked you back on the other half?

Dr CARNE: There were also significant issues about the severity of the crime and public security. Because we do not have a forensic service to refer them to, they were justifiably—They did their best. I have no problem with them; we work together very well. They did their best to divert people when they could, but they have a responsibility under the Bail Act and so forth to also look after the public weal. They did their job, and I think they did an excellent job. If we had found more people to divert, I am sure they would have done their best to assist in diverting the ones we identified.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would it not have been desirable for you to have screened everyone?

Dr CARNE: Of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the screening tool used in the gaols is correct, the courts only picked up half. This morning Dr Matthews said that in his three screening tools he picked up 11 per cent as being positive, which was cut down to 6 per cent.

Dr CARNE: I disagree with that cutting down to 6 per cent. I know what happened. I think it is closer to 11 per cent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if your magistrates were only picking up 5 per cent, they were only picking up half. Therefore, if screening were done optimally, you would have picked up the 11 per cent in the court, rather than have them picked up in the gaol later?

Dr CARNE: Exactly, or pretty close to it. I have some other data I want to bring to your attention.

CHAIR: I show you page 16 of the document from the Department of Health. It shows an increase in section 24 referrals—in other words, the police carting someone off to a health service, which identifies the person as being mentally ill.

Dr CARNE: Yes.

CHAIR: Where they identify the person as being mentally ill.

Dr CARNE: Yes.

CHAIR: It has gone from about 1,000 in 1996 to 2,500 in 2000.

Dr CARNE: Yes.

CHAIR: The next page shows the number of medical practitioner-initiated—section 22s they are called. This has dropped between 1991 and 2000 but the number initiated by the police has risen quite dramatically. So you have this general involuntary admission process either from the police or medical practitioners, and I assume the police would probably include the courts?

Dr CARNE: You would have to ask them.

CHAIR: I do not know if they are section 33s or not. One of the things given to us by Richard Matthews this morning was that that increase could have been related to the increased use of amphetamines which would have drawn the attention of the police. I asked him whether this was due to amphetamines or due to the fact that community mental health is starting to fall apart.

Dr CARNE: I think you would have to ask Don Weatherburn exactly when the big pulse of amphetamines came into the community. I think Don said in one of these reports from the Bureau of Crime Statistics and Research that it was in about the last year or year and a half that there has been a big increase in amphetamines. I would not explain this as amphetamines, I would explain it as a failure of the community mental health services do to their job properly.

The Hon. AMANDA FAZIO: This morning a fellow made the point that this increase that people have taken place while the heroin drought was going on and most of the heroin users who were not able to buy that drug because of the drought were resorting to injecting cocaine or amphetamines, or serious marijuana abuse, which means that if they had an underlying problem it would have been exacerbated even more because most people who use heroin do not go on a rampage.

Dr CARNE: I think this is a false simplification of the issue.

CHAIR: No, he did not say he was definite. He said it appeared to him, particularly in the past few years, that there has been a dramatic increase in the use of amphetamines and marijuana as a replacement during the heroin drought. The heroin drought did not start last year, it was a bit before that, but it was certainly not 1996.

Dr CARNE: It has not been going on for the past five years.

CHAIR: He did not say that was definite, he said he does not know, to be fair to him, but he said one of the causes could have been the increased use of amphetamines. He also made the interesting comment that we are growing out of heroin, that heroin is an old person's thing rather than a younger person's thing, which I thought was fascinating. I have heard that before in other countries but not here.

The Hon. AMANDA FAZIO: It is not trendy.

CHAIR: It is not trendy, exactly. It becomes a loser thing.

Dr CARNE: Heroin is a completely different drug to amphetamines. We can talk about that, but I do not think it is too relevant. Those figures do not seem to me to be consistent with what I know of the heroin drought and the use of amphetamines. They seem to me to be much more consistent with the gradual deterioration in the standards of care and resourcing and funding of the community mental health services.

The Hon. AMANDA FAZIO: Has there been any change in the training that police have been getting in more recent years so that they might be more attuned to picking up people with mental illnesses so that they are referring them more than they were in the past?

Dr CARNE: Yes, I think there has been. There is no doubt that the police had made an effort to be more sensitive to mental illnesses and that may contribute in part.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have come to these conclusions and you have recommended the extension of your screening and diversion program.

Dr CARNE: It is not mine.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The one you worked on.

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were in the pilot and you wrote it up?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You recommended that it be implemented. It was implemented and funded and it has increased?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense, are you happy that your report's implementation was relatively satisfactory from your point of view? You came to a satisfactory conclusion and Corrections Health implemented it?

Dr CARNE: Yes. My only objection is that it is being run by the Corrections Health Service. I do not think the prison medical service, the Corrections Health Service, should be running a court diversion program. It should be part of the State forensic service. The prison medical service should not run non-prison, court services. That is completely wrong. You are not going to get co-operation from prisoners if they know they are being assessed by the prison medical service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they are going to be diverted you might get some co-operation, surely?

Dr CARNE: That is my subjective opinion. If I cannot get the point across, I have not made the point properly.

CHAIR: The study that has been done in the Mid North Coast Area Health Service, around Kempsey and Port Macquarie, is entirely locally funded. Dr Matthews said he was not aware of the results there, but they seemed pretty good on their report of themselves. That does not mean it has been scrutinised. It has been going long enough and they might have the wrong numbers.

Dr CARNE: Would you like me to refer to a very good report on court diversion, or is there not time? There is a British Home Office report of which I have a copy and which has an excellent description of its effect.

CHAIR: If you would not mind sending it to us, because we are running out of time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When I was saying your report was implemented, despite the fact that it was implemented you said there was one thing you were not happy about. You have resigned from the health service and so did another psychiatrist, I gather, who was the boss. My question is why did you resign and does the resignation of you and Caroline Quadria represent a lack of faith in the psychiatric profession generally in Corrections Health and, if so, is it in big trouble? Is there a crisis in psychiatric services in the service?

Dr CARNE: I am not prepared to make any comments on behalf of any other psychiatrist apart from me. I do not wish to make any comment at all on psychiatric morale. My resignation is complex. I am happy to talk about it outside this Committee but it is too complicated. It relates to industrial issues such as resources and facilities that I thought I was going to be given and was not given, plus the fact that I made certain recommendations that were ignored, and I finally found that I was wasting my time. In essence, that is why I resigned. There were no misdemeanours or anything like that, it was only a reflection on what I was not doing. It was partly an industrial problem as well

as partly a dissatisfaction with the fact that I was paid to do a job, I made recommendations and I felt they were ignored, and I felt I was basically wasting my time working for them. They responded well to the court diversion program but that was a very small part of my responsibility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But some of the other areas where you made recommendations they did not take any notice?

Dr CARNE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that obviously influenced your decision to resign?

Dr CARNE: I felt I was wasting my time there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You must think things are quite unsatisfactory then?

The Hon. AMANDA FAZIO: Stop putting words into people's mouths.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did not resign because it was going well, did you?

Dr CARNE: I do not think I want to make any more comments about that issue, thank you.

(The witness withdrew)

(The Committee adjourned at 5.08 p.m.)