REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

INQUIRY INTO MENTAL HEALTH IN NEW SOUTH WALES

At Sydney on Monday 12 August 2002

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The Committee met at 10.00 a.m.

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PRESENT

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

The Hon. P. J. Breen
The Hon Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. J. H. Jobling

BEVERLEY RAPHAEL, Psychiatrist, 73 Miller Street, North Sydney, sworn and examined:

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

Professor RAPHAEL: As Director of the Centre for Mental Health, the policy advisory body in mental health.

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

Professor RAPHAEL: Yes, I am.

CHAIR: The Committee has received a submission from the department entitled "Submission No. 267 Inquiry into Mental Health Services in New South Wales" under the authorship of Mr Bob McGregor, the acting director-general. Would you like that to be included as part of your sworn evidence?

Professor RAPHAEL: Yes, I would indeed.

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

Professor RAPHAEL: Yes, I am aware of that.

CHAIR: To put things into perspective, you briefed the Committee in May.

Professor RAPHAEL: No, I briefed you informally prior to the formal establishment of the Committee, earlier in the year.

CHAIR: Since then, after a call for submissions, the Committee has received some 300 submissions, many from relatives and many from organisations and private citizens. As a result of that and of many hearings the Committee has a number of questions which I am sure you will be able to help us with today. Is there anything you would like to say before we commence?

Professor RAPHAEL: Yes. First, I am delighted that the Committee has heard extensively from the community. There is every intention that we should move forward positively and certainly we have been very grateful for your interest and involvement. Second, as is recognised around the world there is an extensive and severe set of problems in mental health. Every jurisdiction in Australia and across the world is struggling to come to terms with the extent and severity of the problems. I have provided the Committee with details about that. It would be fair to say that it has been very difficult for all jurisdictions to come to terms with the extent, severity and impact.

For example, in our original submission we pointed out that in any one year up to 85,000, or more, person days are lost due to disabilities associated with mental ill health. It has enormous social and economic impact on the community. The department and the Government are committed under the current second national mental health plan and a third plan is currently being prepared. A planning day for that will be held with other jurisdictions on 6 September and committees are working on the Australian health care agreements, which will be reformed.

We recognise from reading about the various issues brought before this inquiry that there are a number of key issues, and I am certainly keen to address them. However, it is important that the Committee knows that we have also done additional things since the report was tabled. I read with great concern of the experiences of people, and we are as deeply concerned as you are. The department is certainly not suggesting that everything is all right, we have put before you the planning that is happening and our attempt to improve mental health services across the State. We recognise that the base we started from was low and the Minister has given substantial support and money and further support is coming in and will continue to come in.

We are extremely committed to these issues and to making them happen at a grassroots level. Some submissions related to that and that is extended in a range of ways in some of the activities now on the ground. Nevertheless, we recognise, as you do, that there is a need for an increase in our staffing

levels and further skills within the staffing mix. With respect to those skills, the Mental Outcomes and Assessment Training Program is building on those skills and enhancing the capacity of the workforce to respond. I note also that Mr Puplick raised privacy, that is a matter we need to deal with. He mentioned MHOAT, the mental health outcomes and assessment tool, and that is a systematic documentation which does not cut across privacy.

I would be happy to provide the protocols for that to the Committee. It will be extremely helpful in improving the quality of services and ensuring that there is an opportunity for us to judge when something goes wrong. In addition, since I last spoke with you, there has been an extensive involvement in looking at the quality of mental health services and the outcomes. New South Wales is the first State under the national information strategy to have a process in place to assess outcomes and to look at the numbers of people we see and what is happening to them.

In essence, although that data is not yet fully available, we are progressing with it. It will give us better information of when things are going wrong. With respect to some of these tragic incidents we have put in place an overarching committee to monitor trends and look at any underlying systems fault. That committee will be chaired by Professor Peter Baume, as an independent chair for the Government. It will have its first meeting at the end of this month. Certainly, issues have come up about the matters I read about in the transcripts with regard to a number of areas: for example, child and adolescent mental health.

We sincerely hope that the inquiry will give obvious weight to this extremely important area. We recognise that mental ill health is a growing burden, but it is quite true that there is now documented evidence that much of that commences with vulnerabilities and problems in childhood which need to be actively addressed in both prevention and treatment strategies. I am concerned that because of the focus of much complaint is often in the adult services that the needs of children may not be recognised. I sincerely hope that the inquiry will make some strong recommendations about that.

I noticed also in some of the matters before you that there has been concern about accountability at an area health service level. That is a major area in which we have a number of strategies that come into place. We hope that they will do better, for example, in the planning templates that the area health services must submit for their money, in the performance indicators on which they must provide significant data and in the new linked monitoring process for areas about any incidents. In addition, reporting on actual staff numbers, programs in place and outcomes will give better accountability.

Furthermore, we have taken a significant number of matters to do with the management and access of beds, which is one of the great sources of concern. That is to be managed centrally so that we have a day-to-day picture of exactly what beds are occupied and when there is a shortage of beds. As occurred in the middle of last night, I am rung to find a bed when one is needed. We have an active central process in place now to try to have better control over what is happening, and access to beds at a local area level. I am also very pleased to say that in the last month the reporting on quality indicators is now under way and I can provide a list of those indicators.

CHAIR: Yes, we would like to see those.

Professor RAPHAEL: In addition, I note that there was concern about older people's mental health. We have established a planning group for older people's mental health and currently we are looking at a particular concern and at the broader planning group set up under the GAP initiative. The matters of concern centre around disturbed behaviour by people with dementia and the perception of the exclusion of dementia from the Mental Health Act, although that is actually not the case. We have set in place a planning process with other aged care services to provide better services and some of the senior people who have been concerned about there being inadequate services in this area are actively engaged in this planning process with us.

It will also involve there being a co-ordinator in each area health service for the delivery of specialist mental health aged care services and for consultation arrangements with the aged care assessment teams who are delivering much of the assessment at the local area service level. I note also the concerns shared by the department about forensic mental health. I inform you that we have funded the position of a State director for forensic mental health and are currently trying to recruit for that position. In addition we have appointed Professor David Greenberg to co-ordinate the court liaison program. I note that the Committee heard very interesting evidence from the Port Macquarie program on that.

That co-ordination process and a full report on it is currently in process. That process will assist with deflecting people from unnecessary areas of imprisonment. I note also that the Committee had considerable concern about carers. We have funded, under the Government's funding strategy, a significant enhancement for carers across New South Wales in a range of different settings including opportunities for further advocacy by them. We note also the Committee's concerns about the United Kingdom's mental health bill, which is not yet an Act, and would be very happy to respond to questions about that. Community treatment orders, one matter brought forward by them, is one issue which has been in place in New South Wales for many years.

With respect to the provision of diversionary services, the court liaison program works closely with the area health services and is backed by them in those areas where it is established and will be extended further to those. We monitor closely the financing in the area health services. Details of finance might be better addressed by the chief financial officer, Mr Barker, but I am happy to inform you that we monitor that in addition to the monitoring now in place from the central finance section of the department and that this close monitoring has increased significantly in the past 12 months, with both the finance section monitoring and also monitoring through the Centre for Mental Health and reporting processes in the templates that have been set up by the resource manager in the Centre for Mental Health.

In addition, there are now active reporting frameworks to address what is done in the use of the funding for the services that are delineated in the planning documents that you have mentioned. That has been one of the complexities, because, as you would be well aware, the area health services act as autonomous bodies under the Health Services Act of 1997 and it is their job to deliver services. It is the central agency's job to influence that delivery of services as much as possible, and we work in close liaison with the area health services to try to facilitate and improve that.

Another important issue raised by you relates to the mental health workforce. Again, this is a major problem across Australia. We have put in place a number of initiatives to try to enhance the nursing workforce because there is a crisis in the Mental Health nursing workforce, which is a crucial issue across the State and elsewhere. We are pleased to be able to inform you that at least some of those initiatives have started to pay and we have 24 nurses with scholarships to do postgraduate training in mental health nursing. At least 15 have come in and another potential 18 under some of the strategies for mental health nursing. That is a small amount compared to what we need but it is the first stage of these strategies we have put in place. Mental health nursing is a national priority and there is a strategic group under the National Mental Health Working Group to try to address it.

The incentives to get psychiatrists to country areas and to support them have been increased but we are putting in place a much stronger liaison with areas about recruitment. It has been my opinion that that needs to be strengthened because it is difficult to ensure that high-quality psychiatrists, allied health workers and nurses are actively sought, and the process of collaborating between areas and the central office to enhance recruitment is a critical one in the future. There is a need to better sell the benefits of mental health nursing opportunities that are available as well as opportunities for psychiatrists. In the latest budget enhancement we have put in specific money for visiting medical officers [VMOs] and psychiatrists positions, and I am pleased to inform you that in the Illawarra at least two such positions have been funded already in the time since the funds were recently released with the extra $20 million.

I also draw your attention to some of the initiatives for giving consumers a better say in some of the regular meetings with the New South Wales consumer advisory group, which is a well-performing non-government organisation. We have developed and are in the process of putting in place a consumer measure to report on services in an active way both in satisfaction with services and in areas where they see there is a need for service improvement. With respect to the areas' response to some of these tragedies you have heard about, we have worked with areas to enhance their complaint management processes and also to build their strengths with respect to suicide prevention. In the original document you were provided with—and you can be provided with further information about the circular 98/31, which is the department circular advising on the management and identification of risk for people who are at risk of suicide—we initiated a provision of the suicide protocol and risk assessment and had it set in place. In the provision of this is a greater process for assessment of risk and response to risk when it is assessed, including better details about the observation of patients, and we have built that into the Mental Health Outcomes and Assessment Training Processes. It is important documentation for all clients.

We are also looking at how we might better avail ourselves of the information that has come with respect to any review of incidents, and that review process and the determination of trends will be

one of the important items on the agenda of the overarching committee. In looking at the suicide data we have also liaised with the Coroner and a meeting was set up with him last week to go over issues he had concern about. We responded to each and every one of the coronial recommendations, and I have details of that, should you wish. At the meeting with the Coroner he indicated he would like this to be an ongoing one. Unfortunately I was unable to attend because I had the flu, but my staff attended. I will be meeting with the Coroner personally subsequently. That is an important loop in informing us of reviews where we might have done better.

I re-emphasise the fact that we recognise there is a need to do better. We are working actively with the area health service to deliver services to ensure this happens, but we will be very much looking for your recommendations to support our processes. We also recognise there is a need to build the resource base. That involves both a potential commitment, which the Government has made and will continue to make, as well as ensuring that we can have staff. We have a large number of new beds opening in the accelerated program over the next 12 months. In addition we have supported accommodation beds set up in partnership with the areas and non-government agencies. The staffing issues for the inpatient beds will require extensive education and training and recruitment strategies, and some of those are currently under way.

In addition, there is now a regular meeting between me and the areas with regard to the implementation of their various strategies and a review process whereby if we are concerned that there is a problem in performance they will meet with me and the deputy director-general of policy to review what has been happening. Many of the areas have faced difficulties with staffing and again this comes back to both the education and training provided at the area health service level and the support provided through liaison with the institutions providing nursing education, including the College of Nursing. In addition, as you would know, the department has had a task force for the prevention of violence in the health workplace, prevention and management of violence, and when the consultancy for the education and training program is completed, as it will be shortly, we will be rolling out further education and training for nurses. A large number of strategies have come from that task force, which has had its final meeting, and its final report will be provided, including more security officers at area health service level and greater attendance to some of the better reporting of critical incidents when they occur. In addition, there will be the provision of security of physical structures, impact on design and support for nurses.

The first-ever survey in this country of the experience of evidence by health workers, including mental health workers, is in a research report currently under peer review and will provide data on this experience, which we recognise has contributed to concerns about the workforce. It is clear it is not just for mental health but in other settings which focus on some of the aggression experienced by health staff. It might be noted that there is interest in this report in what we can do to improve this setting, which ranges from the strategies to change the physical environment through to the strategies that might impact better on a day-to-day level on the nurses' and other health staff's capacity to have a de-escalation set of skills, prevention skills, as well as an appropriate duress response. The various working parties under the task force have had representations from the professions with respect to these matters.

With regard to the information systems, they are now delivering the national minimum data set and will also be providing data on outcomes. The outcomes for adult services training have been rolled out and will be collected and will provide data on service effectiveness as well as the impact of the services we are providing. I note in addition that in some of the matters raised by you the issue of dual diagnosis—mental health and drug and alcohol—is a critical one. I concur with this and see this as an issue that is of relevance both here and internationally. I would be happy to talk to the strategies in place and will be rolling out to areas to support and assist areas with this. With regard to this being a national problem, there is now a national task force to look at the connection between mental health and drug and alcohol issues and what might be done better to respond to this. We have a clinical working group, and a task force has been set up by the Premier and which Professor Ian Webster and I co-chair to particularly look at young people who are vulnerable to homelessness.

I note your concern about homelessness. We are active members of the partnership against homelessness, and that will be one of the key areas targeted by the dual diagnosis State task force. In addition, we are addressing partnerships with SAAP as well as the revision of the joint guarantee of the service. With respect to homelessness, we have set in place a number of initiatives to try to look at what we might do better with supported accommodation both in the current rollout of supported accommodation and with respect to support for people from the clinical side of service delivery. We have now released a supported accommodation strategy and will be liaising with areas to ensure its implementation. In addition, we recognise there are particular needs associated with support for not only

the workers in that setting but the carers and families. New strategies will be working with the carers of people with schizophrenia to specifically address that matter.

I would be very happy to talk on any or all of these issues and further issues with respect to your questions.

CHAIR: The first series of questions should go to the issue of funding and budget.

Professor RAPHAEL: Yes, certainly.

CHAIR: We heard evidence the other day that although you might allocate a budget to an area health service, about 25 per cent of that disappears for administrative purposes. What is the usual level that an area health service pinches out of its mental health budget for things like telephones, cleaning, lift maintenance and ground care?

Professor RAPHAEL: There is an overhead component of budget.

CHAIR: How much is that?

Professor RAPHAEL: It is not a specific section, and that is one of the things we are working with Mr Barker, and I am sure he would be happy to provide evidence on that further.

CHAIR: What sort of level is it?

Professor RAPHAEL: It is varied.

CHAIR: Is it 5 per cent, 10 per cent, 30 per cent?

Professor RAPHAEL: It is nearer to 20 per cent—20 per cent to 30 per cent in different areas.

CHAIR: So when you say the mental health budget is quarantined for mental health care, you lose 20 per cent of it straightaway just for overheads?

Professor RAPHAEL: Budgets have an overhead proportion. We monitor that. We have had difficulties in the past which we have now started to get a much better handle in areas in the current planning being asked to identify exactly what the components of overheads will be. While that has been a problem that has been of concern to us, we have been attempting to actively pin down and get a consistent figure for the overhead budget.

CHAIR: The issue of transparency has been a specific concern of just about every single group coming before us.

Professor RAPHAEL: Yes.

CHAIR: Many have suggested that there should be a board of mental health, a special area health service called mental health even, so we can take the money out of the general budget for area health services, where it seems to wash around. The Centre for Mental Health has been trying for how long, as well as various Ministers. I can remember when we were in government, every Minister wanted it quarantined, and every year the community says the Minister may allocate this amount of money but it is not getting here. What steps have you taken, what are you doing right now, to make sure that every dollar allocated for mental health services comes to mental health?

Professor RAPHAEL: First of all, we ask for quite specific reporting on what has been spent and what it has been spent on.

CHAIR: And they give it to you?

Professor RAPHAEL: Yes.

CHAIR: Are you happy with the accuracy of the information?

Professor RAPHAEL: No. It is improving progressively.

CHAIR: Has that information then been made public?

Professor RAPHAEL: We could certainly provide you with what information we have available.

CHAIR: We would certainly like that. From 1995-96 through, please. If we could have the accurate information from the area health service of what they say to the Minister that they are spending.

Professor RAPHAEL: Yes, that would be in their annual reports.

CHAIR: I am aware of that, but we cannot get every annual report. They are no longer tabled in Parliament. It is very difficult for us to collect that information.

Professor RAPHAEL: Certainly we would provide that for you. Could I comment further? One of the things that we do currently, my resource manager, who is an accountant by background, and I meet with Mr Barker. Mr Barker has now put in a line item of reporting on the mental health budget. We are moving to get much greater accuracy since that line item has come in this year.

CHAIR: Whilst allocations have been done on line items and the areas can vary them, line item reporting has been in since God made little apples. Why is Mr Barker suddenly concentrating on mental health line item reporting?

Professor RAPHAEL: It has not been reported on a regular basis, as it is now. Mr Barker, as the chief financial officer, could address that in more detail. I would like to say that Mr Gibson and I meet with each area chief executive officer [CEO] to go over the budget and to endeavour to get any explanation of any discrepancies. The critical issue is to try to address a uniform overhead process. I would support a concept of the area directors having senior and direct reporting to the CEO so that the governance can be stronger at an area health service level.

CHAIR: In other words, you would see a senior person—and the reports recommended that be a medical person—actually having control and responsibility for reporting on expenditure to the CEO?

Professor RAPHAEL: Yes.

CHAIR: Is it possible for that expenditure to be made public at the time, that is, to report to the community?

Professor RAPHAEL: I see no reason why it would not be possible at all.

CHAIR: That would overcome many of the problems. We could have clarity and transparency. Local people could then understand the amount of money they have and how it is being spent. They are the three serious concerns that every single person has come to us with.

Professor RAPHAEL: I understand that. I have had those concerns myself and I have been trying to pursue them.

CHAIR: The Centre for Mental Health does not have control of the budget?

Professor RAPHAEL: No, we do not.

CHAIR: You do policy, planning and strategy?

Professor RAPHAEL: And we recommend allocations. We have monitoring capacity, but we do not have power and control. Mr Barker would certainly be able to speak to you further on those financial matters. I would like to reiterate that we are extremely committed to making it work at an area health service level.

CHAIR: Should we beef up the powers of the Centre for Mental Health in that regard as a reporting power?

Professor RAPHAEL: Yes.

The Hon. JOHN JOBLING: If I understood you correctly when we were dealing with the mental health budget, it was suggested that about 20 to 25 per cent went to general administration and maintenance.

Professor RAPHAEL: That is right.

The Hon. JOHN JOBLING: Is it also possible that the area health services in their budgets for other disciplinary areas are taking out a similar percentage for administration and general maintenance?

Professor RAPHAEL: Yes.

The Hon. JOHN JOBLING: How much then of the areas health services' costs are communal costs? In other words, it is a little bit like a shopping centre where everybody is paying in but there may come a point where the organisation can actually siphon money out of a budget and put it to any purpose it wants or, dare I say, to a slush fund.

Professor RAPHAEL: My own experience is that the majority of the areas are very concerned. That often depends on an area's commitment and capacity to look at this. Many areas have been made more complicated by the sectorisation of the areas. So there is one lot of reporting to a sector level, as is the situation in the Northern Rivers—which, in my opinion, is adverse to an overarching mental health budget and reporting strategy. I believe that mental health must be clinically streamed in every area health service. It is certainly true that all areas would have to report on an overhead. That is part of the running costs of an establishment. We trying to get a much clearer delineation of the costs in the overhead that are attributed. That is what we are working with now.

The Hon. JOHN JOBLING: Does the Centre for Mental Health extract from the area health service budgets all these components of general so-called funding and maintenance and get an absolute total—which, I am afraid, we might find is humungous?

Professor RAPHAEL: If you want to ask about all the things that an area does for mental health, it does many more things in many areas that are actually costed in the mental health budget. When we look at our interstate comparisons, for example, at one stage we looked at the number of people with a primary psychiatric diagnosis who were occupying general hospital beds, not in a psychiatric unit but separately. It was the equivalent of an over-300 bed hospital in New South Wales.

The Hon. JOHN JOBLING: Equally if you go down this track and an area health service is adjusting its costings and moving them on this basis, it tends to make an overall nonsense of trying to adduce at the end what is the real amount of money spent in mental health, what is quarantined and what is transferred out.

Professor RAPHAEL: Yes.

The Hon. JOHN JOBLING: It could easily be argued that an even bigger percentage than 20 to 25 per cent is being moved out.

Professor RAPHAEL: Yes, it could happen. What I would like to see is a clear delineation of the overheads and cost structures. Then we can all work together with transparency about what the elements are with respect to the budget and what is a proper charge against mental health.

The Hon. JOHN JOBLING: Should the areas be obliged to clearly identify this to you in each of their annual reports?

Professor RAPHAEL: Yes, that would be good.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: According to the Council of Social Service of New South Wales [NCOSS], the non-government organisations [NGOs] in New South Wales are getting 68 per cent less than the national average, Is that true?

Professor RAPHAEL: That is true, and that is related to many factors. Can I discuss that?

The Hon. JOHN JOBLING: Yes.

Professor RAPHAEL: The factors include that the national average is particularly high because Victoria includes and charges NGOs in a totally different way to New South Wales. There is no agreed national definition of what NGO charging is in the national survey data. So a range of different things come in under NGOs. One of the things Victoria does, all of its disability support comes in under NGOs. We believe that NGOs have a major role in disability support, and our rehabilitation program identifies that. What we are trying to do now is to look at where areas are providing that disability support which might be more properly provided by NGOs, as well as funding some of the strategies within NGOs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Already Victoria has double the national average.

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would seem the New South Wales budget is a third of the national average. If Victoria has a far better integrated system and, it would appear, spending six times the amount that New South Wales is spending—

CHAIR: Eleven times.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Eleven times more than New South Wales, that is a huge difference.

Professor RAPHAEL: It is a huge difference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talk about integration with the community. Why is the New South Wales figure so low?

Professor RAPHAEL: It is low for historical reasons and because much of the work that Victoria identifies as NGO funding is being done by our area health services. For example, living skills centres are frequently provided by area health services out of the health budget, not the NGO budget. There are a lot of industrial implications in changing that, but that is one of the things we have asked the areas to address. There are issues that are appropriately managed by NGOs, and that is one of them, for example. Certainly, the provision of that sort of support is more effectively done by community organisations ultimately.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has mainstreaming undermined mental health in the sense that now mental health patients have to go to casualty departments where staff with mental health training are not available? Casualty departments state that 10 percent of their patients are people with mental health problems. Does that mean that the mental health budget goes into the casualty budget and not much of it gets delivered?

Professor RAPHAEL: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that another way of siphoning off money?

Professor RAPHAEL: No, I do not believe it is being siphoned off in that way at all. We see that as a critical issue. Around the world the presentation of mental health clients to emergency departments is being seen as a major component both of mainstreaming and the way in which people are presenting for care. We have set in place a program of mental health nurses in emergency departments and have provided a handbook to increase skills. I believe you have early copies of that handbook, but I would be happy to provide them to you.

CHAIR: Yes, please.

Professor RAPHAEL: That is published and I will send it to you.

CHAIR: As you read through the transcript, if I say "yes, please", that does not mean we will write to you and ask for the information.

Professor RAPHAEL: No, we will send it to you. You can take it for granted that I will send you everything you want.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Given the huge number of mental patients in gaol, should you not ask for some of the gaol money back? Basically, these mental patients are being treated inappropriately in gaols. Why do you not say, "We want to treat them properly as mental patients. Give us that money."?

Professor RAPHAEL: As you know, we have planning for a large forensic hospital separate from the prison complex. Although it will be situated on the Long Bay site, it is outside the prison complex. That will be a shift into the provision of care in that context. That should be up and running within the next three years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Should this hospital be associated with Long Bay gaol? Should it not be separate from Long Bay gaol?

CHAIR: I give a direction that members stay on questions about money, because we have to get through a series of matters with Professor Raphael.

Professor RAPHAEL: I will come back to mainstreaming, which is part of the question the Hon. Dr Arthur Chesterfield-Evans asked. I believe that mainstreaming is of advantage to mental health because of the high level of physical and mental health co-morbidity, the need for thorough investigations and the need to have mental health problems and disorders accepted as health issues. I have been in mental health since 1964, and I believe that there is a great disadvantage for mental health to be separated off with respect to both the quality of care and the capacity to normalise and respond appropriately in providing care. I do not believe that there was any adequate recognition or investment in mental health in the days of the major psychiatric hospitals.

The Hon. JOHN JOBLING: You referred to the differences in costings of items in other States, particularly, I presume, in Victoria. Has the Centre for Mental Health undertaken a full comparison of costings of each of the support services, whether it is undertaken by government or by NGOs, and compared Victoria and New South Wales in both dollar and percentage terms?

Professor RAPHAEL: What we have compared is the available data from Victoria and New South Wales with respect to survey data from the National Survey of Mental Health Services. That data comes to us, but we do not have the fine grain data from Victoria. I supposed that links to the fact that we do not have access to in-depth data from other jurisdictions, only what is reported in the National Mental Health Report.

The Hon. JOHN JOBLING: Have you sought that information to give you a clear financial picture? Obviously there are problems about where the money is spent. Have you actually sought the data from them?

Professor RAPHAEL: I have sought it from them, and it is being discussed currently under a program under the National Mental Health Strategy as to how we can define these services. What happens is that Victoria just makes a cut-off of X per cent of the mental health budget. So it includes a wide range of things.

The Hon. JOHN JOBLING: Mr Chair, could we get the comparison?

CHAIR: The comparison would be available from the Commonwealth.

Professor RAPHAEL: Yes, it is.

CHAIR: The Commonwealth collects all this information. We can get the information from the Commonwealth.

The Hon. JOHN JOBLING: I would like to see what the States have done.

CHAIR: We know that Victoria spends vastly more money per head of population in mental health than New South Wales does. There is no indication that Victoria is grossly inefficient. It spends vastly more as a percentage of its budget on community-based care than New South Wales does. Those

Commonwealth figures are readily available and we already have them. What I do not understand is how New South Wales with a higher percentage of its population having mental illness—as is clear from the statistics—thinks it can provide those people with an adequate level of care when it does not fund anywhere near the national average or even where we can see best practice comparisons with Victoria or Queensland? New South Wales has slipped behind, has it not?

Professor RAPHAEL: This—

CHAIR: The answer is yes or no to the question. We have slipped behind, have we not?

Professor RAPHAEL: Could I comment? We did slip behind, but we are progressing to very close to the national average with the enhancements, which have come in. The enhancements include $107.5 million. We are in the last year of that, and it is recurrent funding. There is an extra $20 million recurrent now and there will be ongoing developments of that kind. So we have moved from being right behind to moving much more towards the national average—although it will not come out in the next report but when the enhancements hit in. Mr Pearce and Ken Baker could dissect the detail of that more clearly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of the budget on mental health do you believe should be spent in the community versus in acute hospitals? All we ever hear about is hospital beds and how poor community services are in New South Wales. When all the reforms are in place and things are going wonderfully, what percentage of the budget will be spent outside and inside acute hospitals? What is your target, your direction?

Professor RAPHAEL: My target is that more than 50 per cent should be spent in the community. Could I comment? Victoria's community care is community residential. Many of those community residential settings are similar to our long stay beds. That is one reason why there is such a higher proportion. We do have community residential and we have the sort of supported accommodation. But the proportion in the community is really like small institutions in the community. I have been to visit them and look at them. They are attractive, but some of our patients who are residual, in chronic and non-acute beds now, are incredibly ill and disabled. Although we would try to shift some of those people into community residential in the same way, for many of them we believe that in terms of both their proper care and safety of the community that is not possible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In 1982 there were 3,698 beds according to your submission to us.

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I could not see anywhere the number of beds now. There is the number of increased beds, but not the total number of beds.

Professor RAPHAEL: The total number is 1,970. I can provide that for you.

CHAIR: Leave that broken up into acute beds, forensic beds, community beds for rehabilitation, small institutions and group homes because you count the beds in group homes, too, do you not?

Professor RAPHAEL: No. They come under supported accommodation.

CHAIR: We want to know precisely what that is made up of because we have had announcements from the director-general of 190 new acute beds, then the Minister announced 162, and last April Mick Reid announced 300 beds. We do not know what those beds mean and we do not know where they are.

Professor RAPHAEL: I can provide those details for you.

CHAIR: On 16 July we sent a question to you asking for an answer to where the beds are. Today is 12 August. It would have been nice to have those figures before us before we had the hearing today.

Professor RAPHAEL: I apologise. Here it is. That is my copy. I would be happy if you would like me to talk to it today.

CHAIR: This is where the new 300 beds will be.

Professor RAPHAEL: Yes.

CHAIR: Will they be opened this year?

Professor RAPHAEL: This year or early next year.

CHAIR: They include supported accommodation beds?

Professor RAPHAEL: Yes.

CHAIR: Which is why I asked you earlier whether they include supported accommodation, to which you said no.

Professor RAPHAEL: I am sorry, you mentioned the group homes.

CHAIR: I presume that group homes provide supported accommodation.

Professor RAPHAEL: It depends. Some are and some are not. I apologise. I did not intend to mislead you.

CHAIR: You will need to give us—

Professor RAPHAEL: I will give you a breakdown of exactly what the supported accommodation is.

CHAIR: Of the supported accommodation it has "100 various".

Professor RAPHAEL: That is in the process of being allocated. There has been a tender process and the tender is going out for non-government organisations and it is being advertised now. These beds will be run by non-government organisations. We have gone to area health services to ensure that they will provide adequate clinical support. Where the beds will be allocated will be determined—

CHAIR: What is the cost for these?

Professor RAPHAEL: The cost for which ones?

CHAIR: We cannot find this in the budget.

Professor RAPHAEL: I can certainly provide that for you.

CHAIR: The amount of dollars involved in what are called new funds.

Professor RAPHAEL: Yes.

The Hon. AMANDA FAZIO: Has the tender process been managed centrally?

Professor RAPHAEL: Yes.

The Hon. AMANDA FAZIO: Do you think that is the best way to ensure an equitable distribution of services across the State?

Professor RAPHAEL: In managing that tender process we took into account the resource distribution process and the knowledge of where most disadvantage was. We have used a central tendering process to try to ensure equity because we believe it is critical that these supported accommodation beds are distributed to the areas with greatest need and where there is a readiness to provide clinical support from the area health services. The tendering process was done through the requirements of the department. An outside, independent person, the Chief Executive Officer of the

Mental Health Co-ordinating Council, participated in that. It was all done in a very thorough and appropriate way to ensure equity. We are very concerned about those matters. Indeed, many of the new beds funded that are currently in the process of opening are in that process because we addressed the need in rural areas, which had been sorely under resourced and their need not met.

The Hon. JOHN JOBLING: And it still is.

Professor RAPHAEL: Yes, I agree with you.

CHAIR: The question is specifically about the tender process.

Professor RAPHAEL: Yes, the tender process was done centrally in line with the departmental requirements.

CHAIR: How many of the beds will be opened and operating by the end of December 2002? For example, not all the beds in Tweed Heads will be opened.

Professor RAPHAEL: No, not all of them will be opened because we cannot get nurses not because of a shortage of funding.

CHAIR: How many beds will be physically opened in December 2002?

Professor RAPHAEL: We hope that the beds in Taree will be opened. The intent in Taree is to have all of the beds opened. There is a very active recruiting process.

The Hon. AMANDA FAZIO: If you had the ability to have all the staff required on day one would you open all the beds on day one?

Professor RAPHAEL: Yes, of course.

The Hon. AMANDA FAZIO: Or do you prefer a staged opening?

Professor RAPHAEL: When there is a new unit, like Taree, a staged opening is good because it gets everyone skilled up. But we believe the need is so great that we want the beds opened as soon as possible. We certainly want every bed that can be opened before the end of the year to be opened. The Centre for Mental Health is supporting the areas to do everything we can to recruit nurses, including overseas recruitment. But that is the key issue that will delay the opening of beds. I cannot guarantee that this will happen to the fullest extent by the end of that time because of nursing issues. But what I can say is that—

CHAIR: The reason for asking the question is that Christmastime is the winter for mental illness, is it not?

Professor RAPHAEL: To a degree it is, but not totally. Sometimes we have quite a lower period over Christmas. We have a bad time in spring and we have a bad time when a new wave of drugs comes into the city.

CHAIR: Of those beds, how many do you reckon will be opened and operating, again where the money is flowing, in December 2002?

Professor RAPHAEL: The money will flow, and is flowing, to all of these. It is not a question about the money. It is a question about recruitment at a local level and what capacity we have centrally to influence that.

CHAIR: I do not see the Tweed here.

Professor RAPHAEL: Because the Tweed is already expected to be opened.

CHAIR: But it has not got 30 beds open, I can assure you.

Professor RAPHAEL: No, I can assure you that it has not, too.

CHAIR: It has not.

Professor RAPHAEL: I know.

CHAIR: Yet it is down as 30 of the beds under Mick Reid's plan.

Professor RAPHAEL: It was intended that it should be opened. Recruiting at a local area health service level is critical because the funds are there. As you know, there was difficulty in recruiting a director.

CHAIR: If you really want to know a bit of local history, they started advertising it a bit late.

Professor RAPHAEL: Yes. That is a critical issue.

CHAIR: They waited until the doors were almost opened before they advertised it.

Professor RAPHAEL: If you have helpful suggestions about how we can assist recruiting at a local level, because we cannot recruit to those areas. Wherever we can recruit—

CHAIR: Part of the problem is that you cannot start recruiting until the beds are open, then it is too late to recruit because then you have to wait three months for everyone to challenge and so on. The recruitment process is too long.

Professor RAPHAEL: Could I comment that we provide funds ahead of time whenever requested to assist with recruitment.

CHAIR: That does not mean that the area health service spends the funds when you ask them to.

Professor RAPHAEL: No.

CHAIR: That is the difficulty. I appreciate that the Minister has allocated funds.

Professor RAPHAEL: Yes.

CHAIR: What we do not know and what the community does not know is whether the funds are being spent on what the Minister and the Parliament has approved them to be spent on. That is the difficulty. We want to know precisely how many you expect to be opened in December 2002.

Professor RAPHAEL: I expect, but I cannot guarantee, I want that—

CHAIR: All the Illawarra ones?

Professor RAPHAEL: No. Possibly Illawarra, but they have good recruiting in Illawarra. They have a very active postgraduate educational program and a strong nursing school at the University of Wollongong. They do not have trouble recruiting. Taree, I think there is great support from the CEO and from the nursing schools linked to the area. I believe they will be able to open. Tamworth has already identified difficulties, and we are trying to assist them. I believe Hunter will be able to open. The acute unit at Dubbo will not be on line because there has been a change in the planning process at the local area health service, so it will not be on line until later. They want to change the whole plan for Dubbo Base Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have all these with the caveat that they rely on the work force—we have five-year trained nurses from university and a huge shortage of them—it effectively means that you can say: We would like all these things to be opened if we can staff them. But we pretty well know that we cannot staff them because the average age of nurses is 47 and rising, or some extraordinary old age. No-one wants to do five years training, that is three years of nursing and two years of postgraduate or whatever, and then become a psychiatric nurse. Very few new ones are coming on stream. They will not come on stream, will they? Is this really going to happen?

Professor RAPHAEL: We have done a number of things including re-recruiting people. Some of the areas have quite a pool of nurses who are being re-recruited and who are already in place. We are

part of the overseas initiative to try to recruit overseas nurses, and there are number of mental health nurses in that. Centrally we have put funding into local regional universities to work with areas to try to recruit nurses, but I agree that this is a problem. I do not know what extra you would like to suggest that I could do about it.

CHAIR: Let us go back to the number of beds that will be opened. Sydney Children's Hospital, eight acute beds?

Professor RAPHAEL: Yes, we hope at the latest March next year.

CHAIR: The New Children's Hospital, eight?

Professor RAPHAEL: Eight at the latest March next year.

CHAIR: Cumberland, six?

Professor RAPHAEL: They are already open.

CHAIR: St George?

Professor RAPHAEL: And Sutherland, they should be opened by the end of the year.

CHAIR: Does St George include Sutherland?

Professor RAPHAEL: No, the beds that were not opened at St George are going to be opened.

CHAIR: Morissett non-acute?

Professor RAPHAEL: Yes, funding has been provided and I am just checking up. I believed they were opened, but I am getting confirmation of that.

CHAIR: The 32 at Bloomfield?

Professor RAPHAEL: We believe they will be ready by Christmas.

CHAIR: South East Sydney, 20? Does that include Sutherland?

Professor RAPHAEL: Yes, it is the whole of South East Sydney. It does not include the Sutherland beds listed. These are non-acute. We believe there will be 12 probably by March next year.

CHAIR: 12?

Professor RAPHAEL: And these extra eight to make the 20, that is currently under negotiation with the Minister as to where they should be placed.

CHAIR: That will be after March next year?

Professor RAPHAEL: Yes, in about March next year.

CHAIR: The 20 at Macquarie?

Professor RAPHAEL: We are hopeful that will be before the end of this year. The Hunter fellowship ones are already in process, the Central Coast and we want the supported accommodation as soon as possible.

CHAIR: Do you think they will be in place by Christmas?

Professor RAPHAEL: Some of them will be, but not all of them.

CHAIR: Does that all add up to 300, without getting out a calculator?

Professor RAPHAEL: It is 2002-03, yes, if we cover 2002-03.

CHAIR: Is that 300 beds?

Professor RAPHAEL: I have not added up this list, but there are, yes.

CHAIR: It does not look like 300.

Professor RAPHAEL: There are others within that. If you want the list to cover the 300 I will provide it.

CHAIR: The announcement was 300 beds.

Professor RAPHAEL: Yes.

CHAIR: It was 226, then it was 300. Money is coming in here and there. It is too hard for anybody to understand.

Professor RAPHAEL: I will provide you with a clear outline.

The Hon. JOHN JOBLING: You indicated that on some occasions that you could supply these projects with money in advance.

Professor RAPHAEL: That is correct.

The Hon. JOHN JOBLING: Does that happen very often?

Professor RAPHAEL: Certainly, we do it wherever it is requested or we suggest that it is available to the areas.

The Hon. JOHN JOBLING: What sort of lead time would this involve? Would you supply the money before we see beds come into operation?

Professor RAPHAEL: It could be up to six months. We have to monitor it very closely, and we do if that is the case.

The Hon. JOHN JOBLING: The area health service would draw down the money from you. You supply it and they invest it.

Professor RAPHAEL: That is right. They would invest it in advertising for staff. We would want to see active recruitment for it.

The Hon. JOHN JOBLING: Are they?

Professor RAPHAEL: I believe that they are.

CHAIR: It is the chicken and egg. Until you provide the money they cannot advertise for the staff. Until they have the staff they cannot put their hand out for the money. It is a very circular argument.

Professor RAPHAEL: But we do provide it. We will give them pre-recruitment.

The Hon. JOHN JOBLING: I am curious to know what happens to the money if it does not come on line within six months. Do you monitor that money?

Professor RAPHAEL: We do, as far as is possible.

The Hon. JOHN JOBLING: If they do not perform within the schedule do you take it back?

Professor RAPHAEL: I would like to take it back.

The Hon. JOHN JOBLING: Once you supply it, it is out there and it is committed.

Professor RAPHAEL: Yes.

The Hon. JOHN JOBLING: You cannot get it back and check that they are performing?

Professor RAPHAEL: Yes, we do check.

The Hon. JOHN JOBLING: What do you do if they are not performing?

Professor RAPHAEL: Withhold resources from the following year until we get compliance.

The Hon. JOHN JOBLING: Has that happened to any area health service in the past year or two?

Professor RAPHAEL: Yes.

The Hon. JOHN JOBLING: Which ones?

Professor RAPHAEL: South West Sydney.

The Hon. JOHN JOBLING: Is that the only one?

Professor RAPHAEL: Perhaps a number of others. I would have to check my list.

The Hon. JOHN JOBLING: Could you let us have that list?

Professor RAPHAEL: Yes.

CHAIR: There are number of big issues: forensics, the outcomes in terms of monitoring suicide, community mental health and community-based services, and supported accommodation and homelessness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The resource distribution formula, the RDF, is coming from funding of non-health services.

Professor RAPHAEL: No, it is for health services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are only bringing it in four new mental health services and there is a sort of pious hope that it will come in but there is no time stated in your submission to us. I notice that you, yourself, are ringing up trying to find beds, which seems extraordinary in the sense that you are personally involved to fix this deficit.

Professor RAPHAEL: That is because the person who normally does it is away. I do allow my staff to have leave.

CHAIR: The issue is the RDF, if we could get on to that.

Professor RAPHAEL: Yes. The RDF is used to allocate all new funds. It is not used to redistribute them. Differences in the RDF relate to historical funding: for example, in areas where there is a fifth schedule hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that is such a huge distortion on the funding—

Professor RAPHAEL: Yes, can I just—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS:—that it means that the ones that have not got it are never going to catch up, are they?

Professor RAPHAEL: Well, they are. That is where the money is being allocated. Furthermore, with respect to the network arrangements which are now in place, there is a western, a northern and a southern network. We have our co-ordinating unit. Dr Grant Sara is co-ordinating that process. The only reason I handled the call last night is that he was on leave until this morning. That network process means

that we are having new ways to ensure access to the non-acute resources by areas that do not have them. That will be part of this development process. There are clinical protocols being—

CHAIR: There are three questions about the RDF. One is: Is it a good thing to have an RDF? Do you think it is good to spend all your mental health money with the area health services, which to my knowledge since at least 1988 have been far less than forthcoming and transparent and accountable with mental health money? Do you think it is worth throwing good money after bad? That is the first question.

Professor RAPHAEL: I think that the work we have done progressively has enhanced accountability at an area health service level. I recognise that it is still not transparent enough but I certainly think it has improved. The areas are responsible for the delivery of services. That is their legislated brief. I cannot control that delivery of services. It is not my—

CHAIR: No, but is it possible to go back to a step where you had an area health service called mental health, where an area health service across the whole State bought services, if you like, from an area health service?

Professor RAPHAEL: Yes, purchaser-provider, but it still requires accountability.

CHAIR: The question is: Do we need an RDF to spend the money like we have spent the money—we are told we have spent the money—across the State in a fair way to each of the area health services on the basis of their populations and their needs?

Professor RAPHAEL: I think it has been helpful with regard to ensuring—

CHAIR: Do you think that is the way to go for mental health? That is the question.

Professor RAPHAEL: I do, but with much greater accountability and refinement of the RDF.

CHAIR: The second question is: Should the RDF for mental health have different things in it: for instance, the preponderance of different types of mental illnesses? Dependency is different from general health.

Professor RAPHAEL: I think that there are many factors which should be the same, including socioeconomic factors and single parenthood. When I came the RDF was based on the number of single males in a certain age group, which only dealt with people with psychosis and did not deal with the need. We have changed that. Certainly—

CHAIR: So there is a development of the RDF at the moment?

Professor RAPHAEL: Yes.

CHAIR: Is that a public document?

Professor RAPHAEL: Mr Pearce could speak to you about that. It is still in draft form.

CHAIR: So we still have not got it. You are now developing it but it has different things in it—

Professor RAPHAEL: It takes into account—

CHAIR:—than the ones for emergency medicine or general hospital care?

Professor RAPHAEL: It taken account also the fact that care is provided in the community—we need to provide it. It also takes into account the levels of severity and disability associated with mental illnesses. Our planning templates also take that into account.

CHAIR: If you had an RDF in place it would be easier to follow the money for someone in, say, Northern Rivers to long care—non-acute care—in another area. It would be easier to follow the money.

Professor RAPHAEL: I think there need to be quite specific funding arrangements so we make sure that—

CHAIR: You can still follow the money. If there is an RDF you give the money to Northern Rivers and if they decide they want to set up their own rehab or their own long-term care—

Professor RAPHAEL: But then they account to us for what they are spending the money on.

CHAIR: Yes, sure, but if you have an RDF entirely you have all the money for Northern Rivers—

The Hon. AMANDA FAZIO: Could Dr Raphael continue with her answer?

CHAIR: She is not answering the question.

Professor RAPHAEL: I wanted to explain to you that the RDF only provides for distribution to the area; it does not provide for distribution within the area.

CHAIR: No, I understand that. Say, for example, that Northern Rivers has no long-term beds at the moment and no rehab. It depends, as you said, on the three new sectors you have set up. Those patients from Northern Rivers go to Northern, for example.

Professor RAPHAEL: Yes, that is right.

CHAIR: If it were all given to Northern Rivers under the RDF as everything else is meant to be then it would be perfectly clear that they are buying for Northern Rivers patients services at Morisset.

Professor RAPHAEL: Yes.

CHAIR: At the moment it is not clear like that, is it?

Professor RAPHAEL: No, it is not.

CHAIR: So that is the reason for an RDF. Will the new formula include that sort of detail for transfers?

Professor RAPHAEL: Yes, it should but that is dependent also on the Government's broader new funding initiatives including episode funding and the funding frameworks. Mr Pearce and Mr Barker are better able to talk to that.

CHAIR: The only way that, say, Northern Rivers or Orange can establish their own base services for long-term and psych rehab and so on is if they know they have a certainty of this amount of the mental health budget.

Professor RAPHAEL: Yes.

CHAIR: At the moment you have superimposed on the area health service money the existing services for long term and rehab. Did you say north, south and west?

Professor RAPHAEL: Yes.

CHAIR: So it is quite different from any other service in the State, is it not?

Professor RAPHAEL: No, there are many examinations of networking in the State currently to try to look at these issues. Quadrangles and other networks are also being established. The paediatric network is one such network. There are also networks under the greater metropolitan transition plan. So there are a lot of networks being set up.

CHAIR: But does that arrangement not stop the movement of any of those sort of services out into the countryside and out into southwest Sydney, for example?

Professor RAPHAEL: No, nor would this networking stop that at all.

CHAIR: So we could expect to see long-term care and psych rehab in Lismore, Orange and Dubbo?

Professor RAPHAEL: If it is appropriate. You might not want to do cardiac transplants in Lismore. So it depends on the specialty needed and the critical mass of staffing. That is where there may be transfers and determinations about where they should be—

CHAIR: Ten per cent of the State lives in the Hunter and 10 per cent lives on the North Coast of New South Wales. Both those areas have a high proportion of people with mental illness.

Professor RAPHAEL: Yes, and a bit of the northern network, the Hunter and the Mid North Coast and Northern Rivers are already working in some collaborative framework.

CHAIR: I know that, but that means that somebody from Lismore has to travel to Morisset and somebody from Coffs Harbour has to travel to Morisset. That is crazy stuff.

Professor RAPHAEL: I agree. What we want is something that happens differently from that. What you brought up earlier is critically important, that there is strong co-ordination and management of mental health at an area level by someone committed in mental health.

CHAIR: It is not happening now.

Professor RAPHAEL: It happens in some areas but it certainly does not happen in your area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a commitment at the time of the $107 million that there would be full involvement of NGOs in the planning process, particularly in relation to expenditure on community care and NGO-delivered services.

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems from the submissions to us that the Mental Health Implementation Group has not played any role in allocating funds. How were the NGOs and mental health consumers involved in that process of planning the expenditure of that $107 million?

Professor RAPHAEL: It was presented to the Mental Health Implementation Group. The proposed allocation was discussed with them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they have any feedback loop from what they said? It was one thing to be presented with a relatively firm health allocation. It is one thing to say, "The here are the facts. It is now set in concrete. What is your feedback? Do you like it?" and then call that a consultation process. But how much did they actually determine where the money went?

Professor RAPHAEL: Their submissions and advocacy to the Minister determined a lot of that in the first place. They were presented with it and asked for feedback. The allocations were determined centrally.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did this hugely increase their allocations?

Professor RAPHAEL: There has been an increase in their allocations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How come they have such a small percentage of the money?

Professor RAPHAEL: It is to do with the allocation and determination of the disability support component. Many of the original allocations in the $107.5 million were to do with the essential development of acute units in rural areas.

CHAIR: This is the problem. The community identified to us that of the $107 million more than a third was taken away for salary rises and the like. The amount the community got was $400,000 of the whole $107 million.

Professor RAPHAEL: I would like to take that on notice, please.

CHAIR: Take it from me, the figures show that there was a very small increase in spending for NGOs. While I appreciate that you are trying to pick up the problem with acute, it goes back to the question that Arthur Chesterfield-Evans asked: What is the proper balance between community and acute? If you have no community then everybody has to go to acute. If you have no acute you need higher support in the community. Where are we are now between acute services, including long-term, and community-based services? What is the balance at the moment?

Professor RAPHAEL: There are many different forms of community-based services. They range from clinical services to NGO services. I wanted to separate the community NGO services which are often called community from the clinical service delivery. I would be happy to provide figures do you.

CHAIR: Clinical services are only part of the problem, are they not?

Professor RAPHAEL: Yes.

CHAIR: The need for supported accommodation depends on good clinical base services in the community, but it is not all about that.

Professor RAPHAEL: No.

CHAIR: Good. So we can separate the clinical funding for both the community-based services—what we have now and where we are going. That is what we want to know because at the moment it looks like more and more funding is going to acute services. I do not know whether that $107 million will establish a whole lot more mental health teams in the community.

Professor RAPHAEL: A very significant number more mental health community-based staff were within that allocation. About 700 if I remember rightly. I will check that.

CHAIR: I know that it is difficult but I would like to know how that compares with Victoria and Queensland.

Professor RAPHAEL: Yes, as far as we have data available.

(Short adjournment)

CHAIR: The next area I wish to discuss is outputs and I am particularly interested in the issue of suicide. I know that that is a bit of a headline grabber, but there was a major report on suicide by the Legislative Council. I cannot ignore that. The report is titled "Suicide in New South Wales" of November 1994.

Professor RAPHAEL: Yes.

CHAIR: The issue there was raised in 1994, that "the Minister for Health ensure equity in the provision of mental health services across the State" and there was a recommendation in the report on some of the issues about children's health and the issue of Aboriginal health. I will not re-canvass a lot of that stuff, but one of the big issues that can be measured is the number of suicides associated with mental illness.

Professor RAPHAEL: Yes.

CHAIR: Just recently in the press there was a report about schizophrenia which stated that 84 per cent of people who died last year and who had schizophrenia died of suicide. That is a horrendous figure. I do not know how accurate it is. Each year one in six people who has schizophrenia commits suicide. That is also a horrendous number. Are they accurate figures?

Professor RAPHAEL: They are based on what is called for the low prevalence disorder study which was identified in the same report. That is a study that was done in three States. It was before my time here, not including New South Wales, and it looked at people who could be identified as suffering from an illness. I do not know the accuracy of the actual numbers of suicide deaths, but it is certainly true

that there is a much heightened risk at certain times and that that is an active part of what we need to address and what we are trying to address.

CHAIR: So that same study, you have had a good look at it?

Professor RAPHAEL: Yes, I have read it. Do you have a copy of it, because I could give you one.

CHAIR: I do not have.

Professor RAPHAEL: I could provide you with a copy.

CHAIR: If you have done a critique on it, I would be more interested in that because more importantly it applies to New South Wales. That would be much more valuable to us than reading the study.

Professor RAPHAEL: I would need to take that on notice because I have read the report but I have not written a critique.

CHAIR: Would you do a critique of that as a matter of course? I do not want you to do extra work.

Professor RAPHAEL: It depends on the time line, but I will try to get something done for you. I have some further data on suicide, if you like.

CHAIR: Up until 1995 I am aware that there were suicides reported and that the subset of those were suicides under care. I am aware that those figures have not come out for a while. I want to know why they have not. It occurs to me: how can people do planning, how can communities be concerned about clusters in their own areas or planning for that, or have strategies developed, unless they know the numbers?

Professor RAPHAEL: Can I go into that in detail?

CHAIR: Sure. What is sent to the Centre for Mental Health is de-identified data from an area health service with initial and age groupings on suspected or possible suicide. It is not confirmed suicide, which makes it difficult for us to assume that it is suicide. However, recent data since we made a submission to you in a report from Western Australia where they have very extensive and long-term data and linkage of data which does not exist in this States as yet—

CHAIR: It used to exist. In 1995, the number of suicides for people in the subset who were under care was reported.

Professor RAPHAEL: Yes. What I am saying is that the accuracy of that data was reviewed. I came into this job in 1996 when a new framework to make it more accurate was put in place. What we do, because we do not have linkage with the names of the people who come in with the agreed suicide definitions in either the Aboriginal Institute of Health and Welfare [AIHW] report on suicide or on the Coroner's report, we have a process whereby we might be able to link them. But can I tell you what we can tell you about the data on suspected suicides that was coming in?

CHAIR: Yes.

Professor RAPHAEL: Fortunately a report was released recently from Western Australia which showed that the suspected suicides between 12 and 18 per cent of the total suicides. What we have been able to do is graph our suspected suicides that have come to us against the total suicides, and I am able to report to you—and I can provide that graph to you—that we fall within the same percentage as the other States, in that 12 to 18 per cent.

CHAIR: So how many suicides per year would there be of patients who have a mental illness?

Professor RAPHAEL: There would probably be at least two-thirds, but not all of them would have been in contact with a mental health service.

CHAIR: No, numbers, numbers.

Professor RAPHAEL: Well, it is probably about 400 or so, but they would not have all been in contact with mental health services. That is what I am telling you. If we were to make estimates of how many have been in contact with mental health services in New South Wales, estimates would probably be 125 within the time frame of reporting, which is either presented in the last month or as inpatients.

CHAIR: I do not want absolute numbers, but if you look at outcomes, which is what you talked about earlier, and trying to measure outcomes, one of the serious outcomes is deaths.

Professor RAPHAEL: Yes, I agree.

CHAIR: It is very important for us to be able to know if a person is part of the mental health service—has been identified and has been under the care of a mental health service, whether in an acute hospital or not in an acute hospital—and how many of those people commit suicide. Then, once you have found out how many, under what circumstances. It is the risk management part of it.

Professor RAPHAEL: Yes, exactly. We are constantly monitoring the suspected suicide reports to look at what the risk factors were, and that is built into the revision of 98/31 and into the protocols of the Mental Health Outcome Assessment Tool [MHOAT].

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We do not seem to have these figures.

Professor RAPHAEL: What I am saying to you is that I can provide you with a graph which shows that the suicide rate has fallen, as far as we can tell, during the past couple of years. The peak was 1997-98, and we would hope that what we have been doing has had some impact on that, but it is extremely difficult statistically to prove that that is the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You must have suicides in hospitals and you must have suicides within a certain time.

Professor RAPHAEL: We have reported suicides and we have suspected suicides, but it is only a suicide when it is confirmed by the Coroner. What I am saying to you is that, on the best available estimates of what that is likely to be, we now have data which we are happy to provide you with which says that we are between 12 and 18 per cent.

CHAIR: Between 12 and 18 per cent of what?

Professor RAPHAEL: Of the total suicide deaths.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are talking in a vague of a vague, are you not?

Professor RAPHAEL: No, I am not.

The Hon. AMANDA FAZIO: No. Dr Raphael gave us some firm numbers.

Professor RAPHAEL: No, I am telling you that we can suspect something is a suicide, but it is only a suicide when it is confirmed by the Coroner.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. When you got the definitions of suicide, they must have always been vague like that. If you take the ones for the 1980s and the 1990s, they had the same problem about being vague then. So, in a sense, if the definitions remain the same, although the areas may remain the same, the numbers must be able to be put in a table and looked at as a trend. Can you give us those numbers?

Professor RAPHAEL: That is what I am offering you now—a trend.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said it was a graph, presumably with error bars.

Professor RAPHAEL: It is a graph in terms of what was reported to us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give us a table? I do not think you have said it clearly.

The Hon. AMANDA FAZIO: Can you not understand a graph?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No. I would rather have a table. Can you tell us how many people have died from year to year, how many of them were within the groups and how many without the groups, and if there are areas in that of 10 or 15 per cent, or whatever percentage it is, and whether they are Coroner-confirmed ones or suspected ones?

Professor RAPHAEL: Yes. Our problem is that we do not know which ones were or were not confirmed by the Coroner. We can only compare the rates.

CHAIR: If you add to your suspected ones the Coroner's ones, that gives you a total number of suspected plus confirmed.

Professor RAPHAEL: No. The Coroner's ones may be within or outside. They may be overlapping, so it is not a total.

CHAIR: But once they are confirmed by the Coroner, they are no longer suspected. They are actual.

Professor RAPHAEL: That is right.

CHAIR: I know there is a difference between this year, 2000 and 2001 and that the Coroner's cases might be a year later.

Professor RAPHAEL: They may be, or a couple of years.

CHAIR: Therefore you have to take out the suspected and add that to the actual.

Professor RAPHAEL: That is right.

CHAIR: But in fact it does not change much of the numbers, I would not have thought. How many does the Coroner deal with each year?

Professor RAPHAEL: I do not know how many he deals with each year.

CHAIR: If a patient dies in one of your acute hospitals and you think that they might be a suicide because they have been found hanging in their cell, they are suspected.

Professor RAPHAEL: Yes, that is right.

CHAIR: They are still dead and they have still hanged, but it may be murder.

Professor RAPHAEL: Yes.

CHAIR: But, at the end of the day, that suspected one does not disappear. It is still suspected.

Professor RAPHAEL: Yes.

CHAIR: And you can either make that person an actual death from suicide confirmed by the Coroner, or not?

Professor RAPHAEL: Yes. Look, I am not trying to obfuscate.

CHAIR: I know.

Professor RAPHAEL: I am very happy to provide you with what we have been able to assess with this research report, to give comparisons and to show you what the pattern is between suspected and reported.

CHAIR: Is this pattern across the nation?

Professor RAPHAEL: We have data from Western Australia and from New South Wales and we also have some projections. It shows that the pattern is similar to the Western Australian pattern in that there is a decrease.

CHAIR: The Commonwealth funded, with the help of all the States, a major suicide prevention strategy.

Professor RAPHAEL: That is correct.

CHAIR: A certain number of dollars went with that and went to each State. Did you delegate that with a strategic plan down to areas?

Professor RAPHAEL: There was a specific Commonwealth allocation which was principally an initiative for rural youth suicide. We delegated that directly to the areas and we monitored. We have an evaluation report on it. Secondly, there is new Commonwealth money which comes via the State branch of the Commonwealth. A senior officer in my department who sits on one of the committees of the national strategy council, Kym Scanlan, works with them and there will be more money coming through that process. But we allocated $15 million in recurrent money from the State itself towards suicide prevention. We have a whole-of-government suicide prevention strategy signed off by all Government departments, which we are monitoring.

CHAIR: Your share was 15?

Professor RAPHAEL: Yes.

CHAIR: But some other parts of government would have got more money apart from that?

Professor RAPHAEL: I have no idea what they got. We know that they all signed onto the strategy.

CHAIR: That would have been police and community services and so on?

Professor RAPHAEL: Yes, that is right.

CHAIR: It is a real shame in many ways that when the whole of government does something—such as the money that housing puts into mental health is very large yet it is identified as housing money when it effectively is an important part of mental health.

Professor RAPHAEL: Yes.

CHAIR: What really, I suppose, bugs me is that the community cannot see what government is really spending on mental health.

Professor RAPHAEL: I agree with you and it would be really good as we have a joint guarantee of service with housing and a memorandum of understanding which is now being extended to include DOCS and the SAPP projects as well.

CHAIR: That is a large amount of money and from our evidence housing is one of the most cooperative arrangements.

Professor RAPHAEL: It is. It is excellent.

CHAIR: But again that $15 million you got for your money, how much of that was used centrally by the Centre for Mental Health for developing plans and so on and how much of it actually got to the ground?

Professor RAPHAEL: All of that went to the ground.

CHAIR: So you already had a strategy in place?

Professor RAPHAEL: We developed a strategy. That went out before the strategy. Much of that went to where we knew there was a potential to impact on suicide.

CHAIR: Did that go to employing people to actually do counselling and identification?

Professor RAPHAEL: Yes. It particularly went to services for young people who were at the highest risk at that stage.

CHAIR: That is what was identified in the report?

Professor RAPHAEL: Yes. It particularly went to services with young people, including services for young people with depression. We put additional funds in nonrecurrent from the government in Schoolink which was one of the additional programs that came on.

CHAIR: Was Schoolink money extra from that?

Professor RAPHAEL: Yes.

CHAIR: There was the money that the Department of Education put in for?

Professor RAPHAEL: Yes, with counsellors' training part of it.

CHAIR: In schools and so on. That is probably one of the more effective of the programs.

Professor RAPHAEL: Yes.

CHAIR: Does that show up on assessment when you do the validation of these programs?

Professor RAPHAEL: Yes.

CHAIR: You spend the money, you validate; does the school process show up well in validation?

Professor RAPHAEL: It does, extremely well. It is one of the ones that New South Wales has been leading with respect to that.

CHAIR: That is separate again. That is government money; it goes into education but it is not identified as mental health money?

Professor RAPHAEL: That is right. I absolutely support what you are saying about the need to identify some of these other sources of funding because mental health is such a big problem everybody has got to be in there and everything everyone does. The broader community has to be involved. Mental health touches every family.

CHAIR: If you are going to look at mental health funding, if you are going to make sure it is spent as best it can see it has got to be transparent and accountable.

Professor RAPHAEL: Yes.

CHAIR: So that the money we spent on education might be all wasted. It might be all just a waste of time?

Professor RAPHAEL: Yes.

CHAIR: Unless that is evaluated properly I am not sure we are getting value for money for our mental health

Professor RAPHAEL: Are you talking about education in schools?

CHAIR: Yes.

Professor RAPHAEL: What we are doing with respect to that is evaluating those programs. For example, Mental Illness Education Australia, we evaluated that and modified the program in accordance with it. One of the findings from a large range of research studies is that telling kids directly about suicide does not help. In fact it may make them more at risk. That is why we have invested in dealing with depression which is the commonest preceding factor and, as you know from the other papers, a very high number of kids, particularly in the adolescent years, develop a major depression. So our program of school link is targeted to increasing the skills of schools and school counsellors. There is also a program funded by the Commonwealth, but we are part of the roll-out in New South Wales, called Mind Matters which is to increase the work in schools in a positive way about positive mental health initiatives. We also fund some programs called RAP, the Resourceful Adolescent Program and ACE, Adolescents Coping with Emotion.

CHAIR: That is not mental health money, is it?

Professor RAPHAEL: It is.

CHAIR: So some of the money you spend in schools is mental health money

Professor RAPHAEL: Yes. It is programs and then we would fund it with the school but it would be mental health staff.

CHAIR: That is why I asked the question before: How much of the mental health money is spent by the areas? How much is spent on whole of government? Is that $15 million you allocated before—

Professor RAPHAEL: That is to the areas totally.

CHAIR: So the extra money for schools is different. How much money is that involved?

Professor RAPHAEL: $5 million plus.

CHAIR: Do you have any other allocations from the Centre of Mental Health to other government agencies for that sort of work?

Professor RAPHAEL: We have funded some NGO programs. If you are talking specifically about school, we have funded an officer to be involved in the rollout of Mind Matters and we have funded Mental Illness Education Australia and the Peer Support Foundation, so we have a number of non-government programs that we have funded as well.

CHAIR: So when you look at the whole of government that does not include the allocation that governments make to education?

Professor RAPHAEL: No.

CHAIR: So there is much more money we are talking here than just the mental health money?

Professor RAPHAEL: Yes.

CHAIR: But again we have to be accountable about that in terms of whether it is improving mental health or not?

Professor RAPHAEL: Yes.

CHAIR: Who does the assessment of that?

Professor RAPHAEL: Improving mental health or not?

CHAIR: Yes.

Professor RAPHAEL: There has been an inadequate information system to do that until this information system we are rolling out. We got a total of $12 million from the Commonwealth to roll that out and I am pleased to tell you that we are doing that currently. As I said, we are ahead of the other

States with respect to this and we will have outcomes assessment as part of the future. That is not available for everybody now but it will be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are NGOs to be involved in that?

Professor RAPHAEL: They are in the next stage. We have made a commitment to work with NGOs with respect to both the MHOAT training and outcome measurements with NGOs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The MHOAT seemed to be very individually based and people are complaining about how long it takes to fill in but I notice you did not have much data from area health services or from NGOs and there was a comment in your submission 267 to that effect, that the data was not available and I think it was not even going to be available.

Professor RAPHAEL: It will be available. It is not available now. Do you want a copy of the MHOAT protocols? MHOAT is a big reform for services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People have complained that it is very detailed and it takes an immense amount of time and yet that is individual detail being filled in by individual clinicians at the coalface, as it were, whereas even bigger things such as how many beds there are or what services are being delivered by area health are not being delivered. Aren't you surveying individuals rather than a bigger picture?

Professor RAPHAEL: This is part of good clinical care. This is a response to reviewing instances and looking at the clinical notes. The aim of this is to have good documentation of a thorough clinical assessment process. We are having a consultation on 28 August to slim this down but we rolled it out because it had been developed through a research based study and it was used in three areas when we rolled it out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The problem with the health system as a whole is that it has great clinical care but the big picture gets overlooked in the sense that you have really good care on a one-to-one basis in the acute systems but you do not put enough money into the preventive systems or community-based systems to prevent people leaning on the government.

CHAIR: The issue we were going to was do you have a mechanism for assessing whether the government's money is being targeted properly and whether or not the programs you have put in place are effective?

Professor RAPHAEL: Yes.

CHAIR: That is what the MHOAT is about, that is what he is trying to say.

Professor RAPHAEL: Yes, that is what MHOAT is about because ultimately to judge the effectiveness we must know what happened to individuals and accumulated data of individuals. We must also know if the program is being delivered. We have a policy which is trying to look at how you can check that the core elements of the program are being delivered through an audit process and that depends on the evidence base for the program. The first area where we are doing that is with the early psychosis programs which are a hopeful and positive initiative for making things better.

CHAIR: We will come to that shortly. If I can very briefly get out of the way the issue about lists of patients because this is coming to what MHOAT is about, the unique identifier and so on. You and I had a conversation the other day because we had people coming to the Committee saying that they would like to have a list of patients who had a mental illness: Police, community people, etc. You told me that the old list, which I think was called CRISP,was closed.

Professor RAPHAEL: That was closed down years ago. It was an information system.

CHAIR: But now you indicated to me that the Commonwealth has provided you with funding to produce an e-record in compliance with the new health records privacy Act which means that you will be able to keep tabs, if you like, on people who have a mental illness in a highly private way but that nobody else will have access to that unless they are a person providing a clinical service.

Professor RAPHAEL: That is correct.

CHAIR: MHOAT , as I understand it, will then be able to be fed into their record?

Professor RAPHAEL: Yes.

CHAIR: That is why you will get a better clinical watch of what is happening and the services that are being provided?

Professor RAPHAEL: Yes.

CHAIR: The question still remains with somebody who is acting strangely with a knife on Bondi Beach, how would you be able to get access to information about that person, if you know who they are, so that police and others can deal with the issue in an inappropriate way?

Professor RAPHAEL: The clinician making an assessment of the behaviour will be able to access the clinical records.

CHAIR: So the police will have to call for a clinician to come forward?

Professor RAPHAEL: Yes.

CHAIR: And then that clinician will get the information and advise the police on a need to know basis?

Professor RAPHAEL: Yes, on a need to know basis. If the person is a known client of the service but many people who behave strangely, it may be their first presentation.

CHAIR: That might be their index presentation?

Professor RAPHAEL: Yes.

CHAIR: But again I am comfortable to answer the question that I asked myself, I suppose, that we do not need a list as such, as long as we have got enough people in the service so when the police are confronted with somebody they can call a mental health team and get access to information that they need via that person. Currently the police evidence is that that is not available to them. What have you done—not planning—to boost the support for the police if they call a mental health team?

Professor RAPHAEL: First of all, we have had a consultation process and we have rolled out, putting into effect and monitoring new protocols for coordination between mental health services and the police. Brand new MOU and protocols.

CHAIR: Has that been signed off?

Professor RAPHAEL: Yes, it has.

CHAIR: Have you got a copy of it?

Professor RAPHAEL: Yes. This one is much better. There are clear flowcharts. Furthermore, we have a regular meeting of the committee which involves us, the police, the ambulance and the emergency departments to monitor this with monthly reporting on programs and that will continue from now on. So we will know where there is a problem. The police are also monitoring waiting times etcetera, so there will be a combined monitoring process and reporting back from area health services about those.

CHAIR: When you get the *Hansard* can you confirm what I said before? I was just putting that information onto the record for saving time purposes but is what I said to you reasonably accurate, the Commonwealth funded a boost to give you e-records ahead of everybody else?

Professor RAPHAEL: Information records, yes, electronic records, that is correct. When we made a successful submission to the Commonwealth we are the first State to do that and it is quite stringent.

CHAIR: If there is anything else you would like to add to that when you get the *Hansard* would you please inform us?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been said that if people cross from one area health service to another their community treatment orders do not apply. Is that so?

Professor RAPHAEL: Usually there is a notification process, and they can still apply. It is a matter of ensuring their service shifts from one area to another.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In practice often they are homeless and shoot through.

Professor RAPHAEL: Some do, and we would try to monitor that and follow them up. There is a process for following up someone who does not present on the regular basis that is required for the community treatment order.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably that person would be found in their new location?

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are they able to be looked up and found?

Professor RAPHAEL: Yes, they are able to contact us and find us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are able to find the community treatment order [CTO] from the other area?

Professor RAPHAEL: Yes.

CHAIR: How can they do that?

Professor RAPHAEL: They can ring up the local clinicians or the place where the person came from.

CHAIR: Is there not a list of community treatment orders? They are public court orders.

Professor RAPHAEL: Yes, they are, I will check exactly where the list of CTOs is held. We have knowledge of it within the Centre of Mental Health under the forensic regulatory component of our reporting.

CHAIR: But they are not necessarily forensic patients, are they?

Professor RAPHAEL: No.

CHAIR: A CTO is granted by a magistrate. Therefore there must be a public statement that X has a community treatment order, they are not private hearings before the magistrate.

Professor RAPHAEL: I cannot confirm where that is held. I will find out for you.

CHAIR: On Wednesday of last week the Committee was told that if a person has a CTO and skips across the border no-one chases them and the CT0 is not enforceable.

Professor RAPHAEL: Across borders they are definitely enforceable. We have a cross-border agreement.

CHAIR: But not if they move within New South Wales.

The Hon. AMANDA FAZIO: Last week the Committee was told that if someone was within a particular area health service and a CT0 was applied to them and they moved to another area health service they sometimes did so to avoid the CTO being applied.

Professor RAPHAEL: Yes.

The Hon. AMANDA FAZIO: When one is granted, is it granted for the whole of New South Wales or only if they stay in a specific area health service?

Professor RAPHAEL: It is usually related to a specific place from which they receive treatment. I will confirm the details of that and advise you in writing.

CHAIR: I am aware that the Minister has made arrangements with Queensland and Victoria, and that appeared in the gazette last February. However, can the person be traced from Sutherland to Liverpool?

Professor RAPHAEL: My understanding is that they can, but I will confirm that.

CHAIR: If not, what steps will you take as a policy, enforceable through funding if you like?

Professor RAPHAEL: I understood that was being done, but I will find out.

CHAIR: If a person from Sutherland turns up at Liverpool there is no record of the CTO.

Professor RAPHAEL: Normally it would be on their record.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is one thing to have it theoretically traceable, the practical reality is another thing.

Professor RAPHAEL: Yes. I will confirm what currently happens.

CHAIR: How proactive are the teams in the community to stop someone from being readmitted? If the teams are not making sure that people take their pills, providing rehabilitation and support, of course those people will go back into the acute system. Of course you need more beds and that puts more and more money into the acute service.

Professor RAPHAEL: I emphasise my absolute commitment and the department's commitment to community mental health. All the evidence is that there has to be a balance of in-patient and community services. I absolutely support that. We have put in money for new community mental health members and teams.

CHAIR: How much of the new money is community based?

Professor RAPHAEL: I can give you a breakdown on that.

CHAIR: The $37 million was for wages, and some of the wages are within the community. What are the new initiatives? How much of the $170 million—

Professor RAPHAEL: Did you say $170 million?

CHAIR: Was it not $170 million all up for three years?

Professor RAPHAEL: No, $107 million. I wish it were $170 million.

CHAIR: Yes, you are correct. It was $107 million and another $20 million announced by the Premier, so is now $127 million. Over the next three years what is to be spent within the community whether supported accommodation, rehabilitation or other?

Professor RAPHAEL: Yes.

The Hon. AMANDA FAZIO: Early in this inquiry the Committee heard evidence from a consumer group that represented people with mental health problems. The group raised concerns about when a person has an acute episode and were in rented accommodation. Often the person would lose his or her accommodation and possessions. Often people with mental health problems are quite lonely and do not fit into the community.

Professor RAPHAEL: Yes, they do not have a network.

The Hon. AMANDA FAZIO: Often a pet is their sole companion. When they have an acute episode they lose their accommodation, possessions and pet. When released after the acute episode they are left virtually with nothing and have to start from scratch, which would mitigate against their successful rehabilitation. Are you aware of any community services for mental health patients in that regard that would provide support for them to keep their residence?

Professor RAPHAEL: Some local community groups have consumer consultants, and in the area health services there are facilitators and social workers. I cannot guarantee that that would happen every time. It is something that should be taken into account. Sometimes staff members take the pets home and mind them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have figures on how many community treatment orders are successfully completed? At the end of a community treatment order does the person who is responsible for supervising it send it in? Can you say that 90 per cent of community treatment orders go through to finality, or not?

Professor RAPHAEL: I will take that question on notice. I mention another initiative with police. We have funded an education program and one of the first stages of that is a two-day conference with police on mental health. It is to be held in Goulburn on Thursday. I will speak at that conference as will the commissioner.

CHAIR: There is a need for some basic levels. I refer to homelessness and housing. The Committee has received a number of submissions from organisations such as the Richmond Fellowship and the Bea Miles organisation about boarding houses and homelessness. It appears that if you are providing supported accommodation for a person with a mental illness, from the Department of Health you would get about $10,000 for a high-needs a person.

Professor RAPHAEL: No. The Department of Health is funding supported accommodation. For example, in the current funding it is $43,000 to the NGOs.

CHAIR: For a high-needs disabled person it is $70,000?

Professor RAPHAEL: Yes.

CHAIR: Previously, the Department of Health provided $10,000, you say it is now $43,000. The Richmond Fellowship told us that they took in a mentally ill patient and the maximum they could get for supporting a person with a psychiatric disability in their accommodation was $10,000.

Professor RAPHAEL: I will take that on notice.

CHAIR: If it is now $43,000 that is still short of the $70,000 that is available for a person who has a physical disability.

Professor RAPHAEL: That is true. It depends on the level of disability. That is one thing that we are happy to look at in detail with you. The $43,000 is based on the best estimates we have made in getting an appropriate responsive system. But in essence there are additional funds; the areas will be providing clinical care on top of that, without additional funding.

CHAIR: That is true. Disability funding gives extra money for recreation, et cetera. What funds do you provide for someone in supported accommodation in the Richmond Fellowship home that has five or six clients? Do you have the same requirements as those with the disability? For example, do you have single rooms?

Professor RAPHAEL: There was certainly that requirement under the Disability Services Act but we would fit in with the needs of the population. Single rooms are the preferred option.

CHAIR: You made the point about a guarantee of service. Are you aware that under the Department of Ageing, Disability and Home Care arrangements there is an absolute life-long guarantee of service that has been signed off by the Minister? Is that true of mental health?

Professor RAPHAEL: No.

CHAIR: Would you be working towards that? Do you think it is an appropriate way to go?

Professor RAPHAEL: The consumer movement, and I agree with it, seeks both disability support and also hopeful options. They are strongly focused on recovery. Disability for life may be the case in a proportion of mental health clients, but it certainly is not the lot of them.

CHAIR: While they are disabled would you sign off on that sort of level of support for mentally ill disabled people as well as the physically disabled people?

Professor RAPHAEL: I will take that question on notice. For example, a patient who spoke to me at the end of a discussion with consumers said that he had totally changed since he had been on clozapine, the new anti-psychotic agent. He said his mental health was different and he was going back to work and his whole life has changed. We have to bear in mind that labelling someone as disabled for life may have adverse consequences.

CHAIR: If he gets well, of course he does not need support. The guarantee does not have to be taken up for the next five or six years, but if he decompensates and comes back into an acute service he will not go straight back to work. There will be a period of rehabilitation.

Professor RAPHAEL: I will take that on notice.

CHAIR: How much money do you allocate for supported accommodation for outside recreation, socialisation, education opportunities and employment?

Professor RAPHAEL: We do not allocate specifically to those components. That is part of the package that the NGO might put forward. I cannot comment on that.

CHAIR: We are not talking about only acute care, because that is getting better. After that there is rehabilitation, which includes socialisation, education and employment.

Professor RAPHAEL: Yes, we would be very keen to support employment programs that will help rehabilitate people and get them back to work. That aim is present in young people with psychosis, to get them back into education. We do not provide the education but we might provide the interventions to facilitate that.

CHAIR: In Port Macquarie the Committee heard evidence about a place that provides employment training for people, but there is no money to run it. Would that money come from Mental Health or should it come from the Minister for Industrial Relations, John Della Bosca?

Professor RAPHAEL: Certainly resources should come from other agencies that are responsible for people with disabilities. One problem with the deinstitutionalisation process was that Mental Health felt it should take on responsibility for every facet. Only relatively recently other agencies have acknowledged their role, as they do for anyone else with any illness.

CHAIR: It is the mainstreaming of educational training that should go to the disabled; whether psychiatrically disabled or older or whatever?

Professor RAPHAEL: That is right.

CHAIR: So we should be looking at providing money for education and retraining, from both the Commonwealth and the State governments for that?

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your figures the number of nurses as a percentage of the clinical workforce is down to 52 per cent, and falling.

Professor RAPHAEL: I beg your pardon? Did I say that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, it is in the submission, Report No. 267, that it is falling slowly as a percentage.

Professor RAPHAEL: No, we are getting it up. We are getting the numbers up.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not saying that you should have nurses rather than psychologists. There is a shortage of nurses and the age of them is rising because if one was going to do five years at university nursing is not the job one would go into.

Professor RAPHAEL: It is three years and then the post-graduate work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it ends up as five years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are having a range of services with a graded system that is community supported, people may have to negotiate with a landlord or check whether the medication is being taken, and they may have to talk to the relatives to see how the patient was going and so on within the CTO system, is it not reasonable that you would have a greater percentage of less-trained people doing some of the other jobs? Perhaps people would be trained in other areas to increase the lower end of the grade, the preventive end, and keep your highly trained staff for more difficult tasks.

Professor RAPHAEL: I support that process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If that flexibility is not available you would not be able to expand all the services. You said that unless you get the people you cannot open the beds. That sounds like a recipe for things staying fossilised for the very few.

Professor RAPHAEL: I am very actively involved in trying to get nurses. What you say is correct. That is one reason why non-government organisations would be best to run living skills centres. Currently many of those are run by the clinical staff and they would be better employed doing more direct clinical work. There are industrial issues involved that we are trying to deal with.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are expanding the service because you have a poor amount of NGO funding and a poor number of NGOs, and you agree that you want more preventive services at that end, surely that is not an industrial issue. You should be able to employ any nurse who wants to come.

Professor RAPHAEL: Yes, we are. What I am saying is that if nurses are already occupying a certain position, that is the job that they are employed in.

CHAIR: In other words, can you replace nurses with social workers?

Professor RAPHAEL: Yes.

CHAIR: That is an industrial issue that was clearly identified in the Richmond report. The big problem with that report is that it refers to negotiations with unions about changing roles.

Professor RAPHAEL: Coming back to the particular question you ask, social work skills would be ideal in many circumstances for negotiating the complexity of access to the various domains of social welfare.

CHAIR: Housing and all those things?

Professor RAPHAEL: Yes, that is correct.

CHAIR: So you might be able to alleviate the number of nurses you need if only you got the right people to do the right jobs, rather than having nurses doing everything?

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But in this graded system, it has been commented that there is not an overall plan. In this document you have given us, which admittedly is answering the terms of reference, there is no evidence that there is an overall plan for New South Wales.

Professor RAPHAEL: With the workforce.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With the workforce, with the types and nature of graded accommodation for greater support systems.

Professor RAPHAEL: There is a document on supported accommodation, which I will provide.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there are document, an overall plan, for mental health services in New South Wales?

Professor RAPHAEL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can we have a copy of that. We have not had a copy of that, have we?

Professor RAPHAEL: Yes, you have.

CHAIR: Finally on that, the issue of nurse practitioners.

Professor RAPHAEL: Yes.

CHAIR: We spoke to the guy from Port Macquarie, Mr Phillip Scott.

Professor RAPHAEL: Yes, I read his transcript.

CHAIR: That is an outstanding example of a Commonwealth Government-funded trial which has now been picked up by area health services, not just there but across the area health services.

Professor RAPHAEL: Yes.

CHAIR: That is really a role for a nurse practitioner.

Professor RAPHAEL: I agree with you.

CHAIR: What steps are you taking to get that role established as a nurse practitioner role?

Professor RAPHAEL: As Ms Meppem identified in her submission, I have been strongly supportive of the nurse practitioner role.

CHAIR: As I have.

Professor RAPHAEL: Yes. You would be aware of the barriers.

CHAIR: Yes, I am. But this is one area where the clinicians—we spoke to a number of forensic mental health psychiatrists on Friday. They were very supportive of the nurse practitioner role, which is recognition of what they do.

Professor RAPHAEL: Yes. And the other area we have talked about is the mental health liaison nurses in the emergency departments. That would be an excellent place to take that up. So I am very supportive and we are actively looking at how we can progress that.

CHAIR: The one area that probably should not be part of our inquiry, because it was not identified by the Richmond report in any way that I can see is this the issue of forensic patients and the forensic nature of illness. We gave you a copy of page 16-10 of the mental health inquiry by the Legislative Council in 1855 and take the opportunity to table the report on Lunatic Asylums in New South Wales, Minutes of Evidence, ordered by the Council to be printed on 6th June 1855 and also the Select Committee on the Lunatic Asylum Tarbin Creek, dated 21 October 1846.

Professor RAPHAEL: Yes. I have not read those in detail recently. These inquiries are the history of mental health—a movement forward and a movement back. The community stigma, the failure of mental health, of mental health problems and illness to be considered an illness like any else. People's fear of people who are mentally ill and their concern that they will be violent and hurtful to them. All those things have contributed and I think you have an incredible opportunity now to put in place things that will prevent us from getting down those—

CHAIR: We can only make recommendations to the Government, which has the put things in place.

Professor RAPHAEL: Yes, I understand that.

CHAIR: On page 10, in the second section, which talks about people who were ill, I suppose, it says:

> Authorise the Government to move to a public lunatic asylum and detained there until certified to be sane every such person and also persons committed to prison for want of bail declared to be a … be insane.

That is saying that the Act of the Council in 1843 insisted that if you are not sane you should not be present, which brings me to the issue of forensic patients. In 2002 the Committee did what this Committee did, visited the prison.

Professor RAPHAEL: Yes.

CHAIR: We had not read this report at the time.

Professor RAPHAEL: No.

CHAIR: There we found the 90-bedder—is it 90 beds?

Professor RAPHAEL: Yes.

CHAIR: At Long Bay prison.

Professor RAPHAEL: Actually it is 89.

CHAIR: Of that about 30 beds are for forensic patients.

Professor RAPHAEL: Yes, formal forensic patients.

CHAIR: Formal patients, patients who are declared not guilty by reason of mental illness.

Professor RAPHAEL: Yes.

CHAIR: We found they were treated no differently from the prisoners who are there either because they had a sprained ankle or because they had a mental illness as part of serving their prison term.

Professor RAPHAEL: Yes.

CHAIR: So here we find people who are identified in the Act of 1843 and under the current Act, people who are prisoners when they should not be. We found them dressed in their prison garb, they were guarded by prison officers. This is a prison, not a hospital, under the 1843 Act or under the current Act. Can you please tell me why I saw people who are forensic patients dressed in prison garb being guarded by prison officers in a prison?

Professor RAPHAEL: I can tell you what I know about that currently. That is that these people are within a hospital within a prison. I understand there are both clinical staff and prison staff. We do not consider this situation ideal. That is why a new forensic hospital is to be built, and that will not have a prison surrounding it.

CHAIR: As I understand it, the new service you will offer is 120 beds, is that correct?

Professor RAPHAEL: It will be 135.

CHAIR: That will be a hospital?

Professor RAPHAEL: Yes, it will.

CHAIR: With not a prison officer anywhere near it?

Professor RAPHAEL: That is correct.

CHAIR: It will take patients who are forensic patients?

Professor RAPHAEL: It will take patients who are forensic patients.

CHAIR: It will take patients from the general community who are in need of high security?

Professor RAPHAEL: Yes, that is correct.

CHAIR: It will take patients from the prison who are mentally ill who need high security?

Professor RAPHAEL: Yes.

CHAIR: And people from the remand centres who are seriously mentally ill as well?

Professor RAPHAEL: Yes.

CHAIR: So this will be a high security mentally ill hospital?

Professor RAPHAEL: Yes, it is. Bearing in mind that in some instances there will be some people looked after within the prison in the hospital.

CHAIR: You are going to have to establish a hospital inside the prison to look after the patients who are currently in the prison hospital?

Professor RAPHAEL: That is right.

CHAIR: What is there today to stop those people who are forensic patients not wearing prison garb? What is to stop that today?

Professor RAPHAEL: I will take that on notice.

CHAIR: To identify them as not being prisoners?

Professor RAPHAEL: Yes, I will take that on notice.

CHAIR: What is there to stop you today from changing the nature of the security being offered at that hospital from prison security to health security? That is what you are planning to do, is it not?

Professor RAPHAEL: Yes, in the new hospital, definitely.

CHAIR: You will have to make a plan?

Professor RAPHAEL: Yes.

CHAIR: Move all of those people out of there while you pull that down and build it again?

Professor RAPHAEL: Yes. It will be a decanting process.

CHAIR: So, when you move them out of there are you are not going to take the prison officers with you, are you?

Professor RAPHAEL: No.

CHAIR: You are going to take them to a health facility when you move them out.

Professor RAPHAEL: Yes.

CHAIR: And when you move them back it will be a health facility?

Professor RAPHAEL: Yes.

CHAIR: So, why do you not do it today, where they are now?

Professor RAPHAEL: We believe that might run the risk of disrupting the process of the new hospital. We would have to train and employ security people, I believe. I am waiting for legal advice on what is advisable and possible, and I am happy to provide you with written advice.

CHAIR: It just occurred to me that although you cannot do it today, you will have to do it when you move them out.

Professor RAPHAEL: Yes, of course.

CHAIR: And you will have to do it when you move them to the same spot, but again outside the wall?

Professor RAPHAEL: Yes.

CHAIR: What steps have you taken, what training program, how many staff are you going to have?

Professor RAPHAEL: There is currently a planning process with Corrections Health.

CHAIR: It is nothing to do with Corrections Health. This is now a New South Wales health service.

Professor RAPHAEL: It is. Corrections Health is an area health service separate from the prison. So, they are heavily involved in the planning.

CHAIR: They were the last fifth schedule, I am aware of that. Prisons hospitals were the last fifth schedule. In 1989 all the other fifth schedules got out of being fifth schedules. That was the remaining one.

Professor RAPHAEL: I am not familiar with that.

CHAIR: The prisons area health service or Corrections Health was established when Hannaford was Minister and Ron Penny was put in as chief executive officer. That was the beginning of the separation.

Professor RAPHAEL: Yes.

CHAIR: But now it does not seem to have been separated enough.

Professor RAPHAEL: It will be progressively separated. They had a planning day recently. They are looking at a new name for it. They are separating it totally from that system. The State director will report to me as well as to them at a process that looks at linkages with the community and identifies people in area health services with responsibility.

CHAIR: If you establish a hospital within the prison for ordinary prisoners, again you will have to go through this whole arrangement. I do not know about the rest of the Committee but I am not entirely happy with the impingement of Corrections into the health service even for someone with a sprained ankle.

Professor RAPHAEL: Yes.

CHAIR: Again I am very concerned about what we saw at Mulawa and at the reception centre.

Professor RAPHAEL: Yes.

CHAIR: Without doubt Mulawa has to be the worst facility I have seen for a group of people—I think the figure is 60 per cent—who have a mental illness of our women prisoners.

Professor RAPHAEL: Many of them have been severely abused and have profound histories of—

CHAIR: Even the occupational health and safety reports out there are nothing short of appalling. I do not want to make this too strong, but it really was a shock for me to see a group of people that we now have been 60 per cent mentally ill, 80 per cent of them have a drug problem as well, which I would like to come to next, if I could, and they are treated in the most unhealth way.

Professor RAPHAEL: Can I guarantee you that we are doing everything we can. I hear what you say and I will provide you with a brief as to why we can or cannot do what you want. I reassure you that I am deeply concerned. My senior people in the department are deeply concerned and they are trying to address this issue. We realise it is not appropriate either for the rights of people. We also have to weigh in mind that we have a proper facility, bearing in mind that our role with respect to forensic patients is both their care and safety as well as that of the community more broadly.

CHAIR: Where would a forensic patient who is female be housed?

Professor RAPHAEL: Currently there are some beds in Bunya, and there will be a ward for women in the new centre.

CHAIR: The Bunya unit is medium security?

Professor RAPHAEL: Yes.

CHAIR: Where would you put a high security female patient who is a forensic patient, not a prisoner? They are all out at Mulawa, are they not?

Professor RAPHAEL: Yes. And occasionally we have had one in Long Bay.

CHAIR: That is still controlled by prison guards?

Professor RAPHAEL: It is.

CHAIR: And they are still dressed like prisoners?

Professor RAPHAEL: Yes.

CHAIR: How long ago was Mulawa identified as being totally inadequate?

Professor RAPHAEL: I do not know.

CHAIR: As long as you have been there?

Professor RAPHAEL: Yes.

CHAIR: So, before 1996, even?

Professor RAPHAEL: I cannot comment on that. I will take that on notice.

CHAIR: I do remember a plan to build something differently at Mulawa, which never happened.

Professor RAPHAEL: Yes. The issue is what you have highlighted, in that there is the overlap between Corrections and Health, and sorting out those issues is really a critical one.

CHAIR: I remember the big brawl between Yabsley and Collins, when prisons were still fifth schedule, but we are talking 15 years ago, almost. I do not think I can ask you for a recommendation for this Committee, because that would have to be a whole-of-government decision.

Professor RAPHAEL: Yes, I agree.

CHAIR: But something has to be done. We sent you questions, again, on that issue on 16 July, asking:

> The Select Committee on the Increase In Prison Population … heard that NSW was the only state not complying with the National Medical Forensic Policy.

Professor RAPHAEL: It should be the mental health strategy. That is true.

CHAIR: It went on:

> Has the Department of Health initiated any funding proposals that would enable NSW to comply with the National [Mental] Forensic Policy …

Professor RAPHAEL: Yes.

CHAIR: We are the only State, are we not?

Professor RAPHAEL: Yes we are, with a hospital in a prison, yes.

CHAIR: And the only State in the whole of the English-speaking world, except two States in America that I could find, where we treat forensic patients as prisoners. Nowhere else in the English-speaking world, and I do not think much of Europe. But in the English-speaking world—England, Canada, the United States and all of Australia—have moved away from that.

Professor RAPHAEL: Yes, and we are moving away from it.

CHAIR: But they have all done it.

Professor RAPHAEL: Yes, I concur.

CHAIR: The other question was, during the evidence of Mr Richard Matthews, Corrections Health Service referred to a draft plan for forensic services in reference to changes to the Bail Act and bail hostels. Do you know anything about bail hostels?

Professor RAPHAEL: Only in reading your transcript. Bail is looked after by Corrections, not Corrections Health.

CHAIR: Yes, I know. Has the Minister for the Health or the Minister for Corrective Services undertaken a review of the conditions of the Mum Shirl Unit that you are aware of and is there a printed document?

Professor RAPHAEL: There is not a printed document and I believe there is a review process under way. I will take that on notice to give you. I apologise if you have not had responses to those, we usually do them quickly.

CHAIR: These were relatively urgent because we knew you were coming. Then there is the issue of the court liaison services. Again, we have been impressed by the trials, but we are not necessarily pleased about where these people go. If they are identified as having a mental illness, they still end up at the remand centre or at Mullawa.

Professor RAPHAEL: I think there are two complex issues here. One issue is that they may end up there because their mental illness is not the cause of their criminal behaviour.

CHAIR: I accept that.

Professor RAPHAEL: That makes it more complicated. They should not end up at Mullawa because we have not been able to provide care for them. I cannot guarantee that, but I can undertake to try to clarify it.

CHAIR: You might read the evidence we received last Friday from Dr Michael Giuffrida.

Professor RAPHAEL: I have not read that. It has not been made available yet.

CHAIR: We went through that very carefully step by step, going from the police cells to the court and so on. I found that whole area very difficult.

Professor RAPHAEL: It is extremely difficult. It is very worrying, particularly if you take many of the people who end up within the prison system with a mental illness. Many of them would have been better served if we had early intervention services. There is now a move for juvenile justice to be much better linked.

CHAIR: We have not had any evidence from juvenile justice yet. We may not have time to hear that.

Professor RAPHAEL: A lot of this comes back to the point that Dr Chesterfield-Evans made about the importance of prevention programs. That is one of the things we hope will impact both on the male and female populations in that trajectory into prison.

CHAIR: We may have to get you back to give further evidence because there are a number of issues still to be dealt with. The other issues I wish to address are the rehabilitation process, clubhouses, children, advocacy, homelessness and supported accommodation.

Professor RAPHAEL: I agree that they are major issues. I would be happy to respond to all of them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I also flag sections G and H of your submission 267 in response to the terms of reference on service mix and data collection. They are lengthy sections but they tend to be unspecific.

Professor RAPHAEL: It depends what you want. This was intended as a background submission, as you would be aware.

CHAIR: It was a good submission.

Professor RAPHAEL: It was intended to give you the background of what has been happening. That was the purpose.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you look at people released from gaol, people from non-English-speaking backgrounds, indigenous people—

Professor RAPHAEL: What page are you looking at?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you look at page G.5, there is very little specific information.

Professor RAPHAEL: Sometimes things are not specific because the information has not been available. The importance of the information systems cannot be overemphasised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When we ask what is available in the way of institutions and plans for people coming out of gaol and people from non-English-speaking backgrounds, they would stand out because they are, in a sense, discrete areas.

Professor RAPHAEL: People coming off bail would only be our responsibility if they have a mental health problem. They are not our responsibility—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are not all forensic. A point that has been made from the Select Committee on the Increase in Prisoner Population is that there would seem to be a large amount of undiagnosed mental illness in the prison system.

Professor RAPHAEL: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The fact that you did not have programs for people coming out of gaol would not be surprising if they have not been identified as mental patients. But they are falling through the cracks totally, are they not?

Professor RAPHAEL: Not totally. I would say that we are trying as far as possible to ensure if there has been an identified mental illness that we provide both the appropriate outreach and contact for after care.

CHAIR: Another issue that raises many questions, which we may ask you about next time, is the dual diagnosis, which is now called mental illness substance abuse.

Professor RAPHAEL: Co-morbidity, yes.

CHAIR: Is that the appropriate acronym?

Professor RAPHAEL: I think you can call it what you like. Nobody has come to an agreement nationally.

CHAIR: It is a big issue.

Professor RAPHAEL: It is an enormous issue.

CHAIR: We received evidence, which was shocking to the people who did the study and to us, that of the people who have a form of mental illness in prison—85 per cent of males and 90 per cent of females—50 per cent of the men and 70 per cent of the women had a co-morbid drug and alcohol problem.

Professor RAPHAEL: Yes.

CHAIR: That is much the same result as the homeless population studies.

Professor RAPHAEL: The homeless population study has been done on a specific sample. So it is hard to generalise to the total homeless population. It is easier with the prison population, because you have demographic factors. It was done on the same survey questionnaire as the national data. It is much better for generalisation than the homeless one.

CHAIR: Those figures were surprising to me, although they are not surprising if you read the evidence we have received. For example, at Lismore we have a mental health ward, Richmond clinic, and across the road the brand new Riverlands centre, which is the drug and alcohol ward. The constant complaint from people who have written submissions is that if you have a drug and alcohol problem and a mental illness, you are told at the drug and alcohol centre, "Go away and get your mental problem fixed and then we will treat you." If you go to the mental health centre you are told, "Go away and get your drug and alcohol problem fixed and we will treat you." Because of the separation of funding of drug and alcohol and mental health, there does not seem to be any coming together, which is of concern.

Professor RAPHAEL: It is of grave concern to me.

CHAIR: Can you tell us what you think about all of this.

Professor RAPHAEL: First of all, we did do service delivery guidelines to have integrated care. They have not been as effective at the grassroots level as I would have liked. There is a national task force, which I am co-chairing.

CHAIR: Is there a reason for that?

Professor RAPHAEL: Both services are very pressured. I think also there has been a shift in culture. I have done a presentation on this. I could provide you with the overheads. I think there has been a shift in culture so they come from very different cultures. In my opinion, mental health and drug and alcohol issues are very closely united. Most people with a major drug use problem have a mental health problem. I do not see them as totally separate at all. I have run combined services in other settings and I certainly see we have to move much closer together than currently exists. I have had meetings with the drug programs bureau to look at how we can bring some of things together and I am currently putting forward a program so that all mental health staff will be trained in the management of drug and alcohol problems.

CHAIR: Part of the evidence before us was that patients were OK when they took their medication and stayed off the marijuana or if people were drinking alcohol it was very hard to keep them taking their anti-psychotics.

Professor RAPHAEL: It is an enormous complex problem and it is one that has to be tackled very hard.

CHAIR: Do other States deal with it differently? We are going to Victoria next week to have a look.

Professor RAPHAEL: I understand it is a problem there, although they have some co-morbidity units. If you are travelling in Victoria there is a unit run by Dr Tim Rolfe which is excellent. We have some units that are functioning very well as dual diagnoses units. But it is my belief that it is core business in mental health services.

CHAIR: The first evidence we received about this was from Sister Marie Harris, the nun who said that these are the most toxic and dangerous patients in the health service and that it is an issue that nobody wants to dealt with. Drug and alcohol and mental health do not want to touch it, yet they are there.

The Hon. AMANDA FAZIO: And it was reinforced the other day at the public hearing attended by family members and carers that it was a prohibition in getting access.

Professor RAPHAEL: I agree with you that it is a big issue and I do not think that it is right. What we are doing to progress things urgently is to ensure our mental health staff are better trained in this area so that they can respond and it is not a matter of sending someone off. One of the tragic incidents that was quoted was where someone was sent off and had trouble accessing one of the services. That is an example we do not want to happen.

CHAIR: We do not have very many residential drug and alcohol services, do we?

Professor RAPHAEL: No.

CHAIR: Yet many of these people are so unwell that they need a residential place where they are cared for, whether in a hospital or in supported accommodation. They are very toxic and cannot look after themselves and they turn up at the Karitas centre, which is full of mentally ill patients.

Professor RAPHAEL: Many of these people who are toxic also have a mental illness. Certainly marijuana and the amphetamines have caused a change in pattern. People tell me that the marijuana in this day and age is much stronger; I do not know.

CHAIR: The police are concerned that they are now filling up the paddywagons and the cells.

Professor RAPHAEL: It is a very tragic and acute problem. Certainly the concept of a drug-induced psychosis is losing meaning because the psychoses are complex and many of them stay.

CHAIR: We need to explore the need to change the Act to make that happen. How do we put advocacy into the mental health bill? There is the issue of the right to have a treatment plan that is enforceable, which is not in the current bill. That is what the British are thinking about.

Professor RAPHAEL: They have not done it yet.

CHAIR: But that is in the proposed Act. We would like to discuss with you next time the need to look at a place for relatives within the mental health service as advocates or as part of the patent's care and the issue of privacy versus access to information of these people who are central. Also, we want to discuss the issue that when you get the unique patient identifier, that person should have allocated to him or her a single case manager, whether it be a psychiatrist or whatever. There is also the issue of barriers for people who live within one area health service or even within an area health service. For example, people who live at Paddington cannot get into the Karitas centre which might be running an early intervention program. How do we overcome those sorts of difficulties? Then there is the issue of people who are dangerous and are, if you like, forensics-in-waiting.

Professor RAPHAEL: That is certainly one reason why we see an important unit being part of the new forensic hospital with respect to that population.

CHAIR: There is this whole issue of what happens with the index admission for a psychiatric illness. These are the people who are most likely to commit suicide or self harm and so on. I am talking about the early presentation of a 19-year-old who comes for the first time with paranoid schizophrenia. In the old days they had Macquarie Cottages. This is the wonderful glow in the 1950s.

Professor RAPHAEL: I was there.

CHAIR: In those days you could have months in Rozelle Hospital, then step down to Macquarie Cottages. The new drugs have changed the need for a lot of that.

Professor RAPHAEL: But there is still a need for rehabilitation and in-patient centres.

CHAIR: If we could walk through those steps—what you have actually done, what you are doing and funding—at the next meeting.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My comments earlier were related to page G.4, not G.5, because the answers do not correspond to the same numbered questions.

Professor RAPHAEL: If you formalised what you want me to respond to, I will be happy to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The more general issues such as service mix. That, in a sense, is the essence of the community-based aspect.

Professor RAPHAEL: You want more detail about the community-based aspect?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. You say that your vision is it will have more than 50 percent of the budget. Obviously it will integrate with health, housing, prisons, NGOs and ethnic organisations, that is, specific population groups. People say that we either give a small grant to the NGOs or advocacy groups or it dissolves into waffle. At what point do you say we expect this level of people, say category A, to function with this level of support and category B need this much support and it is envisaged that these types of organisations will do it for so much per head? The demands, the expected level of service in dollars per year, if you want to put it that way, who is likely to deliver that and look at that in a systematic, full-time equivalent of staff in terms of—

Professor RAPHAEL: We have that for the clinical services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems that there is a lack of position in other services?

Professor RAPHAEL: That is right, and that would have to be developed. That is not currently available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if you are talking about the deinstitutionalisation since the Richmond report, the process has been going on for nearly 20 years. Surely, there must be some looking at it in a systematic fashion?

Professor RAPHAEL: Yes. Could I comment that the documents we have provided you is the first attempt to look at it systematically. We have focused on clinical services. Planning for the third

national mental health plan specifically looks at what service mix is and how it should be identified. Although there are specific requirements that we talk about in terms of community-based services, assertive treatment and things like that, there is not a breakdown that has been agreed as a framework for non-government and supported accommodation as yet.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there must be various models that can be discussed.

Professor RAPHAEL: There are models that we discussed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The point has been made by the Centre for Health Service Development that there is no plan in New South Wales, although the Hon. Amanda Fazio says that one has been provided. There is not one in this area.

Professor RAPHAEL: There is not one for the–

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your response, in your submission 267, there is not a laying out of this. We have had evidence that if someone in the community goes on holidays they are not replaced.

Professor RAPHAEL: I cannot comment on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if someone in our hospitals goes away for one shift, they ring the nursing agency and bring in someone else or roster someone else. That does not happen in the community.

Professor RAPHAEL: Yes. That is part of the—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a vagueness that the community does not matter as much, that is what I am saying.

Professor RAPHAEL: I would not agree that it does not matter, but it may be that that is translated as not mattering perhaps because of the acuity. But, certainly, we have spelt out what is needed in terms of a template for clinical centres. We have not spelt it out for the others. My responsibility has been about the clinical services and how they interdigitate with others.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the project to deinstitutionalisation from the clinical has been going on since 1983. To say that it has not been gotten around to yet is an extraordinary omission.

Professor RAPHAEL: But it is not an admission. Actually, we are the only State that has a template of any kind.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But Victoria has better community services than New South Wales. No-one disputes that.

Professor RAPHAEL: They may have that, but there has been no overarching template plan for these services as we have them. We are the first State to have that. We do not have all of the other community services. We do not have it for the NGOs. We hope to work towards that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words, you are saying that if the others grew up like Topsy with historic things there is the point that they have still delivered, some would argue, a better service in that there are much more community resources available and more NGOs.

Professor RAPHAEL: Yes. And, as I pointed out to you, the definition of "community" is complex. What we have focused on is ambulatory care in the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those models, surely, must now have been discussed?

Professor RAPHAEL: Yes, they have been discussed and looked at.

Two reports by the Legislative Council 1845 and 1855, the list of beds and the graph provided by the witness tabled as public documents.

CHAIR: Next time I would like to talk to about personality disorders and how we get that into the area of care.

Professor RAPHAEL: It is an enormous area, and Victoria has a model that we have looked at with respect to service through the implementation group and through close consultation we are trying to work out what should be done.

CHAIR: This is not an easy task. I will try and arranger a time for you to come back with, at your suggestion, Mr Barker or Mr Pearse.

Professor RAPHAEL: Probably both.

CHAIR: If we have misunderstood anything or you think you could make it clearer—

Professor RAPHAEL: That might be the case, because I think some of the responses to the community I was having one mindset about community and you had a different one. Some of those may not be accurate.

CHAIR: We can get that clarified. If there is anything you want to add or something that you think we have dead wrong, tell us so in plain language.

Professor RAPHAEL: I will.

CHAIR: Obviously, we will come back to you again. When we write the report we may need to have a quiet word with you to ensure that we have it right.

Professor RAPHAEL: I am very grateful for your interest and involvement in this. We are trying to be as clear and transparent as we can.

(**The witness withdrew**)

(**Luncheon adjournment**)

STEPHEN HEMBER ALLNUTT, Clinical Director, Long Bay Hospital, Corrections Health Service, of 1 Berry Road, St Leonards, sworn and examined:

CHAIR: Dr Allnutt, in what capacity do you appear?

Dr ALLNUTT: As a forensic psychiatrist.

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

Dr ALLNUTT: Yes.

CHAIR: Would you like your written submission, No. 281, to be taken as part of your evidence?

Dr ALLNUTT: Yes.

CHAIR: Did you receive a subpoena under my hand to appear before the Committee?

Dr ALLNUTT: Yes, I did.

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

Dr ALLNUTT: Most of my statement is contained in my submission but I suppose in summary it would be that the forensic mental health services in New South Wales are lagging behind international standards. Some innovative and courageous efforts have been taken by Corrective Services and the Corrections Health Service recently to begin to work toward a better forensic system. Most importantly, we need to capitalise on this and take forensic mental health services in New South Wales into the new millennium as leaders, or at least bring them into line with international standards of practice.

CHAIR: In 1843 and Act of the Legislative Council—it preceded what is now euphemistically termed responsible government in New South Wales—went to the issue of, as we know it, the current schedule 2 arrangement. The second part of it authorised the Governor to remove to a public lunatic asylum and detain there until certified to be sane every such person and also persons committed to prison for want of bail declared by a like certificate to be insane. So in 1843 an Act of Parliament in this State required that anybody who was mentally ill not be in a prison but be removed to a public lunatic asylum. In 2002 forensic patients and patients on bail are currently under guardianship of the corrections system, not the health system. I assume that we have not slipped back in legislative terms. Currently the chief health officer has exactly the same responsibility to remove people from the prison system to the health system. But the health system operates within the prison system. At Long Bay we saw forensic patients dressed in prison garb and guarded by prison officers, which is what could not happen in 1843. So if you are talking about moving into the next millennium perhaps you are talking about the year 3000 for New South Wales, because we ain't there yet. Professor Raphael came before the Committee this morning. She will get back to us on legal advice about the care of people. I share with all members of the Committee a huge concern about the treatment of forensic patients who are not prisoners who are being looked after by prisons health in a prison guarded by prison officers and the treatment of what are clearly disturbed patients in Mulawa at the remand centre, people who are mentally ill. It may be that they have committed crimes; maybe they have not because they have not been judged yet because they are on bail. Those people are in a prison. So tell us what we should do to get them out of there and into health services, because I gather that is why you have come to see us.

Dr ALLNUTT: In my view the legislation in New South Wales is almost adequate to allow for the management of mentally ill offenders in more appropriate environments outside prison.

CHAIR: There are three types of mentally ill offenders. You might describe them. The first are people who are not guilty by reason of mental illness. The second are people who are guilty but have a mental illness. The third are people who have not yet been judged either way and who have a mental

illness. Could you talk to us first about the forensic patients, the people who are found not guilty by reason of mental illness?

Dr ALLNUTT: I do not suppose that I am saying anything new to you when I say that people found not guilty by reason of mental illness in most other English-speaking Western countries are not placed within a prison environment. Because they are judged to be not responsible for their crimes—speaking not as a lawyer but as a forensic psychiatrist—they are not legally punishable. The focus is on security and rehabilitation rather than security and punishment.

CHAIR: Do we share what we do in New South Wales with any jurisdiction in the English-speaking world? Can you point us to another place in Australia or elsewhere?

Dr ALLNUTT: I think that there are some States in the United States where it happens.

CHAIR: Canada, the United Kingdom?

Dr ALLNUTT: Not Canada, not the UK, not many States in the United States either. It does not happen in most States in Australia except for Tasmania, where it does happen. I cannot answer about Asian countries and Eastern Bloc countries but I am unaware of any English-speaking Western country that we identify with where these people are placed into prison environments other than some states in the US.

CHAIR: That puts us into a certain little category, does it not?

Dr ALLNUTT: Yes.

CHAIR: At the moment they are held at Long Bay.

Dr ALLNUTT: At the moment they are held at Long Bay hospital.

CHAIR: In a prison hospital, which is no longer schedule 5; it is now an area health service.

Dr ALLNUTT: That is correct.

CHAIR: Corrections health.

Dr ALLNUTT: Yes.

CHAIR: So what can we do to get those forensic patients out of prison garb?

Dr ALLNUTT: I think that we could legislate that forensic patients cannot be placed in a corrective environment.

CHAIR: We have already done so.

Dr ALLNUTT: I am not sure that that is legislated. I think there is a legislative option—

CHAIR: No, I am not talking about people with mental illness; I am talking about people who have been found not guilty by reason of mental illness.

Dr ALLNUTT: For people found not guilty by reason of mental illness there is a legislative option not to place them in prison, but I believe they go into the prison hospital by default because, essentially, there are no acceptable maximum security beds in the community.

CHAIR: That means that we have to change the Act, does it not? If you say it is possible for people who are not guilty by reason of mental illness under the current Act to be placed in a prison then we should be changing the Act, should we not?

Dr ALLNUTT: That is what I suggest. You could legislate that they should not be placed in the correctional environment, that they have to be scheduled or transferred to a secure forensic hospital that is not under the prison—

CHAIR: I am transposing into Peter's territory here. You said that while the current Act does not stop you doing that, the current Act does not require you to do that, does it?

Dr ALLNUTT: No, it does not. On my understanding of the Act it does not require you to do that.

CHAIR: We will get Peter Breen to draft the amendments. If the current Act allows us to treat people humanely but also allows us not to do so then we have to change the Act if we are going to live within what the rest of the world is doing.

The Hon. PETER BREEN: You said that the Act was adequate, did you not?

Dr ALLNUTT: I think that the Act would be adequate if there were enough resources. In other words, if we had secure beds in the community, using the prison as a default to place these patients would not occur. But I do think that to ensure better practice it would be better if it were legislated that that could not occur or should not occur.

CHAIR: Earlier Professor Raphael said that the department was moving to create a new facility of, I think, 135 beds on the same spot in a new facility at Long Bay, outside the walls, for the provision of services for all patients who need high security, which would include the forensics until judged otherwise by the tribunal. If we are going to ensure that they end up in a new facility, we will have to change the Act as well, otherwise they will end up in the prison hospital where they will also re-commence, will they not?

Dr ALLNUTT: There is potential for that, yes.

CHAIR: Okay, so we will have to change the Act. The second thing is something I mentioned to Professor Raphael: they are going to build that new facility, which I think will be opened by 2005 or 2006, and they will therefore have to pull down the existing one. They now will have to decamp all the people from there who are forensic patients, that is, patients in a prison hospital who are using it for sprains and cuts as well as for mental illness. They will have to decamp them from there to some other place—obviously not in a prison because there ain't no room in the prisons anyway and there is no hospital in a prison. They were have to find a new place, and when they find the new place it will have to be a health facility because the new facility will include anybody who is in a high security category and who needs mental health's care. Then they will have to be moved back to the place which was purpose built. Should we not be thinking about changing the nature of Long Bay hospital tomorrow as we see it—in other words, replace all the prison guards with health security guards?

Dr ALLNUTT: Look, I think that would be a reasonable option. I would not say we should do it tomorrow—we have to think of the security aspects of that—but certainly we could work towards that. I think that it is possible that we could manage people within that environment until the hospital is built with health personnel. I think it is possible that we could manage them in normal clothing and not in prison clothing. It is also possible that we could manage them with health staff, not prison guards. We would have to be very cautious before we implemented that, given that the hospital was built with a particular way of managing people in mind. We would have to be cautious and have to ensure that there are enough resources and we would have to ensure that the personnel there are adequately trained, forensically trained, to manage people like this. But I think that would be entirely possible, if that is the case.

CHAIR: Given the fact that every country in the world, and that makes a population of 600 million or 700 million people we are talking about, could give us any number of guidelines on how we might do that, we are not breaking new ground here, are we?

Dr ALLNUTT: As far as treating forensic patients or high security patients is concerned?

CHAIR: As far as treating forensic patients who are not in a prison is concerned?

Dr ALLNUTT: No, this is not new ground.

CHAIR: So it would not be hard to find in any state in Australia, Canada, the United States or the United Kingdom any number of models of training programs for security staff?

Dr ALLNUTT: No.

CHAIR: It would not cost a lot of money to buy the intellectual property, would it?

Dr ALLNUTT: I am not sure about that. I do not know about the cost of it, but it would be possible to get the expertise.

CHAIR: In other words, we are not experimenting; this is not a new experiment; this is something that everybody else does?

Dr ALLNUTT: Yes.

CHAIR: Does any member have any question about treatment of the forensics themselves rather than the people who are under trial or are on remand, or whatever? If not, let us now go to the people who are prisoners and who have a mental illness. They are guilty of a crime and they are incarcerated under a court order, but they have a mental illness. Where and how should they be managed?

Dr ALLNUTT: The prison is a kind of community. People in that community have mental illness—there is a group of them who have mental illness of varying degrees of severity and who have varying degrees of need and varying degrees of risk. The approach to the management of people who are found guilty and are placed in prison and who are then found to be mentally ill is, I believe, to adopt the same approach as one would adopt towards anybody in any community.

CHAIR: Okay.

Dr ALLNUTT: First of all, one should ensure that one provides care that is as close to or at least equivalent to the quality that one would get in the community outside a prison. And because a person has a mental illness, that does not mean that they cannot cope in the prison environment. It depends on how severe the mental illness is. Generally the threshold that dictates admission to a psychiatric hospital from a prison is the same threshold that frequently dictates admission to psychiatric hospitals in the community—that being whether or not one meets the terms of the Mental Health Act and whether or not they are at risk to themselves or others or are incapable of caring for themselves within that environment.

CHAIR: That would be about the same as any other community member.

Dr ALLNUTT: Yes, any other community member.

CHAIR: Do you think that people are therefore held in high security areas longer because they have a mental illness than people who do not have a mental illness who are imprisoned? In other words, there is a step-down arrangement. One might go to Long Bay for a short period and then go to a medium security prison, and then to a prison farm, and then home.

Dr ALLNUTT: Let me just say that there are people within the prison community who are not in Long Bay hospital who have mental illness.

CHAIR: That is right.

Dr ALLNUTT: Ideally, anybody within a prison community with a mental illness who meets the terms of the Act should have available to them the mechanism whereby they can be scheduled under the Act, removed from any environment where they are a risk or pose a risk, and placed within a psychiatric hospital, treated, and then returned back to the prison. That psychiatric hospital ideally should not be within the prison environment. It should be outside the prison and run by Health. In other words, there is a provision whereby the psychiatrist can schedule a person. They get transferred out of the corrective system into the forensic system, are treated and then are transferred back into the corrective system.

CHAIR: Take asthma and an exacerbation of asthma which is the sort of thing you are talking about and equivalent to mental health. They get taken off to the Prince of Wales hospital or St Vincents from Long Bay and they are guarded by prison officers while they are in the Prince of Wales hospital. What you are talking about is that they have to go to an acute psychiatric institution because they are scheduled, which is Part 1of the 1855 consideration, and they go off to the Caritas centre where they are

admitted under a schedule 2 provision which means that they have to be guarded by a prison officer. It is no different than being carted off to St Vincent's with asthma, is it?

Dr ALLNUTT: I think that with a mentally ill person, there is a different issue. There is the issue of competency and consent.

CHAIR: No, they are prisoners.

Dr ALLNUTT: They are prisoners, but for a mentally ill person, as far as the treatment of the mental illness is concerned, there is an issue of competency to consent.

CHAIR: But that is why they are scheduled.

Dr ALLNUTT: That is why they are scheduled.

CHAIR: There is no choice about being scheduled. Competency and understanding mean nothing. Consent means nothing if a person is scheduled.

Dr ALLNUTT: But that is one of the purposes or one of the reasons why a person is scheduled. That is one of the reasons why a psychiatrist is provided with the legislative right to treat somebody against their will.

CHAIR: That is right. We have been through that. They are in the prison hospital or they are in St Vincent's hospital being guarded by prison officers because they are an involuntary patient. Once they become a voluntary patient and are no longer scheduled, should they are not be moved back to a prison hospital and be looked after by the psychiatric team within their own community?

Dr ALLNUTT: Yes, as long as they are safe in that environment, yes.

CHAIR: And that is no different from anybody else in the community?

Dr ALLNUTT: That is no different from anybody else in the community, no.

CHAIR: Except that it is a different community. Are there any questions about that?

The Hon. PETER BREEN: Can I clarify a couple of definitions? My knowledge is a bit short here. When you talk about a forensic patient, do you mean someone who was not guilty by reason of a mental disorder?

Dr ALLNUTT: "Forensic patient" covers three different types of patients, as we discussed earlier. One is people who are found not guilty by reason of the mental illness, a person who is unfit to stand trial, a person who is neither but in prison and mentally ill and transferred; and, in some other jurisdictions, a person who is on remand undergoing psychiatric assessment, which is not an option in New South Wales. That is another option that should be considered here, but it is not an option in New South Wales.

CHAIR: In New South Wales, they are not called forensic patients, are they? The first group is those who are found not guilty and they are the ones who are found not to be able to be trialled.

Dr ALLNUTT: Which is unfitness.

CHAIR: And the third group are not covered by the Act in New South Wales.

Dr ALLNUTT: There are people who are sentenced and are mentally ill, the transferees. But there is also a group who are on remand. In other jurisdictions frequently people who are not bailable as of right or who seem to pose a significant risk and about whom the court has a question of their mental state—whether the question is fitness, insanity or treatment recommendations related to sentencing—there is sometimes a legislated option whereby that person from the court can be legislated to enter a forensic psychiatric hospital.

CHAIR: That is not available in New South Wales?

Dr ALLNUTT: That is unavailable.

CHAIR: It was available in 1943, but it is unavailable in New South Wales in 2002, which is what I pointed out earlier.

The Hon. PETER BREEN: They were found guilty?

Dr ALLNUTT: No, they are not found guilty. They are on remand.

CHAIR: No, these are the ones who are on bail.

Dr ALLNUTT: No, they are on remand. They are not bailable as of right. In other words, a person comes in front of the, say, District Court on serious charges and the judge has some question about their mental state and would like some answers in relation to fitness to stand trial, for example, and would then order that person to be placed in a secure forensic hospital where they can be assessed properly and treated by a psychiatrist. A report is generally then written for the court, not for either party, by the psychiatrist on the issue of fitness and treatment recommendations, and the person may then returned to court and the legal process continues, at which point the person may be remanded back to the hospital, may be remanded into custody or may be returned to the community, depending on the stage of the proceedings and the findings of the judge at that time. That is a whole process that is absent in New South Wales.

CHAIR: But the reality is that if you are a woman in New South Wales, that is available to you. The Mulawa centre is the one that we will talk about shortly, but the Bunya centre allows for people who are on remand to go there and for forensic patients to go there.

Dr ALLNUTT: Yes, it does but—

CHAIR: That is not legislated, but the practicality for the women is there.

Dr ALLNUTT: For the men as well because it is not legislated that they undergo proper assessment. Put it this way, there is no onus on the court to seek out its own information about the mental illness. It is left up to the parties to find someone to do that and generally it is settled in an adversarial situation. Frequently the court does not get its own expert evidence.

CHAIR: But for the women, it is available at the Bunya centre. If they are a high security problem, there is no solution. If they are a male, they end up at Long Bay, which is a prison.

Dr ALLNUTT: That is right. If they end up at Long Bay, at the moment there is a psychiatric assessment done. It is most commonly done only for the magistrates. Infrequently we get requests by the District Court for a report, but that is infrequent. People are remanded for reports, but frequently from the Magistrates Court. We do provide those reports, but what there is not is a legislated requirement by the court to seek out its own psychiatric evidence or being able to place a person in a forensic hospital. The problem is that it is not possible to assess a person properly when the person is sitting in a prison, not in a hospital—and not in Long Bay hospital: I am talking about a prison. It is difficult to provide a court with a comprehensive psychiatric assessment and opinion under those circumstances.

CHAIR: Or the remand centre at Silverwater?

Dr ALLNUTT: Or Silverwater, no. When I say it is not possible, it is possible, but it is not best practice to do it that way. It is better, if there are questions about mental illness, to do the assessment in a psychiatric hospital where the resources and the opportunity are available.

CHAIR: If a person got to the Supreme Court without a proper psychiatric assessment you would have to say that everybody was irresponsible, would you not, for the delays in getting to the Supreme Court? The District Court is bad enough; it takes six months for it to get to the District Court. The magistrate you would understand—we will go through that process in a moment—but to get to the Supreme Court and not have a psychiatric assessment has got to be extraordinary, has it not?

Dr ALLNUTT: I suppose it varies from case to case but there is no legislation that I am aware of for the court itself to seek its own assessment.

CHAIR: Can they do that voluntary though? Does the judge or the magistrate have the power to say "Look, I want this guy seen by somebody"? I know they have because they can send them off for an assessment at any time. The court can inform itself. It is not required to but it can inform itself. Is that true?

Dr ALLNUTT: Yes. I think the court can.

The Hon. PETER BREEN: It depends what they plead. If they plead not guilty it is not an issue.

CHAIR: If they plead guilty?

The Hon. PETER BREEN: If they plead guilty, but most people plead not guilty, that is the problem. So forensic or psychiatric reports, if you plead not guilty it has got nothing to do with your defence.

CHAIR: If the judge sees somebody who is clearly out of it do they not take the opportunity to have an assessment made?

The Hon. PETER BREEN: Not if they plead not guilty.

CHAIR: The judge just sits there like a dumbo saying "Here is this person talking to himself, wandering around the court all day", and they do not say to the barrister "Have you got a psychiatric assessment on this guy?" They do not do that?

The Hon. PETER BREEN: It is never that obvious unfortunately.

CHAIR: Occasionally it must be that obvious. Can the judge take it on himself or herself to require an assessment of the person?

Dr ALLNUTT: As far as I am aware he or she can, yes.

CHAIR: But they are not required to?

Dr ALLNUTT: There is no requirement.

The Hon. PETER BREEN: They are very reluctant to as well if they plead not guilty.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Jonathan Carne did this. I was on the select committee on the increase in the prisoner population and Jonathan Carne and a mental health nurse did a pilot program at the Central Criminal Court in which they were assessing patients coming in there for mainly petty offences but I think they were assessing anybody who came in there for anything, and they found a huge incidence of mental problems and even incapacity to plead, that was sort of grinding on and the magistrate was very grateful. That suggests that in the framework Peter Breen is suggesting, if they plead not guilty then the system just grinds on adversarially to find out whether they are guilty or not guilty. If they are barking mad and the judge does not actually say "Gosh, they are barking mad to my questions", then there is not a pickup mechanism, is that the problem, which is what Brian is suggesting? There is simply is not a pickup mechanism. Nobody says "Hang on"—first question—"Are you sane enough to plead at all?" and the second question, "Now you have made your pleading shall we decide whether you are guilty or not?" There is no first step; there is no screen that says "Are you sane?"

Dr ALLNUTT: My understanding is that at the magistrate level the issues of insanity and fitness are not examined, it is only when it goes to the higher court. I think that the mental illness options that the magistrate has are defined under sections 32 and 33 of the Criminal Procedures Mental Health Act where the magistrate has the ability to dispose of the matter under section 32 or section 33 if there is a mental illness issue and if the risk to the community is not so great, and I suppose other legal criteria that the magistrate considers such as severity of the charges, etcetera. My understanding is it is only at the higher court where fitness and the mental state at the material time of the offences and, I suppose, presentencing issues and mitigation issues are considered.

CHAIR: This is where the 1843 Act says that even when they come up for bail that should be considered, whereas now if you go before a magistrate the first thing that is going to happen is, for example, you are asked "You are charged with murder?" "Yeah". "Do we give you bail?" That is the next question that they ask and the court says "Well, no, it is a serious offence", or if it is not murder, say it is robbery, do you give him bail? This is where we understand the Port Macquarie organisation comes in because you cannot bail them if they have got nowhere to go. There are no bail hostels at the moment. This is a homeless person who may not be barking mad, as my colleague puts it, but will not attend reliably and they are mentally ill, they have got a mental illness of some sort, and the magistrate is not required at all to have an assessment made but a forensic service is not available to every magistrate, so what happens?

Dr ALLNUTT: I do not think it is a requirement.

CHAIR: They end up at the remand centre at Silverwater which is where we saw a whole lot of them sitting there on a CTO or not on a CTO, on pills or not on pills, on drugs or not on drugs, and they are bundled into prison.

Dr ALLNUTT: In my experience what happens in other jurisdictions where there is the option of a secure forensic hospital is that, especially in more serious offences, for example, a homicide, where there is a question of possible mental illness, that individual would then be remanded into a forensic psychiatric hospital for assessment because it is such a serious charge and it has such serious implications for the public and is of such great public interest.

CHAIR: We are just talking about shoplifting at Parramatta at the moment. What is different about shoplifting at Parramatta? If you go to the Parramatta Court and there is no forensic service there you end up at Silverwater, mad as a meat axe in Silverwater without treatment.

Dr ALLNUTT: Correct. In those circumstances, if you appear before the magistrate—and again I think that helpful mechanism is the same threshold that is applied to anybody with a mental illness in the community as far as requiring secure care or non-consenting care—if you have a certain charge and you come under the Mental Health Act, the magistrate does have the option of section 33 and can dispose of the matter, but the magistrate may wish an assessment to occur and there is nowhere for the person to go for that other than prison if the person does not return to the community. What happens is that in my understanding—I do not want to speak for magistrates here but as an external person observing the behaviour in the courts—the magistrate is in an unenviable position; the magistrate has to consider whether the person has a mental illness, has to consider what is in the interests of the individual and, at the same time, has to take into consideration public safety. In addition to that the magistrate may wish to follow the option of, say, a section 33 and send the person to a psychiatric hospital but it then depends on whether the psychiatric hospital has beds and whether they are prepared to admit this person. The psychiatric hospital is in a very difficult position because the person who is appearing before them may be somebody who they assess as too dangerous for their hospital.

CHAIR: So they go into Grafton Gaol?

Dr ALLNUTT: So they end up back in the gaol.

CHAIR: They wait six weeks before they get an assessment and then they come back before the magistrate again, they still have not had their assessment and the magistrate has no choice but to let them out because there has not been a psychiatric report done while they have been sitting there, if you like, barking mad; they are sitting at Grafton for six weeks; no report; back to the court; the magistrate says "I am not going to imprison the guy for another six weeks while I wait for a non-existent report" and he lets him go. The next day they have done the same thing again, the same disturbance, the same throwing of a rock, sitting in front of cars; the police pick them up and around it goes again. I am not talking hypothetically, I am talking about at least 10 patients I know about in Lismore recently.

Dr ALLNUTT: There is no system that is going to be perfect. Can I just say that I suppose the model forensic psychiatric service is an integrated service and the model forensic psychiatric service is administered in New South Wales by a statewide forensic directorship that has the administrative powers to influence the entire State and the movement of people within the State.

CHAIR: Have you applied for the job?

Dr ALLNUTT: No.

CHAIR: Has anybody you know of applied for the job?

Dr ALLNUTT: I believe there are some people who are being approached. Forensic service then has four important arms: it has a court liaison arm; it has an inpatient psychiatric assessment and rehabilitation arm; it has a community arm and it has a corrective mental service arm. All of those arms need to link in and communicate about people who come into the forensic system. The information about that individual then flows around the system. So the system is integrated. The prison psychiatric services are communicating with the court liaison services who communicate with the inpatient services who communicate with the community services, and the information about any particular individual that is within the forensic domain is accessible at any time by anyone in any one of those four arms..

CHAIR: The reason that has to be pretty special is this is not a community like any other community, is it? This is not a community within the prison system or the bail system which is accessible by the patient's relatives, is it? These are just mentally ill people living within a community like any other community but they have not got access to their relatives, have they?

Dr ALLNUTT: They have got access but far less access.

CHAIR: They are not under the careful supervision, if they want to, of a relative?

Dr ALLNUTT: No.

CHAIR: So this has to be a very carefully organised and structured little setup, does it not, with a very powerful boss to make sure it works?

Dr ALLNUTT: Yes. I think that the director has to have the mandate to be able to influence movements.

CHAIR: I think we have talked about all the groups that I wanted to talk about. We have talked about the three groups: We have talked about the forensics; the not guilty by reason of mental illness and others; we have talked about the mentally ill in prison. The other group we have not talked about is the people who have got a mental illness within a prison; we talked about them being cared for like any other community and there is a third group, the group on remand or bail, the whole bail issue, which I think we have talked about too, have we not?

The Hon. PETER BREEN: I think we have established that they are all called forensic patients.

CHAIR: No they are not, not in New South Wales. The important thing is they are not in New South Wales. That is the important thing that Dr Allnutt has made clear to us, that the only people in New South Wales who are forensics—correct me if I am wrong—are people who are found not guilty by reason of mental illness and those who have been found not to be able to plead. All the others are not forensics. In other jurisdictions they are.

Dr ALLNUTT: The people who are mentally ill and transferred to Long Bay Hospital under the Act.

CHAIR: But they are only forensics while they are there.

Dr ALLNUTT: They are small 'f' forensics.

CHAIR: So that is the difference between us and every other jurisdiction.

The Hon. PETER BREEN: How do you describe this group who are on remand and who are awaiting psychiatric assessment?

CHAIR: They are just prisoners.

Dr ALLNUTT: They are sentenced prisoners. Unless they are scheduled and transferred to the Long Bay Hospital only once they arrive at Long Bay Hospital, at that point, do they become forensic

patients. If they are under the schedule waiting for transfer they are still not forensic patients. They are prisoners on remand. .

The Hon. PETER BREEN: Scheduled patients are all involuntary?

Dr ALLNUTT: Scheduled patients are involuntary, yes.

The Hon. PETER BREEN: Is it correct to say that people who are voluntary patients cannot be described as scheduled patients? Can you volunteer to be scheduled, for example?

Dr ALLNUTT: No. The crux of being scheduled is to give the treating team two rights. One is to put you in a secure environment or detain you, and the other is to treat you against your will. Ideally a person should be scheduled when they are not consenting, but sometimes a person may be consenting but requires detention because of risk to self or others independent of capacity to consent. Even though they are consenting for treatment while unwell, they still pose a risk. In other words, the psychiatrist needs to be given the legal right to lock their door and take away their rights. It would be a criminal offence to do that outside the legislation. To detain them, hold them or restrain them would be seen as assault.

CHAIR: The same rules applied in 1843. The matter had to go before two justices and be signed off by two medical men to get a confinement against one's will. These days the matter goes before only one justice and the person is represented.

The Hon. PETER BREEN: In those days instead of being called a scheduled patient the person was called a dangerous lunatic.

CHAIR: It was effectively the same as a schedule. I refer now to forensic mental patient beds in the community. At the end of the day the Mental Health Tribunal takes a forensic patient and over time and with treatment the patient is moved from Long Bay, where his high-security needs are met, to Morisset or Bunya, or a number of other medium-security places. The patient is still under the control of the Mental Health Tribunal. The patient can then be released into the community to live there under certain conditions. As you identified, the problem is that there is not enough staff to look after forensic patients. The tribunal has a problem in identifying patients who are able to go into the community while still offering protection for the community. How can that circumstance be improved? That is issue number one.

Dr ALLNUTT: One thing we need to work towards is some sort of community forensic psychiatry model or service. That can come in a variety of shapes and forms. One of the most cost effective ways is a community forensic liaison service to which people can plug in when they return to the community. They can go back to their community psychiatric services but there would be consultation and liaison with trained forensic psychiatric nurses, social workers, psychologists or psychiatrists who may meet with the team. With the general community psychiatric team they would be responsible for the follow-up of that person in the community.

Having said that, some people who go back into the community may require more intense follow-up or are regarded as a greater risk than average. The forensic psychiatric services may take direct responsibility for those people. Let us say that a person who had been charged with homicide is released into the community. That person may be followed up by the forensic psychiatric services. The forensic services may take some responsibility for a particularly small group of high-risk patients but the majority of their work is done in liaison with the community teams.

In my experience the community teams currently feel quite overwhelmed because they lack the expertise and feel threatened both professionally and physically by some of the patients that they manage. Overall they do as good a job as they can, but they could be doing a far better job if they had the support of a forensic psychiatric service.

CHAIR: Say, for example, I was a forensic patient at Long Bay and over time I got a bit better and was transferred to Morisset or a community cottage at Bunya, and then to an outside cottage and then I was allowed to go home to Lismore because I had done pretty well for two or three years after going through the Mental Health Tribunal. Say I was transferred to the care of the local psychiatric team in the Northern Rivers Area Health Service and they said, "My goodness, a forensic patient who has killed three people. What can we do?" Are you saying that there should be a liaison person who instructs the

service people about what is needed? That service would have to keep an eye on me just like everyone else.

Dr ALLNUTT: A person like that may not come under the pure liaison oversight. A person like that may be the direct responsibility of a trained forensic psychiatrist and his treating team.

CHAIR: But they are not available in country New South Wales, surely?

Dr ALLNUTT: They may not be, so consideration needs to be given—

CHAIR: That means I could not go home to Lismore, but I could go to Orange. Terrific!

Dr ALLNUTT: Consideration is to be given to that. Otherwise the resource to manage that person in that environment should be provided.

CHAIR: If we had forensic mental health teams across the State, as you are suggesting, there should be one in Lismore.

Dr ALLNUTT: Hopefully there would be.

The Hon. AMANDA FAZIO: Are forensic patients released on parole?

Dr ALLNUTT: Forensic patients do not come under the jurisdiction of the Parole Board. The review tribunal is their parole board, in a sense.

The Hon. AMANDA FAZIO: I was wondering whether the Probation and Parole Service needed to fit into that pattern of care or supervision after people are released from gaol.

Dr ALLNUTT: Forensic services work closely with Probation and Parole, but not necessarily for individual forensic patients. They may work closely with people under certain conditions, or people who are placed in the community under legal conditions. If they breach those legal conditions they have broken a legal requirement and therefore can be placed back into prison. Ideally, if a forensic patient breaches the conditions, and there is a question of risk, the person should be readmitted to a psychiatric hospital and not placed back in prison.

The person would be under forensic psychiatric services. There would be a process of risk management. The person would be placed in the community, followed up by forensic psychiatric services and if he starts becoming unwell and develops, for example, the same delusions that he had when he committed the previous crime the issue of risk arises. That person would be readmitted to a forensic psychiatric hospital, stabilised, treated, and over time may be released into the community.

The Hon. AMANDA FAZIO: Some inmates at Long Bay have developed some sort of mental illness while in gaol. What happens to them?

CHAIR: That has been dealt with already. They are treated within their community, which happens to be a prison. They can get parole with the condition that they go to their mental health services.

Dr ALLNUTT: That is correct.

The Hon. AMANDA FAZIO: What happens if they complete their sentence but they are still as mad as cut snakes and should not be let out.

Dr ALLNUTT: The Parole Board sometimes will ask us for a report, and we will give our recommendations. The recommendation may be that on release the person should be released to a community psychiatric service or should be followed up by a psychiatrist within the community.

CHAIR: Do people ever stop being a forensic patient? Once a person becomes a forensic patient does that change?

Dr ALLNUTT: I am not 100 per cent sure. On release transferees stop being a forensic patient unless conditions are applied prior to release.

CHAIR: Under schedule two, a transferee would go back to prison, he is a prisoner after all?

Dr ALLNUTT: Yes.

CHAIR: But a forensic patient who has gone through Long Bay, Morisset, the cottages, and home to Lismore, spent five years in the community, would that person cease being a forensic patient? There are only about 400 in the State.

The Hon. PETER BREEN: A person is only a forensic patient while within the prison system.

CHAIR: No, the person remains a forensic patient while ever under the control of the tribunal.

Dr ALLNUTT: Yes, but the tribunal loses legislative control over that person although it may follow them voluntarily. I will check that with the tribunal.

CHAIR: They are released to the community under conditions. My question is do they ever remove those conditions?

Dr ALLNUTT: I cannot answer that question. The tribunal is the best place to ask.

I asked Professor Raphael whether there is a list of forensic patients, because it is a public list—after all, it is a court order and is therefore a public list—and if the name can be accessed. You can find out whether someone is a forensic patient but you cannot find out whether someone is merely ill. That list is kept by the department and my understanding is that the police can access that list at any time, because it is a public document. There is nothing secret about it and it is not an invasion of someone's privacy to find out whether they are in gaol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, it is an invasion.

CHAIR: No, it is not. It is a court order. If a medical practitioner is struck off and is not allowed to prescribe, that is announced in the *Government Gazette*.

The Hon. AMANDA FAZIO: But only once.

CHAIR: I can ring up and ask whether a certain doctor is able to prescribe morphine, and the department will answer yes or no, because it is a public document. It is not an invasion of their privacy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is one thing to be a public document but you do not see people on a train reading the *Government Gazette*.

CHAIR: It is not published on the front page of the *Sydney Morning Herald*.

The Hon. AMANDA FAZIO: That would be absurd.

CHAIR: But it could be published in the newspaper.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it was put on a database which every police officer could access, as discussed by the Privacy Commission, the fact that it is made public means that privacy is not a consideration.

CHAIR: Their address would not be published, but you can find out whether person X, Y or Z is a forensic patient, because that is public information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I wonder if Professor Raphael would be unhappy about putting that information on a central register with the new cards. Chris Puplick would be jumping out of his skin.

CHAIR: Professor Raphael indicated that the centre has advertised for a directorship. Did that advertisement indicate the breadth of the responsibilities of that position?

Dr ALLNUTT: I have not seen the advertisement, so I cannot comment on that.

CHAIR: Are you aware of the service offered at Port Macquarie?

Dr ALLNUTT: I am aware of the court diversion service.

CHAIR: Would you be happy if a court diversion service was run by a nurse-practitioner, as practised at Port Macquarie?

Dr ALLNUTT: I worked in Auckland, New Zealand at the Mason Clinic. I was its clinician who consulted with the court liaison nurses. That service was run by a very experienced nurse. The positions were provided to nurses with a lot of experience and who had a very good understanding of the legislation. That service worked very well and worked in conjunction with psychiatric consultation. In other words, if the nurses had any queries I would be available to discuss that with them.

A service like that could run with an experienced nurse at its helm. A court liaison service is a triage. This can be seen, in distant terms, as a nurse in an emergency department. It is one of the first ports of call when assessment occurs and the nurse would advise the magistrate as to what in his or her experience would be the best thing. That advice might be for a specialist psychiatric assessment, or it may not be. It can run, but the nurse needs to be experienced, needs to have a good understanding of the legislation and needs to have psychiatric backup if required.

CHAIR: It seems to me from the Port Macquarie one that the most important feature is that they are able to recognise illness and know where to find the help and are plugged in well to the community-based services and health services. It seems to me they have to be pretty smart and know the system but also to be able to pick people who need help. Not to diagnose nor to treat, that is not what he said. As a nurse practitioner, a senior nurse, it is obviously working in Port Macquarie and there are a whole lot of reasons why, but that is the sort of model you saw in New Zealand, was it?

Dr ALLNUTT: That was the model in New Zealand, and the nurses we had there were superb and it was a sought-after job for nurses. I think the nurses that worked there and I think here in New South Wales, the nurses in the court liaison service now will find there is a huge amount of job satisfaction for them. Their clinical skills improve in that position because in a sense they have to make important clinical decisions.

CHAIR: In difficult circumstances.

Dr ALLNUTT: In difficult circumstances, and in New Zealand they do a good job.

CHAIR: They get validated by expert advice, if you like?

Dr ALLNUTT: Yes. There is a lot of validation in that position.

CHAIR: Do you think they save the courts a lot of time and money in the New Zealand experience?

Dr ALLNUTT: Yes, I think they do. I think it must be very difficult for magistrates to be confronted with somebody who is behaving in an unusual way and have to make some kind of determination about what to do with them, balancing community safety and individual rights. I think the court liaison service will bring that extra bit of the pie to the table for the magistrate and assist the magistrate. We have been very fortunate to have recruited Professor David Greenberg, who was statewide director in Perth, to Sydney. He has greater experience and since he has been here we now have—he and Ben Nelson have been administering about seven courts. I have been working with them and our hit rate has been approximately 90 per cent as far as successful admissions under section 33. It is somewhere around that. I would not say it is exactly 90 per cent but it is a very high hit rate.

CHAIR: How many have you missed? Of the ones you have hit, yes you have got those right, but how many have you missed, that get picked up later in the remand centre?

Dr ALLNUTT: That I do not know, but that data I am sure is being collected at the moment. I am not sure about that. You will probably have to ask Professor Greenberg.

CHAIR: In New Zealand do you know what the miss rate was? If you hit 100 and you get 90 per cent, this one needs care, but you must miss some who get picked up later?

Dr ALLNUTT: The identification of criminally ill in the criminal justice system depends on a number of factors. It goes right to the first contact with the police, whether or not the policeman who picked up the person picks up any clues around mental illness. If so, he reports that to the nurse, whether the Corrective Services person who is responsible for the person in the cells picks that up and whether that gets communicated, and then whether or not the person gets to see the nurse. Then, it depends on the clinical acumen of the nurses themselves and then it depends on whether or not the legal process take that into consideration in order for the section 33. There are a lot of factors.

CHAIR: The section 33 is admitted and they rush off to whatever and they say no, not sick enough to get into our place today, come back in four days time?

Dr ALLNUTT: Yes.

CHAIR: In other words, the service you are trying to schedule them to is full or it is 4 o'clock and everybody has gone home or whatever. For the court liaison service to work you have to be backed up by very competent community and inpatient service?

Dr ALLNUTT: Yes, that would be very helpful, however I think the problem historically with section 33s has been because nobody is there to do the assessment, the patients who have been sent have not been people who truly should be disposed of by the section 33. So, the identification of the section 33 patients has probably improved and that is why less of them are being sent back. I am not saying none of them are, but the hit rate is pretty satisfactory.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems from talking to Phillip Scott that the Port Macquarie one is working quite well and that was from a model from somebody else, if I recall.

CHAIR: Hunter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the work of Jonathan Carne suggested that quite a lot of people at the central criminal court had psychiatric impairment and it seemed from the raw, rough figures that came from Phillip Scott that it was highly cost-effective in what he was doing and what he was doing just in incarceration costs quite apart from court costs. If the incidence of this remains high, it a reasonable thing to say that every court should have a court diversion officer as a matter of routine and that that would be likely to be cost-effective within the court and criminal justice system?

Dr ALLNUTT: I think that would be ideal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that is an impossible task? It would seem to be a basic element of justice, would it not?

Dr ALLNUTT: I do not think it is an impossible ask. There may be some cost-effective ways of providing that service. In other words, you do not necessarily have to have a nurse in each court. Some courts have a lower turnover and you could have a nurse available to a court or you could transfer patients identified with mental illness or people potentially with mental illness to a court where there is a psychiatric nurse.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That assumes diagnosis. We are looking at a situation where a diagnosis may not be made.

Dr ALLNUTT: No, it does not assume diagnosis, it assumes identification. Before a nurse can see somebody, somebody has to identify them. Whether you identify them in this court cell or that court cell, is just the identification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Unless you had universal screening. When I say universal screening, every prisoner who comes by. That may be an excessive ask, that every prisoner gets talked to by a screening person. The people who are talking about developmental disability believe that a considerable number of people in the criminal justice system were right at the bottom end

of the IQ level or falling into trouble because they could not manage their lives or they were gullible and were the fall guys for other people's more intelligent machinations. Presumably they could also be picked up by the same screening process so the cost-effectiveness would double or would increase by an added factor?

Dr ALLNUTT: If you had a screening process, that would improve your identification, the rate of identification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Experienced nurses, for example, who are running this are likely to be able to identify both those conditions?

Dr ALLNUTT: Mental illness and developmental delay?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr ALLNUTT: Yes, they should be able to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There would be a high pickup rate initially and then it would drop as a number of people were screened out and they did not re-present?

Dr ALLNUTT: Yes. When you are talking about mild delay, it can be quite difficult to pick up. It can really only be more objectively diagnosed with IQ testing or something like that, some sort of neuro-psychological testing, but certainly an experienced clinician could pick up somebody in the lower IQ domain or develop a suspicion that a person may be developmentally delayed.

CHAIR: What about the MISA—the mental illness substance abuse? Is it straightforward or very difficult to tell the difference between somebody who is substance abusing and somebody who is just psychotic? A 19 year old rocks up out of it, seeing and hearing things, and you do not know whether it is the drugs. It can happen quite suddenly, can it not?

Dr ALLNUTT: It can happen quite suddenly. It depends on a number of factors. It is sometimes difficult to pick out and sometimes it requires a comprehensive assessment to distinguish between the two.

CHAIR: Not something you would do in the police cells at 4 o'clock in the morning?

Dr ALLNUTT: Difficult to do it in that circumstance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From what Phillip Scott was saying to us the other day, he can see people in the police cells. The police identify somebody that they think is not quite the full quid in mental state, whether they have a developmental disability or because of drugs or whatever. Phillip can see people in the prison cells. He can only access their medical records if he has consent from the patient. That indicates that he takes the view the patient is sensible enough to make a decision. If they are worse than that, obviously even the police will recognise they cannot make a decision for themselves and have to be taken off elsewhere. My concern is, if you have a 90 per cent hit rate, in other words you are right in 90 per cent of cases, it means you are missing a lot.

Dr ALLNUTT: No, we are saying—I do not want to quote the percentages.

CHAIR: You have a 10 per cent false positive rate; you must have a very high false negative rate?

Dr ALLNUTT: No. Of those we are recommending under section 33, a very high rate of them are successful at admission.

CHAIR: You mean compulsory admission?

Dr ALLNUTT: Yes, under section 33.

CHAIR: Section 33 is not all compulsion. If you lock them up under section 33, those patients could be identified as needing psychiatric care but can be voluntary patients.

Dr ALLNUTT: Yes, they could be voluntary patients.

CHAIR: So, they are not all scheduled. When you send somebody up under section 33, they are admitted to care.

Dr ALLNUTT: That is correct.

CHAIR: You have only a 10 per cent negative rate who get sent home.

Dr ALLNUTT: No. Returned to the courts.

CHAIR: All right, they are sent back to the cell. But there must be a number that you do not send up whom you should have sent up. If you have a 90 per cent hit rate, that means you are missing someone and you do not know what the answer to that is.

Dr ALLNUTT: No.

CHAIR: That is different from what you said earlier.

Dr ALLNUTT: No. I am saying our hit rate, the admission rate, of those who are identified is high. There is a percentage that we identify as meeting the terms of section 33 who are not admitted. I am not talking about missing people with mental illness who should be section 33.

CHAIR: Of the people in the community who are not prisoners whom the police pick up or that mums and dads take to see the Caritas Centre, they have a very low strike rate. They rock up to the Caritas Centre and they say "No, take him home."

Dr ALLNUTT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are in court. It is more likely to be admitted because of the significance of it in the global environment. It is not purely a psychiatric decision.

CHAIR: What I am saying is your best chance of getting admitted to the Caritas Centre is to cause a disturbance enough to be picked up by the police or go through the juvenile justice system, because the mums and dads have a strike rate which is close to zero.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Not to mention the general practitioners.

CHAIR: Not to mention the general practitioners. That is the difficulty. If we set up a forensic service that has a 90 per cent hit rate when, if you took the same people as a parent along to the same place with the same level of disturbance, the hit rate would be lower. That is the evidence we have received to date. Has anybody done that comparison?

Dr ALLNUTT: I do not have any data on that.

CHAIR: If the Court Liaison Service is successful, we will fill up our acute beds and the mums and dads will get less and less access. Do you understand what I am talking about?

Dr ALLNUTT: Yes, I do.

CHAIR: Is this a problem that happens everywhere else but not in New South Wales? Is it a fantasy?

The Hon. AMANDA FAZIO: A delusion.

CHAIR: I have fantasies, not delusions.

Dr ALLNUTT: The problem with beds and resources is a problem everywhere in the world. There is no service that has the amount of resources that makes everybody happy. Every service is limited in that. The frustrations that families have with regard to access to psychiatric care is common to almost

any jurisdiction that I have worked in. Sometimes it is not that the resource is not there. Sometimes it can be the perception of the family that this is what they want but that is not necessarily what is required. They have unrealistic expectations. Sometimes it is because the resource or the system fails them and the beds are not there.

CHAIR: Currently our problem is while there are many of these people in the criminal justice system, they are not even being presented to be refused. The mums and dads can take their son or daughter whom they are worried about to the Karitas centre. The forensic services are not there to ensure someone who is equally sick can get presented under section 33 to access the Karitas centre. We have not got to the stage where they are pinching the beds. It is analogous to the court diversion process for drugs. When the Government and the community set up the Drug Court diversion service to treatment, suddenly treatment positions that were available for the general community dried up and people had to go to prison to get access to the services. That situation has now been corrected. I was concerned that a forensic service would not have that same initial impact and dry up the community access to the beds. Do you understand what I am talking about?

Dr ALLNUTT: Yes, I understand what you are talking about.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not your problem.

Dr ALLNUTT: Unfortunately, a person who succeeds to get admitted under section 33 has got there through, I suppose, unacceptable means, in a sense: they have got arrested. That is one way of looking at it. Another way of looking at it is that that person is a community person and that person has got a bed. So there are two ways of looking at it. Whether they had to offend to get a bed is an unanswered question. But that person at least got the bed that he or she required.

CHAIR: Is the fact that they had to commit a crime to be noticed, which is what the police said to us, recognition of a failure of an early intervention community-based service? There are a lot of people who otherwise would be called forensics-in-waiting. As the Hon. Dr Arthur Chesterfield-Evans said, they are barking mad and simply have not yet smashed the Hon. Amanda Fazio. When they do, they are found not guilty by reason of mental illness. Then they become a forensic patient. There are a lot of people who are forensics-in-waiting. I am trying to find out how many of these people who end up in the prison system and under section 33 get admitted would have been picked up and more appropriately handled if we had a better community mental health service.

Dr ALLNUTT: A better community health service would go a long way to better identifying mentally ill people and impacting on their behaviour that is a consequence of their mental illness. However, if you are looking at violence in the community committed by mentally ill people, first of all, looking at broadly defined violence—and I am talking about a push to homicide—only 10 per cent of those with severe mental illness ever commit a violent offence; 90 per cent do not. That means that the base rate of violence is extremely low. Certainly, the base rate for serious violence amongst the mentally ill community is very low. Confronted with a pool of severely mentally ill people, it is very difficult to identify which one is going to hit Ms Fazio. We probably could identify a certain population that would be a high risk—that 10 per cent, who would probably be male between the ages of 15 and 30, have active symptoms of psychotic illness, be substance abusing and disenfranchised and have a history of mild antisocial behaviour.

CHAIR: Lowish IQ?

Dr ALLNUTT: Maybe lowish IQ, maybe not. It is a particular group. We could probably identify that group. That is the forensic type of group. There are others that the mothers and fathers may bring, with even lower risk of violent offending. To to be able to correctly identify the person who would have been violent if not admitted on admission is virtually impossible. If we want to ensure that no mentally ill person with a serious mental illness is violent, we should admit every mentally ill person. We cannot reliably identify them.

CHAIR: In other words, our current knowledge is not good enough.

Dr ALLNUTT: It probably never will be because the base rate is so low. You can develop the best tools for assessment of violence with high accuracy and still not pick them up.

CHAIR: The community worries about mad people who bash others. That does not happen, but that is the concern in the community.

Dr ALLNUTT: That is the concern. Unfortunately, Hollywood has done mentally ill people a disservice by its portrayal of the bad guy in the movies as having some kind of mental illness. The perception is that anybody with a mental illness is dangerous. This is patently not the case. The clinical fact that seems to contribute most to violence in the community is drugs. If you are walking down the street and there is a man who is intoxicated or on drugs coming toward you on the other side and a man who is actively psychotic but with no drugs coming towards you on your side, if you across the street to the man on drugs you have made a bad decision.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems to me from what you say and from the work of the Select Committee on the Increase into Prison Population that the number of people who are mentally ill or developmentally delayed in prison is so high that a universal court diversion system would be cost-effective. That also relates to the evidence of Jonathan Carne and Phillip Scott and the evidence on the make-up of the prisoner population in New South Wales. Do you think that is reasonable? This is critical recommendation, from our point of view, in terms of criminal justice, court resourcing and mental illness.

The Hon. AMANDA FAZIO: How are you going to divert the people with developmental delay? They are not like people with a mental illness where you can give them therapy or medication.

CHAIR: Often people with developmental delay have more need for supported housing. If they do not have it, they may become homeless or be led into gangs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They need to be diverted into some type of support service because, often, they have committed minor crimes.

CHAIR: The difficulty is identifying how to do it without interfering because they will run away. It is a difficult matter.

Dr ALLNUTT: Only certain people can be diverted.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not saying they can all be diverted. The question is whether it is cost effective.

Dr ALLNUTT: Those who commit minor crimes and do not particularly pose a significant risk to the community, to me it is less about the court diversion system but rather what you had a brief discussion about, that is, where you put them once identified. If people are identified and are going to be diverted, some of them need a place to go. The people who should have been diverted and end up back in the prison environment are people for which there was not a place to go and by default they have landed back in prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is an event that identifies a need. Once they are in the prison system, a large amount of money will be spent keeping them incarcerated. If it is a money problem, the Government is about to spend a lot more. So we are looking at cost effectiveness in terms of public policy.

Dr ALLNUTT: In terms of statewide funds, it is probably a cheaper option to house that person in a community halfway house than it would be to house that particular person in a correctional environment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A halfway house for the mentally ill person or supported accommodation for either the mentally ill or developmentally delayed.

CHAIR: Out of 100 people like that, how many do you have to put in supported housing to save one of them going to prison?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If 100 of them are going to prison, that is a sub-population.

CHAIR: The Hon. Amanda Fazio was talking about the need to identify early people who have mild developmental delay to try to avoid them getting involved with problems. If you provided $1 million worth of funding for that group, how much would that $1 million save you in terms of the cost of prison at the far end? That is the full answer to the question we have raised.

Dr ALLNUTT: I cannot answer that. You would have to ask the number crunchers that one. I am not sure about that as far as money is concerned. My understanding is that a community halfway house or service would be a cheaper option than a correctional centre.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your submission you said that there a great deal of documents report inadequacies in the New South Wales forensic mental health services system. You stated:

> Forensic mental health services in New South Wales has been roundly criticised in national and international circles. In the last decade there have been a number of documents produced by a variety of consultants both nationally and internationally, all reporting similar inadequacies and providing recommendations.

Could you give us some of those references?

Dr ALLNUTT: The three documents that come to mind are the Barclay report, Findley Jones and Blueglass.

CHAIR: There have been a lot of Barclay reports. Which one are you talking about?

Dr ALLNUTT: I am not sure which one. I would have to look.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you send us those documents?

Dr ALLNUTT: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would be much easier to refer to existing work. You also said that you thought that the Long Bay hospital was a disastrous decision in terms of setting the direction for forensic mental health services in the State. You said that the courageous decision being touted by Corrective Services and Corrections Health to build a gaol hospital close to Long Bay but outside the prison is a break in that strategy. Do you believe that the Long Bay hospital will be sufficiently distanced from the culture just over the wall to make it a huge triumph or are you a little concerned about it?

Dr ALLNUTT: I do not think there are many forensic psychiatrists in New South Wales who are entirely happy with the hospital being next to the prison.

CHAIR: Why? What difference does it make where it is?

Dr ALLNUTT: Stigma is one big one. The mentally ill are still identified with the corrective system. However, I think that it is so important that our hospital is built outside of the correctional environment, administered and staffed by health, that if this is an opportunity for us to do that and to take that first step then we have to take it. It would be better to build a secure forensic hospital at a distance from the prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are saying that in terms of political reality you will take half of what you want, but you are not delighted.

Dr ALLNUTT: That is correct. We are not delighted, but we can live with this. It is a step in the right direction. It allows for the philosophy to start occurring, the correct philosophy to be applied which is what is absent at the moment. The building of the forensic hospital inside the prison was where the philosophy got lost. It is interesting that a forensic hospital was built in the prison at the same time that other States and other countries were building forensic hospitals outside the prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have now managed to get them over the wall, but not far away.

CHAIR: Given real estate in New South Wales, in Sydney in particular, and the need for security and, therefore, some perimeter and the like you have to put it out at Lithgow, in the middle of nowhere or in the city of Sydney and then you are very limited because there are not too many choices.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Plenty of real estate is being flogged off at the moment.

CHAIR: Transport for relatives, et cetera, has to be considered. You really are very limited in how you can provide a sensitive site. Why do we not just give it a new name? If people stopped calling it Long Bay and, instead, called it Matraville you would have an existing centre where there is, because of the prison population, a good transport system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It worked for Barden Ridge, Lucas Heights.

CHAIR: It is like suburbs that change their names to get rid of stigma.

Dr ALLNUTT: That is probably something on the cards. The other thing is the design of the place so that it does not look like a prison but a hospital.

CHAIR: Do you know when they painted it inside?

Dr ALLNUTT: No.

CHAIR: After this inquiry was notified. Otherwise, it was grey concrete inside the whole place.

Dr ALLNUTT: Yes, I know that. I implemented that before the inquiry, but it was painted only after the inquiry was notified. I put forward the suggestion that they should paint the place.

CHAIR: I can tell you that they painted it after the inquiry started.

The Hon. AMANDA FAZIO: Was the new hospital designed in collaboration with mental health professionals so that they felt that the accommodation to be provided for new forensic prisoners would be adequate and the most appropriate that could be put in place?

Dr ALLNUTT: The actual planning of the structure of the hospital has not, as far as I am aware, started yet. I am informed that the clinicians will be involved in the process. I think that is absolutely vital.

CHAIR: Why?

Dr ALLNUTT: We bring the understanding of the clinical needs of the design, how the hospital should function.

CHAIR: Everywhere in the world has these places. You simply waste a lot of time in getting a New South Wales solution to a problem that 600 million people around the English-speaking world have.

Dr ALLNUTT: I do not think that we should reinvent the wheel.

CHAIR: Exactly! But that is what is going to happen, as sure as eggs.

Dr ALLNUTT: There are plenty of good examples. The Mason Clinic in New Zealand and Victoria. Queensland just build a new service. The Queensland one is quite impressive. There are plenty of examples. I think that the architect needs to adopt the best of the lot, look at them, the characteristics of each one and design one for New South Wales.

CHAIR: Is it not a form of intellectual snobbery to say: Queensland is all right and Victoria is all right, the one in Main, Boston, Holland and everywhere else is all right. There are thousands of them. Why do we not just build it? It would save a lot of time and hassle. Certainly, you would not advance science much if New South Wales had its special solution.

Dr ALLNUTT: If we are so far behind, we may be in front. We have an opportunity to look at each one and design a hospital that takes into consideration all the faults in all the others.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Malabar Treatment Works was built underground because the designer was worried about snow.

The Hon. AMANDA FAZIO: I would also suggest that given some of the design faults pointed out to us in the view of the existing Long Bay facility that it would be worthwhile to have people who have to manage it—

CHAIR: I am sorry, I am being cynical. A lot of time has been wasted. Take day surgery centres, for example. A lot of time can be wasted. Let us build a centre, but you have to allow six-months for consultation, which means that the Government does not spend the money. For heaven's sake, everyone in the whole world uses the one design for day surgery centres, because it works.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Brits have a hospital design committee that keeps improving by increments and builds them all according to an evolutionary process.

CHAIR: You can waste at lot of time because New South Wales Health is going to build only one of these things. We are not going to learn incrementally like the Brits. We are going to build only one, and that is it.

Dr ALLNUTT: Hopefully, it will not be only one. Hopefully, it will be a group of hospitals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hopefully, it will be a number of small ones.

Dr ALLNUTT: Hopefully, it will be a hospital that will begin with a model of care in mind and not just the building. That is where the clinicians have to be a part of it. First, we have to identify what a model of care will be and then look at designs that are around that will allow us to adopt that model of care.

CHAIR: How will the people of New South Wales be certain that we will not do too much belly-button gazing before actually getting something that is better than what is Dickensian?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are taking an anti-intellectual position.

CHAIR: No, I am not.

The Hon. AMANDA FAZIO: I was involved in the design of nursing homes, and I can tell you that if you let the architects do it themselves they will come up with corridors that you cannot get two wheelchairs and two beds through at the same time.

CHAIR: It is a matter of the clinicians being happy. I know that the clinicians have to have ownership: the nurses, the doctors, the cleaners and everybody has to have ownership. But I am concerned that we will try this trick of 99.99 per cent of the English-speaking world, 600 million people and 54 governments have not got it right but we in New South Wales, who have not even advanced from 1843, will do it right for you. It beggars belief. I bet you we try it.

Dr ALLNUTT: That could be the case. We could take this opportunity to try to get it right. But as far as clinical input, and even though we are getting off the topic I want to say this, I worked at the Mason Clinic for 4½ years. The Mason Clinic is worth a visit because it is absolutely the antithesis of what you would imagine a secure forensic hospital would look like. First of all, it is built on, or right next to, or on an old technical college campus. The technical college campus is almost right next to the Mason Clinic. The students walk past it. There are no high fences around the hospital. There are no high wire walls. The hospital is not staffed by any correctional or security staffed. It is staffed and managed by nurses. There are no bars. It provides an harmonious, therapeutic environment. The important thing about any forensic hospital is that you have developed security with dignity. There is a view that the two cannot occur together, but they absolutely can. It is to provide a therapeutic environment that is secure, and it is absolutely possible to do that. The Mason Clinic is an example of that. The clinicians there had input. There have been no major incidents in the Mason Clinic in the 10 years that it has been there.

CHAIR: It is high security?

Dr ALLNUTT: It is high security, medium security, low security unit.

The Hon. AMANDA FAZIO: Would the high security forensic patients there be the equivalent of the high security ones at Long Bay?

Dr ALLNUTT: Absolutely. New Zealand's most dangerous mentally ill people are housed there. In a hospital we design in New South Wales, politically it is important to have a wall but as far as the design is concerned it can be humane and you can hide security within the design so that it looks like a hospital. You must remember that people live in this place for years, some of them for their entire lives. To provide them with an environment that is just a room and a view to a concrete wall is inhumane.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about high-quality psychiatrists and difficulty in attracting them. We have struck a couple of people who have resigned from working as psychiatrists in Corrections Health. I gather that there is difficulty getting people to work in the system as it is, is that right?

Dr ALLNUTT: I think that is more historical than current.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has there been an outbreak of optimism?

Dr ALLNUTT: Yes, there is an outbreak of optimism. In the past two years, with the promise of a new hospital and the advent of court liaison services I think there is optimism among the psychiatrist who work there. As far as whether or not you choose to work there, I think that is just a perspective. Some of us are of the view that you can affect more change from working within the system and others are of the view that you can effect change by working from without the system. The Mental Health Tribunal may agree with us that the quality of psychiatrists working in hospital has improved in the past two years. Historically, it has been very difficult to attract psychiatrists, but I think that with the promise of a new future people are remaining in the system and people are interested in coming to the system. I get calls from registrars all the time who want to come to work with us. They are becoming more and more interested in forensic psychiatry. However, it is important that that momentum continue because if that momentum is lost people will become disillusioned.

CHAIR: This is a very difficult area that Richmond did not attract at all, yet it is an area that, apart from the occasional article, does not surface because it is out of site out of mind. But it is significant for us to look at and we have received quite a number of submissions about it, mainly from psychiatrists and workers from within the system rather than relatives or, obviously, patients. Thank you very much for your time today. If you think you need to correct something or if you do not think you have made yourself clear and you would like to provide us with additional material, please let us know. We may come back to you when we write our report to get you to look at the recommendations we might have to ensure that they are sensible and that they are in line with the sort of thing that you and your colleagues agree with. If you need to contact us again, please do not hesitate to do so.

Dr ALLNUTT: It would be better if forensic patients were administered by a forensic mental health tribunal, that decisions around their movements—

CHAIR: They are.

Dr ALLNUTT: No. That executive oversight is removed. In other words, political oversight is removed. I worked in Canada. There is a model for that. It works very effectively. It speeds up the process. It is probably in the interest of the community to consider that.

CHAIR: After the last review of the Mental Health Act Dr Hayes brought that forward to the Minister and the legislation was drafted to allow the Mental Health Review Tribunal to have the final say. Both the Government and the Opposition declined because at the end of the day the Government is always going to be who is held responsible for public safety. In issues of public safety the Government always is finally responsible and therefore should have the final say. I do not believe, and even Dr Hayes did not believe, that at the end of the day his decisions did not live, even if there was a bit of a delay. So I accept what you say and it is consistent with the advice received from Dr Hayes, who argued it

passionately. But at the end of the day he is not going to be found responsible by the people of New South Wales if somebody who is a forensic patient is released and commits a crime; the Government is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a paper on the Canadian model, which you are suggesting presumably in preference to a number of other possible models from other jurisdictions?

Dr ALLNUTT: Yes, I can try to find information on that for you. It would be interesting—and I am not sure that there is a paper that looks at this—to know whether there is more offending in a system where there is executive oversight than in a system where there is no executive oversight but rather decisions are made by legal people and clinicians that understand the issues probably better than the politicians. It is probably—I say this really guardedly—in the better interest of the public that those decisions are made closer to the ground by people who know the patient, who know the law, who understand the quality of resources available than by executive oversight at a distance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, if executive oversight significantly overrides the expert opinion it is likely a lot more people will be locked up. In order to increase a perceived safety in the public interest or the political interest, whatever you want to call it—the perceived public interest by the political interest, which might be the self-interest—you will lock up a lot more people. So for the sake of a possibility, because the probability here is very difficult to assess by anybody—

Dr ALLNUTT: It is difficult to assess. I could name individuals who, looking at every clinical, and criminalogenic factor, are not a risk but remain incarcerated.

CHAIR: That is right. I can tell you of five.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is quite worrying if a lot of people in that category are being locked up basically because politicians are timid.

CHAIR: No, it is because there has to be community faith. If one of these people who we say is absolutely no risk commits a crime we lose all community trust. Then you get more stigmatisation and more worry. It is the real issue.

Dr ALLNUTT: Because incidents in New South Wales are not reported as often as in other jurisdictions there is a perception that executive oversight works. I would say that better decisions would be made by a forensic mental health body. That would be in the interest of the community because these five people have taken five beds. Those five beds are not available to five people in the gaol so those five people are going to go into the community and they are not going to get proper treatment.

CHAIR: No, it is not quite like that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think it is.

CHAIR: The tribunal recommends going from Long Bay ward A to Morisset; from Morisset to step-down care within the Morisset grounds; from Morisset grounds to out there in the community. There is a whole step range.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But he is saying that the whole thing is delayed because they are clogging up the higher level beds so they cannot start stepping down.

Dr ALLNUTT: The decision-making process is delayed.

CHAIR: In Government, if we had taken Dr Hayes's suggestions on every single patient—and the Minister for Health always agreed with Dr Hayes, always, but the Government disagreed regularly—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean the Government overrode the Minister for Health?

CHAIR: Absolutely right.

The Hon. AMANDA FAZIO: The Executive.

CHAIR: The Executive Council, the Governor-in-Council. The Minister for Health always agreed with the head of the Mental Health Review Tribunal except that he could ask for certain extra opinions or clarifications. But at the end of the day if the Minister does not agree with the director the director resigns. That is what happens. So at the end of the day the director had to understand that it was a government decision. The Minister would always support Dr Hayes and the review tribunal but it is the government of the day that has to bear the responsibility; not the Minister for health and not Dr Hayes but the government—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, the Minister for Health would be the one fronting the TV.

CHAIR: No, he would not.

Dr ALLNUTT: If you remove executive oversight then it—

CHAIR: It is like the Parole Board. It has the final say on who gets parole.

The Hon. AMANDA FAZIO: Except for the *Daily Telegraph*.

CHAIR: No, the Parole Board does have the final say but there is a huge amount of regulation about how it does it. If you want the same as the Parole Board, which is what you are talking about, then you have more regulations and more hoops. But at the end of the day the Parole Board bears the responsibility.

Dr ALLNUTT: Would that not be the same for forensic mental health?

CHAIR: Except then we have a whole lot of Acts of Parliament come forward to keep people in prison.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which were supported by a video of one of the relatives of the victims in an interview with John laws. That was the principal evidence given to support that legislation.

CHAIR: We then move legislation to keep people in the mental health service, the same as the parole service.

The Hon. PETER BREEN: It will be overturned by the High Court, though.

CHAIR: That is right. That issue is one of the most vexing but it is not as though it has not been considered. It has.

Dr ALLNUTT: I understand that.

(The witness withdrew)

(The Committee adjourned at 3.55 p.m.)