

REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

At Sydney on Tuesday 8 October 2002

The Committee met at 9.30 a.m.

PRESENT

The Hon. Dr Brian Pezzutti (Chair)

The Hon. Dr Arthur Chesterfield-Evans

The Hon. John Jobling

HENRY PETER BURNELL HARVEY, 32 Pritchard Street, Wentworth Falls, sworn and examined:

CHAIR: What is your occupation?

Dr HARVEY: I am a retired medical practitioner but I am an official visitor to the Health Department mental hospitals.

CHAIR: Which particular hospitals?

Dr HARVEY: Liverpool, the Kiloh Centre, Prince Henry, and the Sydney Private Clinic, and formerly Caritas.

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

Dr HARVEY: As an official visitor, and private citizen perhaps.

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

Dr HARVEY: I have read them, yes.

CHAIR: You have made a submission, which is number 288. Would you like that submission to be included as part of your sworn evidence?

Dr HARVEY: Yes.

CHAIR: Should you at any stage consider 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 your request, but you should be aware that the Legislative Council may overturn the Committee's decision and make that evidence public. This is a major submission about the official visitor. Would you like to make an opening statement?

Dr HARVEY: Yes. Firstly, we do sign a contract of ethics and confidentiality about our work but I presume that does not prevent me giving evidence to you?

CHAIR: I think you should avoid mentioning individual names or anything that may identify an individual.

Dr HARVEY: I can show you what we signed, the ethics and confidentiality document which says that "A person must not disclose any information obtained in connection with the administration or execution of this Act"—this is part of the Mental Health Act—"unless the disclosure is made with the consent of the person from whom the information was obtained, or in connection with the administration or execution of this Act, or for the purposes of any legal proceedings arising out of this Act, or in accordance with the requirement imposed under the Ombudsman Act 1974, or with any other lawful excuse".

CHAIR: I am advised by the clerk that you can effectively report on your observations while you are doing that work, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: He can report with regard to administration. The confidentiality agreement is mainly with regard to patient confidentiality, not with regard to how the system actually works.

Dr HARVEY: That is true, but when I approached the Principal Official Visitor she would like to spread it to any information that we have.

The Hon. JOHN JOBLING: You might note, Mr Chairman, the last comment that was made in relation to the view that the principal operator would like to have it applied to everything. In other words, it would be a blanket estoppel on that basis.

CHAIR: If that direction or advice was applied, how could one even report to the Minister on what one saw?

Dr HARVEY: I should not say "everything", but she would spread it. I think that is exaggerating a bit. When we wanted to report back to the units of our complaints, she said that we were only to report to her and not give a copy of our report to the units.

CHAIR: So what you are saying is that if you are visiting a unit, for example, Liverpool hospital or Caritas, and you identify some problems, then your chain of response is to the principal visitor and not to the unit itself?

Dr HARVEY: The report that we put in must not be seen by the unit but there is an official visitors book. We are expected to bring up problems with the unit. We are not told, at the teams that I work with, to write in the official visitors book what we have. At first I gave them a copy of our report and I was told that it was a confidential report and I must not do it, but then we write in the things that we are reporting up the ladder, and the things that we think ought to be fixed we discuss with them and we write them in. This is one of my complaints, there is no mandatory requirement for the unit to even read our official visitors book or to act on it that I can see in the Act anywhere. That we can write down the complaints....

CHAIR: It occurs to me that one of the valuable things that you might do is have the official visitor's comments on the mental health service incorporated into the area health services annual report to the community. You say under the current arrangements that is not possible because your report must go to the Principal Official Visitor?

Dr HARVEY: That is right, yes.

CHAIR: In simple terms, how would you describe the job of an official visitor?

Dr HARVEY: Sort of an ombudsman. There is a history that I have given you here that goes right back to the official Lunacy Act of 1843. That is in the Mental Health Act, section 226, page 111, I think.

CHAIR: It is mentioned extensively in the 1855 report.

Dr HARVEY: Yes, and our duties are spelt out but, as I see it, a visit is a pretty arduous ordeal; you are there for about four hours, having driven down from the mountains, and in that period I would like to show you later all the things that you are supposed to cover: from hotel services, from the amount of drugs used, from the way the records are written, talking to individual patients—and you can imagine how far you get talking to five very certifiable people and sorting out the truth from fantasy and hallucinations. We do all this, and a whole lot more. Have you got copies of the official visitors handbook?

CHAIR: Yes.

Dr HARVEY: Have you got a copy of the report we are required to fill in?

CHAIR: Yes, you included that.

Dr HARVEY: So we go around trying to fulfil all these roles and then we fill in that form—I have got a spare copy if you need one—the official visitor's monthly report, and we collect a whole lot of information and we look at all the registries: we are supposed to look at the medical records of the patients, at the drugs prescribed, at the seclusion registry, the ECT registry, the incidents and violence reports registries, analyse everything that has happened there, and report back and fill in this quite

extensive form. When we have filled it in we do not know what happens to it. We get no feedback. Occasionally if you refer a matter to the Principal Official Visitor you will get a report back from one of her underlings—never from the organ grinder, always from an underling. Often, the issues that require following up are totally ignored. At least we are not informed of any action.

I do not know the constitution of the office of the official visitor or her secretariat. I am told that she is only half time and works in another building to her secretariat analysing reports from 58 units and 70 agencies. She could read them all; they are only two a day and they are not all that big. But the information which we strenuously gather could be of great value if it was cross-analysed and fed back to us. If you look at the duties of the official visitor, it requires that we be given a report every three months. I have been attending for 20 months and I have not seen a report yet. Going back with my colleagues, the last one I can find was January 1998. There may have been others but there certainly have not been any since March 2001. So we collect all this information and it is valuable and it is hard to gather and we feed it into a system and we get no feedback. This is one of my complaints.

CHAIR: These are unpaid jobs, are they not?

Dr HARVEY: Not quite. We get paid the princely sum of \$23 an hour with no travelling time allowed.

CHAIR: And the persons who are appointed—I know in Lismore they used to have usually a local solicitor and a local medical practitioner.

Dr HARVEY: They are not necessarily local. It is a medical practitioner and another person who is usually a social worker, an ex nursing administrator, perhaps a counsellor or somebody with a little bit of medical expertise or social expertise. Two are required and one must be a medical practitioner. These hospitals are required to be visited monthly. Often there are not enough visitors to do it or they are not available, and that part of the statutory requirement is not always met. One of my complaints is that it is putting an awful lot on—I am a retired cardiologist and chest physician and one of my colleagues was a Deputy Vice-chancellor of the University of New South Wales, another was a nursing administrator, another was a social worker and we are asked to consider such things as, "Do you consider excessive amounts of medication are being prescribed?". You walk into a unit with 30 or 40 people, some of them talking to the walls, some of them prancing up and down shouting for the nurses and you are supposed to look at this.

CHAIR: It is difficult, but it is most important from a public perspective that you are a person from outside coming in and seeing if people are getting a fair go.

Dr HARVEY: That is right.

CHAIR: So as to advocate on behalf of consumers to ensure that the issues of importance to their welfare are addressed properly in the hospital and the health system. So you are visiting hospitals. Do you visit the community mental health teams?¹

Dr HARVEY: No, they are different. Have you had any input from the official visitors before?

CHAIR: No, not for this inquiry.

Dr HARVEY: Or the community teams?² Probably you have.

CHAIR: When I was the Parliamentary Secretary for Health I used to meet with the Principal Official Visitor for the Minister regularly every three months.

Dr HARVEY: That is required by the Act.

¹ If the Chair meant "Mental Health Agencies" Dr Harvey wishes to state that "we do visit them".

² Dr Harvey meant Consumer Advocates etc.

CHAIR: That is right. I used to sit there and the Principal Official Visitor would come in and talk to me about issues which would then be taken up by the ministerial advisers with the department. That is what I know about it.

Dr HARVEY: The consumers, there are many types—I am not familiar—I sort of sidetrack all the while but when I came into the system it was out of sync with the training program and I was given no training. I am a cardiologist. I was sent all the material and the names of the people I was to visit, and when I suggested that perhaps I could be introduced to them they said you ring them up. I said, "How do I go to Liverpool hospital?" They said, "You ring up and make your own arrangements." I thought, well, okay, I will try to find out. I did not know who the people were until I met them at the door. The hospital did not know I was coming. I am not on their list of staff as an official visitor but they were very polite. They knew that they should have official visitors but from my point of view I was never given the training.

Some months later after I repeatedly pointed this out I was given three weeks notice to say that a special training day had been arranged for me to go through all this material. It just so happened that that day was right in the middle of a week I was to be up at Mudgee at a music festival. My wife had been waiting for this for a year and I said, "I'm not going." They did not even consult me as to when to have it, so they cancelled it and I have never had any training. I have just sort of read the Act and tried to talk to the Principal Official Visitor.

CHAIR: So when you are appointed there is no induction process.

Dr HARVEY: There should be. It is in the Act.

CHAIR: But there is not from your point of view.

Dr HARVEY: I was not—that is all I can say.

The Hon. JOHN JOBLING: Is that a common view that may have been expressed by other official visitors in other areas?

Dr HARVEY: We are very widespread and there is one meeting a year. You know who the other visitors are but it is not like you people in Parliament—you do not run into them. I only meet them once a year at that meeting.

The Hon. JOHN JOBLING: So it is not a complaint that has been raised.

Dr HARVEY: It is. At the same time as myself another—I cannot mention the name—quite illustrious official visitor had the same problem. I do not know whether his has ever been addressed. I cannot tell you how many other people have not been trained.

CHAIR: But when you raised this at the yearly meeting—you have been to one yearly meeting?

Dr HARVEY: I have been to two yearly meetings.

CHAIR: Has this been raised at the yearly meeting?

Dr HARVEY: No. The yearly meetings are very structured. They are held at a hotel. They consist—I can give you a program of one of them—of some very useful lectures by psychiatrists. A very good one was given by a police officer. I do not know whether you have interviewed police who have to deal with these people on the streets when they are let out. She was wonderful, Vicki Arantz. I do not know whether I should mention her name. People like this talk and then at the end on the second time there was an allowance for discussion and it was cut very short because the meeting was running late.

The Principal Official Visitor was supposed to give us a report, the title of which was "What happens to your reports when we get them?" Her formula was to list all the reports, subdivide them, so many about "food", about "the toilets", about "not seeing enough of the patients", that "it was dirty".

She just went through all the complaints. She did not ever tell us what she did with them or what happened to all this information that we feed in. So that is the official meeting, and then you might meet a couple of other people but there is really no question time. It is all didactic and instructive. There is not enough question time.

CHAIR: But when you stop for morning tea do you get the impression that other people have the same problem?

Dr HARVEY: I know, we have had a couple of meetings with four or five of us who I know and one with the director, Professor Raphael of the Centre for Mental Health. We have raised all these complaints with her. It was just before Christmas last year and she asked us to put them in writing but not until February because she was going away on holidays. I did put them in writing and I have not yet received an answer.

The Hon. JOHN JOBLING: Would you perhaps concur from what you have said that a reasonable person or a committee might have their suspicions that in fact the official visitors are not receiving training before undertaking their jobs as a general purpose?

Dr HARVEY: I cannot really answer that—

The Hon. JOHN JOBLING: As a suspicion.

Dr HARVEY: I think some. I am sure that not everybody has been properly trained but I do not know in that group of people who come from all over the countryside how many have been doing it. A lot of them have been doing it for a long while and have a good relationship with the units they visit and know exactly what they are doing. But to come into the system at this stage is a daunting experience because the Mental Health Act is very complex and the requirements are pretty strenuous.

CHAIR: It may be even more difficult now with the Privacy Act in place. We might write to Bev Raphael to see whether or not patients had to give approval for their records to be looked at under the new privacy principles. The training seems to be a problem but what opportunities are there for an individual visitor to provide any form of individual advocacy for a patient?

Dr HARVEY: To the department?

CHAIR: For a person.

Dr HARVEY: For a patient?

CHAIR: Someone has put a letter in the official visitor's box. It may say, "Get me out of here. Satan is coming."

Dr HARVEY: They all do.

CHAIR: But if you find that someone does need advocacy what avenues are there for you to provide individual advocacy for some of the people in these hospitals?

Dr HARVEY: The official visitor's box is locked and we are the only people who have a key. We have to make sure that it is in the appropriate position where patients can see it. We found that some were hidden away but now in all the units I visit they are where the patients can see them. There is a notice beside the box telling the patients a little about their rights. Virtually the first thing we do when we arrive is open the box. After we read what the people say we go through records and discreetly raise points about Joe Blow and ask where he is. We make it known through the unit, although it should be notified, that this is the day we are coming. We are not always sure that that is done. There are so many things to check. They should know that we will be there. We seek out everyone who has put in a complaint and talk to them. This is hard going because, as I said, many of these people are off the planet and to try to sort out what they are saying can be pretty demanding.

Quite a few of the complaints have substance. They might be about the state of the bathrooms or not seeing the doctor for a week. We take that up with management. If we can sort it out it goes

under "Issues raised with the medical staff which were settled satisfactorily". If the complaint is that the unit is dirty and there has not been a light globe in the toilet for three weeks and you say that to the manager you are told, "We go to the maintenance staff and get nowhere. We are in a big hospital and we are only one tiny bit of it ." We then put that to the Principal Official Visitor, saying that maintenance is appalling at—you can possibly guess which hospital I am referring to. She then may or may not take it up with the area director. But it often disappears from our sight. We do not know what has happened to our referral upstairs. We get no feedback.

CHAIR: So there is no closure of the loop in quality terms?

Dr HARVEY: Exactly.

The Hon. JOHN JOBLING: If it was a less than major problem do you, as an official visitor, when you come back the next time take any steps to see whether it has been fixed if it is something such as that?

Dr HARVEY: Yes. Do you have a copy of this document?³

The Hon. JOHN JOBLING: Yes.

CHAIR: It is part of your submission.

Dr HARVEY: It is the bottom thing on page 1 of the official visitor's report. The official visitors scheme is a great scheme. If it worked properly we would have the best mental health service in the world. It would not be perfect but the official visitors could make a huge contribution because there are a lot of talented people. We have to get this photostatted or make notes ourselves. There is nothing in our instructions to tell us to follow up the issues that we raise. We have to do it ourselves. There is nothing in our instructions about what to write in the official visitors book for anybody to look at it or to take action.

The Hon. JOHN JOBLING: But you do it as a matter of course?

Dr HARVEY: Yes, but I cannot speak for the rest.

CHAIR: Your reports are only seen by the Principal Official Visitor. They may never get anywhere near the Minister or the department or the hospital; they may just gather dust. Apart from those problems, are there any problems with access?

Dr HARVEY: No, the units are very cooperative. I think they realise that we are there for the good of the patients and for the good of the staff and they do not withhold matters from us. They mostly accept our suggestions. Sometimes they just throw their hands up and say, "We have been trying to rectify this but we cannot get anywhere."

CHAIR: Would it be helpful if we were to recommend that your reports should go to the chief executive officer of the area health service?

Dr HARVEY: Yes, I think that would be a good idea. Area health services are required in their annual reports to report complaints and what has happened to them in terms of resolution or how many have been referred to the department or the complaints unit and so on.

CHAIR: But here you have an official whose job it is to seek out any problems or abuses, yet your chain of reporting is to the Principal Official Visitor.

Dr HARVEY: That is right. The Principal Official Visitor is required to have an advisory committee which is to meet regularly. That was last elected the time before last. It was not mentioned in the last meeting. I do not know who the current members are, who the secretary is, how to approach them.

³ The O.V. Report Form

CHAIR: Because you have had no newsletters?

Dr HARVEY: Exactly.

CHAIR: Have you ever got on the phone yourself and rung the Principal Official Visitor?

Dr HARVEY: Yes. For six or eight months I have not done it. She is not available on the phone. She has a paging system which she never answers. You are told she will ring back, which does not happen.

CHAIR: Is that because the Principal Official Visitor has a problem with resourcing or do you think it is the nature of—

Dr HARVEY: I cannot answer that. It is only hearsay but I believe she is part time and works in another building. One of my major recommendations is that the Principal Official Visitor should be full-time and she should visit herself and not just sit back and do all the paperwork.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you know who is on that advisory committee? Are they departmental people or are they—

Dr HARVEY: No, they are elected from the official visitors.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you been involved in an election?

Dr HARVEY: One, when I had been in the job for two months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you know who the people were?

Dr HARVEY: A couple.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they send out some CVs as with a university senate election?

Dr HARVEY: No, they are nominated on the floor at the time. Interestingly enough, there was no doctor and there was no male on the committee that I last heard elected. When I referred matters to that committee they said they could not meet because they were awaiting a reply from the Minister on a detailed report they had sent in in February. In brief, the report asked that the requirement for a doctor for each visit should be changed to a medically associated—I cannot think of the right word.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To broaden it?

Dr HARVEY: Yes. They did not get a reply to the report from February to November so the committee did not meet. I do not know whether it has ever met since. I have never seen a report from them. It is a committee of us, and if it is a committee of us I think we ought to get reports.

CHAIR: So do you think that at the moment the official visitor program in New South Wales is almost moribund?

Dr HARVEY: It is a good program, it is just—

CHAIR: I do not mean moribund from what happens on the ground but with regard to whether the Minister is receiving any information whatsoever that is useful to him or her to act upon?

Dr HARVEY: You said you were sitting in on some of those meetings. We do not know what is happening. I do not know whether it is moribund. It is certainly sick in my opinion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was there any attempt to suppress your giving evidence here?

Dr HARVEY: I have written to them and rung them so many times. I am just here. If they tell me that I am not allowed to give evidence—I am a contractor; I am not an employee. We are contractors. We get no superannuation or sick pay or anything like that. We get paid \$23 an hour to go out there and grapple with a system which is difficult.

CHAIR: So you are appearing here now as a private citizen who happens to be an official visitor?

Dr HARVEY: That is right.

CHAIR: Is that because you got a letter from the Principal Official Visitor saying "Thou shalt not divulge anything"?

Dr HARVEY: No, I have not.

CHAIR: That is something you sign.

Dr HARVEY: Regarding this Committee?

CHAIR: No, regarding your appointment at the time.

Dr HARVEY: That bit I read out to you, I thought it excluded me. It is a legal requirement, is it not?

CHAIR: If we could briefly move on from that, if you found something in your visit that really concerned you—say the ECT records were not up to scratch or you could not find any consent for ECT or any magistrates orders and yet there were 20 people having ECT every day—and you put this in your report would you note that in the comments part of the official visitors register at the hospital?

Dr HARVEY: Yes.

The Hon. JOHN JOBLING: Who else would be notified?

Dr HARVEY: It appears in this monthly report.

The Hon. JOHN JOBLING: What I deduce you have said to us is that you put it into the report, send it off if you are worried to the principal visitor and you have no idea of what happens?

Dr HARVEY: No, not with ECT.

The Hon. JOHN JOBLING: But who else would you report to if there was a major problem such as that?

Dr HARVEY: Sometimes you find that the anaesthetists are not signing for ECT or there is no consent form. We get the book out. Everyone has a proper register. We write a stern message across it that the anaesthetist is not signing this and there are three consent forms missing, please correct. It is always done.

The Hon. JOHN JOBLING: That does not mean that it is still not happening; it is just that they have fixed their clerical error.

Dr HARVEY: And then they do not repeat it.

CHAIR: Say a patient put in the box that Mr X or Miss Y, a registered nurse working in the unit, physically assaulted the patient. I know that some of these people are, as you say, off with the fairies, but that is a complaint about something serious. What would you do about that?

Dr HARVEY: We would talk with the person. We would see the incident report book, see if it was written up. It might say "Nurse Jones got angry and pushed me up against the wall". We would talk to the medical director and we would try to get satisfaction from that individual kind of case. A place like Kiloh might have 30 or 40 incidents in a month—people falling or people shouting or breaking windows or throwing things. If you report to the Principal Official Visitor that the level of violence in the unit is unacceptable you do not get any feedback. You can look into all these individual reports.

CHAIR: Is there any alternative pathway for you to voice your concerns?

Dr HARVEY: We used to get these answers saying, "We suggest you discuss these matters with the medical director". I sent a slightly angry letter saying, "We have always discussed every matter we refer to you to the medical director first." They feel that they cannot do anything because of the structure of the unit or the admission policy is such that there are too many violent patients and too few nurses and you are getting a high level of aggression." I do not know what she can do about it—probably nothing.

CHAIR: Do you think the official visitor should have access to the chief executive officer of the area health service?⁴

Dr HARVEY: Yes. I think she does, doesn't she?⁵

CHAIR: I am referring to the official visitor. Suppose you are visiting Sutherland and you see a problem, and you are not happy with the answers that you get, or the medical director says to you, "Look, we have tried really hard on this one, and we cannot get anywhere. We cannot get light bulbs, we cannot get windows fixed, and we have glass all over the place. We should have perspex. OH and S have been and done a report on dangers to our staff, we have too much violence and not enough security staff here." So if the medical director weeps on your shoulder—which seems the much more likely thing to happen—do you think you should have access to the chief executive officer to make sure that the CEO has that message from you as the official visitor?

Dr HARVEY: Either the CEO of the hospital or the area health service. I do not know whether the official visitor has the time to be making appointments with the CEO.

CHAIR: It is very easy for the CEO to say, "I did not hear anything about this. Goodness gracious me! I am here, but this matter has not got to me. How could I know about this?" Often, ignorance is bliss.

Dr HARVEY: I have said to the people at Liverpool, "I suggest you document every single request you made to the maintenance department and append to it, "We are informing the CEO and the health department that we are getting no action on this." I mean, as official visitors we can identify the problems, but we cannot solve them all.

CHAIR: Although most of you are very senior people—ex vice-chancellors and so on, people with clout, and people who would be looked up to by the community as people who could fix things, as people with integrity, knowledge and wisdom—and you are sitting down and having a cup of tea with the medical director of the unit and you are both whingeing to one another about the same things, the community does not know about it.

Dr HARVEY: The medical director says he has talked to the CEO of the hospital.

CHAIR: The community do not know that, and your role is to give the community confidence that there is community oversight by a senior person. Yet all that happens is that you are having a chat with the medical director and writing official reports, and you yourself are not comfortable that those reports are getting anywhere.

⁴ Not the P.O.V.

⁵ I misunderstood this

Dr HARVEY: That is right. That is why I am appearing before the Committee today. I agree with what you have said. The aim of the Act is very good, but to my mind it is not as effective as it could be.

CHAIR: Do you think the official visitor should have access to the Health Care Complaints Commission?

Dr HARVEY: I think she does.⁶

CHAIR: I mean you as an individual.

Dr HARVEY: One major complaint—which may even have come to the attention of the House—was referred to us and then on to the Principal Official Visitor as a very serious complaint about management and treatment. We took it as far as we could. We got no feedback except by keeping in touch with the relatives although the patient was now out of hospital. The relatives were very unhappy with what the Principal Official Visitor was doing, so she said, "I suggest you take your complaint to the Health Care Complaints Commission." We said, "Until we get this matter settled and some answer back from you, we are not going to that hospital again. There are a whole lot of complaints about this unit." The answer that came back from one of the secretaries was that as the matter was now in the hands of the Health Care Complaints Commission, the official visitors would not be receiving any more information. I rang up and said, "Look, the complaint came through us. I am not going to go back until I can face those people and the community with a response." But she told them to go to the Health Care Complaints Commission.

CHAIR: Did the Health Care Complaints Commission, which may have received that complaint from them—

Dr HARVEY: They did make the complaint.

CHAIR: Did the Health Care Complaints Commission then come and talk to you?

Dr HARVEY: No.

CHAIR: So the Health Care Complaints Commission did not involve you in any way with its inquiry?

Dr HARVEY: No. I did ring the relatives of this particular patient only two days ago, in the knowledge that I was going to appear before this Committee, and they said they had had a most satisfactory contact with the Health Care Complaints Commission and were very happy that a lot of things were happening; that they were much happier people after going to the Health Care Complaints Commission.

CHAIR: But, in your view, as a community person visiting that place and identifying the problems, those problems should have been sorted out locally in the first instance, because most of these local issues are referred back by the Health Care Complaints Commission to the area health service to sort out locally.

Dr HARVEY: Yes.

CHAIR: Unless they are very serious or significant things and the result of might be that someone will be deregistered or counselled. But your reports and your access to the CEO are very limited.

Dr HARVEY: Yes.

The Hon. JOHN JOBLING: Surely the official visitor who instigated the report and set in train the process which led to the Health Care Complaints Commission's involvement would, at the

⁶ Again, I am assuming the chair meant P.O.V.

end, expect an acknowledgement such as, "We acknowledge the complaint. This has been done, that has been done, this is still to be done, and that cannot be done."

Dr HARVEY: The Health Care Complaints Commission might have said that to the Principal Official Visitor, but we do not know that, except if we find out by ringing up. Maybe we are going to get something, because the report by the Health Care Complaints Commission to the relatives and complainants is confidential and therefore the relatives could not tell me what the report said. But they said they were much happier.

CHAIR: Given the people are reliant on, say, the Sutherland mental health service, if the process takes a long time, that means that they cannot, with confidence, use the service until the matter is sorted out.

Dr HARVEY: Yes.

CHAIR: To that extent, the community should be concerned that people might not have faith in a particular organisation.

Dr HARVEY: Yes. It is unusual, in the public health and mental health system, to find patients and relatives who are sufficiently au fait and sufficiently intellectual to make a logical complaint, as these people did. Many complainants are street people who are frequently going in and out of these units, and if they have complaints they would never get them that high up the ladder anyway.

CHAIR: Can relatives complain to you that they cannot get service?

Dr HARVEY: Yes.

CHAIR: How do they do that? If they are visiting a hospital, do they see your name up there in lights at the front door saying that the official visitor is Dr X?

Dr HARVEY: No.

CHAIR: Should that information be available at the front door?

Dr HARVEY: I think it should be notified who the official visitors are. There is a telephone number beside the official visitor's box.

CHAIR: Say my daughter has a problem with the mental health service at Sutherland, for example, and asked who the official visitor was, would the CEO know that there was an official visitor?

Dr HARVEY: I should hope so.

CHAIR: You cannot be certain. The mental health team know that there is an official visitor, but would the CEO know that there was an official visitor?

Dr HARVEY: The Principal Official Visitor would not notify him or her as to who the official visitor is, but I am sure the CEO would know that there was an official visitor.

CHAIR: You did not get a copy of your letter of appointment.

Dr HARVEY: I have a copy of the letter, but no carbon copy is referred to.

CHAIR: But they did not say, "We have notified Liverpool hospital of your appointment."

Dr HARVEY: No, they do not notify the hospital of that.

CHAIR: So the CEO may well not know whether there is an official visitor and who that official visitor is.

Dr HARVEY: But the CEO would know about the requirements of the Health Act and should know that there should be an official visitor. It is his responsibility to know that there is one.

CHAIR: Do you know whether Liverpool hospital knows whether you exist?

Dr HARVEY: I know the chief executive officer, Dr Sandra Hoot, does because I am going to see her again on Thursday.

CHAIR: But she is not the CEO.

Dr HARVEY: I know. I do not know whether the CEO does. I think he must, because complaints about maintenance keep getting sidetracked. I am sure they use our ammunition to try to ensure some things get done by saying, "The official visitors are complaining about the state of the bathrooms," or something like that. I think he must know.

The Hon. JOHN JOBLING: If the patient is in Sutherland hospital, again using that example, there is an official visitor's box and a telephone number, but those are principally designed for the use of the patient.

Dr HARVEY: Yes.

The Hon. JOHN JOBLING: How does the family, who may well be quite lucid and concerned, find you to make a secondary contact or raise a problem with you?

Dr HARVEY: That is another problem and I do not know how well it is being addressed. Patient information often is not received by the patients and the relatives. All of the units will say, "We tell them when they come in how to make complaints, and we point to the notice." But these people are off the planet when they come in, and probably anything you tell them is not being taken in. The notice tells them how to make complaints. Some of them have an information booklet. I do not know whether that is a requirement. It tells relatives how to get in touch with official visitors if they have complaints. I have suggested—and I have had no response, so maybe they are doing it—that it be a requirement that every patient, on their assessment, have the name of the primary nurse, if they have adopted that system, or of the psychiatrist, and one of these who goes through it again with them about four or five days later—and that they not just be given a piece of paper when they come into the hospital—so that they really understand their rights and responsibilities and the means of access to assistance.

CHAIR: What my colleagues are asking is: Do you think that should also be made available to the relatives?

Dr HARVEY: Yes, it should be. The patient should have it. And if a relative comes in, that relative should be given an information booklet.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems you were not encouraged to come and give evidence to the Committee. In fact, it seems to be the converse. From looking at the form, it is not, in the sense, data based. If the official visitor goes through it, it is all verbal. She would have to pick out that so many people talked about food, or whatever. The information is not quantified.

Dr HARVEY: If it is, we do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is not designed with tick boxes, such as "satisfactory" to questions such as, "Is the food okay? Is the bathroom okay? Is the treatment okay?" There is no room for opinion.

Dr HARVEY: There is room for comment on a lot of the matters.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are not quantified in the sense that you would say the standard is five, but if one is terrible there should be monitoring. In a sense, the questionnaire covers a number of areas.

Dr HARVEY: Yes. I do not mind gathering information if it is valuable. As I said to my colleagues at the meeting, "If somebody asks me to count the number of trees on Pacific atolls to find out how many palm trees, pandanus, and how many pines there are, I do not mind doing that if you are going to do something with that information. But, if you want me to do assiduously gather accurate information, I would like feedback on what you are doing with all that information." We are required to put in the classification of the patients. They can get that off the computer. It would be more interesting to know their diagnosis, age, sex, ethnicity and whether they were re-admissions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not getting epidemiological type information. If there were a lot of admissions and if the violence is not improving and the mental health supervisor is saying, "There is nothing I can do with policies and the admissions we get", that suggests that the community mental health situation is very bad.

Dr HARVEY: I know that the Principal Official Visitor and the director of mental health go to the unit⁷ but I wonder when they last spoke to a mad person. My complaint is that they are living in cloud-cuckoo-land and they are not visiting. What was your question again? I got sidetracked.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not collecting information in a systematic epidemiological sense.

Dr HARVEY: There is another committee which the chairman is probably aware of called the Mental Health Outcomes and Assessment Training project [MHOAT] and whenever we try and bring this up we are told to wait until MHOAT comes out and then they will redesign everything.

CHAIR: MHOAT has been trialled for 1½ years now and it is now simplifying that, because it was a very difficult 25-minute job.

Dr HARVEY: I think that is another problem.

CHAIR: I refer to your appendix, which states that your concerns are aggression management and safety. You say, "The design of some units are so that newly admitted and violent patients mix with the rest of the unit population." That is a problem. You say, "Insufficient one-to-one treatment for each patient by doctors, nurses and paramedical staff. Reliance is placed entirely on drugs to bring new admissions under control." Are you saying that there is not enough security staff to allow the staff to get on with their job of actually managing the patient?

Dr HARVEY: In some places—Kiloh, for instance—there is no separate security person. You have to ring the main hospital, the university campus and get the security person to come down if someone goes bananas and they are trying to restrain him. I am not saying that the nurses are involved in the restraining. The nurses are involved too much with paperwork, if anything, but there are not enough nurses. There is something like five nurses to look after 32 or 33 patients and every one of them wants to talk and the nurses have a lot of paperwork and other things to do. They are stuck in a hospital. My complaint is that you see these people in there and a lot of them say they see a doctor once a week. If they are sick enough to be in hospital they should see a doctor every day. That is the way I was brought up, no matter what hospital, and it might be the registrar or a psychiatrist. Some have been trying to push a primary nurse so that Nurse Ann is your nurse and when you have a problem you can go to her. However, the shifts change and you meet an amorphous group of people but no-one is responsible for you and some of these people will not participate in programs.

CHAIR: Can you can imagine someone with heart failure or a complete heart block only ever seeing a nurse?

Dr HARVEY: Every day they see a doctor.

⁷ This is wrong. They don't go.

CHAIR: In cardiology they might see a doctor but these people are not being seen by a doctor every day. If they are sick enough to be in an acute ward they should be seen once or twice a day by a psychiatrist or someone who is responsible for the medications that are handed out for the management of their condition.

Dr HARVEY: A lot of these nurses are extremely competent, caring and wonderful people but if the patients could even spend 30 or 40 minutes every day with their primary nurse just talking and getting things off their chest—it does not necessarily have to be a doctor. Doctors are not the only gods and saints in the system, but the patients are not getting enough one-to-one care, in my opinion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do they all have a one-to-one care person assigned?

Dr HARVEY: No. We have instigated this in two places. A couple of the older nursing people do not like this. They do not like the nurse to be attached to one person, but like to have a whole shift come on and you read the report and then the next shift comes on. The Primary Nurse System is generally accepted, although there are is no instruction that I am aware of and I do not know how much it is used throughout New South Wales, but if I was the Principal Official Visitor I would look into that and see that every unit had a primary nurse.

CHAIR: Is there much difference between what happens in some of our inpatient psychiatric units and a prison?

Dr HARVEY: The patients would possibly say no, but if they are in there under a restraining order, schedule 2A or a magistrate's order they are in prison virtually.

CHAIR: Do they actually get out into the sunshine or to wander around in recreational areas?

Dr HARVEY: It depends. Some of them have to get permission. The voluntary patients can walk out any time they like.

CHAIR: The involuntary ones do too. If you read the police reports thousands have gone missing.

Dr HARVEY: They are about 5 per cent or 10 per cent of the incident reports.

CHAIR: Your other complaint is the use of seclusion units, padded cells with television monitoring. Is that because there are so few staff?

Dr HARVEY: This is hard for us to determine. You really should be going to a lot of units or perhaps have somebody look at them because the policies are very different in a couple of the hospitals I visit. If a bloke is walking up and down the corridor screaming and shouting some units would prefer to get a couple of strong male nurses to give him a shot, lay him down and talk to him. Others would prefer to put him in the seclusion unit and let him work it off and talk to him. Some people prefer to use ECT and others prefer to use drugs. There is no correlation, gold standard or best practice principle, nor should there be perhaps, but it would be nice to get some analysis of what is happening.

CHAIR: In your experience it must be frightening enough to be mad but even more so if no-one can speak to you in your language. Is that an issue?

Dr HARVEY: Yes, we look at that. It is much more of a problem, because of the demography, at Liverpool than Sydney private or even at Kiloh. They all do try and provide interpreters, even an interpreter who can deal with you for an acute problem for 20 minutes, but some people cannot speak a word of English and you feel so sorry for them and the staff cannot do much about it. They get the interpreters in, and they are good, and there are notices in about 20 languages up on the board telling them their rights and so on.

CHAIR: But if they try to exercise their rights nobody can understand a word they are saying?

Dr HARVEY: They have to get the interpreter back in.

The Hon. JOHN JOBLING: Does the interpreter know when you are coming and that you have five ethnic, non-English speaking patients?

Dr HARVEY: They do not know we are coming. It is very probable that person will not get to see us because they will not know we are there and they will not be able to put anything in English into the official visitor's box.

The Hon. JOHN JOBLING: It does not work then. It is pure chance that an interpreter is there because unless the unit knows you are coming to see patient X, who is of a specific background and they arrange for an interpreter to be there, you say it is highly unlikely that it will happen, other than by pure chance?

Dr HARVEY: If they all had a primary nurse, a good contact or even their own doctor who interviews them about their complaints with an interpreter, the doctor should explain what official visitors are and if he said, "You ought to bring this up with the official visitors" it is then up to the unit. I do not know if this is happening because I only see when people get through that system, which is rare.

The Hon. JOHN JOBLING: It is hard for a patient in that situation to have any comprehension of what is available and what you are?

Dr HARVEY: Yes, I agree.

CHAIR: In 1846 official visitors had the ability to report to the Governor?

Dr HARVEY: Yes.

CHAIR: That is going well beyond reporting to the chief executive officer or to the area health service, but it is actually an official report to the people. If you do not get satisfaction by reporting to the official visitor, should there be a mechanism that you should be able to report to the Governor?

Dr HARVEY: If the official visitor system were working properly that would not be necessary. If you have a proper official visiting system they should be able to address all the problems that we in the lower echelon bring up to them. If not, the system is not working.

CHAIR: It says in the official blurb you gave me that you have extensive powers of investigation.

Dr HARVEY: Yes.

CHAIR: Do you know what those powers are?

Dr HARVEY: No, I do not.

CHAIR: Have you ever tried ringing the number here for appointments, 9620 8218?

Dr HARVEY: Is that for the patients?

CHAIR: It says, "A dedicated official visitor telephone number 02 9620 8218 is available for patients to be put in touch with the official visitors in their area."

Dr HARVEY: Yes, that is used.

CHAIR: So people actually ring you direct?

Dr HARVEY: No. They are not given our names direct.

The Hon. JOHN JOBLING: It is a call centre type number.

Dr HARVEY: I am glad that they cannot because I do not want them ringing up all day and night. They ring the office (and occasionally they complain that nothing happens), and the office then picks one of the official visitors and rings them up and says, "Mr Joe Blow at Liverpool wants to speak to you. This is his number. Will you ring him back or will you go and see him?" and we are required to do that.

CHAIR: So that works?

Dr HARVEY: That works.

CHAIR: It says, "The official visitors have a large power of investigation and inspection of mental health, hospitals and health care agencies, ie, every part of the hospital or health care agency, and access to any record or piece of paper relating to the care, treatment and control of patients and their discharge."

Dr HARVEY: We are not restricted. No, that is observed.

The Hon. JOHN JOBLING: You fall into a black hole.

CHAIR: It further says, "Unnecessary, detailed or intrusive inspections or inquiries are not conducive to development of such goodwill." It says before that, "Official visitors are often dependent upon the goodwill of staff to alert them to situations of concern." If you investigate too thoroughly, then the staff get offside. If you investigate and write reports, you know where they go. What confidence can the staff have, a nurse or wardsmen, to come to you and see if they can get something done?

Dr HARVEY: We are on the staff's side just as much as the patient's. If you have good staff who are contented you will have better patient treatment. I have said at the bottom of both my reports that there are some wonderful people in the system. It is absolutely amazing what they put up with and what they tolerate. Nurses are abused, shouted at and called all kinds of foul and filthy things, and they take it. We are on their side as much as anyone else's. We will investigate a complaint as far as we think. I do not see how you can be too intrusive. How can you be too intrusive if you are finding out exactly what a patient is complaining about?

CHAIR: Do staff complain to you? They must make complaints to you as well.

Dr HARVEY: We always ask them what they would like us to investigate. They might say, for example, that the unit is cleaned only in the morning and that by mid morning men have been pissing on the floor, there are cigarette butts and so on and maintenance will not send the cleaners back. We provide advice to them. For example, I might ask, "How are you standing up?" Some staff will feel stressed. They would like to spend more time with patients and do less filling in of paperwork and reports. We speak to social workers, wardsmen and everyone else. It is a big job: In four hours we speak to everyone there if we can. We get only a four-hour glance at what has happened over a whole month.

CHAIR: You are not limited to one month, are you? You can go more often.

Dr HARVEY: Yes, we could go back if we had the time. I should also mention that section 237 of the Act refers to "authorised visitors". This is a committee appointed by the Minister that visits every now and again. We are not told about this. We went to one unit and found that the day before the whole committee had gone through and, with our reports in front of them, had investigated the unit and submitted a report that we do not see. The nursing administration and consumers were invited but the official visitors, who know a hell of a lot about the unit, were not there. This happened at both Kiloh and Liverpool. I have the program: welcome by the Kiloh centre, presentations by the medical

superintendent, the head of the nursing unit, managers and this, that and the other—management group and consumer care. We found out about it only by chance.

The Hon. JOHN JOBLING: Are they checking up on you?

Dr HARVEY: I do not know. You would have to read section 237 of the Act to know that.

CHAIR: It would have been good if you had got a copy of the committee's report.

Dr HARVEY: Even if we had been invited to attend. We go there every month.

CHAIR: The committee might discover something that you do not know about. My big concern is that people should be made aware of what is going on in psychiatric hospitals in their communities. It is about not accountability but transparency more than anything else. Otherwise you end up with another Chelmsford or another ward 22B—the Townsville case. I discussed with committee staff when we started this inquiry the fact that official visitors are important because they are the window through which the community can look. Official visitors can exercise community judgment; they are not departmental employees and so on.

Dr HARVEY: Exactly. I think we fill a very valuable role even by turning up. Regardless of whether our reports go anywhere, at least there is somebody there. It is also good for the Minister to say that he has OV's available in there every month to say all that is supposed to happen. When we stopped going to Liverpool because we were not getting any satisfaction the medical director and the nursing manager were quite concerned.

The Hon. JOHN JOBLING: Who beyond a limited number of people were ever aware that you had stopped going to Liverpool?

Dr HARVEY: The Principal Official Visitor knew: She is our boss and we told her.

The Hon. JOHN JOBLING: That is bureaucracy; it is locked in.

CHAIR: Does the Minister know that you have stopped visiting?

Dr HARVEY: We have still had no answer about it. Because of representation by the medical director and so on and because I have made an appointment with Dr Sandra Hoot on Thursday, we are going back. I do not know whether the Minister knows.

The Hon. JOHN JOBLING: In other words, nobody outside a very limited number of personnel within the system were aware of the fact that official visitors had stopped going to Liverpool. Everybody else was totally unaware—the public was unaware.

Dr HARVEY: One consumer advocate whom I spoke to said, "We're very angry with you; you haven't been to Liverpool for four months." I replied that there was a very good reason and told her. She then said, "Good on you; go for it". People were not informed.

CHAIR: What you are saying today is almost exactly the same as what was said by the official visitors to the Governor in 1845. The manager of Tarban Creek took no notice of the official visitors and treated them with considerable disdain. Almost the same things are still happening.

Dr HARVEY: The system is not run efficiently. That is why I am here. I feel that I have done my best. I do not know how much longer I will have the energy to do this. I am thinking strongly of just giving it up but I thought I would like to see your Committee perhaps do something before I drop out of the system.

The Hon. JOHN JOBLING: In view of your last comment, if you had a magic wand—I will grant it to you—what three major improvements would you make to the system?

Dr HARVEY: To the official visiting system?

The Hon. JOHN JOBLING: Yes.

Dr HARVEY: First, I would make the official visitor full time.

CHAIR: The Principal Official Visitor?

Dr HARVEY: Yes. Secondly, I would get the Principal Official Visitor in touch with her troops on the front line not just with the war office. I would get her to visit some units, give some feedback and get the whole system working properly. I do not know what the third change would be.

The Hon. JOHN JOBLING: I selected three only because I thought you might have a truckload. Is there anything else?

Dr HARVEY: They are generalisations. I will leave it at that.

CHAIR: Would the office of the Principal Official Visitor then be a separate, independent office? He or she would still have to be appointed by the Minister.

Dr HARVEY: Yes. I do not know what else she does. She has a second job. I think there is enough for her to do. There are 58 hospitals and 70 agencies. She is responsible for the visiting of all of those units and addressing every matter that is raised, which is delegated to secretaries of capacities we do not know. We do not know whether they are trained social workers, for example.

CHAIR: They could certainly bring wisdom and hopefully a little more transparency.

Dr HARVEY: Yes.

CHAIR: Thank you, first, for taking the time to see us and to write your submission; and, secondly, for being involved in what I have always considered to be an important part of the Mental Health Act. It has been there since the 1840s because people want to be confident that somebody is looking over the shoulder of those who look after people who perforce often do not wish to be there—they are involuntary—and ensuring that they are treated with fairness and dignity. Thank you for appearing before the Committee. Let us hope that we can continue to attract people of your calibre to the job.

(The witness withdrew)

JENNIFER ANNE GRAY, Director, Drug Programs Bureau, NSW Health, 73 Miller Street North Sydney,

DAVID ANTHONY McGRATH, Psychologist and Acting Clinical Director, Drug Programs Bureau, NSW Health, 73 Miller Street North Sydney, and

GREGORY STEWART, Chief Health Officer and Deputy Director-General of Public Health, NSW Health, 73 Miller Street North Sydney, sworn and examined:

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

Dr GRAY: Yes, I have them here.

Mr McGRATH: I am.

Dr STEWART: I am.

CHAIR: A major submission has been made by NSW Health and it has been taken as part of the sworn evidence. If any of you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. You should be aware that the Legislative Council could overturn the Committee's decision and make that evidence public.

Dr Gray, first of all, I thank you for agreeing to appear before the Committee today. We are extremely grateful for your time, and I apologise for disrupting your leave. I sincerely hope we have not interrupted your day too much, but I know you understand the significance and importance of the subject this Committee has been inquiring into, and it is grateful for any assistance you can give. I acknowledge that your expertise is in the area of drug and alcohol, not mental health. Therefore I have decided to make a brief opening statement that will explain the importance of your input to this inquiry.

First of all I put on record that you are appearing here today at the Committee's request as the director of the drug and alcohol section of NSW Health. I do not expect you, as a public servant, to have to comment on or answer questions that concern government policy other than that which has been established. I am also aware that NSW Health has been briefed on the broad nature of the Committee's inquiry today. You have been invited to appear today because throughout the inquiry a major theme has emerged—co-morbidity of mental illness and drug and alcohol abuse, commonly known as dual diagnosis. On that point, the Committee is concerned that dual diagnosis was also used interchangeably as a term to describe intellectual disability and mental illness.

Sister Myree Harris of the Society of St Vincent de Paul, a person whose commitment, passion and productive input in the area of mental health services cannot be questioned, suggested that the Committee might adopt the American term, mental illness substance abuse [MISA]. The Committee has adopted that suggestion. Two predominant areas of concern had been expressed to the Committee by nurses, psychiatrists and mental health workers in general—forensic mental health and MISA. They are also inextricably interwoven. Dr Giuffrida, forensic psychiatrist and visiting medical officer at Mulawa, in evidence before the Committee expressed the serious nature of the two issues:

... approximately half of the population of the prison at any one time is on an antidepressant or antipsychotic drug.

Serious substance abuse is rife with a rate of amphetamine use of 45 per cent. The drug that is the most likely substance to be present as a cause of drug-induced psychosis is used by 45 per cent of women.

Much has been said about co-morbidity of psychiatric disorders ... What we often see is not dual but triple and quadruple diagnoses. A common combination is a woman with a developmental disability or brain damage, personality disorder traits, drug abuse of a polydrug type and then ultimately presenting with a drug-induced or other psychosis.

Furthermore, Dr Giuffrida outlined the increasing pathway from substance abuse to mental instability to prison:

It was rare to see a woman charged with armed robbery, but now I see people coming in on armed robberies all the time. There is a greatly increased incidence, as indicated by the previously mentioned polysubstance abuse. These substances are more potent. They are more likely to have medical and psychiatric complications with those substances, not the least of those being drug-induced psychoses.

The Mental Health Review Tribunal informed the Committee of the lack of a coordinated approach to service delivery:

Other issues similarly reported and discussed by tribunal members around Australia relate to the lack of expertise in treating and working with people with dual or multiple diagnosis (including drug and alcohol). In the absence of clear service pathways and "buy-in" by clinical services, people with dual diagnosis are frequently passed from one department to another.

... NSW also needs to progressively review and reconfigure services according to need and changing demand according to increased understanding of the service mix required by people with mental illness who increasingly spend less time in hospital.

What I am hoping you can clarify for the Committee today is the multistreams of drug and alcohol funding, who funds, where does it go and who administers it. I am aware that Mr Barker is the chief financial officer, but the Committee need not go into in-depth analysis. I am simply after who funds what. As the director of the Drug Programs Bureau, and with the assistance of the excellent policy people at NSW Health, I am sure you will be aware of the terrible situation with MISA. I know that some officers of NSW Health were present during our public forum to hear the harrowing stories by family members of the impossibility for some people with MISA to obtain treatment for either problem. The Legal Aid Commission referred to "tragic results" because of lack of seriousness in recognising MISA patients. It said:

The tendency to refuse service to people with dual problems of mental illness and drug usage has, in our view, been the cause of some tragic incidents.

The commission concluded:

For patients with a dual diagnosis of drug addiction and mental illness, there appears to be little assistance for the drug addiction while the patient is in hospital, and when patients are discharged from hospital it is into hit and miss arrangements with drug rehabilitation services.

Clearly, there are gaps in the system. NSW Health informs us that hospital services are concentrating on the most acute incidents of mental illness. Do drug and alcohol services have the same service approach, in which case the evidence suggests that some of the State's most acutely mentally ill patients also are the people who have the same acute drug and alcohol problems. Following any opening statement you may wish to make, can you inform the Committee what role and what steps the Drug Program Bureau has and is taking in regard to mental illness substance abuse, either independently or in coordination with the Centre for Mental Health and the area health services? I have read that opening statement just to clarify some issues that I think are important.

Dr GRAY: We have prepared a presentation. I am aware of the time, so I will have to go through parts of it faster than I would otherwise have liked to.

CHAIR: You will provide these slides to the secretariat?

Dr GRAY: Absolutely. My starting point—as you will be aware because you were involved—in May 1999 we had the New South Wales Drug Summit and I think everybody agrees it has been a watershed. Things have changed enormously in how we manage drug and alcohol in New South Wales. It has been so successful that prior to 1999 New South Wales had lost its premier status, if you like, in the way other States looked at our management of drug and alcohol. That has now changed. We are now seen as leading the way within Australia, and many other States have subsequently had a Drug Summit.

I want to take you through the systemic reforms and changes that we made. When I listened to the quotes in your opening statement, Dr Pezzutti, you were talking about a systems issue. We have spent the past three years—and we are three years into the first four-year cycle of the Drug Summit—changing in a fairly dramatic sense, a whole paradigm shift, the way we manage drug and alcohol in New South Wales. The first slide shows— but I will not go through it in length—the government approach. Many of the clients that we talk about actually need to be managed by a multiplicity of

agencies outside of health. Just briefly, we have had that \$118 million over four years and another almost \$9 million in addition went to Corrections Health. We have put in new treatments—

CHAIR: Sorry, how much?

Dr GRAY: An extra \$8.4 million went to Corrections Health service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell me how much that is as a percentage of the whole budget and what percentage change it is over the prior four years?

Dr GRAY: There was a base amount of \$70 million that we operated on which is a combination of money from the national drug strategy and from the State matched funds that have been pre-existing since about 1987, 1988.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you were on \$70 million and now you have got an additional \$30 million a year basically?

Dr GRAY: Exactly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you went from \$70 million to \$100 million, is that right?

Dr GRAY: It has gone up to that. It is actually ratcheting up now over the four-year period but you need to take out the capital amount as well. In new money the additional money for the last financial year was about \$32 million. That is excluding the money that we are getting through the Commonwealth for diversionary programs.

CHAIR: When did the four-year program start?

Dr GRAY: 1999.

CHAIR: So this year's budget should be how much?

Dr GRAY: About \$40 million in new money.

CHAIR: No, it was \$70 million when you started. It would be \$110 million this year, is that right?

Dr GRAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And how much of that is federal?

Dr GRAY: The federal is a little bit difficult to aggregate but it is about \$16 million. It is the national drug strategy money.

CHAIR: Altogether or just in addition?

Dr GRAY: No, it is not in addition. It is complicated to separate out because the national drug strategy money is about \$16.9 million recurrent. That is the original money that came after Bob Hawke cried and the whole new money drug strategy approach began.

The Hon. JOHN JOBLING: Is that included in that figure you are quoting?

Dr GRAY: No. This money right here is brand new drug summit money. This is on top of—

The Hon. JOHN JOBLING: The \$70 million included the \$16 million?

Dr GRAY: That is right.

CHAIR: So you are saying the budget this year is \$110 million for 2002/2003; of that only \$16 million is Commonwealth money?

Dr GRAY: Basically yes.

CHAIR: So there is absolutely no more Commonwealth money since 1999 into your recurrent budget?

Dr GRAY: It depends on how you determine recurrent—

CHAIR: No, it is very simple. If the Commonwealth gives you money for drugs, how much is it?

Dr GRAY: The Commonwealth gave us what is now about \$16.9 million. However, since that time there has also been the national illicit drug strategy which is part of the tough on drugs strategy of the Commonwealth government. Some of that went direct to non-government providers, not through the State. Some of it actually came through Treasury. In addition, we have what is called NIDS colloquially, NIDS 1 and 2; we have now got NIDS 3. NIDS 3 is the money that is coming to the State for diversion, and that is about \$10 million per year at the moment.

CHAIR: So how much Commonwealth money is in the \$110 million, is the question?

Dr GRAY: Of the \$110 million probably about \$20 million of that would be Commonwealth money.

CHAIR: Could you seek to clarify that for us?

Dr GRAY: Yes.

CHAIR: You might get Mr Barker to do the analysis because it seems to me if you are saying the Commonwealth over the past four years have only provided you with \$5 million more in recurrent terms, that does not sound like the amount of money the Commonwealth is spending on drugs and drug rehabilitation in this State, because I have seen the Commonwealth budgetary figures which are vastly more than \$5 million extra.

Dr GRAY: But that is where we need to separate out the recurrent and the nonrecurrent because the national illicit drug strategy money, which commenced in 1998, is not designated as recurrent. It may become recurrent but at the moment it is not considered to be recurrent. That is why I am making the delineation.

CHAIR: That is why I asked you the question about spending \$110 million in 2002-03. The question from Dr Arthur Chesterfield-Evans is how much of that \$110 million—whether it is recurrent, nonrecurrent, whatever it is—is Commonwealth money?

Dr GRAY: I just gave the answer to that question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you give us a table with "Years" across the top and "Sources of money" down the side, so that we can compare across periods? Because we always get something like this, \$118 million over four years, and then you say it is phasing up and ratcheting up, in other words, it is promised and then most of it does not come until later. We never get a clear perspective.

Dr GRAY: I understand what you are saying Dr Chesterfield-Evans, however, I would like to be quite specific, I came here and said that one of the things I was going to do was to take us through the drug summit. This amount of money talks very particularly about the drug summit; it talks very particularly and most specifically about the reforms that we have put in place since the drug summit. The drug summit occurred for a reason; it occurred for the reason that we needed to have new investment in drug and alcohol to better manage the problems within our community.

That \$118 million is only drug summit money. It is complicated but it is complicated because there have been additional amounts of money that have come from the Commonwealth. As I said, we have got \$10 million this financial year from the Commonwealth. I might add that that money was only actually signed off last week even though it is supposed to have been cash rolled from the beginning of this financial year, and even though it was agreed to in a contract with the Commonwealth two years ago. We cannot at this point in time know for sure that come 1 July next year with the Commonwealth money that has been allocated as part of the \$5 hundred million that you are talking about, Dr Pezzutti, whether or not New South Wales will continue to be cash flowed or not.

CHAIR: I am aware of that. The reason we asked the question is because all this "Over four years" stuff we have had for just about every other service. I am also aware that the Commonwealth is directly funding a large number of the rehabilitation services through the NGO sector, which again we cannot get too much visibility of, and that is a real problem for a committee like this which is meant to be recommending a strategy. All we want is what Dr Arthur Chesterfield-Evans asked you, and we need it within two weeks please because we the need to have this information when we are starting to write our report. Can you do that, Dr Stewart, do you think?

Dr STEWART: Can I make a couple of comments, Mr Chairman? The first is the \$118 million over four years actually underestimates the ongoing recurrent amount because in the first year of the drug summit funding, 1999/2000, a much smaller amount was spent recurrently because the services were not cranked up. As they come online the recurrent amount is about \$32 million, Dr Gray, something like that?

Dr GRAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: These sorts of things always look like propaganda and it does get our backs up—it gets my back up—that we get this propaganda sort of stuff without an overall picture. This happens to us time and time again.

Dr STEWART: We can certainly provide a table that says that in 1998/1999 there was this amount of base State money, there was this amount of base Commonwealth money, and we can escalate that because the new money that has come in, as Dr Gray just talked about, relates mostly to diversions and additional Commonwealth money relates to money funded directly to non-government organisations which we cannot count in our allocation.

CHAIR: I understand that but again, just on the injecting room, for example, the budget on that blew out from \$1.2 million to something like \$5.5 million. So of that \$110 million you are spending this year, we would like to know—perhaps you may not have that sort of detail—is about \$2.5 million of that going to go on the injecting room program?

Dr GRAY: If I could clarify it, that \$118 million and \$110 million do not include that amount at all. There was an initial allocation for the medically supervised injecting room within that. That ceased when that money was expended. The additional money actually comes from a separate source of funding and we have not included it in there.

CHAIR: This is where the people of New South Wales must just tear their hair out. That is drug and alcohol money. If it means that you have to inflate your budget of \$110 million to include that, that is realistically part of the response to the Drug Summit, and the Minister for that is still John Della Bosca. Why on earth can you not include that in your drug and alcohol budget, because it is a legitimate part of the drug and alcohol strategy by the Government and the department to properly investigate? Why do we never know this stuff up front and out the front?

Dr STEWART: It is a different source of funds. We will provide the table the Hon. Dr Arthur Chesterfield-Evans wants.

The Hon. JOHN JOBLING: Can you identify if there are other issues similar to, as was quoted, the injecting room? If we can look at the total as we come down each year and then other inputs, particularly into the drug and alcohol program, or if it comes from Treasury additional funding,

if it comes from transfers from a fund and equally to try to identify, as best you know it, other NGO inputs federally.

Dr STEWART: I would be very unhappy about providing information about NGOs. We do not acquit that money.

CHAIR: Of the money that you acquit, like the injecting room trial, that is legitimate money spent up-front by the Government. It is investing in drug and alcohol treatment options, and we want to know that. I cannot see why it would not be included.

Dr STEWART: It is the way the department counts it. The department counts it in a different bucket, not in the bucket called Drug Summit, but we can provide that.

CHAIR: It seems weird to me that we have mental health funding which excludes the provision of housing. I would have thought that as a whole-of-government response to mental illness and the treatment of people with mental illness we would include the cost to Government of providing supported accommodation and the housing component of it. It seems bizarre to me that we do not ever know the real cost that Government pays to provide all the services for people with mental illness and, in this case, people who have substance-abuse problems.

The Hon. JOHN JOBLING: It leaves the department exposed to people saying, perhaps erroneously, "Why don't they do this" or "They are not spending enough on that" when in fact the credit should be due for some of the moneys that you are spending. For our purposes, to identify the whole bucket of money—and, sure, we can see the layers later—that would be a tremendous help and might well stop some of the arguments.

CHAIR: If we start making recommendations and suddenly the Government says, "But we are doing that. We are paying the money here, there and everywhere" how do the people of New South Wales give due weight to the commitment by the Government to the treatment of people who have substance-abuse problems? It is a real issue. We are not critical of your budget or what you do, but we cannot see where all the money for drug and alcohol is being spent and where people can go to get increases in that area.

The Hon. JOHN JOBLING: The alternative is: Is it being spent or is it being shifted to another segment?

CHAIR: That is the other problem we have with mental illness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask, in that vein, what money is not being spent by the Department of Health? It would seem to me that a large chunk of the drug and alcohol money is actually being spent on the prison system. I was on a committee for the prison system. Every second day we pass laws that ratchet up the penalties with the tough on crime nonsense we have to go through. Can you tell us how much money which the Health Department considers mental health money is paid either by the Department of Housing or by the Department of Corrective Services? If you cannot, would you then say that these have nothing to do with you, or are you, as your slide suggests, taking a holistic whole-of-government approach? In that case, if other departments are spending the money in the area that impinges on yours, would you be aware of them?

CHAIR: I think some of those issues will come up after we have heard Dr Gray's presentation.

Dr STEWART: Your question was how much money we spend on mental health. I assume you were asking on drug and alcohol.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your case it is drug and alcohol. Obviously, we would like to know it for mental health as well but I understand that that is not your particular area.

Dr GRAY: Just as a point of clarification I would like to say that since the Drug Summit we have put in very strict reporting systems. Everybody who is funded through New South Wales Health

with Drug Summit money provides quarterly activity and financial reports and we provide those reports to Treasury, so it is accountable. We do know where the money is and we do know what it is being spent on. We have established benchmarks.

The Hon. JOHN JOBLING: But does anybody else?

Dr GRAY: Treasury does, absolutely, and we have to—

The Hon. JOHN JOBLING: But we do not.

Dr STEWART: Those matters are all open for questioning at estimates. I am fairly sure the Minister got some questions about the drug budget.

CHAIR: That is why the Minister is coming back to see us. It is a separate matter.

Dr GRAY: I am very conscious of your time so I will try to go through the things that are most important. From the Drug Summit, as I said, we have embarked on a systematic process of complete reform. We have taken the new money and new systems to integrate within existing drug and alcohol treatment. Our starting points have been to have a holistic view of the client. Issues to do with family and housing and education and skills training are as important as the medicine that we provide people to cope with their drug dependence. As you can see, it includes mental health. We have also looked at equity issues, putting a lot of attention into rural, regional and Aboriginal communities, isolated communities, to make sure that things are culturally appropriate. In terms of the guiding principles, within this slide the thing I would like to bring to your attention is the importance of having networks. We have an area health service structure. However, not all NGOs operate in every area health service.

People do not necessarily want to go to their particular area health service to get the exact sort of treatment that they require, given that there is a diversity. There is a huge range of treatments that people would require and different ways in which they get managed. So we are building very strongly a regional approach, a network approach, so that people can move from area to area and not be found by the system that pertain to the particular area that they came from. If you move from Casino to Aubrey you might do that for all sorts of reasons but you might also do it because you want to have the particular treatment that is available in Aubrey that is not available or is different in Casino. We have also put in a lot of effort in formalising links between the drug and alcohol units to get some consistency and standards. We are working very closely with all the division of the general practitioners. We have put GP liaison people in every area health service and so on.

We are working very closely with Aboriginal medical services because, as you would appreciate, the management of drug and alcohol problems, and including mental health problems, with Aboriginal communities is something that the whole nation is struggling with. It is something that people are struggling with indigenous populations on an international basis, so we have put a lot of effort into that. We work closely with mental health, working with child and adolescent services and also with corrective services and the juvenile justice systems because they are extremely important. To do that, we have to invest heavily in training. We have to make sure that we have a skilled and flexible work force, the demands of managing drug and alcohol, the demands of managing changes in drug use. You mentioned before from corrective services the quote in terms of amphetamines.

The whole issue of amphetamines and amphetamine-related psychosis, as opposed to a person having a pre-existing psychosis, is something that has come, it is new, it has occurred within the past few years. There were pockets of it but it is something that the system as a whole has to learn to respond to very quickly. For the very skilled and able staff and medical practitioners with years of experience, it is not such a tall order. For an NGO worker who is there because they themselves used to be substance dependent, learning new skills for how to manage more complex issues is quite problematic and complex so we need to spend a lot of time in assisting them to get to there. Simply the question in terms of finance, we are establishing benchmarks and putting in place the good evaluation. Actually pertinent to the questions you were asking, where does the money go? How do we know it is effective? What are the outcomes? What is changing? What is happening that is making a difference in the lives of people in New South Wales? Why is it better spent here than in something else? Why is it better to invest in drug and alcohol than putting additional main roads in place?

Those are the sorts of things that we think we are accountable for. They are the sorts of ways we are evaluating our own programs and setting benchmarks so that we can answer those questions most effectively. Pharmacotherapies, just very quickly, expanding—it was always methadone, methadone, methadone. Then we had the *Women's Weekly* drive to naltrexone which sent a lot of people bankrupt. Now we have introduced buprenorphine. I have written there the continuum just to show you that it is not one or the other, that there are different stages in people's using histories and we need to move them through. I am happy to go into more detail if you wish but it is just to give you an overview. In terms of quality, again you would all be aware from the Drug Summit the huge complaints that were levelled against us because of the quality of the methadone program. I am very confident, particularly having sworn on oath, to say that we have made dramatic reforms in the program.

We have put in place a process of accreditation. We have new ways of managing doctors who prescribe poorly, leading on to several of them actually now being deregistered from practising ever in methadone and pharmacotherapies. We have completely changed the whole way we train doctors so that we are much more confident that what we are getting is a better quality of service. Similarly, that clinical operators in private clinics do not do it just for profit, that they actually have a whole set of standards and we enforce it. We go out and visit, and we make sure that we feel comfortable about what they are doing. Every time we get a complaint from the community we investigate. We go and see what it is that they are doing.

CHAIR: And you visit the public ones as well?

Dr GRAY: Absolutely. The public ones are part of the process of accreditation and we treat them all the same. All of them are providing a treatment to the people of New South Wales and therefore all of them must meet a certain level of standard. I will come back to case management because I think it will be something you will be interested in. Again the partnerships, we have invested heavily with the Pharmaceutical Guild in New South Wales to encourage pharmacies to take on board management of methadone and opiate clients. You would appreciate that there is a resistance. Mr Jobling, you have an earlier history in this. There is a resistance to managing opiate-dependant people because of the way in which they are perceived. So we have been working carefully and closely with the guild to encourage pharmacists in. But to do that we have to make sure that every client that we send out calling is stable, every client that we send out to the GPs and the pharmacists we have to make sure we are comfortable with, that we are confident that they are actually able to manage a community based setting. These things do not happen in a day. They do not happen in a week but they have been occurring over the past three years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this mainly referring to the methadone program?

Dr GRAY: That was just the pharmacotherapy section but when I say, "methadone" I actually mean buprenorphine as well. Buprenorphine was only registered in August of last year so we have only had it for 12 months. We have 1,100 people now actually being dosed with buprenorphine and including within the correctional setting where it is proving to be a very popular form of medication.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have—

CHAIR: Just let her move on because this is all about treatment of drug and alcohol problems, is it not?

Dr GRAY: That is right.

CHAIR: This is not our particular bag.

Dr GRAY: Detoxification, again we have established new detoxification services and improving the links. You will see the after-care options. Earlier you made a comment about people falling between the cracks and so on. Everything that we are doing is setting about to try to seal those cracks, to make sure that if someone comes out of a setting that they are actually managed more

effectively. Similarly, we talk about ambulatory care. You can see the ambulatory detoxification, in part that occurs to people in any setting. They could be in a mental health ward but we are able to provide ambulatory detoxification to them in that setting so drug and alcohol specialists can go there and provide and oversee and monitor their ambulatory detoxification in that hospital setting, in addition to in people's homes and in addition to people coming through a pharmacy and so on. We have the three new units which I am sure you are familiar with. It has given us an extra 46 beds in the State. Residential rehabilitation as well, we have put in an extra 70 beds—

CHAIR: You say you have residential rehabilitation.

Dr GRAY: That is right.

CHAIR: How many beds are there currently in New South Wales owned by New South Wales Health?

Dr GRAY: We have the figures here. New South Wales Health has just put in an extra 72 beds through the Drug Summit process. We have been awarded through the Commonwealth money for diversion so we are putting in an extra 70 beds there, Commonwealth money but New South Wales Health-managed in collaboration with the NGO sector.

CHAIR: How many rehabilitation beds for drug and alcohol problems are there in New South Wales?

Dr GRAY: We do not have the figure here. We do not have the complete figure here. We will take that on notice. It is approximately 160.

CHAIR: Sweden and Switzerland both have about 1,700 for the same population. That is to give you some idea of the issue.

Dr GRAY: That is right, but Sweden and Switzerland do not have a pharmacotherapy program. We have 15,000 people in pharmacotherapy programs so there is those differentiations.

CHAIR: Both Switzerland and Sweden, in terms of rehabilitation, have long-term rehabilitation beds. They are talking 1,700 versus our couple of hundred in New South Wales.

Dr GRAY: Indeed, again because we do not have time, there is a whole body of international literature that does not dramatically support residential rehabilitation as the most efficacious form of treatment.

CHAIR: But if you are going to do it the same as mental health, if you are going to do deinstitutionalisation, going out to community-based services, then you have to fund up the community-based services to be at almost the same cost as in-patient care, otherwise it will not be effective. So if Sweden and Switzerland have 1,700 beds for the same population and we are saying, "Oh no, we do not do it in places like that; we do it in the community" show us the budget for that sort of drug rehabilitation. It is costing Switzerland, in our terms, something like \$250 million a year for rehabilitation alone. Where is the \$250 million a year in New South Wales for drug rehab? It is just not there. That is why I ask the question: How many long-term rehab beds do we have for people who are going onto long-term rehab from drug and alcohol problems. You say a couple of hundred.

Dr GRAY: That was pre-existing the new growth of an extra 142 beds that has occurred in the last few years. The pre-existing budget, the pre-Drug Summit budget, was about \$16.9 million. They were funded by services. At the Drug Summit we established a per bed day benchmark figure precisely to address your issue so that we make sure that the quality of service is there. So 72 new beds are funded in that pro forma and the additional 70 from the Commonwealth are funded from that pro forma. The Commonwealth Government, through NDS, put in an extra, I think, 40 odd beds. That is the growth that has occurred. It has doubled our capacity. I misunderstood your question. It is not a couple of hundred; it is in the order of about 500 residential rehabilitation beds in this State, but I will give you that figure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give us the number of beds again with their funding chronologically in a table? Can you in addition give us the full-time equivalents in community support workers? We do not want to be obsessed by bed numbers particularly. We want to know how many beds there are but we do not want that to be the only index. We feel that there are too many beds and not enough community support. So we would like full-time equivalents in community support and perhaps a breakdown of whether they are social workers, nurses or what they are.

Dr GRAY: I understand. To do all that is cumbersome and in fact—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One would have thought that it would be at your fingertips. It is not an unreasonable request.

Dr STEWART: Are you talking about mental health here or drug and alcohol, Dr Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like both actually. The reply I got on 267 did not really address that. It was the one from mental health to the detailed questions which had been the previous terms of reference.

Dr STEWART: We can add to our table the number of residential rehabilitation beds from 1989, 1998-99 up to current. The issue about community workers is more difficult for us. Dr Gray might explain why.

Dr GRAY: We are going to an integrated service system in terms of social workers and so on and so on. We have a far greater skills mix so that we do not have people who are there just doing outpatient counselling. We prefer a system whereby people are rotated through systems. They might work a few days a week in different services so that we are getting that skills mix.

CHAIR: The generic community drug and alcohol worker.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The problem we have with that is that it would appear that there is not accounting for mental health in the community. When we have asked how much money is being spent on mental health we are told that the area health services fund things like casualty departments and things like that from that budget and it does not actually get to where it is needed. So while it is great to talk about holistic things in a philosophical sense, if you actually want to see—

Dr GRAY: It is actually not in a philosophical sense, sir, and if I could interrupt you I will give you a case in point. One of the slides we skipped through in terms of rural is part of the Drug Summit money. We established two multipurpose services for the Mid North Coast and for New England. Both are holistic, both use a skills mix. Both have quadrupled the number of staff. Mid North Coast started off with 13 drug and alcohol staff prior to the Drug Summit. That was the total to manage drug and alcohol problems on the Mid North Coast, bearing in mind that there had not been a new injection of funds for a decade. The staff is now 40. That is a significant difference. That is the sort of thing we are seeing. The same exists in New England. That is the sort of expansion we are seeing.

We have put in eight specific drug and alcohol counsellors for rural areas, eight drug and alcohol clinical nurse consultants in each of the rural areas—very specific positions—17 GP liaison officers in each area health service. But we also have the multipurpose service. When we allocated the money we did not say, "You must have an FTE of three or five", given that we have to take into consideration the varying nature of each service. What you need to cover for the whole of New England is very different from southern—different populations, different clusters, different pre-existing services.

But that is separate from the first part of your question about beds. We can give you that, bearing in mind that the money, whether it is NDS or NCADA, which are State-matched funds, is kind of a splitting of hairs. Some NGOs have preferred for their entire budget to be called Commonwealth funding because administratively it was easier for those NGOs. Some of them are

split. We will do the best that we can. Where it is imperfect it is because of 10 or 15 years of history of financial allocations. Odyssey House, a very well-known and respected NGO, has three different funding sources within the Commonwealth in and of itself in addition to the State money. We will do what we can but it will be messier than you would like it. But it is simply messy because money has come in different streams from different markets. The Commonwealth expects us to account for each differently. NDS one is different from NDS two is different from NDS three. Each of them must be categorised. Each has a different set of reporting requirements. That is the reason for the lack of precision.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It worries me that you talk always about holistic stuff and multiskilling and stuff and when we ask where the money has gone and when the relatives say to us, "There are no services where I am" then the thing dissolves into clichés of management good intentions, if you see what I am saying.

Dr GRAY: I hear what you are saying. I could not support that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I would not expect you to.

Dr GRAY: I mean it quite seriously. I swore on the *Bible* and I take it seriously. We have an integrated service system. As I said, the system is growing. It is growing rapidly and it is growing well. You can look at what has happened for a whole lot of outcomes. If we get to those slides you will see the changes that are occurring within the system. We monitor the outcomes of the programs. People's engagement in crime plummets. People's social functioning increases significantly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are these figures from the MHOAT?

Dr GRAY: No, it is from the brief treatments outcome module. We have the slides here if you are interested. It was designed by NDARC, the National Drug and Alcohol Research Centre. Just briefly, the key point I would like you to take away from here is centralised intake. We have taken on board the issues of falling between the cracks. In each area health service now—it has been operational for about eight months so it is still nascent but it is moving—there is a single telephone number. Clients or family members of clients can get a clinical assessment over the phone. There are clinicians sitting on the other end of the phone. In some area health services it is a dedicated person; in other areas it is rotated. It depends on the staffing configuration.

The person's treatment history is taken. They may have had detox three times that year. Therefore we need to be looking at what is the best treatment for that person at that time. A referral is made. If they wish not to identify themselves we ring the service and say, "You may get a call from a person. This is what we have advised them over the phone." It is working very well but it is still nascent. In part it is to make sure that people have access. What is the entry point into the system, which is the point you are making? How do people get into services? Who looks after them? What are the best services for them to have and how do we make sure that they are being engaged and that the contact actually occurs? That system is being developed. It is in place. It is there. You can ring the numbers, but we are still working with it to refine it.

CHAIR: If I am at Moree where do I go?

Dr GRAY: There is a number for New England Area Health Service. It is on some of the local buses. It is in the local newspapers. In the Moree community health centre you would see that number. In GPs' offices in Moree you should see that number. That is how it works. I do not think you want us to go into diversion programs at this stage.

CHAIR: No.

Dr GRAY: I mentioned before that we work very closely with Corrections Health. Pre-existing National Drug Strategy money we gave \$1.3 million to Corrective Services, which is how they employ their counsellors.

CHAIR: NSW Health funds a Corrections-operated service?

Dr GRAY: Yes.

CHAIR: It is nothing to do with Corrections Health?

Dr GRAY: As part of the National Drug Strategy, 10 per cent of the money had to go to law enforcement. That was the \$16.9 million I spoke to you about before. About \$1.35 million of that goes directly from NSW Health to Corrective Services to spend on drug and alcohol services in the correctional setting. This is separate from any allocations to Corrections Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We did not know that, did we?

CHAIR: Yes, we did. How much did you say it was?

Dr GRAY: It is about \$1.35 million.

CHAIR: The hepatitis C review says that in 1999-2000 \$6.28 million was spent on drug and alcohol rehab in New South Wales prisons. Would that have included the money you just said went to corrections?

Dr GRAY: The only answer I can give to your question is that Corrective Services tells me that they spent \$1.3 million on counsellors. Whether they call that part of their drug and alcohol rehabilitation I am not sure. The reason I am not sure is that that was a pre-existing situation. Following on from the KPMG review that was done of the correctional setting post Drug Summit a series of 42 recommendations were put forward. Corrections Health, Juvenile Justice and Corrective Services are in the process of reconfiguring their services for drug and alcohol in line with those recommendations.

CHAIR: Still, a fair bit of money goes from NSW Health to Corrections, not Corrections Health?

Dr GRAY: That is right.

CHAIR: And you give money to Corrections Health as well?

Dr GRAY: That is right.

CHAIR: How much do you give Corrections Health?

Dr STEWART: All up or in drug and alcohol?

CHAIR: Drug and alcohol.

Dr GRAY: The specific allocation for drug and alcohol—the rest of it was subsumed in their ordinary budget—was \$8.3 million or \$8.4 million through the Drug Summit for Corrections Health. They also get between \$600,000 and \$720,000 for the six-bed detox unit as support for the adult Drug Court. They have been the specific allocations. In addition, we have provided them now with an extra \$670,000-odd to run a post prison release program for us that we are developing across the State, and then miscellaneous amounts of \$60,000 for a data coordinator and so on.

CHAIR: If somebody comes in as part of the diversion process as an alternative to gaol do you pay for them over and above what you provide in the community?

Dr GRAY: Yes.

CHAIR: Is that part of your sum funding to Corrections Health?

Dr GRAY: No, because we do that differently. They have not actually entered gaol.

CHAIR: But they are sentenced.

Dr STEWART: It does not go through Corrections Health, Dr Pezzutti.

CHAIR: It is a separate issue?

Dr GRAY: There are two—

CHAIR: So that \$6.8 million you just talked about was just Corrections Health for use within the corrections service plus some of the post follow-up money.

Dr STEWART: It was not 6.8, though.

CHAIR: What is the figure?

Dr GRAY: You mentioned 6.8; I mentioned 8.4. That is over four years.

Dr STEWART: Your document has 6.8.

Dr GRAY: That is Drug Summit money. The key Drug summit money was rolled out over four years.

CHAIR: I know that. How much are you spending per annum in Corrections Health for drug and alcohol services? How much do you give them out of the drug and alcohol budget this year?

Dr GRAY: It is \$8.4 million divided by four.

The Hon. JOHN JOBLING: It is basically one-quarter.

Dr GRAY: That is right.

The Hon. JOHN JOBLING: It is an even sum per annum; not a variable some.

Dr STEWART: No, like the rest of the Drug Summit money the buildup occurred over three of four years. Perhaps we can add the numbers to Dr Chesterfield-Evans' table.

CHAIR: If you would not mind, because that is important. The amount you have been giving Corrections is a relatively constant amount over many years?

Dr GRAY: That is right. The \$1.3 million to Corrective Services is a constant amount. It has been going on for quite some time.

Dr STEWART: Historically, we have funded Corrections Health for money that is used on drug and alcohol initiatives.

CHAIR: But just as part of their general budget?

Dr STEWART: There would be specific purposes as well. But, like any health organisation, Corrections Health spends general money on people with drug and alcohol problems.

CHAIR: But again I say this is where you underestimate what you spend. If you look at just the care of in-patients, that does not come out of drug and alcohol money; that comes from acute overnight admissions, does it not?

Dr STEWART: It does.

CHAIR: So you fund Corrections Health for certain programs.

Dr GRAY: That is right.

CHAIR: But they would spend much more than that on drug and alcohol problems.

Dr GRAY: That is right.

Dr STEWART: Or health issues related to drug and alcohol. Hepatitis C would be a good example.

CHAIR: Yes. That is why we have the hepatitis C program of rehabilitation services and so on.

The Hon. JOHN JOBLING: Can I ask a question to clear something up in my mind? You indicate that you supply funding on an annual basis to Corrective Services and Corrections Health. Obviously, they expend this money. I presume they report on an annual basis to Health on the total expenditure.

Dr STEWART: I will have to defer to Dr Gray in terms of reporting from Corrective Services.

Dr GRAY: Corrective Services report on an annual basis.

The Hon. JOHN JOBLING: Is that on both segments?

Dr STEWART: No.

Dr GRAY: We give one allocation to Corrective Services. It is divided into two amounts, but we give them one allocation.

The Hon. JOHN JOBLING: Therefore, for Corrections Health, you would get an accurate expenditure each year?

Dr GRAY: Corrections Health, on money that comes from the Drug Programs Bureau, is reported on quarterly. The actual figures are half a million for police cells, \$1.24 million to run the detoxification units that they have established in three of the gaols, and \$700,000 for pharmacotherapy. That was just Drug Summit funding. You add to that \$600,000 to \$620,000 for the Adult Drug Court.

CHAIR: So some of the Drug Court funding does come from you?

Dr GRAY: Yes, it does.

CHAIR: That is why I asked the question earlier.

Dr STEWART: By and large, I think all the Drug Court funding comes from us and is allocated out, but not necessarily to Corrections Health. The allocations for the Drug Court come through Health, do they not?

Dr GRAY: They come from Treasury to Health. There is a specific allocation for the Adult Drug Court.

CHAIR: And that is part of your \$110 million budget?

Dr GRAY: It is separate, but yes, it is added on top.

CHAIR: So of all of the little pockets, this is one?

Dr STEWART: That account specifically for the provision of drug and alcohol programs.

CHAIR: But Corrections Health does not necessarily see that money?

Dr STEWART: Yes. They run the program.

CHAIR: Do they then run the programs, for example, for someone diverted to a methadone program or a buprenorphine program or a rehabilitation program at Namatjira House or somewhere? That does not come out of Corrections Health money; that comes directly to another funded body, like an area health service, does it?

Dr GRAY: That is right. There are two different diversion programs. The Adult Drug Court is an in-custody program. If a person is referred as part of the Adult Drug Court to a residential rehabilitation facility, that is funded by the Drug Programs Bureau specifically for that purpose.

CHAIR: But they can do an internal, in-prison one as well?

Dr GRAY: Yes. In prison, the Adult Drug Court pays for the MRRC detoxification service.

CHAIR: You have a detoxification service starting at Bathurst gaol. My understanding is that that was opened two or three months ago and that it is yet to receive its first patient. Is that your understanding?

Dr GRAY: I will have to take that question on notice. I can talk about the ambulatory work that has gone on with the detoxification unit.

CHAIR: No. I understand you have opened a new 10-bed detoxification service at the Bathurst gaol. I understand the Minister opened that some two or three months ago. Although it is fully staffed, it is yet to receive its first patient.

The Hon. JOHN JOBLING: You're joking!

CHAIR: No. This is my understanding. Do not take this as absolute gospel. I have not rung them to check, but I have been told that it has been open for two months and is fully staffed, yet it is to receive its first patient.

Dr STEWART: We will provide information on that, Mr Chairman.

CHAIR: My understanding is that it is awaiting the installation of security cameras.

Dr GRAY: Thank you. I would like to say that there have been delays in the building of all of the detoxification services in the prison system, funded through the Drug Summit, which is why we have put so much effort into detoxification in the cells. But those delays are actually outside the health system.

CHAIR: The point is that you are still paying for those services, and they have yet to have a single patient go through those units. That is a tragedy.

Dr GRAY: We may be paying for them, but we are paying for them within Corrective Services, and Health cannot be held responsible for what happens in Corrective Services in terms of difficulties in actually getting the buildings built.

CHAIR: We will come to that in our final report on mental health. But the issue is that, as part of your \$110 million, you are paying for a service, all of the staff and the running costs, but you have no patients going through those units.

Dr GRAY: I am really sorry to have to say this, Mr Chairman, but we do. That is the point of ambulatory detoxification. It is the same when you are building any detoxification facility: they take time to build.

CHAIR: If you are providing the service by ambulatory detoxification, why did you build a 10-bed detoxification unit at Bathurst gaol, and staff it, and not have anybody go through it?

Dr STEWART: It was built for the purpose of detoxification. I think Dr Gray is saying—and we will get back to you on the exact detail of the staffing—that the staff are doing things in

relation to ambulatory detoxification. They are not sitting there doing nothing, which was the implication in the question.

CHAIR: But why build a 10-bed unit within a prison and not use it?

Dr STEWART: For the purposes of detoxification. But, if there is a delay in the capital side of it—which sometimes occurs, if there are delays in putting on doors or whatever, I do not know the answer to that—the staff are being used otherwise in a useful way. We will get back to you and clarify that. They are not sitting there doing nothing.

CHAIR: I was going to ask you about that later.

The Hon. JOHN JOBLING: I might return to my earlier question. You indicated that you supplied about \$1.3 million directly to Corrective Services, which then uses that to supply counsellors in the prisons service. That is directly from Health to Corrective Services. Therefore, as you have indicated, Corrective Services supplies you with a quarterly report, or is it an annual report?

Dr GRAY: It is an annual report.

The Hon. JOHN JOBLING: That shows where the total sums are expended, if they are expended.

Dr GRAY: They do not do that. They do it as a global amount. They just say, "We have spent this amount."

The Hon. JOHN JOBLING: So you have no check on the spending of the money that you supply them?

Dr STEWART: The important point is—

The Hon. JOHN JOBLING: If they siphon it off, or move it somewhere else, you do not know about that?

Dr STEWART: The important point here is that we are required to provide, out of this component of Commonwealth funds, 10 per cent for law enforcement. We provide it to Corrections, and they tell us they spend the \$1.3 million on counsellors.

The Hon. JOHN JOBLING: But you have no means of checking that?

Dr STEWART: Because we are just a post box for that. You will have to ask Corrections how they spend the money.

CHAIR: But the Commonwealth, with any of its grants, requires a response from the agency that it funds. So the Commonwealth would require a response from you on how that funding was spent.

Dr GRAY: There is one caveat to that. As part of the Drug Summit, the Drug Offensive Act was repealed. As a consequence of that repeal, we ceased to be the Drug and Alcohol Directorate. As the Drug and Alcohol Directorate under the terms of the agreement with the Commonwealth, we had responsibility for administering all those funds. We now have no statutory authority at all in that regard, so that we are now simply, as Greg said, the post box, on the transit side of that.

CHAIR: Can the Commonwealth ask New South Wales Corrections how it spends the money?

Dr GRAY: The Commonwealth can ask me, and we will forward that request on to Corrective Services.

The Hon. JOHN JOBLING: Have you never done that?

Dr GRAY: We have done that.

Dr STEWART: Annually.

Dr GRAY: That was the point behind the KPMG review. It looked out how services were being run in the Corrections Health system.

The Hon. JOHN JOBLING: So you do that annually, as Dr Stewart now tells me. Therefore they would respond to you. You are telling me they respond by simply saying, "Thank you very much. We got \$1.3 million. We expended the lot." That is what I deduce from what you have just told me.

Dr STEWART: I do not know the detail of that. We can provide the detail. But, surely, it is a matter for the Commonwealth what reporting it requires from an agency that is not New South Wales Health. I am quite happy to answer questions on what New South Wales Health reports. But I cannot possibly answer on how Corrective Services responds.

The Hon. JOHN JOBLING: You said Corrective Services reports to you.

Dr STEWART: As a mechanism for it to go back to the Commonwealth. It is the Commonwealth that provides the funds. It is the Commonwealth that should ask the additional questions.

The Hon. JOHN JOBLING: You say you are just a post box, and I can accept that. You say that they report to you at the end of the year that they have expended that sum of money. You simply accept that, without any checks. You raise no questions, and you have no reason to question that report. You just sign off on that report and send it off to the Commonwealth.

Dr GRAY: That is not the case at all.

The Hon. JOHN JOBLING: Are you saying that you do check, then?

Dr GRAY: We check that Corrections Health does. Corrections Health is in situ and, and Corrections Health—

CHAIR: We are talking about Corrections.

The Hon. JOHN JOBLING: I am only dealing with Corrections.

Dr STEWART: The checking is done by Corrections Health.

Dr GRAY: I understand the distinction between the two. Corrective Services we provide money to through the National Drugs Strategy. We provide an allocation straight to them.

The Hon. JOHN JOBLING: They report to you annually that they have expended it.

Dr GRAY: That is exactly right. In terms of the activities—

The Hon. JOHN JOBLING: And that is the end of the checking process for you?

Dr STEWART: I will ask Dr Gray to talk about the detail that they require. Mr Chairman, I cannot help because I do not see the detail of all the reporting that goes through the New South Wales Department of Health. My understanding in relation to this money is—

CHAIR: If I could just make the point that all of these Commonwealth drug strategies are signed off by Commonwealth Ministers. This is not something that the Commonwealth just dreams up all by itself. These are cooperative arrangements. The Commonwealth says, "Here is \$16 million, \$1.3 million of which we would like you to spend in the prisons because we take the view, as do all Ministers around the table, that while you have in prison large numbers of people who have a drug

and alcohol problem it would be a good idea to provide them with some drug and alcohol rehabilitation services." Now, that is the big picture.

Dr STEWART: But they do not go into that detail.

Dr GRAY: That is not quite the way it happens at all. They give us an allocation and say that 10 per cent of that needs to be spent, and it is up to the States to allocate which component of law enforcement gets what amounts of money. The decision on funding Corrective Services for \$1.3 million was made more than 10 years ago.

CHAIR: By the State Government.

Dr GRAY: By the State Government.

CHAIR: And the State Government could change that tomorrow if it wished.

Dr GRAY: The particular portion of allocation. It cannot change the 10 per cent.

CHAIR: No. But it can use that money on law enforcement somewhere else if it wishes.

Dr GRAY: Theoretically, I expect it could.

CHAIR: It could give it to Police rather than Corrections.

Dr GRAY: The Government could make that decision.

CHAIR: The State Government.

Dr GRAY: The State Government could make that decision.

CHAIR: The Commonwealth Government says, "Here is \$1.3 million. Spend it on law enforcement drug and alcohol issues." So it is not just the government saying, "Give it to Corrections, and we don't care about it." It has come through the States, and the States have discretion on how it is spent.

Dr GRAY: That is right.

CHAIR: To that extent, the Commonwealth says to New South Wales, "We gave you money for drug and alcohol services in law enforcement. How did you spend it?" The Commonwealth has a legitimate reason for asking that question.

Dr STEWART: Of course.

Dr GRAY: That is right, and we answer on the basis of what we are told by Corrective Services. There are two ways in which we get that. One way is that we get the on-paper financial acquittal of the funds, which is very rudimentary. In addition, at Corrections Health/Corrective Services we have the equivalent of a service level agreement. So they work together. The whole purpose of the KPMG review, which took place post-summit, was to look out how to do business better. They are in the process of working out how to do business better. That includes much greater and more effective management of that \$1.3 million, with Corrective Services and Corrections Health working in partnership around that. That is how all of that actually works.

The Hon. JOHN JOBLING: Could you indicate to the Committee, or come back to the Committee, as to what questions you might have asked over the past couple of years to satisfy yourself that that money was expended?

Dr STEWART: We can come back to the Committee on that. Is that in terms of the development of the service level agreement?

The Hon. JOHN JOBLING: That is the \$1.3 million. Did you ask any questions? If so, what were those questions?

Dr STEWART: Dr Gray has just said that we have a service level agreement.

Dr GRAY: The answer is the KPMG review, which is four volumes thick.

The Hon. JOHN JOBLING: I do not need to read the review. I just need from you people how you have satisfied yourself. Have you asked any questions about the \$1.3 million?

Dr STEWART: We will provide that information.

CHAIR: Do you think that \$1.3 million is well spent on drug and alcohol issues by Corrections, in cooperation with Corrections Health?

Dr STEWART: If I could make this point in relation to that question. First of all, things do happen about this. Secondly, in the end, surely it is the Commonwealth's responsibility, since it is the body to whom we report, to ask those kinds of questions. It is Commonwealth money. The Commonwealth has been satisfied for 10 years. It apparently has asked us no more questions.

CHAIR: As Dr Gray has said, the Commonwealth gives you 10 per cent of that money to spend at your discretion on law enforcement. The Commonwealth could say, "Gee, New South Wales, you would be better off giving that to Police." New South Wales could say, "No. We will decide how we spend the money on law enforcement because we have that discretion." The Commonwealth could therefore ask you, "Do you think this money is well spent by Corrections in the prisons, or do you think you would get more bang for your buck if you spent it in the courts?" That is a question that the Commonwealth could legitimately ask. It cannot ask you how the money was spent in prisons. You have allocated it to prisons.

Dr STEWART: But they could direct, and the Commonwealth does direct, although less than they have in the past, exactly what money is spent and on what kind of programs. They do not in this case. The key point is that if there is an implication that the \$1.3 million is not being spent on health-related activities or counselling, then we certainly reject that.

The Hon. JOHN JOBLING: But you do not know.

Dr STEWART: We do know.

The Hon. JOHN JOBLING: How do you know?

Dr STEWART: Because we get reports.

The Hon. JOHN JOBLING: So they do report to you?

Dr STEWART: I have said that and so has Dr Gray.

The Hon. JOHN JOBLING: What is in the police report?

Dr STEWART: I do not know the details of the report because I do not see all the reports that come in but we will provide that detail to you.

CHAIR: We will read the transcript, but I got the impression from Dr Gray that it was a fairly perfunctory report of the spending of \$1.3 million. If you are now saying it is more than a perfunctory report and it is part of the service agreement between Corrections and Corrections Health, that would be interesting.

The Hon. JOHN JOBLING: I think you indicated that you supply to Correctional Services for correctional health somewhere around \$6 million to \$8 million and that they report to you on a quarterly basis of progress expenditure and provide an annual report on the moneys.

Dr STEWART: Corrections Health?

The Hon. JOHN JOBLING: Yes.

Dr STEWART: Corrections Health reports in this way: on a monthly basis Corrections reports to the New South Wales Health Department on its expenditure and the CEO is required to sign that off—and I personally did that when I was a CEO—on a monthly basis. "We spent this money this month, this is what our monthly budget is, this is what our year-to-date budget is and these funds are all expended according to the determination." On a quarterly basis, as well as that, since the Drug Summit we have required all services receiving specific Drug Summit funds—or specific drug and alcohol funds, I should say—to report to us in much more detail, which Dr Gray can talk about, on how they are spending their money. I can tell you that that has led to some questioning from the health system about how rigorous we are in terms of reporting. We want to be rigorous in relation to how we spend our money from the Drug Summit.

CHAIR: And yet, to be perfectly frank, you appear vaguely unconcerned as part of NSW Health. You think it is the Commonwealth's problem to look at how Corrections is spending the \$1.3 million.

Dr STEWART: I am not unconcerned but it is difficult for me as the chief health officer or anyone within NSW Health when there is a mandate of 10 per cent to go to Corrections Health to have any powerful levers in relation to our money.

CHAIR: The 10 per cent does not go to Corrections Health; it goes to Corrections.

Dr STEWART: I beg your pardon.

CHAIR: But that is entirely a matter for you. For example, if you thought it was a waste of time giving it to Corrections in terms of bang for your buck in terms of drug and alcohol rehabilitation, you could advise the Minister by saying, "Let us take it away from Corrections and put it somewhere else".

Dr STEWART: We could, but as I understand it, that is what the whole KPMG review was about.

CHAIR: We are talking now about how the \$1.3 million is spent on Corrections services, which is where we started.

Dr STEWART: We will provide more information about how that is acquitted, but if you need the detail of how that was spent, clearly, as the Health Department we cannot answer in relation to Corrective Services, which is where I started in the first place.

CHAIR: Dr Gray indicated at the very end of her statement that there is a working partnership between Corrections and Corrections Health on how this money is expended. Is that what you said?

Dr GRAY: That is right.

CHAIR: I do not want to verbal you. Is that what you said?

Dr GRAY: That is what I said.

CHAIR: So, therefore, Corrections Health should have some view on how well that money is spent, should they not? If there is a close working relationship between Corrections and Corrections Health, then Corrections Health should have a view on whether they think that money is well spent, moderately well spent, passably well spent or very poorly spent?

Dr GRAY: I think their view is that in the last three years the greater cooperation between the two services has actually brought about a situation where the money is being managed more effectively than in the past.

CHAIR: Not the management of the money.

Dr GRAY: Sorry, by "the money" I actually meant the activity that the money buys.

CHAIR: In other words, the outcomes you are producing?

Dr GRAY: That is right, the outcomes. They have actually significantly improved the outcomes.

CHAIR: Do they measure any of those outcomes?

Dr GRAY: Again, I keep using the KPMG study, because they are actually working through all those recommendations. They have taken those recommendations, which involved an external body looking at the whole way in which those three services did their business and in doing that, they came up with those recommendations and they are now being implemented.

CHAIR: Corrections Health could point to some outcomes from the expenditure of the \$1.3 million by Corrections on various services to do with drug and alcohol rehabilitation within the prison system run by Corrections?

Dr GRAY: Yes.

Dr STEWART: Yes, we can do that, but it seems to me that the fundamental issue is this: this is an upper House Committee inquiring into mental health services in New South Wales. If you require details about how Corrective Services spends its money, it seems appropriate that you direct those questions to Corrective Services. It would be inappropriate for Health to be speculating on how they spend their money. Surely, it is appropriate for Corrective Services to come here if that is required.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot have it both ways.

CHAIR: Dr Gray said that they are now comfortable that New South Wales Corrections Health is working with New South Wales Corrections to see that that money is targeted and getting better outcomes for the \$1.3 million. I am not verballing you, am I?

Dr STEWART: Yes, we are doing that but my point is a procedural one. If you want to ask the details about an agency and how they spend their money, you should ask that agency, not another agency.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You cannot have it both ways. If you say you have a holistic mental health system or drug and alcohol system where all parts of government contribute to that, and if your responsibility is that outcome, then whether the Health Department does that outcome or whether another government agency or subcontracted non-government organisation delivers that outcome, surely you must be aware of what is happening if you are responsible for the output. Otherwise, Corrective Services would say, "Gosh, we get a bit of money from Health, we manage our programs this way." What are the drug and alcohol programs and are they being managed by an other department? If you are responsible for the output, surely in an holistic system you must be aware of what they are doing with the money that is contributing to the area of responsibility that you have.

Dr STEWART: I am sure this discussion on the details of how Corrective Services spends money on counsellors will be useful in the upper House committee on mental health completing its report. The answer to your question is this: We will provide more information in relation to the KPMG report, but I do not accept that because NSW Health is involved in the roll-out of services for the Drug Summit, that NSW Health is responsible or can answer for every service that is provided in relation to the Drug Summit. There are services that we have nothing to do with. If you asked me a question, for example, about training, which is a matter for the Department of Education and Training, then I think it would be reasonable for me to say, as I have said in relation to Corrective Services,

"Ask them, don't ask us", because otherwise we are getting into areas we simply do not have the expertise or the knowledge to answer.

CHAIR: The point we are trying to make to you is simple. If the New South Wales Government has options on this 10 per cent on how it gets expended, given that the Commonwealth gives it to you under the general heading of law enforcement for drug and alcohol issues and given that there is a discretion within government, then NSW Health and Corrections Health could advise NSW Health that they think that the money being spent by Corrections is a waste of money or very good bang for the buck. At the end of the day you could put your view to your Minister, who could go to Cabinet and say, "We think they could spend that \$1.3 million, which is government money currently allocated to Corrections, better with police or a police strategy." You could do that.

Dr STEWART: We could.

CHAIR: That is the point we are trying to make, that is all and, therefore, the interest we have is whether Corrections Health takes a view, in looking at the partnership agreement, that you are getting as good a bang for your buck for the \$1.3 million as that being spent elsewhere?

Dr STEWART: But the original question was how the money is being acquitted. We are quite happy to provide information about how that money is being spent in the context of the KPMG report three years ago, which said there ought to be greater cooperation between Corrections Health and Corrective Services with those funds which are, in the broad, being used for drug and alcohol services. We will provide that information to the Committee.

The Hon. JOHN JOBLING: In describing a government body as the principal agency or the peak body in the role of drug and alcohol treatment and development, and mental health treatment and development, it would be reasonable, would it not, to describe NSW Health as the principal agency?

Dr STEWART: What is the answer to that, Jennifer? The answer is that the roll-out of the Drug Summit is a whole-of-government approach.

The Hon. JOHN JOBLING: I did not say "Drug Summit". In matters relating to the fields of drug and alcohol treatment or mental health treatment and advances, is it not so that the principal agency would be the New South Wales Department of Health?

Dr STEWART: In relation to drug treatment, yes. In relation to a broad range of services about drug and alcohol—drink-driving, for example—the answer is no.

The Hon. JOHN JOBLING: You want to have your cake and eat it too. You do not oversee the programs, you do not determine best programs, you do not have any input into determining best programs.

Dr STEWART: Which question do you want me to answer?

The Hon. JOHN JOBLING: You somewhat remind me of Public Works many years ago and I suggest we could do without them.

Dr STEWART: Can I answer that question.

CHAIR: Yes, you can answer that because the question Mr Jobling asks is very important. For example, if Corrections was operating its \$1.3 million with programs that NSW Health thought were an absolute waste of time and contradictory to government policy or the whole direction of government policy, we would expect you to do something about that?

Dr STEWART: Of course, and we would do something about it, but that is not the question, that is not where we started from. We started from a question about reporting.

CHAIR: That is exactly the question that Mr Jobling asked.

Dr STEWART: We have now gone on to a question about what input the New South Wales Department has in terms of services provided for drug and alcohol. Of course, we have a role. I think it is important, though, to talk about how the Government has responded to drug and alcohol in general, not just the Drug Summit because the Health Department is not the leading agency.

CHAIR: Mr Jobling asked specifically: Are you the lead agency?

Dr STEWART: The answer is no. The lead Minister is the Special Minister of State. The lead agency—and they remind us of this from time to time—is the Cabinet Office.

CHAIR: So in other words NSW Health is not the lead agency responsible for advising government on drug and alcohol treatment programs?

Dr STEWART: No.

Dr GRAY: We are no longer the lead agency. We were, prior to the repeal of the Drug Offensive, but that was stripped away from us. As a post-Drug Summit process the Office of Drug Policy was established in the Cabinet Office. They have the coordinating role of policy of all types across government to do with drug and alcohol.

The Hon. JOHN JOBLING: Mental health—

Dr STEWART: We cannot talk about mental health. We are talking about drug and alcohol.

The Hon. JOHN JOBLING: Of course I can ask you a question about that.

Dr STEWART: You misunderstand me, Mr Jobling. I am trying to answer your questions, but it gets confusing because we are mixing up drug and alcohol services and drug and alcohol treatment services. Of course the Health Department is the lead agency in relation to drug and alcohol treatment services. We provide those services. It is our responsibility to provide them. After the Drug Summit, reconsideration was given to which government department will be the lead agency in relation to drug and alcohol services because they involve things that are much greater than just treatment services. They involve a whole lot of things that I have just talked about, such as training, police response, the response in youth, DOCS, so on and so forth.

CHAIR: In terms of Corrections Health providing a rehabilitation service, surely counselling services in prisons run by Corrections, not Corrections Health, is regarded as a treatment service, is it not?

Dr STEWART: It is a treatment service.

CHAIR: Are you comfortable with the way in which outcomes are being sought under the new arrangement of the Drug Summit and Mr Della Bosca's control of the Cabinet secretariat? Are you comfortable with the way in which that is operating in terms of the delivery of services for treatment?

Dr STEWART: As I understand it, you are asking me whether we are comfortable in relation to the \$1.3 million that goes to Corrective Services to provide counselling, is that question?

CHAIR: Yes.

Dr STEWART: The answer is that we will provide you with more information in the context of the KPMG review. I am supposed to be at a meeting of metropolitan chief executive officers, representing my CEO. I would be loath to leave without the matters here being finalised. We were expecting to talk for an hour. Dr Gray has not even finished her presentation yet. Obviously, I will not leave but I am wondering about the time frame.

The Hon. JOHN JOBLING: Dealing with correctional health, I presume that as you get from Corrective Services a monthly report, a quarterly report and an annual report, which obviously

have been coming in for some time, can we have an overview of that for the years 2000-01 and 2001-02?

Dr STEWART: In relation to which specific aspect?

The Hon. JOHN JOBLING: Corrections, in relation to correctional health where you are spending some \$6 million to \$8 million, where you say they account to you and it is ticked off on a monthly, quarterly and annual basis?

Dr STEWART: That is right.

The Hon. JOHN JOBLING: Can you do that?

Dr STEWART: Yes, we can but work will have to be done by my staff and I am struggling to see how information about how Corrections Health provides its global budget is relevant to an upper House committee on mental health.

The Hon. JOHN JOBLING: I do not think it is your place to say; you are beginning to annoy me.

CHAIR: He is talking about the terms of reference. There is an interest because the way in which that public policy decision is made may inform us about how we might make suggestions about other public policy issues. There is a specific area regarding drug and alcohol problems and mental health. The way in which government and the department have structured public policy directions, payments and relationships will have a big impact on us and any suggestions that we might make about other relationships between, for example, Health and Housing or Health and Education. There is a public policy issue here about how it has been adopted before and how well it works. That is why these questions are being asked. I am sorry, but they are public policy issues. We are going to make revolutionary suggestions about how we might improve mental health services in this State and this is one of the ways that we can get to what you are comfortable with—because at the end of the day you are the lead agency for treatment in New South Wales.

Dr STEWART: For drug and alcohol services, yes.

CHAIR: Also for mental health services, which is what we are inquiring into. Drug and alcohol services are another way in which government deals with an issue across agencies, involving the Department of Health. That is what we are talking about.

Dr STEWART: Thank you, Mr Chairman. Can I clarify what Mr Jobling requires in terms of financial reporting?

The Hon. JOHN JOBLING: You say that you receive a monthly report, a quarterly report that you test and obviously an annual report, which will show how money is expended, the areas in which it is expended and any problems that you have encountered. I am interested in 2000-01 and, if it is available—I accept that the second set of figures may not have been finalised, but it should have been as most public accounting would have been done by now—2001-02.

Dr STEWART: I am sorry if I am annoying you, Mr Jobling, but the issue for me is precision. I can provide to the Committee the annual financial reports of the whole Corrections Health Service—to the \$35 million or \$40 million that is expended. If that is what is required, I will provide it. I can provide as well the specific reporting that is done in relation to drug and alcohol services—the quarterly reporting that Dr Gray talked about. If that is required, I can provide that as well. I need to know what is required.

The Hon. JOHN JOBLING: We may as well have both.

CHAIR: We would like to have both of those reports as it helps us to break down the figures.

Dr STEWART: For 2000-01 we will provide a copy of the Corrections Health annual report that contains the figures. As for 2001-02, you are quite right: The annual report has not been produced yet. But the financial statements will be pretty close to being finalised and we will provide them. Dr Gray will also provide some kind of summary of reports that she receives in relation to specific drug and alcohol programs.

CHAIR: How do you think having the drug and alcohol unit within the Cabinet Office, as a result of the Drug Summit, operates? Do you think it has been a move forward in terms of providing drug and alcohol services or dealing with the problem of drug and alcohol abuse in the community?

Dr STEWART: The Government made a decision in relation to how drug and alcohol services in the broad would be provided, and we work within that system.

CHAIR: That is a policy question, is it not?

Dr STEWART: Yes, you are asking me about government policy and I am working within that policy.

CHAIR: It is unreasonable for me to ask, therefore, whether you think this works as a way of delivering whole-of-government coordination?

Dr STEWART: Yes, it has worked very well in terms of the roll-out of the many programs that came from the Drug Summit and the existing programs in terms of cross-government coordination.

CHAIR: Do you agree it gives more transparency in attacking an issue?

Dr STEWART: The advantage in terms of the roll-out of government policy is that the system that is now in place for drug and alcohol services is a cross-government approach. There is involvement from a central agency and from the peripheral agencies in a much more coordinated way.

The Hon. JOHN JOBLING: Are you still worried about any area where you feel we could work harder to do better?

Dr STEWART: In relation to drug and alcohol policy, no. We are working extremely hard.

The Hon. JOHN JOBLING: So you are perfectly satisfied with all areas?

Dr STEWART: I am never perfectly satisfied but there is no area that I can say we are not dealing with in the way that public policy and the roll-out of public policy is done in a democratic society. Dr Gray, when she finishes, will be able to explain exactly the kinds of things that we are doing.

CHAIR: We have heard evidence that a criminal record makes it more difficult for somebody to get mental health housing or access to drug and alcohol treatment services. Is that true? Does mental illness or mental illness plus a criminal record make it difficult to access drug and alcohol services, such as detox and treatment?

Dr GRAY: No, that is not the case. People coming out of the correctional setting get priority access to all of our pharmacotherapy services. If you commence treatment in the prison setting on methadone or buprenorphine, we must find a place for you on a methadone or buprenorphine program as soon as you come out.

CHAIR: What about mental illness? We have had so much evidence to the effect that if you are mad and you are on drugs neither service will look after you. Are you telling me that is not the case?

Dr GRAY: I do not think that is the case in drug and alcohol. In drug and alcohol very careful determinations and decisions are made about what the status of the person is. We must be careful about putting people into particular services where it is not good for them or for the other

clients. Therefore, we find other ways of managing that person. I gave the example before about detoxification. It is not appropriate to have a severely mentally ill person in a regular detoxification unit because those units are not set up in terms of security or staffing to manage people with extreme mental health problems. The far better option is for that person to receive drug and alcohol treatment in the setting to which they are most suited. It is what I mean by ambulatory: We bring those services to those people at that particular point in time.

CHAIR: Do you mean an acute ward? If there is a dual problem do you think a person should be managed in an acute mental health ward or under the care of a mental health team in the community and you bring your worker to work alongside the mental health team?

Dr GRAY: That is the best way for the system.

CHAIR: Is that currently the direction in which you are moving?

Dr GRAY: Absolutely.

CHAIR: Rather than a stand-alone detox unit importing mental health workers?

Dr GRAY: Absolutely because to do the latter is extremely disruptive to all other clients in the service. For example, people who are psychotic require an enormous amount of attention and the risk of self harm and so on is great.

CHAIR: So the point of contact for someone with mental illness substance abuse should be the mental health service, with the drug and alcohol people providing a service within that?

Dr GRAY: Exactly, to provide the appropriate level of support so that those people are managed in the best possible manner.

Mr McGRATH: It also depends on the acuteness of the individual conditions. Obviously if a person's drug and alcohol condition is more acute they can be managed in a drug and alcohol unit. I think Dr Gray is saying that when the mental health problem is considerably acute the best place to handle somebody is in an acute mental health facility.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you deliver quality drug and alcohol services within mental health hospitals? If you are saying that they are the primary agency for people with mental health problems, you would be the secondary agency—you are happy to be the secondary agency if there is a significant mental health problem—and you are capable of delivering ambulatory drug and alcohol services to patients within mental health hospitals. Is that what you are saying?

Dr GRAY: It is no different from providing ambulatory care to somebody at home—for example, home detoxification.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that you provide adequate drug and alcohol services within mental hospitals?

Dr GRAY: The system is growing, as we talked about before. We have already explained that it has taken quite some time to get the system ready and able to take on the full range of people who come before it. But it has certainly been improved dramatically and I feel far more confident now than I would have felt three or four years ago.

The Hon. JOHN JOBLING: That is principally in the city; in urbanised areas. What about the country?

Dr GRAY: No, that is precisely why I gave the example of the mid North Coast and the growth in staff from 13 to 40. It makes a huge difference in what you can do and how much you can support the broader community-based setting and mental health services with 40 as opposed to 13 staff.

The Hon. JOHN JOBLING: That is the mid North Coast but there are many other parts of New South Wales.

Dr GRAY: That is just an example. We have put an enormous range of services—expanded services—in every single area of the State and throughout all rural area health services. We have specific home detoxification programs established and home ambulatory care.

The Hon. JOHN JOBLING: You have moved away from the original question which was about somebody who had a severe mental illness along with a drug and alcohol problem.

Dr GRAY: I am sorry, but I moved away only because Dr Chesterfield-Evans asked about our capacity in the system.

CHAIR: The Riverlands Centre in Lismore is a good example. I think it has about 30 beds.

Dr GRAY: No, it is a 16-bed unit.

CHAIR: It is quite large. If somebody comes to the Richmond Clinic, the mental health hospital in Lismore, with a drug and alcohol problem, why is there a detox unit for the non-mentally ill—we think that is important—but for the mentally ill, who have many other problems, treatment is provided within the Richmond Clinic? Withdrawal from alcohol is probably the most dicey of all withdrawals, is it not?

Dr GRAY: Yes.

CHAIR: You can withdraw from just about everything else without any problems. Yet do we have the medical or clinical expertise in our mental health acute wards to do major withdrawal that you have resident within the 16-bed detox unit?

Dr GRAY: There is no reason why the medical and clinical expertise in Riverlands cannot be brought across to the Richmond setting. That is what we are saying. Riverlands was designed after enormous community consultation. It is a premier unit that, as you are well aware, was designed with the Aboriginal community in mind. A lot of time went into looking at the range of services and how best to deliver those services. That is what has occurred. The clinical staff at the centre are more than able to provide clinical support to people in the Richmond unit. It does not mean that people in the Richmond unit need to be physically housed or located as patients in the Riverlands setting.

CHAIR: It is a source of staff to be used for at-home detox, outpatient detox or even detox in a medical ward.

Dr GRAY: That is right. Remember that we talked about not holistic government but holistic services. The counselling service and the methadone program are also located at Riverlands. It does case management. A range of staff is available to provide support to people in the Richmond unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting that if someone has a mental health problem and a drug and alcohol problem your model is that they should go into the mental health area and you will provide ambulatory equivalent support to that mental health unit to deliver the drug and alcohol services. Is that the model that you are using?

Dr GRAY: The answer, as Mr McGrath mentioned before, is the level of complexity. We see it as people being on a continuum. At one end of the continuum are the people with drug and alcohol problems whose level of mental health problems are possibly no greater than those of us here today. Then you move to people who have been in Corrections and so on. Then you have those who have had drug-induced mental health problems that are quite specific and need to be dealt with in a particular fashion. Then you have those who have significant drug and alcohol problems who have self medicated but that self-medication has become a dependence in and of itself, as well as mental health problems.

That is before we do the overlay of ethnicity, Aboriginal status, whether they are young or older, whether they have been drinking or using drugs for 40 years and so on. I guess the answer is

that it depends on which part of the continuum. For the people who are at the more extreme end of the continuum who require significant drug and alcohol support, the system that we are building—I put it in the present tense; we are not there yet—is one that will enable our staff to move easily and provide inter-mental health services with the level of support they need. Where someone has long-order mental health problems, where they can comfortably be accommodated with Riverlands Centre without creating havoc among the staff and without causing distress to the other 15 people, that is fine, but that is a clinical decision about where they are on the continuum.

Dr STEWART: It depends on the individual case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are talking about people in the continuum. At one end of the spectrum they are sufficiently mentally ill to have to go into a mental health unit. That unit is staffed 24 hours to deal with mental health problems. Either those staff have to be multiskilled to deal with the mental illness and the drug and alcohol, or the drug and alcohol person comes in as an ambulatory resource in addition. If that is the case the ambulatory service has to be 24 hours, presumably, does it not? In other words, your ambulatory service has to be pretty damned good because it is providing an in-patient service 24 hours a day and presumably it will also be available for a 24-hour ambulatory service outside of hospital? Are you anywhere near that degree of ability?

CHAIR: The question we are asking is, if the Caritas Centre sees someone who is brought in by the police because he is running around through the traffic and shouting at the moon, how do they know whether this is a drug and alcohol problem—in other words, an acute psychosis problem—or it is a person who has an acute baseline problem? They take them to the Caritas Centre, which is absolutely full, and it says they are not sick enough to come in there and there is no bed anywhere so they take them back to the cell. The Hon. Dr Arthur Chesterfield-Evans is asking if we have a 24-hour mental illness service, given that we are seeing this huge increase in toxicity over the past four or five years. It is a new game of mental illness substance abuse, more toxic patients being presented in a more toxic or more violent way and by the police more often. Do we have a need for an acute response, like the Alex Wodaks of this world, to get out of bed in the middle of the night to go along to the Caritas Centre?

Dr STEWART: We have an acute detoxification capacity. We have that. We have detoxification beds explicitly, either medical or non-medical—

CHAIR: But they have a mental illness as well. You do not know whether they are mentally ill, they are just psychotic and throwing things at the moon. They get carted off to the local mental hospital or the admission centre or the emergency department. The Hon. Dr Arthur Chesterfield-Evans is saying if we have a 24-hour service for mental illness, do we have a 24-hour service for consultation and treatment for substance abuse?

Mr McGRATH: The important thing to remember is that the onset of withdrawal takes a period of time. So the onset of withdrawal is not going to be immediate. In most cases people in those conditions will be intoxicated rather than withdrawing.

Dr STEWART: But the answer is yes, we do. In the larger centres we have staff specialists, CNCs and a range of staff. In the country we do it differently, through centralised intake to some extent. It is impossible to expect Moree hospital, to use your example, to have the range of services that are available at St Vincent's Hospital. There is a range of services in drug and alcohol that is available 24 hours a day. For example, Dr Wodak would-be on call for drug and alcohol services, shared with one or two or three other doctors. I do not know the details.

CHAIR: Given that your proposal is for the ambulatory care to be provided within the mental health service if there is a serious mental issue—which is what we are concerned about, the treatment of people with mental illness plus substance abuse. We have reached the stage where we can ask the questions that we really want to ask which are, if you think that is better provided within the mental health service with the drug and alcohol people coming in, I can accept that as a reasonable policy process in combination with the mental health people, rather than sending someone who obviously has a serious mental illness to a drug and alcohol service. I can accept that. We are asking is there an availability of that support for our mental health team who are already overburdened?

Dr GRAY: Sure. We also have the specialist advisory service of which Dr Alex Wodak is a member. That is a telephone system whereby they can ring up and say we have this person presenting in this particular way, what should we do with him immediately?

CHAIR: In other words, acute intoxication plus what happens when they come off?

Dr GRAY: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I go one step down the spectrum? The ones who have mental illness and/or psychosis, you say they should go to mental health facilities supported by you. Let us assume they cannot get into that mental health service, because it would seem there is a big problem at the door, at the admission, there are not enough beds. So, they are not able to be admitted but they certainly are drug and alcohol affected and possibly mentally ill. There is often some difficulty in deciding at the time when they are psychotic as to why they are psychotic, presumably, or the hospital decides that they are toxic and not mentally ill, in which case they are about to be booted out from the case of the department or the mental health facilities into the street. The police are saying what will we do, we cannot send them back, they are violent, or whatever. Do you have the capacity to deliver the services then, 24 hours a day, around the State, and to what extent?

Mr McGRATH: If the presenting condition matches with treatment that is available, that would be possible. It depends on the level of the mental health problems that exist in that patient.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely it depends on the resources available in that area?

Dr STEWART: It is also about treatment, how we boosted up these kinds of treatment in specialist services as part of the additional funds that have been provided, because funds have been provided for a range of additional expert drug and alcohol staff and staff specialists, from clinical nurse consultants to general staff working in detoxification units or more generally across the State. It is worthwhile talking about that, because that seems to me to be where the question is coming from.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is part of the full-time equivalents that I was asking about earlier.

Dr STEWART: We cannot comment on what happens to a patient with predominantly a mental health problem, because we came along to talk about drug and alcohol. It does not fall within the public health division. But we can talk about drug and alcohol services.

CHAIR: To be perfectly frank, we have had a huge amount of evidence about the people who are admitted who are seriously mentally ill. We have had submissions from the police, not just the Police Association but the police service, complaining that they take people to these places and they are not sick enough. Chances are they have both a mental illness and a drug problem. If they are one of the homeless out there, there is a 70 per cent chance they are mentally ill and, of the ones who are mentally ill, a 60 per cent or 80 per cent chance that they have a drug problem. We are talking about a large population and a significant problem. We have this not just from the police but from mental health workers and others. What I want to know from you is when they get admitted we have now established you would rather bring the drug and alcohol people in to work with the mental health people. Let us leave that aside. The Hon. Dr Arthur Chesterfield-Evans is now asking, when parents front up with a son or daughter or someone fronts up with a husband or whatever, and they say she is really sick and she has had three marijuanas today or four pills today, they say she is not sick enough to be admitted, go away. We have had lots of letters like that and we had a whole forum like that.

Dr GRAY: I would say three things about the letter. That is where the centralised intake would come in. If it is after hours it makes it more complex, but that is why we have the specialist advisory service and the alcohol and drug information service [ADIS] which is run by Dr Alex Wodak out of St Vincent's Hospital. We have on-the-line councillors all the time.

CHAIR: Is there somewhere we can take them that night? They are not mentally ill enough to be admitted to our mentally ill place.

Dr STEWART: If they are well enough to be admitted with a drug and alcohol problem, a range of services are available. If the predominant issue is about detoxification, notwithstanding that there may be some mental health symptoms as well, they will be dealt with in the way we deal with people who need detoxification. We can talk about that. Predominantly what you seem to be talking about are people with mental illness. While we are saying there are specialist services available that can be provided in the context of mental illness, it does not seem to me to be a reasonable approach or an approach that makes sense to say if there is no access because they are not sick enough to come under mental health, there is an automatic access under drug and alcohol if consequential to the mental health problem they have some substance use issue. As you have said, lots of people who have mental health problems have substance use issues. We are talking here about the spectrum. This is an important way to look at it—from here, where he needs acute detoxification, to here, acutely psychotic and drinks a bit too much.

CHAIR: We are asking the question because when they take them to the mental health place or the casualty department and the psychiatrist or the clinical nurse consultant comes to the emergency department, they say not sick enough to be scheduled, sorry. There is a problem, and the community mental health people, the crisis team, say she has just had too much to drink, she is psychotic but she has had too much to drink, not our issue. What does the family do to get care for the person who is both mentally ill and who has been abusing substances but not mentally ill enough to be involuntarily admitted?

Dr STEWART: Given time, because we run out in two minutes, it seems to me you must have addressed that question to other people from Health or to many other witnesses here, and I am not sure it is possible for people talking about drug and alcohol to add anything to that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We would like you to answer for the department. The department's reply to my submission admitted that 16.6 per cent of people have some need for specialist mental health services. This is term of reference G5 in your submission No. 267. It says that New South Wales currently provides specialist mental health for about 1 per cent of the population. Surely all the stuff about range and spectrum, and so on, you are saying it currently provides specialist mental health to 1 per cent of the population, and 16.6 per cent have some level of need for specialist mental health care. That is an admission that you are doing one-sixteenth of what is needed and there are still 15.6 per cent that are not being adequately covered. Is that not really what we are on about?

Dr STEWART: Can I go back to my question? Yes, there must have been witnesses to whom you have asked that question. What I am saying is, the agreement we had about coming here today is that we are experts in drug and alcohol services. It would be inappropriate for the chief health officer, who has no administrative role in the department in mental health, to start speculating on those kinds of issues.

CHAIR: And the bottom of the road, though, we have had lots of people who say mental illness substance abuse, and if you are mad we will not treat your drug and alcohol problems. If you are just sad, we will not treat your mental health problems.

Dr STEWART: But who is saying that? The department is not saying that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is coming in the door to us.

CHAIR: They come to the emergency department. Who makes the decision about whether they get acute care for their mental illness and their substance abuse at the same time, or do they say we will treat the mental illness and not the substance abuse or we treat the substance abuse and not the mental illness? This is where we get this terrific divide between two services. This is a concern expressed to us. If you say it is not out there, perhaps we have missed the last five minutes of life, but that is not what we have been told.

Dr GRAY: Let me say, this particular slant on the case management. Underpinning that are treatment plans. This is part of what we have been putting in place for the past few years. It takes time and I accept it takes time for those families we were talking about before, FTEs and so on. We have

had to build up nursing reform, we have had to take the generalists, or a the non-specialists, and train them and train them and educate them so that when they present at an emergency department they have a better idea of what it is they are seeing and what it is they are doing. The relevance of that to this is that for case management we have a plan, everybody at the moment coming into pharmacotherapy treatment, and we are looking to roll that out across other forms of treatment as well—detoxification, residential rehabilitation, outpatient counselling, and so on.

At the moment everyone in pharmacotherapy who comes into the public system has, every three months, a look at what their goals are, a look at what is happening with them, a look at where their success is going, a look at what they are achieving, a look at what they are not achieving. The relevance of that is that it is enabling us to better manage what is actually happening with those individual clients. It is then enabling services to better manage, to get a better framework, a better grip on what is happening within that service as a whole: what are the demographics; what proportion of their particular client population is male or female, have kids, do not have kids; have particular types of drug use, and so on. As we roll that out you will find increasingly that the sorts of issues that you meet will be addressed and will be made more appropriate. That is what we are trying to do.

CHAIR: One of the issues that I would like to talk to you about to see if you have an opinion on because it is not part of government policy or not government policy, is do you think there should be ways of providing for involuntary treatment of people with drug and alcohol problems as there is for mental illness problems because often the madness or their behaviour is related to drug and alcohol problems; their psychosis is not endogenous, it is something that is produced by the things that they are taking?

Dr GRAY: The answer I would like to give to that question is one that is based on our experiences at the moment with diversion: diversion, which is people coming before the courts, are before the magistrates, not going further but going into treatment.

CHAIR: That is sort of a voluntary form of coercion?

Dr GRAY: It is. The same with the adult drug courts. I think it is too nascent yet to give a definitive answer to your question because we are still learning how to provide treatment in a coercive system. We have had treatment as voluntary full stop; we have now had treatment involuntary plus the adult drug court, and now we are expanding that. As we are doing it we are learning more and more about how best to do it; from simple things about compulsory urine testing to non-compulsory urine testing, and so on.

CHAIR: Are the early indications from the compulsory or coercive voluntary—I suppose is the best way of putting it—improvement in the health status of the people over time?

Dr GRAY: What we are finding is that with MERIT—the Magistrates Early Referral Into Treatment—50 per cent of the people coming into the program have never before accessed treatment at all. So that is really significant. That means that necessarily it is having a positive health impact on those people. That is the whole area that we are moving in and looking at quite closely and, again, tying these domains of case management into those. We want to have a system where it does not matter if you are voluntary or you are coerced, you get the appropriate level of treatment.

CHAIR: You get the same treatment, I accept that, but, again, if you have got somebody who is a bit is mad plus they are on drugs and they commit a crime, is the MERIT program available to somebody who is both mad and has a drug problem?

Dr GRAY: The MERIT program has fairly strict criteria around that for the safety of the client because MERIT is done in a semi-supervised setting, if you like, so we have to really balance the needs of the client with the needs of the State. Really strong determinations are made around those.

CHAIR: About who is eligible?

Dr GRAY: In terms of eligibility; in terms of degrees.

CHAIR: That is, again, part of the problem, a lot of the people coming before the courts do in fact have a mental problem, a mental illness, and that mental illness may well make it impossible for them to comply with a MERIT type program, in other words, a drug and alcohol stepped program of some sort, and therefore they are unsuitable. That is why—it is just my impression from reading the submissions we have received—there are real problems with people who have got a mild form of mental illness or a form of mental illness or a developmental disability, plus a drug and alcohol problem, where otherwise they might have got access to the MERIT program but because they are not really suitable they do not get it.

Dr GRAY: I understand that, Dr Pezzutti. I think, as with any new programs, you tend to start off smaller in vision to try to get the various elements in place. That is what has been occurring with the MERIT program. Secondly, just to bring it the full circle back to where we started with the funding, as of July next year there is no certainty that the Commonwealth will continue to sign off. So we do not know if there will be a MERIT program or not. It is less responsible to build a full system at the moment when we are not actually sure whether it will continue or not. We have still got lessons to learn in this area.

CHAIR: In the MERIT program there is a series of experiments, I am aware of that, and there are Commonwealth funded programs: there is the court liaison service, as it was initially. That has been picked up by Corrections Health and expanded as years have gone by on the advice of the Chief Magistrate and others. That has been picked up as a program that not only works but provides good outcomes at reasonable cost. So if the MERIT program, on its assessment, is turning out good outcomes for reasonable cost, then the chance of that being picked up by New South Wales out of undifferentiated Commonwealth funding has got to be relatively high. Or you could pinch the \$1.3 million from Corrections and apply that to MERIT if the New South Wales Government thinks it gets better bang for its buck out of that. It is all part of law enforcement, is it not?

Dr STEWART: MERIT certainly is.

CHAIR: MERIT works, and you do not think Corrections works; then you pinch the money from Corrections and just tell the Commonwealth it will be better to put the money into MERIT. These are options for State governments to consider. You can advise on best options.

Dr STEWART: We clearly want to discuss that with corrective services.

CHAIR: We might have to too. Thank you for your time. We went into the drug and alcohol area early because we need to know how it is set up. We do know that this is an anomalous type of arrangement with Corrections. You then explained how the funding of that worked—and we were happy with that—and your relationship in terms of the accountability of that is entirely clearer to us now. Again, that relationship and that sort of funding goes to other public policy areas which we may or may not wish to address in this report, and other issues which we have to address: how to best provide services to people who have mental illness and substance abuse and how best we can advise on that totality.

Dr STEWART: Mr Chairman, may I just make two last points? Firstly, as to clarification, I was genuinely earlier on, Mr Jobling, struggling with what you wanted. Now that I know, that is fine, we will provide that information. Two points: the first is you asked me earlier about the model of the Office of Drug Policy, the model that says that the lead agency is the special Minister of State and the lead bureaucracy, if you like, is the Office of Drug Policy. I said yes, it has been a successful model, and I reinforce that, it has been a successful model. However I do not want there to be any implication that I am saying that this is a model that will work broadly in relation to other issues, because it might or it might not. It works in relation to drug and alcohol because there is such a range of agencies responsible for various aspects of it.

The last point I want to make is about the term "MISA". I think I would be fair to say—Dr Gray might want to comment—that we would have some slight concerns about the "A" in that. It has been a long time since we described anyone as being a substance abuser. We have said for many years "substance use". I do not know whether the Committee might like to consider "MISU", but there would be some issues about using "MISA" because it has been a long time since we branded people with the term "substance abuse".

Dr GRAY: It is true. We use "substance use" and "misuse" and in fact you will find WHO does the same thing. WHO used to call it "substance abuse" but actually moved away from it because of the pejorative label that it gave to people.

CHAIR: I do not think we need to be, as a parliamentary committee, so politically correct because any use in New South Wales of, for example, cannabis—until we have the trial being undertaken, if it starts, about the use of cannabis for medical reasons—would be an abuse under the Act. So, therefore, to use "SA" is not a problem for us. If at the end of the day, in five years time, we all change to "SU", terrific.

Dr STEWART: I just wanted to put the point.

CHAIR: But we do not like the use of the term "dual diagnosis" because it is unfair to people who have a dual diagnosis—a mental illness and developmental disability. To put them in with a completely different group of people who have different needs and different antecedents and different demands on a system does not help us. There are other forms of dual diagnosis too, of course: mental illness and dementia—another difficult area.

Dr STEWART: It is an imprecise term.

CHAIR: It is. Therefore, for special areas it has got real implications and the cause of much of the problems we have exacerbated in the past five years for mental health services. There is no doubt in my mind that mental health services are not what they were in 1998, but then mostly because the demands are different since 1998, would you agree with that? Neither of you are in mental health but from where we sit things have got a lot worse since 1998 in terms of the demands on the system, not the services have got worse or the people are no good, but the change in the nature of substance abuse has created a whole dimension for mental illness in the treatment of people with mental illness which was not there before at the same level.

Dr GRAY: Just for clarification, the Office of Drug Policy only manages drugs. It does not coordinate alcohol.

CHAIR: Yet the biggest substance abuse in this State would have to be alcohol, would it not?

Dr STEWART: Tobacco perhaps.

CHAIR: Thank you very much for your time. If we have got any other questions for which we need clarification, should we write to Greg Stewart to pass through to you any issues?

Dr STEWART: We will start preparing the additional information but the prompt will be something from the Committee I assume.

CHAIR: If we are writing something and we want a quick answer from the department we would be best to work through you, Greg?

Dr STEWART: In relation to this, yes.

CHAIR: And then you could go to Dr Gray or to Dr McGrath to get a response for us?

Dr STEWART: That is fine. For clarification on information we have provided today we will start getting information together as soon as we can and when the prompt comes from the Committee for further information—I think we have a pretty good list of it—then we will respond to that expeditiously.

CHAIR: We are looking for a bit more than that. Perhaps even a bit more guidance on that. If when we are writing the report we come up with a great suggestion or a great solution to save the world we would like to roll that past somebody to see whether it is practical. In other words, we would want to not look like dills because we do not know that topic as well. If we need some advice on

whether something is practical we might want to ask questions like that and you might have to go further up the chain. We might ask you directly for things that are practical and you might advise us. If you feel you cannot, that is fine, but we might come back to you on simple questions of public policy direction which are practical. If you are able to help us with that I would be very pleased. If you are not able to help us with that just say you cannot help us with that.

Dr STEWART: For those kinds of things in relation to today it is better for me for administrative simplicity, but for issues that in the end are going to be a response from the department it remains better to go to the director-general, but I am quite happy to be involved in that.

CHAIR: We are just looking at how we write this report and how we write recommendations as well. At the end of the day those consultations, except for what we have in here, will not be departmental responses necessarily in print; they will simply be quiet advising, and that is the difficult thing.

(The witnesses withdrew)

(The Committee adjourned at 1.15 p.m.)