REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

At Sydney on Tuesday 30 July 2002

___

The Committee met at 9.30 a.m.

PRESENT

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

The Hon Peter Breen
The Hon Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon John Jobling

CHAIR: I declare the hearing into mental health open and thank Dr Jean Starling for attending.

JEAN STARLING, Chairperson, New South Wales Faculty of Child and Adolescent Psychiatry, c/- Department of Psychological Medicine, The Children's Hospital at Westmead, Locked Bag 4001, Westmead, 2145, sworn and examined.

CHAIR: What is your occupation?

Dr STARLING: Child and adolescent psychiatrist.

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

Dr STARLING: I am appearing as the Chairperson of the Faculty of Child and Adolescent Psychiatry of New South Wales.

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

Dr STARLING: Yes, I am.

CHAIR: Would you like your submission, which is No. 92, to be included as part of the sworn evidence?

Dr STARLING: Yes.

CHAIR: If you should consider at any stage during the hearing or during your evidence that, in the public interest, certain evidence of 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, but I draw to your attention that the Legislative Council may pass a resolution to overturn the Committee's decision and make this evidence public. Thank you very much indeed for submission. Although it was relatively brief, it covered the issues that I am sure we will explore this morning. Would you like to make a statement or tell us what you think we need to know?

Dr STARLING: I suppose I am giving only a very small part of the whole picture, but the first thing I would like to say is that, as a representative of child and adolescent psychiatrists in New South Wales, I am delighted that issues such as medication of children and mental health issues are on the table for this Government and for this Committee. I think it is really important that these issues are taken very seriously indeed and our group appreciates that. That is partly why we wanted to make a submission—in recognition of the importance of this Committee. The areas in which we are interested are the treatment of children and adolescents who have psychological problems, not just the methods of the treatment but also getting access to treatment. I think access to treatment is quite a problem. It is in fact being addressed at the moment by the Centre for Mental Health so a lot of our concerns are being addressed. Apart from treatment and access to treatment, the other issues that my group is very concerned with are the rights of children and the rights of children not just as they relate to ethical and legal treatment but to a lot of psychosocial issues such as the way children are treated and what happens to children that impacts very severely on their mental health. There are a lot of aspects to the prevention of child and adolescent mental health problems.

CHAIR: The issue that you first drew to our attention is the survey that was done in 1998 in which the prevalence of mental illness or mental health problems was identified in some 14 per cent of children. What sort of problems are we talking about here?

Dr STARLING: The most common problems in children are probably behaviour problems and things like conduct disorders or disorders where children have severe behaviour problems such that that disadvantages them at school and interferes with their ability to function and to get an education. That would be by far the most common. Attention deficit hyperactivity disorder [ADHD] is of course a very common disorder. The other big group of disorders we are looking at are things like anxiety disorders, such as anxiety about going to school and various kinds of phobias which can interfere with a child's level of functioning.

CHAIR: Are any of these precursors to what we might see as a problem, not just for the family, but for the community—perhaps not at the time, but later in life?

Dr STARLING: Yes. A lot of behaviour disorders do settle as people mature but the ones that do not would lead to things like antisocial personality and criminality. There is quite good evidence, for example, that if a child has a severe behaviour problem at the age of four or five, that is one of the best predictors of major problems with the behaviour at an older age. Clearly if we can prevent a lot of criminal behaviour, that would have a huge impact on our society. The young people who have major criminal problems are not only a huge drain on society but they are also in terrible distress themselves and do not lead very productive lives.

CHAIR: When behaviour problems exist before young children go to school, what steps are taken and can be taken for such a young age group that would enable them to be managed and to manage their lives better?

Dr STARLING: The best evidence of behavioural problems in very young children is actually helping families to manage those behaviours better because it is comparatively easy, if you have a four or five year old with behavioural problems, to start using fairly simple and kind techniques that can manage that behaviour in a family context whereas once they are a teenager it becomes much more difficult. A lot of this work is supported by the Government and by the Department of Health. Programs such as public-private partnerships [PPP] and other programs which actually teach people parenting skills will help them to manage their children's behaviour. The other perhaps major psychiatric disorders that I have not mentioned which has huge implications for later life are anxiety and depression. It is clearly shown that if you have severe problems of anxiety, such severe anxiety that you have problems going to school, then that leads to problems such as agoraphobia which has a huge impact on work and education in later life. Depression is now considered by the World Health Organisation to be one of the major diseases that impacts on people's social and economic functioning.

The Hon. JOHN JOBLING: Dr Starling, for my benefit as a later member of the Committee than some of my colleagues, could you tell me what percentage of these children might come from what you describe as a basic dysfunctional type of family? In other words, I would just like to check the background of the families.

Dr STARLING: That is a very good question. It depends on the problem. If you are talking about a severe behaviour disorder, then you are quite right—in fact, perhaps even going past a dysfunctional family into a family where there is severe socioeconomic disadvantage. There is often child abuse or neglect and these children often have parents with severe behavioural problems themselves. They may have parents who are criminals or parents with drug problems and then you are much more likely to have a child with behavioural problems. Definitely behavioural problems are strongly, but not entirely—because this can happen in very ordinary families as well—linked to family difficulties and family disadvantage. Problems like anxiety disorder and depression have quite a strong genetic basis to them, so they do run in families. But often we are looking at the kind of very ordinary everyday family that in fact is not dysfunctional but does tend more towards anxiety or depression. So, really, through no fault of their own, there is a bit of a weakness in the same way as a family might have a weakness for heart disease.

The Hon. JOHN JOBLING: If we are looking at maximising the effect of assistance and treatment would we get a better result from directing that more towards the family or towards the children, or does it need to be a composite of both?

Dr STARLING: The younger the child, the more it needs to be directed to the family. If you worked, say, with a four-year-old or five-year-old child without working with the family, that would be an utter waste of time. There are limited techniques for working individually with a four-year-old, obviously. Those of us who have had a lot of contact with four-year-old children would know that. So I would definitely advocate family based approaches. Even with things like anxiety and depression, you would want to be working with families as well, but then the young person would need some help. So it would be more of a composite approach.

CHAIR: Have you had much association with the Families First initiative?

Dr STARLING: I have not worked with it but I have quite a lot of knowledge of it, yes.

CHAIR: Was that done in consultation with the college?

Dr STARLING: Definitely, and certainly with child psychiatric input, yes.

CHAIR: What training do preschool teachers have to recognise these sorts of symptoms early and advise a family to get help?

Dr STARLING: I could talk about teachers in general. I am not sure specifically about preschool teachers. The New South Wales Department of Education and Training, with the school counsellor network, has quite a good system of early identification. So you would be looking at a few key indicators such as behaviour problems, problems with learning and problems with concentration. Hopefully, they would then call in families, or call in parents to express their concern and suggest that something extra should be done about it. The schools themselves offer quite a lot of good programs. Sometimes the children who are missed are the more anxious or depressed children who become withdrawn and sit quietly in a classroom. Often their academic performance goes off and no-one knows exactly why. They do not cause any trouble, but they could be the ones who are harder to identify. A program called SchoolLink is encouraging schools to recognise depression in children and to try to address it at the moment.

CHAIR: We have established through other inquiries that, if a child is falling behind in his or her studies, one of the symptoms from that is misbehaviour at, say, ages seven and eight. What is done when that occurs? Are they taken to child counselling or do psychiatrists and doctors become involved?

Dr STARLING: I am sure that the Department of Education and Training could speak to that a bit more than I could. If the systems were working well, a teacher would talk to a school counsellor who would then assess the child, talk to the teacher, and then usually call in a parent.

CHAIR: What sort of level of training do these counsellors have to recognise and appropriately refer students to the Department of Community Services or to somebody in Health?

Dr STARLING: My understanding is that school counsellors are fully trained teachers with a full psychology degree on top of that. I am talking about the State system which is more informal than the private system. I think they would also have a year's training as a school counsellor. So they are highly trained and they also have regular in-services. It then depends on how well they know their local area and their referral networks. That is usually something on which a lot of their time is spent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Speaking of families and family support, I understand that in the 1970s the child support system was changed. People got welfare but there was not as much support for families. Prior to the 1970s there were fewer families on welfare, but they had a visiting component which then gave them advice. In the 1970s the system changed and more people got welfare as a result of the supporting mothers benefit. However, the counselling outreach service was not available. Do you know whether that is true? If so, has it had any effect?

Dr STARLING: I am sorry, but that is not something on which I can comment sensibly.

CHAIR: Have any of these early intervention programs which are being run by the Department of Education and Training been evaluated to so how many children they pick up? Are the programs overenthusiastic in picking up children, or do they not pick up enough children?

Dr STARLING: They are often evaluated on how they work. In relation to the numbers of children that they are picking up, I understand that Professor Joe Ray, one of the people involved in the big national survey, where the 14 per cent figure comes from, said that it appears as though depression and anxiety are quite frequently missed. The programs that identify those problems in schools and then refer them work reasonably well. That is the group of children that are least likely to be seeing anybody or having any treatment.

CHAIR: Have there been any studies of children to see whether or not the symptoms or the signs that are picked up at the age of five or six are further exhibited if there is intervention or no intervention?

Dr STARLING: Definitely. Most of the problems at five or six would be behaviour problems. Depression and anxiety come a bit later. But it certainly appears that, if you have behaviour problems at five or six, you can predict that those behaviour problems will continue and get worse as a teenager. As adults about half continue and about half improve. Some programs in America have been shown to improve that, but there is a lot of funding involved. You can imagine running programs and then following up somebody for 10 or 20 years.

CHAIR: It could be quite cost effective.

Dr STARLING: Exactly. You will be keeping people in school. They will be not just be happier, healthier human beings; economically they will also be productive.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In an inquiry into early childhood intervention one of the questions that was asked was whether there should there be universal child care to pick up kids who had family problems and give them a structure. What is your opinion on that?

Dr STARLING: Universal child care for every child, or universal preschool?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Preschool or indeed day care. At what point do you think those things should be available?

Dr STARLING: That is a difficult question. I think it depends on your political position as well. I am not talking directly about political aspects, but about what we believe is best for children. In my opinion, children who are at a severe disadvantage would do better if they spent more time in a good child care program that offered education and socialisation. Children who are in good, competent families will do as well, if not better, in those good, competent families with good social networks.

CHAIR: There are fewer and fewer children in families. In 1983 I noticed when I was in China that there was only one child in a family of two or three grandparents and two or three adults. Socialisation now is quite different from what we might have seen 30 or 40 years ago when families might have had six or seven children and they would have been part of a broader family in which there were seven or eight aunts.

Dr STARLING: That is right.

CHAIR: What steps should we take, or can we take, which is what the Hon. Dr Arthur Chesterfield-Evans is leading to, for better socialisation and peer matching?

Dr STARLING: In that case I would have thought that a good kindergarten or early child care program would be excellent. There are also families who are well aware of the problem and who, if they had only one or two children, would have them actively involved at play groups, social networks and with mothers who get together so that the children have a lot of social time together. In a sense there are families who already address this. But I would agree with you that a preschool child spending time solely with adults is not a good idea. Those children tend to enter primary school and have a lot of difficulty managing.

The Hon. JOHN JOBLING: So far the discussion has centred principally on children and families that I might describe as capital city or Sydney-centric. If I am right, most of the practising professionals in your field would be based in the metropolitan area. How do we deal with and identify these problems outside the metropolitan area?

Dr STARLING: I have some experience in that regard because I am one of the co-ordinators of the Child and Adolescent Tele Psychiatry Program. My last trip to the country was Tamworth one month ago and Inverell two months ago. The schools are very good, as they are generally throughout

New South Wales, and they have superb links to local communities. We gave a talk in Inverell and 65 professionals working with children attended. Inverell has a population of about 5,000. There were community service people, teachers and school counsellors. What they make up for in the disadvantage of having fewer professionals is that the community networks are stunning. Often, families who are at risk are almost known to people in advance. Sometimes that creates a problem as well by stigmatising families. Usually, teachers can predict that a child will have a problems much earlier than those problems would be predicted in the city, because a child in the city would be a total stranger to them.

The Hon. JOHN JOBLING: I should, therefore, conclude that the percentage of children in the country with problems will be less than those in the city because they would be identified earlier.

Dr STARLING: Certainly, at times it can be identified earlier, yes.

The Hon. JOHN JOBLING: What do you do with children in the country who have a problem and perhaps the area does not have the structure that, say, Inverell has? How do you proceed to deal with those? What help is available to them?

Dr STARLING: They would still have a school counsellor. Usually, school counsellors in the country deal with more than one school. Their schools could be an hour also or way, which means school counsellors would spend a lot of time in the car and, therefore, less time seeing people. But school counsellors would still be able to identify them and sometimes put programs in place in the school, then refer them, if necessary, to community health centres or other non-government organisations. They would not be able to see as many people.

The Hon. JOHN JOBLING: But it would be highly likely that their training would be fairly light on, if I can put it that way? I am thinking of the country schools I know of where there are counsellors.

Dr STARLING: I could be wrong, but I think school counsellors have mandatory training. They would have the same training, but they may be someone who is just starting out or is filling the position temporarily. I do telepsychiatry consultations over the television screen. Last week I saw a boy from Moree. He is from a school whose counsellor is an acting school counsellor. The counsellor is trained, but she is in her intern year. The school had seven principles in the past six years. In the particularly socially disadvantaged areas there are quite significant problems with staffing.

The Hon. JOHN JOBLING: How would you devise, put in place and see through a treatment regimen for a child with either anxiety symptoms or behavioural symptoms?

Dr STARLING: This is just an example of what I have done very recently. The child's parents, the child, a local community or psychologist, who is very good, and a school counsellor was at the conference. We discussed some more evaluation of him. The school counsellor and the psychologist from the community health centre will start a management program with him and his family.

The Hon. JOHN JOBLING: The program goes into place, but how do you as, obviously, the consultant in the field for that child assess and follow up on that case to ensure that things are improving?

Dr STARLING: With this case I would see them again on the TV screen. It is not ideal. It is, obviously, quite different from seeing someone in person, but it is a significant improvement on not seeing anyone.

The Hon. JOHN JOBLING: Over what period would it take place?

Dr STARLING: This child would probably be seen for several months. As a psychiatrist I would be involved in advising, and the main co-ordinator or therapist would be the community health centre psychologist who is excellent. She is a very competent woman.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a lot of discussion at the early child intervention committee about screening and its cost effectiveness. The general feeling was that teacher training for kindergarten teachers and better liaison was better than having some expert wander through once in a lifetime, as it were.

Dr STARLING: Yes, I would agree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If that is the case, should there be means tested child care or preschool so that the kids most at risk are identified? Assuming that they did not go to either preschool or day care how would they be identified if there is not a screening program? Is it worth having means testing for child care or preschools to get over the problem of richer kids going to child care and the poorer ones not, or richer kids going to the good ones and the poorer kids going to a lady who has kids in the backyard, or whatever? How would you approach the problem?

Dr STARLING: There is another group of professionals who see virtually all children, and obviously that is the maternity hospitals and the early child professionals. That is a little bit earlier on. Quite a lot of research has been done on home visits.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they are babies.

Dr STARLING: That is right. What you will not identify here is, obviously, behavioural problems in babies. What you will identify is indicators in the family that would suggest that those children could have problems later on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, that is what we found in the early intervention committee. The problem was that after the first visit to the early childhood centre those most at risk are most lost to follow up. The big problem was there was a period until they started school when they were not noticed. I presume you would think that the earlier kids are hardwired the bigger the problem. If you get them at five it is a lot worse than getting them at two. What do you suggest could be done to identify this problem?

Dr STARLING: That is one of the bigger, hard questions. Ideally, people would remain involved with the early childhood centre a little bit longer. You would keep popping back, every six months or so, not necessarily for these kinds of check ups but to check the other things you need to check up on, such as that children are growing normally, that they do not have scoliosis and basic health care checks. That would be one way of doing it. Another group of people who see a lot of these children are general practitioners and hospital casualties, but, again, they tend to be places that are very busy and very rushed. They do not necessarily do this kind of work. I think you would find that some of those children at risk would frequently see doctors.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they do not see the same one.

Dr STARLING: No, exactly. They do not see the same doctor because with our current system, and it is very useful if you need to see a doctor because you turn up with your Medicare card and you see a doctor, these kinds of families may see 10 different doctors in a month. Again, the doctor will not see enough of the child to notice that the child is at risk.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense we are very macro in our view. Do you think that means tested child care should be available?

CHAIR: We are done with that one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She has not answered it.

CHAIR: Because she cannot.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not mind if she says that she does not know.

Dr STARLING: I think there are disadvantaged children who are discovered and benefit from subsidised child care, and sometimes community services does that.

CHAIR: They do.

Dr STARLING: They do that quite significantly. But I am not sure that I am qualified to comment in a broader sense on that, I am sorry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When the supporting mother's benefit came in, there were not home visits for families receiving benefits. Do you think it would be a good idea if ongoing family advice through the early childhood centre were not just in a centre but through an outreach facility?

Dr STARLING: Yes. It is very expensive and we would have to look at cost benefit, but a lot of research has been done on visiting at home for everyone with new babies. I know that some people, in a sense, do not need it. But even a family not on welfare, perhaps a mother in a far-flung suburb who has no car and is at home with the baby, employed but on a low income, is probably at high risk of depression and probably could benefit from home visiting.

CHAIR: We will find out a bit more about the Family First program, which has been piloted in a number of areas and which is exactly why are we are not talking about.

Dr STARLING: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your submission you talk about the small amount of spending on adolescent children relative to the amount of mental illness, compared to spending on adults. Obviously, you would like to increase that spending to the same level.

CHAIR: If that is the question, let her answer it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She is going to say yes.

The Hon. Peter Breen: Let us find out. Stop leading the witness.

Dr STARLING: I do not know that it should be the same percentage, but it should be more than it is at that the moment. Clearly, for example, the psychogeriatric population has very expensive needs. Yes, little more than it is at the moment, definitely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The argument in adult health care is how much should be spent on acute facilities and how much should be spent on community-based facilities. At the moment the acute are winning hands down. Obviously, you are working in a relatively acute area. Where do you think the resources should go in this large increase?

Dr STARLING: How big is the pie? I represent a group of child psychiatrists who work across a wide variety of fields. Although I work at a children's hospital, I do telepsychiatry to small rural communities that have no choice but to be community based. Most of my work is outpatient work. Admitting an adolescent as a mental health admission should be done only as an absolute last resort.

CHAIR: What services are required, which is in part of your submission. You notice that there are no acute beds for children, and that all services that need help have long waiting lists.

Dr STARLING: Yes. I am aware that Professor Nunn, who is involved in the Centre for Mental Health is in the audience. A lot is happening at the centre at the moment to address this, and that has changed since our submission was written.

CHAIR: Are there more beds?

Dr STARLING: There is an adolescent ward at Campbelltown that has been opened. It is not fully staffed yet. We are now running into staffing problems. There are problems with finding

staff. A ward at Newcastle is about to open and I think it is fair to say that money has been released four wards at the Children's Hospital at Westmead and the Sydney Children's Hospital. Hopefully, there will be some beds and some money to support children in their local area if they have to be hospitalised in an emergency. Hopefully, that will change.

CHAIR: But Arthur's question is, having opened the beds, how many children's mental health community teams are there?

Dr STARLING: I think that would be more the general concern, that it would be much better to prevent it. Sometimes you have to have admissions, but it is much better to prevent an admission and to keep a child with the family. I would have thought you would need community teams that could have an appropriate waiting list for less urgent cases but if there was a crisis could get to see a child that day.

CHAIR: There is nothing like that now?

Dr STARLING: In some areas they have cobbled things together but in some areas definitely not.

The Hon. AMANDA FAZIO: Would many of the young people that you see with some sort of psychiatric problem be in receipt of any Commonwealth payments, like a child disability allowance?

Dr STARLING: Yes, quite a lot are, depending on their problems. It is less likely to be for depression or anxiety, which does not qualify, it is more likely to be children with other problems such as developmental disabilities, who also have a higher incidence of psychological problems.

The Hon. AMANDA FAZIO: So that children who go along okay for a while and then have more acute episodes, or something?

Dr STARLING: Yes.

The Hon. AMANDA FAZIO: Do you think that the financial burden on the parents of obtaining care and medication for them is causing problems within those families as well, because they would not be eligible for concession cards and reduced prescriptions and things?

Dr STARLING: No, that is right, not unless they are entitled to them for other economic reasons. It depends very much on the family's economic position. If a family ends up having to see a psychiatrist privately, that is a severe burden. I would think it would be ideal if families could access public services, but that is often a problem. If you could access good public services it would not be such a financial burden on the family.

The Hon. AMANDA FAZIO: When families have to see private psychiatrists, who are probably members of the organisation you are involved with, do those psychiatrists bulk bill only if you have a health card or do they bulk bill for the general population if there is a need? I know that is a hard question but you might have a feel for their attitude on it.

Dr STARLING: I cannot say that for sure, I am sorry. It is one of those things that people tend not to be very upfront about. Some people would probably make no concessions whatsoever and others would negotiate and make concessions for people in all kinds of economic circumstances. But generally I would say probably only for people with health-care cards. So, it would be a substantial burden.

CHAIR: The big question of course is how many area health services have a child psychiatric service to offer for the public system at all?

Dr STARLING: If we start going outside the Sydney, Wollongong, Newcastle axis, there is a child psychiatrist in Orange who covers most of the Central West, and a child psychiatrist at Albury, both of whom are part-time private and who do a little bit of public work. Apart from that it is the tele-psychiatry service that is run through our hospitals with the Health Department funds.

CHAIR: So, different from adult psychiatry, children's psychiatry has access to the Children's Hospital at Westmead, at Concord?

Dr STARLING: Yes.

CHAIR: Is there anything in south-east Sydney?

Dr STARLING: No. In terms of community teams the Sydney Children's Hospital would have four or five child psychiatrists who also cover the community health centres. The northern area, similarly, has child psychiatrists. There is a shortage. Gosford has one, for example, for that whole area. The south-eastern would be covered by those four or five people. Central Sydney has five or six child psychiatrists. The western area has asked and also Redbank, and the community centres are covered. Penrith and that area, I think, perhaps has one child psychiatrist a day a week for the whole area, and the south-west has one or two for the whole of the south-west. Even in the metropolitan area there are shortages.

CHAIR: How many of those psychiatrists are supported by community mental health teams who deal with children?

Dr STARLING: Officially a couple, probably.

CHAIR: That is part of the problem.

Dr STARLING: Yes.

CHAIR: If a child is admitted to care—we can come back to the community-based service with community psychiatry—currently I am aware of only two places where there are children's facilities. That is at Westmead—

Dr STARLING: At Redbank House.

CHAIR: Yes, and at Rivendell.

Dr STARLING: That's right.

CHAIR: Are there any others?

Dr STARLING: There is Coral Tree at North Ryde and its family assessment as a day program.

The Hon. PETER BREEN: Are there any facilities in the prisons for children, in the youth detention prisons?

Dr STARLING: Yes. In fact, I have some personal experience, as I used to consult to Yasmar. All of the juvenile justice centres have a visiting child and adolescent psychiatrist. Usually it is a small amount, like half a day a week. They also have psychologists and drug and alcohol councillors. So, they have quite big mental health systems.

The Hon. PETER BREEN: Are they comparable to the mental health systems for adults? The numbers are similar, are they not? The number of children to have mental problems is the same as the adults, roughly?

Dr STARLING: Yes, similar. Thankfully there are a lot less teenagers in detention than there are adults. I think perhaps the adult system has more treatment, like it has a Long Bay ward. It has more specialised treatment and more acknowledgment of those kinds of problems. There are staff in juvenile justice who would look after young people but certainly the mental health problems of young people in custody are enormous.

The Hon. PETER BREEN: Do they grow out of them?

Dr STARLING: From my memory, if you have one period of incarceration in juvenile justice, 50 per cent will not reoffend. No, sorry, 50 per cent will not end up in incarceration again, which is actually not too bad.

The Hon. PETER BREEN: That is 50 per cent of the total number?

Dr STARLING: Fifty per cent of the total number who go in once would only go in once. Some go in again, and then there would be a small a group who have repeated offences, who will probably go on to become recidivists.

The Hon. PETER BREEN: Is there any connection, though, between those who are recidivists and mental disorders?

Dr STARLING: Yes. There is actually quite a high one. A psychologist I work with called Angela Dixon has just looked at young women in custody. Ninety per cent of them would have drug and alcohol problems, and the ones who go on to reoffend are the ones whose drug and alcohol problems fail to be treated and usually they are the ones who have had such poor early lives, such bad abuse, neglect and memories of trauma, because they usually come from very nasty circumstances. So, it is very difficult for them to give up drugs and alcohol because they are such disturbed young people that they feel a lot better when they are out of it. They are the group who go on to reoffend and reoffend.

CHAIR: I wonder if we can just get through this business of acute admission. Section 3 of the New South Wales circular that came out in 1990 on the child and adolescent mental health policy says, "Specialist units for adolescents aged 12 to 18 should be available as an area of responsibility." Is the admission of children under 18 to acute general hospitals a regular occurrence in New South Wales and, if yes, are these patients at particular risk?

Dr STARLING: I think yes to both. They are at more risk, obviously, the younger they are. It is not good for a 17½ year old to be with adults, but it is extremely dangerous for a 14 year old to be with adults. A mentally ill young person is a very vulnerable young person. A lot of the adult units are admitting young people out of desperation because there is no other choice. The adult units almost have to be thanked for doing it. The very good adult units would provide a special for those young people to keep them safe and to protect them. So, they have they one-on-one care but it is still by no means ideal and those people's developmental needs are not being met.

CHAIR: Would many of them be admitted to a children's ward in a general hospital rather than to a mental health ward?

Dr STARLING: You do that as much as possible. The hospital I work at has an adolescent ward and a general medical ward. At the moment probably more than half of those beds are taken up with young people with psychiatric illnesses. Anorexia nervosa is very common and that needs medical backup, but I recently had a young woman with schizophrenia in a general ward and people who have had serious suicide attempts. It is often very good because it reduces stigma and it is better for them but the young woman who was harming herself, it was quite difficult to stop her from harming herself because she was just in a normal ward. Even though we tried to keep her safe we had to try to stop her hurting herself and it meant we had to give her quite a lot of sedation to do that, because we could not shut any doors on her, the hospital is not set up to do that.

CHAIR: So, should facilities be available for mental health nurses for the care of children at least in one area in each area?

Dr STARLING: Without a doubt, I would agree.

CHAIR: For example, if I go to Lismore, Orange or Dubbo, it does not matter, they all have children's wards.

Dr STARLING: Yes.

CHAIR: They all have communities of 50,000, 60,000 minimum, perhaps 250,000, where there would be the need to admit the odd child for either assessment or stabilisation of medication or whatever.

Dr STARLING: Yes, true.

CHAIR: How many of those would have trained mental health nurses to support the care of those children in those hospitals?

Dr STARLING: I am not sure. I would not have thought very many. There is the new CAMHSNET scheme, which is the child and adolescent mental health network. That is going to provide significant amounts of funding to have places such as Lismore and the bigger regional areas such as Tamworth where the beds could be used if necessary for young person even with a parent with specialised nursing care. That is going to mean setting those up, and the areas are very supportive for setting them up and training suitable staff.

CHAIR: Currently the acute beds at Redbank House are fairly specialised, are they not?

Dr STARLING: I understand they are designed for young people with serious mental illness who are under a schedule and who can be legally put there and locked up. They are very specialised. Also, with nine beds for the whole State, clearly you will have major problems getting anybody into those beds.

CHAIR: What is the waiting lists for them?

Dr STARLING: Again it is difficult for me to speak for them. Sometimes you are lucky and they have a bed immediately. That would be unlikely. Usually they can find you something within four or five days but sometimes it is three or four weeks.

CHAIR: How many beds are open there?

Dr STARLING: In the acute unit there are nine beds.

CHAIR: How many of them are open?

Dr STARLING: All of them.

CHAIR: That is it for the whole State?

Dr STARLING: There is also a new unit at Campbelltown which I think has 10 beds.

CHAIR: Is it open?

Dr STARLING: Only three of the beds, to my understanding, are open, for staffing reasons.

The Hon. PETER BREEN: You said earlier that there might be a reluctance to make psychiatric diagnoses for young people. Could one reason for that be the lack of beds?

Dr STARLING: Maybe the lack of services in general perhaps. You are quite right. The lack of beds would probably be a reason why a young person might turn up to hospital in my opinion or in your opinion very unwell, and people might say there is nothing wrong with them, and perhaps because with the best intentions they try not to admit them, they do not think they are sick enough to go into an adult hospital, which means they have no services, yes.

The Hon. PETER BREEN: But is there a general reluctance in the profession to diagnose young people as having psychiatric disorders?

Dr STARLING: I think it is something you have to do very carefully. You are always best at what you specialise in and adult psychiatrists would often say they are just normal teenagers.

The Hon. PETER BREEN: That is the question. I think I asked you earlier whether they grow out of it and I do not think you answered that question.

Dr STARLING: If we are talking about illnesses like schizophrenia or severe depression, they do not, they keep coming.

The Hon. PETER BREEN: What about psychotic episodes?

Dr STARLING: Psychotic, no, they keep coming as well.

The Hon. PETER BREEN: Even into adulthood?

Dr STARLING: Yes. If you have one serious psychotic episode, you have a 90 per cent chance that you will have others. Only 10 per cent of people with a psychotic episode will have only one in their lives. If you have an episode as a teenager and you are told there is nothing wrong with you, go away, you are missing the chance to treat them early. The second episode when it happens will probably be worse.

CHAIR: What about the treatment of things like personality disorder, PDSD, all those things that follow major assaults or rape or whatever in children? Where are those services?

Dr STARLING: Some of those children are seen by specialised, for example, sexual assault services or the START services for the victims of torture and trauma. Also, the general community services would be seeing a lot of those children. Sadly, they are quite common things, so a good general community child and adolescent psychologist or social worker would be able to work with those kinds of people.

The Hon. AMANDA FAZIO: Given that people are often reluctant to say to an adolescent that they are schizophrenic, they are a manic depressive or bipolar, whatever, do you think it would better if it was recognised that with young people with behavioural problems—and that would cover some psychiatric problems—that that sort of label could be used and that perhaps the benefits available—I am just concerned about the cost—to kids with severe behavioural problems who get the child disability allowance could be a category so that they can have financial support and assistance for their family to help them?

Dr STARLING: I am strongly in favour of people with severe illness having financial support but I am not sure that giving somebody financial support necessarily leads them into treatment. In fact, my experience is that young people with severe mental illnesses usually know that they are unwell. I would actually say to a young person, "You are hearing voices. I am wondering if your thinking is a bit scrambled." I would talk to them about psychotic illnesses because the stigma in psychiatry with teenagers is a lot less than it is with adults. If you have ever seen *Girl, Interrupted* or the movies about psychiatric illnesses—I have teenagers come to see me and bring their friends to meet their shrink.

CHAIR: Because they recognise it.

Dr STARLING: They recognise it. Some young people deny but most young people recognise that they are unwell, and as long as you are straight with them and you are not nasty about it or judgmental, they will accept that they are unwell. Sometimes it is harder for their parents to accept, but I would tend to be very direct with young people. The other thing is that if you are direct with them, they then understand that you are not trying to trick them. Once you have tricked them, they become very unhappy with you, which is very reasonable. Some of the severe behavioural problems, which also need help, are often very difficult. A very healthy normal young person who has become very depressed will not be very impressed if you tell them that they have severe behavioural problems because, in fact, they do not. They are emotionally very distressed.

The Hon. AMANDA FAZIO: Following on from a question asked earlier by the Hon. Peter Breen about the juvenile justice system, I think you said that 90 per cent of girls in the juvenile justice system who reoffend have a mental health problem. Do you think there are adequate linkages between the juvenile justice system and outside community health resources when those young people are

released? If you could ignore the financial considerations, what would you see as being the best way to try to link those people into services not so much to stop them from reoffending but to give them support to manage in the community?

Dr STARLING: Ideally, before someone leaves the juvenile justice system they would be linked in with the local community support people. I agree with you that it is a huge problem. There are some community juvenile justice systems but people are usually in juvenile justice for a period of time. Often they go to court and they are released on the spot, and the plans for their discharge and for looking after them when they leave just disintegrate. They disappear, and they are seen again when they reoffend. I would agree with you on that one.

CHAIR: Are you aware of the program in Port Macquarie that looks at young people going before the courts and linking them into a whole range of people?

Dr STARLING: No. That sounds like a very good idea, though.

CHAIR: That system?

Dr STARLING: Yes.

CHAIR: In the same way as there is a forensic service for adults, is there a forensic service for children?

Dr STARLING: In the community?

CHAIR: Yes, forensic advice to the courts and so on.

Dr STARLING: Yes, definitely. There is a whole juvenile justice network in the community. Part of the problem though is that often the young people are very mobile and the juvenile justice centres are a long way away. A girl from Moree who offends would go to Sydney. She is in detention in Sydney. She may well be put on a bus back to Moree and she virtually disappears. The Moree people may try to find her but by then she may have come into Sydney again with friends. They are a very mobile population. Another thing is that often the severe reoffenders have no family or no family well enough to look after them.

The Hon. JOHN JOBLING: Does that lead you to the situation that the so-called paper trail or paper records are not keeping up if you move from Moree to Sydney and back to perhaps Bloomfield? Is that also part of the problem that might well be causing these people to fall through the net or get lost?

Dr STARLING: Perhaps. Definitely, they are difficult people to track. I am not sure if partly though—this is not the mental health population but more the juvenile justice population—they perhaps sometimes make themselves difficult to track. Perhaps you have an offence and you will be lucky enough to be let out on bail. You may consider that it is a good decision to move before your court case. So they are hard people to track almost.

The Hon. JOHN JOBLING: So when they are picked up in the system, for whatever reason, I can understand that part. I am just concerned that, as you said, in Sydney you may see one of 10 doctors in a practice and a different one each time. If there is a mental illness that can be picked up quickly enough, you do not have to reinvent the wheel?

Dr STARLING: That would be ideal. There are significant implications for privacy on that.

CHAIR: The unique patient identifier and the large amount of money that New South Wales Health is proposing to spend—I think the figure is $450 million—that electronic record will have the immediacy, hopefully, and also the privacy protections that are required.

Dr STARLING: Yes, that would be great.

CHAIR: But that is a way off yet. Is there anything that can be done in the meantime?

Dr STARLING: I suppose that before that is done it would be a matter of the people who do see them making perhaps more of an effort to, if they know they are moving on, to try to hand them on to somebody to make contact with that person and help make it a lot easier for the young person to see somebody, rather than just giving them a phone number.

CHAIR: Does the legal service help you in this regard to find these people—the legal aid teams who have to support the children going before the courts?

Dr STARLING: I cannot speak for legal aid. I would have thought there are other issues that the legal aid people perhaps that would make them unwilling to help us track down some of our clients. That would be my guess.

The Hon. JOHN JOBLING: Can I draw from what you are saying to me that most of your professional colleague are sufficiently busy that having seen the patient the ability to continue to pass on or track is not being dealt with particularly well with sufficient rigour by your colleagues? Is that a fair conclusion to draw in the average case?

Dr STARLING: I think so. We make an effort sometimes to actively follow up people. In a sense, you are right. There are time issues about that. If someone does not turn up and I maybe ring them up or write them a letter and they do not turn up again, they get lost in the system. If they do not want to see me, unless they are seriously mentally ill and they are a danger to themselves or to others, in a sense it is their right not to see me. So there are some difficulties with actively following up people but I agree that it should be done more often.

CHAIR: We have seen some startling evidence about child abuse and the way in which DOCS does or does not handle the matters. Is that the same problem in children's mental health? In other words, the number of people who come to your attention or the attention of the mental health teams are simply not able to the followed up because there are not enough staff?

Dr STARLING: Especially in the more disadvantaged Sydney areas and in rural areas, that would certainly be the case. If you are in a rural area and you are the only mental health worker for children in a 50-mile radius, actively following up one family might take you many, many hours and then there are other people you cannot see so it becomes an issue of prioritising, certainly.

CHAIR: I know that the national mental health plan funds the child psychiatrist visiting Lismore. These are only five-year plans. Your concern is that when they stop some of the initiatives will stop or be handed back to the States and the States will not pick them up. What evidence do you have for that concern?

Dr STARLING: I suppose there are always pressures.

CHAIR: I understand that there is pressure but I know that the mental health plan is an agreed plan signed by all the Ministers so it is a co-operative plan. The Commonwealth put some money up front to initiate some services. I assume that they will be analysed and assessed to see if they work?

Dr STARLING: Yes.

CHAIR: If they work, I do not think the money will disappear.

Dr STARLING: No. One hopes that the Commonwealth would keep funding it, which would be excellent.

The Hon. JOHN JOBLING: The question perhaps more easily put is: Can you explain to us your reasons for the fear that you expressed?

Dr STARLING: It is just that often it is not even a State-Federal issue. Perhaps it is that often special programs get swallowed up, and sometimes they get swallowed up by area health services—

CHAIR: And then they drop.

Dr STARLING: And then they drop. For example—this happens with State and Federal governments—you find an excellent initiative and you provide a certain amount of money to fund that initiative, and the area says, "We need money in such and such" and the money slips sideways. I think there has been a lot of work done in actively pursuing some of the money in the State Government recently, and we certainly support that continuing as an initiative.

CHAIR: We have that evidence for adults as well and the accountability of the centre for mental health in terms of the money, which they do not have access to. We will certainly ask Professor Raphael about that.

Dr STARLING: Yes.

(The witness withdrew)

GEORGIE MARIE FERRARI, Executive Officer, New South Wales Association for Adolescent Health, PO Box 341, Leichhardt, and

MARGARET PEARL VERATAU, Private citizen, XXXXXXXXXXXXX, affirmed and examined:

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

Ms FERRARI: Yes.

Mrs VERATAU: Yes.

CHAIR: Ms Ferrari, would you like to make the submission tendered in your name part of your evidence to the Committee?

Ms FERRARI: Yes.

CHAIR: If at any stage either of you should consider in giving your evidence that in the public interest certain evidence or documents that you may wish to present to the Committee should be heard or seen only by the Committee, the Committee will be willing to accede to your request. However, I must warn you that the Legislative Council can vote to overturn that decision and make your evidence public. Would you like to make an opening statement about your submission?

Ms FERRARI: The association is concerned that the opinions and experiences of young people are presented and heard at all levels of society and government. You will appreciate that on issues such as mental health it is important to ensure that the experiences of mentally unwell young people are presented appropriately. Hence we did not feel it was appropriate to bring a young person to an environment such as this. That is why we are pleased to have Margaret Veratau with us today to present the experiences of her family with these issues. In preparing our submission we also gained, through the use of focus groups, the experiences of young people. We also went to our membership organisations and to youth health organisations that we work with directly in putting together our submission.

CHAIR: I am astonished that so many organisations have worked so hard to make what appear to be fairly straightforward submissions but which I know have been negotiated. How many organisations are you associated with?

Ms FERRARI: About 100 organisations, individuals and other peak bodies are associated with youth health. You will appreciate that the youth health sector is not huge; it is not like the mental health sector, for example. It is a much smaller sector in terms of direct service provision to young people in the health area. However, I was overwhelmed by the number of people who got in touch with me when I said that we were making this submission and sought their feedback and input.

CHAIR: We are very thankful for that, and thank you for the submission. Would you like to make any other comments about your submission or the terms of reference of the inquiry?

Ms FERRARI: The issues that we would really like to raise—perhaps we did not raise them as firmly as we could have in our submission—are homelessness and accommodation; the need for increased funding for a range of services; the integration of care, including care around discharge planning for young people; the need for a wider range of services for young people, including non-clinical services and community support programs; and the need for more mental health promotion and awareness.

CHAIR: You heard the evidence of the child psychiatrist this morning. You comment in your submission that services battle against inadequate funding, responding to young people with increasingly complex lives and issues while trying to prevent negative health outcomes from things such as substance abuse. Would you like to enlarge on that comment?

Ms FERRARI: Certainly. That comment was made by a youth health service manager on the Central Coast who, as he said, is very familiar with his environment, the demographics and the problems that young people present with but who is increasingly frustrated with the lack of support—not only financial resources but other resources—at his disposal to work with these young people. We are seeing an increasing incidence of mental health problems coexisting with drug and alcohol problems. Margaret has had first-hand experience of that.

CHAIR: Mrs Veratau, would you like to outline your experience briefly?

Mrs VERATAU: I have a son who is now 20 who was admitted to Westmead psychiatric acute unit. He has been associated with marijuana use and a major issue for us as a family is that he is often not well enough to be at home but he is not sick enough to be in hospital. For four years, despite a lot of trying, we have not been able to find any suitable accommodation for him. I finally got him into an adult psychiatric home that was very unsuitable for a young person—it was the only place that I could find—but they demanded absolutely and utterly that he did not smoke marijuana. But the fact is that a very high percentage of young people presenting with psychiatric problems are using marijuana and/or alcohol. In New South Wales I am aware—Georgie could confirm this—of no dual diagnosis treatment. There is apparently a project in Victoria, and the Richmond Fellowship here addresses the problems consecutively. You are either a drug addict or you have mental illness but you cannot have both. The reality is that they go hand in hand. While we can sometimes deal with our son, he has no insight into the fact that the marijuana is probably causing his psychotic episodes.

CHAIR: We have identified the problem of health funding for drug and alcohol problems in one pile and then money for mental health in another pile. That does not meet the significant combined problem. What problems have you had accessing care?

Mrs VERATAU: I reiterate that generally for four years we have not been able to access that. At this very moment I have my son living with his biological father up in Papua-New Guinea in a village. They could not cope any longer. He has come back here. I have got the support of the early psychosis program at the Prince of Wales Hospital in the southern district, although I am not really entitled to access that because I live in Paddington and I am out of the area. That is another big issue. You have to swap around. These kids are moving from one place to the other and they just dump them because they are not in the relevant area any more.

CHAIR: I am sorry, but south-east Sydney covers Paddington.

Mrs VERATAU: No, it does not.

CHAIR: Trust me. South-east Sydney is right smack dab in the middle of the South East Sydney Area Health Service.

Mrs VERATAU: You have Darlinghurst, and perhaps I am saying the wrong names, but Paddington does not fit in with the program from the Prince of Wales Hospital. It definitely does not.

PROFESSOR NUNN: It is an area boundary.

CHAIR: It is inside the South East Sydney Area Health Service boundary.

PROFESSOR NUNN: But it is an area boundary. That is what she is saying. There is a boundary between them.

CHAIR: You are saying that the South East Area Sydney Health Service has split itself up into boundaries for mental health care. Is that your understanding?

Mrs VERATAU: Well, definitely I know that my son cannot access the Prince of Wales Hospital's program.

The Hon. PETER BREEN: Where does he have to go?

Mrs VERATAU: He has to go to Darlinghurst. If he is sick and he is psychotic, he has to go to Caritas at St Vincent's.

CHAIR: We will get that clarified by Professor Nunn who will follow you, but this is extraordinary.

Mrs VERATAU: That is genuine. It is definite that he cannot access it. He cannot get any treatment and I can give you some examples. My son has been on a community treatment order which means—because of his violent behaviour and because he went to court, he was placed on a community treatment order—that he has to have an injection every month, by law, and if he does not have that, the police can be sent. That would be a worst case scenario. He never had a case manager. He had nobody from mental health, yet mental health had designated that he must have that injection. I would personally go through the trauma of trying to get my son to come, crying and screaming that he did not want this injection.

The Hon. PETER BREEN: What was the injection for, do you know?

Mrs VERATAU: It was a depo-antipsychotic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Modecate, presumably.

Mrs VERATAU: Yes.

CHAIR: You are saying that he does not have a case manager.

Mrs VERATAU: Yes, but he is no longer under that treatment order. When that treatment order finished, that was it; there was no more treatment. He has no medication under that.

CHAIR: When you try to access care when he goes off, so to speak, how did you find that when he was younger? I am not talking so much about now.

Mrs VERATAU: When he was younger, as a parent I knew nothing about mental health whatsoever. I just sensed that there was something very wrong with my son. I rang around all these places that I had heard about, and maybe he was smoking marijuana or maybe he was not. I finally got in contact—once again, not with the Prince of Wales Hospital who said to me, "We cannot deal with your son. You live in Paddington. You have to go to Caritas." They have what they call the People in Early Psychosis Program as well. I got very, very good help from them for the first 12 months. They recommended that my son go out to Westmead psychiatric unit. He broke out of the hospital within hours. He smashed a window, broke out and came home and said that I needed my brains blown out and that he would do that. I called the police because I felt that the threat was genuine.

He was taken to Caritas by the police. Prior to going to Westmead, he had already seen somebody at Caritas being harangued and medicated. He went there and the person who had admitted my son was on leave. The director of the hospital said, "No, I am not going to re-admit your son to Westmead. I do not think he is sick enough. I am not willing to do that to an adolescent child." I said, "Well, what do I do? Are you saying that my son will not hurt me?" He said, "No I cannot guarantee that, but I am not going to reschedule him." So we had our son, on the recommendation of the other doctor, out on the street. He is just about to turn 16 and he was sleeping in what he described as a cardboard box because we said, "You need to go back to hospital." That was my original encounter. We got help there for about 12 months and then he became too difficult. At 17, he was just dropped and he had no more help. We have never had housing. I have tried. You can see that I am a reasonably articulate person. I have tried and tried to get accommodation for my son where he will be supervised and not get into harm.

CHAIR: Well, he must come to the attention of the police from time to time. What happens then?

Mrs VERATAU: He has. He is on record there. We have a policeman in our area—at a very compassionate young policeman who is a youth liaison officer—and I have often dealt with him. My son one day said to me, "Mum, will I go to gaol?" I said, "Why, what has happened, Robbie?" He

said, "The police came and got me at the pharmacy." I said, "Why? What happened?" He said, "I took a bandage from the shop." I said, "Well, Robbie, why did you do that?" He said, "My leg was hurting, Mum, and I did not have any money." I said, "Well, you cannot do that. What happened?" He said, "The police came and took me to the police station, looked me up on the computer, and took me home." So we do have some very good young police officers working in that area but the older ones would not be like that.

The Hon. PETER BREEN: I would be interested in hearing your experience with this dual diagnosis problem. There is one group of people who say that if someone is sick, they should be treated regardless of whether they are sick as a result of a psychiatric condition or whether it is brought on by using drugs. There is another group of people who say that unless people stop using drugs, they cannot really say whether it is a genuine psychiatric condition. Do have an opinion about that or an experience that you would like to tell us about?

Mrs VERATAU: I certainly have an opinion. It is a very difficult issue and you will not get anybody concurring in the medical profession or outside. We have just been discussing this. There is a huge, huge association with marijuana use and psychosis. Nobody will deny that, but when I suggested that perhaps my son developed a psychosis because he used marijuana, people said no, not necessarily because we have not got an increase in schizophrenia in our society. If the presence of marijuana is a factor, then you would expect an increase in schizophrenia, but I personally would actually like to get involved in some sort of research to refute that. I heard the conversation in which it was mentioned but people are very reticent to diagnose somebody with schizophrenia because once they are labelled with that, they are stuck with it. Basically with the World Health Organisation [WHO] definition of schizophrenia, within six months you will never be labelled with schizophrenia anyway. Do the doctors who are here agree with that?

CHAIR: Yes.

Mrs VERATAU: So there is definitely an association, without question, of marijuana use with psychosis, but whether marijuana actually causes a psychosis is a topic of great disagreement because there is not evidence to show that that is true.

The Hon. PETER BREEN: What do you say to people who will not treat someone while they are still using marijuana or some other drug? What do you say to that?

Mrs VERATAU: I have not had that experience but when my son first went to hospital I had doctors telling me that there is nothing wrong with my son and saying, "Get him off the drugs and he will be fine. He is not psychotic." But in fact, if you take the Diagnostic and Statistical Manual of Mental Disorders [DSM] definition, his criteria would not meet "psychosis". There is very much a controversy right across the board throughout mental health about which one is causing what and whether people should treat it. People do have that experience. There is no question of people being told, "I cannot treat your son because he is using drugs."

Ms FERRARI: I think that that line of care is very problematic for young people particularly because they are poly drug users. They are not just using cannabis. There is a whole range of other drugs that they may have access to throughout their mental illness, perhaps through self-medication or perhaps not—who knows? I think there is a whole range of factors behind that, but I think it is very unrealistic to say, "We will not treat a young person who is using drugs for any mental health problems that they may present with" because most young people who are mentally unwell are using some form of drugs. That means that most young people who are mentally unwell will not be treated for any mental illness and will miss out. We will not be treating these young people with anything.

The Hon. PETER BREEN: Better to be stoned than mad—I think that is the expression.

Ms FERRARI: Absolutely, and a lot of the young people see it that way. They would rather have the stigma of being a junkie than the stigma of being a psycho, to use language that they have said directly to me.

CHAIR: The issue of whether or not marijuana causes psychosis is one issue, and whether or not it causes long-term psychosis is a different issue.

Mrs VERATAU: Yes.

CHAIR: But certainly people who have psychotic illnesses also use drugs as part of their own response to being mentally ill.

Mrs VERATAU: Yes.

CHAIR: But if somebody turns up and they are psychotic, not under proper care and control and are a danger to themselves in terms of their reputation and finances, et cetera, they are still not mentally ill until we have excluded the drugs. This is part of the problem. That is the definitional part, and that is the part that you get to force people to have that treatment—"You cannot have treatment unto you take the drugs away." This is part of the real issue of separation of the two buckets of money, if you like. Until somebody is mentally ill without the drugs, they cannot come under the Mental Health Act. This is a problem that many parents and many relatives face in dealing with their son, daughter, husband, or brother, et cetera. We have to try to sort that one out as part of this inquiry. It is certainly a big issue that has been identified in the current changes to the Mental Health Act in Britain.

Mrs VERATAU: It is a major issue because they are separate and they need to be together. They have to be worked out hand in hand.

The Hon. AMANDA FAZIO: You have told us about problems that you have encountered in trying to get treatment for your son over the past six years or so. What services would you like to see made available? What difficulties that you have encountered do you think would be easily changed, so that families with a young person who has psychotic problems like your son's would be able to get treatment and a more immediate response?

Mrs VERATAU: I think the major issue is appropriate accommodation. It is a huge stigma and a refusal to acknowledge that they are unwell at that age. They are adolescents and so you have got that problem of adolescents in the first place. It is that need to be supervised. My son's future quite genuinely at the moment, unless we try to support, support, support, is in doubt. He cannot manage money at all, and even if he was on whatever, he would have to be given money each day. He cannot manage and you have to remind him even to wash himself and eat correctly. There is no way that he could go into Housing Commission accommodation. He needs to be in a home and there are many young people like him who have appropriate supervision where they do not feel stigmatised and where they can actually sometimes do part-time work whenever that would be possible. At the moment, he will be one of those people who is out on the street and the other alternative is that he is going to go to gaol.

The Hon. PETER BREEN: Has he being to places such as Odyssey House?

Mrs VERATAU: No, he has not been to Odyssey House.

The Hon. PETER BREEN: I think you have to be off drugs to go to Odyssey House.

Ms FERRARI: This is one of the problems that we face all the time in dealing with this issue. Even the youth refuges will have a zero tolerance policy of drug and alcohol abuse which I completely understand because they have other residents in there as well and they need to consider safety, not only of their staff but also of other residents in there. There are very few secure housing units or places where young people can go and who are either mentally ill and/or drug and alcohol users.

The Hon. PETER BREEN: Is it your experience that these institutions are becoming less and less tolerant of drugs? For example, I think that Odyssey House used to have a policy that they would treat people even if they were on drugs, but then it was changed.

Ms FERRARI: Yes. I think that the growing zero tolerance message is perhaps pervading throughout, but I think that the safety of workers and other residents was a big concern for a lot of the management committees. They are all small non-government organisations [NGOs] or supported

accommodation assistance programs [SAAPs]. They have management committees that are concerned for the welfare of the other residents.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Zero tolerance is, shall we say, a philosophical fashion that has been influenced probably by American approaches.

Ms FERRARI: Certainly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To what extent do you think that zero tolerance in residences is influenced by American dogma? How much is it influenced by real experience, and how much do you think that legal liability influences it?

Ms FERRARI: I think it is probably a combination of all those things that come into a pervading zero tolerance message and I think it is talked up, certainly in literature from the United States, as really working. I do not know that it does work with adolescents because it sends a message that if they stuff up once, they are out, and it does not take into account the concept of relapse which is a very common concept and now generally recognised around the world in terms of addiction therapies. Relapse is a natural part of a natural stage of becoming well again. If young people are told that they have one chance and that is it, and that they are out otherwise, that is a very threatening thing to have hanging over them. It will replicate other previous instances of being kicked out and being abandoned or whatever. I do not think it is healthy.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This is a pretty naive question, but how much violence do you think is drug related in refuges? Is it worse with amphetamines than with narcotics, or what is the story? Does that change with the change in drug use patterns?

Ms FERRARI: I am probably not completely qualified to give you an informed answer on that. I know that obviously some drugs bring on more violent behaviours than other drugs. But you should probably talk to somebody such as the Youth Accommodation Association to get a clearer picture.

The Hon. JOHN JOBLING: I wish to explore a little further the comments that you made regarding accommodation. What would you like to see by way of available accommodation for somebody such as your son or perhaps a rebellious teenager who may or may not be using drugs?

Mrs VERATAU: I cannot speak so much about the rebellious teenager, but for those who are mentally unwell a home-type environment is necessary. You would have people in separate rooms in that house, but they would share the kitchen and the bathroom. Depending on the severity of their illness, they would have supervision. In extreme cases some people would need supervision 24 hours a day and some would need supervision on a daily basis. That would ensure that they had a roster and that they did their cleaning, cooking and that type of thing.

The Hon. JOHN JOBLING: I refer to the comment that you made about your son leaving Westmead. How would you ensure that they stayed in that accommodation and that they did not go whenever they did not like something? How would you maximise the benefits for those children?

Mrs VERATAU: It would take into account the different levels of illness. If they are in an acute ward usually they are severely ill and they are quite psychotic. Usually they will be of harm to themselves or to somebody else. If they are scheduled they are in the acute ward.

The Hon. JOHN JOBLING: Let us assume that it is not a patient who has been scheduled.

Mrs VERATAU: They will probably want to be there as long as it is reasonable accommodation. They want that. Mentally ill people do not live on the street by choice; it is just that they cannot organise themselves not to live on the street.

The Hon. JOHN JOBLING: I accept all that. Ultimately, I am getting down to the taking of medication which, in many cases, is a critical factor. The difficulty that has been encountered in many places is that they take the medication for a while, they feel well, and they then decide not to continue

taking that medication. There is no way that we can compel a non-scheduled patient to take his or her medication, and therein lies the problem.

Mrs VERATAU: But if they are supervised you are definitely going to encourage them to take that medication. If they are well enough they will take their medication. If they are not particularly well they will forget. All of us forget to take our medication from time to time, but young people or adolescents who are disturbed need that supervision. That is what they did at one of the adult institutions where my son was placed. They had the medication, the chemist provided them with capsules and they were presented each morning and evening with the medication. These people were adults, but young people probably need more supervision. When they are well enough they will often take their medications. When they do not take their medication they are quite convinced that they do not need it.

The Hon. JOHN JOBLING: That is the conundrum that I am trying to solve. If they are well and they become responsible they probably will take their medication, with some minor supervision. I am equally concerned about what treatment we can give to those who cease to take their medication because they feel well and they believe that they do not need it. What can you do to compel them to take it?

Ms FERRARI: I refer to an experience I had a couple of weeks ago, which might shed a bit of light on this issue. I sat in a room with 14 young people, all of whom had had a lot of experience in the mental health system, both in New South Wales and in other States and Territories. If you walked into that room you would have had no idea that any of them had had a history of mental illness or that they were currently mentally unwell. They were part of a day program which was a drop-in sort of service in south Sydney where they could come and go as they liked. There was a pool table and youth workers with whom they could connect. It was not specifically for mentally unwell young people; it was for any young people, so there was that integration factor. But they had formed key contacts and links with three workers at that service who were there specifically to work with these mentally unwell young people.

They all spoke about the fact that the relationship they had with those workers helped them to stay well. If they rang up and they were not feeling great the worker would say, "Have you had your medication this morning?" They would then say, "Yes, I must take my medication." There would then be in-depth discussions about how their medication was important, even though they were feeling well. That was a model that seemed to worked well for those young people. I went away and I thought about it. I realised that it is because young people want to feel normal. They want to be integrated into normal adolescent activity in society and peer groups. They want to have a sense of being like any other kids.

This South Sydney Youth Service does all those things and meets all those needs. Those young people mix with other young people who do not have a mental illness. They go out on activities on their own and meet with other young people. That sort of mainstreaming is keeping those young people well. They all said, in different ways, "If it were not for this place I would be homeless, I would be on the street, or I would be in prison." That service helps with their accommodation, with employment opportunities, with their pension and with all the things that they need to do to keep functioning in society. It has different levels of support.[1]

CHAIR: Is that replicated elsewhere within the system?

Ms FERRARI: The problem with that is that they have Federal funding to do this project for three years. They have to be evaluated and all that sort of stuff. There is no core central place where you can get funding to provide services like this. There are little pockets. Margaret described what supported accommodation she would like for her son. The Richmond Fellowship at Emu Plains has an adolescent unit that does exactly that—it has different stages of supported accommodation. It has other units or houses across the State for adults, but there is no consistency with that. So if you do not live in Emu Plains you cannot get into that adolescent unit. It is like a patchwork of services and providers.

---

[1] South Sydney Youth Services does not offer accommodation.

The Hon. AMANDA FAZIO: We have had evidence from other people who have come before the inquiry about people with mental health problems who manage to get independent accommodation. They might be living in a boarding house, or whatever, they have an acute episode and they go to hospital. As a result of that they lose their accommodation and their possessions because often they are just bundled up and put out in the street. If they have a pet—often people with mental health problems are quite lonely and isolated so they try to get a pet and form some sort of attachment—they lose all those things.

If young people manage to get independent accommodation and they lose it, that may well result in the long term in them ending up homeless. They lose everything that they managed to get together. Apart from the south Sydney service that you were talking about, which sounds as though it helps people overcome those problems to a certain extent, what community support would you like to see available to stop people losing everything and to prevent them from being doubly punished when they have an episode or their condition becomes worse?

Ms FERRARI: The sorts of services that south Sydney provides could be replicated anywhere. The key thing with that is that one person contact. A young man that I talked to said, "I know that I can ring Suzie at any time of the day or night if I am in a crisis." Suzie would be the person who would go to that boarding house and say, "This young man, who has had to be hospitalised, will be back in two weeks. Let us arrange for his rent to be paid while he is not here." Those are all the sorts of little things that you do not even think about. Somebody who is mentally unwell probably does not have the capacity to think about those things at that stage. It really is about individuals and services looking out for individuals. I cannot see how it could be done in any other way.

CHAIR: So this is the appropriate empathetic case manager?

Ms FERRARI: Absolutely. I do not believe that that necessarily has to be within the health system. It can be equally well managed, and sometimes better managed for an adolescent, in a community environment or an NGO setting because in those settings there is not an association with a hospital.

CHAIR: It could be as simple as a youth worker with no particular training other than being a bit organised and who knows the steps that have to be taken.

Ms FERRARI: Yes, someone who has had some in-service training or some background in and some understanding of mental health and drug and alcohol issues. Most of the youth health workers that I work with have had some of that training, either through TAFE or through in-services.

CHAIR: You talked about young people ending up in adult wards. The alternative would be young people ending up in an ordinary medical ward in, say, St George or Sutherland. Is that alternative acceptable?

Ms FERRARI: That is hard question to answer. I would then wonder whether their special needs would be addressed in that generalist ward. So you would have to measure the harm that could be encountered in that environment against the harm that would certainly be encountered by putting adolescents in an adult ward. Since writing this submission I have actually heard of cases of young people being in adult wards for protracted periods of time. I have heard a few hair-raising stories.

CHAIR: Another important issue is the treatment of PTSD, anxiety disorders and personality disorders, which is not part of the Mental Health Act. They are very unwell but they are not mentally ill. How would that be best managed?

Ms FERRARI: That is a really difficult issue. It must start with GP training. We know that GPs are where young people first present. They will present to a GP before they will go to a youth worker, a guidance counsellor, or many other things. So GP training must be increased around the issues of drug and alcohol problems, mental health and specifically around youth. We also know that some GPs are terrified about treating adolescents, as I think are a lot of the general medical profession. I was talking with Margaret about this before we came in to give evidence.

Mental health and drug and alcohol issues are a problem to deal with. When you have adolescents on top of that it is like a double whammy for the medical profession to work out. GPs have said to me that they are scared to ask young people about the state of their mental health or their drug and alcohol taking in an eight-minute or 12-minute consultation because of the can of worms or Pandora's box—terms that GPs have directly used when speaking to me—that it will open up. One issue is that their Medicare billing will not cover the half-hour consultation that that could stretch to. However, they also do not necessarily feel that they have the skills to deal with it.

CHAIR: Once they have taken that first step of seeing the GP and the GP discovers that there is a problem, if the GP then decides to put them in some sort of care or treatment what happens then?

Ms FERRARI: I know that GPs feel inadequate in their ability to refer patients in a lot of areas. They may know where to refer patients suffering some sort of sexual trauma or something like that. They would refer them to a rape crisis counselling-type centre or service. But patients suffering post-traumatic stress disorder, mild depression or things that are in that grey area, may not be covered by the Mental Health Act. I think they feel a lot less confident about knowing how to treat that.

CHAIR: The Mental Health Act in Brisbane has enabled the establishment of an advocacy service. Do you have a view about what that advocacy service might do and whether it would be of any use? I am talking about a mental health advocacy service. People suffering a mental illness are not very good advocates. Sometimes their relatives are not good advocates either. We need someone who knows the system and who will do the bargaining for them, if you like.

Ms FERRARI: I think that would be of enormous benefit to the medical professionals and also consumers, for want of a better term, who are accessing the system.

CHAIR: That goes to the question of youth workers you are talking about benefits. What sort of professional standards should they have in terms of ethics? Our concern for young people would be that they might be caught up with, in the extreme, a paedophile or something like that; or they might be treated inappropriately by someone and be more damaged than helped.

Ms FERRARI: In the youth health sector everyone has to undergo a police check before working with young people, and the same goes for youth workers. However, it should be noted that I came from New Zealand and no police check was done on me in New Zealand. I could come into this country and I may have a criminal record in New Zealand, but no crosschecking is done. That is a concern. I suppose if I had a criminal conviction you may not let me in any way. I may be able to slip in somehow and start working as a youth worker in another country. But my organisation has looked at a code of ethics for youth workers and youth health workers. It is a complex issue because to sign up or comply you have to canvass a whole range of issues. There are those who are not for it and those who are absolutely pro some code of ethics.

CHAIR: If the non-government organisations were to achieve funding from the Federal Governed the State Government the local government or some benevolent organisation would most of those require six-monthly progress reports on achievement?

Ms FERRARI: Yes, absolutely. Almost all funding agreements that I am aware of, the New South Wales and Federal funding agreements, have quite strict reporting requirements in terms of health outcomes.

CHAIR: The Commonwealth would have an understanding of all these little projects that it runs or the State-run projects. Somebody would give some evidence-based information to say that one thing works and another does not work or that one thing works but costs a lot of money, and that something does not work and it costs a fortune or it does not cost much. Is there a place where a community or a relative might identify a need by looking at this plethora of programs to see what might be appropriate?

Ms FERRARI: It is an interesting question, and I know that New South Wales Health has just funded the Centre for the Advancement of Adolescent Health at Westmead Children's Hospital to do phase two of a comprehensive study across the State. Phase two involves looking at models of the

best practice and evidence of what works in terms of delivering youth health services and programs across New South Wales. I could probably report better on that in a year, once they have done that work. A couple of years ago my organisation wrote a document on models of best practice in youth health that looked at the principles that should underpin how we work with young people.

CHAIR: Could we have a copy of that? It would be worthwhile.

Ms FERRARI: Certainly.

The Hon. AMANDA FAZIO: You said that the South Sydney project is Commonwealth-funded for three years. Do you know which Commonwealth department is finding it?

Ms FERRARI: It is through the suicide prevention strategy. It might be Family and Community Services. That is where funding for most of these projects come from, through either illicit drug strategy or suicide prevention strategy money.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Later we will hear from nurses, but I understand that nursing is now a four-year university course with mental health two years on top of that. People have put to me why anyone would want to be a mental health nurse when they could get a lot more money for a lot less time in a lot of other professions. It was put to us in the DOCS inquiry that a lot of people involved in child welfare had been welfare people. They had learned from life, if you like, without qualification. But that has changed with university-based people coming in. What is the background of most youth workers now? What would you see as desirable and achievable for the future?

Ms FERRARI: The reality is that most youth workers are young people. They would be between the ages of, say, 19 and 26. Some of them will be fresh out of university. Some of them will have psychology or social science degrees of some description. Others will have hands-on experience through their late adolescence or teen years. They may have been involved in user groups and moved through to roles of co-ordinating or facilitating groups. TAFE New South Wales runs youth work qualifications. Many of them are studying for that qualification and working as youth workers, or they have just graduated from the course. It is a two or three-year comprehensive course. It involves work placements and practicals. That would be my preference for where the profession should head, that the majority of youth workers in the field should have recognised, formal qualifications.

That qualification includes work in drug and alcohol, mental health and, obviously, a large amount of work on adolescent development and issues around that. That would certainly be my preference. I want to make a distinction between youth workers and youth health workers because there are youth workers who are working in generalist youth services across New South Wales and then there are 14 or 15 youth health services, most of which are situated within the area health services. You may have heard of High Street Youth Health Service, Harris Park, Traxside in Campbelltown and those sorts of services. I would say that 90 per cent of those workers are professionally qualified in their professions. They will have nurses in those services.

CHAIR: They are almost D and A service, are they not?

Ms FERRARI: No, they are a holistic youth health services. They provide DNA services. Some of them have secondary needle exchange programs, but they provide a range of services and they often have relationships with their closest hospitals, and they may have doctors who come in and do two or three hours a week in the service. They may even have dentists. They will have legal services provided from that centre, and you would find that almost all of those youth health workers of various descriptions, health promotion workers and the like will all have some territory qualification.

CHAIR: The first program was run at Harris Park, was it not?

Ms FERRARI: Yes, High Street was firstly funded as Harris Park, yes.

CHAIR: That has been very successful. Has that been adopted in any other area health service?

Ms FERRARI: Yes, it has, to varying degrees of funding. High Street is very lucky in that it is well funded and well supported through Western Sydney Area Health Service. Others have enjoyed less funding for obvious reasons, just that there is not a lot of money to go around. The funding for that program came through an initiative called the Innovative Health Services for Homeless Youth, through the Burdekin report around homelessness. You may be interested to know that the whole funding program is being reviewed at the Federal level. They are just about to finish writing that up. It can be obtained through Family and Community Services at the Federal level. It would be very interesting because they are looking at best practice and models of best service delivery. High Street was examined, and they did focus groups with lots of young people who were there.

The Hon. JOHN JOBLING: I note in your submission that there is only a small reference, but you express a great concern about facilities and resources available to country youth mental problems. Could you amplify on that? How can we overcome some of the problems?

Ms FERRARI: Whenever I talk about young people and the problems or illnesses with which they are presenting I always say that if the problem is bad for adults who have mental health problems then it is even worse for adolescents who have a mental health problem, then it is even worse if you can imagine that they are rurally based or isolated in the community, and then it would be even worse if you were Aboriginal. It is like these layers upon layers of how it must be if you are any of those categories. We certainly have great concern for the mental health of rural and regional young people in New South Wales, specifically because the resources are where the population base is because that is where the most people are. In rural and regional communities transport is a huge issue. On the South Coast in the Shoalhaven we know that transport for young people to get to the local youth health service, one bus runs once every three hours. If they miss that how will they get there? There are all those sorts of issues. Doctors not bulk billing in small communities is a real concern, so if young people have to present anywhere they will go to the accident and emergency department. Those people may not be either equipped or skilled in how to work with those young people no matter what they are presenting with, whether it is a cold or a mental health problem.

The Hon. JOHN JOBLING: How do we improve access for these people, bearing in mind the accepted break between this side of the sandstone curtain and the other side is about two-thirds urbanised and one-third rural? There is quite a large potential population.

Ms FERRARI: Absolutely. It is a mix of training to up skill health workers in those communities to be more aware of issues surrounding young people, generally around adolescent health and development of the issues, then focus more specifically on issues such as mental health or drug and alcohol issues. Then I would recommend that a lot more mental health promotion be done in those areas with mental health awareness raising.

The Hon. JOHN JOBLING: How would you do that, bearing in mind that a lot of the country towns might have between only 500 or 3,000 people in total? You have a small youth population, but transport is difficult and there is no youth worker. What do you suggest we do in such a case?

Ms FERRARI: There are ways around it and I know that the Southern Area Health Service has employed a fantastic program and, again, most of the money is Federal. It has established a youth health service, or a youth service in Goulburn, which is a multidisciplinary service that involves medical services, education services and legal services in the old courthouse building. They realise that they are attracting the youth of Goulburn, but what about the outlying areas? They went to the Federal Government and applied for further funding, and have received it, to employ a youth outreach worker. That person recently leased a seven-seater van. The centre is providing its own transport to get young people to that service and outlying communities and areas. Again, this kind of work is expensive. It is not cheap. Health promotion work is costly. I can understand why Treasury does not like it.

CHAIR: Equally, the prisons are very expensive.

Ms FERRARI: Yes, and that is the point of Mrs Veratau absolutely.

Mrs VERATAU: That is a comment I have been making. So often I cannot believe that our society cannot see that the cost of having somebody in prison as compared to providing them with support has to be much cheaper.

CHAIR: We visited a prison yesterday and the evidence was that 90 per cent of all women who are in prison have a mental illness or disorder and it was 86 per cent for males.

The Hon. JOHN JOBLING: And or with a drug problem.

CHAIR: Mental illness or personality disorder plus or minus drugs was half of that. The combination was half.

The Hon. JOHN JOBLING: When dealing with the concerns of treatment of serious mental illness your submission states that numbers are often marginalised or trivialised by mental health services. I would be interested to hear you expand on that and perhaps give us examples, regardless of whether they are anecdotal.

Ms FERRARI: Again, it comes down to the lack of awareness of adolescent development in mainstream health care services. A young person may present to a general practitioner, a community health centre or other with some sort of minor illness and it is not deemed to be critical enough or serious enough for her to be referred to any sort of crisis and assessment team or any assessment team at all because they will know that those assessment teams are absolutely stretched beyond coping point any way. If you referred a young person who was, perhaps, exhibiting some concerning behaviour, but was not in crisis or was not psychotic and you referred to a crisis or assessment team of any sort for her to attend, they would send her straight back, probably with a rude letter: Do not waste our time. I understand that because they are stretched beyond capacity.

The Hon. JOHN JOBLING: Have you come across those, in fact?

Ms FERRARI: Because I am not a front-line worker, it is not something I experience on a day-to-day basis but certainly I have had anecdotal feedback from the workers I meet with regularly and talk to often that this is the case. They know it is not worth sending a young person with even pro-dromal behaviours or whatever to those sorts of services. They have to wait until something happens.

The Hon. JOHN JOBLING: In other words, you are becoming reactive rather than proactive?

Ms FERRARI: Yes.

The Hon. JOHN JOBLING: Obviously you raise the question of the divide within the mental health services, where other mental health issues associated with attention-seeking behaviour are not a legitimate concern. Again, is that the same situation or is there other anecdotal evidence that can give us some understanding of why you say that, because it is a concerning comment?

Ms FERRARI: Certainly, and again it relates to a lack of understanding of adolescent development. Margaret's experience was that this may be just attention-seeking behaviour or it is because he smokes marijuana that he is exhibiting these behaviours, rather than having a more in-depth understanding of what was going on. A lot of these things may be put down to adolescence rather than some serious underlying concern.

The Hon. JOHN JOBLING: Could that be said as either a cop out or an incomplete understanding and training in the field?

Ms FERRARI: Absolutely.

The Hon. JOHN JOBLING: Rather than the fact that there is no point in sending them on because they are too stretched and they cannot do anything about it?

Ms FERRARI: I am sure there is a combination of factors at play with that phenomena, absolutely.

The Hon. JOHN JOBLING: Just to help me understand the umbrella you work under, you indicated there are about 80 organisations that belong. Do we have a list of those? It just helps us to understand the breadth from where you are coming.

Ms FERRARI: Sure.

CHAIR: We have had evidence from some of the umbrella groups but also from some of the things under their umbrella, because sometimes they fit into two or three umbrellas.

Ms FERRARI: Yes.

CHAIR: I would appreciate that, if you could send it in.

Ms FERRARI: Yes.

The Hon. AMANDA FAZIO: Have the organisations you deal with commented about having any problems with refugee young people who are exhibiting mental health problems because of the traumas they encountered before they came to Australia, and do you think there is an adequate level of service for those people, particularly given their language skills?

Ms FERRARI: That is a good question. I know that several of the youth health services located in areas like Fairfield-Liverpool and the Canterbury youth health service that is based in Belmore have said to me that is something they are seeing more and more of. They do refer on. I think youth health services are in a good position to know everything in their local area, everything they can refer on, and they certainly do. My understand is that where they do not feel they can work with those young people appropriately or adequately they refer to organisations that work more with traumatised new immigrant groups. I think probably more could be done that is specifically focused for adolescents who are newly arrived.

CHAIR: What about the trans-cultural mental health team, do they do work with them?

Ms FERRARI: Yes, they are an organisation we have an affiliation with and have worked with on different issues. In fact we ran training for our youth workers on female genital mutilation in conjunction with trans-cultural mental health. They do not necessarily see that their expertise is adolescents, so we can work quite complementary to each other in that field.

The Hon. AMANDA FAZIO: At the beginning of your evidence you said there were a number of other areas you wanted to talk about that were not necessarily covered in detail in your submission. There were two of those I was interesting to see whether you had any extra comments on. One was discharge planning and community treatment and the other was mental health awareness and promotion. If you could talk to us about the problems with that at the moment and what you would like to see done.

Ms FERRARI: I think Margaret has probably illustrated pretty graphically the lack of discharge planning that she has experienced, and that is something we have also witnessed. We are not a direct service provider so when parents ring me I know they are at their wits' end because they have probably gone through the phone book and searched and searched. I probably get one or two calls every month from parents saying "Where do I put my child? This is what his problems are and what the issues are. Where do I physically locate him and what supports are there for him?" All I can do is ring around everywhere I can and find out how old that child is and do my absolute best to try to find a place. But if I am getting those calls, and I am at the end of the line absolutely in terms of service provision, you wonder how many other people are getting called and how desperate are those parents. Margaret and I were talking before and, as she said, she is an articulate, middle-class woman. Imagine if you were a single, Aboriginal woman living at Mt Druitt with a mentally-ill young person. How could you access those services?

Mrs VERATAU: I would like to just make a comment, because I found that astounding. The second time my son was admitted to Prince of Wales I was told, "Your son has to leave now, we cannot afford to keep him here anymore. He is still clearly not well and we cannot find any

accommodation. You had better find some somewhere. Can you get somewhere for him?" We were desperate and we felt as a family we just could not have him at home, he was still too volatile. So as a family we finally had no choice, we bought a unit because he cannot stay anywhere, no-one would tolerate him. A landlord would have him out or whatever. That is a genuine situation. It was an absolute disaster. So, from one health area, early psychosis, they demanded, that is all the choice you have. I rang the other fellow from Darlinghurst and he said to me that I could not put him somewhere like that, that we were setting up for total failure. Where do I go? That is my situation even now. Generally, I have no safe place to put my son.

Ms FERRARI: Margaret's son is currently living in a backpackers. So, under the Burdekin definition of homeless, her son is now officially homeless. While he is not on the street, that is the reality.

CHAIR: The other question that Amanda went to, that is the promotion and community education part?

Ms FERRARI: Certainly. One of the groups of young people I spoke with about what they would like to see that would help them to have better outcomes with their mental health, what they said was that they would like more awareness given to mental health illnesses, particularly for young people, that in high schools young people are educated about mental illnesses, that they are told about it and the stigma therefore is broken down. So, they will know about depression and psychosis and they will know what schizophrenia is. Just education campaigns. They were so emphatic about it, they mentioned it probably four or five times in the hour that I was with them, how important it is to raise understanding around mental illness. They said not only for young people who are potentially at risk of mental illness but for the wider community to more broadly accept them and understand where they are coming from.

CHAIR: It occurs to me that young people care more about their mates than perhaps older people care about their friends. They know them a bit better too, they are a bit more intimate with them. If the young person decides that one of his mates is a bit psycho, where do they send them? What would you advise if you were running an education program? You would still have a referral point, a 1300 number or something.

Ms FERRARI: Yes. That would be ideal, some central point.

CHAIR: "My mate's doing this, what should I do?"

Ms FERRARI: Yes. We know through research that has been done that young people will firstly go to each other for advice and support. Then they will go to a parent or a trusted adult. Maybe they will go to a guidance counsellor. Youth workers are down on that list. They will probably go to a general practitioner before that just for accessibility and understanding and awareness of where those people are. It is important that we work out where young people would go and make sure that those people they turn to have the right information, right advice and right knowledge levels to adequately deal with them or refer them on.

CHAIR: Who owns 13HELP, the phone number?

Ms FERRARI: That is a good question, I do not know.

(The witnesses withdrew)

(Luncheon adjournment)

KENNETH PATRICK NUNN, Area Director of Mental Health, Children's Hospital, Westmead, sworn and examined:

CHAIR: What is your occupation?

Professor NUNN: I am a medical practitioner and child psychologist.

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

Professor NUNN: I am appearing as the Area Director of Mental Health for the Children's Hospital.

CHAIR: That is an area health service in itself, is it not?

Professor NUNN: Yes. It has a statewide remit.

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

Professor NUNN: Yes.

CHAIR: Would you like to take the submission you have given me today, which does not yet have a number, as part of your sworn evidence?

Professor NUNN: I would.

CHAIR: If you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. However, you should be aware that the Legislative Council may overturn the Committee's decision and make the evidence public. You heard the evidence this morning of Dr Starling, Georgie Ferrari and Margaret Veratau. Would you like to make any comments on what they had to say, or would you rather simply address the issues as you have in the submission?

Professor NUNN: The evidence I heard this morning emphasised to me the sheer range of representing anything to you accurately. As a clinician—and I am an active clinician—the issues that Margaret Veratau raised this morning are not isolated incidences. They are daily incidences in the life of those of us who are dealing with psychotic young people, and distressing. The second thing is that the points that Georgie made are very real. The distinction between psychosis induced by illicit substances and psychosis that arises so-called de novo is artificial because in young people the tendency to use illicit substances as a form of self-medication is very strong, and vice versa. The induction of psychosis by much of the modern illicit materials is much more effective. Many parents who grew up for instance in the 1960s and 1970s regarded marijuana as a pretty tame substance because what was available at that time was largely cellulose and not much active ingredient. Now, with hydroponic marijuana, people are getting very high concentrations. Anyone who uses marijuana on a regular basis, even in moderate doses, is likely to develop paranoia, depression or certainly profound motivation and concentration difficulties. So I think there is a problem.

The issue raised this morning of withholding treatment of psychosis, if it is in young people, is not only unwise; it amounts to neglecting our duty because you exclude, effectively, 90 per cent of the young psychotic population. Many of them will need to be treated for some time before they relinquish their use of illicit substances. They will need a period of time when they are treated with antipsychotic medication or antidepressant medication, depending on their dominant picture. Dr Starling was right to emphasise that there is in some sense or other someone and somewhere giving some sort of coverage. But I think all of us are deeply aware that the coverage is shallow, the collaboration between multiple agencies is inadequate and the fragmentation of all the different areas working towards the care of these young people needs to be bound together in a much more coherent, effective force that does not correspond with government portfolios.

CHAIR: That is very difficult, is it not?

Professor NUNN: It is. However, we are trying to work on that with the concept of networks. I think the point that Margaret made this morning, the words "out of area"—and in that case it was not even out of area; it was out of the boundary within area—most of the young people we are dealing with, the more disadvantaged they are and the more disturbed they are, these kids do not actually think about which health area they fall within, where their parents happen to be and if their parents happen to be separated. Of course, when they move from area to area privacy walls is a very real issue and material does not pass, let alone between agencies such as the Department of Community Services and Health.

So the information, which is the fundamental underpinning of care, must be coherently gathered together in a way that is likely to serve the needs of these young people, who will not be looking after their own information. And some of their parents are not either. These young people are not going to be able to do it, just as they are not able to regularly reregister with Centrelink. The kids who are really psychotic and whose families are struggling to keep them will not turn up, get their appointment, get their medical certificate, turn up to Centrelink in a consistent way so they will have their supports continually dropped - and what accommodations they have is jeopardized - and there are real initiatives going on with adults with accommodation but very few with children.

Accommodation is an issue about which we are all deeply concerned.

Those are my responses to this morning's evidence.

I have a brief summary statement. Thank you for inviting me to give evidence to the Committee today about mental health. I make it clear from the start that I am focusing on the needs of children and young people and the services that attempt to meet those needs. I have prepared a brief submission in which I try to address the issues of importance in sustaining and developing these services. In summary, the mental health of young people should not be romanticised as normality or dramatised but addressed thoughtfully and strategically. It is about those strategic issues that I would like to talk today. I apologise in advance if I seem to be too far away from the very real issues that Margaret and others talked about this morning.

CHAIR: You are going to talk about framework issues.

Professor NUNN: Yes, framework and structural issues. Mental health problems in children and young people are serious in their nature and extent, especially in the intellectually disabled, those with acquired brain injury and the medically complex. Of special concern to me are those in rural settings and the indigenous population. We have established a statewide network over the past seven years, but it is a very small contribution to a very big problem. Normalisation as a concept has not served us well. I distinguish that from mainstreaming in relation to mental health, especially in relation to the intellectually disabled and those at risk of suicide and drug abuse. We know that normalisation has been ill conceived and has led to a reduction in services. If you normalise suicide and drug abuse, they both increase. They were built on good ideas to reduce stigma, but there has been no significant reduction in stigma and it has caused major problems.

There has also been a failure on the part of my own specialty in psychiatry, particularly child psychiatry, to lead in shaping community awareness and in reconfiguring medicine to respond to the mental health needs of children and adolescents—I go into that in some detail in my submission—in particular as a profession that creates access. There are major structural factors in the administration of government that make it difficult for any government to act effectively. These include the leakage of mental health funds at each level of cascade allocation—I do not think that is anything new but it is important to mention—the competing priorities on area health service chief executive officers' attention and consciousness; the fragmentation of statewide initiatives by area health service structure, even though that structure may have its own strengths; and the very small infrastructure of child and adolescent psychiatry within the medical juggernaut, which when divided by nearly 20 becomes almost infinitesimal.

Within health, although much progress has been made, the fundamental relationship between paediatric and psychiatric services has now become of paramount importance. Referring back to this morning's proceedings, we believe we must use paediatric facilities effectively and support paediatric facilities. If we are to ask them to take children who require more mental health expertise to manage, we must look at ways of supporting them. But at the same time we acknowledge that there are some—particularly older teenagers—with drug-induced psychosis who may end up being able to be managed only in existing adult facilities. Last year there were more than 300 of those. That is not good enough and, bit by bit, that number must drop.

The integration of child and adolescent mental health into paediatrics would, and does, require at this moment in time paediatric leadership to make room for child psychiatry in the bosom of paediatrics and to welcome mentally ill children and their families into our great paediatric hospitals. I believe it is time to end the segregation of mentally ill children from paediatric care. However, child and adolescent mental health cannot be delivered in isolation within health. I appreciate that "whole of government" has become a cliche but we need whole-of-government solutions on the ground. I am not talking about memoranda of understanding or something that has happened within the offices of different departmental members; I am talking about on-the-ground solutions for what I call "multi-portfolio" children.

In my submission I talk about the problems of recruitment, which are considerable. However, all the problems that I mention are tractable. There are solutions, and we have solutions if we have the purpose to pursue them. I reiterate that point because I want to strike a balance between recognising, on one hand, that there are fundamental structural issues and, on the other hand, that they are not infinite issues—they are not beyond the wit of man to solve. We can now see ways of dealing with them. The problems of recruitment are considerable but the principal obstacles lie in the low priority given to child psychiatry in the medical curriculum at medical schools, the college membership training for paediatricians and physicians—that is a broader issue—and the inertia of medical colleges, including the College of Psychiatry, to modify the configuration of training to the mental health needs of the community, especially child and adolescent mental health needs. I do not deny that many good things are done in all of these areas, but the movement on these issues is nothing short of glacial and needs to move faster.

Finally, there are major opportunities to address many of these issues and I believe the current Government is committed to doing that through the newly developing child and adolescent mental health services network. However, no government can act in the absence of community support. The problem with community support is that it is conflicting in its demands. A specific example of this conflicting demand is the problem of illicit drug use and psychotropic medication for children. I detail this in my submission. The community has a very small appreciation of the full extent of the problem facing us. Everyone appreciates it at some level but I do not think anyone is aware of the sheer immensity of the changes in our practice. In child and adolescent psychiatry, the age at which we have been identifying and seeing kids with major alcohol and drug abuse problems has dropped and the rate of psychosis has increased. Margaret's point this morning was absolutely right. People have said that the rate of schizophrenia is exactly the same. However, those rates are determined by excluding drug-induced psychosis, and there is no doubt that drug-induced psychosis has increased. Margaret was astoundingly well-informed about the debate—that is exactly the issue.

On the one hand, there is almost a quiet acceptance of the normality of heavy alcohol use and marijuana use. On the other hand, there is an abhorrence in the community about using psychotropic medication to treat depression and anxiety. A large number of people are quite happy to say, "I don't like it, but young John completely wipes himself out every Friday night. Now he has been prescribed some antidepressants but we can't have that." That is an interesting example. Self-medication is approved of completely within the community among the young but the medical use of psychotropic medication is savaged almost weekly. Of course there is inappropriate medication use and of course there are rogue practitioners who behave inappropriately. But the vast majority of practitioners wait far beyond the time when a young person needs this medication and prescribe it very reluctantly and often in inadequate dosages. I use that as an example of the fact that the community does not always understand that it has mutually conflicting awarenesses.

My aim in giving evidence today is to highlight the fact that the failure to address the needs of children and adolescents with such a long trajectory in the health system would be to fail

fundamentally in our task. At the moment within the allocations there is a tendency to focus more on the 80-year-old with five years to go than the five-year-old with 80 years ago—and that is not to take away from the needs of the geriatric population. If we look at the trajectories—Professor Vaughan Carr from Newcastle has done yearly costings of schizophrenia with and without treatment and they are enormous in terms of loss of work not only of the person affected but his or her family—

The Hon. JOHN JOBLING: Is it possible to obtain those costings?

Professor NUNN: Yes. More positively, my aim is to encourage everyone to recognise that what we do today with our young people—I heard multiple references to this morning so I suspect that I am merely reiterating this point—will determine whether they are hospitalised or gaoled, are unproductive or live productive and satisfying lives. In the most difficult cases we may sometimes offer palliative care. But at the moment psychiatry does not have a conception of itself as providing palliative care. With those brief introductory comments, I am happy to answer questions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I congratulate you on your brilliant political analysis of the situation—if you ever need a job in politics give us a call—accept for the bit about thinking that politicians wake up every morning and think about how they will solve the problems. I had ideals like that once. I agree with your analysis of the difficulties of interjurisdictional or interdepartmental problems. At a mental health level, doctors seem to have a problem with illegal drugs: "Take away your drugs and then I'll talk to you." How can that be addressed? I remember being in casualty and saying, "There's a junkie down the end but I'll sew up this guy first." That is how doctors think.

Professor NUNN: I think the principal of a moral paradigm has dominated us, if it worked, I wouldn't have a problem. I could happily become moralistic; I am naturally inclined to take the moral high ground—my wife tells me that pomposity is my regular stance. The problem is that it just does not work. We must be radically pragmatic and ask, "What are we going to do that will make anything better, whether or not we win the moral argument?" The fact is that we must initiate treatments in a less than optimal situation with the aim of reducing harm and getting things a little closer to where they should be.

In the case of Margaret Veratau's young boy, who was referred to this morning, treatment can be initiated. It may not be as good as it would be without drugs, but it will be a lot better than not doing anything at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What initiatives need to be taken in the profession to get them to cross the border? Presumably they think that self-medicated drugs diminish the power of treatment. That is like saying, "I will not do your coronary bypass until you stop smoking." It is the same mentality only perhaps it is even more so.

Professor NUNN: That improves your figures, no doubt.

CHAIR: It does.

Professor NUNN: It is fantastic for your figures because you just exclude all the people who are non-motivated. I think that is really good if you want to get good figures. On the other hand, if you want to help the people who are there, you have to work out whether that is going to increase motivation in that population. That might be a good strategy in the occluded coronary artery population, but in the population where motivation itself is one of the central targets for the illness, then it does not work. If you decide to have a reading test for blind people or a hearing test for deaf people, then you put in the motivation test for mentally ill people and the people who come up the other side will always do well.

CHAIR: We have had one of the leaders of the field, Professor Webster, talking to us, and we have had Jean Lennane who dealt with alcohol and mental illness. There does seem to be a real problem of getting the profession to take drugs other than alcohol and alcohol as a serious professional interest, and then to get the psychiatrists to work with the same people in the same way as a physician might well work with a cardiologist or with a cardiac surgeon. That just does not seem to happen. Is there an ingrained reason for that?

Professor NUNN: I think there are a number of reasons. The first is that we psychiatrists as a group have become very good at defining what we are not going to do. We build large furrows between us and any other specialty and, of course, the more of objectionable the symptomatology, the more likely we are to dig a deep and terrific furrow. We use the term "personality disorder" and as the late David Madison said, "Who, with any brain disorder you like, has not got a personality disorder?" The word "personality disorder" is just the least helpful term in psychiatric treatment and "conduct disorder" is shortly after it. I think that is the first point. That may be because the boundaries of the wider psychiatry have been drawn, the fear was that you would just get overwhelmed, and I understand that fear. But I think it is better for us to say, "Look, there are all those issues out there. We might not be able to deal with them all", but what we normally do is we build up explanations post hoc for why we are not doing that, such as "They do not respond". Oncologists do not do that, "They are social problems, not psychological problems". I cannot tell the difference, "This is an emotional behaviour disorder and not a psychiatric disorder"—I do not know what that means.

I have been studying in the field for years and years and I do not understand that distinction. Emotion and behaviour are the thing that psychiatrists deal with all the time. I think the other problem is that the drug research literature is dominated by social explanations. Those social explanations very rapidly move into the nature of everything. People believe that when you try to address the problems, you have to try to address the nature of everything. As enlightened as it might be for us to see the connectedness of everything with everything else, it is not actually very helpful if you have to get up in the morning and do something about it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One of the things that struck me when I did psychiatry was the trend toward pharmaco-psychiatry, that is, rather than look at it socially, there is a huge pharmacological company incentive, if you want to call it that, and people do not want to talk to people beyond the initial diagnosis. They say, "Hang on, it is a biochemical disorder mate, and we have the pill for you." That is the alternative to social explanations.

Professor NUNN: I think the trouble is that that is what too much of psychiatry has ended up becoming—either the warm and fuzzies who want to relate to the meaning of everything in psychotherapy endlessly and only deal with the people who can afford to do that, or those who want to see that this can all be dealt with by medication. The reality is that good practice medicine is capable of holding both of those in view and saying that there is a human and a family between the biology and the social framework and of dealing with that by keeping that in mind.

CHAIR: We have got past that. We can do that with palliative care, which is much the same thing where you look at the patient and all the warm and fuzzy things plus offer some medication is as an adjunct, or as the main therapy.

Professor NUNN: I agree.

CHAIR: If we can do it with palliative care, why can we not do it with mental illness? At the end of the day, someone who has schizophrenia has schizophrenia forever.

Professor NUNN: Yes.

CHAIR: All we can do is give then coping mechanisms, help them to get rid of the psychosis and complications of that which we have to manage. There is no real difference, so why can we not seem to get what is sexy from the treatment of somebody who has cancer pain and do that for an 18 year old who has psychological and mental pain?

Professor NUNN: Yes. I think it is because mental pain is seen to be moral inadequacy whereas biological pain is seen as, "You are the tragic victim of biological forces beyond your control." Underneath it all is the belief that if only these people were somehow strong enough or if only their parents were good enough, they would not be suffering from this disorder.

CHAIR: The Mental Health Act which the Brits now have on the table, which you have probably seen, goes to the whole issue of mental disorders and personality disorders.

Professor NUNN: Yes.

CHAIR: But it also goes to the whole issue at the end of the day of tests of compulsory treatment, namely, that there be an advocacy service and that there be a treatment which will work—in other words, you cannot give out treatment which may not work—and the third thing which impressed me is that there is a wider use of compulsion, not just of the individual but of the service in the absolute requirement for everybody to have a case manager, the case manager being responsible to ensure that that they have got advocacy but not doing advocacy, and this whole issue of evidence-based practice.

Professor NUNN: I agree with all of those initiatives and all of us have looked on and said that we think there is an enormous amount of good in that. In child psychiatry, one of the problems is that we have suffered from the evidence base. As you know, the pharmaceutical companies do not see children and adolescents as a major area of interest. Therefore the research on children and adolescents lagged sadly behind until President Clinton made a stipulation that future renewal of psychotropic medications should include paediatric data. We are often working with medications for which the company itself will disown us in the process of doing that and put everywhere "Not recommended for use in children". However, mental illness almost does not seem to understand the pharmaceutical industry and insists on adolescence as the main time during which schizophrenia will begin to develop, and 25 per cent of those with manic depressive illness and bipolar disorder will present before the age of 20. It is a highly underrecognised—one of the most underrecognised—disorders in psychiatry.

CHAIR: As a result of Menadue in terms of frameworks, the Minister set up a series of very good consultative processes with the professions—not just doctors, but nurses and others—to come up with what are best practices or pathways of care—they are not recipes, but pathways—especially in chronic illnesses. Then he announced the funding of $2 billion in extra money but it did not apply to mental health. The mental health announcement was made later. Is that part of the problem—that we deal with health, and then we deal with mental health?

Professor NUNN: It is a fundamental structural problem. If you look at all the mental health initiatives of various sorts, what really strikes you is that there is an enormous amount going on but the left hand, the right hand and so on do not get a chance to meet each other. This is not only an Australian problem; it is a Western World problem. There is a lack of integration and the problem is that when they do try to integrate it, what they say is, "We will put you all in a room and talk together." What normally happens is that each group talks about their particular agendas for their group. You actually need to have a structure for how they relate to one another interdepartmentally and, under what circumstances, who calls the shots.

CHAIR: The issue that has been brought to our attention has been the fact that 30 per cent of patients in a medical ward will have a mental illness and of the people who are in psychiatric wards, many of those have a physical illness.

Professor NUNN: Yes.

CHAIR: They often are co-located, as at the Lismore Base Hospital where you have the Richmond clinic and the wards which are separated by less than 60 metres, but the two places might as well be 200 kilometres apart.

Professor NUNN: Yes.

CHAIR: It is getting close integration within a physical area or a physical facility, such as at a hospital. For example, the Missenden Centre at Prince Alfred Memorial Hospital could not be further away from the Prince Alfred Memorial Hospital if it tried, even though it is within hospital grounds. How do we overcome that issue?

Professor NUNN: It is a fundamental issue which has bedevilled us—the mind and body split by which we have doctors of the mind/doctors of the body, hospitals of the mind/hospitals of the body, medications of the mind/medications of the body, as if the mind does not occur within the body. That is something that we are largely trying to get over, but to get over it properly you have to have

paediatricians doing child psychiatry and you have to have child psychiatrists being active at the medical interface and not off on their own with a place on their own, out the back. There has to be an integration of practice and an integration of training.

We have two colleges—the college of physicians with a paediatric section and the college of psychiatrists—and the children just do not understand that. They refuse to conform to those college structures. Paediatricians deal with an enormous number of mental health problems yet have training which equips them to know how to resuscitating a neonate but not on how to manage an aggressive teenager, even though they will actually spend more time dealing with the latter than the former. Child psychiatrists gradually become de-skilled medically over time until they are in danger of being the most highly paid social workers in the system. We are trying to really change but part of that is fundamental to the structure that we are trying to dismantle.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I suppose that since I have become a politician I think of funding in portfolio areas and in departmental areas. How do you get an interaction of agencies? The problem is that you have the difficulty of a generalist who can deal with everything but is not very good at it, and there are specialties where you need more specialists but you have a specialist in the wrong area. How do you want to do this integration at the grassroots level? You can do interdepartmental committees and staff, and joint funding of facilities—both of which seem to happen—but how do you get this integration at the grassroots level? How do you then have that integrated unit responding proportionally to its population?

Professor NUNN: I will tell you what we have been doing. We have increasingly been bringing paediatricians in to work with us and we have been increasingly encouraging child psychiatrists to have medical interests and skills. We are working and co-locating everything within children's facilities and working together closely in medical teams, but that is the exception rather than the rule on a national level.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It has been said to me that psychiatrists are so limited at the moment that they do the diagnosis. Treatment is delivered by nurses if it is medical, and by some sort of social or youth worker if it is not medical. Each of those groups is short on numbers. When you refer to integration you are talking as though psychiatrists are highly paid social workers, are you not?

Professor NUNN: Not really. What is happening in child psychiatry, we have still committed ourselves to keeping treatment and assessment together. When people say that they do assessment only and that other people do treatment, they no longer know how to assess. In the end you need people who are actively involved in being helpful to young people. Even if you cannot do as much as you would like, it is important that you do not develop a triage system that effectively triages you out of interacting with young people. I know that that happens, but we certainly think it would be a degeneration.

The Hon. JOHN JOBLING: You presented us with an interesting challenge when you referred to children and adults. You made a fairly strong statement when you said that mental health services are just as important as any other area of medicine. How do we go about getting paediatricians and leaders in your field and in the psychiatric field to work together and overcome these differences, with specific reference in this case to adolescents and young children, bearing in mind that your paper has been presented on an organisational basis?

Professor NUNN: I believe that there is a real concern in paediatrics. However, there are pressures to bear on current leaders of paediatrics which make them reluctant to take child psychiatry fully into the structure. Let me give you an example. If a disruptive young person presents to the Children's Hospital at Westmead and that young person is difficult to manage—the facility was developed to manage medically ill children who were essentially co-operative and who were with co-operative parents—staff may say, "This is a distressing thing to manage." So there are occupational health and safety issues with nursing staff. These children are not always pleasant children. They are not all unpleasant, but some of them can be very difficult to manage.

That is not the image of the children's hospitals that is portrayed when you are wanting to get the charity dollar. When you want to get the charity dollar you have a rather soft, gentle image—

perhaps of a baby, or perhaps of a young child without hair who is suffering from a malignancy—all of which evokes within us appropriate responses of wanting to care. It is not the little bugger that comes in who is difficult to control, who is swearing and biting and who is objectionable. He does not have written on his forehead that he was abused. A high proportion of conduct disorder kids who present to acute facilities like accidents and emergency have been abused kids. But they do not come over as poor little buggers—they come over as rotten little bastards.

The difficulty is that that does not evoke empathy; it evokes wanting to push those kids away. They are not help seeking; they are help rejecting. That is a fundamentally different role. Our paediatric colleagues do care about it, but they also wonder what is happening to our institutions. Suddenly, it is no longer, "What does the child need?" It is, "What about our hospital?" All those things are tractable. All those things we can deal with. But it requires an enormous commitment to do that.

The Hon. JOHN JOBLING: That is a fairly strongly worded indictment of a lot of your fellow members in the profession. Do we then have to go back to basic training at the MBBS university level and teach undergraduates to associate these issues? If that is the case, I take it from what you have said to me that it will probably be a decade or more before this problem comes under control.

Professor NUNN: I think it will take a lot of work and a lot of effort. But, like all things, we have to start with undergraduates. I know so many young people who come into medicine who are interested in psychiatry. Then for a variety of reasons they are gradually discouraged away from it. Amongst those reasons are my own colleagues. I, as a psychiatrist, have to take responsibility. Some of our colleagues come over as very non-compassionate. I know a lot of my colleagues are very compassionate in psychiatry, but some of them come over as non-compassionate, non-accessible and they are able to draw very tight lines in the sand in relation to what they will do and what they will not do.

It is very hard to admire that, however much that person may contribute in the long term. Young people are looking for leaders who will inspire, who will tell them that what they are doing is worthwhile. The general message that they get is, "That work is pointless. You cannot make any difference anyway. The system in which you will work will abuse you, and a lot of psychiatrists go mad anyway. It is the nature of the work and it is the nature of the beast." I am exaggerating but, in one way or another, that is what happens in tearooms in hospitals right across the country.

The Hon. JOHN JOBLING: Nothing has changed in that regard.

CHAIR: But the stress is there as well. They know what they can achieve.

Professor NUNN: Exactly.

CHAIR: They know what can be achieved with the facilities and the resources. There is a huge gap in the public system and they become so stressed by that issue that they simply leave.

Professor NUNN: That is correct.

The Hon. JOHN JOBLING: We have a gap in the system. If it is likely to take several decades before that situation is improved what should this Committee recommend that could be undertaken by you and your colleagues and perhaps by paediatricians? What should we be looking to implement to start to improve this problem?

Professor NUNN: First and foremost, it is where the priorities lie. One of the things that the Parliament does is express the priorities of the people to the professionals.

The Hon. JOHN JOBLING: We have given you the magic wand. Let us take politicians out of the equation.

Professor NUNN: You are very important in the equation. Let me tell you why. Every time a chief executive officer in a country area of New South Wales gets up in the morning, he or she thinks

about those things that have to be done to make his or her political masters happy. The political masters will be thinking, "What are the things that we can do in the long term—priorities that the public are also demanding?" At the moment, if you design a medical course based on that, it would look very different. For instance, you can get through the whole of medicine and know practically nothing about child psychiatry.

We have actually organised to send a very practical and simple journal to every final year medical student in an attempt to do something about it. But that is a very tiny thing. The reality is that in general medical training you can learn about cardiac resuscitation and you can actually do it so many times through your training, but you would learn nothing or very little about how to talk with a young person. That has improved a little, but there needs to be a thorough shake-up. You can be a paediatrician and do your entire course, and do a few lectures on mental health, but one-third—and probably a lot more—of your work will be mental health work when you get out, if you are a community paediatrician.

There must be a clear recommendation in colleges that the priorities have to change now, so that in the next year the examinations will reflect that. GPs are small business people in medicine. There must be a way of communicating that there is a whole customer group out there that is actually in need of this product. Unless it is done in that way it will not work. That is our experience. It has to be done using a small business method, or it will not work. So there are those sorts of very practical things which I think would make a radical difference. Information has been developed for every one of those groups. We could immediately put that in place if they were interested.

The Hon. AMANDA FAZIO: Given your level of experience in this field, is there any country that is actually doing things right? How do you think we came to be on such a different path?

Professor NUNN: The answer to your question is that they are not. England is developing some new areas in the Mental Health Act. It is 10 years since I worked in England, but I am in contact with them and I visit them regularly. They have a more separated service than we have, which is very worrying. In the United States of America, managed care dominates. It really is very hard to compare. Right across Europe the only places that have anything comparable—anything that would really make us sit up—would be Scandinavia and Switzerland. They have 10 times the number of child psychiatrists that we have and Britain has. So I think that they have a different situation. We would not get to that. They have a completely different structure. They have very little acute structure and massive community structures tied in with every hospital. It is a totally integrated system, but it is very hard to duplicate that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that nothing is happening?

Professor NUNN: A relatively alienated part of the profession, that is, child psychiatry—the sleepy hollow of child psychiatry, within the relatively isolated area of mental health—has suddenly found that the whole community is facing really major issues, all of which they have some expertise to address, but they represent merely a small commando force faced with what amounts to a full-scale invasion from the enemy.

CHAIR: I refer to the trickle down effect of money. Every Minister that I have known—and I have been a member of Parliament for a long time—from Peter Collins down to the present health Minister—quarantines health money and every area health service pinches that money. The Minister keeps pouring money in and it keeps pouring out. The Centre for Mental Health has no idea what happens to the money. Once they have argued for the money and it is provided to the areas there is no accountability. Areas health services have no accountability. How can we achieve accountability for money that is allocated by the Parliament and by the Minister?

Professor NUNN: That can be done as the allocations go down. First of all the allocations must be worded properly. More is being done in that area from Treasury right down. In my view there must be a delegation of budget.

CHAIR: But more than that, it is not the delegation of budget I am worried about, it is the accountability of the budgetary process.

Professor NUNN: For instance, if you were to know that in a certain area health service an area director of mental health had the delegation to go up to $500 only then you would know that that area director is completely nobbled. The ministerial intent is not able to be worked through because the area director of mental health is not in a position, he or she would not be on the executive discussing the budget let alone having a budgetary allocation. That has to happen. But, obviously, that happens within areas. What priority does that CEO put on mental health, let alone child and adolescent mental health?

The Hon. JOHN JOBLING: Is that common in most areas or only a few?

Professor NUNN: What is that?

The Hon. JOHN JOBLING: Where the CEO does not invite representative to the executive meeting that deals with the area mental health director? In other words, he does not get there. Is that a common happening? You comment about that in quite some detail.

Professor NUNN: The way I would put it is that I think that, of course, many good CEOs are doing that, but not enough.

The Hon. JOHN JOBLING: Are we talking city? Are we talking country? Are we talking you?

Professor NUNN: No, we are not talking me. In fact, because I am a formidable person in terms of looking after my own budget—I fight for it energetically and protectively.

CHAIR: Some of your money is State money?

Professor NUNN: Yes, that is right. No, what I am talking about is the average area director in rural areas in particular.

The Hon. JOHN JOBLING: It is rural areas you are talking about?

Professor NUNN: Yes, I am.

The Hon. JOHN JOBLING: What is it, about three-quarters of them, 90 per cent of them?

Professor NUNN: I think you can say that a substantial proportion of them—

The Hon. JOHN JOBLING: That is over 50 per cent, any way.

Professor NUNN: —would have to fight for their place in the sun to get mental health on the agenda with the CEOs, bearing in mind that these CEOs have a short lifetime in rural areas. They are under enormous pressures. The question is whether mental health, and child and adolescent mental health are important enough?

The Hon. JOHN JOBLING: What are the metropolitan figures? Is that the same percentage?

Professor NUNN: The problem in metropolitan areas is, again, some glorious examples of honourable people. But the thing in mental health is that if you put in a requisition for the replacement of a light bulb so that people do not trip over outside and it has to go through three layers of bureaucracy to get it approved, that is not an effective system, if you want something to happen. Obviously, when the Minister wants something to happen he want something to happen and he tries to make it happen.

The Hon. JOHN JOBLING: Could I be a little more difficult and press a little harder to try to get something. We have now come to the conclusion that 50 per cent of the rural—

Professor NUNN: I said—

The Hon. JOHN JOBLING: You said a majority, so that is at least 50 per cent.

Professor NUNN: Okay.

The Hon. JOHN JOBLING: Can you give me some examples of metropolitan ones, even allowing reasonable anecdotal examples.

Professor NUNN: To be concrete, if mental health is to be a priority you have to be able to have speedy mechanisms of decisions about the use of money so that simple things can be repaired, so that simple things can be done and so that the money is used as it should be.

The Hon. JOHN JOBLING: Pick me one unnamed metropolitan area.

Professor NUNN: The example I gave is an example I know of. It is in a mental health facility. You may say that perhaps the lights are not replace in a non-mental facility, but this one was important in terms of occupational health and safety. Or, to give an example of leakage in which things go wrong with mental health money, when money goes to places and mental health services pay more for the same service than non-mental health services.

The Hon. JOHN JOBLING: What sort of service?

Professor NUNN: If you get a meal in a hospital is it a mental health meal or non-mental health meal? If it is a mental health meal it may cost you more in some health services because they know that service has new money. Or, if you are in the situation where you have a shortage of accommodation and you have to pay for accommodation, and you have to pay more for that accommodation because you are a mental health service than you were a cardiology service, that would be important.

The Hon. JOHN JOBLING: Has that happened to you?

Professor NUNN: What I can tell you is that it is happening across the state, and I can tell you that it is happening but not because the Government wants it to happen.

CHAIR: No, that is right.

Professor NUNN: What is the purpose of giving enhancements if the purpose of the enhancement is undermined?

The Hon. JOHN JOBLING: It is bureaucratically driven or CEO driven?

Professor NUNN: It is driven by the fundamental belief that pervades the community that mental health problems are not really of the same value problems as medical problems. The attitude is "What is all this new mental health money about?" "It is a lack of character?" "We are looking after all the losers."

CHAIR: "Throwing good money after bad."

Professor NUNN: "Throwing good money after bad." This is "mental wealth", not mental health. If new enhancements can be used for the funding of the infrastructure that already exists then it will be diverted. All I am saying is that mental health in the bigger scheme of things is quite a small fish. Child and adolescent psychiatry is mere whitebait.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You referred to personality disorders.

Professor NUNN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that this is of great importance in mental health in prison and justice facilities?

Professor NUNN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The area where the psychiatrist says it is a personality disorder, you grew up wrong, your wiring is wrong if you like, it is not a mental disease now because it does not respond to any pharmacotherapy. But everyone else says that it is still a huge problem. They are going to gaol and doing a lot of destructive things.

Professor NUNN: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What could you say about that, and how does it to develop?

Professor NUNN: First of all, "personality disorder" is not supposed to be used for people who are under the age of 18, but it is. The group for whom it is used most commonly is kids who are very disruptive, particularly young girls who repeatedly cut themselves not with a view to killing themselves but with a view to getting relief from tension. We have had a special concern for the self-mutilating kids because we believe they have a very high rate of having been abused, having early psychosis or depression and a large number of them are as a diagnosis also post-traumatic kids, who have had very dramatic events not just abuse. They are kids who are labelled with personality disorders and will be "chucked out" of a treatment facility. Their personality disorder means that we do not treat them. The problem is that treatment methods are being developed, but if someone is not treatable at the present time that represents a challenge to most other areas of medicine, not a basis for exclusion as it is in many mental health facilities and by many mental health practitioners.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Cancer does not work.

Professor NUNN: Cancer does not respond, so, sorry, you are obviously an imposition on the system. Cancer is a challenge to research, to manage, to palliate and to share in the struggle. So too should personality disorder be such an opportunity

CHAIR: We have to conclude because we have run out of time. I would like to thank you very much indeed for both your submission and your time today, especially for being here early to hear what else was being said and give us an overview. You will be provided with a copy of the transcript and, as I said before, if we asked the question wrongly or if you think you would like to add to the answer or give us the other questions we should have asked then we would be delighted if you could give us the question and the answer to fulfill our needs. We may well come back to you for further comment, particularly when we start writing the report. The worst thing we could do is, having got the evidence misrepresent it or not present it in its best light. Anything further you write to us will be covered by the previous arrangement under parliamentary privilege.

(The witness withdrew.)

KATHRYN ANNE ADAMS, Professional Officer, New South Wales Nurses Association, 3/28 Philpott Street, Marrickville, New South Wales,

PETRUSIA BUTREJ, Professional Officer (Occupational Health and Safety Co-ordinator), XXXXXXXXXXX, and

SUSAN ROBYN KARPIK, Nurse Manager, XXXXXXXXXXXXXX, sworn and examined, and

JOHN JOSEPH GERRARD LYONS, Clinical Nurse Consultant, Mental Health, XXXXXXXXXXXXX, affirmed and examined

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

Ms ADAMS: Yes.

CHAIR: Is the submission under the name of Sandra Moait the submission to which you will speak?

Ms ADAMS: Yes, it is.

CHAIR: Would you like that to be part of your sworn evidence?

Ms ADAMS: Yes.

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

Ms BUTREJ: As a representative of the Nurses Association.

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

Ms BUTREJ: Yes.

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

Ms KARPIK: As a representative of the Nurses Association.

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

Ms KARPIK: Yes.

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

Mr LYONS: As representative of the New South Wales Nurses Association.

CHAIR: Are you conversant with the terms of reference?

Mr LYONS: Yes.

CHAIR: If any of you should consider, 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 then the Committee would be willing to accede to your request. But you should note that the Legislative Council my overturn the Committee's decision and make that evidence public. It has not happened, but it could. This is a very good submission. I am really pleased that you are here today. How would you like to present the evidence you want to give today so that we might then question you about it? We are in your hands on this.

Ms ADAMS: I would like to make an opening statement about our submission. I brought with me today an expert on occupational health and safety, Ms Butrej, and Mr Lyons from rural areas. Then Ms Karpik and I will field the other questions with our expertise in mental health.

We thank you for the opportunity to appear before the select committee today. We are here representing the industrial and professional issues of nurses in New South Wales. We represent more than 48,000 members. The main issues we are concerned about in mental health—and I think we covered them fairly well in our submission—are access to mental health services and to qualified mental health professionals for the community of New South Wales in both rural and urban areas. The current shortage of nurses has added to this dilemma and we believe this needs close attention from all health planners as well as from government. We have noted in our submission that there is a problem with access throughout all areas of the State, particularly in rural areas.

Lack of beds in mental health settings must be addressed, in our opinion, and the location of beds is also an issue for careful consideration. Education of all health workers is paramount, in our view, in relation to mental health. We see it as a pressing problem and of high priority. Mental health clients continue to face a great deal of stigmatisation from the influx of inexperienced generic mental health workers coming into our sector, as well as from the community at large. We would like to see some sort of media campaign and a positive image placed on mental health overall and mental health workers and, in particular, nurses of course.

CHAIR: Do I understand that mental health nurses are being replaced by more generic workers in mental health areas?

Ms ADAMS: Yes.

CHAIR: And that is a concern, is it?

Ms ADAMS: Yes, it is. As I said, we would like to see a positive image of mental health in a huge media campaign. That would be great. We believe funding issues are a huge problem, and it was good to hear the previous speaker talk to that. We believe, as you do, that area health service budgets are not quarantined and transparent as they claim to be. We would like to see independent audits carried out so that mental health money is going to mental health direct care services. The Federal Government has offered financial incentives to get general practitioners to rural areas. We believe that these financial incentives should also be offered to nurses to get them to relocate to rural areas as well.

CHAIR: It has to be one of the areas for the nurse practitioner?

Ms ADAMS: Yes.

CHAIR: Are you a nurse practitioner?

Mr LYONS: I am an authorised nurse practitioner.

CHAIR: But there are not very many of you, are there?

Mr LYONS: There are nine authorised.

CHAIR: How many of them are mental health?

Mr LYONS: Two.

Ms ADAMS: And only one is working at this point. We believe that violence against nurses and other health workers is a huge issue and warrants close scrutiny by this Committee. We mentioned in our submission that violence against nurses is unacceptable behaviour and we would like to see the results of the research currently being collected by the New South Wales Health Violence Task Force to be used to inform activities. We commend the Minister for Health's initiative to employ mental health nurses in emergency departments, however we would like more money there towards refurbishment of emergency departments. I think we all know from the papers that there have been a

lot of problems in a lot of emergency departments. We would like to see nurses employed in emergency departments on a 24-hour, seven-day-a-week basis, not just office hours.

The MHOAT—the mental outcome assessment tools—is in place in all mental health areas, it is mandatory. Although we believe in good health outcomes, and are certainly supportive of that, this is a great bugbear for our members because it is taking too much time away from direct patient care. We have had a meeting with the director of the Centre for Mental Health and the nurses of New South Wales to come to some agreement on MOAT, and that was reasonably satisfactory, but we still believe that some investigation needs to be under way that looks at the financial resources and equipment involved in MOAT. In our view, a lot of areas are underresourced. I think John could attest to that as well.

CHAIR: Is it just that it takes a long time to fill out or that it does not give you results?

Mr LYONS: Both.

Ms ADAMS: Both.

CHAIR: There would have been consultation before it was done, surely?

Ms ADAMS: There was consultation. We have been on the steering committee from the beginning. Unfortunately, there was not enough consultation with clinical people who actually use the MOAT system. There is a lot of repetition in it which the Centre for Mental Health has now acknowledged. It is quite beneficial having a meeting with the nurses. They have realised that they are doing the majority of the data entry—surprise, surprise! They took on board a lot of our problems and have promised to rectify them. So, we will be keeping them to that.

We acknowledge that NSW Health and especially the Centre for Mental Health has done a large amount towards mental health and mental health nursing. We have sat on a mental health nursing committee which eventuated with large sums of money for recruitment and retention, and we have been the recipient of one of those grants. At the moment we are doing a project to look at the caring for mental health of nurses in New South Wales. That is a huge project.

CHAIR: That is about retention, is it?

Ms ADAMS: Retention and recruitment, yes. Yes that one is certainly retention. That is about all I want to say. We are here to answer the questions from our submission.

CHAIR: Would any of you others like to add to that from your own perspectives? On occupational health and safety, I know that Royal Prince Alfred was fined $170,000, and that is not the only one. You are basically from the country, in the Illawarra, where there has been considerable publicity. From a clinical point of you would you like to add more?

Mr LYONS: Just on the things Kate mentioned about MOAT. As part of a quality assurance program since it was implemented in our area at the beginning of the year I have been keeping a record of it. Previously we used to use a four-page assessment tool that was very comprehensive and basically covered most of the information required in MOAT, whereas MOAT is now about 34 to 36 pages, depending on presentation. So we have gone from four to 36 to get reasonably the same amount of information. It has gone from about 35 to 40 minutes of administrative work up to 140 minutes. That has been very consistent for the past eight months or seven months, and it is pretty much reflected by most clinicians across the State that I have spoken to, that it has taken them about that long, anywhere between two and three, to do the data entry. There is also an electronic component to it as well. Obviously a lot of mental health services do not have clerical support, so it is up to the clinician to do the data entry as well.

CHAIR: From that MOAT report we are meant to get quality assessments of the quality of the service and outcomes, results?

Mr LYONS: There is no question about getting outcomes later. No-one is complaining about that. No-one is complaining about the fact that there is a formalised assessment tool across the State.

What clinicians are complaining about is the amount of time it is taking, and in a rural area when you are spending 140 minutes filling out one assessment, you have to do either one of two things: reduce the number of clients you see or do the paperwork haphazardly.

CHAIR: As a consultant, though, you would be able to size up the situation quite easily without doing 35 pages.

Mr LYONS: No, because the requirement is that there is some expectation by some people who have been involved in MOAT that in the initial stages MOAT will take the place of the progress notes. From the viewpoint of a coroner's court or any legal situation where your notes will be called into question, you still have to fill out all those.

CHAIR: Sue, do you have any comment?

Ms KARPIK: Just to add to Kate's comments about emergency departments. It might be very useful to have drug and alcohol services working closer with mental health services and certainly have that drug and alcohol presence in the emergency departments too, particularly for people who have dual diagnoses—that is, mental health and drug and alcohol problems.

CHAIR: Trish?

Ms BUTREJ: The issues around violence stemmed from a number of causes from my perspective. I look at quite a few mental health units across the State. Some are quite new and some have been around for a long time. Issues I come across typically are that some of the mental health units are not very well-designed for the type of clients they take. They might have originally been designed as a low-care unit but because of the lack of acute beds and the lack of high-security beds they are increasingly being forced to take very acute patients when they are not designed to manage very acute patients. Sometimes the units are quite small, with perhaps two or three staff on duty, including on night shift, so that if you do have a psychiatric emergency it is almost impossible for those few staff that are there to manage that patient properly. Sometimes there is not a doctor in the hospital, so by the time a doctor is called and arrives there are issues around managing that patient in the time.

The results from that research report still are not available, the one currently being conducted by the Violence Task Force, however the Centre for Mental Health also has another project running, an acute services project, and that is also looking at violence. So, some of the statistics that are available in the interim report, and hopefully will be available in the final report, are also quite interesting. That study separates out high acuity compared to lower acuity units, and the violence experience is compared between the two. Those results are quite interesting. I do not know what more I can add to what we have already put in here.

CHAIR: Before Richmond we had Senter, where a lot more violent people, long-stay people, were locked up in the central places, whether it be Bloomfield or Fletcher or Gladesville or Rozelle. Then we reduced the number there and where you would have an acute facility, that was at a certain level, it occurs to me that those facilities were well-designed for those people, we are now dealing with more violent and much more acute patients and a combination of patients within an acute ward and much sicker than they were. Is that where most of the occupational health and safety issues come from?

Ms BUTREJ: Certainly that is part, and increasing drugs and alcohol. I think part of the issue stems from community and mental health services not being as extensive as they could be. That means that when a patient does leave the inpatient facility, they may not be getting as much support in the community as they need so they tend to keep coming back to the unit.

CHAIR: From an occupational health and safety point of view—if we get that fixed first—you think the workplace needs to be re-engineered, which is what the fine was all about, but the number of nurses and the number of support people within those units, is it your view that they should be improved? How could they be improved?

Ms BUTREJ: Staffing level and skill mix. More staff to actually be out there talking to patients. It is difficult when you have very few staff to large number of patients to give them that therapeutic time and to even observe their behaviour to look for signs of potential escalation of symptoms. If there is only one nurse to, say, seven or eight patients compared to one nurse to four patients, it is a lot harder to do that necessary observation. Experience also has an impact there. So, more experienced nurses are better at picking up signs that escalation of symptoms may be occurring.

The Hon. AMANDA FAZIO: It has been put to me by somebody involved in the Illawarra area that some of the more violent episodes in acute wards could be minimised to a certain extent by segregating male and female patients. They have put to me that you get perhaps the more violent male patient who will pay undue attention to a female patient and that will cause a disruption where you are treating acute patients, and nursing staff will have to come in and try to separate that problem and then manage it in the longer term, as long as the two people are there. Do you agree with that, or not? Do you think that would help with occupational health and safety?

Ms KARPIK: I am unsure of the answer to that question. There seem to be a lot of priority groups that should be segregated one from the other, like young people from older people or younger people from that middle aged group. It is very difficult to determine how you can best segregate different groups within the acute units. Sometimes having females with males can create better behaviour from both genders. It is very difficult. I cannot really comment on that with any assurity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are there problems with the Mulawa correction facility and specifically the clinic in the Mum Shirl unit complying with the Occupational Health and Safety Act?

Ms BUTREJ: I did have a look at that a while ago but I do not have the report with me. We did make recommendations in relation to the Mum Shirl unit and I think from memory I thought there was a bit of inadequacy in relation to duress alarms. They were not always available for nurses to wear. I would have to look at the report to give you a better response to that but there were occupational health and safety issues at Mulawa, including the Mum Shirl unit, but I just cannot remember offhand exactly what my comments were.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yesterday we went out to correctional facilities and they said that all mobile phones are to be banned from 5 August. What would your comment be on that?

Ms BUTREJ: In terms of staff not carrying them?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. All persons will not be allowed to carry mobile phones.

Ms BUTREJ: Visitors already cannot bring them in. I presume that the total ban would relate to staff not using them as well. I have not seen any of the staff using mobile phones while I was there. People had two-way radios and the staff communicated using two-way radios. I would assume that the mobile phone ban would not include those two-way radios as a form of communication in emergencies.

CHAIR: There are some other issues that I think can only be answered by nurses. There has been a suggestion that there should be perhaps an increase in the use of other groups of people within the treatment of people in and outside hospital, in the community and in hospitals, for example, the inclusion of more psychologists within the service as part of the team. Would the nurses feel threatened by that? Do you think they would add to the situation or detract from it?

Ms KARPIK: From an inpatient point of view—and it is an acute inpatient setting—I think the multidisciplinary team is paramount to have access to psychologists, occupational therapists and social workers in particular. When patients are acutely mentally ill it is very necessary. In terms of nursing, nursing is always 24 hours a day, seven days a week.

CHAIR: You do the bits that everybody else does not do.

Ms BUTREJ: That is what it seems like from time to time. Going back to the occupational health and safety situation, I think sometimes nurses' time is taken up with jobs that could be done by other people and it impacts on the role of the nurse. It is hard to be therapeutic if you are also the minder of the door or the person who has to answer the phones and do those sorts of things. It is not just the professional people. I think it is really necessary to have a range of support in an acute setting.

CHAIR: Within the community setting, does your mental health team or your approach include psychologists?

Mr LYONS: I am a bit different because I work with one other person, and we cover a huge geographical area. She is also from a nursing background. But a lot of community teams in regional towns or centres like Dubbo, Orange, et cetera, employee social workers, psychologists and occupational therapists as that generic term "mental health worker". All those disciplines have their place, and we are not bagging them or saying anything derogatory about them. The difficulty is that only nursing has the training and the experience in the areas of pharmacology, which is a very important area. It is not the only area but it is very important in terms of management in terms of the side effects. If people do not pick up those side effects and continue not to provide active intervention in terms of physical disorders that will mimic mental health disorders—and there is a variety of those. I have seen many times where things have not being picked up because of that.

CHAIR: It has been raised with us in a number of other submissions that we could reduce the work load of nurses by using other people like psychologists in particular, social workers and occupational therapists, but nurses will always be essential even for handing out a pill. Occupational therapists will never hand out a pill; neither will psychologists. Nor will they be responsible for doing a blood glucose level and all the other things. Is there more scope for us to allow the specialists, who are the nurses, to do nursing and leave some of the MOAT stuff, the assessment stuff? In other words, part of that darn form could be filled out by others.

Mr LYONS: It should be filled out by others but in a lot of places psychologists, occupational therapists and social workers are refusing to do it, and it is falling back to the nurses.

CHAIR: That form is designed to be a bit more rigorous in terms of which box you tick, is it not, for someone who is trained but not a specialist in the field?

Mr LYONS: Yes. In some ways that does a disservice to those people who have those specialist skills because it does not extend that and it makes it difficult in a lot of ways. I do not think it was intentional but MOAT was set up for a generic mental health worker. I think that is dangerous; where you get that generic model then people will get left by the wayside.

CHAIR: We have evidence from Jem Masters about that in particular.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask you about the training of mental health nurses? I gather that there is an increasing age in mental health nurses because they are not getting recruited. Is that right? And that is because now there is university training and a specialty on top of that so it is six years for a job that is not as well paid as most six-year trained jobs and you might get belted up as well. That is how it seems to an outsider. Is this true? What is the mean age? Are people coming in? What could be done? Could you simply have mental health training with some degree of medical training, rather than having such a huge amount of medical training first, to shorten the course? Are there other ways that it could be done? It seems to me that the way we are going we will run out of mental health nurses altogether, will we not?

Mr LYONS: I think so. The average age is 45 to 47. Prior to the introduction of tertiary nursing, in nursing all over the average take up in terms of percentage into mental health was about 4 per cent. Since the introduction of tertiary training that has dropped to under 1 per cent. I am not for one moment advocating that we go back to the hospital-based system. A review done by Delahunty and others in about 1992 picked mental health as nine out of the 10 options available in terms of areas of speciality. Mental health was number nine and community mental health was number 10. So it does not have a good reputation in that sense, which is a bit unfortunate. Although that report is 10 years old, I do not think that has changed. If I knew how to fix that I would not be sitting here. We would have been able to fix it by now. I agree that there has to be a better way of doing it.

CHAIR: In craft group terms there was always the nurse and the College of Nursing and there were the midwives and the psychiatric nurses. They were the three identified. If you were a triple certificated sister, they were the three certificates you would have. People did them in that order so most of the people who went into mental health were triple certificated. They were the highest skilled yet the pay was not there.

Ms ADAMS: Obviously the pay issue is another issue being addressed by our association at this point, which of course will go across all areas of nursing. Also on the point of specialising, we agree that we are in danger of losing our mental health work force.

CHAIR: How many of the nurses in mental health nursing are called clinical nurse specialists [CNSs]?

Ms ADAMS: I do not know.

CHAIR: Because it is up to each area and each institution to determine how many they will have out of those available. If they are all specialists in the field and they are working as specialists why are they not paid as clinical nurse specialists? In your case that is clear: You are a clinical nurse consultant working in a nurse practitioner role. That is obvious.

Mr LYONS: That took four years to achieve.

CHAIR: I bet it did. So the ability is there for the area health service and of the money the Minister allocated, an extra $107 million, more than a third of that went to pay rises that have been promised—not the current one—but it did not accomplish the increase in the number of clinical nurse specialists or clinical nurse consultants, which many of the numbers should be seen as in mental health because they work both in the hospital-based system. You work across both, do you not?

Ms KARPIK: No, I am only the inpatient units.

CHAIR: Is there a person in your area who looks after both?

Ms KARPIK: No.

CHAIR: So it is a flat structure. What has been achieved in that area?

Ms ADAMS: Very little. The opportunity for clinical nurse specialists exists. Obviously the more junior nurses cannot apply for it until they have experience in mental health and as soon as they do they are certainly eligible.

CHAIR: How many of the nurses who work in your area have been working as clinical nurses?

Ms KARPIK: I think our area may be rather unique because we have not had a good solid mental health nursing work force to pick from so there are a few old people like myself who work in the area—

CHAIR: More experienced.

Ms KARPIK: We have had to grapple with new graduates. We have had to take on new graduates with enthusiasm. We have promoted our services at the local university and we have worked a lot with the nursing department. For the past four years we have been running a post registration mental health nursing course—that is a workplace-based course—and we have provided a mentorship program which actually places more stress on the more senior nurses to do the teaching in the workplace. The other day I was looking at the number of CNSs or clinical nurse specialists that we have. In the work force in one of the units we have 21 full-time equivalents and I think we have 4.5 clinical nurse specialists, people who are nominated, put themselves up, have worked that little bit harder and educated themselves. They were approved and they are working as CNSs. One of those people was an enrolled nurse for a number of years and spent a lot of time in mental health nursing.

He went to university and gained his degree, and he has been working for two years. He has done our post registration course and he has been working for two years and he is currently a CNS. So there are some young staff who we are promoting to that level fairly quickly. It depends on the enthusiasm of the nurses, how much they are prepared to put into it.

CHAIR: And also how much their area health service is prepared to pay.

Ms KARPIK: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That sounds like a very good mentoring, apprenticeship type program. This is kind of filling the jobs at the top with very good people. In the old days you could be a single certificate nurse in psychiatry and you did a little rotation to general nursing and you got through, I think, in three years you were qualified in psychiatric nursing, just as a normal general nurse did a little bit of psychiatric nursing in their three years. Would something like this produce more graduates who are pretty functionally useful in a more realistic fashion? We really must get more hooch at the bottom—I gather that that is a bad word now—or more input of people from the bottom.

Ms KARPIK: We have had nurses from the general hospital, the emergency department and the intensive care unit who have chosen to come to mental health. They are very experienced general nurses who come to our facility for a change, which is good. They have done our post-registration course and are working with us. We class those nurses as being new to mental health so, although they are experienced, there is still a lot of work for them to do in our environment. However, they usually pick up on mental health nursing quickly and function very well within our service. Some cross-fertilisation goes on because they bring with them skills that help us in our environment.

The Hon. JOHN JOBLING: I refer to two areas in your submission to the Committee. You indicate that the association considered that many mental health services in this State are far from adequate and fly in the face of the national mental health plans and standards. You also pick up on the rural problems, which are of great concern. Would you care to comment on your first point in the third paragraph on page 7 that many mental health services are far from adequate?

Ms ADAMS: Do you want us to elaborate on that statement?

The Hon. JOHN JOBLING: Yes, to clarify it for the Committee and for the record. Where are they inadequate and how do they not meet the standards?

Ms ADAMS: In that instance we are referring to consumer advisers and saying that that service is often tokenistic in the extreme. Far too many area health services employ consumers not on a regular basis but on an ad hoc basis. They have proven to be a quite good resource in most area health services.

The Hon. JOHN JOBLING: Is that because of the use of a particular area health service, funding or standards across the board?

Ms ADAMS: It is a local area decision. Some local area health services have proven to be very good as far as consumer advisers go whereas others have been very tokenistic: they have them but they do not provide a very good service.

The Hon. JOHN JOBLING: Is the problem city or rural based?

Mr LYONS: It is probably rural based, but there is an access problem for many consumers.

The Hon. JOHN JOBLING: I turn now to the forensic side. In your submission you refer particularly to the 62 forensic clients living in the community. You say that there are very few specifically educated forensic mental health nurses working in the community due to a lack of educational opportunities available to community mental health nurses. What do you mean by that?

Ms ADAMS: There is only one forensic community mental health nurse in Sydney. Other nurses working in the community do not have the knowledge or experience to deal with these people.

That nurse faces the huge problem of trying to deal with some 62 people on his own; obviously he must have help from community nurses.

The Hon. JOHN JOBLING: You comment about the lack of educational opportunities. What does that mean? Is there no course?

Ms ADAMS: We believe some in-service training in dealing with forensic clients would be advisable for community mental health nurses who have these people in their areas.

The Hon. JOHN JOBLING: Can they not access these courses? Are the courses available?

Ms ADAMS: They are not running the courses.

Ms BUTREJ: There are no courses.

The Hon. JOHN JOBLING: Who was running them before?

Ms ADAMS: They have never been run. We have been trying to get them up.

The Hon. JOHN JOBLING: Do you think a course should be introduced?

Ms BUTREJ: It is a specialty area.

The Hon. JOHN JOBLING: I accept that. You suggest in your submission that there is a lack of educational opportunities. What is being done, or what should be done, to establish such a course?

Ms ADAMS: The one clinical nurse consultant, who also has a clinical caseload, is trying to educate everyone.

The Hon. JOHN JOBLING: That is not satisfactory, is it?

Ms ADAMS: No.

The Hon. JOHN JOBLING: What do you suggest should be done to overcome the problem?

Ms ADAMS: We think more community forensic nurses should be employed and some sort of in-service professional development should be developed by the Centre for Mental Health.

CHAIR: Have you had discussions about this with the tribunal?

Ms ADAMS: We raised the matter with the tribunal.

CHAIR: It is going through a process of self examination. Would this prevent a forensic patient from being taken from low-level care and placed back into the community? Would it inhibit the placement of such patients in the community?

Ms ADAMS: I do not know.

Ms BUTREJ: We do not know enough about that.

The Hon. JOHN JOBLING: I am surprised that there are only 62 such patients in the community.

CHAIR: There are not many in the whole State. I think there are only 400 in total.

The Hon. JOHN JOBLING: How would you go about establishing this course or in-service training? There seems to be a gaping hole in this area.

Ms ADAMS: It is an excellent suggestion to progress discussions with the tribunal and work up something. The Centre for Mental Health must organise something locally.

The Hon. JOHN JOBLING: Has it done anything at this stage to your knowledge?

Ms ADAMS: No.

CHAIR: There is no forensic service in New South Wales; that is the problem.

The Hon. JOHN JOBLING: You identify the fact that there is no service but why do the major players allow this gap to remain? Is it fair to assume that you all know about it?

Ms ADAMS: Yes, I think everyone must know about it.

The Hon. JOHN JOBLING: I think you heard Professor Nunn's evidence. He was fairly forthright about his organisational views. From a practical point of view, how do you view the relationship between paediatricians and psychiatry professionals in dealing with certain patients who fall over the line or who can be left outside it?

Mr LYONS: A lot of it comes down to the rapport and the relationship that is built up with local specialists. Professor Nunn's specialty is obviously adolescents and children. If the mental health service can build up a rapport with any specialty, it will work very well. In my area my colleague who is an adolescent mental health nurse works fairly well with a number of paediatricians. However, it takes a lot of work to develop any relationship. It is the same as developing a rapport with the local police or ambulance service in order to work together. I am lucky in that, because I cover a large rural area, I get to see a lot of people and build a rapport with them. However, that becomes more difficult as you move up the chain as there are operational difficulties. It is a huge problem in a place such a Sydney as opposed to Coonabarabran. On a local level many people are going out of their way to develop those relationships but there are no formalised links between services.

The Hon. JOHN JOBLING: One deduces that there is potentially a major problem at the level of the upper echelon, the colleges and even that of general practitioner training.

Mr LYONS: Yes.

The Hon. AMANDA FAZIO: On pages 10 and 11 of your submission you refer to the availability and mix of mental health services in New South Wales. On the bottom of page 11 you also talk about how nurses report having to discharge the least acute patients in order to make room for new patients. This creates a revolving-door process and the care that you give patients before they are booted out early is lost because when they return to care you must start from scratch. Do you believe there could or should be a place in the provision of mental health services for a small clinical residential service for people who are not ready to return to the community and become the responsibility of community mental health teams but who are not sick enough to warrant being admitted to an acute hospital ward?

CHAIR: Like a convalescent place?

The Hon. AMANDA FAZIO: Almost. It could be like the deinstitutionalised program where there was a range of services on campus, from locked wards for really disturbed people to accommodation for people who were starting to develop community living skills again so that they could live independently. That lower range of service does not seem to exist any more. Do you think there is a place for not mini institutions but clinical residential accommodation where people could receive nursing care, social education, supervision by psychiatrists or whatever to take the burden off acute wards and ensure that the discharge plans that you develop for patients have a chance to work and people progress to living in the community again?

Ms KARPIK: I am not sure what the answer is. There has been pressure recently on our beds: we have had too many patients and not enough beds to put them in. We usually go through the patients in the ward, one by one, looking for those whom we can fast-track into group homes or residential-type services. We look for people whom we can fast-track into drug and alcohol

rehabilitation settings or patients that we can send home to relatives. That is often the primary search: for patients to send home to relatives or carers, with additional services provided by community teams. We occasionally have patients who are a placement problem: they do not have families or carers or a place to go. They must then wait for a position in one of our facilities or in that of another service. We would have a couple of such people a year in our service. We have 54 beds and cover 300,000 people.

The Hon. AMANDA FAZIO: You might not have enough patients in Coonabarabran to warrant such a facility.

Mr LYONS: It is not so much the number of patients but the geographical area. I cover 20,000 square kilometres across Coonabarabran and Coonamble shires, including Coonabarabran, Coonamble, Baradine and Binnaway. Because we are on the edge of the New England Area Health Service we also drag clients from New England into Baradine and further afield if needs be. We also have a huge recruitment and retention problem. We have advertised twice for rural mental health workers but have received no responses to those advertisements. In many ways it is a good idea, especially since our receiving hospital has about 32 beds and covers more than 50 per cent of the State in terms of admissions. Whether you would be able to staff such a facility is another question. But the idea has merit.

CHAIR: Do any of the multipurpose centres being built around the State include the provision of mental health services?

Mr LYONS: No. Baradine is an MPS. In our area we could not survive without the district hospitals or MPSs because we do admissions to them as well when somebody needs hospitalisation but forcing them to travel 320 kilometres would make their recovery very difficult.

Ms BUTREJ: In relation to whether a supervised group situation being in between might be useful, it depends in part on the patient's diagnosis. For example, not all mental illness results in a loss of living skills. Sometimes the concern is for people who may have severe depression or they may be suicidal. If they are discharged too early before the depression is managed adequately, they may go home and it may escalate fairly quickly and you could end up with an attempted suicide or a successful suicide. That can cause the nurses quite a bit of stress in relation to the concern about patients being possibly released a bit too early before they are ready.

CHAIR: They feel as though they have failed.

Ms BUTREJ: That is right, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many beds are closed because of the shortage of trained staff in a psychiatric area? Everybody talks about how many beds there are, but it seems that a lot of them are not staffed and that they are not open. Is that right? If it is, how big a problem is it? Can the union answer that?

Ms ADAMS: No, I cannot. I do not know how many are closed, actually, I could not answer that.

CHAIR: The number of unfilled beds is 103.3. The equivalent full-time staff [EFTS] or specialist nurses are not available, but the country is at 37.6. However, that does not answer the question.

Ms BUTREJ: My perception is that the wards or the beds that tend not to be opened are mostly medical. My perception from mental health units that I visit, and I visit quite a few, is that most mental health wards have very high occupancy rates. In fact, they are often over full and staff shortages are scattered around the State. The mental health units tend to operate a bit short staffed rather than close beds.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think it was Kempsey where they told me that they had enough facilities for a certain number of beds but they had only enough staff for some of them.

Ms BUTREJ: Kempsey had a fairly low care unit. That is where a patient was murdered by another patient last year. That unit was closed and they are currently refurbishing what used to be the maternity unit as a new mental health ward. It is about to start.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Will you have enough staff?

Ms BUTREJ: At this stage, they do not seem to be particularly worried about that. They do have existing mental health staff who are working there.

CHAIR: We have a number of new places opening at Coffs Harbour, Tweed Heads and Taree but many of those are building up their numbers slowly.

Ms BUTREJ: That is right. They do not always open all the beds at once.

CHAIR: They had not planned to.

Ms BUTREJ: For example, if they have a 30-bed unit, they may initially open only half of those beds.

CHAIR: Of course. They are built for expansion.

Ms BUTREJ: Yes.

CHAIR: The Minister has announced 30 beds at Tweed Heads, but they will only ever open 15 in the near future.

The Hon. JOHN JOBLING: And see what you get after that.

CHAIR: After that the issue would be whether they need to open all of them. It would be stupid to build it later.

Ms BUTREJ: Sometimes they open them progressively to enable procedures and systems to be tested and developed. They partly open a unit before they go to fully opening the unit. The new Kempsey mental health unit will be a 10-bed low care unit. It is not designed to take very acute patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What percentage of the nurses that are registered are working? I gather that of all the nurses working overall, only half the registered nurses that are trained are working. Is the rate better or worse in mental health?

Ms ADAMS: It is probably about the same.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Considering the shortage of nurses and the decline in psychiatric nursing experience, would it be fair to say that the maintenance of psychotherapeutic skills in general nurses is not really a service requirement and is rarely in job descriptions?

Ms ADAMS: Yes, it is rarely in job descriptions, that is for sure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think it is given low priority? In other words, do general nurses have well-maintained psychiatric assessment skills?

Ms ADAMS: No, they do not. It is a flawed area.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So in fact we could not put mentally ill patients in a general bed or get a general nurse to cover it?

Ms ADAMS: They are constantly in general beds, of course.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Without psychiatric nurse support?

Ms ADAMS: Yes.

CHAIR: Thirty per cent of patients in a medical ward have a psychiatric illness.

Ms ADAMS: That is right.

CHAIR: And that is why you need your other skills, because they end up as medical patients in your psychiatric units too.

Ms ADAMS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is quite a problem, the lack of psychiatric skills in the general nursing profession?

Ms ADAMS: Yes. A lot of area health services run courses—not a lot, but I know one which is in Sydney—for nurses working in general areas and who want to know how to deal with people with mental illness. They ran a very good one, but not all area health services do that, certainly. I also think that another area that needs great improvement is the university system and encouragement by certain universities—you could say which ones they are—of the students to undertake mental health at an elective or give that little or great value. You can tell which universities you are going to get undergraduates from who are interested in doing a new graduate transition program for mental health. It is very dependent on lecturers.

CHAIR: There is a statement on page 10 in the third paragraph which caught my eye, " ... the continual wastage of 35 per cent of nurses per annum". That sounds like a huge turnover. Does that just look like that to me, or has that always been happening—that about one-third of urban nurses disappear every year because people are going through it? Is that what happens in medical wards, orthopaedic wards, surgical wards and so on?

Ms ADAMS: Yes. That is what is happening.

CHAIR: But is that different from a paediatric ward, an orthopaedic ward or a surgical ward or whatever?

Ms ADAMS: It is different. Mental health is one of the areas that has the most problems in recruitment and retention.

CHAIR: Does that mean that they are disappearing from a particular institution, or out of that 35 per cent wastage, are they going to another place?

Ms ADAMS: They could, yes.

CHAIR: So they could stay in mental health nursing, but they leave Illawarra and go to Lismore, or leave Lismore and go to Orange, and so on.

Ms ADAMS: That is my understanding. They could be still in the system.

CHAIR: So they are not lost to the system. The way that is written, it looks like a loss. I am aware, that depending on how one collects the figures, it could be different from that.

Mr LYONS: A percentage of those would be lost to the system because it just becomes too much for them.

CHAIR: When they take time out, do they come back?

Mr LYONS: Some do, some do not.

CHAIR: At Illawarra, would you, as a general principle, have some nurses who find it all a bit over the top and who are having a really bad run, that you give them a month in a medical ward or handing instruments in a theatre for a little while?

Ms KARPIK: Yes, we do have a system. If nurses want to move to have a break, or for whatever reason, we can move them within a unit because each of the units has a different role and provides a different environment for them, or we approve secondments to the general hospital. Our recruitment problems are not too bad. They are going to be firing up again when we open our Wollongong unit early next year, but at the moment things are not too bad. I think that may have something to do with the fact that we have a good relationship with our nursing department at the Wollongong university and our mental health services are promoted by the university staff. The university has also gained some scholarships so a number of nurses in our service are doing studies to master's level which are fully sponsored and they are full fee paid courses. There is a fairly good link with the university. Some of our nurses who have taken on extra studies have actually gone overseas in their usual travels. Our post-registration course and the university courses carry overseas, and that has actually helped them to stay in mental health nursing overseas.

CHAIR: That has been a nursing thing for a hundred years, has it not—get your ticket and go travel.

Ms KARPIK: Yes.

CHAIR: I will ask John Lyons to comment on the first two examples given by the New South Wales Police Association. The first is about a man who was threatening people in the street and who was grubby and dirty and so on.

Mr LYONS: I have got a small number of clients, so I could almost put a name to that. I could change X to Y and it would almost meet the criteria. From a personal perspective and because I have been where I am now for nearly 10 years, I have been able to build up a rapport with clients like that and probably not see any improvement in terms of social skills. In actual fact, in terms of the social ability for the community to manage somebody like that, there have been vast improvements.

CHAIR: You can organise a team of friendly people who go and throw some food in the fridge and so on?

Mr LYONS: We organise Meals on Wheels. I talk to the police every time I am in the area when they are available and I talk to the local general practitioner and staff at the hospital. I ask them how so-and-so is doing and I keep a management plan at the hospital for when they present. The difficulty is that in that presentation, he does not meet the criteria under the Mental Health Act for admission.

CHAIR: But he is getting his medication once a month and they give him his shot.

Mr LYONS: He is getting his medication but in terms of the amount of time of community services that someone like that would take up in a town, that would be huge.

CHAIR: I notice that both people in the first example X and in the second example Y are living alone. This is probably the most expensive way of supporting somebody, is it not?

Mr LYONS: For sure. To run a proper community mental health service costs as much as it is used to cost to run the big hospitals.

CHAIR: Is that the mistake that Richmond made—that he thought that he would save money?

Mr LYONS: I would have to say yes, and certain people saw it as a great way of saving money.

CHAIR: His report actually states that 80 per cent of the savings would go back to the State.

Mr LYONS: Yes, whereas in fact that 80 per cent should have gone to community and mental health.

CHAIR: Yes, so we are still behind the eight ball in that regard. But this whole issue of how we get those basic human caring services, such as washing clothing and giving somebody a meal, are hardly things that one would expect a clinical nurse consultant to rush in and do every day, but that can be done by a community group, et cetera. We have received lots of submissions from community aid groups—and the New South Wales Nurses Association points out on page 11 the invaluable role performed by non-government organisations—so should we be putting more money into NGOs? An extra $107 million was announced by the Minister with great fanfare and $300,000 of that is going to NGOs. That was the increase in funding and they get less than 1 per cent of the mental health budget. Would we get more payback if we gave them a few more dollars?

Mr LYONS: Depending on where it was placed. Because I work in towns with small populations, it is easy to combine the Department of Community Services, community health and myself and whoever else may be involved. The problem is that the bigger the town, the more difficult it is to keep that together in that way because of all the other inputs. NGOs definitely have a place, but it should never be seen that NGOs would take the place of good clinical care.

CHAIR: No. I am talking about non-clinical care.

Mr LYONS: Sometimes that can be a danger.

CHAIR: No, I mean non-clinical care. I mean supporting somebody in a house. One does not have to be a clinical nurse consultant to be a house manager. In fact very few of them are nurses. If a clinical nurse specialist or the community mental health team come in once a week, they could have a chat to them and ask whether they are taking their pills and whether there are any mental health problems. They could say, "Call me if you have a problem", and that sort of thing, and that still costs $80,000 per person per year for what Richmond refers to as the high-dependency people. If they had to provide nursing care as well at that level of five patients, the cost would be vastly more. It would be double, really.

Mr LYONS: I think there is a place for it, but it has to be done properly. I do not think as a State we have done that very well. That is not casting aspersions upon anybody. I think it has been very ad hoc.

The Hon. JOHN JOBLING: I refer to your comments on duress response and psychiatric emergencies. The comment was made that mental health units should not be built in facilities that are too small to mount an effective and rapid duress response. Obviously that would occur at smaller hospitals as opposed to a major facility. What do you see as being too small?

Mr LYONS: If you need to restrain somebody you adequately need five people. So you need enough space for five people to work together. They do not want to be on top of one another and you have to maintain safety.

The Hon. JOHN JOBLING: What size hospital—in this case a country hospital—would we be talking about? How many patients would be in the hospital?

Ms BUTREJ: You need to have enough staff on duty on each shift to provide those five people. One of your staff members may be injured. If it is in a general hospital your other patients still need a level of supervision. So you would need somewhere where, even on night shift, you have at least 10 people on duty at night in the whole facility.

The Hon. JOHN JOBLING: What sorts of beds are we talking about? I presume that the hospital will be in a country town.

Ms BUTREJ: About a 50-bed hospital.

The Hon. JOHN JOBLING: In other words it is a reasonable size town. It is not a small town such as Merriwa, Denman or Scone.

Ms BUTREJ: We had issues raised with us by nurses. For example, at one rural hospital—a 30-bed hospital roughly—they have three staff on duty at night to cover all the wards. They do not have a separate mental health ward, yet police sometimes bring very acutely ill mentally ill people to that hospital. There is no doctor on duty and there are no mental health trained staff; yet they are receiving mentally ill patients in an emergency department where there is one nurse on duty and only two others to assist if there is an emergency. It is those sorts of situations where there is a capacity for tragedies to happen.

The Hon. JOHN JOBLING: I take it that Nimbin is out of the equation.

Ms BUTREJ: It was not Nimbin.

Ms KARPIK: I do not know whether it is the size of the hospital that is so much the issue as to having a system there. Even with your big hospitals with lots of staff, if you have not got a system in place you will not have a reliable duress response. That is the issue.

(The witnesses withdrew)

JEREMY CHARLES MASTERS, Director, Operations, Child and Adolescent Mental Health Services, XXXXXXXXXXXXXX, and

IAN RICHARD WILSON, Practised Development Fellow, Professorial Mental Health Nursing Unit, XXXXXXXXXXXXX, affirmed and examined:

CHAIR: Mr Masters, in what capacity are you appearing before the Committee?

Mr MASTERS: As President of the New South Wales branch of the Australian-New Zealand College of Mental Health Nurses.

CHAIR: Are you conversant with the Committee's terms of reference?

Mr MASTERS: Yes, I am.

CHAIR: Would you like your submission No. 258 to form part of your sworn evidence?

Mr MASTERS: Yes.

CHAIR: Mr Wilson, in what capacity are you appearing before the Committee?

Mr WILSON: As a member of the Executive of the New South Wales branch of the Australian College of Mental Health Nurses.

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

Mr MASTERS: On behalf of the New South Wales branch I would like to acknowledge the main authors of our submission, Mr Scott Fanker and Mrs Sandra Hoot who, unfortunately, cannot be with us today, Mr Wilson as part of the writing committee and the executive that proofread and added things to the submission.

CHAIR: It was a lot of work doing those, was it not?

Mr MASTERS: They were a lot of work.

CHAIR: Would you like to make a further statement?

Mr MASTERS: No.

CHAIR: Mr Wilson?

Mr WILSON: Apart from saying thank you very much for allowing us to appear before the Committee, I was not sure whether you knew very much about the College of Mental Health Nurses.

CHAIR: It is worthwhile giving us that information. There is a College of Nursing and the College of Mental Health Nursing and, as I said earlier, in the College of Nursing there was the midwives and psychiatric nurses. You have developed yourselves into a college separate from the College of Nursing.

Mr MASTERS: Yes, we have. Initially we were the Congress of Australian Mental Health Nurses. We have been formed for about 28 years now in all States of Australia, and since 1996 the New Zealand branch has been included.

CHAIR: It is the Australian and New Zealand College?

Mr MASTERS: Yes.

Mr WILSON: College of Mental Health Nurses, yes. We are the professional body.

CHAIR: It is not royal yet.

Mr MASTERS: No.

Mr WILSON: It may never be.

CHAIR: What does the college do.

Mr MASTERS: We look at the professional issues associated with mental health nursing and represent those members on ministerial inquiries and task forces. We are the professional voice of mental health nursing across Australia and New Zealand.

CHAIR: Do you have educational standards for entry?

Mr MASTERS: As fellows of the college there are educational requirements and set criteria to be a fellow, which is a minimum of three years membership with an educational background as well as achievement in mental health nursing that promote the profession.

CHAIR: Do you run or foster programs for training?

Mr MASTERS: Since 1998-99 we have had a ceding grant from the Office of the Chief Nurse and we have worked in partnership with the New South Wales College of Nursing to form modules for the Graduate Certificate for Mental Health, and we have put together seminars and workshops with the College of Nursing.

CHAIR: Have you accredited any university courses for entry?

Mr MASTERS: We do not accredit as such, but we have had advisory roles on curriculum at the universities. At times we have been asked to by the Nurses Registration Board. Certain members of our college have been more active in those roles from their own professional background and their occupation.

CHAIR: I ask these questions as a matter of interest, but I wonder whether there is not a role for the college in setting up standard minimum entry level for entry into the practice of psychiatric nursing in particular, for a whole lot of reasons that your paper clearly enunciates. Whether that is done by you or you contract to a number of institutions, but across the nation because of portability it would be good if there were standards that they could teach in a different way like the college of anaesthetist or surgeons, or whatever.

Mr MASTERS: We are putting together a position statement about credentialling for members and for nurses entering into mental health. That is being driven by one of our members in Newcastle, but it is across all branches across the international college. There is also work with the New South Wales College of Nursing about credentialling and accreditation.

CHAIR: Are you part of an international college?

Mr MASTERS: That is the Australia and New Zealand, yes.

CHAIR: Does that go to any other international affiliations?

Mr MASTERS: We have had representation on the International Nursing Council. One of our former presidents had a chair at the conference in Geneva and has represented us in the United Kingdom as well with the Royal College of Nursing.

CHAIR: Are there any chairs of psychiatric nursing?

Mr WILSON: Yes, there are. I currently work with one of them, Professor Edward White, Professor of Mental Health Nursing at the University of Technology, Sydney, and Director of the South Eastern Sydney Professorial Mental Health Nursing Mental Unit. Professor Michael Hazelton is at Newcastle University and Colin Holmes is at Western Sydney.

CHAIR: Are there any others in other States?

Mr WILSON: There are, yes.

CHAIR: You have a research base and a training base, and you have people who are on curriculum course for nursing at the major universities that teach nursing?

Mr WILSON: Yes.

Mr MASTERS: Not from the college itself.

CHAIR: No, but there are professors of nursing who come from a psychiatric background who are right in there when they develop the curriculum for nursing. That is the important thing.

Mr MASTERS: Yes.

CHAIR: How do you attract people to go a bit further than that basic stuff? There is a huge demand for what goes into a course like that.

Mr MASTERS: It is very difficult to attract people in and, as our submission says, try to attract the generalist nurses or the combined course graduates into mental health, particularly when there has been a push from some of the universities and the health services that say they have to do 12 months post graduate in medical surgical before they can go into mental health. We would challenge that because there are those nurses who want to go straight into mental health nursing when they graduate from university. It is a battle. Sometimes lecturers and tutors at universities will say, "You have to do medical surgical first."

CHAIR: What is your view about that?

Mr MASTERS: I am appalled, to be quite honest. In fact, from my occupation where I am at the moment I am trying to attract three new graduates into mental health next year. I am having a bit of a battle with the co-ordinator of the new graduate program, but we have got it through. Other area health services have done that. Earlier I heard Sue Karpik speak about the Illawarra and how it has a new graduate program. I support that.

CHAIR: Do you have a fight with the registration board in this regard? The registration board does not require it?

Mr MASTERS: No. In fact, Michael Cleary from the registration board would support direct entry into mental health nursing.

CHAIR: How many people who might do an honours degree in psychology and would otherwise be registerable as a psychologist go into nursing as a secondary degree?

Mr MASTERS: I know one psychologist who is employed as a nurse. He is employed within Correctional Health. He was a psychologist, then he did nursing. That is the only one I now of.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What made him change? Is there more money?

CHAIR: No.

Mr MASTERS: No. I do not think it would have been. I think he wanted to care for patients within the mental health sector.

CHAIR: The relationship is quite different, is it not.

Mr MASTERS: Yes.

CHAIR: How could we, not make the training more utilitarian because we have to have a good foundation otherwise you do not grow, do more to make mental health nursing more attractive and more fulfilling?

Mr WILSON: In our submission we outlined some of the deficits that we see currently in both undergraduate and postgraduate education. But in line with the problems in undergraduate education in particular there are the experiences that people have during the clinical placement in mental health facilities. That has often been identified as being problematic for nursing students, given that there is not necessarily the required support that would give them a reasonable experience. Research shows that the vast majority of undergraduate nurses choose not to go into mental health because of their experiences.

CHAIR: They go there and say, "Oh, my God!"

Mr WILSON: Yes. For a number of reasons. I think the acuity of inpatient units can scare people. Also the fact that inpatient staff tend to be busy and do not have enough time to provide support to nursing students, so overall the experience is not one that leads nursing students or undergraduate students to choose mental health nursing.

The Hon. JOHN JOBLING: Your submission is suggesting that that they are there more or less filling in time to complete their assignments without really picking up the skills.

Mr WILSON: That is right, yes.

Mr MASTERS: To give an example, I had some students recently on my unit. They were there for two weeks Monday to Thursday, eight to 1.30. That was their clinical placement. They could not get involved in the activities of the unit. So, there is a need to increase their clinical placement to make it attractive to undergraduates to come into mental health.

The Hon. JOHN JOBLING: That would go back to the major training course, though, would it not?

Mr MASTERS: Yes.

The Hon. JOHN JOBLING: This is your block time or core time there. It needs to be dealt with so you can become involved rather than being supernumerary.

Mr MASTERS: In other professions you have a 140, 200 hour placement on the unit so they actually get used to the environment. They do not feel scared. Quite a few undergraduates who go to mental health feel scared when they arrive there.

CHAIR: Even community mental health services are almost entirely emergency response teams. So, they are not seeing anybody get better.

Mr MASTERS: That is right, and most inpatient facilities are a revolving door. All you see is the acutely unwell patients coming—

CHAIR: And going out again.

Mr MASTERS: Yes. Whereas, when I trained 15 years ago we had patients who went home really well, rather than coming in really acute and going home subacute but still needing intensive work because of the patient flow.

CHAIR: When did you get into mental health nursing?

Mr MASTERS: I got into mental health nursing in 1986.

CHAIR: Post-Richmond?

Mr MASTERS: Post-Richmond. I came from the United Kingdom. I was general first, then paediatrics and then child and adolescent mental health through paediatric training. When I arrived in Sydney in 1987 I did my post-graduate through Rozelle.

CHAIR: Did they do children and adolescents then?

Mr MASTERS: No, I did child and adolescent in the United Kingdom.

CHAIR: Rozelle never handled children except for the mentally retarded kids?

Mr MASTERS: That was Gladesville.

The Hon. AMANDA FAZIO: There were two things I wanted to get some comments on from you. On page 13 of your submissions where you talk under the heading "The changes that have taken place since the Richmond report" you say that these could be a further development and enhancement of community-based mental health care and treatment when necessary but you do not propose that you have stand-alone services.

Mr WILSON: No.

The Hon. AMANDA FAZIO: What would you like to have there?

Mr WILSON: I think we made the point that the move to mainstreaming of mental health services has been beneficial in some regards, not necessarily in all regards. I reviewed the Nurses Association's submission and saw the point that they made in relation to mainstreaming and I disagree slightly with some of the comments that they made. I think it has improved access for consumers into mental health services and in general medical services. One of the issues is about providing more medical services, more funding, more staff to increase the services currently available, to improve services that are currently available.

The Hon. AMANDA FAZIO: So you prefer to see an enhancement of the current services rather than the development of newer type services?

Mr WILSON: Rather than reverting to stand-alone systems, yes.

Mr MASTERS: With an integration across the spectrum so the inpatient facilities and the community team work in unison rather than actually having stand-alone designated teams so that they work together, and using the health promotion model, prevention, early intervention stuff.

The Hon. AMANDA FAZIO: The other question I have may be of more interest to you, Jem, because it relates to adolescents. It was said to us earlier this afternoon by one of the witnesses that it seems to be acceptable in the health system to spend an awful lot of money looking after an 80 year old in the last five years of their life rather than looking after a younger person who could live to 80, which was an interesting comment. Page 17 of your submission says that the availability and mix of child and adolescent mental health services and mental health services for older people are other obvious examples of circumstances where there is a need for investment and development. Do you want to elaborate on that for us?

Mr MASTERS: I can talk about child and adolescents particularly. We have been fortunate in New South Wales that in the past 2½ to three years we have had a commitment from the Centre for Mental Health and from the Government to put money into child and adolescent resources. My unit at Campbelltown is example: $3.2 million for the facility with an additional 10 beds for young people up to the age of 17 or 18. John Hunter at Newcastle is having a new facility. The funding is coming but he has been a slow process. In the past 20 or so years the facilities had only been at Westmead, at Rivendell and at North Ryde. An additional eight beds were created at Redbank in 1992 and they were the only gazetted acute units for young people under the age of 18. Those resources are there, but the

community resources as well, we need to look at early intervention, early prevention strategies. If we can tap into child and adolescent resources, looking at Families First,—that has been another initiative that has gone out. People with mental illness are being looked after by mental health practitioners. So, those areas have been developed or are being developed but0 the resource has not been there.

If you look at the statistics and the funding, child and adolescent mental health would only get 8 per cent of the overall mental health budget up until the past two or three years. It is now being funded slightly differently and we have to thank the Centre for Mental Health for that. Similarly, the aged care sector. A lot of people do not want to look after elderly people with dementia or with mental health problems. Particularly with the start of Alzheimer's in the elderly. People do not want to look after them and the resources have not been there.

Mr WILSON: I think also one of the difficulties that inpatient facilities currently deal with is that they have a mix of adult and aged care populations, which is not optimal for either group. While suffering the same disorders and problems, there are different needs between the aged population and the adult population. Thinking about some of the stuff the association talked about in terms of violence and aggression in new patient units, the aged care populations within new patient units is at particular risk at times of being secondary victims of violence and aggression. So, a lot of people would be crying out for separate services and separate inpatient units particularly.

The Hon. AMANDA FAZIO: Can I follow that up with an issue for both age groups, adolescents and older people, in relation to people from the non-English-speaking backgrounds. One of the witnesses earlier today said the organisation she dealt with had some instances of young people who had come to Australia as refugees and who were severely disturbed because they had been traumatised in their home countries. Do you think the services we have now—and I know that some older people from non-English-speaking backgrounds become more difficult to manage when they develop mental illnesses because they stop using English, and that is presuming their English was okay to start with—our current services for adolescents and older people with mental health problems, do adequately cater for people who do not have decent English-language skills?

Mr MASTERS: I think across all sections of health we have a problem with accessing interpreters, accessing the multicultural centres who are able to provide us with the support and the understanding of somebody's cultural background, regardless of where they are from. I know the multicultural mental health service, it is really hard to get resources to access different area health services other than in western Sydney, where they are based, and it could take two or three weeks to get a person from the multicultural centre to come out to a regional area. Even if it is crossing from western Sydney to south-western Sydney it is a problem. I think that is not just within mental health but across the board.

CHAIR: This is the problem of attaching for convenience a service into an area health service. Central Sydney, for example, has the forensic pathology service. You try to get that used by anybody else, and so on. While they are meant to be statewide services, accessing them, if you are not in that area's services, you do not get.

Mr MASTERS: And those with hearing impairment, which is based at central Sydney. I did not realise you can get a machine that types with telephones, because that is all done through central Sydney with the hearing-impaired.

CHAIR: That is part of the budget leakage process.

Mr MASTERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am interested in this idea of getting nurses. You have some suggestions in your submission. You said just a moment ago that you want them to go from the nursing course directly into mental health as a specially rather than medisearch. In psychology, which presumably is some sort of basis for working in mental health, you go straight into doing mental health in universities. Why would you not have a specialised mental health nurses degree, as opposed to a general nursing degree and then mental health as a specialty? Surely we are making a huge hurdle if you are only getting a subpopulation of those who have done four years?

Mr MASTERS: I personally believe that we should have an integrated training system for nursing, but with specialty areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mean earlier? Within the four years?

Mr MASTERS: Well, currently it is three years for nursing. Similar to the UK-CC model, up until just recently where you did 18 months of a generic course and then branched off into mental health, paediatrics or midwifery. That would look at some of the issues, but I think one of the big things for nursing is that maybe students, undergraduate students, choose the last semester what they want to specialise in and those who want to do mental health could do longer-term clinical placements.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you taken this to the universities at all?

CHAIR: It could work against then if they had to choose to do psychiatric nursing from the beginning. That is a three-year waste if they get there and do not like it, whereas nurses move in and out of various jobs. It is one of the great multifaceted professions, is it not?

Mr MASTERS: It is. Dulhunty and Stevens—and I know the Nurses Association were talking about this earlier on—have done a lot of work previously on the choices for students. Not much, apart from Brenda Happell down in Victoria.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not the case that lots of people going through university start on courses, find they do not like them and drop them but get credited with some of the units they have done, and instead of doing a three-year course they do a four-year course because they drop a few units along the way and pick up a few units? That would be quite possible, would it not? Presumably if they hit the acute ward and did not like it and got out of it, they could still salvage 2½ out of their three years or two years out of their three years?

Mr MASTERS: There is anecdotal evidence that some students who go into nursing go in because they get direct entry and then drop nursing and go on to do another course, maybe one of the sciences, social work or psychology. Because it is a lower TER, they actually get in through the back door.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That used to happen with teachers college scholarships in my day.

Mr WILSON: There is a system in place for people completing a three-year comprehensive undergraduate degree to go into a 12-month program within hospitals or area health services as new graduate nurses. Those people rotate around a combination of medical and surgical placements within the hospital as part of a sort of fourth year apprenticeship style program. There are some areas that offer specialist mental health transition programs for new graduates as a means of recruiting people into mental health services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you found the universities responsive to these concerns? Are they concerned about the number of graduates in each discipline they turn out, and are they willing to be more flexible in order to get those graduates?

Mr WILSON: The universities have to manage those competing demands for all the specialties, asking for time. In the submission we have talked about the content of course curricula, clinical placement time and that sort of thing. I guess the universities have a number of specialties that are competing for time within courses and time on clinical placements, and mental health must compete with all of those. Some of the universities are willing to talk to people about reviewing curricula. There is currently a review funded by the Health Department of post graduate mental health nursing education and undergraduate mental health nursing education offered through New South Wales. That is only being kicked off now, but the idea hopefully will be to look at what drives nursing education, what the links are between nursing education and policy imperatives, practice issues, trying to develop some linkage there. Up until now things seemed to develop independently.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It could be a problem that you wanted one thing and this Committee wrote a fine report, but if the universities are cutting their cloth to fit the undergraduate market, if you like, whatever we said may have made no difference but you are saying that that has been addressed in this new committee.

Mr WILSON: Yes, hopefully.

The Hon. JOHN JOBLING: I notice in your submission you put what you describe as a widely held view in the profession and then proceed to argue that. It goes along the lines that there has been some degree of erosion of the mental health nursing skills base. You then proceed to deal with the question of polarisation between hospitalisation versus community groups, the skill of the nurses working in inpatient settings on the average has declined, and the practices become somewhat ironically, as you say, custodial in nature. Is it your view that that is so, and is that the reason it is so, and how does one turn it around?

Mr MASTERS: I take the view that it is becoming a custodial role within inpatient services, and the skill mix and the skills of those nurses have been eroded. A lot of the experienced senior staff have moved into the community where there is more independence. They are able to work in solitude and have those skills. They have to think very quickly, particularly on crisis teams where you are dealing with life and death situations. There is not the mentorship happening within the inpatient units that was there 15 to 20 years ago, where you had the experienced senior nurse who got alongside clients and talked to them, and people like Ian and myself would observe what was going on and have that role model. Those role models have left the inpatient services, to some degree. There are the odd few who are around. Those who come in sit behind the goldfish bowl and observe, particularly in acute units where there is an observation area, and the clientele are out in a day room. The nurses feel scared. They do not have the skills to go out there and sit and talk to people who are psychotic or having delusional thoughts but observe. When the situations become drastic they are out there with the PRN medication, rather than defusing the situation prior to this.

Mr WILSON: We are trying to make the point that the mental health nursing work force is ageing and not being replaced at the rate that wastage is occurring amongst people with skills and training in specialist mental health services. We also make the point in the submission that inpatient units are often staffed by those new graduate nurses who do not have the skills by virtue of having undergone the undergraduate programs where there is a varying level of quality and degree of content. These people then have to confront difficult working environments, an increase in the acuity of the patients, an increase in the throughput level of activity in the inpatient units so they are not getting a chance to develop and consolidate those skills.

The Hon. JOHN JOBLING: So if your new graduates are coming in principally through the hospitals and then with experience moving on, there is quite a major problem developing.

Mr WILSON: Yes, a serious leakage.

The Hon. JOHN JOBLING: If they are not gaining the experience through the hospitalisation, how do we go about turning that around?

Mr WILSON: Again I think reviewing the undergraduate curricula, trying to consolidate and establish reasonable standards. I think one of the issues we face now is that there are no standards across the different universities for mental health content in course curricula. It is up to the universities themselves so the number of face to face teaching hours, the number of hours in clinical placements varies from university to university. If we could establish some sort of standard that was satisfactory to the universities and the College of Mental Health Nurses that would be one step. Increasing the number of people able to provide support to new graduate nurses in inpatient units during their clinical placements, and that is both the responsibility of the inpatient units, the services and the universities.

The Hon. JOHN JOBLING: It is obviously then a problem for the patients, the new graduates nurses into the institutions who are not getting the experience. Therefore, one could assume that it will be unlikely that they will then graduate out into the community where there is equally a

small number and if that is not growing where does that take the profession for support in the community in say a decade?

Mr MASTERS: In dire straits, I believe. The crisis that is actually occurring within the impatient facilities will go out to the community as well because you will not have those resources, the skills that have been there.

The Hon. JOHN JOBLING: Does this then leave at risk the patients who would perhaps be sufficiently stabilised to be able to go back into a community home or into the community or their family with regular community mental nurse visiting?

Mr MASTERS: I would say so.

CHAIR: The medical model is a very simple one. You have the Australian Medical Council which dictates to universities and accredits universities for their graduates, both in Australia and in New Zealand. The Australian Medical Council actually sits above the universities in New Zealand and says, "This is what you must reach". So there is a standard. The second thing that happens is that all junior doctors, before they get registered, must do a year as a resident to get onto a training program. To get a provider number to work in the community you have two to three years plus whatever your college is and then you are able to go into the community. Surely that is not a bad model for a group of professionals who will work pretty well independently as a team in the community. Is there anything wrong with that? It is not a particularly expensive program. It is certainly paid for by the State. It delivers a level of practitioners who are acceptable in the community.

The Hon. JOHN JOBLING: How do you intern?

CHAIR: They intern now. What happens now is that they are not being interned; they are just going in there as a work force but they are not supervised. They do not have a rotation process which is supervised by the postgraduate medical council. All resident doctors have to be supervised to ensure that they get a bit of obstetrics and gynaecology, et cetera.

The Hon. JOHN JOBLING: I accept that, but that does not solve the problem.

CHAIR: It does in a way.

The Hon. JOHN JOBLING: Let us hear from the witnesses.

Mr MASTERS: The internship years of the new graduate programs, like the Illawarra's new graduate program for mental health, the ones we are putting in place in different other area health services, look at those skills and provide the new graduate with a core basic skill level. But it is attracting people in and getting the numbers to do that internship.

CHAIR: But if they are guaranteed to have a pathway into being an independent practitioner, if you like. The great attractiveness of psychiatric nursing and midwifery is that you become the person. You are the man—

The Hon. AMANDA FAZIO: Or the woman.

CHAIR: You know what I mean. You become the guy to whom the patient turns for care.

The Hon. JOHN JOBLING: Specialist or professional might solve the problem.

CHAIR: Professional carer. This is one of the attractions for midwifery and psychiatric nursing, although they are slightly separate. That is why people did that training. Surely the mentoring that goes with setting up a program, because the university or the area health service guarantees that if you come to work with us you will go through this course but if you go to work in that one you are just gun fodder.

Mr MASTERS: Unfortunately that is how it has been, just a pair of hands who can sit there and be a number on the roster.

The Hon. JOHN JOBLING: In your discussion under 4.7 on page 17 you discuss the service mix and interface and the difficulties of co-existence between mental health and drug and alcohol problems. You make the comment that mental health services and drug and alcohol services are reluctant to jointly manage this group of clients. You also deal with intake criteria and turf disagreement. Is this common across the various area health services throughout New South Wales?

Mr MASTERS: I would say it is very, very common that drug and alcohol will not accept a patient or a client who has a mental health problem, and mental health will often say that it is a drug and alcohol problem so we will not accept them. Or you have situations where emergency departments will phone mental health services and say, "We have somebody who is acting out. They are under the influence. They have to be mental health. They are aggressive so it has to be a mental health problem." Nurse consultants or the mental health teams will turn up to an emergency department and the person will just be under the influence of alcohol or other substances.

The Hon. JOHN JOBLING: What are you doing to overcome and address this problem? By training or by what other means?

Mr WILSON: I think most services are moving towards a collaborative model where drug and alcohol services and mental health services work together to establish service agreements, criteria for treating patients with dual diagnoses, that sort of thing.

The Hon. JOHN JOBLING: Institutionally I can understand that you will run into that, irrespective of what. If we are doing this, what sort of period are we likely to see before something will effectively work? Groups talk all the time, but when will we achieve?

Mr WILSON: I am not sure that it is within the scope of our role to outline time frames and expectations.

The Hon. JOHN JOBLING: Hypothetically, what period of time would you think it might come to pass?

Mr MASTERS: Crystal ball gazing, I would say within three to five years that possibly there would be some understanding between drug and alcohol and mental health.

The Hon. JOHN JOBLING: What two or three steps or actions would most likely make that happen?

Mr MASTERS: Having a memorandum of understanding [MOU], partnerships and co-joint positions may well change that. We have started to achieve that with clinical nurse consultants being based in emergency departments.

CHAIR: Some nine to five.

Mr MASTERS: In some areas. In other places it will possibly change as well.

CHAIR: The MOU with the police does not work. We have heard that in evidence.

Mr MASTERS: I have read that transcript. I would say that the big picture memorandum with the police does not work but it is working in local areas. There is a pretty good working relationship with the police in local areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In some local areas.

Mr MASTERS: Yes.

CHAIR: The big picture is okay but the Police Association clearly points out where it has failed more often than it has succeeded.

The Hon. JOHN JOBLING: You can see even from this little contretemps how the public perception is that patients are falling through the cracks or being passed around. We must figure out how to change that.

CHAIR: Margaret Veratau said that it was happening to her son this week.

The Hon. JOHN JOBLING: Now that you have your druthers in general terms, what do you think we should be doing? What should we try to persuade the various colleges, major players or the government to implement to start this process, make it work and to overcome the perceived problems?

Mr WILSON: We structured our submission in two parts: nursing issues and service issues. They are the two aspects. We are looking at strategies for dealing with nursing issues: improving undergraduate courses, providing better postgraduate education, including support for in-patient units, improving in-patient facilities and so on. There are then other issues relating to the services, such as the lack of beds and so on.

CHAIR: How will you turn out psych nurses in paediatrics when you have no psych beds in paediatrics?

Mr WILSON: That is right.

CHAIR: We have heard evidence from elsewhere about the need for consultant support for mental health teams—people who used to be in the system but who are now being disestablished, such as a specialist, consultant psychiatrist or VMO who is there not to treat patients but to support mental health teams. They provide peer or lean-on support and advice. Surely that could help.

Mr MASTERS: It could help if you had them.

CHAIR: They are being disestablished at the minute.

Mr MASTERS: Having that peer support and somebody to bounce ideas off would benefit the service greatly and promote the professionalism of mental health professionals so that they could do what they are geared to do not only in the community but in in-patient units. That sort of peer support is all very well but you also need the troops.

CHAIR: The difficulty is the wastage rate of 35 per cent per annum. Something must be done to stop that high rate of wastage. In northern Sydney there used to be a consultant who provided not patient care but advice to the teams. The teams owned the psychiatrist.

Mr WILSON: We are looking specifically at clinical supervision for mental health nurses—not using people from other professions to provide support but providing that support from within.

CHAIR: The consultant would not have to be a psychiatrist but could be one.

Mr WILSON: Yes. It has been demonstrated around the world that clinical supervision is effective in reducing the stress of nurses working in acute environments. It reduces burn-out, turnover rates and so on. It is an effective tool for providing support for mental health nurses. Various area health services are currently trying to implement programs of clinical supervision. The University of Technology is about to start offering a short course in clinical supervision for mental health nurses. That is a very practical means of addressing some of these issues.

CHAIR: When patients are discharged from public hospitals or psych units there is a discharge summary. However, when you write to a GP saying, "Your patient, Mrs So-and-So, has a history of blah, blah, blah" nobody from the community mental health teams responds to say, "Joe Bloggs who you discharged two weeks ago is still diabolically ill and if you send us another one like him it will be the end of the world" or "We went through the program and he is now doing this." There is no feedback. Of all the services, the revolving door at the moment is mental health services.

Mr MASTERS: That picks up on the earlier point about having an integrated model of care, where there is a constant feedback loop with in-patient community teams in local areas and they can support each other.

CHAIR: When you came into the system you said that you saw people get better: You saw them go from Rozelle, to the cottages and then home. There ain't no cottages any more.

Mr MASTERS: Yes, that is a big problem.

CHAIR: Your argument goes particularly to the systemic issue of institutions and deinstitutionalisation. Yet in the United Kingdom, Canada and even Italy—which probably had the most successful deinstitutionalisation—there is reinstitution of some institutions. I do not mean 100-bed institutions, but there must be some sort of step-down care that is supported by highly trained professionals—not just doctors and nurses but psychologists, social workers and OTs. Rehabilitation cannot occur in a five-bed home unless you spend a lot of resources.

Mr MASTERS: If you have a series of homes, a community centre to which clients can go to access resources and a team that supports people within group homes. The 30-bed group homes on the northern beaches or in Darlinghurst are not ideal.

CHAIR: No, but Macquarie Cottages were cottages in a cluster. The baby seems to have been thrown out with the bathwater. Macquarie Cottages were probably the most successful part of Rozelle.

Mr MASTERS: There is a partnership with NGOs and the Department of Housing to provide that sort of infrastructure in the community.

CHAIR: The only problem is that Health gives them $10,000 maximum to look after them in a group home while the Department of Ageing, Disability and Home Care [DADAHC] gives them $70,000. If Richmond Fellowship gets a Health client with high-support needs, it gets $10,000; if it gets a DADAHC patient, it gets $70,000. Whose needs and care costs are greater? I do not care how you arrange it, you still need the clinical specialist or the disability workers to check. The community-based services that you talked about and want to encourage got only $300,000 from the $107 million. If you want more work from them and the sort of support that cannot be provided in an institution, you must have the money.

Mr WILSON: There is no doubt that we need medium-stay beds, long-stay beds and secure beds in almost every local area health service.

The Hon. JOHN JOBLING: But the beds are not there; that is the bottom line.

Mr WILSON: Bottlenecks are forming in acute units because there is nowhere for people to go and waiting list are developing because we cannot discharge people from acute units.

CHAIR: We know that is happening. People go from those units, onto the street and then back again. We were told that this morning.

The Hon. JOHN JOBLING: Or they are gaoled.

Mr WILSON: Or they stay in in-patient units for months at a time.

The Hon. AMANDA FAZIO: We heard some comments earlier today about the need for greater mental health awareness and promotion. Do you agree and do you think that would assist in some way in addressing the terrible problem of lack of community understanding of mental health problems, the lack of rights accorded to people with mental health problems and the low regard with which they are generally held in the community? It is odd in this day and age when someone with an intellectual disability is regarded as having certain rights and status and there is a responsibility to discharge with regard to their care, accommodation and so on, yet those same rights are not afforded to people with mental health problems. I am not saying that people with disabilities should not get

what they have got, but I am at a loss to understand why people with mental health problems do not receive the same things.

Mr WILSON: It is difficult. The rights of people with mental health problems are clearly defined. It is mostly the attitude of the community and staff in mental health services that is at issue. State and Federal government programs looking at destigmatising mental health go some way towards addressing this problem, but they obviously do not go far enough.

CHAIR: I remember vividly in 1994 when I was parliamentary secretary how Richo promised that there would be an advertising campaign as part of the mental health strategy at that time. That did not happen until almost 1999 and it was not as good as it could have been. Almost exactly the same technique could have been applied as was used in the AIDS campaign, except it would not have been aimed at one in 10,000 people but one in five. The bowling ball in those advertisements would have taken out one in every five people. If the advertisements had depicted five people, all five might have been identified as suffering from mental illness.

Mr MASTERS: Everyone remembers the grim reaper advertisements on television but no-one remembers the kid with schizophrenia going out on the boat.

CHAIR: That is right. We see whole-page advertisements about AIDS, homosexuality, antidiscrimination and so on. The difference is that when the disability Act was signed off the Minister made a covenant with the disability service providers that they would be deinstitutionalised. The Hon. Ron Dyer signed a legislated guarantee that when those 2,500 people eventually came out of the institutions they would be guaranteed a level of service.

The Hon. AMANDA FAZIO: Is it service for life?

CHAIR: Yes.

Mr MASTERS: I think the early intervention and prevention stuff should start in schools and be destigmatised there. I think we should target school awareness programs. Perhaps that is how we could start to attract young people into mental health nursing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I want to put some quantification on Brian's point about a revolving door between the community and the hospital system. We must strike a balance between the hospital and the community. At the end of the day what percentage of nurses will work in the hospital system and in the community?

Mr MASTERS: It is possibly 70 per cent within the hospital system and 30 per cent in the community.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That seems an extraordinarily high base number in hospitals.

Mr MASTERS: You need those numbers to cover shifts and to maintain safety.

CHAIR: If it was the other way around you would not need it? It is a serious question. That is what Hon. Dr Arthur Chesterfield-Evans is coming to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a serious question because everyone talks about beds. They are obsessed with beds in intensive treatment and then they say, "Oh, well, they come in too crook." In spite of all the intensive care facilities, that is what the intensive care people say.

Mr WILSON: I do not think it is that. Community mental health teams are made up of more than just nurses. There are psychologists and social workers as well. I do not think anyone would dispute the fact that community mental health teams would benefit from having additional funding and additional staff because of the size of their caseloads which are often just unmanageable.

CHAIR: No, let us just cut through this. The issue is that the Minister has promised 300 new beds. I have not been able to find out yet—and I will find out from Beverly Raphael soon—where those 300 beds are. If they are acute beds, where is the benefit? If you put 300 beds in the community, you could do it at one-tenth the cost and you might save yourself putting 30 beds into an orthopaedic service.

Mr MASTERS: You could look at an ambulatory care model possibly in the home for mental health patients.

CHAIR: Absolutely, and we do not have that now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In all these submissions, no-one is proposing that.

Mr MASTERS: Off the record, there is actually a strategy for hospital in the home within my own area health service and that has gone up to the centre.

CHAIR: That is not going to be any more expensive than being in a hospital.

Mr MASTERS: It is actually cheaper.

CHAIR: In fact, you could shift the cost to the Commonwealth, which they would be quite happy about.

The Hon. AMANDA FAZIO: The State Government will be thrilled.

CHAIR: Seriously, the hospital in the home program was funded by the Commonwealth to shift costs to it because that was better quality service which does not cost much more than hospital treatment. It is not cheaper, but it does not cost much more but increases the quality and the range of expertise in the community as compared to the citadels and cathedrals.

Mr MASTERS: It is actually cheaper. If you have 15 clients under ambulatory care in the home, it is cheaper than having 15 clients within the inpatient service.

CHAIR: We will wait to see central Sydney's costing on it all, but in accrual accounting terms, it is probably a little bit more expensive. But at least that arrangement is paid for by the Commonwealth, and the Commonwealth is quite happy with that shift because it is better.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you are talking about a ratio of 70/30 of nurses in the community versus the hospital, what percentage of community health team would be nurses?

Mr WILSON: I do not think there is any standard. It varies from service to service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but we are talking about what is best practice. It depends on whether you consider supported accommodation helpers as being in the community health care service. Part of it must be definition, but can you give us some idea of how many people you are expecting?

Mr MASTERS: I would say that for the community team, it is a multidisciplinary team approach that actually is client focused, so if you have clients who are needing cognitive behavioural therapy [CBT], you would actually use a psychologist or somebody who is trained in that area to deal with that client's needs and their treatment plan. If somebody is on medication and needs to be closely monitored for side effects, you employ nursing staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if I am the chief executive officer and I am putting together a team, how many do I appoint of each discipline in that team in terms of job allocations and the money allocations?

Mr MASTERS: It is difficult to actually put a figure on it, to be quite honest. I would look at skill mix and service needs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are going to advertise for these people. You are setting it up in a perfect state. You have to say that you want X doctors, X nurses, some social workers and some housing liaison persons and volunteer co-ordinators and NGO liaison officers—whatever. What mix are you going to get? How many nurses will you need? There must be a range of answers all over the State and there must be a best practice model from somewhere, surely.

Mr MASTERS: I am not sure whether there is a best practice model for professions within the community. I could say personally that my preference would be 60/40, that is, 60 per cent nursing staff and 40 per cent allied health and support staff because then you have actually got the full range of services.

CHAIR: It would depend a little bit on whether there are general practitioners in the area who are experienced in mental health and so on.

Mr MASTERS: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As you cannot answer me straight off the bat, can I conclude that there has not been a lot of literature and discussion of this and that it has developed very differently in each area whereas in hospitals I dare say that people could give me an answer pretty quickly? Presumably hospital administration courses could tell me exactly how many of each category.

Mr MASTERS: For nursing in a hospital, you have actually got a formula of patient hours per day per nurse, and you look at that in regard to your budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. Can we conclude that the literature on community health support, despite the fact that we are well down the track with the Richmond report, has not been studied in anything like the same detail to give any sort of managerial guidelines?

Mr MASTERS: To be quite honest, yes.

CHAIR: That is quite interesting, considering that everybody went through the same process. I thank you for your time and your efforts. I know that it is not just a matter of sitting down and bashing something out. You have to consult because you represent an organisation. I thank you and the people who worked with you for doing that. As a result of today's hearing, you will receive a transcript. Please correct it if you think that we got the questions wrong or you are not happy with the answer that is printed. You might want to correct it or add to it, so please do so. We may have to get back to you again about some of these matters and you might get a phone call from Bayne McKissock before we draft the report to ensure that we have not got it wrong. Thank you for your attendance.

(The witnesses withdrew)

The Committee adjourned at 4.20 p.m.