

REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

**INQUIRY INTO MENTAL HEALTH ISSUES IN NEW SOUTH
WALES**

—

At Sydney on Thursday 1 August 2002

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. Dr Brian Pezzutti (Chair)

The Hon. Peter Breen

The Hon Dr Arthur Chesterfield-Evans

The Hon. John Hatzistergos

The Hon. John Jobling

PHILIP ANDREW SCOTT, Registered Nurse, XXXXXXXXXXXXXXXX, sworn and examined:

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

Mr SCOTT: As Court Liaison Clinician for the Mid North Coast Area Health Service, and also as a representative for the Mid North Coast Area Health Action Group, which is a group of people from that area.

CHAIR: Would you like the excellent submission you have made, which is numbered submission No. 67, to form part of your sworn evidence?

Mr SCOTT: Yes.

CHAIR: If at any stage during your evidence you feel that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be pleased 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.

Mr SCOTT: Yes.

CHAIR: Your submission is one of the few pieces of evidence we have received on how to do it and how to do it right. We are very interested in your submission. Would you speak to it briefly and state if there is anything further you would like to add before we ask you questions?

Mr SCOTT: If I may, I would like to make a brief presentation of 10 to 15 minutes. The aim is to summarise my submission. I humbly thank the honourable members of the Select Committee on Mental Health for allowing me, on behalf of the Mid North Coast Area Action Group, to address you today. In 2000 the action group was formed in response to a clear need for the intervention on behalf of mentally ill clients who were coming into contact with the criminal justice system and with law-enforcement agencies. This small group of concerned carers, supporters, mental health staff and the local magistrate lobbied for a court liaison service to be trialled in the Port Macquarie-Kempsey area. The need for this position was in response to seeing clients with mental health issues becoming imprisoned because of the court's limited options. The reason why there was very little choice other than imprisonment was due to the lack of mental health support in this area. It is with this situation in mind that the submission was presented.

The Port Macquarie area population is approximately 67,000 and Kempsey has a population of 27,000. The concept of criminalisation of the mentally ill and the positive correlation between the closure of psychiatric beds under the Richmond report is of a great deal of concern to our group members. The failure to create enough community facilities to care for these people and the large increase in the rates of imprisonment of the mentally ill are seen as directly related to the ongoing aspects of the implementation of the Richmond report. According to figures, as many as 85 per cent of prisoners have a drug and alcohol problem relating to the reason for imprisonment. It is estimated that 50 per cent of female prisoners have a severe mental illness. These figures, unfortunately, do not comment on the estimated percentages for males. However, it is clear that the figures could be very high.

I believe closely associated with the implementation of the Richmond report is the deliberate dismantling of the schedule 5 hospital system. The schedule 5 hospital system combined the care of people with mental illness, drug and alcohol problems, development disabilities, intellectual disabilities or psychogeriatric problems. The implementation of the Richmond report effectively saw the dividing up of service responsibilities into separate departments: mental health services; drug and alcohol services; psychogeriatric services under Aged Care; and the developmentally disabled under the Department of Community Services. All these separate departments require individual administrative structures and duplications of associated costs to run and house each service separately. In addition, we are now seeing non-government organisations taking over the traditional government role, adding another tier of structural management.

This restructuring may well be rationalised by highly educated people in influential positions. But these people are sadly oblivious to the anguish and disgust felt by carers and professionals who are living with and caring for people who need access to the services. Access to the services is very difficult because of fitting the criteria. When you do happen to succeed, you are met with the never-ending waiting list, due to budgetary constraints. It is these people who are unable to access services and/or those who are falling through the ever-widening gap of the mental health system that come into contact with law-enforcement agencies. Gaol is not the place for people suffering from mental health issues. We feel that the impact of changes in the psychiatric hospitalisation and/or asylum has frustrated carers and professionals in not being able to refer correctly assessed clients into specialised care. Specialised care—meaning the environment is understanding and therapeutic—is almost non-existent for clients who have, for their own safety and that of other people, the need for asylum and long-term care, which is essential.

The impact has been that now the role of the State correctional services has been to include taking responsibility for the care of people who previously would have been placed in long-term rehabilitation or in psychiatric hospitals. They will always be a group of people for whom asylum is necessary. Asylum should be provided for the protection of those whose mental illness makes them unable to maintain a reasonable life in the general community. Despite the best intentions, mental health services are unable to assist these people maintaining a reasonable community life, due to the lack of resources, such as accommodation and rehabilitation services. One of the most frightening outcomes of the shift of responsibility for the mentally ill being placed on police, the correctional system and public hospital system has been a tragic loss of life due to inadequate levels of care. An example is the murder of a mental health patient in Kempsey District Hospital last March. This incident resulted in the immediate closure of Ward 149. It was eight months later before an announcement on the lack of mental health beds in Kempsey was made. It will be a much longer time before patients can be treated in the Kempsey area.

It is the family who take on the burden of care when recognised agencies are unable to fulfil their roles. Since the closure of long-term psychiatric beds, the people who have filled these beds just have not disappeared. They are now found in other areas, such as gaols, although most have retreated into hostels and profit organised boarding houses, which makes them very vulnerable to exploitation by people who see them as easy pickings. The lucky ones have actually been welcomed back home by their families. However, ageing parents inevitably find it very difficult to cope with them, let alone the amount of rigmarole the parents and support workers have to go through in being able to secure some type of respite care for them. The unlucky ones end up living on the streets, and follow-up and service provision are extremely difficult. Funding arrangements for mental health in the area remains unclear. Without direct access to funding and budgetary information, I do not think it is appropriate for me to make comment on budgetary aspects. However, I am aware it would appear that as of March 2002 Port Macquarie Base Hospital Mental Health Service has received only one additional full-time staff since beginning in 1995. The service is operating with a staff level designed for the 1980s. Due to the proportionately high level of indigenous population compared to other areas in New South Wales, our group is concerned about the apparent lack of appropriate staff and resources available to the community.

It has been the aim of the stakeholders group to encourage community participation in integration of all appropriate services, including health, in the shared care of mentally ill persons who have come in contact with the criminal justice system. This is a means to help the obvious lack of mental health services in the area. Attached to my submission is a paper I prepared called "Positive Outcomes for Mental Health Clients", incorporating a collaborative care or justice care program.

CHAIR: Did you bring that with you today?

Mr SCOTT: Yes, I did.

CHAIR: Would you like to table that?

Mr SCOTT: Yes.

CHAIR: Are you happy for it to be released publicly?

Mr SCOTT: Yes. The future of the court liaison service in the Port Macquarie and Kempsey area is presently unclear. We have no indication of ongoing funding after 30 June 2003. At present service provision for mental health to the smaller towns and villages, such as Wauchope, Laurieton and the Camden Haven, has been non-existent. For citizens in outlying areas to access mental health services they have to travel to Port Macquarie, which is up to 40 kilometres away, to attend the Port Macquarie Base Hospital accident and emergency department. However, when clients are suffering from mental illness and they come in contact with the court liaison I refer them to the local mental health team with reference to support access to psychiatric services. The mental health team is very important with the role I have as court liaison and being able to provide options to the court with reference to a client coming in front of the court.

Each time I have utilised the Port Macquarie Base Hospital mental health team intake service the response has been immediate and the standard of care has been excellent. However, due to apparent funding shortfalls the provision of long-term case management has been heavily restricted to a point where acceptance of case co-ordination by the mental health team is practically unachievable. This makes the options available to the court with reference quite difficult. As I said earlier, the court liaison relies very heavily on mental health services within that area, not only for schedule 2 access for involuntary patients but also as a means for secondary professional consult for my benefit of management. I humbly thank you very much for allowing me to speak to you this morning.

CHAIR: Thank you very much. The trial program it set up is very complete, with a full range of community services involved. Could you tell us the services that are involved in your court liaison trial?

Mr SCOTT: At the conclusion of my initial submission is a list of all members of my group.

CHAIR: That is at the very last page, is it, page 10?

Mr SCOTT: The last page, yes.

CHAIR: That is the Mid North Coast Area Health Service, the court liaison consultant, the magistrate, the administrative support officer, Jill Scott, and the mental health team from Port Macquarie Base Hospital.

Mr SCOTT: It is the very last page. It is in handwriting with an indication of who they are.

CHAIR: You have police, general practitioners, the Department of Education and Training, the Probation Service, the area health service, consumer representatives, the Department of Housing and so on.

Mr SCOTT: Yes.

CHAIR: This is a very complete list of whole-of-government response as well as community response?

Mr SCOTT: Yes, I would agree with you there.

CHAIR: This is a highly co-ordinated approach not just to identification but also a form of court diversion by giving the magistrate better options.

Mr SCOTT: Yes.

CHAIR: Where do you get the funding to set up a service like this?

Mr SCOTT: If I may very briefly go through how the service began, in 1997 a fellow by the name of John Sharples, who is actually the court liaison nurse in the Hunter area, was the person who originally set up the court liaison. In his first year of running his service from James Fletcher Hospital he went around to the different areas. Luckily, he came into our staff room one morning and was sitting down at the base hospital, where I worked in the community health team. He spoke about a system for people who were going to court and who had a mental illness, and he was talking about a

diversionary program called court liaison. That was very well accepted by me because at that time, 1999, I could see a lot of my case management clients falling into that area where they were becoming criminalised as part of their mental illness.

CHAIR: You were working in community mental health at the time?

Mr SCOTT: Yes. It became a very good option for me to follow with the support of the Director of Mental Health Services, who at that time was Mr Ted Campbell. We also put in a submission for funding through the local area health service. In the year 2000 there was an advertisement in the paper. Being a registered nurse, I applied for the job and was lucky to be employed.

CHAIR: Was that an advertisement from the criminal justice system or from the area health service?

Mr SCOTT: From the area health service. When I started the program the model I was following was the initial one at James Fletcher Hospital under John Sharples. It was with the guidance of John Sharples that I was able to put down the basic structure to develop the Mid North Coast Area Court Liaison Service. The structure was firmly based, and I appreciate the court liaison service for allowing me to be part of the formation.

CHAIR: Your position is funded by the Mid North Coast Area Health Service?

Mr SCOTT: Yes.

CHAIR: But where did the funding for the administrative support and others come from?

Mr SCOTT: It is my understanding that it is a three-year Commonwealth grant.

CHAIR: Who owns the grant?

Mr SCOTT: The Mid North Coast Area Health Service, mental health.

CHAIR: It came from the Mid North Coast Area Health Service as a trial under the new National Mental Health plan?

Mr SCOTT: I would imagine so. I am sorry, I cannot make any comment.

CHAIR: Do you have any idea of its value?

Mr SCOTT: I do not have direct access to budgetary, but I believe—

CHAIR: We will ask Mr Clout for that. He has been very helpful. That funds not just your position but also the administrative support?

Mr SCOTT: Yes.

CHAIR: Obviously, there are voluntary and other contributions by Housing, Community Services and the court system itself?

Mr SCOTT: We as a community were seeing a formal crisis. I can only put it that way. In talking with different departments we could identify a problem and by working together we could identify what type of resources we had and what we could put in place. The problem that I saw as the major role—

CHAIR: If we could just stay with the funding for a minute, does the funding also go to the court diversion process for drug and alcohol? Do you have a court diversion process for drugs in Port Macquarie?

Mr SCOTT: My funding is for mental health services. However, my autonomy allows me to be practical. When I am in the court situation, it is very difficult to distinguish between drug and alcohol, mental illness, intellectual disability, head injuries and welfare problems. It is difficult to identify them and put them into a certain area and for me to treat only those people.

CHAIR: You treat anybody who comes to the court who has a disability or an illness that could be of interest to the court before the court looks at the case?

Mr SCOTT: That is correct. One of my aims as the court liaison officer is to liaise. I do not treat people. I possibly am able to assess a person, and how I assess a person is by utilising my expertise that I have learnt as a psychiatric nurse and as a general nurse over the last 30 years. The major assessments I do are, firstly, to look at the risk assessment with reference to suicidality; secondly, to make sure that they are not psychotic; and thirdly, to see that they are not suffering from a substance withdrawal syndrome.

It is also primary to be able to identify to the court options available to the court other than imprisonment. Prior to my starting in this role, and after speaking to the local magistrate, Mr Evans, it made his options very limited with reference to what he could do with these people who were coming in front of the court with minor charges.

My field of work is in the Local Court; my window of access to the court system is purely through a mental health and health issues avenue only. The way I can converse with the court is through the ability to retrieve the client's personal permission for me to represent them from a mental health and health aspect. The way I do that is by getting their signature, and I indicate to them the consent that I am able to access medical records. That accessing of medical records fast-tracks the requirement sometimes for medical records to be presented to court, so that when a person does come to court I am able to access them on a very brief basis, identify what area they can go into for support, also to access evidence to the court indicating their possible illness if they are suffering.

CHAIR: Do you provide a formal written advice to the court, or is that done verbally?

Mr SCOTT: It depends on the time. Sometimes I have 20 minutes to prepare a report. Usually I do a handwritten report, which is written in nurses' progress notes.

CHAIR: When you write that report, do you identify for the magistrate the options for care; in other words, the service availability?

Mr SCOTT: That is my aim. My aim also is to be able to guide the client to that service. If the client is not willing to go to that service, the magistrate may very well order the person to go there. Especially with drug and alcohol services, the client needs to be willing to go to that service.

CHAIR: You must have enormous co-operation from the Mid North Coast Area Health Service.

Mr SCOTT: I cannot commend highly enough the support I have locally; they are excellent. All the services that are essential for support for people in the community—from the Department of Housing, mental health, drug and alcohol, the head injury service, the Department of Community Services, probation and parole, the police, correctional services—are working together and are very supportive of my position.

CHAIR: How many people would you see per week?

Mr SCOTT: In my initial submission I submitted a document for the first 12 months. If I may now submit a document for the next 12 months.

CHAIR: Page 5 of the positive outcomes paper sets out the percentages.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The document indicates 187 clients per year, is that correct?

Mr SCOTT: That is for the first 12 months. In the preceding year, up until the end of May 2002 I saw a further 204 clients. Since that period until yesterday I saw another 38 clients. Over the 25-month period, a total of 430 clients have been referred to my service.

Motion by the Hon. Dr Arthur Chesterfield-Evans agreed to:

That the document entitled "Court Liaison Clinicians Service, first 23 months, dated June 2002" be publicly released.

CHAIR: How much time would you spend with each client?

Mr SCOTT: On average, between four and five hours per client. That includes report writing, following up with agencies, accessing of medical records and accessing of services through referrals.

CHAIR: Do you follow them up? In other words, do you check that what you have arranged and what the magistrate has agreed to are provided?

Mr SCOTT: With the court process and the magistrate's implementation of the court process, as an example, a person who is mentally unwell is picked up by the police. That person would go to the local police station, and the police would identify that person as being unwell. That person also would be going to the court the next day. The police or the correctional service people usually would ring me on my mobile phone, they would leave a message on that mobile phone, and I would then access the cells prior to court that morning.

Prior to starting court at 9 o'clock I would see the client, I would speak to them and get their verbal or written release of information, and I would then be able to access any notes at the local hospital with reference to that person for presentation to the court that day. That would indicate to the magistrate straightaway, as quickly as I possibly can, that this person does have an issue and is receiving or not receiving medication, giving the magistrate a fair idea of what type of support is available.

The magistrate is then able to put that person on correctional bail. Knowing that information he has expressed to me, he feels much more comfortable in being able to give that person bail, if he knows that the person is going to have some type of follow-up and some type of community input, and keep an eye on that person. Whereas prior to that, the magistrate would find it very difficult to give that person bail because of safety factors.

CHAIR: The person would be remanded in custody otherwise?

Mr SCOTT: Yes.

CHAIR: It must be a huge saving on the system if they are able to access services rather than be required to go to the remand centre.

Mr SCOTT: I was planning to speak about outcomes, if I may.

The Hon. JOHN HATZISTERGOS: What is the rate of reoffending during the period that your clients are on bail under your supervision?

Mr SCOTT: If I may firstly comment on the form of bonds. For example, under the Crimes Act there are section 10, section 9 and section 12 bonds. The section 10 bond is where a person is put on a bond for 12 months, and in that period conditions can be attached to that bond for them to go and get help. It also requires that person to be of good behaviour. In my experience, the instance of reoffending of such a bond is quite low.

To support what I am saying comes back to outcomes. It comes back to being able to identify how effective the court liaison service has been. I am in a position where I can do that personally, because I am that the only one involved with that. When I do a demographic check, I have a register of all the people whom I have come in contact with. I also have statistics that I have to put in for the health area. Apart from those statistics, I have my own statistics.

The Hon. JOHN HATZISTERGOS: Section 10 bonds under the Crimes Act would normally only be granted in cases involving relatively low levels of offending, because no conviction is involved. What is the rate of recidivism in cases in which more serious conduct is involved, where persons are placed on bonds?

Mr SCOTT: In the court that I work in, there have been 30 section 12 bonds over the last two years. Those section 12 bonds are deferred gaol sentences. I have added up the number of years that they have been deferred, and it is 47 years.

The Hon. JOHN HATZISTERGOS: They are not deferred gaol sentences; they are deferred sentences, are they not?

Mr SCOTT: My understanding is that they are deferred gaol sentences.

The Hon. JOHN HATZISTERGOS: It is a suspended sentence, which is different.

Mr SCOTT: It is my understanding that if the person was not on a bond, they would be in custody now. May I table the register.

Motion by the Hon. Dr Arthur Chesterfield-Evans agreed to:

That the document entitled "Mid North Coast Area Health Service Court Liaison Service—Court Outcomes of Clients Referred to Court Liaison Services—June 2000 to July 2002" be made publicly available.

The Hon. JOHN HATZISTERGOS: What is the rate of offences being committed by people who are on bail whilst they are under your supervision?

Mr SCOTT: I am sorry, I am unable to comment on that.

CHAIR: How many of those people comply with their bail conditions?

Mr SCOTT: If I can make a general comment in relation to section 12 bonds. There have been no breaches of section 12 bonds in the first two years. However, I am unable to make comment on section 10 and section 9 bonds because I have not correlated that information. But it is my feeling that the least severe the bond, such as a section 10 bond, the more likely they are to reoffend.

The section 9 bond, they have offended maybe up to five or six times over the first two years. What I am saying is the outcome of the bonds has been quite positive in stopping the reoffending of those people coming back and why that is, I believe, is because services have been put in place so that they do not reoffend, for instance, homelessness; they are referred to the drug and alcohol area for rehabilitation, those types of small offences which come under those sections such as language, verbal police and all those types of things that happen which may not be very serious in charging offences but they take up the court's time. When the police are seeing these people on the streets day after day they feel they need to do something about these people and they feel that the only thing they can do is to pick them up and either get them charged or take them somewhere to get some help for them. Unfortunately they see that by putting it through the courts they are actually bringing attention to the deficit in the supports for these people. With that in mind, I believe that it has been positive and I believe the reoffences are actually quite minimum.

CHAIR: The question really was how many of them comply with their bail conditions? In other words, if you do set up something for housing, community services, mental health, drug and alcohol, how many of them actually comply with those bail conditions?

Mr SCOTT: Every one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: A very high percentage?

Mr SCOTT: A very high percentage. As I said, I would imagine there would have been one or two that actually absconded and left the area; a warrant would have been issued and that would have been indicated when the warrant was issued; they would have been picked up and brought back to court.

CHAIR: When they get to the hearing date—because the bail condition would be until the hearing date—are those hearing dates vacated sometimes by the courts or are they always held and if they are held does everybody turn up for them?

Mr SCOTT: It is my experience that everybody turns up for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I clarify, are you saying the less the crime the less the reoffending rate? In other words, the bigger crimes get more, or the other way round?

Mr SCOTT: The other way round.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The greater the crime the less the reoffending rate?

Mr SCOTT: Yes, that is my experience. For instance, section 12, being a sentencing option, in my experience I have had no breaching of a section 12 whereas I have had breaching of section 9 and section 10 bonds.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are pretty small offences though, swearing at a policeman or something like that?

Mr SCOTT: Yes. So it is usually coming back when they do break and they go and get drunk, and they are walking the streets and the police come up and confront them, then they verbalise back and it just escalates. It is those small types of crimes that are being recognised as being—

CHAIR: A symptom.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The police here are doing what they can, as you say, and taking them to court. It is like me trying to get someone some help to lose weight and stop smoking before they have their heart attack and the system says no, they have to have their heart attack first; we haven't got enough resources otherwise. Is it the same with the police, they cannot simply take somebody to get help, they can only take them and charge them? Is that the story?

Mr SCOTT: I took the opportunity to ring James Fletcher hospital yesterday and I asked the court liaison clinician there what type of rates were under section 24, which is the police access to the gazetted area. He indicated to me that there were one in eight admissions to that area. So there was an increased amount of police bringing people into hospital for care. The situation I see in Port Macquarie—

CHAIR: You cannot do that in Port Macquarie, can you?

Mr SCOTT: No, you cannot do that.

CHAIR: So that anybody from, say, Kempsey or Port Macquarie or even Coffs Harbour—Coffs Harbour is a bit different, you are able to do it in Coffs Harbour now I understand?

Mr SCOTT: That is correct. There is a gazetted unit in Coffs Harbour and also in Taree.

CHAIR: So if somebody was picked up in Port Macquarie they would either have to take them to James Fletcher or up to Coffs Harbour or Kempsey?

Mr SCOTT: Practically what happens is the police pick them up in Port Macquarie, they identify that they have a mental health issue or they are concerned about their health, they take them to the base hospital—the base hospital is the Port Macquarie Base Hospital—and they are assessed in the accident and emergency department by the mental health team. That then indicates they are seen by a doctor, a doctor then initiates a Schedule 2 under the 1990 Mental Health Act, they are then transported to the nearest available gazetted bed.

CHAIR: That is only if they are involuntarily admitted. Can they be voluntarily admitted if they are picked up by the police under this section 26?

Mr SCOTT: It is my understanding that once a person goes to a public hospital and if he is taken there by police, it is everybody's right to be seen and assessed by a doctor and if that doctor has indicated for that person's treatment that hospitalisation is required they will be offered hospitalisation.

CHAIR: But that can be either under compulsory, schedule 2, or they can be offered it voluntarily?

Mr SCOTT: Under Form I, I believe that is.

CHAIR: Would you know about those?

Mr SCOTT: I'm sorry, I do not feel confident—

CHAIR: Say, for example, the police picked somebody up just wandering the street committing no offence but they think they are a risk to themselves; they take them up to hospital; they end up in either Newcastle or Coffs Harbour or they end up in Port Macquarie as a voluntary patient. There is no charge necessarily involved with that, is there?

Mr SCOTT: No, there is no charge.

CHAIR: But if there is a charge involved, for example, they are throwing stones at cars as well as being obviously a danger to themselves and they are mentally ill and the police take them off to Port Macquarie hospital because they think that is probably the most important thing rather than the charging, they may still charge them. How many would be charged under those circumstances and how many would not be? In other words, are the police doing both?

Mr SCOTT: It is my understanding that the first option the police would do would be to take the person to the hospital for assessment. If the assessment indicated that they did not need hospitalisation, the police would then charge them and take them to the police station. So they then come in front of the court. If they were admitted as a voluntary patient into ward 1A at Port Macquarie Base Hospital they would go as a voluntary patient and as soon as the voluntary hospitalisation has finished the staff would indicate to the police that these people have now been discharged; it is then up to the police to go around and make charges if they think it necessary.

CHAIR: How accurate are the police in assessing the people whom you need to see? In other words, you saw 187 in the first year; how many other people when they actually got to court did you recognise as needing help and court diversion that the police had not picked up? In other words, some you were called by the police to see in the cells beforehand, or whatever, how many of them when you were just around the court or the lawyer for the patient?

Mr SCOTT: The process that I go through is a screening process. I would imagine that there are people going through the courts still that would obviously be mentally unwell but have not been picked up.

CHAIR: I did not mean that. You say that the police do a good screen first and you get notified about them early, etcetera. Are they pretty accurate with that or are there still people who come to court from police cells that you do not know about, you are approached either by their family or by their solicitor to have a look at them?

Mr SCOTT: I have found that the police have been reasonably accurate. However, when you are looking at a situation on the streets, the person could be under the effects of substances, the police will look at that situation as being a combination of mental health and the effect of substances and people in the street would be seen as more of a community risk. Therefore they tend to go on the side of getting help for these people, so they actually come in.

The Hon. JOHN JOBLING: Your information so far is principally dealing with adult offenders, I take it. Do you have any contact with the juvenile court in particular and looking at how young children and adolescents are handled? I would also like to touch on the question of the indigenous person or Aborigine and how you deal with them and the question of trust establishment. If we could deal with the young people, children, minors and adolescents?

Mr SCOTT: In my first year, from memory, I saw 10 adolescents ranging from the age of 10 years two months to the age of under 18. Since then that has increased but I believe it represents that between 5 and 6 per cent of the referrals that I have I see people under age 18. The amount of contact I have with the services with reference to adolescent mental health is with the mental health services and the adolescent workers. Once those adolescents have been charged they then fall under the protection and care of juvenile justice and I have a very little contact with them then after that.

The Hon. JOHN JOBLING: What happens with them and under what system are they dealt with once they go into juvenile justice, or do they fall through the net?

Mr SCOTT: I feel I am unable to talk for the juvenile justice area but I believe that possibly when they first come into court that up until the stage that I started they were falling through the net. I am at least picking up some of them.

CHAIR: Do you believe that the court again is one of the triggers for some of these people to actually get access through juvenile justice programs to the help that they have probably not accessed before?

Mr SCOTT: I think once people go to court it is the crisis period and unfortunately I can say it is when it comes crunch time.

CHAIR: For both the patient and the services?

Mr SCOTT: Yes, and it is not only juvenile, it is also for adults and also for geriatric type of people.

The Hon. JOHN JOBLING: Just coming back to the juveniles, if they were identified where would they go for treatment? Have they got to come to Sydney or are there any other options, particularly for young adolescents or juveniles?

Mr SCOTT: The support that we have available in Port Macquarie to do with mental health and adolescents is actually through the adolescent mental health worker which is attached to the Port Macquarie Base Hospital mental health team. My understanding is there are two workers who are covering that amount of people. So their caseload I would imagine would be very heavy. I am not privy to how many they have in their caseload but every time that I have referred clients to that service they have responded in a very positive way; they have seen them, reported back to me, so I can then report back to the court with reference to their progress.

The Hon. JOHN JOBLING: With the mid North Coast area you would have a fair drainage area of indigenous population. In some of the evidence that was given to us there were concerns expressed that they would only talk with their own people, that the question of trust is difficult to establish and to get them to undergo treatment outside of the family is a very very large problem. What experiences have you had in that field?

Mr SCOTT: Working in court liaison has been a very rapid learning curve for me over the last two years. You have Kempsey which has a very high percentage of indigenous persons—I believe 38 percent of the population—and that is represented with the amount of people coming to court, similar types; between 30 to 38 percent of people actually going to court in Kempsey are indigenous orientated.

Port Macquarie has much lower indigenous appearances in court. The percentage of people coming to court is a lot lower than what it is in Kempsey. When I go to Kempsey the approach is that the court and I need to adjust ourselves when we try to communicate with that group. In communication with that group professionally I need to recognise that possibly coming from a white

background is not the most therapeutic in getting people talking on a truthful level. As a result of that, the use of Aboriginal liaison people or consumers has been utilised in a way to break that communication down, especially when we are communicating with people who have committed a crime and, also, when they are in the cells they sometimes do not want to talk to me, but if I get a fellow like an Aboriginal mental health worker to come with me, he or she is able to communicate much better.

I also have been concerned over the last 12 months also about the actual effect of Aboriginal males coming into contact with the courts. They are coming into contact with the court on charges such as domestic violence orientated types of crimes associated with alcohol and with low self-esteem and a very poor opinion of themselves. As a result of that the community is setting up a men's group to look at these types of issues within the Kempsey area. It is utilising the existing resources within that area to start to mobilise those types of areas to work for the best outcome.

We find that my role is not actually to provide the therapy but to motivate and point that person in the right area and get those services motivated in being able to put the services in and that is where I find the motivation and the liaison between all those services in being able to work together as a community as being quite useful. In Kempsey, for example, I have found it quite frustrating personally because I believe there are 38 different welfare-orientated bodies to help, however, to my knowledge there is not one organisation set down to provide accommodation for Aboriginal men or white men who are homeless. There are agencies that are opened that can assist on a very part-time basis of possibly four hours on a Wednesday morning and they can assist through the Department of Housing in getting emergency accommodation. What I am saying is that the services are there but they are all in different bags and the aim is to work those services together to actually have a much more forceful type of outcome for our clients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that they are too fragmented? Have they grown up like Topsy? Are they all small and inefficient? Is that too harsh? Do they all have different roles? What do you think is the answer to that? Obviously, we are always torn between services that need to be specialised and services being large enough to be viable.

Mr SCOTT: I think in small communities like these people do not need, when they are in a state of crisis, to be told to go to the community health centre and when they go there they are told, "Sorry, that is not our area. It is the Department of Housing." When they go to the Department of Housing they are told, "I am sorry, we don't have anything available. I suggest you go to Centrelink". They go there and are referred to the Salvation Army and then referred to neighbourhood centres. For people who are in crisis I would imagine that is very distressing. What I am seeing is the idea of going to one place where people can actually access services and have assistance in accessing services.

CHAIR: It is meant to be the role of any of the services that are offered, that when someone comes to their service, even if it is inappropriate, to ensure that they go to the right service and make sure they get there. That is my understanding of the way the whole-of-government response is meant to be, that every shop is a one-stop-shop, if you like. The issue of supported accommodation is a very vexed question. The Attorney General, in the last amendments to the Bail Act, talked about establishing bail hostels. Have any been set up in your area?

Mr SCOTT: No.

CHAIR: Would supported accommodation, while you get all these other things done, be part of what you are talking about here as a solution for Aboriginal men and non-Aboriginal men?

Mr SCOTT: Yes. I see that that would be extremely valuable as an option to the court in providing the magistrate with confidence in being able to put that person on bail.

CHAIR: Even if there were a flat or house available from the Department of Housing that would not be a solution unless it was supported accommodation, is that right?

Mr SCOTT: That is correct.

The Hon. JOHN HATZISTERGOS: What is in your relationship with Probation and Parole?

Mr SCOTT: In both Kempsey and Port Macquarie the role that I have with Probation and Parole has been very interesting in that they are very supportive of me. My understanding of Probation and Parole is that they have certain legislation responsibilities which I am not under and they have to report with reference to the types of recommendations for sentencing and things like that and also the overall supervision of persons coming out of gaol and while being sentenced.

The Hon. JOHN HATZISTERGOS: But there are similarities here. You get court reports and so do they. They give sentencing options and they supervise.

Mr SCOTT: With the court reports, I need to express this to you: My qualifications are as a registered general nurse and a registered psychiatric nurse. When I write a court report it is my observation that I am reporting on and it is also the evidence that actually has been derived by consultation with that person with a professional person in a mental health service or within a drug and alcohol service, so when I write a report it is actually a summary of what has actually happened to that person when they have had contact with other services. That, I believe, is the major difference. When I do a report I am not actually indicating an outcome myself, I am actually indicating the outcome of the mental health service options and the drug and alcohol service options rather than my options. Do you see what I mean? I would very happily get up and say to the magistrate, "Yes, this person is very unwell, Your Worship, and I recommend this person go to drug and health services, to mental health services, to Housing" all those types of things, but if I recommended that without actually getting the okay from those services for me to say that, I believe I would be doing the court a disservice.

CHAIR: So you help the magistrate to do specific things like suggesting a person go to this drug and alcohol service or to be cared for by this person?

Mr SCOTT: Yes.

CHAIR: So there are very specific bail conditions.

Mr SCOTT: Yes.

CHAIR: What John is asking, I think, in that these are court-initiated things, but if they are coming out of prison and somebody who has been paroled from prison and is in the community they often have conditions of parole. Are you involved with those as well?

Mr SCOTT: No, I am not, at this stage.

CHAIR: When they do their paroled hearings in the court—I presume they are hearings, are they, John?

The Hon. JOHN HATZISTERGOS: No, if they have been paroled they would be out in the community and they would be under some sort of supervision.

CHAIR: But when they get a parole order, they get conditions for parole, do they not?

The Hon. JOHN HATZISTERGOS: Well, they are under supervision.

CHAIR: Who does the plan that enables parole?

The Hon. JOHN HATZISTERGOS: I imagine Probation and Parole.

Mr SCOTT: My understanding is that a forensic mental health patient coming out of the system would be under the supervision of the Mental Health Tribunal, which then oversees the treatment of that patient. When a patient returns to the Mid North Coast Area Health, for example, the people responsible for submitting a treatment plan would be the mental health service of that area.

CHAIR: The tribunal would say that a forensic patient could be released under certain conditions in the community?

Mr SCOTT: Yes.

CHAIR: They are very special and a very small number. The tribunal would then have to be assured that a proper program was in place before they are released?

Mr SCOTT: That is correct.

CHAIR: What about an ordinary person coming out of prison who may need access to services? Is that done by the Corrections Service with the Parole Board? In other words, they identify the particular service, the particular conditions and the particular conditions under which the parole service then supervise?

Mr SCOTT: I find that I am unable to give you a straight answer but it is my belief that when people actually come out of gaol it is recommended that they go to the mental health team where they live and to make contact.

CHAIR: So that contact is not made by the parole service; it is something that the prisoners themselves have to do?

Mr SCOTT: That is my understanding. I suspect that the Parole Service can help initiate contact and allow them to go there, but I am not aware of any direct involvement of Probation and Parole in contacting mental health services in the Port Macquarie area that include the treatment and care, on an ongoing basis, of a person coming out of gaol

CHAIR: In terms of assisting the parole board in making its determinations, the identification of where they are, where they are going and what sort of service they might need would be valuable as well from a mental health point of view?

Mr SCOTT: I would imagine so because at this stage my service is actually looking at going in. My aim is to divert them from going into gaol. My focus has not been coming out of the prison service coming in. I see that as a very big gap in the service provision to these people.

CHAIR: John, does the Parole Board look after the supervision of bail conditions and bonds?

The Hon. JOHN HATZISTERGOS: They can in relation to bonds if that is a condition of the bond.

CHAIR: What about if there is a section 12 certificate?

The Hon. JOHN HATZISTERGOS: There will usually be an order that they be subject to the supervision of the Probation and Parole Service.

CHAIR: They might have a custodial sentence that is delayed or whatever on a bond, and the Probation and Parole Service looks after that bit.

The Hon. JOHN HATZISTERGOS: They would not look after an ordinary person who is on bail because they would not have entered a plea.

CHAIR: Who supervises the bail conditions that are applied? Say I am granted bail to appear under certain conditions in two months time?

The Hon. JOHN HATZISTERGOS: Normally the court itself.

CHAIR: The court does that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously, this is a pilot model but it seems a personal model that is almost idiosyncratic and it is working partly because you are in a small town where you know everybody. You are doing a psychiatric assessment, you obviously have the credibility to get the okay to be a treating person, you become a case manager, you then facilitate with a number of outside agencies in both Port Macquarie and Kempsey, you then liaise with the probation and parole people so you do not get them offside and you advocate legally all those functions. To what extent can this model be extrapolated to other situations where people do not have that mix and skills—which do seem impressive, without wishing to lay it on too thick. Can you suggest how we would adapt a model like this across a broader front?

Mr SCOTT: If I may suggest the model utilised in the Hunter Valley at the moment under John Sharpells, which is very similar. It was the basis that I set up my model. As a psychiatric nurse I see this as being part of my job description or whatever. I do not see it as something I should not be doing. I see that as a normal role of a person in my position. I do not see it as being anything exceptional.

CHAIR: You think these could be nurse practitioner roles?

Mr SCOTT: I am a sole practitioner. I am a sole worker. Unfortunately I am not recognised as a sole practitioner, I am recognised as a staff nurse year 8 thereafter. I am aware that other court liaison services are recognised at a level which is more appropriate to the service.

CHAIR: We had Judith Meppem in yesterday, and the number of nurse practitioner roles that have been approved is fairly limited, but that is going to increase in the next little while. This is what is clearly an independent nurse role, is it not?

Mr SCOTT: Yes.

CHAIR: If we set it up as Arthur said, if it were to be copied in each area health service—perhaps you might need more than one in some area health services because of the size of them—Arthur is really asking is that something we can populate? Are there plenty of people like you around?

Mr SCOTT: The answer to that—my background, I started my general nurse training next door in 1978, in Sydney Hospital. I worked there as a general nurse and did my training there, and then I moved to Rozelle Hospital and did my psychiatric training at Rozelle Hospital. At the time I was doing my psychiatric training at Rozelle Hospital it was a very large hospital and the amount of experience I have gained by working in those large institutions has been invaluable to me in my own professional approach. When I was working at Rozelle I considered myself very lucky to have the experience of being able to work with not only the mentally ill but also with the drug and alcohol people in the McKinnon unit, working with people such as Dr Jean Lenane, in the head injuries unit, in ward 3, which is part of the brain injuries unit, working in the rehabilitation areas, such as 9A and 11A, where you are looking at deinstitutionalising people early in those times and being able to move them through supported forms of accommodation, going from an acute area into a rehabilitation area and then going into supported accommodation and then looking at individual type accommodation. I believe that type of training was invaluable to me.

After I left there I worked as the community psychiatric nurse at Ballina. I worked for four hours per day as the psychiatric nurse at Ballina. My wife also is a nurse and we set up shop up there. The problem I was having at that stage was the implementation of the Richmond report. At that time it was my understanding that a lot of money that was allocated for the implementation of the Richmond report was for the closing down of these large institutions with the money to be allocated to those clients, to those people, and the money was supposed to follow them. I noticed that money did not follow them and when I got to a place like Ballina I had 17 people who needed a halfway house and I found it very difficult to set it up because of lack of funding. I became very frustrated with that and left the Health Department and joined the army.

I then worked in the army for several years as a nurse and I became quite experienced in dealing with people and dealing with different cultures. When coming out of the army after the Gulf War I went back to the country and I reinitiated working back into community. I believe that as a nurse I am not a mental health worker, I am actually a nurse, and that nurse covers everybody in the

community. I believe possibly that is something I consider important for being a nurse. Other people may find it very difficult to see so broad in taking that aspect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Your curriculum vitae suggests you are not Joe Typical in being able to find plenty of people out there who see it as their job and are then able to execute it.

Mr SCOTT: I believe everybody, a nurse to the standard I work with, is quite capable of doing the job I do.

CHAIR: Could you identify in your area two or three different nurses who could do your job?

Mr SCOTT: Yes.

CHAIR: So, say Central Sydney Area Health Service may need eight or nine people like you, or 10 or 12, depending on the court, it would then rely upon the responsiveness of the agencies, because most area health services have this band of services to get that co-operation in a timely manner so the court can then appropriately divert them? That is the problem, is it not?

Mr SCOTT: Yes, it is.

CHAIR: To what extent does the phone call you make from the court liaison service make them sit up and take notice? What is it about the court liaison service you set up in the Port Macquarie, Kempsey area?

Mr SCOTT: I do not know, but I go to them and I try to talk to them in a way that is—

CHAIR: Clinician to clinician?

Mr SCOTT: Yes. I have the advantage, I believe, in working in an area health position of being able to access the Port Macquarie Base Hospital ward, for example. I am freely able to walk in the door. I walked down the ward, all the staff know me. I am able to access, I know what is happening in the ward. I know the policies and procedures of that. For instance, if there is a requirement, the mental health team or the drug and alcohol team need assistance with escorting people who needed hospitalisation and they need staff to go with them, I can fulfil that role. The day before yesterday I assisted with taking two clients from Port Macquarie to Cessnock under the MERIT program. It was an assistance that I assisted that service to do that.

CHAIR: That is all part of building up your credit points in networking program.

Mr SCOTT: I believe so. I know that is very airy-fairy and possibly it is not very professional.

CHAIR: No, it is trying to make something work.

Mr SCOTT: I believe so.

The Hon. PETER BREEN: Is not one of the advantages of your position that you can assess a person? In this John Sharples model, the point at which somebody is diverted is the point immediately following the assessment. I would expect someone with your experience could diagnose a person as to what particular form of mental aberration or illness they were suffering from?

Mr SCOTT: Again, I am a registered nurse. My role is not to diagnose people but to identify and to report that to people who are able to diagnose.

The Hon. PETER BREEN: I will bet you are right in about 99 per cent of the times when you say this person has such and such.

Mr SCOTT: I believe my observation skills are very honed.

CHAIR: Even if they were good or not good, it is the accessing of a mental health team that has the ongoing care, that is the trick, is it not?

Mr SCOTT: Yes, and it is also being able to question and to be able to confidently indicate and advocate on the client's behalf where they are not able to do that.

The Hon. PETER BREEN: If you are in a court and you see someone in the dock, you can probably tell what is wrong with them?

Mr SCOTT: On occasions. I have a problem. I am unable to represent a person in court unless I have their written permission to do that. If, for example, a person is in the dock and they are obviously unwell, irrational behaviour, and the magistrate identifies that, the magistrate would ask the court proceedings to be held over until the court liaison person, me, would be able to have a talk to them. I would then address that person in the cells, usually in the cells attached to the court. If that person did not give me their verbal or written permission to talk on his behalf in the court to say what is happening—and that has been the case on several occasions, where the person is totally unwell and needed further treatment—I would then go back to court and indicate to the court that I have approached this fellow and he or she has not given me permission to talk to the court about his mental health problems, however it is my observation that this person is requiring further assistance. The magistrate then has a very clear message to enact a section 32 under the Mental Health Criminal Procedure Act, where the matter is held. The person is then taken, in my case, to the base hospital at Port Macquarie or to Kempsey District Hospital. They are assessed by a doctor there. The doctor then indicates whether that person needs diverting into the Health Department. If there was no need for that person to be hospitalised, they are then returned to the court and the court is then resumed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could I ask one last question, and that is about costings. I was a member of the SCIPP committee, the Select Committee on the Increase in the Prisoner Population. The extraordinary cost of prisons was one thing, and the prisoner population is rising dramatically, as you may know. It would seem that with all your efforts you could get an idea of how much time people would have been in gaol if you had not been beavering away—

CHAIR: Even if it is just remand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even if it is just remand, because I think 23 per cent of prisoners are on remand, and in a sense every person who is not in gaol is saving \$60,000 a year. If you could get us costings of this, it would enable our report to be immensely more powerful, because if you have dollars that is power.

Mr SCOTT: In my submission with reference to the section 12 bond, I have indicated that there have been 47 years of imprisonment saved just under that section 12 bond.

The Hon. JOHN HATZISTERGOS: I read that, but it does not actually follow. It does not necessarily mean that a person who gets a deferred sentence would otherwise have gone to gaol if the that person had not been given a deferred sentence.

CHAIR: No, it does not.

The Hon. JOHN HATZISTERGOS: There are a lot of other sentencing alternatives which could have been applied.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But even in remand, how many of them would have been remanded? Presumably, as in risk management, you have a worst case scenario and then you multiply that by the probability of it happening to get the actual cost. That is the essence of risk management. You may have to do a couple of multiplication by probability factors from other courts that are not doing your program to get those numbers. Do you have any more figures, if you like, to which people could apply these equations to get to a costing that would enable us to come to some conclusion, or could you suggest some other process or person who might be able to do that?

CHAIR: I might be able to interpret that a bit better to solve both questions. What the Hon. John Hatzistergos has pointed out is perfectly correct: just because somebody has a deferred sentence of four years imprisonment, that does not mean that if your service was not there, it would not have been a deferred sentence. The success in identifying and getting people into services that mean that they comply with their conditions of parole should be measured. I think you said 47 of them have kicked over the traces during that period for serious matters where gaol sentences were involved. That would then have to be matched by somebody out of a pool of like people.

Mr SCOTT: That is right. I think it just comes back to being identified either as a health service responsibility for these people or a correctional service responsibility. I suspect that it will still be a cost of the taxpayer whether they are in correctional health or Health. I have to say that it would be a lot cheaper to keep them in the community and in the Health areas.

The Hon. JOHN HATZISTERGOS: Has Don Weatherburn looked at this and evaluated your service? He has done that for the Drug Court and worked out the savings that have accrued from alternatives.

CHAIR: The Hon. John Hatzistergos is right. The issues are the recidivism rate during the period of parole and the frequency with which a magistrate would give such conditions versus another magistrate who is not as certain about access to care and recidivism and so on in another area. Does Lismore have a service like this?

Mr SCOTT: It does at the moment. It started approximately a month ago and it is under correctional health.

CHAIR: With the changing patterns as a result of the instituting the service, which gives us the best clue about whether the service is saving people and also saving money, that should be able to be quantifiable if you get a peer place where you get the same service charges and the same sort of people, match them up and see what happens. That is something that Don Weatherburn can do. It is a research project of considerable importance.

Mr SCOTT: If I can be of any assistance to do anything, please ask. I am not a research person.

CHAIR: That may well be our recommendation, that the pilot project be looked at as a research project to determine its accountability in terms of dollars and savings.

The Hon. PETER BREEN: Who is doing the program at Lismore?

Mr SCOTT: My understanding is that it is under correctional health and is being done by a person by the name of Bill Law.

(The witness withdrew)

(Short adjournment)

EDWARD JAMES CAMPBELL, Director—Mental Health, Port Macquarie Base Hospital, P O Box 2466, Port Macquarie, 2444, sworn and examined:

CHAIR: Would you like submission No. 201 and your supplementary submission No. 253 to be taken as evidence before the Committee?

Mr CAMPBELL: Yes.

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

Mr CAMPBELL: Yes, I am.

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, but you should be aware that the Legislative Council may overturn the Committee's decision and make that evidence public. Before we commence, do you wish to make some clarifying comments on the evidence given by Mr Philip Scott?

Mr CAMPBELL: If that is okay with you, that would be fine.

The Hon. PETER BREEN: Can I just check whether it is appropriate for evidence to be given in relation to the testimony of a previous witness?

CHAIR: I am aware that Mr Campbell was here during the whole of the evidence. He came down with Mr Scott. We can take evidence from wherever we get it, and this is a public hearing. I am sure that if that Mr Scott has any further clarifying comments he wishes to make, he can deliver them in writing.

Mr CAMPBELL: It is just that I was part of the original submission, to which Mr Scott alluded, when we put together the application for the trial project. It is my understanding that one of the questions you asked, which Mr Scott was not sure how to answer, was the cost of the program. To my knowledge, we budgeted for \$70,000 per annum.

CHAIR: Including his salary?

Mr CAMPBELL: That is all up. Mr Clout can give you the finer details on that, but that money included the whole lot.

CHAIR: Does that pay for the support worker, Ms Jill Scott?

Mr CAMPBELL: Jill Scott works for the Port Macquarie Base Hospital mental health service and her support to this program is given gratis.

CHAIR: If we were to set this up as a model to be used elsewhere, that would have to be increased by a support person.

Mr CAMPBELL: Yes, I would think so. You may not be able to rely on that gratis support elsewhere. The other thing I would like to say is that it is also my understanding that the Department of Health has agreed to subsume Mr Scott's position and recurrent funding at the expiration of the grant period. That may not have been conveyed to Mr Scott in writing at this stage but I understand that that is the case. I give you this information by virtue of my position on the area mental health executive.

The Hon. PETER BREEN: Is that over and above the six-month extension he has had to his current contract?

Mr CAMPBELL: That is my understanding.

CHAIR: Are they intending to establish a service like this at Coffs Harbour?

Mr CAMPBELL: I am unable to answer that question. That has not been discussed in my hearing at all, so I think that is a matter for Mr Clout to negotiate with the Centre for Mental Health.

CHAIR: Because to have a full service for the Mid North Coast Area Health Service, you have to have one in Taree as well as in Coffs Harbour.

Mr CAMPBELL: Yes, you would.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That money, however, is coming from Health. If Mr Scott is doing as well as he sounds as though he is doing, he is saving money from Corrective Services. If Health funds him, clearly that is a transfer that presumably Health would be keen to organise.

Mr CAMPBELL: Yes. That is a minefield I prefer not to get into.

The Hon. JOHN JOBLING: Because you will never get out of it.

Mr CAMPBELL: That is right.

CHAIR: There are lots of services like that that Health provides. The contribution of Housing in mental health is huge. I guess that is a health service that is being offered by Housing to health services. That is a whole-of-government issue.

Mr CAMPBELL: Yes.

CHAIR: Are there any other comments you would like to make?

Mr CAMPBELL: Yes, just one or two. From my position as the director of mental health in Port Macquarie and the contact I have with consumers and stakeholders, the constant report that I get about the mental health liaison service is that it is of incredible value to people in the community. They feel that for the first time there is at least somebody who will advocate to see that the best service possible is provided for their son or daughter or whoever goes before the court. I hear that constantly so I share that with the Committee. The other thing I would say is that I believe my recommendation to you would be that this pilot project from my point of view has demonstrated that it now should be subject to a rigorous investigation as a proper research project. There is enough prima facie evidence to warrant that and I think that is the purpose of a pilot. I think it has achieved that and it now needs to be put into the hands of someone to rigorously investigate it.

CHAIR: The Commonwealth provided the original grant and it would have to be a ministerial council matter. Certainly the fact that Mr Clout has taken it in as part of his recurrent funding indicates to me that the area health service certainly thinks that it is worth pursuing.

Mr CAMPBELL: Thank you. If I may, with the Committee's indulgence, I will take two minutes of your time to make a brief statement. Firstly I would like to thank you for the opportunity of coming here and talking to you. Secondly I would like to say that where possible when I am giving an opinion and I think it is the opinion of another group or person I may be representing or conveying, I will try to make that clear to you. In general, the opinions I am giving are purely my own opinions. The scope of your inquiry is very broad. Looking at the Richmond report and its implementation is an interesting thing to do so many years down the track. Therefore my comment about the whole thing, and given that I was in the area when the Richmond report was first of all implemented, is that I still believe that the basic principles are sound. I think that as a general principle where we can provide services at the local level, this is a much more preferable option than providing them at a distance.

However, implementation of the Richmond report has been a difficult task and has been a very big task. I do not believe that the process was ever funded appropriately. I do not believe that the concept realisation of the infrastructure was appropriate. I have alluded in my comments to you in my report that at the time the government of the day was influenced by Northern European reports, which basically were coming out of Scandinavia and the like, and were more reticent to look at the southern

European reports, particularly those coming out of Italy which were much more cautious in terms of how much money government could save by winding down the big institutions.

Without dwelling on hindsight, the decision not to listen to the more experienced southern European reports was regrettable. Nevertheless, having said that, I want to make particular comment about Professor Raphael. I want to say that I believe she has been a very fine administrator. She is a visionary, tenacious and committed. From my point of view, without her efforts mental health services in this State would be considerably diminished. Nevertheless, despite all her best endeavours and efforts, we are left with a system that is still barely managing to get by day by day. We have doctor shortages, insufficient staff in general and chronic accommodation problems. We have what I believe to be inequitable funding and we have this poorly articulated resource dispersal rationale. I will talk about that later or you might have questions on that.

In general, in my submission I tried to put some of the big picture issues and address systemic problems. I did on occasion illustrate with particular examples that are relevant to me because that is what I draw most of my experience from in relation to mental health in New South Wales. From a personal point of view, the last nine years have been extremely difficult. Apart from all of the mental health problems, I have been part of that privatised hospital. As such, my service and my staff have had to battle some unique political and bureaucratic difficulties, in some cases quite malevolent. Nevertheless, we have battled on and in the words of Dr John Meadth, who is the Official Visitor who comes to our service, his most recent assessment of our service was that it should be used as a State rural model. I do not want to dwell on the past. It was difficult for us all in very difficult political and bureaucratic times. I do want to say though, in fairness, that in the last few months, in particular, since the appointment of some key people in mental health in the Mid North Coast, there has been an entirely different climate. I am delighted about this. However, it is still in its infancy. Although I am confident, I am cautiously optimistic.

CHAIR: Is that as a result of the four-point plan?

Mr CAMPBELL: The four-point plan and the appointment of Mr Chris Foster and Dr Michael Paton into the area and, under Mr Clout, the model of having an area-wide mental health service has made a huge difference to me, and I hope it will make to my service. I believe some of the historic problems we have dealt with now not only have a commitment from the people in area health that they will seriously address them but they wish to address them as well. I am very grateful for that.

CHAIR: On page one of your submission No. 201 you say that the Richmond report identified that 80 per cent of projected savings could go back to Treasury, but you reckon that about 90 per cent did. In other words, the mental health budget actually diminished following the Richmond report?

Mr CAMPBELL: The time that was done, that was certainly the lay opinion and the opinion within the professionals. I was not at that stage in a position to verify that, but they are the sort of figures that we were advised Treasury of the day was looking at saving.

CHAIR: Some questions have been compiled by the secretariat as a result of other submissions. There is evidence that the average provision of acute psychiatric beds in New South Wales approximates the lowest levels internationally. Theoretical or average provisions have provided an overall guide for planners, such as Professor Gavin Andrews. Would you say that "average" provisions allow for the problems of distribution that must be overcome?

Mr CAMPBELL: Problems of distribution?

CHAIR: In other words, providing a number of beds across the State per head of population is one thing. Does the distribution of those beds to areas increase or decrease the average provision?

Mr CAMPBELL: The difficulty that we face is that in 2002 more people are more vocal about having the resources locally. That was not quite the general view some time ago. Therefore, the distribution pattern is important for local sensibilities. Logically, from my point of view, the nearer the carers, relatives, support personnel and services are located, the more efficient the operation. So when we aggregate positions into particular localities we gain some benefits, but we also have some

discrepancies. For example, one of the issues that is constantly being raised with me by my community advisory committee is the question of whether or not Port Macquarie should have a gazetted unit. That is a complex issue that involves many questions. Leaving aside those questions and looking at it from the point of equity, if it is going to be the pattern that base hospitals look like having a mental health unit with gazetted components, then logic would suggest that would occur at Port Macquarie.

CHAIR: Would that mean, for example, when allotting so many beds per 1,000 people, even adjusting for incidents of illness, the number of beds would have to be increased for regional areas to overcome distance problems?

Mr CAMPBELL: Yes. I think there would be general opinion that although we have increased the number of gazetted beds, we still have not sufficient.

CHAIR: The Minister has just opened a new unit at Taree and at Coffs Harbour and the unit at Kempsey is being rebuilt. Would that provide the area health service with what would be called the average number of beds, given the large population in that area health service?

Mr CAMPBELL: It would, on a statewide basis, very favourably position the Mid North Coast, absolutely.

CHAIR: Looking at international comparisons, would that be the average number?

Mr CAMPBELL: No, it would still be below.

CHAIR: In other words, the Mid North Coast is comparatively better off, or will be when all the beds are opened. My understanding is that only half the beds at Coffs Harbour are open at this stage.

Mr CAMPBELL: That is correct.

CHAIR: And at Taree?

Mr CAMPBELL: It is still not at full capacity.

CHAIR: The Kempsey unit is being enlarged as it is rebuilt, is it not?

Mr CAMPBELL: Yes, it will go to 10 beds in a very similar model to the one at Port Macquarie.

CHAIR: They do not have beds for scheduling there?

Mr CAMPBELL: No, they will not.

CHAIR: You do not have beds for scheduling at Port Macquarie, do you?

Mr CAMPBELL: No, we do not.

CHAIR: We will come to that issue shortly. Does an estimate based on "average" best indicate the needs when the occupancy and demand are above average or, indeed, no hospital accommodation is available at all on a statewide basis? I am talking about long stay, rehabilitation and so on.

Mr CAMPBELL: Long stay and rehabilitation are major issues. In the Mid North Coast long stay and rehabilitation services really reside around Morisset.

CHAIR: That is out of area.

Mr CAMPBELL: That is out of area, yes. The scheduled units at Coffs Harbour and Taree to hold long stay—and I am talking of 12 months and in excess—can hold people up to six months or

more but there is a process of double checking to make sure that they are not being held there inappropriately. The long-term rehabilitation services are few and far between. Mr Scott alluded to that in his comments about the schedule 5 hospitals being wound down. The difficulty we have is not that the number of people in our area who need this intensive amount of support is great, it is the amount of resource demand that these people bring with them. We are not able to provide them with the level of intensity of rehabilitative support that they require if they are going to be able to live a semi-independent life back in the community.

CHAIR: When we talk about the average number of beds internationally, is that broken down into acute, long-term and rehabilitation beds or is it just a bed is a bed?

Mr CAMPBELL: I am unable to answer that question. I would have to go back and look at the literature.

CHAIR: Obviously there may be a need to know the number of paediatric beds, psychogeriatric beds and so on, and then there is the dual diagnosis issue and whether they are scheduled or not. These are important issues.

Mr CAMPBELL: Yes, they are.

CHAIR: If we identified that New South Wales was short of 800 acute beds—which is one of the issues that Professor Raphael has written about that could be distributional—the shortage could be greater on a distributional basis?

Mr CAMPBELL: Yes.

CHAIR: But it does not necessarily take account of long stay and rehabilitation and some psychogeriatric issues.

Mr CAMPBELL: No.

CHAIR: Has Port Macquarie Base Hospital sent patients to hospitals in Sydney, for example Royal North Shore Hospital, because no other appropriate beds are available in New South Wales at the time? If so, would this occur on an occasional or frequent basis?

Mr CAMPBELL: Sporadic. We had a period earlier this year where I personally phoned 29 facilities around the State in an attempt to find a bed. That was an unsuccessful attempt, by the way. On other occasions we have phoned in excess of 10, 12, 15 facilities and transferred people from Port Macquarie to Liverpool, North Shore, Hornsby and Gosford and on one occasion we were in the process of getting someone ready to take them to Orange. That has not happened in the last three months. Since then there has been a different system operating. Up until then I was required to find the bed. Having in frustration referred the problem of the 29 unsuccessful attempts directly to Professor Raphael, she felt that perhaps another system was needed. Now what I do in my service is contact Taree, if there is no bed I contact Coffs Harbour, if there is no bed I contact James Fletcher. If there is then no bed, it is referred through to the area health to find the bed.

CHAIR: Is that bed-finding process like the intensive care bed-finding process where it is now centrally co-ordinated where someone has a vision of which facility has an empty bed?

Mr CAMPBELL: Yes.

CHAIR: Are these beds for your schedulable patients?

Mr CAMPBELL: Yes. They could be for voluntary patients too in that sometimes we need a bed, not having one, and if a voluntary bed is available at Taree and they have the space to take them, they are agreeable.

The Hon. PETER BREEN: Is it possible that someone-else is now making the 29 phone calls?

Mr CAMPBELL: No, I do not think so. I think what Professor Raphael has instituted now is a statewide bed monitoring system. I do not think it is operating perfectly yet, but it is well under way. It does not require that kind of effort.

The Hon. PETER BREEN: When you said earlier that beds were available in places such as Taree, where you referring to these types of beds?

Mr CAMPBELL: The beds I was searching for in particular were beds for scheduled patients, they were involuntary beds.

The Hon. PETER BREEN: What beds were you referring to previously that were vacant?

Mr CAMPBELL: Sometimes we will be told that the units at Taree or Coffs Harbour or even James Fletcher do not have any room for involuntary patients but they do have beds available for voluntaries. Sometimes that distinction is made. I can make contact, as I did in the series of 29 phone calls, which, I hasten to add, was the exception and not the rule. I think we were told on three occasions that voluntary beds were available, but not involuntary.

The Hon. PETER BREEN: Can you explain the difference between voluntary and involuntary?

Mr CAMPBELL: A voluntary bed is where you are unwell, you recognise you are unwell and you wish to go to hospital to receive treatment. An involuntary is where you are unwell, you do not realise it, but we decide you are going.

CHAIR: The unit at Port Macquarie Base Hospital was designed to house scheduled patients with a view to its being gazetted under the Mental Health Act. As I understand it, this has not occurred because of the operating and ownership clause. Could you explain that?

Mr CAMPBELL: As best I can. As best I understand it, the Mental Health Act does not allow the provision of scheduled facilities gazetted beds within a private hospital. Port Macquarie Base Hospital is a private hospital.

CHAIR: That is very interesting because the evidence we got at Port Macquarie was that Port Macquarie is a privately owned, privately operated, public hospital. That is exactly its situation. The fact that it is privately operated might be the problem. It is a public hospital. Mr Clout clearly stated that it is privately owned—the buildings are owned by somebody in America.

Mr CAMPBELL: Yes.

CHAIR: It is privately operated by Mayne.

Mr CAMPBELL: Yes.

CHAIR: But it is a public hospital with all of the things that go with being a public hospital, except this. My understanding is that it will require a change to the Act. That means that something like the Northside Clinic could not take scheduled patients because it is a private hospital.

Mr CAMPBELL: That is my understanding.

CHAIR: There are other hospitals like that in the State.

Mr CAMPBELL: St John of God is another one that comes to mind.

CHAIR: Hawkesbury is a public hospital that is privately operated.

Mr CAMPBELL: Yes. Does that have gazetted patients?

CHAIR: I do not know the answer to that question.

Mr CAMPBELL: I do not know. I followed up on some stories that I had heard that St John of God at Richmond was taking involuntary patients, but what they told me is that that is not the case. Although the patient may have come from an involuntary status, the patient was voluntary when the patient got there.

CHAIR: In other words, you cannot schedule 2 somebody? That is the Hawkesbury hospital?

Mr CAMPBELL: Yes.

CHAIR: That is the same sort of set up at Port Macquarie?

Mr CAMPBELL: Yes.

CHAIR: What is the cost to patients as a result of this, and what funding would be required to Gazette those beds?

Mr CAMPBELL: My opinion is that although the original intention was for that unit to hold gazetted patients, I do not believe that what was developed is adequate. If I may indulge the Committee with the story of the Port Macquarie Base Hospital ghost, it will illustrate my point. Prior to there being any patients in the Port Macquarie Base Hospital mental health unit I arrived one morning to be told that, unfortunately, the ghost from the old Hastings Hospital must have been packed and transported to the new hospital because it appeared last night. The story went that the security guard on rounds came into the then vacant mental health unit and, in checking out the rooms, suddenly felt a gust of wind that blew the door shut. It was then followed by some sort of poltergeist-like experience when a bed and the furniture began to elevate and move around the room. Fearing for his life, the security guard put the heel of his boot right through the door and sent it crashing out of its surrounds and escaped with his life. The ghost has never appeared again and the security guard was asked to find another job. There was some suggestion about a non-prescribed medication. But the point is that the building that was built to hold people securely it far from that.

CHAIR: In other words, he kicked the door and it came off?

Mr CAMPBELL: Yes, he kicked it straight out. The question is what would it cost. It would probably need some addition to the existing building, which is an excellent facility for voluntary patients. There is an adequate capacity to put an extension on that and have a unit for secure patients to the site. That would need to be done. The current building would not, in my opinion, be viable.

CHAIR: There would be a capital cost?

Mr CAMPBELL: Yes.

CHAIR: When it was first opened my understanding is that it was opened with two staff and that the number of staff stayed the same.

Mr CAMPBELL: Yes, two staff per shift.

CHAIR: It was built with a capacity increase more than was needed initially, but as you have increased the number of patients through it the number of staff did not increase.

Mr CAMPBELL: Correct. And I understand that Kempsey will be staffed fairly much on the same basis, that is two nurses per shift. We find that two nurses per shift are very difficult to manage in terms of creating a therapeutic program.

CHAIR: How many patients do you have there now? What is your capacity?

Mr CAMPBELL: Ten.

CHAIR: You think that is understaffing for the nature of the patients you have?

Mr CAMPBELL: Yes, I do.

CHAIR: But it may not be understaffing, depending on the patients, might it?

Mr CAMPBELL: When you have an inpatient unit it is very important that there be a therapeutic program, one that involves the traditional talk therapies but also one that involves some sort of diversion therapy so that people are kept involved and active, and linked into the community in general. With two staff on deck and the requirements for occupational health and safety we are very limited in what we can do with people. We need probably an additional person on the day shift seven days a week to enable that. I think that is probably a better model, anyway.

CHAIR: Again, from talking to Mr Clout and also the chief executive officer of Port Macquarie Base Hospital, my understanding is that mental health is not a profit-generating centre?

Mr CAMPBELL: Correct.

CHAIR: It is purely a service provision process.

Mr CAMPBELL: That is correct.

CHAIR: My understanding is that Port Macquarie Base Hospital psychiatric service closed for a period.

Mr CAMPBELL: Correct.

CHAIR: Why was that?

Mr CAMPBELL: I alluded in my comments to some difficult times, both politically and bureaucratically. It was one of those. At that point we were facing the reality that we would be so over budget because of a non-topping up of our original budget that Mayne was not prepared to wear what was looking like being a 25 per cent budget blowout.

CHAIR: They are responsible if they overspend the money? They have to put money in?

Mr CAMPBELL: Yes.

CHAIR: But there is other money of that public provision, non-profit centre that it can manipulate and I do not mean that in a nasty way, such as transport and a few other things in the same budget that they have to manage.

Mr CAMPBELL: Emergency comes under the direct bill budget, and that will have an overrun by definition. Oncology, mental health—

CHAIR: Transport.

Mr CAMPBELL: I am not sure about that one.

CHAIR: Some areas of the hospital are not profit generating, but they have to live within a very specific budget otherwise Put Macquarie has to make it up.

Mr CAMPBELL: Yes.

CHAIR: If they do not spend that amount of money they do not get it.

Mr CAMPBELL: Yes. I think the hospital has some discretion that if, at the end of the year, it is under in one section and over in another it can even those out.

CHAIR: Is there enough guidance for the provision of service at the Port Macquarie Base Hospital in the contract between Mayne Health and NSW Health to prevent Mayne from not providing a public service?

Mr CAMPBELL: Absolutely. What we are required to do, although it may be put simply in the contract, is quite prescriptive in the sense that we are to provide a level three, four, five depending on where you like to draw the definition of service. That is quite prescriptive. It indicates registrar and VMO support. It indicates extensive community mental health. It indicates quite specific clinical nurse consultant level.

CHAIR: It looks like a public hospital.

Mr CAMPBELL: Yes. It looks, smells and tastes like a public hospital.

CHAIR: Because it is. Have you ever been told not to pursue a service that did not produce a revenue?

Mr CAMPBELL: Absolutely not.

CHAIR: Because it would not be of any great value, would it?

Mr CAMPBELL: Certainly.

CHAIR: Do you have private patients in there?

Mr CAMPBELL: Rarely.

CHAIR: Just like any other public service.

Mr CAMPBELL: Yes, rarely.

CHAIR: Where do private patients with psychiatric illnesses go in Port Macquarie?

Mr CAMPBELL: In Port Macquarie there are those people who have private cover who do not wish to declare it when they come to the base hospital. Therefore they cannot activate it, if you know what I mean. They are, technically, privately covered but they choose not to use it. There is that group of people. Those in Port Macquarie who wish to use it tend to go to the private hospital with a consultant psychiatrist visiting them on a one-to-one basis in the hospital. Or they go out of town.

CHAIR: Some funds do not cover private psychiatric service, do they?

Mr CAMPBELL: No, it is just a matter of what your cover costs.

CHAIR: If I were privately insured and I went to Port Macquarie Base Hospital psychiatric unit and I decided to pay for it, would that give Port Macquarie psychiatric services a boost in income or does it simply have an amount of money to spend whether it raises money or whether it does not raise money?

Mr CAMPBELL: I stand to be corrected here, but the only patients I am aware of that we have been able to charge for have been the occasional DVA patient when the hospital has exceeded its annual free quota. There might have been one or two last year.

CHAIR: Each area health service gets a target for revenue raising, regardless of whether they exceed it. If they exceed it they get to keep the money, if they do not then they are not penalised. You are not aware of that arrangement?

Mr CAMPBELL: No.

The Hon. PETER BREEN: We spoke with Prisons last week and we were told they had a problem at Grafton gaol, that they would need to fly a psychiatrist up from Sydney because no psychiatrist was available to come, for example, from Lismore.

Mr CAMPBELL: Yes.

The Hon. PETER BREEN: Are there psychiatrists available in Port Macquarie who would be available to go to the prisons?

Mr CAMPBELL: No. I will try not to be too longwinded, but my understanding is that across Australia there is a net loss of psychiatrists each year. In other words, we are getting a smaller and smaller pool.

CHAIR: Is that just in the public area or generally?

Mr CAMPBELL: You cannot really quote me on this because I do not know it definitively, but a friend of mine who is on the National Mental Health Council told me that across the board there is a net decline. That poses a real problem. It means that in Port Macquarie, for example, we have three qualified psychiatrists, one of whom for lifestyle reasons works one day a week, one works 2½ days a week and one works full time. In a population of roughly 70,000 in the district we do not have enough.

CHAIR: There is one at Kempsey.

Mr CAMPBELL: Jim Holmes is at Kempsey part time. That just is not enough to even go remotely close to covering the need. Marie Shaw is working a couple of days a week and working on psychotherapy in particular and I think there is a three-year waiting list for her. For Brian and Meredith it is at least three to four months before you will get a preliminary assessment.

The Hon. PETER BREEN: Has the shortage in psychiatrists been taken up by psychologists?

Mr CAMPBELL: One of my suggestions in that submission is that they be looked at, and there are models for that. I advise you that Beverly is not very happy with that suggestion. She does not agree with that.

The Hon. PETER BREEN: But people are going to psychologists when there are no psychiatrists.

Mr CAMPBELL: In rural areas general practitioners will tell you that if they can work with a good psychologist they are off and running. That is one option. The other is that we have, with the support of the area health, begun to toy with the notion of what we call "grow our own psychiatrist". We have identified some young general practitioners who have an interest in psychiatry who now, with Terry Clout's support and the University of Newcastle support, have agreed to meet next Wednesday to explore this notion further.

I believe that we can, from within our own area, identify a number of young GPs who would like to do psychiatry training provided they could stay at the Mid North Coast Area Health Service and not have to leave. If we can do that, our aim would be for us to grow our own, and what the rest of Australia does is their problem.

CHAIR: The increased role of psychiatrists has been raised in a number of the submissions we have received. We have been told that psychiatrists are part of the community mental health team. The Commonwealth is trying to encourage the division of general practitioners by giving GPs new item numbers. That may assist a little.

Mr CAMPBELL: Yes, I think it will; I think it is an excellent notion. At the moment in Port Macquarie we—I say "we" because this is a collaborative effort between the division of GPs and ourselves—are in the process of getting GPs accredited under this new scheme. The next process will be to accredit the psychologists, and we hope that jointly we will be successful in attracting a better outcomes grant. We have been shortlisted for that, and next Monday we are being interviewed by the Commonwealth.

CHAIR: That will be another trial?

Mr CAMPBELL: Yes. But that would give us \$100,000 for three years. We could do something with that.

CHAIR: That goes to the other issue you raised about the prescribing of psychotropic drugs, which you suggested might go to the clinical nurse specialists. The problem is trying to find someone who can be responsible for the prescription of drugs, or simply varying the dose, and not having access to a doctor to do it.

Mr CAMPBELL: Yes.

CHAIR: Currently you use your resident medical officers and your registrar for that?

Mr CAMPBELL: Yes.

CHAIR: How do the members of the community mental health team go about adjusting doses?

Mr CAMPBELL: They cannot. They have to talk to the GP. In about two weeks time we will have our second-year registrar in place, so she will be available to help the community team. You have seen the quality of some of our community team members. With some formal education and accreditation, a person like Phil could quite happily amend a psycho traffic medication prescription.

CHAIR: That could well be part of a nurse practitioner approval process, because some of the nurse practitioner processes allow for limited prescription on a protocol and consultation basis.

Mr CAMPBELL: Yes.

The Hon. PETER BREEN: Could you explain the process of amending a psychotropic medication prescription.

Mr CAMPBELL: We are talking about medications that are really for mental illnesses, which affect the neurotransmitters in the brain, mood, stability, and matters of that nature. It is a particular class of medications. From a theoretical point of view, there is no real reason why a good training program could not be put in place to bring clinical nurse consultants or clinical psychologists up to a level where they could prescribe that class of medication.

CHAIR: It is less likely that it will go to the psychologist; that would be a huge revolutionary change.

Mr CAMPBELL: That is right. My point in raising it was to say that we have to think outside the box if we are to meet the problem head on in rural and remote areas.

CHAIR: Certainly the nurse practitioner model has been criticised in Australia, particularly in New South Wales.

Mr CAMPBELL: Yes.

CHAIR: How many schedule five nurses were lost with the closure of beds and so on?

Mr SCOTT: I went to a College of Nursing course which indicated to me that for psychiatric nurses to continue going into that stream, it would need a 7 per cent increase in nurses to be trained each year to allow the level of psychiatric nurses to stay the same.

CHAIR: When the schedule fives closed, people like Mr Scott moved out and went to Ballina, because they were not necessarily suitable; they were working in wards, long-term rehabilitation or whatever. How many of them simply left?

Mr SCOTT: The present level is estimated at 3 per cent. So we are looking at a loss of 4 per cent registered psychiatric nurses not staying in that stream, and that has been over the last 20 years. So you are looking at a huge loss of psychiatrically trained nurses.

The Hon. PETER BREEN: Yesterday we heard evidence from a woman whose son was suffering from psychiatric disorders. She had a huge problem in that he could not be treated unless he was drug-free. We discovered that quite a lot of institutions will not deal with people who are on drugs, particularly young people. Conversely, a large number of young people—and the suggested figure was up to 90 per cent—who have psychiatric problems use drugs in order to relieve the symptoms. We heard an expression "better to be stoned than mad". How do you deal with someone who comes to you who is obviously on drugs and also may or may not have an underlying psychiatric condition?

Mr CAMPBELL: If a person presents and they are clearly under the influence of a medication and they are unwell, they will go into ICU until we get that clarified. At that point they will be assessed. A psychiatric consultation will be sought, and a mental health team assessment will also be sought. Collaboratively a decision will be made about whether the person is to be referred to drug and alcohol services, brought into the mental health unit, treated as an outpatient, or not treated at all.

However, the problem is that in the Richmond report drug and alcohol services were hived off from psychiatry. I think we created a systemic problem here; we created a gulf between the two. My opinion is that they should be reunited.

John Anderson, from the Westmead Hospital's research into females who are on the methadone program, would suggest that somewhere between 60 and 80 per cent of them have an untreated sexual assault background. If that is the case, what we are doing in the methadone treatment is treating a symptom, rather than treating the cause. Whilst they are seen under the drug and alcohol umbrella, that will remain so. Perhaps it would be better to treat them under a combined umbrella and solve this problem of people being flicked between one part of the service and another.

CHAIR: If they come to you and they are on the methadone program and they have PTSD, would you treat them for the PTSD while they are still on methadone?

Mr CAMPBELL: We do not have any embargo on that. But what tends to happen is that the person does not see themselves as having a PTSD; they see themselves as having a drug problem. They can simply say to us, "I have a drug problem," and that is the end of the issue. I can say to them until I am blue in the face, "I think you have an underlying PTSD problem."

CHAIR: When we visited the prison recently we were told by corrections health officers that of the 90 per cent of women with mental illness who were in prison, 67 per cent of them have a coexisting drug problem. For men, I think the 83 per cent of men in prison who have a mental disorder of some sort, 50 per cent have a coexisting drug problem.

Yesterday we were told that 75 per cent of the people who are homeless have a mental illness of some sort, and most of those people have a drug problem as well. That indicates a large number of people who have combined problems. It seems bizarre that one has a drug and alcohol directorate and the other has a centre for mental health and it seems they do not talk to one another. How can we overcome the problem of this huge abyss between the two services?

Mr CAMPBELL: At the risk of being flippant, the problem was created with an administrative pen.

CHAIR: In June we were told that the people who are mentally ill and have a drug problem are the most toxic and violent people. In Port Macquarie, if you have to look after those sorts of people, you almost need the old padded room that general hospitals used to have. In Parramatta District Hospital in 1970, the first room inside the front door was a padded room with mattresses all over the floor. The police would bring the patients in, and they would be given formaldehyde just to get some control of the situation. I do not suggest that is what we should be doing today.

Mr CAMPBELL: No. But I think it recognises that there is a multiple diagnosis problem. We have not struck this yet, but it is a matter of time before we have the trifecta of a basic mental

health problem compounded by a drug and alcohol problem, superimposed by an AIDS dementia. When that hits us, we are in trouble.

The Hon. PETER BREEN: You will definitely refer those on, will you not?

Mr CAMPBELL: Absolutely. We are gearing up for our first AIDS dementia; it cannot be too far away.

CHAIR: Last Monday we were told that the department is planning to build a secure hospital at Long Bay, excising the existing prison hospital and putting within it the people within the present system who have mental illnesses and need security, and also community people who are so unwell that it is necessary to have that high level of security to protect the staff. That is only 140 beds for the State. Where are the security beds at the moment in the State that you are aware of, high security beds that protect the staff, not forensic patients, not people under the court system at all?

The Hon. PETER BREEN: Can we just clarify this forensic patients definition? What do you understand by that?

Mr CAMPBELL: I understand forensic patients to be those patients who have a criminal offence in addition to a mental illness and who are currently incarcerated.

CHAIR: Not necessarily scheduled? They are there because of the courts?

Mr CAMPBELL: They are there because of the court sentencing.

CHAIR: Are they all not guilty by reason of mental illness or can some of them be guilty but have a mental illness?

Mr CAMPBELL: They can be both.

CHAIR: But they are the forensics. The courts put them there.

The Hon. PETER BREEN: When you refer to gazetted patients—

Mr CAMPBELL: Involuntaries, I'm sorry. People who are in hospital against their will.

The Hon. PETER BREEN: Is that the same as gazetted patients?

Mr CAMPBELL: Gazetted patients, sorry. We use the terms interchangeably, yes.

The Hon. JOHN JOBLING: At this stage you point out the potential problem that we are likely to be facing: those with mental illness in one box; those with a drug and alcohol problem in a second box and your fear of the AIDS dementia third box appearing. What would you say to us we should be looking at to try to open up the passageways between these three separate castles that appear to be being built? In other words, how do we (a) bring the empires together or (b) commence? It is going to take time getting them to talk to one another and work with one another. What steps would you be suggesting to us, as a practical person?

Mr CAMPBELL: It is a good question. I have on several occasions this year reminded the mid North Coast drug and alcohol service that its strategic plan specifically includes a section to develop a conjoint program between itself and mental health and as yet we have not done that. So that is sitting there. I am unable at this point to activate that. However, I believe, and I think that Professor Vaughan Carr at Newcastle probably would agree with me on this, that we need to think about bringing the two major issues of drug and alcohol and mental health back together.

The Hon. JOHN JOBLING: How aware then are most people of what I will call the third box, the AIDS dementia one, which does not appear to have been raised by other areas and concerns specifically to us? What thoughts or preparation, to your knowledge, are being undertaken for this to become the third arm of the problem?

Mr CAMPBELL: I do not think the numbers will be great but they will be quite severe nonetheless. What we are doing is we have supported one of our part-time staff to gain an appointment with the AIDS Council working in the mid North Coast and we will be sitting with them as soon as he commences work to set up a memorandum of understanding. So we actively plan to work together. I believe we will be able to achieve that with them but I think the whole question of drug and alcohol and the gaps that are allowing people to fall through are just so large that it needs to be tackled systemically.

The Hon. JOHN JOBLING: Are you aware of any actions talked about or under way that may be being undertaken by any of the area health services or looked at by New South Wales Health as a whole or is it just a forgotten land?

Mr CAMPBELL: I am not aware of any efforts in this regard. There may be but I am simply not aware of them.

The Hon. PETER BREEN: Just on that point, in the same vein you asked a question about what happens to dangerous patients at the moment and I do not think that you answered it.

Mr CAMPBELL: Dangerous patients: we need to involve the police in their apprehension, if you like, and then they are taken to a scheduled unit which would most probably be James Fletcher in this case, and they would be sedated before, during and after arrival and then a decision would be made after probably 36, 48 hours as to how this person pulls up after the medication and what is going to happen there. Now if the person in the meantime has committed a violent crime then of course we are in the forensic area.

The Hon. PETER BREEN: Where do you send them?

Mr CAMPBELL: They will be taken probably to Long Bay and they may be held there on remand and then imprisoned there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In terms of resources, Mr Scott has given us evidence that he liaises with community facilities and places people in community facilities. The essence of the Richmond report was of course to create community facilities as alternatives to institutional facilities. The evidence we had yesterday from NCOSS, the New South Wales Council of Social Services, was that New South Wales has only roughly a third of the Australian average of community services and only a third as much of the Australian average of NGO services. Now that would suggest an absolute wasteland relatively to what they should be in the community. Do you think those figures are accurate and do you think that in fact it is a wasteland in the community, and, if that is the case, then clearly the Richmond report has simply meant that very little money has gone there in New South Wales?

Mr CAMPBELL: I cannot accurately comment on the figures except to say that at a gut level they sound in the ball park to me. Certainly from a practical point of view in Port Macquarie we have the inpatient unit, we have some housing provided by the Department of Housing for people with mental illness where those people can be case managed by members of my service—and that covers probably some 20 to 30 people—we have one NGO, which is Centacare, that offers some accommodation for people with a mental illness and they are sort of case managed, looked after by Centacare—that covers about 15 people—we have one group home in Port Macquarie that is run by the Department of Health at Kempsey—just don't go there—which has, I think, four or five beds which we find it so difficult to get patients into we do not bother referring any more, and I think that is Mr Scott's experience as well. That is it.

The problem for us is that we do not have a cascade, if you like, of accommodation options where we can step people down from hospital in a therapeutically sensible way and also we cannot step people up. We have to wait until the wheels fall off and then intervene—and there are lots of reasons for that—and even if we could intervene earlier we do not have the facilities for these people to go into. We do not have respite care for the carers. I have just asked my staff to give me the figures on this: currently I am aware of a number of people who have chronic and severe mental illness who are being looked after by their parents and in those cases both parents are well into their eighties. The chances are that in four or five years these young patients will be on their own, but they cannot

survive. The only option that we have for them is to somehow send them to Sydney, but if we do that your own figures suggest they are going to finish up in the DOS houses anyway because they do not have the coping skills to be able to manage independently.

CHAIR: Can I go back a step? Going back to the issue of drug and alcohol plus mental illness, in Lismore we have got a major new building called Riverside which is a brand new drug and alcohol service built separately from the hospital, up the hill and away from the psychiatric unit. As far as I am aware when we did the drug summit the only beds of a long term rehabilitation nature for drug and alcohol problems in New South Wales were at Orange or at the Buttery in Lismore, the only country based beds. That was done by the professor who runs the Riverside clinic. He wrote the paper on regional services. Do you have any long-term rehabilitation services for drug and alcohol in your area?

Mr CAMPBELL: No.

CHAIR: You share that with the rest of New South Wales?

Mr CAMPBELL: Yes. We are not unique in that.

CHAIR: When we did the drug summit I do not remember mental illness appearing as a major feature, do you, Mr Jobling?

The Hon. JOHN JOBLING: It is again a separation of the two areas. It dealt purely with drugs.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hard drugs partly with alcohol.

CHAIR: This is the problem, that we are not well set up to treat drug and alcohol problems from a long term rehabilitation point of view, in the country anyway, and even in the city, apart from the centre out at Fairfield. Langton Clinic has closed, it is a daily only placement and there is no residential arrangement.

The Hon. JOHN JOBLING: Wasn't there are a drug and alcohol—more particularly drug—one being set up at Port Macquarie?

CHAIR: That is an NGO.

The Hon. JOHN JOBLING: I accept that it is an NGO but it is one that is there.

CHAIR: It just comes to the attention of all of us that the number of long-term rehabilitation beds for drug and alcohol are not there. The long-term rehabilitation for psychiatric service in the country is at Bloomfield. Is there anywhere else that you are aware of?

Mr CAMPBELL: Only at Morissett.

CHAIR: Is Morissett only for forensics or not?

Mr CAMPBELL: No.

CHAIR: So again the issue that Peter raised about the dangerous mentally ill patient, they almost invariably become forensics anyway because when they are dangerous they commit a crime, whether it is bashing a policeman or whatever, they become forensics by order of the court.

Mr CAMPBELL: In some sense our gaols have become our de facto Schedule 5 hospitals.

CHAIR: That is the evidence that the police gave. That is the evidence a number of people have given, precisely that, and that is a problem, but they do not offer the long-term rehabilitation services. You have been in the service for a long time, as has Mr Scott, but the evidence we got was that if prior to Richmond you had your first exhibition of schizophrenia aged 19 you would be in Rozelle for three to six months, then you would go to Macquarie Cottages for about eight or nine

months and then you would go home. These days you get admitted into an acute ward for two or three weeks and you go home. Is that the difference? Am I portraying it accurately?

Mr CAMPBELL: I think the Epic program, which was designed to treat early onset psychosis, picks up the flavour of the Rozelle and Macquarie. It is saying that on presentation of first episode psychosis we need at least six to nine months of intensive work.

CHAIR: Is that in operation anywhere in New South Wales?

Mr CAMPBELL: In some forms it is although I cannot give you a precise rundown also where it is operating.

CHAIR: Professor Raphael told us about all these wonderful programs but we have not found the evidence that any of them are operating.

Mr CAMPBELL: Their people are using elements of Epic. They are saying in the mental health services "We will try and treat first presentation intensively" but in actual fact I do not think that is coming close to the mark. My problem, for example, in relation to that is I have two child and adolescent mental health workers; we have no resident child psychiatrists. We get support from a flying psychiatrist from Westmead one day a month. The conditions of employment of those two child and adolescent workers is that 50 per cent of their time must be spent on promotion of mental health and the prevention of mental illness so, in effect, I have one full-time caseworker. I cannot do it.

CHAIR: You might not be able to do it but the parents and kids—

Mr CAMPBELL: Have to do it.

CHAIR: If 1 per cent of the population has schizophrenia and it exhibits itself at 16 to 29 years—

Mr CAMPBELL: Even earlier than that.

CHAIR: Even if it does, that indicates a large number of beds are needed for the initial presentation if the Epic Program is going to be done?

Mr CAMPBELL: Yes. You have just jogged my memory. I believe there is a new program called Camslink. Precisely what it is or does I am not certain. I do believe, however, that it will involve the building of a residential adolescent unit somewhere in the Hunter in terms of the north and the ceding throughout a catchment area of some resource people, but that is all I can tell you about it at this stage. I understand that there is a meeting in Port Macquarie on Monday about Camslink and that is a Department of Health meeting at the Terry Clout level. I am not involved in that.

CHAIR: How many new people with schizophrenia would be identified in Port Macquarie per annum?

Mr CAMPBELL: New people?

CHAIR: Initial presentations?

Mr CAMPBELL: I would have to go back and check on the numbers, but I think we would be looking in the order of—and I am guessing now—20 to 30.

CHAIR: In the tens?

Mr CAMPBELL: Yes. When we see them and it is their first presentation to us, it may not be their first presentation by the time they get to us.

CHAIR: How many would be first presentation, in other words, 16 or 17 year olds found in a phone booth, cowering and worrying that someone is chasing them?

Mr CAMPBELL: I have not got those figures and would be guessing, but I think it is a little bit more than we would think at the moment. It is a bit germane to the point of determining—first of all, the diagnosis cannot always be made that it is schizophrenia. Often the presentation is through a drug overdose and we have the problem to sort out first of all whether what we are seeing is prodromal schizophrenia or whether it is drug induced and that often take some years to determine but in that area, it is enough to cause us some worry.

CHAIR: The child psychiatrist on Monday said that if you have one episode of psychosis it will not be the last.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ninety per cent.

CHAIR: In 90 per cent of cases it will be an ongoing matter.

The Hon. JOHN JOBLING: It might a long lead time or a short lead time.

The Hon. PETER BREEN: The question that was not answered was whether or not drug-induced psychosis is in the same category.

CHAIR: She said if they present with psychosis only 10 per cent will never have another episode, whether or not it was drug induced because marijuana-causing psychosis might unmask an initial one and may simply trigger the exhibition rather than the condition.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mentioned that 50 per cent of your child and adolescent workers' time is in preventive work. Do you think that is time well spent?

Mr CAMPBELL: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You obviously do not like them being removed from their therapeutic tasks but you think that the preventive tasks they do are important. Is it necessary for a psychiatrist to do that?

Mr CAMPBELL: Yes, I believe so. This is a personal philosophic point of view I offer now but at some level, if we do not spend some of our resources to try to turn off the tap, then we are morally responsible. I can spend whatever the Government gives me on treating the people who have already developed the illness and still come back with my hand out for more, so from whatever pie I am given I need to make some determination about how much should be spent prodromally, and that is an issue that is currently out in my community through our consultative process. I want them to grapple with the issue. They have tried to duck it in the past but I am not letting them now. They have to give me advice on this. Do we spend 5 per cent of our resources, which we currently are?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On child and adolescent prevention?

Mr CAMPBELL: Yes, or do we up that. I think we have to up it but what is the figure? I am not sure but I would think probably 20 per cent would be not unreasonable. If I were to suggest that we take 20 per cent of our current resources and put them into child and adolescent prevention I would be lynched.

CHAIR: You would have to close a ward for six weeks of the year.

Mr CAMPBELL: Yes, so I have to try and squirrel that away from growth, and my difficulty with growth is that we do not have a rational funding or resource allocation formula. What happens is that people get bits and pieces added on to their service. Sometimes it comes directly with strings attached from the Commonwealth and sometimes it just comes in terms of a position for case management, but we do not get workable units that come with a combination of psychiatrist's time, therapist's time and part of a vehicle to drive these people around because you cannot have a community mental health team that cannot get out of an office. We are not providing our resources in workable units and that issue needs to be addressed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I tried to ask a couple of witnesses what percentage of the nurses should be in acute units and what percentage should be in the community and 70:30 was one figure given. What percentage of psychiatric service personnel do you believe should be in acute units as opposed to the community or would you say that was an artificial distinction anyway which should be further classified?

Mr CAMPBELL: Yes, I think it needs to be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What comments would you make about that?

Mr CAMPBELL: In voluntary units such as Port Macquarie you need ideally what I would call 3:3:2 staffing, so there would be three staff on in the morning, the afternoon and evening shifts and that should be made up of two nursing staff and one non-nursing staff. That could be a psychologist, an occupational therapist, a diversionary therapist or the like. For the community I think the team should come in groups of three, which should contain a psychiatric nurse, an allied health person and some component of medical. When you get an increase in resource you get a lump.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But how many people should be in acute units compared to how many in the community as a total number of full-time equivalents?

CHAIR: If you have 100 nurses, would you put 80 in the community?

Mr CAMPBELL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And 20 in the hospital?

Mr CAMPBELL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would be an 80:20, the exact opposite to the guy who wanted it 70:30 the other way around?

Mr CAMPBELL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had great difficulty getting the breakdown of how much from the area health service budget actually gets to mental health. A suggestion has been made that money has been pilfered along the way by health service administrators from mental health to other services. NCOSS went so far as to say the budget was adjusted to pretend it was in mental health when it was not, which is a stunning allegation. Is the money for mental health in your area accountable and can you trace it all? Also, do you believe the figures are correct?

Mr CAMPBELL: I can trace every dollar that comes to the Port Macquarie Base Hospital Mental Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not quite the same thing, is it? The area health service budget?

Mr CAMPBELL: I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can do the ones in your hospital but not the ones for the area health service mental health as a whole?

Mr CAMPBELL: No.

CHAIR: Unfortunately, we must now conclude this hearing. You will receive a transcript. Would you please help us by adding anything that you may have not mentioned, especially on the last issue. The Committee may also contact you to seek further assistance. Thank you for appearing before the Committee.

(The witness withdrew)

(The Committee adjourned at 1.10 p.m.)