REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

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At Sydney on Wednesday 31 July 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 A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. John Jobling

MICHAEL ALWYN ROBERTS, Chief Executive Officer, Dharah Gibinj Aboriginal Medical Service, Aboriginal Corporation (Casino), 43 Johnston Street, Casino, and

LEXIE CHRISTINE LORD, Volunteer, Dharah Gibinj Aboriginal Medical Service, 43 Johnston Street, Casino, sworn and examined:

CHAIR: Mr Roberts and Ms Lord, in what capacity are you appearing before the Committee?

Mr ROBERTS: As the Chief Executive Officer.

Ms LORD: As a volunteer.

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

Mr ROBERTS: Yes, I have read them.

Ms LORD: Yes, I am.

CHAIR: Would you like to make your submission, which is our submission No. 119, part of your sworn evidence?

Mr ROBERTS: Yes, I do.

CHAIR: If either of you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee would be willing to accede to your request. But you should be aware that the Legislative Council may overturn the Committee's decision and make that evidence public. The issue of mental health and Aboriginal mental health, in particular, is of considerable concern. Therefore, we are very pleased to have received your submission. Would you like to make a statement before we ask you some questions?

Mr ROBERTS: Yes, I would. I come from an area up on the far north coast of New South Wales. In the area I come from over 2,200 Aboriginal people live there. On the far north coast, we have the most Aboriginal people in our area, which ranges from Grafton to Tweed Heads. All over there is about 6,500 Aboriginals. Over the years suicide, or any sort of mental health issue, has emerged in our communities. It is something that has not been addressed of late because of the high rate of drug abuse and alcoholism in our communities. Our people do still live on Aboriginal reserves, if you like to call them that.

CHAIR: In particular at Tabulam and Muli Muli?

Mr ROBERTS: Yes, and also the Box Ridge area. Any collection of statistics that may arise when people say they have got a mental illness is very unreliable, I feel. I think that has been shown too throughout the years because our people do tend to shift around from place to place, they are not very stable. Hence if the are reported in one locality as having a mental illness, they could move to another place. Also with this unreliability of the collection of statistics, our people are sort of ashamed to say that

they have a mental illness or that they have got something wrong with them. That is just the way we are. I might add, we have had 10 funerals just recently. They were not actually related to mental illness or any trauma like that, but we had about 10 deaths in the last four or five weeks and our communities are in constant mourning.

CHAIR: How many of those deaths would have been suicides?

Mr ROBERTS: There would not have been any of them.

CHAIR: Pastor Roberts passed away.

Mr ROBERTS: Yes, that is right. Just to give you one little scenario, if I may, just recently on one or our Aboriginal reserves up in the Casino area, one person committed suicide by hanging. He was in public view of everybody, including the young children. The authorities were there and I am sure they tried their hardest to explain that this person has got to stay there for the Coroner, but the person was not even covered by a sheet and there was not any attempt to cut the person down. That happened a few months ago. Like I said, with all the deaths happening, we are in constant mourning. Soon after that unfortunate event, several of his relations wanted to copycat what he had done. That went from Tabulam down to Yamba to Grafton where his people come from, because we are nearly all related to everyone up there. There were about four or five young men wanted to commit suicide.

The team that came in there from mental health in Lismore, sure, they meant well by getting a group of people together and saying, "Let's go and talk to these people out here", but the manner in which it was done was not culturally sensitive. They just came in and wanted to take over and talk to our people, but not understand the process of what we were actually going through. In the end, they were shunted off the reserve really and we were sort of left to fend for ourselves, to deal with our morning, our grief. Just recently I was involved in a steering committee from January to December 2001. The steering committee was for the Aboriginal and Torres Strait Islander [ATSI] mental health project, which was a twelve-month project. Lyndall Smith, which is her married name now, was the project officer on this particular project. I think the money came from the National Mental Health Reform Incentive. It was part of the Second National Mental Health Plan.

Coming from the plan itself, Aboriginal mental health was identified as a priority for the Northern Rivers area under the partnership platform of the plan. With Lyndall's hard work and, I suppose, drive and initiative to put something behind it, because she is very sincere when it comes to Aboriginal mental health, especially up in our area, we addressed all the different policies that were linked, especially the Northern Rivers Area Health mental health strategic plans and the New South Wales Aboriginal health strategic plans, and the Aboriginal deaths in custody comes into it too. She worked very hard to deliver a report on that. Unfortunately, I cannot deliver that today because it is just a draft copy at this moment. Since I was talking with Lyndall last Thursday, as yet the draft report has not been signed off or ratified at this moment.

In the report itself Lyndall has recognised the need for more Aboriginals to be trained and for some sort of training system set up so that they have a diploma in Aboriginal mental health. Our mental health is different to white man's mental health because of our different cultures. There is a need for more people to be out there. Even

the mainstream workers are understaffed at this time. Mental health as a whole over all of New South Wales and Australia has been identified recently and over the last few years.

If you want to take things from the Richmond report to say let us keep our people at home, which is what we want to do, again you are saving the dollars from cluttering up the hospitals, because of the cost of keeping a person in a place such as where I come from, Richmond Clinic. If we can keep our people at home, it will be all the better, but we need people out there who know what is going on and can also service our people and understand them. So we do need to listen to what our people are saying.

The Hon. PETER BREEN: How many psychiatrists are there in Richmond Clinic? Harry Freeman is one.

Mr ROBERTS: He has retired. Dr Petroff, Dr Fuller—

CHAIR: The lady psychiatrist.

Ms LORD: I was told that she resigned, but I do not know whether that was just from the public system.

CHAIR: There is a registrar, is there not?

Mr ROBERTS: They would have a registrar, yes.

The Hon. PETER BREEN: Do they travel out to the Aboriginal communities?

Mr ROBERTS: Not to the communities, no. They come as far as Casino hospital.

CHAIR: Dr Petroff works from a clinic at Casino?

Mr ROBERTS: Yes. On one day Dr Petroff could have a lot of patients.

CHAIR: Does he see many Aboriginal patients at Casino?

Mr ROBERTS: Not many.

CHAIR: Does he visit your medical service?

Mr ROBERTS: No, he does not.

CHAIR: To your knowledge, does the Richmond Clinic have Aboriginal workers?

Mr ROBERTS: They do have a female Aboriginal mental health worker, and also a male.

The Hon. PETER BREEN: Did I understand you to say that you come from the Richmond Clinic?

Mr ROBERTS: I have worked at the Richmond Clinic for 12 months or more, yes.

The Hon. PETER BREEN: In a paid capacity?

Mr ROBERTS: Yes.

CHAIR: Could you tell us how you found working in an inpatient facility?

Mr ROBERTS: On the first day I walked in there, which was about four years ago, as I walked through the front doors there was a young Aboriginal woman being restrained by five or six people. They were taking her into the lock-up area, and she was grabbing hold of the doorway; she just would not let go. They had trouble getting her through the doorway. She looked up and saw me, with sad eyes, and said, "Please, please, brother, help me." In my first three or four weeks there, because I was not trained to work there, I too found that I was starting to go downhill because I was getting depressed just by being there myself. But after a month or two I started to come good, and I enjoyed working there. I did find the registered nurses to be quite helpful. They were sincere in what they were doing, but they were overworked. I know they have had renovations done there recently, and I think they are going to move into a new area of the hospital itself.

CHAIR: How many Aboriginal clients would have come through the Richmond Clinic as inpatients while you were there?

Mr ROBERTS: Probably about eight or nine.

CHAIR: That is quite a lot compared to the population, it is it not? They would come from Grafton and up as far as Tweed Heads, which includes Woodenbong and the hinterland areas?

Mr ROBERTS: That is right. But the ones I did see there were the severe cases. You would see them out on the street; they were drug users. With our people, you know everybody; you know what they do and all the rest of it. It is not hidden who they are.

CHAIR: When they left the clinic to go back home, were there Aboriginal mental health workers following them up, checking up on them?

Mr ROBERTS: It all depends. In Lismore, there probably would have been; Jackie would have done that. In Casino, in the western cluster as we call it, I think there are only two mainstream mental health workers, but there would have been no follow-up at all really. Our people move around; they could be here today and somewhere else tomorrow.

CHAIR: Aboriginal numbers in prisons are very high. To your knowledge, how many Aboriginal people who are in the prisons have mental illness?

Mr ROBERTS: For a number of years I worked at Namatjira Haven, which is a drug and alcohol rehabilitation centre at Alstonville, not far from Lismore. Because of people coming through there with mostly drug but also alcohol abuse, they did have some form of mental illness. In the time that I was there, there would have been hundreds of people coming through there. A lot of the people who work there did come from the gaol system. They do their three months rehabilitation there, then they are out in the open community again.

CHAIR: Are you aware of a follow-up system for their mental illness care?

Mr ROBERTS: They would have none at all.

CHAIR: In your experience, do Aboriginal people have the same forms of mental illness that the mainstream community might have?

Mr ROBERTS: No, I do not think so. I do not believe so.

CHAIR: What would be the difference?

Mr ROBERTS: With our understanding of mental illness, years ago, back in the late 1960s, when I grew up on an Aboriginal mission just outside Lismore, we looked after our people ourselves, in our own sort of way, whether it be spiritual or families getting around the person and giving some love and care to the person. That is the sort of caring we like to give our people if they are sick. That is why you do not see a lot of people in palliative care or any other institution, or even going to hospital, because we like to care for our people at home, whether they be aged or whatever. Our own understanding of culture is different. There could be something out there that could make these people sick—not actually the mental illness itself or a stigma attached to it; it is just our understanding that there is probably something evil out there that is making them sick. That is how we try to treat our own people.

CHAIR: But they would have the same psychoses, schizophrenia, and illnesses of that nature, from what you saw in the clinic of the patients who were admitted?

Mr ROBERTS: They would have been drug and alcohol induced.

CHAIR: With regard to access to training, from memory it was easy to find female Aboriginal health workers and train them and keep them in the system, but much more difficult to train an older male Aboriginal health worker and keep him in the system. Is that still the case?

Mr ROBERTS: From talking to an Aboriginal male mental health worker recently, he seems to want to go out into another direction of health, whereas the other one is still there. She is hanging in there, but she is overworked and stressed out. One person will look after so many Aboriginal people in their vicinity; she could look after 60 people or maybe more.

CHAIR: Is it a problem for a female Aboriginal health worker to work with Aboriginal males who are mentally ill?

Mr ROBERTS: It probably would be. Just on an OH&S issue, I suppose they could work in pairs. Just recently people have gone out after hours by themselves and they have been attacked by mentally ill people. It is very dangerous. So it would be good if they could go out in pairs.

CHAIR: Where is the training provided for Aboriginal mental health workers?

Mr ROBERTS: At the moment the person that I am aware of goes to Darwin every now and then and does a block release up there. When he finishes there, he will come back and hopefully stay on. But, as I said, he could be moving away from Richmond Clinic. I imagine they have training blocks here in Sydney. But I think it is a lot of hands-on experience.

CHAIR: You said earlier that there needs to be a certificated course so they can take their skills from area to area.

Mr ROBERTS: I think so, yes. There should be a certificate course or diploma, so that these people who are dealing with Aboriginal people who have mental illness have some understanding on the clinical side, so that they know how to give needles if need be, how to assess a person if they have mental illness, and also refer them on to someone else.

CHAIR: Would many Aboriginal people on the North Coast in your area be under a community treatment order—forced medication?

Mr ROBERTS: I am not too sure. There would be.

CHAIR: So your centre, as you go into Casino from Lismore, is on the left-hand side, is it not?

Mr ROBERTS: That is right.

CHAIR: I remember going to the opening of that. How do you provide mental health services out of your centre?

Mr ROBERTS: We have a male mental health worker who comes over once a week every Tuesday and he spends half a day with us. On Monday I talked with him and his supervisor is going to release him for another extra day. Because we provide a medical outreach service to the community that we visit up there he is actually going to come out with us on another day when we do go out, so we will have a full day out there in the community.

CHAIR: You mean in places like Tabulam, Urbanville and Woodenbong?

Mr ROBERTS: Yes, that is right.

The Hon. AMANDA FAZIO: Is the fellow who helps you employed by the local area health service?

Mr ROBERTS: That is right, yes.

The Hon. AMANDA FAZIO: And is he indigenous?

Mr ROBERTS: Yes.

CHAIR: Grafton has an Aboriginal medical service as well. Does it have a mental health worker there also?

Mr ROBERTS: They have. She has been working there now I think for the last 12 months or so.

CHAIR: Is there one in Lismore?

Mr ROBERTS: No.

CHAIR: Casino and Grafton are the two big ones?

Mr ROBERTS: That is right.

CHAIR: So the patients from Baryulgil would go to either? They would come to you at Casino or—

Mr ROBERTS: They would probably go to Grafton more than us.

CHAIR: And the people from Yamba go to both?

Mr ROBERTS: No. They would probably go to Grafton.

CHAIR: So you have doctors visiting those clinics. Do your general practitioner visiting doctors have much to do with the mental illness part of the service?

Mr ROBERTS: Just talking with our own doctor up there in the practice, he seems to think some people with some form of mental illness are actually seeing him. Especially with the high ratio of unemployment in a town like Casino, because we bulk bill we do tend to get people who are coming in from, say, the public housing estates and people who are less fortunate than others. So he has been seeing a lot of mental illness come through there.

CHAIR: There is a lot of strife near one of those housing estates. I have forgotten the name of it.

Mr ROBERTS: Oak Avenue.

CHAIR: Yes. Is that related to mental illness or is that just fighting amongst families?

Mr ROBERTS: I think there is a lot of drug and alcohol involved in it and fighting amongst families, yes.

CHAIR: A drug and alcohol service is pretty well provided at Namatjira House, is it not?

Mr ROBERTS: Namatjira Haven.

CHAIR: Namatjira Haven at Alstonville. Are there any other places where you can access that sort of service? Is the detoxification centre in Lismore about receiving Aboriginal patients?

Mr ROBERTS: I believe Riverlands are getting some in there, yes.

CHAIR: Do they have a drug and alcohol worker associated with Riverlands who visits from a prevention talking point of view?

Mr ROBERTS: They have an Aboriginal female worker who does work with them and I am sure she would provide that support out there.

CHAIR: So there are quite a few Aboriginal health workers in the Northern Rivers in various guises?

Mr ROBERTS: Quite a few but not a lot really, not per capita if you are talking per head.

CHAIR: So how many Aboriginals would live say north of Grafton in northern New South Wales?

Mr ROBERTS: North of Grafton out to Tabulam, those places, to Tweed Heads?

CHAIR: Up to the border to Tweed Heads?

Mr ROBERTS: I would say well over 5,000 and or more.

CHAIR: Quite a lot. Has anybody else got any other questions?

The Hon. AMANDA FAZIO: Have you noticed any correlation between people suffering with mental illness and those involved in domestic violence? Is there a noticeable link in the Aboriginal communities that you deal with between those two issues?

Mr ROBERTS: I think so, yes. Domestic violence is another issue, yes. It needs to be addressed too and I think because you have unemployment and poverty, most families are pretty big, there could be two or three families living in the whole house, so there could be 25 people in one home up there.

The Hon. AMANDA FAZIO: Do you think improved mental health services for Aboriginal communities up there might help improve the domestic violence situation?

Mr ROBERTS: It probably would. We ourselves at the AMS at Dharah Gibinj have formed a partnership with other mainstream people in Lismore in actually running some anger management programs in Casino and they have been well represented mainly by females but males do come along. I think on our first one we only had about three or four people. It has been gradually building up to about eight to a dozen people

turning up. So they do need anger management out there, not for themselves but for their partners also.

CHAIR: Two other brief issues: first, you made a submission on the question of partnership with local general practitioners. A lot of Aboriginal people just see general practitioners and do not go to Aboriginal medical services. Have you had much success in dealing with the Northern Rivers division of general practice?

Mr ROBERTS: At the moment we are doing something unrelated, a cardiovascular project with the division, but our own doctor is also part of the unit over there so he talks with them frequently. But we also do things with the division of the general practitioners and they actually help along the way, yes.

CHAIR: What about Grafton gaol—which is a very large gaol with quite a few Aboriginal inmates—do they have a mental health workers visiting Grafton gaol to see Aboriginal inmates?

Mr ROBERTS: I imagine they would have. I know a health worker down at Grafton AMS does go there once a week. I am pretty sure they would.

Ms LORD: There should be but I could not confirm it.

CHAIR: There was a recent death which is now the subject of an inquiry at Grafton gaol, a suicide, hanging, at Grafton gaol—I think the name was even Roberts, was it not?

Mr ROBERTS: Yes.

CHAIR: The issue that I read in the *Northern Star* was that nobody was aware that he had a mental health problem but his wife had had a phone call saying he was very distressed. Is there access for a worker to see Aboriginal people who have distress of that sort in the prison?

Mr ROBERTS: There probably would be.

CHAIR: Is that a reasonable representation of the report in the *Northern Star*?

Mr ROBERTS: Yes. There would be on the day unless they have a shutdown on the day, or whatever they call it, where they lock everybody up and nobody is allowed in or out. That could happen at the drop of a hat really and can be frequent.

CHAIR: That was the first death for some time at Grafton, was it not?

Ms LORD: As I understand, he was in a single room.

The Hon. JOHN JOBLING: In your opening remarks you made some interesting comments that intrigued me a little bit relating to the understanding of the difference of the specific Aboriginal mental health problems to the non-Aboriginal groups. Has anything been done to implement a training program for other mental health workers to make them aware of your spiritual and particular different views so that the people working in the field can understand this and that it can perhaps be

incorporated into their training courses at the basic level so that there is a better understanding? Could you amplify as to what may have been done or what could be done there?

Mr ROBERTS: The hospital itself or the area health does have a training package on cultural awareness but nothing further goes into mental health. That would be a step in the right direction, of course, and I am sure it would help our people and also of the people on the other side of the coin to understand Aboriginal mental illness because I do not think they really do understand the point of view of Aboriginals and also their nature. They could joke around with you at different times and you as a non-Aboriginal could take it in the wrong way and they do not mean anything by it. If you could learn to understand that sort of attitude towards an Aboriginal person you can know and understand all Aboriginal people.

The Hon. JOHN JOBLING: To your knowledge would this package be just peculiar to the Northern Rivers Area Health Service?

Mr ROBERTS: It would be because even our communities up there—and I think we have got something like five or six different Aboriginal communities—every one of those communities are different; you treat them differently because the people are different in those communities. So you would have a different package maybe for people in the Lismore, Casino and Grafton areas and also the Tweed.

The Hon. JOHN JOBLING: So would it be possible—excuse my ignorance in this—in general terms to create a basic package that could be adapted to different areas, taking into account different cultures and different groupings?

Mr ROBERTS: No, not one package, no.

The Hon. JOHN JOBLING: Not a basic one that could be adapted?

Mr ROBERTS: No.

The Hon. PETER BREEN: That is a problem you raised yourself in your submission when you said that the provisions of the Mental Health Act were deficient in terms of the specific problems of Aboriginal people but unless you can articulate what they are it is very difficult to know how to approach the problem.

CHAIR: They are different in every area. Do the mental health workers go to Cabbage Tree to the aid post there because that is a different group altogether again, is it not?

Mr ROBERTS: They are serviced by Ballina but I think there is only one person who works over there in the eastern cluster.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was interested to follow up Mr Jobling's question. The idea of cultural sensitivity is easily understood but in practical terms what would the Aboriginal people need to meet that need and would that be met by training enough Aboriginals to meet that need? Also, what upgrading services or bridging services would you need for non-Aboriginal people to get that

cultural sensitivity and then fit that into the framework that you would like to put together for Aboriginal people?

Mr ROBERTS: I do believe that you would need to have Aboriginal people working with Aboriginal people, mainly because it is hard enough for us as a medical service—we have been operating for three years and it has taken us all that time, maybe longer—to get a foothold in a lot of our communities up there. You maybe an Aboriginal person and they still may not trust you and a non-Aboriginal person is going to take longer to try and get their trust. So you would have to have Aboriginal people working with Aboriginal people I would say.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, though, there are not a huge number of Aboriginal psychiatrists with that specialist knowledge that can come out of the woodwork with that the decent salary package or whatever.

Mr ROBERTS: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So what framework would you want? How many resources? What number of people? What mix of skills do you think you would put together to address the problems or would you say that you have got to have drug and alcohol workers? I suppose what I am saying is we hear that people want more resources but we never hear how you put it together and it seems that that is a problem. If you say we want this, you have got to have a clear pattern of what you are aiming for, otherwise your chance of lobbying for it is small.

Mr ROBERTS: They need moral support for families and also for people who are out there working, such as social workers. When someone goes to see a psychiatrist they need someone there to go with them so they do not have to go by themselves because they are afraid, they will not talk, they need someone to go there and hold their hands really. It is the same if an Aboriginal person goes to a hospital or to a specialist, we always provide someone to go with that person, to take them to the receptionist and say, "This is such and such who is here to see doctor whoever", and what time, or all of that sort of thing. Aboriginal people are still afraid. You talk to any of the older people and they have memories of years ago and those memories never go away. They need the trust and moral support of these people.

CHAIR: Ms Lord has made a separate submission, which is No. 49. It might be worthwhile to hear her now to save her travelling to the forum next Wednesday. Would that be okay by you, Mr Roberts?

Mr ROBERTS: Yes, that is all right. Could I table this other one that I wrote, which is a different one?

CHAIR: Yes.

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

That pursuant to the provisions of section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 252 the Committee authorises the clerk of the Committee to publish the

supplementary submission from Mick Roberts accepted by the Committee during today's hearing.

CHAIR: Ms Lord, you were a nurse practitioner?

Ms LORD: A registered nurse, yes, for the last few years. Did you want me to speak about indigenous health issues?

CHAIR: Yes.

Ms LORD: I will speak for the Aboriginal Medical Service with the background of a registered nurse for many years and working in areas of drug and alcohol, mainly in the academic side of things. I am studying for a bachelor of indigenous studies at the Southern Cross University, mainly dealing with health issues and community development. Some that the issues I see mainly are a lack of staff facilities and lack of understanding of any of the special needs. I spoke with nurse managers and other administrative people the other day and asked what education packages and facilities are available. After toing and froing they said, "Does it really have to be for Aboriginal people? This indicated that the understanding was not there. They do not understand mental illness or holistic wellness, as we often refer to it in Aboriginal communities, because it deals with the spiritual aspects and is connected with people's background and the land. Most non-indigenous people do not understand these things.

There is a great need for Aboriginal health workers. I have inquired where we might find some packages for health training. The only one I have been able to come up with is at the University of Sydney, a Bachelor of Health Science, for mental health workers and one's stream deals with counselling and mental health issues, but there does not seem to be anything at a certificate level or a career pathway where the more effective people who are already in the work could start off and progress.

CHAIR: Would you like to address the other main part of your submission, which is a separate issue?

Ms LORD: Yes. Could I table this document regarding indigenous health?

CHAIR: Yes.

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

That pursuant to the provisions of section 4 of the Parliamentary Papers (Supplementary Provisions) Act 1975 and under the authority of Standing Order 252 the Committee authorises the clerk of the Committee to publish the supplementary submission from Lexie Lord accepted by the Committee during today's hearing.

CHAIR: Your concern is more about staff and carers?

Ms LORD: Yes. I am assistant secretary of the parents and carers group. I have only been meeting with the people for about 18 months. Virtually we are a support group among ourselves because there is nothing much out there for carers. We save the Government a fortune but there is not the mental health staff to also take into

consideration the parents who are particularly traumatised. There is insufficient staff to keep our loved ones over in the clinic. Police take them over and they are turfed out. I have actually had one person, two minutes after he was out, threatening to throw himself under a truck or in other ways commit suicide. If it was not for the Aboriginal Mental Service I do not think he would be alive today. He has attempted suicide by hanging and it is only thanks to them that we have had any help at all.

There is not the staff. I have spoken to the fellow who is leaving at the moment. He was a team leader and it was getting too stressful for him trying to cope. I have actually seen him at a meeting going on to do an evening shift. They were working double shifts while there was some form of training and he looked just about dead on his feet and he was going to do another eight-hour shift. You cannot expect the staff to still stay on top doing that. They knew for about 19 weeks that he was leaving but it is only in the last few weeks that they have advertised. I saw the advertisement for actually three mental health workers at Casino. I do not know if the other two have left and that is why they are calling for three. I have not had time to follow that up yet.

CHAIR: They would need to get someone from the local community to train rather than bringing someone from Blacktown or Redfern, is that so?

Ms LORD: Yes. That is just what is needed—people who are prepared to work out in the outback. People who know that it is a different scenario to working in the cities. That is very important. It is more laid-back but there is a different cultural thing altogether working in the country.

CHAIR: You also mention liaison with police.

Ms LORD: I believe this is very important. Mental health workers cannot come out to the homes because it is a safety issue. Often the young ones when you have to get the police—and the police have been excellent in our cases—but mental health workers are not prepared to come out if there is any violence whatsoever and just being carted off by the police does not build any rapport, which is needed with carers and clients. It was discussed at one stage when mental health people were coming out to see one person that they would not be the ones who would actually put him in the paddy wagon and send him off because you have broken down any rapport you have just built up.

If the opportunity was there that the mental health workers got the police and attended, and the police stood back and were there for safety purposes while the mental health people assessed them, that would be more appropriate. The team would not feel threatened by any violence, the carers probably would not be as traumatised but, more importantly, the consumer who needs the mental health team gets the service. It is totally different to being carted off in a paddy wagon, especially in a neighbourhood where everyone knows the paddy wagon has been there again. I can understand that from an occupational health and safety point of view people cannot come out under those circumstances and just one person going out at night, I personally would not allow that as a nurse manager. There is too much at risk, but that is what has happened.

CHAIR: Is that currently occurring in your area?

Ms LORD: I do not think so at the moment. I think the situation is actually that quite often there are not the facilities for anybody to go out. I do not know whether

this is an ongoing scenario but in the last two weeks a friend of mine has had occasion to ring the acute care team, an after-hours team, and they get actually an 07 number, which is a Tweed Heads number. They have to ring, leave a message and if it is urgent someone will get back. Something that probably nobody has thought of is that often our loved ones have run up huge phone bills and people might only have access to local calls and if they have to ring Tweed Heads to get assistance, they probably cannot make STD calls.

CHAIR: Say, for example, someone is called to a disturbance at Tabulam. Would the team from Casino attend?

Ms LORD: I do not think you would find a team that could go out because they only work from 9.00 a.m. to 5.00 p.m. If you need anybody to come out they would have to come from Lismore, that is if they are not up at Murwillumbah or over at Byron Bay.

CHAIR: So there is only one team for the Northern Rivers Area Health Service?

Ms LORD: Yes, after hours, or the acute team. But as for going out to Tabulam or any other places on the outskirts, I doubt there would be the staff to do that. The police would have to handle it.

CHAIR: How do the police handle those things at places like Tabulam, Muli Muli, Cabbage Tree?

Ms LORD: I have only had experience with ones out at Tabulam. I have found them pretty good considering. Often they have to work alone out there too, but from what I have observed they try to build up a rapport, even with the kids, and I think that is great because they are going to get their trust, but they cannot be expected to do the work of a mental health professional either. There is only so much they can do and that is try to get them to help. I would say that most of them end up in the prison system rather than going to the Richmond Clinic. Because of the lack of staff at Richmond Clinic they are very reluctant to take anybody. They have to do something really damaging. As I said, with one person he was taken on life-support to Brisbane and came back but there was no room at the Richmond Clinic for him.

CHAIR: If I can come back to Mr Roberts. It appears from what you have said that one of the ways that this may be solved is support for families caring for their own in their own home. Has that been trialed or is that available? Are there avenues available for a family with a mentally ill person to start to understand about mental illness and how to care for their family member?

Mr ROBERTS: Not that I know of, it has not been trialed but you would have your different service providers along the way, no matter who they are. It could be the Department of Housing, the Department of Community Services, anybody really. Maybe they need to set up some kind of system where they can all work together to actually provide the best possible care for that person, but when it comes down to someone understanding the person with the mental health illness, you need someone trained in that field, I would imagine, but I do not think there has been anything trialed where there has been care for a particular person in a home environment.

CHAIR: Are you aware of the problem of a carer trying to approach the Northern Rivers Area Health Service Mental Health Service to get care for a relative who is decompensating or getting sicker?

Ms LORD: I have found it extremely difficult because there is just not the staff available. I have spoken personally inside to some of them and they have said, "We just don't have the resources to give you." There was one meeting set up and it was to be re-evaluated after a period of three months but then those team members had gone elsewhere and it was never followed through. I found also that because of confidentiality issues and probably lack of experience or whatever, often they are not prepared to take any information from the carers, who see their loved ones going downhill, and they are observing behaviours.

We also find it frustrating that the police will take them over. They are not interested in hearing everything that has worked up to this. They see the person who can put up a good front for a short time and they say "He's okay, let him go out again"—I understand from a lot of other carers that exactly the same thing happens to them—and within a very short time they are out either damaging families or attempting suicide, and parents and carers are trying to care for them in the home. I can give a rather horrendous incident when every night for about five nights my husband was sleeping across one person's doorway because he was waking up, terrified with the nightmares and my husband was scared stiff he would go out to the garage and try to do himself in again. I had two other males in the house and between us I think we averaged about three hours sleep a night for a week but there was just no way we could get him into Richmond clinic because there were no facilities. It is horrendous having to do that sort of thing, one-on-one, 24 hours a day in your own home.

They do not have the staff nor the amount of facilities either. I know that there will be a new building and I understand some of the beds have gone up to Tweed Heads but that is a couple of hours drive away too. It is great that they are building this new one, and there will be a section for adolescent beds in a small unit, but there needs to be a lot more or else their needs to be support for those carers in the community who are carrying that burden. From our experience, and from what has happened to a friend in just the past week, pressure is being put on the parents to take their adult back into the home. The other lady about whom I am talking is also disabled and pressure is being put by staff to take him back into the home. She is terrified for her own and his safety and for those in the community. He is a risk. People feel as though they can no longer cope and no-one is listening because there is not enough staff there. I understand at one stage Dr Petroff had something like 70 people that he should have seen in one day. Nobody can do that and do justice to really hear about what people's problems are.

CHAIR: Mr Roberts, does the *Koori Mail,* a major publication that comes out of Lismore, carry any stories about mental health? Does it provide any educative articles? Does New South Wales Health put any articles in the newspaper?

Mr ROBERTS: I know that they do have articles on health issues, mainly through our main body, NACCHO, that health issues are always brought up for us, or AMS, or even to get the dollar off the different governments, whether it be State or Federal. But there are also issues about deaths in custody and articles on mental health issues. They do get the word out there.

CHAIR: Do you want to add anything else?

Mr ROBERTS: It would be good to get from the Committee some action in the future, not only for our area but also New South Wales as a whole. Mental health is a big issue throughout New South Wales, also Australia, not only here where people can actually go and see a psychiatrist or a psychologist for help but people in the Far West of the country where there are not many resources for people. That is about all.

CHAIR: You will receive a copy of the transcript. If you think the Committee has not understood the question, or you would like to extend the answers you have given or in consultation with your community we have missed some issues altogether would you please forward that to the Committee to be included as part of your sworn evidence?

Mr ROBERTS: Yes.

CHAIR: Would you please answer any further questions we may address to you as they arise.

Mr ROBERTS: Yes.

(The witnesses withdrew)

JUDITH LOUISE MEPPEM, Chief Nursing Officer, NSW Health, XXXXXXXXXX, sworn and examined:

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

Ms MEPPEM: Chief Nursing Officer, NSW Health.

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

Ms MEPPEM: Yes.

CHAIR: Do you want your submission—No. 267—to be included as part of your sworn evidence?

Ms MEPPEM: The one from NSW Health, yes.

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 would be willing to accede to your request but you should be aware that the Legislative Council may overturn the decision of the Committee and make that evidence public. Would you proceed with your slide presentation?

Ms MEPPEM: Yes. I am here today, not as an expert in mental health services or in mental health nursing, but as the NSW Health, chief nursing officer driving a range of statewide nursing recruitment and retention strategies. I want to quickly go through a slide presentation to provide the Committee with an overview as to what I see are the issues and what has and is being done about them. I have a full handout of slides to provide afterwards. All of the issues that I raise and discuss are relevant to mental health nursing. Please ask me to clarify any issues for you.

This is the latest data that we have available about the potential pool of nurses in New South Wales. There are more than 92,000 registered or enrolled with the Nurses Registration Board and 40,000 work in the public sector and we think about 15,000 full-time equivalents work in the private sector. This information suggest the possible pool of approximately 30,000 nurses who are not working in either the public or private sector, to which I will refer later. The Committee should note that many nurses retain their registration for many years, including post-retirement, even when they never intend to nurse again. This is the most up-to-date work force data for the public sector from our nursing doors information system, the Department of Health reporting system. This information is provided by our Area Health Services. You will note that the positions applicants being recruited [PAR] is currently approximately 1,800 full-time equivalents which is about 5 per cent of the total nursing work force.

CHAIR: This is mental health?

Ms MEPPEM: No, this is total general. I will come to mental health in a minute. One of the central attractions of nursing is the mobility. It provides nurses with the ability to move around, travel and move in and out of the work force. We believe that whilst 5 per cent presents challenges, it is not an unreasonable figure. Casual and

agency nursing utilisation which is currently nearly 3,000 full-time equivalents reflects the increasing casualisation of the work force as they seek flexibility and make lifestyle choices.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: May I clarify that? You are trying to recruit 5 per cent of the registered nurse's work force as we speak?

Ms MEPPEM: Total work force. We are actively recruiting 1,800 full-time equivalent staff [FTES], permanent and full time, and part-time positions but at the same time we are using nearly 3,000 full-time equivalent staff in a range of casual positions, either through casual pools or through agency nurses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That means one in 20 registered nurses, of whom only 50 per cent are working anyway?

Ms MEPPEM: The 1,800 is 5 per cent of our work force, which is 40,000, so we have 92,000.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The work force is 40,000 and the number of registered nurses is 40,000?

Ms MEPPEM: Yes. We have 92,000 registered enrolled nurses who are registered with the Nurses Registration Board. Theoretically one could argue that they might be available to work, but of those approximately 55,000 are working in either the public or private sector. As I said many people—and we did some research which I will come to a minute—never intended to nurse again. They have used those qualifications to move on to other occupations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if you have 40,000 and you are trying to recruit 5 per cent of that at any given time, that means that you have enough vacancies with 5 per cent of that at any time.

Ms MEPPEM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And a lot of those vacancies are long term and unfilled?

Ms MEPPEM: No, they are being filled by a casual pool or agency staff. That is the casual pool. We are currently using about 1,900 full-time equivalents, and our supplementary staff, which is agency and overtime, is approximately 1,023. We are using nearly 3,000.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So a lot of those people presumably are in the casual pool getting more money because the other vacancies are not filled?

Ms MEPPEM: Or they are in the casual pool because they want to work only a couple of shifts a week or they do not want the permanency of a permanent full-time or part-time position. They are making individual choices about what they want to do with their life.

CHAIR: It is very difficult working with a very flexible work force.

Ms MEPPEM: That is right. It is trying to be flexible enough to meet everybody's demands but still need to keep the health services going 24 hours a day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are kind of starving when there is enough food. You have the jobs open, but the people who could fill them do not fill them, presumably because the pay and conditions are not adequate. That would be one way of looking at it.

Ms MEPPEM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is an unusual profession in the sense that the people who want to work do not fill the vacancies.

Ms MEPPEM: They make a choice to work casually or through an agency because of the flexibility.

The Hon. JOHN JOBLING: Equally it could be that, as those people drop out, they keep recreating the vacancies as fast as you fill them.

Ms MEPPEM: I will come to some of that detail in a moment.

CHAIR: How many of those are overseas people of that 92,000 you mentioned before?

Ms MEPPEM: Off the top of my head, I would not be able to tell you that. We register approximately 1,000 overseas nurses through the board each year, but they move in and out of the work force.

CHAIR: But many of those would have kept the registration in New South Wales, even though they are no longer here.

Ms MEPPEM: That is right. That is why we did the research, which I will talk about later. This is a more specific slide regarding mental health, and there are a number of slides around the mental health nursing figures which I extrapolated from our information system for today. This slide—and this slide is in your handout—shows that since 1996—

CHAIR: I wonder where the slides before 1996 are?

Ms MEPPEM: I did not go back any further than that.

CHAIR: Because the number of nurses in the mental health service before 1996 was higher than in 1996. I noticed that from a couple of old annual reports. I wonder if you could provide us with the figures before that?

Ms MEPPEM: We could certainly do that. That shows an increasing number of positions that actually have been recruited since 1996 and it is currently about 9 per cent of the total number of positions that have been recruited. Mental health is the black line and the total number of positions that have actually been recruited is the pink line.

This reflects the need for more people in mental health nursing as part-time employment increases and as the growth in mental health models of care and services increase. It is also in the context of the growing number of nurses in mental health. That was in the submission from the Department of Health. Over the past five or six years the mental health nursing work force itself has grown by about 300 to 500 positions. This trend in positions actively recruited reflects that growth and the growth in services as well.

CHAIR: That is the question I am asking. This is really a revisiting of what has happened since Richmond.

Ms MEPPEM: Yes.

CHAIR: I wonder if it is possible, when you go back to the department, to find out how many nurses were in the system in 1993 so that we get some idea of when there was a devolution to the community and an emptying of places as a result of changes in area health service roles and so on, and whether that had a big impact on the number of mental health nurses that disappeared or moved out of the system?

Ms MEPPEM: In our submission in chapter 6 there is a graph that starts in 1994 and shows an increasing the number of mental health nurses in the work force. The graph is supplied by the New South Wales Department of Health. That demonstrates a growth in the mental health clinical full-time staff since 1993 but I can certainly go back to see whether we had any more.

CHAIR: It would be interesting to see whether the number of mental health nurses in the system when Richmond hit the mark and whether that changed. The challenge for them was to move out of institutions and work in the community.

Ms MEPPEM: That is right.

CHAIR: And they worked in area health services and ordinary mental wards. It would be interesting to see whether some of them simply did not bother.

Ms MEPPEM: I will certainly try to get that information for you. The next slide demonstrates the metropolitan picture of mental health and positions actively recruited against all nursing specialties. You can see that it is currently 8 per cent of all metropolitan vacancies which are attributed to mental health. The picture in rural New South Wales is similar although it is 12 per cent of all rural vacancies which demonstrates that rural New South Wales is having specific issues with regard to recruitment of mental health nurses. I will talk little bit more about that later too. This is the current picture in June 2002 of the mental health registered nurse positions that are actively being recruited by area health services. Again that demonstrates that some of our rural area health services are having significant issues with recruitment of mental health nurses.

CHAIR: That represents a gap for each of them, does it?

Ms MEPPEM: That is right. Unfortunately we do not have figures for supplementary staff by specialty yet. We are working on our information systems to be

able to extract that, but certainly a percentage of our supplementary staff would be mental health nurses working in mental health areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that Wollongong or the Illawarra is the only one that is fully staffed, because it is missing only half an FTE?

Ms MEPPEM: Yes, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are doing well down there.

CHAIR: Does this also reflect the fact that, to be perfectly frank, increased funding has been made available under the new metropolitan funding?

Ms MEPPEM: For growth services.

CHAIR: So these are not long-term positions. I know that the Lismore Base Hospital had an increase in mental health funding and now they have to find the staff.

Ms MEPPEM: That is right, and that is what that is reflecting.

The Hon. JOHN JOBLING: That is a snapshot of data.

Ms MEPPEM: That is right, a snapshot as at June. I will quickly go through some of the issues that are impacting on nursing recruitment and retention. Again this is reflected across Australia and in international health systems. I could present these slides anywhere and they would be very relevant. They are all relevant to mental health nursing's work force. It is a very portable qualification. Nursing is still predominantly female, although not in mental health. Our mental health nursing is predominantly male and is an ageing nursing work force, which I will refer to later. It is now competing of course with many other career options and there are particular issues around the image of mental health. It is a rewarding occupation but it is physically, mentally and emotionally demanding across the board. They are issues that are impacting. We have an ageing nursing work force and this is particularly an issue in mental health where the average age of mental health nurses is above 45.

There are more inexperienced nurses now in the work force and there are some skill mix issues around experienced nurses and inexperienced nurses, particularly in regard to the new models of care that are emerging. We have issues around the power structures and relationships, particularly owing to the fact that the health system is generally a medical model. Mental health is that particular area where there are new models of care emerging where nurses could take a lead. I will come back to that in the moment. Nurses are not homogenous: they want to work where and when they want to work, and they do not normally like being told where they are going to work and what shifts they are going to work. They make legitimate lifestyle choices and we are seeing more and more of our nurses wanting a balance between work, study and family, et cetera. They are asking for more and more part-time shifts and that creates issues for management in keeping the services going over a 24-hour period. Of course we have the impact of seasonal fluctuations, particularly with winter and school holidays and, in rural

New South Wales, with harvesting when all the nurses want to go out to the farm and help.

This is a jigsaw of mine that I have put together which illustrates all the many issues that are impacting on recruitment and retention and are all applicable to mental health. They are all interrelated. You fix one and another one will pop out and create issues. The key issues out of that jigsaw include access to and support for education. This is particularly an issue in rural New South Wales, where getting away from work is a problem. Being replaced to keep the service going is an issue. Also there are issues around cost of education. I have already mentioned lifestyle choices and then what I have grouped together as environmental issues: community expectations—again, this is particularly an issue in rural New South Wales where nurses are so well known by everybody in the community—professional isolation; issues about affordable accommodation; child care; security and violence in the workplace; and issues around workplace relations, such as harassment and bullying. I will come back to what we are doing about these issues. This slide shows just a few of the messages that have been used in campaigns and marketing and promotional endeavours over recent years. They all are sending different, yet very powerful messages. Australian nurses are very good at what they do. It is very disturbing that despite all of our efforts we still are unable to get the media to focus on the positive stories. They only want the sensational bad news stories. We rarely hear about the wonderful things that nurses are doing across our health system.

CHAIR: Is that logo "Nursing 4 life" available as a tattoo?

Ms MEPPEM: Yes. That was part of the Minister's roadshow in 2000. The tattoos were very popular. Has anything being done in New South Wales? A lot of effort has been put in over many years to redress the recruitment and retention issues, and this slide shows just a few examples. We have ongoing annual funding for nursing education, ongoing marketing strategies, and the study leave initiatives where we are now monitoring access to study leave across area health services. In the area health services part of the CEO's performance agreement is to demonstrate that there is equitable access by all categories of nursing staff to study leave. We established the New South Wales Nurses Scholarship Fund, which now has three streams; rural undergraduate scholarships to assist rural people to take up nursing; rural clinical placement grants to encourage metropolitan university students to go out and do some clinical placement in rural New South Wales; and a very large postgraduate scholarship stream for registered nurses undertaking postgraduate study.

CHAIR: How many of those are in mental health nursing? We heard about some in the Illawarra.

Ms MEPPEM: I could give you some figures for our postgraduate scholarships about mental health. We have also just injected some more money, which I will talk about in a minute, specifically for mental health education and scholarships. The private sector survey refers to a survey that we did two years ago to get a handle on the private sector work force. From this year it is now a condition of their licence renewal that they provide us with work force information. So next year we will have some very good information about the private sector work force participation.

CHAIR: In the budget estimates $451,000 was given to the University of Western Sydney. What was that spent on?

Ms MEPPEM: This is in the mental health strategy?

CHAIR: Yes.

Ms MEPPEM: I will talk about that in a minute. As to some of the other recruitment and retention initiatives—I have faded out the ones that do not relate to mental health nursing—we had a major task force in 1996, a specific rural and remote nursing summit in 1998, and a specific mental health think tank, which I will come back to in a minute and was in our submission. We did research into our Nurses Registration Board database where we surveyed 32,000 nurses who were not working in nursing at the time to try to answer questions that were raised earlier. The research suggested that probably 2,000 to 3,000 nurses might be willing to come back to work if the situation were suitable to their needs. They all raised issues parallel to what I raised earlier about the need for flexibility, accommodation, childcare, all of those things. We now have the New South Wales ministerial standing committee on the nursing and midwifery work force. I will detail some of the things they are doing. Certainly we are providing a framework and rolling out a whole range of initiatives to redress recruitment and retention. All of those initiatives had major recommendations that need to be implemented by the system.

Some of the statewide initiatives, other than the trainee enrolled nurse program, are: to fund new graduate transition support into all of our specialty areas so that mental health services can pick up new graduate employment; provide additional funding to help them make the transition into the work force: a whole lot of funding around specialty skill development and mentor programs; a major contract with the New South Wales College of Nursing to provide educational programs, including mental health; some specific mental health nursing initiatives, which I will come back to; and, of course, the latest initiative, which was re-entry support for nurses who have been out of the work force, called Nursing Reconnect. That initiative, which was launched in January, has been and continues to be very successful. The results of the latest report, in mid-July, identified that over 490 nurses have recommenced employment in either a part-time or full-time position, 74 were pending finalisation and another 76 were to be interviewed. We are very hopeful that it will be well over 500 who come back into the work force through this initiative.

Mental health has been successful in attracting around 30 nurses through Nursing Reconnect. Certainly we are looking to roll out a specific strategy to encourage more nurses to come back in through Nursing Reconnect to mental health. In relation to some of those specific mental health initiatives, we had a mental health working group. I know a lot of this information is in our submission. The group is a partnership between the Centre for Mental Health and us, chaired by Professor Raphael. They looked at a whole range of things that have been identified as specifically impacting on mental health nursing recruitment. They have developed a mental health nursing framework that looks at mental health nursing over the next five to ten years. Over $5 million has been injected into the system for additional initiatives, specifically quarantined for mental health. That includes: clinical placement support for approximately 2,500 undergraduate nursing students; specific marketing of mental health nursing; models for preceptor and mentor programs to support new graduates;

scholarships and opportunities for clinical skill development for approximately 350 registered and enrolled nurses; introductory courses in mental health nursing in a range of general hospital settings; and increased access to educational opportunities for nurses in rural settings. Every university and the College of Nursing got money under the $2.3 million grant to do a variety of different things.

Also a new framework is being developed to improve the mental health and wellbeing of nurses in the New South Wales health system. That is going to be called Caring for Nurses. It is along the lines of the Caring for Doctors initiative, which was developed a couple of years ago. The current New South Wales focus on recruitment and retention is a multifaceted one that focuses on four streams to attract more school leavers and mature age entrants to take up nursing; new graduate support as they come into the work force; valuing and retaining our current staff; and, as I said, a return to the work force of nurses who have left; and addressing a range of Commonwealth issues around access to and cost of education, national co-ordination and national work force planning. We are awaiting the release of the report into the national review of nursing education. I understand that it is going to bring up a number of significant issues and recommendations, particularly around undergraduate preparation, and, it is my understanding, the issue of mental health.

CHAIR: Where is the $2 million overseas advertising program that was announced by the Minister?

Ms MEPPEM: That is one of our current strategies that we are rolling out. I could talk about that in a minute. The other report that has just been released is the Senate inquiry into nursing, which was tabled recently. It has made 85 recommendations. Most of those recommendations New South Wales is already progressing. A number of recommendations in that report specifically focus on mental health nursing, around the image of mental health nursing and mental health nursing education. I think all of those things together are going to increase the development of strategies around particularly the mental health nursing work force. With regard to the overseas recruitment, that was about capitalising on Hong Kong, English and Finnish nurses who are interested in working in New South Wales on a working holiday visa. It is a short-term arrangement to assist the work force as we go through the winter months and into the Christmas holidays until the new graduates come on board next year. That has been relatively successful. The team is back and we are waiting to see how many eventuate from that. Nurses like travelling all over the world and we have had a lot of interest expressed in coming over here.

What is the system doing now? As I have said, a multitude of reports, recommendations and strategies are being implemented at local level. Some of them particularly focus on mental health. Particularly relevant to mental health are issues around environmental reform, looking at all of the things in the workplace that make it unattractive for nurses and fixing them, and more focus on flexible work practices. Picking up on the Chairman's comments earlier, it is difficult for people to balance what staff want and keeping a service running on a 24-hour basis. Also relevant to mental health is: access to education and study leave; addressing issues around security and violence in the workplace through the task force and other issues; addressing the issues of all working relationships, harassment and bullying; and continuing to involve clinicians in some of the reform that is going on in the health system. I believe that everybody needs to own this. Nurses cannot turn this around on their own. Nurses and

the medical profession have to own this. Our unions, health professionals, educators and researchers all have to be part of turning the issues around to increase retention, in particular, of nurses.

If I could briefly talk about the nurse practitioner project, I see that this has great potential in mental health. We have had very slow progress to date. To date there have been only seven nurse practitioner positions given full approval. The slide shows where they are. They are all generalist positions. The seventh position was approved last week at Tambar Springs. There are 17 more that have been approved in principle and are having their clinical guidelines developed. For example, Corrections Health is working on 10 positions and New England on another four. I am often asked why there are not more positions. The reasons include the difficulties that our area health services are having in getting medical groups to participate in the process and the hoops that the area health services have to go through in the negotiated implementation policy.

CHAIR: We had a witness yesterday—

The Hon. JOHN JOBLING: He appears on the next slide.

Ms MEPPEM: To date only nine nurse practitioners have been authorised, but, interestingly enough, two of them are in mental health. There is only one practising nurse practitioner, and that is in Wanaaring. I expect David Turcato and Julie Scott to be practising very soon, given that there is now an approved position in the town. Why are not more nurses applying? Feedback identifies that the reasons include: there are no positions in the city and not many positions yet in rural towns, the hoops nurses have to go through to get authorised; and negative pressure from medical colleagues in country towns when they do put up their hand. I have a very good example in one country town where the doctor who was servicing that town withdrew his services when he realised that we were about to approve the nurse practitioner position. Fortunately, the town has been able to get another medical practitioner to take up the service.

CHAIR: John Lyons, who is listed on the slide, is a clinical nurse consultant.

Ms MEPPEM: He is an authorised nurse practitioner but there is not a position there.

CHAIR: There are quite a fewer other clinical nurse consultants in the system. In their roles they are generally more able to act independently. Why are not many more of those being used as nurse practitioners?

Ms MEPPEM: The position has to be approved, and so it has to go through a whole process of development. That is the slide I was talking about before. One of the reasons we do not have more positions is because of the ongoing opposition from some medical groups. The current situation with regard to the project is that we are getting pressure from different stakeholders to either widen the roll-out to the city, devolve the process to area health services, and remove some of the hoops, and on the other side of the fence to stop the roll-out completely and add more hoops to the implementation authorisation process. It is a bit of a no-win situation. After 12 years we are still only at this point.

CHAIR: We are in advance of any other State.

Ms MEPPEM: Yes, we are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are way behind New Zealand, who do this all the time.

Ms MEPPEM: New Zealand has a different model, but it certainly has a lot more nurse practitioners than we have.

CHAIR: Are you surprised having started this many years ago—

Ms MEPPEM: Twelve years ago.

CHAIR: That New South Wales is still leading the field?

Ms MEPPEM: In Australia, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you consider this a dismal rate of progress after 12 years?

Ms MEPPEM: Yes, I am very disappointed with it.

The Hon. AMANDA FAZIO: Is the reason it has not been as successful in New South Wales as it has in New Zealand been mainly due to the attitude of doctors?

Ms MEPPEM: I would have to say so.

CHAIR: Mental health is a classic area where nurses in mental health have been typically nurse practitioners. Mental health is the main area for nurse practitioners.

Ms MEPPEM: I certainly see great scope in mental health for this model. I know that Professor Raphael agrees with me.

CHAIR: It has been a fact of life in mental health that mental health nurses are nurse practitioners.

Ms MEPPEM: Yes, that is right. Both the Menedue report and the Sinclair report recommended the progress of the nurse practitioner services. It is disappointing that we are still only at this point after 12 years. The whole situation is being reviewed at the moment. If I could summarise briefly, the most recent and current statewide initiatives include the accommodation initiative where $4 million over three years has been injected into rural New South Wales to specifically improve access to accommodation for health service professionals.

CHAIR: A lot of that is taken up by young doctors, is it not?

Ms MEPPEM: No, this is in addition to the Commonwealth money for doctors. This is specifically for nursing and allied health. As to the violence task force, there are the strategies that are being driven by the ministerial task force; the working relationship issue has seen a joint statement issued by the department and the Labor Council that harassment or bullying of any staff in our health services is totally

unacceptable. Processes are in place to ensure that nurses and other health professionals feel comfortable about raising issues of concern. The Premier announced a number of weeks ago that childcare places will triple over the next three years. We have done a lot of work on work experience and encouraging schoolchildren to come into our health services, look at what is happening, to use that as a recruitment initiative into our undergraduate programs. We are also working with the Board of School Studies to introduce health-related subjects into years 11 and 12, which could then gain credit in an undergraduate program.

We have a specific Aboriginal nursing project being managed through my office, where we are developing a range of initiatives to encourage more and more Aboriginal people to take up nursing as a career. Workload research is a major initiative that is about to be moved forward. For the first time in Australia, we will be looking at the impact of a different skill mix, different models of nursing care and staffing levels, case-mix-adjusted for patient acuity so that informed decisions can be made about how many staff are needed to staff different specialty areas. That has never been done in Australia before. It is a significant financial commitment. It is going to take probably more than 18 months to two years to do. The EOIs have been advertised, the steering committee meets next week to look at them, and hopefully we will be seeing that research progress very quickly. We have had a significant increase to the postgraduate scholarship fund. The ministerial standing committee I referred to earlier has an action plan that is rolling out a whole lot of strategies relating to nursing recruitment and retention, which are in the handout.

The issues shown on the jigsaw I put up earlier are all very important and must be addressed, but I believe that six or seven key issues are very important and must be addressed. All of these relate to mental health nurses as well as the general nursing population. They are patient acuity; workload and skill mix, which is what our research will look at; access to clinically relevant education, both at an undergraduate and postgraduate level—again, we are anxiously awaiting the release of the national review of nursing education report, which looks at both undergraduate and postgraduate education— communication and involvement; the issue around working relationships and environmental issues; security and violence in the workplace; leadership; and recognition of nurses' input. There is still a perception by many nurses that they are not recognised by their colleagues for the input they have into our health services.

Nursing is a wonderful profession. It is a privilege to be a nurse. It is very demanding work but it is very rewarding. I think nurses are doing a fantastic job. We are certainly working very hard to address the issues that are impacting on recruitment and retention. This is a document we put together in my office that pulls together all the strategies and initiatives that we are moving forward. It is a trigger document for our area health services so they can look at it and see whether they are addressing these things at a local level as well as what we are doing at the State level.

CHAIR: Whilst we have seen a relatively flat level in the number of nurses in the whole system, we are seeing a huge increase in the number of people accessing our public health services, whether it be in mental health, inpatient care or community-based services. To see the gaps arising should not have been a surprise, because the service levels were increasing fairly rapidly. Nurses are working harder than they used to. What compensations are there for nurses to work harder and provide more services, with no increase in the number of nurses to do it?

Ms MEPPEM: One of the issues we have to deal with is that we need a lot more nurses to fill the positions we have, including the growth positions that are introduced as enhancements are funded. Because of this increasing wish to move to casual or part-time employment, we need a lot more nurses to fill our full-time equivalent positions. Nurses are working harder. That is what the research will look at: What impact our increased patient acuity is having on the provision of nursing care. At this point in time we do not have any evidence to substantiate some of the issues that have been raised, but this research will be significant in informing that debate.

CHAIR: Numbers of nurses for the numbers of outputs has been extremely variable. As a chief nurse, what do you get from looking at the number of nurses in a certain service, providing a certain number of outputs, whether it be in emergency departments, inpatient care, or mental health nursing? Could you identify areas that have the appropriate number of nurses, too few nurses and too many nurses?

Ms MEPPEM: That is very difficult to do, because we do not know what the appropriate number of nurses is.

CHAIR: But you must see a band of providing a number of nurses, a number of outputs, and a different number of nurses providing those outputs.

Ms MEPPEM: We do not monitor the different staffing mixes or levels that individual health services have. They benchmark themselves against like services, so you would find that most specialty areas and most hospitals would benchmark each other against like hospitals. There are certainly concerns being expressed about the variability in staffing mixes and staffing levels, but there is no one right answer. It all depends on patient acuity, the geographical layout of the wards and availability of resources. Hopefully, that is what the research will inform the debate on.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yesterday I asked what percentage of nurses in mental health should be in hospitals as opposed to the community setting.

Ms MEPPEM: As I said, I am not an expert at the front-end of mental health models of care, mental health nursing. It would be remiss of me to give you a figure, because it really needs the experts to say this is the sort of care we are providing in a mental health hospital, this is the sort of care we are providing in a community setting. It would vary, depending on what sort of patients those nurses are looking after.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you were setting the staffing levels for area health services, presumably there would be models for the number of nurses you had per patient in hospital settings normally, mental health and non-mental health, would there not?

Ms MEPPEM: No. We do not have a prescribed patient staffing ratio.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There must be hundreds of chief executive officers managing hospitals or area health services who would have those figures?

Ms MEPPEM: The people who manage the mental health services would have an appreciation of what they believe they need for the patient acuity they have, yes, but I do not have those figures.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it commonly discussed?

Ms MEPPEM: Amongst specialty areas, yes. You would find that mental health nurse managers would discuss that amongst themselves, yes.

CHAIR: If there were no community mental health nurses, you would have to have a huge number of people in the acute health services. If there were no nurses in acute health services, you would have to have a huge number in the community-based services. Someone must have come up with different balances in different area health services, depending on the facilities they have and the needs they have. There must be a balance we can look to for best practice—the best balance for what can be looked after efficiently in the community and what should be looked after in acute services. We simply cannot find that out.

Ms MEPPEM: Have you asked mental health? That is the area that would be able to tell us that. I can certainly take it back to them, so that when they come here next week we can pick it up.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When the Committee was set up the Premier said we will have many more mental health beds, which is a good response to the media. However, if the object of the Richmond report was to deinstitutionalise, surely the question is how many people should be in the community and how small a sector we can get by with. I notice in the figures from the health department's response to our questions that in 1999-2000 New South Wales had 93.7 per cent of the Australian average spending on mental health, but according to the NCOSS submission New South Wales is spending 68 per cent less on community mental health services, which is only a third of the Australian average, and that the model State is Victoria, which is spending twice as much as the national average. That would suggest that community mental health in New South Wales is extremely neglected, would it not?

Ms MEPPEM: I would not be able to comment on that; it is not my area of expertise. I notice that page F4 of our submission shows national State benchmarks that relate to the Richmond report. With regard to the workload research I was talking about earlier, which is across nursing generally, one of the specialty areas we have named as needing to be included is mental health, for the very reasons you are raising. But the people in our centre for mental health would be better able to answer that question regarding the balance between acute and non-acute services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is obviously worrying if we ask someone in a senior position about the balance of staffing and they do not know.

Ms MEPPEM: I am sure they will be able to answer that question.

The Hon. AMANDA FAZIO: With regard to recruitment and retention programs for nurses, for nurses who have worked in the mental health area, has there been any indication about their preferences for working in institution-based mental health or community-based mental health teams?

Ms MEPPEM: Certainly none of our research has identified those specific issues. But you will find that in any specialty area—and mental health is no different—there are people who like working in institutional settings and there are people who like the more flexible and laid-back notion of non-institutional care. Mental health nursing has changed so much over the last 10 to 15 years in particular that we are seeing the growth of these multidisciplinary teams where nurses are making wonderful case managers and team leaders. That is where I see the nurse practitioner project being very valuable. So you will find that there will be a mix of people who like to move between the two, and there are some people who only like to work in community mental health services, and some people who only like to work in institutional services. We are also seeing the growth of some outreach programs, so that picks up people who are working in institutional settings being able to also participate in outreach services to the community.

The Hon. AMANDA FAZIO: Another issue you raised in the slides was access to ongoing education. From your work in that area, do you have any information about whether nurses who are currently working feel they have the necessary skills to work adequately as community-based nurses rather than hospital-based nurses?

Ms MEPPEM: Yes. Certainly, I think our educational institutions have to change the way they approach education at a postgraduate level to pick up the changing focus of health care. With mental health, for example, we have a whole range of strategies in place where nurses can access the type of education they want. One of the issues is being able to be released from work and being replaced so that the service can continue, particularly in rural New South Wales. The other issue is cost—in other words, travel to get there and the cost of education itself, that is, university fees. That is one of the reasons why we established the scholarship fund. We also provide funding to area health services and the college of nursing to run their own in-house, home-grown programs. The issue is that there are so many people who want to do it, but it is about being able to meet all those needs.

The Hon. AMANDA FAZIO: You said you have a greater emphasis on engaging young people in work experience in area health services and so on. Is the issue of the repayment of Higher Education Contribution Scheme [HECS] fees in what is probably a relatively low-paid tertiary field something that is working against you in being able to attract young people to nursing as a profession?

Ms MEPPEM: New South Wales believes that it is an issue. On a number of occasions the Minister has called on the Commonwealth to waive HECS fees for undergraduate programs and HECS and fees for postgraduate programs. Our postgraduate programs are currently still a mix: some of them are HECS places and some of them are fee-paying places. It is interesting to note that the Senate report has not recommended that HECS fees and university fees be waived.

CHAIR: When Neville Wran successfully argued to take nursing into the tertiary institutions, that saved the system a lot of money in training. New South Wales

Health used to train its own nurses at its own expense; it now does not, and the Commonwealth does that. But New South Wales still puts a fair bit of money into that combined training. We put an awful lot of New South Wales Health training money into doctors. I think it is vastly more than we are putting into postgraduate training for nurses. Is that true or not?

Ms MEPPEM: Post-graduate education is part of the university sector.

CHAIR: I mean to train an orthopaedic surgeon we have them as an intern, junior resident, senior resident, perhaps three years there as a junior doctor, then we have a year as a registrar, then five or six years of training where we pay them a large amount of money being on-call and paying doctors, VMOs to come in and supervise them doing work. So there is a large amount of investment in turning out orthopaedic surgeons into the community, whether it is in private or public practice. Do we put the same sort of money and the same sort of support behind our specialist nurses?

Ms MEPPEM: There is a large investment at local area health service level in postgraduate education as far as the clinical placement is concerned. So the students are employed by the health service, they are doing their post graduate program and their clinical is going on at the same time; they are working whilst they are undertaking their postgraduate education. So it is a significant investment.

CHAIR: The issue was raised yesterday about whether nurses who are going into psychiatric nursing who have the same mentoring and the same access to be there, are almost supernumerary by number whilst they are learning with an experienced nurse teaching them as they get their hands on and their mind around the psychiatric nursing.

Ms MEPPEM: They would have the same infrastructure around them as any other specialty area.

CHAIR: Do you think that that is where there could be an improvement?

Ms MEPPEM: I think there is always room for more—

CHAIR: No, I do not mean that. Seriously—

Ms MEPPEM: I am being serious. I think that the clinical relevance and the support that all our students, either undergraduate or postgraduate level, are getting, there is always room for more.

CHAIR: The issue was raised yesterday whether or not they are just simply roster fillers or they are actually being trained when they go and do their first year in psychiatric nursing.

Ms MEPPEM: They are. They are part of the staff and it is a different model to the post graduate medical education model, quite a different model.

CHAIR: Is there anything more that you can take from that post graduate medical education model, which works extremely well? It is a lot of money. New South Wales Health spends a huge amount of money on medical education.

Ms MEPPEM: That is one of the issues.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let us not get too carried away with this. I mean the doctors are working their butts off. The fact that they learn something along the way is by the by.. All the hours they spend studying at night to get their exams done is not paid by the health department. We are looking at mental health. Let's not kid ourselves. People who are doing a job on a roster are not having huge amounts of money spent on their training. They are in fact working for much less money than the people who have graduated in terms of being in private practice and fee for service.

CHAIR: In terms of supervised training, they actually have to pay people to supervise them
otherwise the college will not approve their training positions. Going past that, if you like, there is a medical staff council at each hospital; there does not seem to be a nursing staff council or, specifically, a psychiatric nursing staff council; you have to go past that hospital base thing straight to a college.

Ms MEPPEM: Well, it is a different model again. Some of our area health services have well-developed nursing councils—South East Sydney, I can use that as an example—where they would have a nursing council at a local health service level and then they have an overarching area nursing council. It is a slightly different model to the medical council but certainly they are there. They are in our rural sector as well in different forms. But there are certainly opportunities for nurses to have a voice in all of the things that are impacting on them.

CHAIR: As you move more nurses, as you want to move more nurses into this team management role, which they are perfectly capable of doing, would that remove more and more of them out of frontline clinical services and more into administration, which has been my fear for many years?

Ms MEPPEM: I think when you are talking about the sort of model about nurse practitioners and mental health that we were referring to, that is about clinical work and it might be about team leader case management but it is around a model of clinical care. The issue around skill mix and appropriate models of nursing care is something that is in your full set of slides that I did not have up on the screen but that is the other issue that we are addressing and that is what is an appropriate model of nursing care, whether it is mental health or whatever, and what is the appropriate skill mix within that model of care and the fact that you do not need registered nurses to do all things to all men, that there are other models that you can have. That is another thing that this research that I was talking about is going to be looking at. So they are going to be looking at different models, different skill mix and whether that has any negative or positive impact on patient outcome.

CHAIR: We have seen in the police area more use of civilians to do what would be termed police duties but stuff that can be done by anybody, it does not have to be a trained policeman. They have got things that are being done by registered nurses that do not need to be done by registered nurses but can be done by anybody in a support role. Have you looked at introducing more support role people to free nurses up to do what only nurses can do?

Ms MEPPEM: There is certainly a lot of that going on. We are increasing our enrolled nurses all the time again around that skill mix issue, what different skill mixes are appropriate. There is a debate going on about who could legitimately do what is nursing care and there are two schools of thought. That has not been resolved. It is certainly about what the patient needs should come first and that there are a range of models that can achieve that outcome.

The Hon. AMANDA FAZIO: We had raised with us by previous witnesses the issue of mental health staff, whether they are nurses or others, getting burnt out and overstretched because of the nature of the patient that they are dealing with all the time. In your research into recruitment and retention of nurses has that been raised by mental health nurses as a problem and as chief nurse what are you doing about it?

Ms MEPPEM: It has been raised by every specialty that the pressures of work, the demanding nature of the role—and mental health is an example, particularly in the institutional settings—that there are issues around, people call it, burnout. But that is one of the reasons why nursing is such a mobile profession, you can move in and out; you can have time out and you can come back; you can move specialty. That is an issue across the board.

The Hon. AMANDA FAZIO: Have you got particular strategies in place?

Ms MEPPEM: There are a whole lot of things. All of the money that we provide each year is to support the nursing work force as they continue on but also that specific strategy that I talked about in the mental health funding—which is about caring for the mental health of nurses generally—is specifically focused on that particular issue and around the framework that was developed a number of years ago for caring for the mental health of doctors. It is about caring for the carer. That is what is going on at the moment.

CHAIR: The issue of nurses: I remember many years ago when I was a student at Sydney hospital—so a long time ago—seeing nurses almost right in Macquarie Street, saw them again right in the seventies and again in the late eighties and now again the tempo is picking up of dissatisfaction. Is that dissatisfaction just because of worker or because of the nature of the work that they do?

Ms MEPPEM: I think it is a combination of those two and I also think it is a combination of societal issues. It is not just an issue in nursing, it is an issue across all service professions about the fact that you are there, particularly in rural New South Wales, in view all of the time; it is about the need to balance family and lifestyle issues with work too; it is about the growing casualisation of the work force. So it is all of those. In all of the research that we have done money has never come out as the single biggest issue. It is clearly a focus at the moment because of the special case but it is not just money, it is a whole range of other issues, particularly around the environment in which they work.

CHAIR: Has the MOAT, the new forum that has been put in to give some feeling of quality and outcomes for the treatment of mentally ill people, has that been identified by nurses through the nursing stream to you as an issue?

Ms MEPPEM: I think they see the focus on it very positive.

CHAIR: But the work associated with doing it?

Ms MEPPEM: No, that has not come through as an issue to me.

CHAIR: It was identified yesterday - what used to take 20 minutes now takes 120 minutes.

Ms MEPPEM: Certainly the screening that now has to go on across the board is a significant added workload for nurses.

CHAIR: From four to 36 pages was the figure that the nurse practitioner from Coonabarabran identified yesterday. Not complaining about more the accuracy of it or the predictive nature and the usefulness in the work force planning but the time that it takes for somebody to do it which may or may not need a specialist nurse to do.

Ms MEPPEM: It has certainly been an issue.

CHAIR: What about other support mechanisms you can use? The issue that Mr Chesterfield Evans identified of the best mix of community versus in patient care is going to vary from area health service to area health service; for example, central Sydney has got a whole stack of institutions still, but we find that when they move from, say, Rozelle to Marsden centre, in the middle of it beds disappear, nursing positions disappear. We have had evidence about that. What is there at a central level that you identify when you see movements in services? Do the nurses feed up to you about area health services doing a bit of duck shoving with mental health money?

Ms MEPPEM: That would not come to me, it would go to Professor Raphael but certainly the feedback that we get is that when the service configurations are about to change there needs to be attention paid to supporting the staff making those changes and that happens through a variety of funding mechanisms at area health service level, that as the service configuration changes the nurses who are being displaced, for want of a better word, out of that service configuration are supported in making a move into the new service model or where ever they might want to go.

CHAIR: But surely as you move around as the chief nurse—and you have been relatively identified as a leader in the nursing profession for many years—do nurses tell you about these things as concerns?

Ms MEPPEM: Yes, they do, from time to time.

CHAIR: What is the nature of that complaint? I do not mean to put you on the spot but what sorts of things do they complain about? Not being consulted or not being open about it?

Ms MEPPEM: Nurses certainly raise at every opportunity the need for them to be involved in the decisions that are being made. That comes through my office; it comes up at the nurses association conference; it comes up at any forum that anybody from the department is at. That is one of the issues that I have up on the slide that nurses need to be part of the decision-making process and their input needs to be recognised. It certainly is an issue for some nurses.

The Hon. AMANDA FAZIO: Just to follow on a little bit from what Dr Pezzutti was saying, we heard some evidence from people who have been before us that it is not so much resources disappearing from one area health service to another, but almost like buck passing of patients and a lack of transfer of information about patient care from one area to another. Has that been raised with you by nurses?

Ms MEPPEM: There are processes in place that that should not occur. One would hope that would be being addressed at local level if it is an issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Coming back to the issue of community mental health nursing, it has been put to us that if people cannot attend at a shift in a hospital all efforts are made to find a casual or relief staff to fill that vacancy. If somebody is working in the community and they go on holiday or they are absent, no effort is made and the people simply do not get the staff. Has that been your experience?

Ms MEPPEM: That certainly has not been raised with me as an issue. That again would be something that would not possibly necessarily get to me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it is was a standard practice and accepted as a reality and the best that can be done, and nobody could do the job and there are not any relief staff or casuals do not do that sort of work because they do not have the rapport or whatever, this might just be a standard practice that would not even be noticed at head office.

Ms MEPPEM: No, I am suggesting that that should be sorted out at area health service level with the area management, that if the service is continuing and somebody is going on holidays they have to make some very conscious decisions about replacing the person or diverting that service to another—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the area health service was trying to save money on mental health though they might not do that.

Ms MEPPEM: I am sure that would not go unmentioned by the local staff. That would come up to Professor Raphael.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that it is unlikely that that occurs and that evidence is not correct?

Ms MEPPEM: I am not suggesting that, I am saying I have not heard that it has occurred.

CHAIR: Obviously you will get a transcript of today and with that will be some questions which we have asked where we have not got the question quite right and where you think you can add some more information which is what we need rather than what we asked for. We would be delighted if you could do that as a result of today. We may, of course, fix some more questions to deal with nursing and these retention recruitment and policy issues to put to you as we hear from other people. If you wouldn't mind, if they are able to be answered we would appreciate answers to them. When we get to the stage of writing the report we may come back to you to ask if we

have got it right because we hear from lots of people but you have been in this role now for many years and I have to say publicly you will be retiring soon and we have enjoyed having you here.

I remember when you were first appointed the first nurse on the rung, you had to go down about four layers before you got to a nurse and they were usually in human relations or something outside the nursing role. It has been a very positive thing having a senior nurse at that very highest level to drive and luckily women now run into problems that drive the changes, so thank you. Is there anything you would like to finally add?

Ms MEPPEM: No, I do not think so.

CHAIR: If you think of something you will tell us?

Ms MEPPEM: Yes, thank you, Mr Chairman.

(The witness withdrew)

(Luncheon adjournment)

ROSLYN BRAGG, Deputy Director, Policy, Council of Social Service of New South Wales, 66 Albion Street, Surry Hills, sworn and examined, and

TIMOTHY GOODWIN, Senior Policy Adviser, Council of Social Service of New South Wales, 66 Albion Street, Surry Hills, affirmed and examined:

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

Ms BRAGG: Yes.

Mr GOODWIN: Yes.

CHAIR: Do you wish submission No. 192 from the Council of Social Service of New South Wales [NCOSS] to be taken as part of your sworn evidence?

Ms BRAGG: Yes.

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

Ms BRAGG: I will make an opening statement. Firstly, I wanted to outline the role of NCOSS. We are a community organisation established in 1935 and our role is to advocate for disadvantaged people in New South Wales. People with a mental illness are amongst the most disadvantaged people in the community and mental health is a fundamental concern to NCOSS. We see the effective response to the needs of people with a mental illness as a key issue in addressing disadvantage in New South Wales.

The sorts of issues which emerge are poverty, homelessness, unemployment, abuse and, of course, many others. Many people with a mental illness are severely disadvantaged and it is our view that the Government is not meeting its responsibilities to provide adequate and appropriate support to prevent this. From our perspective an adequate response to the needs of people with a mental illness includes an adequate supply of community-based, specialist mental health services, integration of acute and community-based mental health services, appropriate support to people from particular population groups, including people with co-morbidity such as mental health and substance use disorders, effective links between mental health services and other government agencies providing support services, and an adequate supply of affordable and secure housing, which is appropriate to people with a mental illness.

From our work we have identified some evidence of breakdown in the service system to people with a mental illness. A significant proportion of the city's homeless population has a mental illness, which in many ways is an indicator of comprehensive system breakdown. One 1998 study of homeless people using refuges and hostels in the inner city of Sydney found that 75 per cent had one or more mental disorders in the

previous 12 months, including 29 per cent with schizophrenia and 33 per cent with a major mood disorder.

We are also hearing a lot of anecdotal reports of increasing numbers of people with a mental illness presenting at hospital emergency departments. Again, this is an indicator of breakdown in your general health care system. Of course, this is the appropriate response for consumers requiring urgent treatment but the anecdotal information is that consumers are using the emergency departments inappropriately as they had not been able to obtain general practitioner or specialist community-based mental health services.

Also, reports such as that in today's *Sydney Morning Herald* of a coroner's report indicating very clear evidence of a poor response to the complex needs of people with a mental illness. People with a mental illness who also need assistance in relation to drug and alcohol use are particularly poorly supported and the report from the coroner is a pretty good indication of that. Another key issue for us is adequacy of funding. The most recent national mental health report stated that New South Wales has the lowest expenditure per capita in Australia on community-based mental health services, with New South Wales spending approximately 68 per cent less than the national average. There have been significant increases in the mental health budget since then, which are, of course, extremely welcome but we are still well behind on the investment we need for an effective, comprehensive system of support for people with a mental illness. Perhaps more importantly, we need to see these funds actually going to services in the community, which is the critical work of supporting people with mental illness to live in the community.

In addition to adequacy of funding, we are extremely concerned about accountability and transparency for health funds. We have been working towards greater transparency in the planning process so we can observe the development of priorities for spending at State and at area health service level and clearly we see it as important that community agencies, both advocacy bodies and services, have a role in setting those priorities. We are also extremely concerned about accountability for the spending of those funds and at present we have very little information about where those funds actually go, which does not create a great deal of confidence that they are going to the right place.

Specific initiatives we would like to see include making public the performance agreements and the reporting on those performance agreements for each area health service. At present we are told that these are not public documents and are not available. We would also like to see an audit of the funds being spent in mental health and specifically whether the funds are being spent in mental health and also within that budget the balance between acute and community-based services. At present we do not have this information.

As indicators of some of these problems, the announcement in April 2000 of $107.5 million for mental health was associated with commitments directly to NCOSS and to a number of other community agencies that there would be a fully participatory planning process set up around that, that there would be a planning process at the area health service level and that there would be an oversight of this process at State level. There has been no evidence of this actually taking place. Also in the recent budget announcement there was an announcement of a substantial increase in funding and

while we welcome this, it clearly was not actually as accurately represented as it could have been.

Of the additional $50 million, $42.5 million had previously been announced in part of that April 2000 announcement and, disappointingly, that increase actually includes a substantial consumer price index component. At the same time the Government announced an additional $20 million for a number of new beds, however, when we investigated this further we found that that money would roll out as the beds rolled out, so that it was an announcement for the following year's budget. We have requested but did not actually obtain further information about the exact breakdown of these increases.

CHAIR: Mr Goodwin, do you have anything to add?

Mr GOODWIN: I will just add a couple of things to what Ros has said. As we outlined in our submission, one of the main areas or themes that emerged in our preparation for the inquiry was the integration of mental health services with other ranges of services provided by the Government and the themes of inadequate services, inappropriate referral to services and lack of appropriate care, which emerged through those discussions with people. Particularly, we were looking at questions we did address of integration with the aged care services and the question of specialised psychogeriatric services and undiagnosed depression among older members of our population.

We also looked at issues around dual diagnosis as well and I have no doubt that other speakers have already addressed this one in some detail as well, but from the perspective of community organisations, it was a very serious concern in relation to lack of appropriate services to handle dual diagnosis of substance use disorders and mental health issues at the same time and also about the policy and resource constraints that are placed on community organisations working in both mental health and substance use disorder treatment.

We also looked at some other issues around integration between mental health and housing systems. We have a range of concerns in relation to things like the social housing reforms that the Government has proposed and also the lack of movement in the area of boarding house protection and the rights of residents in boarding houses. These are longstanding NCOSS concerns and they are particularly relevant to the inquiry on mental health given the particular population made-up groups of the clients there. We are also looking at the question of how people with mental health issues negotiate their supported accommodation—GSAP—services. Many of our members come from the GSAP services sector and other housing organisations and they are under increasing stress, having not received any growth funding for something like the past eight years. We have a system that is responding to greater and greater pressure in terms of its funding and its response to clients with complex needs. Now there are also additional pressures in terms of how they respond to people with mental health issues and the lack of funding, the lack of expertise and the lack of support from the broader health services to those housing organisations. I will restrict my comments to that at this stage.

CHAIR: You gave evidence of your survey showing that 75 per cent of people who are homeless had a mental disorder of some sort. That is not that different from the 83-84 per cent of males—because I assume many of the homeless people you found

were males—in the prison system. Is there a continuum in your view between those people who are homeless and the people that we find in the prisons?

Ms BRAGG: There would be no question that that is the case. We are talking about people for whom a whole range of support systems have failed and quite often there is an institutional response to that. People whose housing breaks down often end up homeless, particularly if they have got behavioural disorders or drug and alcohol issues then the prison system often picks them up. I would argue both of those are the breakdown of support systems.

CHAIR: The Hon. Dr Arthur Chesterfield-Evans was involved in the inquiry into prisons to which NCOSS made a submission. Has NCOSS done any work on the number of people in prison who would be better cared for in the community as being mentally ill?

Mr GOODWIN: I cannot recall whether that was addressed in the submission. We can take that question on notice.

CHAIR: It is a huge task but if you have done the work the Committee would be pleased to take the information on board.

Ms BRAGG: We do have those statistics. Unfortunately, we do not have them here. Yes, there is a substantial proportion of people in the prison system who clearly require treatment for their mental illness.

CHAIR: We know that but the issue is if community-based mental health services were better funded, better resourced and more money was spent with better facilities it may be that some of the people who are in prison would not be in prison.

Ms BRAGG: Absolutely.

CHAIR: That is the question rather than the number of people in prison at Long Bay and the Remand Centre the figures for which we got yesterday.

Mr GOODWIN: It is true to say—it certainly emerged from speakers at our justice conference that we held last week—that there were a range of support systems that are required in many cases to more appropriately care for people outside of prisons or indeed at the preventative end to prevent it from even becoming a prison issue or a criminal justice issue at the end point. As we highlighted in our submission, the lack of resources in many areas and the failures of the system to provide appropriate care for people in the community end quite often means that they do wind up with the de facto end of the care system which is homelessness or crisis accommodation or various other forms of crisis, including in that situation, the criminal justice system itself. I suspect the changes to the Bail Act will probably worsen that situation in the coming years.

CHAIR: Worsen?

Mr GOODWIN: I would think so.

CHAIR: Part of the changes to the Bail Act has something very exciting called bail hostels. Have you had much consultation with the Attorney General in relationship to what he means by bail hostels and who will operate them?

Mr GOODWIN: I suspect we may have. Our director has been involved in a number of discussions around bail hostels. As I understand it, there is one bail hostel operating at the moment in relation to women prisoners but once again the issue about adequate resources is a challenge as well for people in the bail hostel end of it. It would be welcome if the changes to the Bail Act actually led to an increase in resources for that system.

CHAIR: You point out that New South Wales is relatively poorly funded compared to other States per head of population for mental health. In particular, in community mental health the Minister has announced some initiatives on opening more beds. We do not know whether those beds will be community beds or some of the beds which are opening for Area Health Services like the Tweed, Taree, Coffs Harbour and so on, new inpatient beds. How can we relieve the pressure on the inpatient beds without increasing community-based services?

Ms BRAGG: I do not think you can. I would say that there is a very high proportion—obviously we cannot give reliable statistics on this—of people who end up in acute care for mental health as a result of breakdown in care in the community. Basic things like ensuring people take their medication, for instance, would be a pre-requisite and to ensure that people have the support they need to maintain their housing in the community is also an important way to ensure that their care is maintained at an adequate level.

The Hon. AMANDA FAZIO: You have gone into a lot of detail in your submission about the problems with dual diagnosis and older people with mental health problems and indigenous people but you have not commented on youth or adolescents with mental health problems, or people from a non-English speaking background. Has NCOSS got any information on that? Do you want to give us information about that today?

Mr GOODWIN: In preparing the submission we had some discussions with the Association for Adolescent Health around the issue of services for younger people. We mentioned once or twice very briefly but we did not actually have the capacity in this instance to go into it in too much detail. When we talk about questions of dual diagnosis we talk about housing and specialist services in community care. The issue of services for younger people is a specific headline issue, I suppose, that sticks to one side about how we make sure that any responses to these challenges actually address the specific issues of younger people, particularly issues of continuity of when a younger person is going from a juvenile mental health system into an adult system, and similarly, the spin-offs for that with the criminal justice system. In relation to people from the a non-English speaking background, we did not go into that in too much detail because we are aware of the work that transcultural mental health and other organisations have been doing in that area.

Ms BRAGG: In relation to people from non-English speaking background and temporary protection visa [TPV] holders or asylum seekers, that is, people who have been in immigration detention centres, we identified that as an area where there is an

extremely high level of need. While we would like to do some more research on that we have not been able in the lead-up to this inquiry. We would like to flag that as something that would benefit from further work.

The Hon. AMANDA FAZIO: The lady from the Adolescent Health Service mentioned that that was arising as a service problem for the organisation that she deals with. We concentrate on prisons and mental health but do you have any comments on juvenile justice and mental health for younger people? Is that your area of specialty?

Mr GOODWIN: No, it is not. I do not have specific expertise in this area but the question still stands in relation to the criminal justice system as it stand for adults about how effectively it is functioning and how effectively it is being resourced to actually prevent younger people from entering the criminal justice or juvenile justice systems. People from the Adolescent Health organisation would be better placed to comment on those sorts of diversions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In relation to discharges and community support, in paragraph 4.3 of your submission you talk about people being discharged more quickly. Is that mental health discharges or just discharges from hospitals generally?

Ms BRAGG: We have the figures on discharge from hospitals generally, but our understanding is that that is working in mental health as well as in general health areas and specialist health areas.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the length of stay much shorter in physical health than mental health because of the huge preponderance of day-only admissions?

Ms BRAGG: By and large. Certainly the rates of day-only admissions, I think the target is something like 60 or 80 per cent from the institutions, so a significantly greater number of people go into hospital for non-mental health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The figures for discharging from psychiatric facilities may not have changed by the same percentage as the physical ones in 4.3. Is that right?

Ms BRAGG: They would not have changed at the same rate, but there is pressure to reduce them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have the figures for psychiatric hospital admissions?

Ms BRAGG: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why do you not have those figures? Are they not made available?

Ms BRAGG: We have not been able to obtain them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have tried to get them?

Ms BRAGG: I think we have made a verbal request for them. There has not been a written request for them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is certainly worth us following them up. You have also commented about the importance of Supported Accommodation Assistance Program [SAAP] services. Are they becoming de facto psychiatric services with very little staff?

Mr GOODWIN: In some areas, SAAP services are worried that that is the direction in which they are being pushed. They are particularly concerned first of all that they do not have the resources to take on extra capacity but also about specialist expertise. In preparing our submissions we heard stories from youth SAAP services who were talking about a complete inability to take on anybody whom they suspected had a drug and alcohol or mental health issue. Quite often there were people who were doing the assessment and intake procedures who were turning people away on the ground that they suspected there may be an issue to be dealt with, and the service was not taking them on them because they did not believe that they would be able to get support from the community mental health teams in providing accommodation for that person. So there was a whole range of issues to do with resourcing, skills and assessment as well as the partnerships with other broader mental health systems. Certainly there is a lot of concern in the SAAP services sector about the funding crisis that they are under generally, but also about the increasing pressures they are under in relation to mental health clients.

CHAIR: This is supported accommodation?

Mr GOODWIN: Yes.

CHAIR: The issue there is that many of those people, for mental illness or other reasons, are covered by the non-government organisations. We received evidence from the Richmond Fellowship that Health provides $8,000 per person whereas DADAHC provides up to $70,000, depending on the dependency needs of the person. Is this a particular issue in trying to establish supported accommodation for people who have mental illness?

Ms BRAGG: I think there are two types of supported accommodation involved. There is the crisis-homeless target group that the SAAP services are talking about and then there are services which are specialist residential services for people who have mental illness or other forms of disability. We are actually looking at different types of service here.

CHAIR: I am particularly interested, not in the acute, take them of the street and put them in a backpacker place, but in the long-term supported accommodation, stable housing for people who have a mental illness who need at least stability first before they go on to rehabilitation, employability and socialisation. There are people of whom you would be aware in the non-government organisations who provide that service.

Ms BRAGG: Absolutely. Yes, there are in number of them who do that. There are absolutely insufficient beds and insufficient resources for them to do that work. There is no question about that. A lot of the work that we would like to see being done in that environment we would like to see done on an outreach basis for people who have to find housing through other means, such as public housing, community housing or through the private rental market. Definitely a large population would benefit from residential services you are describing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you agree with the figures cited by the Hon. Dr Brian Pezzutti? If you have a mental illness and if you are getting your money from Health, you get $8,000 but if you have a disability, which presumably includes intellectual disability as well as physical disability, you get $70,000. If you are trying to do good and there is huge unmet need in both areas and if someone said you can have a $70,000 for this or $8,000 for that, you would not need to be a rocket scientist. I am not saying that the disabled people should have less accommodation. Do you have evidence of this type of skewing in supported accommodation?

Ms BRAGG: We are not aware of those specific figures you are working with, though certainly it is the case that the level of funding for services that are supporting people who have a mental illness under Health are not well resourced.

The Hon. AMANDA FAZIO: I think it goes back to the original program of deinstitutionalisation from mental health facilities when asylums and mental hospitals were closed down following the Richmond report. People were put back into the community.

The Hon. JOHN JOBLING: This was a palliative sop.

The Hon. AMANDA FAZIO: They were pretty much left to their own devices within the community, and the range and level of community backups were not there. But in the current deinstitutionalisation program in disability services whereby residential institutions are being closed, people are being rehoused in the community from there, and are guaranteed a choice of where they will live.

CHAIR: And a lifelong care guarantee.

The Hon. AMANDA FAZIO: Yes, but also high quality. It is not necessarily more expensive, but there was a provision of higher-quality care and the funding attached to that. I think that has become apparent in some of the evidence that we have heard. There seems to be a major distinction between the levels of care deemed appropriate for people with mental illness versus people with a disability.

CHAIR: After all, when Richmond came along, the report was both for intellectually disabled people as well as for people who were mentally ill. They were, quite properly, moved out of major institutions into a home-based or home type of care.

The Hon. AMANDA FAZIO: Because the old mental institutions had an inappropriate mix of people.

CHAIR: There are still 2,500 intellectually disabled people who remain to be deinstitutionalised. That will happen over the next eight years. I think DADAHC gave us a figure of eight years for the remaining 2,500. There are 3,700 of those groups of people who may have mental illness as well, but who are disabled. Of that 3,700, one-third have been placed with this lifelong guarantee of care at a high level or a reasonable level, but some of those are $70,000 a place and some of them are not nearly so high. But Health which started the process earlier was not well resourced and has not kept up with inflation. Approximately $8,000 is the figure that we received from the Richmond Fellowship anyway.

Mr GOODWIN: That really highlights that, for deinstitutionalisation to be effective for the people who are being deinstitutionalised, it needs to be accompanied by a shift in resources from the acute end of the care, the residential care, to the actual community-based supports and accommodation, employment, rehabilitation and self-help, as well as all the other supports that people require to live in the community. Particularly when viewed from a human rights framework in the post-Burdekin environment, if you are actually doing it to also uphold the rights and dignity of the people about whom you are talking—your client group who have mental illness—I do not think they are served well by putting them in an inadequately resourced community system where there are so many gaps that people can fall through. I suppose the more recent deinstitutionalisation processes highlights that this is something that requires a commitment to spending, but that is a necessary part or component of that deinstitutionalisation process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On page 6 of your submission you point out that the per capita spending on community-based mental health services in New South Wales is $1.20 as against the national average of $3.70, so it is less than one-third, as you have said. It is actually 68 per cent less than the national average. In the Government's submission on page C2, it claims about the New South Wales Government's health spending is 93.7 per cent of the national average. That is less than one-third and that presumably reflects the difference between community health and the total claimed for mental health. Does that mean that we have a totally out-of-whack system in terms of the amount of resources allocated to community-based care and hospital-based sources?

Ms BRAGG: Absolutely. We have seen that new money going into the mental health budget over the past few years, which we are delighted to see. Of course, the figures on which we are relying are from 1997-98 which are the most recent made available to us. We are in fact relying on the Commonwealth Government's national mental health report to find out a lot of the figures about New South Wales, particularly the breakdown between acute and community-based services. It is very clear that the money that is going into the mental health system in Health is not being targeted to community-based services. From our perspective that is exactly where it needs to go. While acute services are enormously valuable and are often absolutely essential, it is very clear that many of the admissions to acute services could be avoided if we had an adequate system of community-based services.

We have enormous difficulty in tracking down processes by which money is allocated in the Health budget. I mentioned before the planning process which, at the time the $107.5 million was announced in April 2000, involved specific discussions with the Minister's adviser around a guarantee of an open and transparent planning process

which would have participation from stakeholders. It simply has not happened. It is of enormous concern to us that what we see are manifest gaps in the service delivery system that are simply not documented and integrated into that planning process. In fact we have enormous difficulty in finding out when money turns up in an area health service, let alone where it has been allocated. I can only emphasise the extraordinary imbalance between resources to community-based services and the rest of the health system. It would appear to be guaranteed to continue under the system of planning we have in place at the moment.

CHAIR: Importantly, though, even though the money might turn up there, there is no audit that says that it is actually going to be spent on mental health services. That has been the other complaint that you made about audits of area health services, namely, that $2 million might be given by the Minister to an area health service, but there is no guarantee that that $2 million will be spent by the area health service on the reason why the Minister gave them the money.

Ms BRAGG: I think that there are guarantees, and guarantees. From our perspective, no, there is no guarantee. We say that from the perspective of, yes, there is an annual report and there are budget reports and so on that are provided by the Health Department based on information from the area health services, which also put out their own annual reports, but I think that the way those figures are calculated is sometimes questionable. Certainly discussions off the record with very senior people in area health services have suggested that there are may be two sets of books so that their figures are given some assistance to meet government requirements. We are not confident that the figures we have been given are accurate and we would raise questions about the way in which the calculations of what is spent on mental health are made.

Because we do not see and are unable to obtain information about new money going into area health services as it happens, that process of oversight which many community organisations would be very happy to perform, we cannot do. We tend to find out about money that is granted to area health services well after it has arrived and has been allocated. The other disadvantage of that is that community-based organisations are not in a position to put up their hands for that money and seek additional funding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the last line on page 9, which is what you are referring to now, you have said that the figures have been "adjusted", and you have said that senior figures within the Department of Health have said to you, presumably off the record, that the figures are adjusted. People have actually said to you that there are fiddles in order to make it look okay, but the money has gone elsewhere.

Ms BRAGG: Yes. We are talking about senior people within the area health services, not within the department. That is an important distinction, particularly as it is the people in the area health services who have the capacity to do the adjusting. Yes, our information off the record—and of course it is only ever off the record—is that there is not an open, transparent and accurate allocation of funding across the appropriate areas, particularly in relation to mental health, and that that money is moved—adjusted.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even if we were able to get all the figures from the area health services, which does seem to be extraordinarily

difficult, you do not believe that the figures would be a true reflection of where the money goes.

Ms BRAGG: I think that an audit would be a useful first step and I think it is useful then to interrogate that and ask questions about the way in which costs are allocated to particular elements of the mental health budget. For example, costs within a hospital—are they assigned to mental health activities within a hospital, the same as costs are assigned to similar activities in other specialist areas? The proportion of community health funding which is allocated to mental health—does that reflected the proportion of hours that are spent in actually providing those services? I think that they are useful questions that can be asked. Until we have those figures clearly on the table, instead of having simple blanket figures which state that there is a total amount going into mental health without a breakdown into community-based services, we are absolutely not in a position to audit those figures. I would say that the actual total figures that we get you probably would not feel too confident about, but they are a first step in getting to a point at which you can actually ask for something which is more accurate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The other table you have is about the funding percentage that goes to non-government organisations [NGOs]. Again, New South Wales funding is running at 1.7 per cent as opposed to a national average of 5 per cent, which is about one-third of the average rate. We have been told that Victoria has the best integrated health service in Australia. It has a funding percentage of 9.5 per cent, which is almost twice the national average, and also has almost twice the national average in community-based spending. Is there a lesson to be learnt from that?

Ms BRAGG: Absolutely. One of the things I point to is the way Victoria has accountability in health funding. The money is highly accountable in the sense that you can track where it has gone. They do not have the global area health service budgets in the way that we operate here. They have funds specifically tagged for particular services in the community. They do not have this amorphous budget. In discussions with people from Victoria, they found it extraordinary that we could not track funds and ask questions about, for instance, the performance agreements for specific services, which they have access to publicly in Victoria. They have clear accountability processes in relation to particular services. On the one hand, Victoria has done something which New south Wales has been slow to do, but it also has accountability mechanisms which means that they can track the funding and feel with some confidence that the money has gone where it is supposed to have gone. In saying that, I am certainly not suggesting we take on the comprehensive reforms that have occurred in Victoria in relation to funding allocations. But in respect of accountability, there are some lessons we can learn from them.

CHAIR: It is not just the dollars, it is how the dollars get tied up in terms of in-patient care, institutional care, community-based services and spending by NGOs—in other words, NGO activity. Would you support a major revolution in New South Wales to move in that direction?

Ms BRAGG: I think being really clear about where those allocations are and actually having a process of scrutiny about how those allocations are developed and implemented. It would be absolutely essential.

CHAIR: We already have the assessment that New South Wales is spending 20 per cent of the amount that Victoria spends on NGOs and Victoria spends vastly more on community-based services and a bit less on in-patient services. To change that in New South Wales, we would need a revolution of thinking. Would you support such a revolution?

Ms BRAGG: A revolution in thinking which shifted resources into the community, absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have been on a mental health implementation group. The Minister has received the Menedue report and has set up these implementation groups in each area of health. There is a mental health implementation group, which presumably you have input into and feedback from other members. How has that group worked and has that any accountability at a grassroots level? Does the Minister listen to that group?

Ms BRAGG: We are not represented on that committee. That committee has taken on specialist mental health groups. We are represented on another five implementation groups. From our perspective, the gap in the work of that implementation group is oversight of budget. That is a fundamental concern to us. As I have mentioned a couple of times, the announcement in April 2000 of an additional $107.5 million was supposed to go through the process of scrutiny at State level. We had understood that the implementation group would have some role in relation to those funds. That has not happened. The funds have not gone through that group.

CHAIR: When the $2 billion announcement was made, mental health was not made with it. Then the $107.5 million announcement was made separately and that money came in three packages. One package was for wages inflation, which was $37.5 million, which left $70 million. Since then the Minister has announced a whole range of new measures. Some of the $70 million will not be spent for another two years because of the opening of services. From that whole announcement, the non-government organisations got a piddling $450,000 over three years. That is all the non-government organisations got for supported accommodation and so on. In other words, the money was being spent again in acute services, as far as we can tell.

Ms BRAGG: In acute services but also, we have to admit, community-focused services within the area health service. Again, there is no accountability.

CHAIR: What evidence is there that there has been an increase in the community-based services in the areas?

Ms BRAGG: There is no evidence at all. However, we are assured by the Government that has happened, and we do not dare to suggest that it has not happened at all.

CHAIR: The one area in health spending in New South Wales which is not resources distribution formula-based—in other words, population-based—is mental health. I know that they are exploring the possibility, because at least with that sort of resource distribution for population-based funding to area health services you can see where they buy their services. If they buy their services in Lismore or in Brisbane, you

can see it because they have to pay for it. It overcomes the problem with the Central Sydney Area Health Service, which has a large number of big institutions still within it that people from Western Sydney and Lismore come to for care. That service can get the money. At the moment the money is allocated to those institutions on an historical basis and, therefore, you and I cannot see that people from Dubbo, Orange and Lismore are getting their fair share of the dollars that are being spent on mental health services. Even though there may need to be a different RDF to account for differences in incidences of mental illness and mental health problems, you cannot see that they are getting their fair share of the money, let alone follow the money as it moves out of Lismore to Tweed Heads or Prince Alfred, Rozelle or Cumberland hospitals. The big difficulty is not only finding where the money has gone when it is allocated but seeing whether there is a fair allocation.

Mr GOODWIN: That was certainly the concern we had from people when preparing this submission. People talked about the question of how the need is identified, how the planning process occurs in allocating money, where the money is going to be spent and what sort of opportunity there is for community and NGO input to that process when we talk about participation in health decision making. Then there is the whole series of follow-through questions about how the money is spent, where it is being spent and whether it is being spent appropriately.

CHAIR: You end up with very definite boundaries of access, about which we heard yesterday. People who live at Paddington cannot access services at the Prince of Wales Hospital because their boundary for mental health services is around the Karitas collective. Whether Karitas can offer the same services depends on how much historically it has received for mental health funding. People who live at Paddington cannot go to the Prince of Wales Hospital, even though they live in the South Sydney Area Health Service. The boundaries for mental health are completely different and are based on historical formulae. Has that been identified in your submission?

Ms BRAGG: We did not talk about that specifically, but we would note that that is definitely a problem. A shift to an RDF for mental health would be very welcome.

Mr GOODWIN: The other question about resource distribution in that sense which did come up was from people in regional areas was what sort of minimum service you are aiming to provide to people. We heard a lot of stories—and I am sure you have heard them from others as well—from people in smaller regional centres where the community mental health team shuts down at 3.00 on a Friday afternoon. So it is essentially police and maybe a supported accommodation program [SAP] service or two would be the only form of crisis support over the weekend. I know there are clinical issues in relation to how you deliver those services in regional areas. There are particular questions that people in regional New South Wales are facing in relation to these services that they can access particularly out of hours.

The Hon. AMANDA FAZIO: We have heard about some interesting projects funded by the Commonwealth under suicide prevention programs—one in particular in the southern suburbs of Sydney—that seem to be doing good things with young people. Are you in a position to comment on the level of co-operation, if any, between the Commonwealth and the State in the provision of these services and how any successful projects might be replicated throughout other areas in the State?

Ms BRAGG: I do not think we are in a position to comment on that level of detail.

The Hon. AMANDA FAZIO: Many people have said that things would be easier both for health professionals and people in the community, particularly for family carers, if more money was spent on mental health awareness and promotion programs. You mentioned earlier the human rights issues involved with people with mental health problems. Do you believe that changing attitudes in the community and making more people aware of the rights of those with mental health problems and providing more supports to help them live in the community would be of benefit overall?

Mr GOODWIN: That would be of benefit for people concerned. But we would say that extra funding to do that should not be at the expense of extra funding that should be going into the system as it stands now. There is a variety of very basic supports, as we have been talking about, in housing, employment, rehabilitation and all of the things that are required to enable someone to live successfully in the community. Obviously the attitudinal dimension of people around them is an important part of that. If a person cannot get appropriate housing in the first instance, we have to question whether the attitude of the person who walks past them on the street where they happen to be living is more important. All those other services need funding and they also need more of the specialist services we have been talking about before we actually start getting to some of the broader questions of awareness-raising in the general community. I would not like it to be seen as a trade-off from one to the other or of competition between them. The important thing to emphasise here is the extent to which the system as it stands now is currently failing to address the needs of those people and where the priorities should be in addressing those needs above all.

CHAIR: The British are going through a process of green paper-white Paper legislation for changes to the mental health Act. They pick up a whole lot more people in the Act, such as people with personality disorders and mental disorders rather than straight mental illness. It also has the idea of advocacy, such as disability has an advocacy service. Mental health has a legal advocacy service for people going before the magistrate. What do you think of the idea of an advocacy service?

Ms BRAGG: We could see enormous advantages in that. There are two levels of advocacy. One is the individual advocacy to assist individuals to negotiate the system. A lot of people with a mental illness, often a severe mental illness, do not have an advocate, even on an informal basis. I would say there is very clear evidence that the lack of an individual advocate can mean that people do not get the benefits from the system that they would otherwise be able to obtain. There is also the question of systemic advocacy. With groups such as ours, our role is systemic advocacy to seek changes in systems, whether in health or housing, in order to improve the situation for a group in the community, such as people with a mental illness. We would strongly support additional resourcing for this. This is clearly an area where there is an enormous range and scope of work to be done, particularly with mental illness being seen as an issue of responsibility among so broad a range of human service agencies. The need to engage in systemic advocacy in relation to a broad range of government agencies is of growing importance.

CHAIR: In the British Act, they have a requirement for each person to have a case manager, which sounds a bit exclusive. In other words, they have a single person rather than a whole series of people responsible for a person's care. Also, they have a requirement that each service develops a management plan for a person's problem. We do not have those requirements. Do you believe that the case manager should also be the advocate? Can the case manager undertake both roles or should they be separate roles?

Ms BRAGG: There are benefits in having them as separate roles.

The Hon. AMANDA FAZIO: What do you see are the benefits? Do you see that there is a conflict of interest?

Ms BRAGG: There is a potential of conflict of interest between the person trying to organise the care and the person looking after the best interests of the client. Hopefully, the interests would be identical, but I imagine there are circumstances where they can be at odds with one another. Having someone whose specific role is to look after the best interests of the individual and ensure that their rights are adhered to is more likely to produce a positive result for the individual.

CHAIR: An advocate is often outside the system, and the case manager is often within the system, which can create tensions and difficulties for the case manager.

Ms BRAGG: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You had an early discharge forum in October 2000. You introduced a report, which had a controversial cartoon on the front. Did that forum relate to mental health at all?

Ms BRAGG: Yes, we did cover issues of mental health in that forum. I think we looked at that issue quite specifically, on the basis that quite often when we are looking at an early discharge from hospital it is a focus on basically middle-class people, who are surprised to find themselves leaving hospital earlier than anticipated. In such instance, they will be less well than they might have hoped. What we wanted to do is to make sure that we had looked at the needs of people with a mental illness because we were concerned, as I mentioned earlier, about the impacts of what appeared to be shorter stays in hospital to get the anecdotal information on whether or not that was in fact occurring and what that means in terms of the experiences of individual consumers.

We did find confirmation from a whole range of participants that there were decreasing lengths of stay in hospital, and a lot of discussion about the crisis focus of the hospital system. The difficulties flowing from that were that, for instance, people did not have the opportunity to remain in hospital until they had stabilised on medication. As I am sure you are aware, often it needs a number of weeks in order to be confident that the correct dosages and types of medication are in place.

Comments such as that were being brought back to us: about the problems of their inability to stay in hospital for a sufficient length of time; their inability to get in and out at the times they wished to; and also, of course, the basic problem that if you do not have the response to community-based services in place, people can end up in

hospital when they know that earlier and a different form of assistance could have prevented an acute episode.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Therefore a discharge plan is basically of no use without someone to carry it out? Is that the essence of the matter?

Ms BRAGG: For mental health there is quite a different approach to discharge plans than for other health issues. They wanted an entry plan as well as a discharge plan—in other words, to be able to get in when they needed to get in. They asked for respect to be given to an individual's sense of an impending acute episode; that was one issue.

In fact, on discharge the problem had been referred on to appropriate services. If people had appropriate care in the community before they went in, there needed to be liaison with those people. Our sense was that that happened in part and not across the board. Of course, many people who end up in hospital with an acute mental illness episode do not have services in the community already in place, or they may have left the area in which their previous supports were. Actually ensuring that people have immediate linkage to the community-based services was an enormous problem.

The Hon. AMANDA FAZIO: It has been raised with us that often people have to come to Sydney for the acute care that they may need, and they are then discharged and they return to the country region where they live. It has been put to the Committee that this makes having a discharge plan more difficult for them, as well as the fact that they have to cross area health boundaries. Do you have suggestions for ways in which that problem may be overcome?

Ms BRAGG: Certainly that is a problem right across the board for people being discharged from hospital, whether it is a mental health issue or not. It is certainly a systemic problem of which this is one component. I understand that the health department is currently working on the discharge framework. It would be helpful if, in that discharge framework, these specific issues were addressed. I imagine that directions coming from the health department would have a greater capacity to shift things if they are formally part of the policy process. That is one step. Clearly, the shortage of services in local communities is a fundamental problem, particularly for rural communities where the capacity to cross-refer between agencies is very limited. If the service is not there, it is very difficult to then refer to it. Or if the service is already overstretched, you cannot add anyone onto the list.

CHAIR: The difficulty is that if it is any other health service, such as a cardiac service, if the patient goes from Lismore to Sydney, Lismore has to pay Sydney. But if it is decided that mental health patients in Lismore should be transferred to Sydney, Lismore escapes providing the care, because it is a totally different funding process. The RDF does not apply and those cross-border transfers of money also do not apply. There is no disincentive for people in, for example, Port Macquarie and Coffs Harbour not providing the service.

Ms BRAGG: I absolutely agree with what you are saying.

CHAIR: The Minister sends the money, and he is doing it widely, but we are not sure that the money is being spent there. More importantly, there is no disincentive for them not to spend it properly.

Mr GOODWIN: The other concern that people raised with us was that when there are inadequate services, quite often it was left to people perhaps slipping back into more of a crisis mode again and that when they had an area mental health team that was already stretched or had particular eligibility criteria about who it took on, their role was being restricted in that setting to stabilising people and referring them on to GPs for case management, which is another form of cost shifting. But you then had issues of whether that was an appropriate form of ongoing care for people, whether there was the expertise there. Also, in a regional area, quite often where Medicare is being restricted more and more in regional communities, it is also an access question for people, particularly people on low incomes.

CHAIR: We have heard evidence about GPS getting more and more involved in mental health, under the Commonwealth's push to. There are certain incentives for GPs to get involved, through using the general practice framework and perhaps community mental health teams. Is that the way to go, rather than base the community mental health teams in institutions?

Ms BRAGG: There are certainly advantages in having GPs involved in the delivery of care. I do not think we are talking about replacing existing services.

CHAIR: At the moment the community mental health team seems to be based at major institutions, whether it be the Missenden Centre at Royal Prince Alfred Hospital or Cumberland Hospital. In other words, they seem to radiate out from their institutions, rather than being more community based and managed in the community.

Ms BRAGG: We could make the trite comment that you could shift these services to a non-government organisation [NGO] framework, in which case you would have services not based in—

CHAIR: I see nothing trite about that at all. That is exactly what a GP service would be. It is a non-government organisation, whether it is a GP or a community mental health team with a board of management.

Ms BRAGG: I would draw a distinction between the sorts of services provided by a GP and the sorts of services provided by community-based services such as NGOs, not just in terms of clinical care but also in respect of care co-ordination issues. You will generally find that the community-based mental health services will take on questions of organising housing and a whole range of other factors which assist people to live in the community. GPs do not have a good track record in doing this; it is certainly not what a lot of them are trained for. To expect them to take on that role would be unreasonable. In many ways, it is not an appropriate role to assign to a GP.

CHAIR: If you had a community mental health service, instead of relying entirely upon a psychiatrist or rushing back to see a psychiatrist for ongoing care, the GP it would be part of a team. There would be mental health nurses and social workers, and, of course, Department of Housing officers are also vitally important. But at the moment the only medical input is from psychiatrists. Whether or not we start to include

GPs in that treatment as part of the community-based services, rather than all treatment coming from the psychiatrist sitting in either Macquarie Street or one of institutions—

Ms BRAGG: To the extent that it is feasible to transfer some of that role to GPs, of course that would improve access to an enormous range of people. As we know, the distribution of psychiatrists is not equitable across the State, and quite a few people have long distances to travel to access psychiatric care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this really something of a bad joke, to put it perhaps politically incorrectly? The number of GPs who bulk-bill is decreasing, the amount of Medicare services is decreasing and psychiatric consultations take longer than other services. Since Medibank was introduced, Medicare has gone down against the CPI by more than 40 per cent, fee for service is perhaps not the way to go and these GPs may not have the expertise compared to other people who work full time in mental health. Is this a sop on the existing system, when there are not the doctors who are capable, willing or financially advantaged in doing it, whereas the money would be better spent elsewhere?

Ms BRAGG: Firstly, for a lot of people GP services are still not accessible because, as you mentioned, bulk billing is not universal in rural communities. In many rural communities there is no doctor within several hundred kilometres who bulk bills at all, so in many cases we are simply not looking at an option for a lot of communities. But we are talking about a particular sort of care. Whether or not GPs choose to acquire the skills they need in order to provide this care effectively is a big question, and there is also the question of whether that is going to give you the quality of care for a range of consumers who require the specialist support.

The Hon. JOHN JOBLING: Most country GPs are already under overload stress. We are having difficulties filling regional positions. Additional caseload and workload may well drive more of the ageing population out of the profession, which will leave people even more disadvantaged than that they are at present.

Mr GOODWIN: You are also dealing with pressures on GPs to become involved in a whole range of other areas, and through the Commonwealth itself with the enhanced primary care, whether it is diabetes, mental health, aged care, hepatitis C, or whatever. There is significant specialist expertise there that might be needed to treat people adequately. I think that was one of the concerns from people we spoke to. They were not confident that it was going to be appropriate, or they felt that in the region it would not be appropriate to be going down a GP path.

The Hon. JOHN JOBLING: Would it be possible to try to fill this gap by working in a larger number of specialist nurse practitioners in rural areas with specific training in the mental health field?

Ms BRAGG: We would certainly support the extension of the nurse practitioner program. We think it is an excellent program with very good strategies to ensure the quality of care provided. The extent to which that can fill the gap for people with mental illness is a difficult question; certainly we could see it as providing some assistance. I think we are getting back to the question of what is the quality of care that people should be able to expect and how we can best provide that. I feel some discomfort with the pressures from the Commonwealth and the State to cost shift; these

are definitely issues that need to be taken into account in allocating resources. But we do have some understanding of the range of services that would assist people with mental illness. Of course, they are different, depending on the mental illness. We would like to see them provided across the State.

CHAIR: Clearly, GPs would probably see more people for mental illness than anyone else in the State. The Commonwealth is encouraging the provision of a different schedule of times for GPs to see patients with psychiatric illnesses. The reason for the Commonwealth driving that is that when a GP sees such a patient, he or she does not see them because they have neurosis or depression, they take the patient's blood pressure, which a mental health service does not do, nor does a clinical nurse specialist in psychiatry. It is a long way down the track before GPs decide they will be part of this, because it is part of a grand plan. I would like to know whether you think it is a good idea or a bad idea, if that plan were in place, if we can locate with GPs, mental health community nurses and so on, which would be needed to provide outreach services.

Ms BRAGG: There are certainly advantages in co-ordination between the services. One of our main concerns about GPs is access—not just the bulk billing question but also the problem of dirty, smelly people in the waiting room, which quite often means that people are homeless. People with severe mental illness are not acceptable clients for GPs, who, as small business people, are in a position to say to they will and will not accept into their waiting rooms.

CHAIR: Many country GPs have access to a multipurpose centre, which is where they see many of these people. They also see many of them at the local hospital. It will be a long time before the emergency departments of our public hospitals have an appropriate place for a person with mental illness to be triaged.

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Ms BRAGG: I would agree with you. There are certainly gaps in the way that operates. I would say that there is probably a greater preparedness to address some of these issues within a public hospital which is obliged to provide care to anyone who walks in the door as opposed to a GP service which can choose who is allowed in to see the doctor. We would certainly encourage the involvement of GPs but just express some reservations and a perception about how that would be a primary or central source of assistance for people who often find difficulty in getting into GP services now.

CHAIR: If they have difficulty getting into GP services then the place where they go for them is the hospital where the same GPs treat them. That is at Moree and Inverell and places like that. The sort of places you are talking about of course they have access to GP services. Whether they are in their rooms or whether they actually see them as part of the rural settlement plan at a public hospital is a completely different matter and many GPs do in fact bulk bill for some of these people. So you are not going to move someone who has got a cold from Moree to Sydney to get treatment for their cold or their bronchitis. They of course get treated in Moree and any suggestion that they do not is, I think, not true. About the access to care in the same way that people do have access, that is true, but the access through the public hospital system through the rural doctor settlement package and others, is the way it happens.

My concern is how do we get best care for these people in a way where it is as close as possible to them rather than having to travel 60 kilometres or 70 kilometres to get to see somebody who knows something about mental health. If it means rejigging the doctors or moving the nurses out to these places into the smaller communities into community health centres where they can be seen, so much the better. It just has to be a bit better than what we have got now.

Ms BRAGG: You have raised a whole lot of questions that we would agree with in terms of making sure that services are located as close to the person as possible rather than transporting the person from their community somewhere else to obtain care we would certainly be very supportive of providing care as locally based as it is possible to do.

CHAIR: You will get the *Hansard* from today. Some of the questions we have asked may not have been the appropriate questions and some of the answers you have given may need to be amplified by you or we might have the odd word wrong—but Hansard never does that—or wrong spellings, if you can get those back to us we will make those public and put them onto our web just as quickly as we possibly can so other people coming before us will see what you have said and so on. If there is anything you think we have not covered that you think you should have said please send it in and we will simply add it as extra evidence. We may in fact, if you would not mind, as part of this inquiry when we get some evidence from somebody we might need to bounce that off you at a separate time. Would you mind if we did that?

Ms BRAGG: No, not at all.

CHAIR: When we come to write the final report there may be some bits that we may wish you to comment upon before we go into hard print. So there is a bit more to be done yet from the point of view of NCOSS and we may need to get you back at some later time. It depends on what the Committee members wish to do.

Mr GOODWIN: We would welcome the opportunity to come back and amplify other points or to comment on other submissions or drafts.

(The witnesses withdrew)

(Short adjournment)

ABD MALAK, Director, New South Wales Transcultural Mental Health Centre, 5 Fleet Street, Parramatta West, and:

TED QUAN, Representative, New South Wales Transcultural Mental Health Centre, 5 Fleet Street, Parramatta West, sworn and examined:

CHAIR: Mr Malak, in what capacity are you appearing before the Committee—as a Chairman?

Mr MALAK: As a chair of the Federation of Ethnic Communities Council of Australia. Probably I am coming in two ways because we put two submissions, one from the Federation of Ethnic Communities Council and one from the Transcultural Mental Health Centre and I am not sure—I am happy to do both.

CHAIR: You can speak to both. You are conversant with the terms of reference?

Mr MALAK: Yes, I am.

CHAIR: And this admission that you have made is for the Transcultural Mental Health Centre number 228. Which is the other one from the federation?

Mr MALAK: The Ethnic Communities Council.

CHAIR: We will find a number for that one as well so we can refer to it later. Would you like to make those submissions as part of your sworn evidence today?

Mr MALAK: Yes.

CHAIR: Mr Quan, what is your occupation?

Mr QUAN: Psychologist.

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

Mr QUAN: Representative from the Transcultural Mental Health Centre.

CHAIR: And your address is the same?

Mr QUAN: Yes.

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

Mr QUAN: Yes.

CHAIR: If either of you should consider at any stage during your evidence that in the public interest certain evidence or documents you may wish to present should be heard or seen only by the Committee, the Committee 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 the evidence public. Mr Malak or Mr Quan, would you like to make an opening statement that might expand your submission?

Mr MALAK: I would just like to talk about culture and mental health and when I use the word "culture" I mean "way of life", a more wider identification to culture. Culture is determined in a very wide perspective. What is mental illness and what is not.

Just a very quick example, culture can determine sometimes, or the majority of time, if somebody has a mental illness or not. If the person is hearing Jesus' voice; is this person hearing voices, delusions, or a blessed person? A second example, if somebody worship his or her ancestor, that people hearing the voice somebody hears the voice of her father, who has died 50 years ago, come and give them advice. That is what I mean, culture can actually determine what we mean by mental illness or not.

CHAIR: So that might be not otherwise interpreted as hearing voices?

Mr MALAK: No. It can be interpreted it is a very blessed person and every one respect this person. The second one is that culture can sometimes determine how people can receive prevention from mental illness or early detection. An example of that is stigma. In some cultural groups stigma is very high and they deny or cover-up mental illness. It is vitally important for the whole family. We know that health professionals do diagnoses using language and communication and body language. Different cultures can provide body language of different interpretations, and in different cultures the same words can have different meanings to different people. If you say to people, "Do you feel down or have the blues?" What is the meaning? That is why in our work at the centre we have up to 38 per cent of misdiagnoses, people have not the proper diagnosis, plus up to 15 per cent of people are actually being prescribed medication that is not relevant or appropriate and all they want is some counselling service.

CHAIR: You have a lot of statistics in here.

Mr MALAK: Yes, in the submission.

CHAIR: So you are saying there is a false positive and a false negative in diagnoses?

Mr MALAK: That is correct.

CHAIR: What is the false positive rate that you found? Where they found a mental illness where there really is not?

Mr MALAK: Yes and no. With our work we mainly concentrated on the higher, more severe, 2 per cent, meaning that we cannot generalise across the whole system. Thirty-eight per cent of people coming to us had their diagnosis changed. The vast majority of them were changed to post-traumatic disorder, all different diagnoses, and 15 per cent of them had been moved from medication to counselling and some support. With the medication treatment we know that with different ethnic background, different genetics respond differently to different medication and different doses. Up to five or 10 years ago the majority of drug companies tried their medication in specific cultural groups. That is why they are not relevant to some cultural groups. For example, in the Chinese culture even, we have no research evidence to back that, there is still research work in that area. We are strongly advised to give Chinese people a half dose of what you do in general because they can have a very severe reaction to any medication.

As well as language, how to deal with health professionals is very important. In looking at New South Wales data for the past 20 years, we find that people from a non-English-speaking background underutilise community service, early prevention and detection service, however they are overrepresented in forensic and community orders.

When they come to the hospital they come very late but they spend more time than everyone else. We know there are a lot of reasons behind that and some work is being done to deal with that.

In general, mental health is a unique area. People's wellbeing and culture play a very important part and we can provide a huge and sufficient cost-saving to the system and to people's life and happiness, and the whole community benefits if we do the right things. It is easy to do. I remember arguing when we opened the centre, to keep our centre running, if we keep two patients a day out of hospital—

CHAIR: You will save yourself money?

Mr MALAK: Yes. Thank you.

CHAIR: Mr Quan, would you like to add to that?

Mr QUAN: I would like to echo those sentiments that Abd has expressed. Cultural appropriateness is very important. He has mentioned the dosage. The transcultural mental health centre specialists are very aware of dosage for people from different cultural groups. The example that is often cited is evidence from the Chinese community, that side-effects are great because the dosage is for people from where the pharmaceutical companies did the research. It has shown that so many people, clients, who come to our service are badly side-effected and scared off mental health care, and it takes the counselling of a centre like a culturally appropriate centre where the practitioners are tuned in to individual cultures and how they responded to treatment that gives them a type of treatment that saves time by giving them the most appropriate access to health care.

CHAIR: The transcultural mental health service has now been going for how long?

Mr MALAK: Ten years.

CHAIR: Have you been through a review?

Mr MALAK: About two years ago we went through a major review, yes.

CHAIR: Who did the review?

Mr MALAK: Dr Maureen Fitzgerald from Sydney University.

CHAIR: What was the result of that review?

Mr MALAK: The result was more positive things. I am happy to send a copy of the review to the inquiry. To talk about specific things, we need to do more. Currently the phone line we run to provide advice to health professionals and clients is from 8.30 to five and it recommended that it becomes 24 hours. We tried that for about four months and we can see there is a lot of benefit in continuing to do that. It talked about the need to integrate more with the university, to integrate more of the curriculum within the mainstream courses, our understanding of transcultural and multicultural skills, the basic skill for everyone how to work with somebody different from me as a

health professional. It is our experience when we train people we are much better with our English-speaking clients. Everyone is different, there are a huge number of subcultures and all of that. Currently there are 30 bilingual councillors statewide in different areas. The review recommended to double this number plus to centralise. Currently each area is allocated a couple of positions, however they are language-based positions and each area does not have enough need or demand for that language however there is a demand across the area boundary and it would like to see it centrally managed by a centre like us to be able to facilitate the transfer of language resources from different areas to another.

CHAIR: In our words, they found the service was useful?

Mr MALAK: Yes.

CHAIR: That it needed to be increased in its access?

Mr MALAK: Yes.

CHAIR: More an access issue? You come under the umbrella of the Western Sydney Area Health Service?

Mr MALAK: Yes. We are a statewide service but we are managed by Western Sydney.

CHAIR: How much money does Western Sydney pinch out of your budget as a managing agent?

Mr MALAK: None. Actually, I have been short with them. Western Sydney wants to get out of us, we get a lot of benefits. About 28 per cent of our clients, our service, is towards Western Sydney which is more than their percentage statewide.

CHAIR: But in terms of the voices of western and south-western Sydney that would be probably appropriate, would it not?

Mr MALAK: It is. It is definitely appropriate and relevant but some of the 2000 figures, as we have known for a long time, there is increased number of people in North Sydney and in country New South Wales but people concentrate in areas like Fairfield and Auburn, where there is a percentage, but Blacktown has more migrant populations than you have in the total Auburn population. Something like that.

CHAIR: The only other one a bit like you is DAMEC. Have you worked closely with DAMEC. This is the issue of dual diagnosis. It is what again?

Mr MALAK: The Drug and Alcohol Multicultural Education Centre.

CHAIR: They have split already mental health and drug and alcohol into two different multicultural services. Is it time to combine them?

Mr MALAK: I believe it is, and not just drug and alcohol, but gambling as well. Through my centre we managed a gambling service which was funded by the casino. I do not want to be critical but the reality is in Australia we have this very interesting

opportunity. People go out and have a little bit of drinks, very small, and there is no effect. But we need to put things together to be more effective and more useful. We do a lot of projects in Australia but we never follow up what we have done. We still have difficulty working between the area service, between our centre general practitioners and non-government organisations. There is some improvement but there is still a long way to go.

CHAIR: I notice on page 3 of your submission you say that 74 per cent of the clients that you see receive their care for mental disorders from GPs.

Mr MALAK: Yes.

CHAIR: Is that more than the usual community?

Mr MALAK: Yes it is, it is significantly more.

CHAIR: Is that because the GPs they go to speak the language?

Mr MALAK: That is partly. There is probably not one reason, but to speak the language is probably one of the significant ones. The second one is the localities, the GPs are accessible, and the next one is the issue of stigma. There are a large number of reasons but definitely speaking the language and culture.

CHAIR: Yes, the culture as much as the language?

Mr MALAK: Yes.

CHAIR: So even if the doctor comes from the culture but he is more comfortable in English he will go to that GP rather than the language?

Mr MALAK: Yes.

The Hon. AMANDA FAZIO: You said earlier that a lot of people who come to your service are suffering from post-traumatic stress syndrome, and I imagine that would be increasing with the number of people admitted to Australia as refugees. Do you think there would be a benefit in trying to improve the rate at which the qualifications of overseas trained doctors and health professionals are admitted to practice in Australia, given that migration and the intake of refugees tend to come in waves of people from certain ethnic backgrounds and speaking certain languages? Have you any comments to make on that?

Mr MALAK: In general it is vitally important for the bilingual health professional to be organised and to be allowed to work, to be able to provide service not to their own clients but to the general community. After all, it is a resource underutilised. I can say very strongly that the medical association will be a little bit of a closed club and some of its assessments are not fair. That is not just for medical psychologists but a large number of medical assessments. Like nurses, it is much easier to attend a bridging course and get support. We had a bridging course for GPs in Sydney, running in the south-west, which I understand was funded by a Commonwealth-State partnership, and my understanding is it is winding down, in partnership with Sydney University.

CHAIR: When you said you ran a gambling service, does that come out of the community casino fund?

Mr MALAK: Yes, that is correct.

CHAIR: So, you applied like any other organisation?

Mr MALAK: We applied for it, yes.

CHAIR: What is that worth in dollars?

Mr MALAK: About $600,000 a year.

CHAIR: Is that because you had better access to the interpreter service?

Mr MALAK: We use it more than we use the transcultural centre, which houses central work as well as doing some training and health prevention and development and lingual resource, and some community campaign and some research. We provide from 8.30 to five o'clock a health professional to provide service over the phone, and I say I have this client for the past six months, I am not going anywhere and my treatment is not working, can I have somebody to see him?

We employ 120 sessional bilinguists who deal with up to 54 languages, who are professional health workers and we send one of them to actually reassess the clients, like a general practitioner would send someone to a consultant. We do the diagnosis and this requires a case manager who may say that we will be happy to look at the clients every six months to review the matter and because we have the model we have the system. It is easy for us to use the same model and the same people. We train them and it is better for us because we have more work for them and we are not losing them.

CHAIR: Is your service more necessary for what you refer to as CALD?

Mr MALAK: Culturally and linguistically diverse.

CHAIR: Which groups, without being stigmatic again, do you find most use your service in terms of the need for cultural sensitivity?

Mr MALAK: We see our service in providing information in the community campaign mainly targeting recently arrived people and old people with their language and interaction in the community. However, with clinical services at large a vast majority of the clients can be looked after in mental health by using an interpreter as required and health professionals have some cultural skills and awareness. The vast majority can do that. Probably the top 2 per cent or 3 per cent when there is a difficulty and things are going nowhere, they ring us and say they have a problem, they have talked over the phone a couple of times, but somebody must see the clients, because there is no way for us to look after fully 2 per cent of client needs.

CHAIR: There are plenty of Greek doctors, psychiatrists, as well as Italian and Chinese speaking ones but with some of the other new languages they have not developed their own professional groups.

Mr MALAK: That is true and they all need to work as well. I agree that Greeks have a large number.

CHAIR: But not all Greeks are the same.

Mr MALAK: That is right. We had a Greek client living in Kogarah who was happy to see somebody in Blacktown. She wanted to see another Greek guy but she did not want to see the local one for confidentiality reasons and the stigma. The majority of clients come from Greek, German, Polish backgrounds. The younger ones come from differing new groups such as Chinese, Arabic and lately we are getting some smaller African communities and we are not just having a difficulty finding a bilingual professional but someone to speak the language, to talk in Somalia.

CHAIR: This is the group that is not particularly well covered by the Mental Health Act, those with post-traumatic stress disorder, personality disorders, conditions that will not necessarily put them in hospital but where their life is not comfortable?

Mr MALAK: That is true. A large percentage of people who come from traditional families can still survive in Australia and maintain their life because they have family support around them but when you are split from that you have not got the support and the ability to survive and maintain your life and become much weaker. They need a lot of medical and clinical support.

CHAIR: If I live in the country, will somebody from your service travel to where I live or do I have to travel to you?

Mr MALAK: No. We handle it in two ways. We may fly our health professionals but because the majority of them are sessionals, they have other jobs, so we fly them on the weekend. A second way is to use telemedicine. Another way is to actually move the client. For example, we moved a Chinese client from Dubbo. He was single and had no relations in Dubbo and he spent about 40 years in hospital and there was no need for him to be there. That is a sad story because he lost his Chinese and his English. There was no support, no family and there is no need to have a person there and if there is a bed available we will move them for their benefit but the vast majority is done by telemedicine or by sending our health professionals, and we fly them all over the country. However, according to our data we provide the same percentage in New South Wales, however, we strongly believe we are not doing enough, especially in training as a professional and for skills. The problem is that when you go on to training, within two years if you go to the same place the majority is new staff. We will need to do that as regularly as possible.

CHAIR: Apart from sensitising students to the issues as they go through and providing that service, is there anything else you believe you should be doing? For example, do you do much work in the prison system?

Mr MALAK: We go to the prison when we are invited. It is probably a resource-based decision which is through the superintendent of the prison and we go as limited as possible, mainly with an associated management approach.

CHAIR: It is just that it is probably more important for somebody who is locked up to have somebody from outside come and assist.

Mr MALAK: I hope of the inquiry will look at it as some people in prison, because they are mentally ill, finish their sentence but nobody gets them out. Nobody is willing to put the report through that they have finished their sentence and suggest they be moved out to a hospital or a nursing home. They are given a life sentence even if they have been given just two years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they come to the end of their time, surely they are just dropped at the gate or pushed out of the door or are you talking about people with mental illness who have gone in at the discretion of the Governor because they have been scheduled?

Mr MALAK: No, they have not being dropped out. They will not be sent out unless there is a clear psychiatric report saying they are all right or there is another place for them to go, but nobody will take them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are talking about the ones who may be found not guilty by virtue of mental illness or they are unfit to plead?

Mr MALAK: Both ways. They have been sentenced and they have finished their sentence or not sentenced at all. Both groups, they are still there. I am just talking about people in the prisons not people who have spoken with the forensic unit, whom we have a couple around the State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I understood that if you finish your sentence you get released whatever happens, do you not?

Mr MALAK: If you are in the remand centre you are not out. That is my understanding.

CHAIR: This is the remand process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But not sentenced?

Mr MALAK: And there are some people who have been in remand for 10 to 12 years.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They never come to trial?

Mr MALAK: No. I think probably the director of the forensic unit would be the best person to respond to that but my understanding is there is a specific procedure which requires a psychiatric team to do the appropriate reports about the person and that there be appropriate, caring facilities available outside and both barriers are not easy to overcome.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What sort of numbers are these?

Mr MALAK: My understanding is that the majority of people in the gaol in the eastern suburbs, in Long Bay gaol, in the mental health ward, actually need to be moved somewhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have heard that they were overcrowded but we want to break that down to find out how many are on remand and not able to be tried or given bail because of their mental illness and NESB, because obviously that is quite a specific service?

Mr MALAK: I cannot answer that because I have not got the figures, but I do not think that NESB is one of the major issues. It is difficult for everyone.

CHAIR: Page 20 of your report states that the employment of multicultural access workers in mental health was recommended within Richmond. I have read that report but I did not necessarily pick that up. What was recommended and what could have happened?

Mr MALAK: It recommended to employ bilingual health professionals and recommended two strategies—to do access work and bilingual health professionals, and both to a different extent have been implemented. For example, we have 30 bilingual counsellors who were funded in the early in the 1980s over three years, 10 every year, and that has not been increased although the population has increased by 30 to 40 per cent, so the number is too small. You are right that there are a large number of bilingual health professionals employed by the system to encourage people to utilise the system, however, in the majority of cases you have your own workload and sometimes they are in the wrong location for the right language or there are a large number of French or Indian psychologists.

CHAIR: I do not think that New South Wales Health keeps a register of who is bilingual and who is not. As a visiting anaesthetist at Lismore I have certainly never been asked if I speak a language other than English.

Mr MALAK: It happens in some areas, which now try to collect this data but it is actually vitally important for this to be collected and that resource to be utilised.

CHAIR: It is probably more necessary to be culturally aware of different cultures. I might only speak English but I might have lived in Indonesia for five years and although my Indonesian is not good enough to be an interpreter, because you have to be very accurate for mental illness, my cultural approach might be appropriate.

Mr MALAK: Even more than that, we had a health professional working with a large number of Vietnamese clients at Cabramatta and we have done a lot of work with bilingual Vietnamese workers and some health professionals develop better skills to work with clients and it is probably more effective than teaching words in a university.

CHAIR: The other issue that will come to the inquiry is the wider use of psychologists as part of the mental health team. Mr Quan, I know you are not here representing the psychologists generally but are you using many psychologists as part of the team of the multicultural mental health service?

Mr QUAN: Yes. We are talking about the sessional counsellors and the clinical services. It is divided amongst predominantly psychologists, social workers, a few psychiatrists, a few general practitioners and a few mental health nurses, but, by and large, the treatment that the clinical services sessional workers provide can be and is best done by psychologists and social workers in the counselling side. You mentioned earlier on that there are plenty of Greek and Chinese general practitioners but when clients of the mental health service who need a counselling approach go to the general practitioner most of the time they end up with the medical model. Most of the treatments now we know—the other less severe illnesses, including depression—react very well to psychological approaches, and there is quite a bit of evidence of that. Therefore, it is often very appropriate that each referral that comes along from people from another cultural background does come through a centre like the Transcultural Mental Health Service or the bilingual counsellors program for mental health in the State to assess that. It is these practitioners who can best assess it. Of course, the psychologists are well equipped to do a full mental health assessment.

The Hon. AMANDA FAZIO: Earlier you mentioned that as people get older their language skills deteriorate. Is that a particular problem you have encountered? Do you believe that there are adequate services for people with senile dementia in New South Wales generally, given that a lot of services are Commonwealth funded?

Mr MALAK: You are right: When people get older they start losing language and they become vulnerable. A large number of people, especially from Eastern Europe, are single or their partner died. Sometimes they have no family, they have no contact, and it makes life difficult for them. Dementia is definitely providing a measure of difficulty for some of them, and some of them are in nursing homes. HACC did provide some support and some good benefits, especially with the new packages that allow people to be looked after at home. Some ethnic groups find that most effective. However, in general, mental health and dementia at large are probably underresourced, which I cannot understand. I understand from the health management point of view it is easier to save if you are going to look after somebody who is going to have an open heart operation or prevent an open heart operation will save $50,000. But we have difficulty assessing how much it will save the community if we prevent somebody spending a couple of months in hospital. However, it will not be a saving to the community if a person does not work for a long time and is not productive. I do not think mental health and dementia at large get their fair share of taxpayer dollars.

The Hon. AMANDA FAZIO: In the past with family members who either had a disability or a mental health problem, some communities in particular—for example, the Italian community or the Greek community—it was often said, not so much jokingly, that so and so lives in the back room or the cellar and we never bring them out. In some cases a person died and they found a 70-year-old person with an intellectual disability living in the attic and that was because of the stigma within that cultural group. Those sorts of problems are manifesting themselves with some of the newer cultural groups coming to Australia. Do you think there would be benefits in providing awareness programs for them so that they know their rights and what services should be available on a good day so that they can make that contact to try to get services for their family member?

Mr MALAK: It is definitely vitally important. In one case a new refugee family have their elderly mother with them. They did not know that any services existed. Both

parents were working hard and they locked the lady in the house because they were worried about her security. I think she fell and broke her leg and went to hospital, and that is when we discovered what happened. Unfortunately some people in the system tried to say that that family was abusing the old lady, but we intervened and provided them with some HACC support and home nursing. We gave them an idea about what home care can do and all of that, and the life for this family is definitely much better now. Sometimes we jump to conclusions; it is still happening but I hope that it is happening much less than before because we do a lot of community education. It is not enough but we are still doing more. At large, my experience is that it is a good broker or advocate. Usually we find that that provides a saving, even if it is only very small. Usually the client can access some service.

Mr QUAN: It is very important to give other cultures the same level of education or what we call psychoeducation. The Transcultural Mental Health Centre has devised some packages, including one with the South Eastern Sydney Area Health Service recently, to raise mental health awareness or mental illness in families. It is very important to tell recent arrivals that the preconceptions about mental illness in the countries they come from may not really be the same in our western model and that people do get well. It is very sad to see people kept in a room for two years and hidden away from the rest of the world. And we do see them when they get referred to the Transcultural Mental Health Centre. Families do not realise that in the usual course of something as severe as schizophrenia they run their course often within that two years anyway. I think education is very important. That ties in with the point about expanding the bilingual counsellors service. That is specifically the Bilingual Mental Health Counsellors' Service.

As Mr Malak said, there are supposed to be 30 of them in the State at the moment. I think the full-time number is below that at the moment. In fact, I know it is below that. It should be at least 30. If there is a chance to expand that, then we would have a bigger mental health work force that could raise awareness and do psychoeducation that is much needed in the community. At the moment I think the counsellors often do not have the time in the work load although they want to do the work. I think it is worthwhile increasing that number and sharing the load. Raising education so that families know how to deal with mental illness and deal with it sooner would be worthwhile and would produce cost savings in the long term. The evidence is that stigma from the family often means that people do not get the services and the right treatment up front and early enough. By knowing and having the education, they will know that they must access treatment faster when there is a recurrence. That would be more cost effective.

For example, people should not wait until they have to be admitted to hospital for a set period. They could be treated at home earlier, which is much more cost effective. Increasing the number of bilingual counsellors is one step. At the moment, looking at the distribution demographically, the cultural and linguistically diverse population does shift and some areas are left vacant. By having a greater number of counsellors that can be distributed by a central co-ordinating centre, we could provide the right languages in the right quantity to the right areas. This will be very good for looking at raising awareness and also providing appropriate and timely treatment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You seem to be saying that you are making great use of the communities and you are an individual

resource of expertise—a centre of excellence, if you want to put it that way—and you are reaching out magnificently to allow you to facilitate things out there. It struck me from other evidence we have heard that community-based mental health services are very poor and that you might be working in parallel to them, rather than with them. Is that the case, and to what extent?

Mr MALAK: No, we work 100 per cent with them because 99 per cent of our clients come from the health profession, not from the client. We are a resource to the system. When the system is struggling with a client and having difficulty, they contact us and we interfere. That means that we are consultants who back up the system to do the work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if the system had not collected them in a sense you would not have found them. Do many of them come to you directly through the GPs, for example?

Mr MALAK: No, but GPs have to refer the clients to us. The only time we had a large number of clients come directly to us was after we ran the 24-hour counselling line after 11 September. We doubled our client intake by community ringing, and we mainly facilitated access to their local service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From your perspective what would you say are the critical things in terms of improving the rest of the service? You talked about the use of bilingual people and cultural awareness education. What else would you say are the critical deficits?

Mr MALAK: If we have a very strong mental health system looking after the mainstream community we will be in a better position to handle everyone else. The strengths in the mental health system are vitally important. New South Wales has probably one of the lowest per capita funded mental health service. We had a significant enhancement three years ago—we will have the last of it this year—and that provided a huge boost to mental health. However, we probably will not see the full benefits of this new enhancement for another year. I think the same level of extra enhancement will be required.

Mental health can cost us a lot. We can see a lot of waste with people not going to work, sitting in the system. There is an opportunity to make savings. We have a large number of people in hospitals. There is no place for them in nursing homes, and nursing homes cannot provide service for them. People who require longer-term help need not a hospital service but something in between that can provide much stronger care and more support than a nursing home.

CHAIR: Another area of great conflict is when first-generation kids of migrants see this culture, which is a multicultural culture but it is still different from Cyprus, Cos, Israel or wherever, and the huge difficulties they go through in adapting and living within the family but also living within the community. What steps have you taken to try to help communities or families cope with that difficulty?

Mr MALAK: We have done a couple of things. Currently we are finalising a project in partnership with the Children's Hospital to develop an information campaign targeting parents with kids with mental illness. We have produced a family kit in English

with the Centre for Mental Health which is an information package for young people. That kit is culturally and linguistically relevant. We work with all school link co-ordinators. We work with them to train them, and we are integrating our approach for the centre as we did not want to have special training for cross culture. We did not need to have special training. If there is a training course, we integrate cultural issues within the course. One example is the work we did with the University of Sydney School of Medicine when they developed their course a couple of years ago. Cultural issues were integrated in that course, because when it is an elective people have to convert to go there and it is not really relevant. There is a lot of evidence that when it is integrated it actually benefits everyone.

The Hon. AMANDA FAZIO: What are the sorts of issues that you see in terms of the mental health problems of younger people from a culturally and linguistically diverse background? Do you get more young girls self-harming because of the cultural pressure they get at home versus what they can see their school friends being allowed to do quite freely? Are they the sort of examples?

Mr MALAK: It is definitely part of it. You and Dr Pezzutti probably know that kids from different cultures sometimes live in two different worlds: one in the morning at school and one at home. This can place huge stress on them. Surprisingly, in the Westmead hospital anorexia clinic 80 per cent of the 12 beds are for people from two language groups, Arabic and Chinese, from one locality, Auburn. That is part of people's stress. You have a very strict family but there is a different way to deal with them.

(The witnesses withdrew)

(The Committee adjourned at 3.45 p.m.)