REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

At Sydney on Thursday 8 August 2002

The Committee met at 9.30 a.m.

PRESENT

The Hon. Dr Brian Pezzutti (Chair)

The Hon Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. John Jobling

CHRISTOPHER JOHN GUELPH PUPLICK, Privacy Commissioner of New South Wales, Level 17, 201 Elisabeth Street, Sydney, sworn and examined:

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

Mr PUPLICK: Yes.

CHAIR: You have made a written submission, No. 239. Would you like that submission to be taken as part of your sworn evidence?

Mr PUPLICK: 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 such a request. But please be aware that the Legislative Council may overturn the Committee's decision and make the evidence public. Your submission came to us on 19 April. Is there anything you would like to add or would you like to draw our attention to specific issues before we commence questions?

Mr PUPLICK: No.

CHAIR: A number of people who have come before the Committee have asked for a client register—in other words, a register that can be accessed by a number of people for various purposes. What would your view on that be?

Mr PUPLICK: I am highly suspicious about the idea of establishing a register of clients, so described, in that sense. Perhaps I could refer to it for shorthand purposes as a mental health register.

CHAIR: That would be fine.

Mr PUPLICK: My difficulties arise in a whole number of areas, not least of which is the question of what is going to be defined as a mental health incident or what it is that is going to trigger people being placed on the register. The WHO and other health authorities are saying that in developed Western countries the question of mental health and in particular the question of depression may well become the largest public health issue in the course of the next couple of decades. In fact, this may end up affecting up to 20 per cent of the population at some stage in the course of their lives. The question of who is going to be on such a register becomes highly problematic. It becomes problematic in the sense of who compiles the register. It becomes problematic in terms of who has access to the register. It becomes problematic in terms of whether the register is a compulsory register in the way in which, say, notifiable disease registers or cancer registers are maintained.

There are questions about whether a register of this sort would be subject to access through subpoena in a whole range of proceedings, who would be on it—whether it would be all public hospital patients, admitted patients, people seeking assistance from community health centres, whether it would have mandatory reporting by general practitioners, by physicians, by psychiatrists, whether it would be people who are actually diagnosed or whether a practitioner has reason to believe are psychotic or have psychotic personality disorders. How long would people stay on the register, given the fact that people may have very enter sonic incidents of mental health problems? People may be suicidal at a particular time in their life under particular circumstances. They may be subject to feelings of violence and aggression at particular times which do not necessarily last beyond those incidents.

How will the accuracy of the register be determined? How would people be notified that they were being placed on the register? Given the fact that many people are already reluctant to have contact with the health services if they believe that is going to lead to some sort of permanent notification or some sort of permanent record, why would they go and seek treatment if they are feeling depressed if they were under the impression that as a result they would go on a mental health register? You cannot put people on registers without telling them that they are going to be on registers. We do not keep secret files like that. So it would be a positive disincentive for people to seek treatment. It would undoubtedly be a positive disincentive for some medical practitioners to report if there was any mandatory reporting. We already do enough in the health system to put pressure on doctors and other health professionals to act in an unlawful fashion by doing things they are not supposed to do but that they think are in the interest of patients, or not reporting particular matters. That is without coming to the quite separate question of who should have access to such a register where it to be established.

CHAIR: We might come to that.

The Hon. JOHN JOBLING: Mr Puplick, in your statement then and also in your submission you made quite a point about presentation to a person. You refer to certain population groups—refugees, ATSIs—who may not present, and you renote that in additional concerns. Is this purely anecdotal or do you have any hard evidence to support such a statement, particularly in relation to the matter you bring before us?

Mr PUPLICK: I do not have any hard evidence in relation to non-presentations in relation to mental health areas. There is significant empirical data in relation to questions such as HIV and hepatitis C, where there is substantial data. Most recently I can refer you to the Anti-Discrimination Board's report "C-change" on hepatitis C related discrimination. In both the HIV area and in the hepatitis C area there is empirical evidence that people do not go for testing or do not give their correct name, for example when they present because there is a compulsory register in relation to notifiable diseases. In that area there is substantial empirical data.

The Hon. JOHN JOBLING: I just wished to clarify the point that it is a reasonable supposition that you present to us on the grounds of what you believe happens in other areas.

Mr PUPLICK: That is correct, Mr Jobling. I think there is also some empirical data about general concerns of accessing health care services by people in marginalised groups. This can be found particularly in some of the reports by the Australian Institute of Health and Welfare in relation to presentation rates of indigenous people to health services, particularly in the Northern Territory.

CHAIR: It would certainly be a disincentive for refugees because points would be deducted from their acceptance scores.

Mr PUPLICK: That is correct.

CHAIR: There used to be a thing called the computerised psych client register, which was established and enlarged in 1992. I spoke to Professor Raphael this morning about that and she said it was discontinued. Do you remember why it was discontinued?

Mr PUPLICK: No, I am afraid not.

CHAIR: She also told me—this is anecdotal only: she will give evidence on Monday—that there is a register of forensic patients which is maintained by the department. The protocol between NSW Health and the NSW Police for exchange of that information or access to that information has not yet been formalised. What sort of protections would there need to be for even the forensic register to be shared with police?

Mr PUPLICK: The real question about police access to registers, whether they happen to be health registers or any other registers, is to ensure that the access is in relation to something more than simply a trawling exercise. I do not object to people, whether it is the police or others, having access to information which is held by a department like the Health Department if it can be demonstrated that it is to the positive benefit of the individual about whom the information is being sought or if it is to prevent imminent threat to life or health, or danger or security of other persons, and provided—and I think this is the important thing—that there is a proper audit trail and a proper degree of accountability.

For example, with the Roads and Traffic Authority, the police have access to some RTA information. When you interrogate the RTA, all it records is that the information it gave was accessed by the "New South Wales Police Service". You do not know which officers, so you do not have any capacity to find out something that might trigger your suspicion, namely, if a particular officer in a particular station accessed a certain type of information every day for a month. Then you might start asking some questions. But in the absence of the RTA keeping a record, other than saying accessed by the police for "law enforcement purposes", it is meaningless.

So if you have an MOU of any sort, it needs to be one in which the police have to demonstrate a reasonable case for accessing the data, and there has to be an audit which is established so that an oversight body, whether it happens to be the Ombudsman, the Privacy Commissioner or the Police Integrity Commissioner, could if necessary audit that to ensure that what was in fact being sought was information for legitimate purposes and not for voyeuristic purposes or illegitimate purposes or simply for mere curiosity.

CHAIR: The reason for asking that question is the incident in Canberra, which you are probably aware of, of the person who was shot in the neck as a result of police attempting to arrest him. I think the person was acting strangely when approached by two police with mace and batons. I think he struck out and a young policewoman shot him in the neck. The complaint to the investigating coroner was that they could not access this person, who was very well known to the Canberra mental health service, and therefore could have been dealt with in a different way. Mind you, they did not even know the fellow's name at the time. In those circumstances, would it have been appropriate for police to ring NSW Police and say, "We have Joe Bloggs in front of us. We know who he is. Does he have any problems?" Or should they get someone from mental health to come out to the scene?

Mr PUPLICK: My difficulty with all of this is exactly the same as the arguments we get about knowing people's HIV status, that is, if I knew X I would have dealt with it differently. The question is: Why would you have dealt with it differently? I understand; I have a great deal of sympathy for the fact that we are constantly putting on the Police Service and on individual police officers a degree of responsibility and pressure for doing welfare work of one sort or another for which they are not being properly trained or adequately equipped. But that does not mean that in fact you should change the health system or the privacy issues, rather than address the question about recognising situations where it would be appropriate to seek advice from a mental health professional.

CHAIR: Thank you for that good advice.

The Hon. JOHN JOBLING: I do not cavil with the comments that Mr Puplick puts to us, but the difficulty in the mental health field at the moment is principally that it seems to fall through the safety net of almost every organisation and group. Patients who are treated go out, feel better and unfortunately often discontinue their treatment, and the point of last resort to try to deal with the problem and take them to treatment is invariably the police, or sometimes the ambulance service. As it is very specific, how will you first be able to identify this problem? The police may be called to a domestic disturbance, which may or may not have a mental health connotation attached to it, or to an individual who may be affected by drugs and alcohol and/or a mental health problem. The difficulty is in allowing police to go into such a situation while you are finding out. It is very difficult to give them guidance, and without some prior warning or some ability to help them, in many cases they do not to want to attend either, so the person is more likely to do damage, rather than the police being able to try to contain it and knowing what they are going to, what they do not need to do, which is an equally valid argument to the one you have just put to me.

Mr PUPLICK: I come back to the same as the HIV or hepatitis C status. What we have said within the framework of the health system is you adopt universal precautions. You do not need to know whether a person is HIV positive or not. That certainly does not overcome many of the difficulties that you allude to but there are others as well. You might not know whether the person you are confronting has a command of the English language. You as a police officer give them an instruction. You do not know whether in fact they speak English or do not speak English. When they fail to respond to the instruction you make a series of assumptions which are, on those circumstances, usually that they are deliberately defying you and you go on, as a consequence, to act in a particular fashion. That may well lead to very unfortunate consequences and the interaction between the criminal justice system and people whose capacity to understand the English language is one of the other areas which is equally fraught and provides a whole series of difficulties.

The Hon. JOHN JOBLING: But you are less likely, are you not, to get a strange or violent reaction which can occur right up front? You actually get an episodic happening in front of you. I understand that not understanding the English language is fair, but I put to you that I do not think that that is a totally comparable case to put to say that this is why you do not do the other, because the other one is that we need to find a way at least to flag it with a warning—this is what I believe. I am more interested in finding out why you are suggesting that we have to go in first and then find out afterwards.

Mr PUPLICK: I do not think that is necessarily a fair characterisation of what I am saying. What I was asked to address in the first instance was whether the find-out-afterwards approach means establishing a mental health register giving potential access to 13,000 police officers and 3,000 people in the police department.

The Hon. JOHN JOBLING: But you could code and stage it as to the amount of information by way of a warning, could you not? I can understand where you are coming from and your problems. I have no difficulty with that. I am just trying to find out whether there is an alternative or a middle way whereby we can comply with your desires and at the same time try to improve the other end for both the persons involved and the forensic patient or the patient.

Mr PUPLICK: I draw a very clear distinction between a forensic patient and a person who might otherwise be on a mental health register. There are some legitimate differences in terms of forensic patients where in fact there has been what I might call a quality control process whereby assessment has been made and people have been declared to be a forensic patient and there is also a temporal—

The Hon. JOHN JOBLING: But again the police out there need to find this. The person has stopped their tablets, they are stabilised, they are back in the community and now they stop and away they go. Where is the indicator to somebody who is coming to assist that there is a potential problem unless you have this form of register?

Mr PUPLICK: The creation of a register, which has huge implications for people across a whole variety of areas, simply in order to deal with a matter which is a police matter, and which in terms of the absolute numbers, in terms of incidents which might otherwise have been avoided, this is not like a seat belt issue where you are talking about an infringement upon what was otherwise regarded as people's civil liberties and you could quite clearly say, "Here is a solution which would lead to an outcome which would save a considerable amount in terms of human lives and suffering and costs and all the rest of that."

But to say, "Here is a particular problem of the police" and instead of focusing on how we improve the competence and the capacity of police officers to deal with a whole variety of situations, we will potentially impact upon the lives of a significant number of people in the Australian community by creating a mental health register when people who are seen to be mentally ill are still the subject of a huge amount of stigma and discrimination. If I have a register like that, why would you not say to me, "In that case, what I want is for employers to have access to the register so that they can make assessments when they are employing people in significant positions. They might be positions were other people's lives are potentially at risk. I want employers to have access to that." Why should not political parties have access to it, to make sure that they do not preselect people who are not necessarily the full quid?

CHAIR: I will take this just a little further. The police came to us and said that, at the end of the day, they are the community mental health worker, they are the default mental health worker when nobody else can be found. We can advise that they receive adequate training to recognise situations because situation recognition is important. That would require, if they called for assistance from a mental health person to advise them on what might happen or might not happen which is the suggested scenario, that the mental health worker may need to have access to a record. That is a different kettle of fish, is it not?

Mr PUPLICK: Yes.

CHAIR: In speaking with Professor Raphael, I am aware that the New South Wales Health Records and Information Privacy Bill, which has just been passed by the Legislative Council, envisages a unique person identifier [UPI]. Is that correct?

Mr PUPLICK: Yes.

CHAIR: I also heard from her—and we will get this evidence on Monday—that the Commonwealth has given the New South Wales mental health service some funding to be ahead of the game in terms of computerised records. Given what you have said about the audit, in what circumstances do you believe that those records are should be able to be accessed by mental health workers who have appropriate credentials and are given a code to get into it?

Mr PUPLICK: The whole purpose of the health records and information privacy legislation was to facilitate the development of the system of electronic health records in New South Wales. I can appreciate why the Commonwealth has been funding New South Wales on this and that is because the

Commonwealth's HealthConnect system has been so totally bungled that it is now $70,000 and seven years behind where it ought to be. New South Wales, having taken the initiative, now has a piece of legislation which provides those guidelines. Under the provisions of the Health Records and Information Privacy Bill—the Health Records and Information Privacy Act as it will be—there is a very satisfactory arrangement in place, I think, for authorised professionals to access health records.

What we have not yet determined is the architecture of those health records and who should have access, as well as at what level. It may well be that we maintain an electronic health record which is accessible, say, in an emergency department and would allow somebody to establish the name, the blood group, the drug allergies or whatever it happens to be for somebody who is brought in, in an accident situation, but would not necessarily give a person at that level access to details about sexual health services, or mental health services, or prior terminations of pregnancy, or whatever that happens to be. One of the things that will occur, once the health records legislation is enacted, is that a code will be drawn up which will look at the question of how a health record might be structured and who might have access and at what levels, including the very vexed question that I know the Committee has had in a whole series of other instances, the consent of the individual concerned.

At one stage the individual whose health record it is would have to give consent for another party to have access to that entire record, as distinct from the presumption that the minimum data set which might be necessary in an emergency situation could be accessed by any authorised person in an appropriate fashion and at any time. The question that this Committee has had before it on a number of occasions is that people who might have mental health issues do not want that information accessed by other people and do not believe that having a health record simply means that it is open slather and open consent for anybody at any stage. I think it is possible to draw up within a code a series of graduated accesses which would allow for a situation in which an approved person could certify that access to information about mental health is necessary for reasons which may well be the threat to life and health and all the rest of it, and in those circumstances was able to access the information and to provide professional advice to other parties. As you know, under section 17, I think, of the health records legislation, there is an exemption for police and various others in certain circumstances anyway.

CHAIR: That would effectively then be a de facto register, with protections.

The Hon. JOHN JOBLING: With estoppel at different stages.

Mr PUPLICK: It would be a register with certain qualifications to it. Firstly it would not be a disease-specific register; it would be a health record, per se. Secondly, under proposal of the legislation nobody will be in that system without their consent. So in the first instance you have overcome one of the traditional privacy objections, namely, that people have given informed consent. Once they have, then they have agreed to forfeit certain other protections and certain other rights. The third thing about it is that the system, unlike other types of registers, has some integrity in terms of accuracy, and it also has the capacity for the patient, the subject of the register, to have some control over how the register is used.

CHAIR: If a patient who is scheduled comes into a mental health service, that would be an implied consent to get a UPI for a start. They would have to have a UPI for that. At subsequent admissions to hospital of a voluntary nature, would they be able to exclude that information going onto their register under that new Act?

Mr PUPLICK: No. If a person has a health record, it then becomes a requirement on the providers of health services to ensure that they update by way of adding information to that health record. The idea of going along and saying, "Well, I don't want this to go on health record", is in fact going to be very problematic for a lot of health providers because there is no doubt that people will go along to their general practitioner—and this becomes a particular question in relation to things such as sexual health services—and they say, "Can we deal with this, but there is no need to put this on the register?"

CHAIR: On the record.

Mr PUPLICK: I am sorry, on the record. I have no doubt that, with the best will in the world, there will be an awful lot of files in bottom drawers which exist in medical practices and which do not every get into the electronic health record and do not get linked with the UPI. I have no doubt that at some stage the matter will end up with somebody being sued about something that they did not put on an electronic health record which they are supposed to have done and which has had adverse consequences.

CHAIR: That is, the patient individually at a particular time wishing to opt out.

Mr PUPLICK: Yes.

CHAIR: That will probably be more of a problem in the private sector than in the public sector, but it could be an issue for mental health services in particular since the ability of a person who goes to a public hospital for care not to have a record would be very limited, would it not?

Mr PUPLICK: Yes, very limited indeed.

CHAIR: But it may not trigger having a UPI. Is that what you are saying?

Mr PUPLICK: The other thing about it is that, without the world falling down around us, people operate in this community, and in particular in the health system, under a variety of different names. In some areas—community health areas and sexual health areas—we have gone to great lengths to preserve the right of anonymity of accessing health services, and if we had not done that, the capacity to intervene in areas like community mental health, trauma services and sexual health services would have been grossly compromised. Even having a UPI, an electronic health record and having access to all that online to automatically pick up the very people who are most likely to have fallen through the gap and who operate under a variety of different names or who are delusional and tell people things or have things recorded is not going to be a quick-fix solution.

CHAIR: I understand that, but at the individual patient level a record will be automatically kept for whoever they call themselves at that time. They may have a number of UPIs, so there will not really be unambiguous patient records, I suppose. The problem is shown in the AIDS area where the director-general, in carrying out his responsibilities under HIV legislation for protecting the community, does not have information on the serial offender who is spreading HIV, and may not have the same name recorded for somebody who has a mental illness.

Mr PUPLICK: You are quite right in that regard. It is a good example, but I put it to you on the other side that in terms of the great success of our HIV programs and of HIV public policy, can you imagine that we would have had anywhere near that degree of success if people had believed that those HIV records would have been available to the police?

CHAIR: So it is a balance of community good.

Mr PUPLICK: It is a balance, not just of community good, but also a balance of education that we are prepared to put into persuading people that the safeguards in place are sufficient and that they ought not to be overly concerned about co-operating with the system and helping to make the system work. It is a trust question.

CHAIR: There is only one opt-out register that I am aware of in New South Wales and that is the cancer registry for cervical cancer. How many people chose to opt out of that?

Mr PUPLICK: I do not know.

CHAIR: There was an argument about whether people could opt in or opt out, and the Government came to the conclusion that they could opt out. I do not know how many people determined that they would opt out for something as straightforward as cancer screening.

Mr PUPLICK: I presume that the Cancer Council or Jim Bishop could advise you on that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I adopt the devil's advocate position and examine your position, which is somewhat legalistic from a medical perspective. You are saying that the police having access to a register because they want to save themselves or call up appropriate resources is a small issue because they can be better trained. They are obviously looking at cases in which police officers have been injured or when somebody has been shot. Yesterday a family was telling us that they cannot access people and some of them, even though it was not exactly stated, want to know about people who have been on forensic registers, even if those people have come off the register at a later date after a short period, and even if they stayed as a voluntary patient and were discharged. It worries me that we are so scared of doing bad by letting information out that we are unwilling to do good vis-a-vis privacy. No doubt that is not a new argument for you. This issue of records for forensic patients or other patients who might become forensic patients is a problem area.

CHAIR: There are only 400 of them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There are more than 400 who might create difficulties, even though they are not scheduled at the moment.

CHAIR: Forensic is different from scheduled. Scheduling a patient does not make that patient forensic.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, it does not. But if a patient is scheduled it may well result in that patient being a danger to himself and others before he committed a crime. That patient would need to be treated with caution. If you schedule a patient you are assuming that that patient is not competent to make a decision about his or her future. Is this not a King Canute approach? We kicked out the Australia card. Scandinavia has such a card. We now have the Credit Reference Association, which virtually does what it likes so far as the public is concerned.

We have tax files numbers so that the Government can keep track of the money. We will now have a unique person identifier [UPI], but only in New South Wales. Certain hospitals want to use your records to compile medical data. So effectively, medical research will be privatised. We trust that they will not sell that information at a personal level, although insurance companies will want to know about our DNA and about the bad genes we all have.

The Hon. AMANDA FAZIO: Is there a question in that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is a question. The approach has been to keep the information rather than to allow the collecting of information. We then have to control who uses it, who sells it and we then discriminate on that basis. Are we simply taking a King Canute approach? All this information is being collected by increasingly sophisticated means. Increasing numbers of people are wanting to use that information and we are still saying that they cannot have that information, rather than saying, "It may be collected and used in this manner, but no-one will use it in another manner."

Insurance companies might then say, "Your premium is higher because you have HIV", but they should not be allowed to do that. In other words, this is about the use of information rather than the collection of information. Stopping the collection of information may be too difficult. You could stage the information that was being used or you could say that no policeman may look it at unless he or she has a really good reason and police officers would then have to prove that they had a good reason. In other words, the collection of information is okay but it is not okay to use it. Are you not taking a King Canute approach to the collection of data?

Mr PUPLICK: I am almost tempted to say that defence of human rights is always a King Canute issue. This Parliament, for example, has recently given the police power to fingerprint people on the streets.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I did not support that. That is not my fault.

Mr PUPLICK: One either takes or does not take collective responsibility. So perhaps an argument can be put that defence of human rights, in the face of increasing demands of law enforcement authorities, in private sector activities, commercial activities, people who think we should now have everybody on a national DNA register—

CHAIR: With a bar code on the forehead?

Mr PUPLICK: Absolutely. It would be much easier if we simply implanted a chip in every baby, instead of doing the Guthrie test, and we registered them the way we do cats. There is always an argument about that. But I do dispute one issue. I do not say that I put these forward in quite privacy terms; I put them forward in the terms that information about us is personal information. We have a right to control who has access to that, in what circumstances it can be collected and in what circumstances it can be used. Sometimes we do not have very much control over the circumstances in which it is collected.

The law has determined that, in certain circumstances, it must be given over, or it becomes impossible to receive a benefit, or indeed impossible to exist in our community without giving over certain information. The controls are important. You mentioned both credit reference and tax file numbers. If you examine the provisions of the Federal Privacy Act and you examine the provisions of the credit reference reporting legislation and the tax file number legislation, I think you will see the extent to which the safeguards built in there have had to be extraordinarily complex and elaborate.

Not just New South Wales has a UPI; I think you have had some evidence, it was certainly mentioned in one of your hearings, about the information which is available in the Western Australian health system. They have had a much more elaborate linking of patient records for a number of years. Everybody who is in the Federal Medicare system effectively has a UPI because there is a number behind the Medicare number which distinguishes individuals who are on a family card, or whatever it happens to be, and the resistance that Medicare has successfully over the years made to the Federal police and everybody else who has wanted to have access to that.

We have had the same issue with the Guthrie cards—the police wanting access to the Guthrie cards. All that will increase. Every time there is an increase in DNA technology there becomes an argument for more and more access to all these things. So I do not characterise it simply as "a privacy issue". I characterise it as an issue which goes to autonomy. What autonomy do we possess as individuals to control the information about us which is unique to us and which is not necessary to be in the public domain? If it is not necessary to be in the public domain, in which domains other than our own control are we prepared to allow that to be spread about?

You very properly raised the question of the concerns of families, but why limit it to mental health? Why do you not say, "Every family member has the right to know about the health status of every other family member?" I have the right to know—because I am concerned about my brother—whether he has HIV. I care about him very much. I would like to be in a position to help him if he gets into difficulty and I may have to care for him. Why should I not have access to his HIV record? What distinguishes his mental health record from his HIV record? I do not understand why one simply chops all this up into little bits and says, "Mental health is so different." If anything, it continues the stigmatisation of mental health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense that is the social construct.

Mr PUPLICK: All health is a social construct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The stigmatisation is a social construct.

Mr PUPLICK: Health itself is a social construct.

CHAIR: The honourable member must be specific about the information that he requires. He must not debate the issue. I referred earlier to an issue that was raised concerning the need for records and access to those records by the police. I referred to that earlier in order to obtain an answer which would be used in the Committee's report. The honourable member must be specific. He referred earlier to the relatives of patients wanting to know when patients come out of hospital. That is a specific issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I refer to the question of access. Who is to access the medical records? The witness is referring to human rights and to the information that is being collected. The human rights issue is broader than that. Human rights issues apply to a person overall; they do not relate only to whether or not someone has access to information. The question is: What impact would that have on a person? If you are conceding that the collection of data is uncontrolled, surely the use of data should be controlled?

Mr PUPLICK: I am saying that it is uncontrolled in certain circumstances where the Parliament has arrangements or other legislative arrangements are in place which take away the right of people. I do not believe that it is simply a question of saying, "All we have to do is focus on the question of who has access and not focus on the question of why the information is being collected in the first instance." What is the individual benefit?

What is the benefit to the individual—an individual qua individual, or an individual who is a patient, consumer, customer, or whatever it happens to be—which is advanced by the collection of that information. Is there an overriding public interest for that information to be collected? If there is, is that justified and in what circumstances? How narrowly can that be proscribed and then what do we say about who will have access, in what conditions, in what form, and under what degree of accountability?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Let me put to you that this information is collected on forensic and scheduled patients under a statewide unique person identifier system to give people access to that information for their mental health treatment. Let us assume that that is put there when they are scheduled. They would then be able to opt out of the system when they are unscheduled on the assumption that they are competent to make a decision.

When they are effectively scheduled or forensic patients, the police and their next of kin must have access to that information should they need it. That means that the police then do not have to be on their guard all the time. They can say, "This person is a mental health patient", just as they can say that they have a garner or an AVO against them. That information would be available to them through the computer operated police system.

Mr PUPLICK: With respect, I think you are confusing about half a dozen different things in one question. The UPI is not something which exists, in that sense, separately from the mental health record, the physical health record, or the financial health record. Forensic patients are in a quite different category. They have become part of what I might call a judicial system as a result of specific judicial intervention, which requires a whole series of processes which are themselves, of course, public processes in any event. A person does not end up, by and large, in a forensic situation without it having been a matter of public record anyway. So there is that element.

I have to say that from time to time I am not altogether satisfied that everybody who has been scheduled really deserved to be scheduled but, for one reason or another, they have been. But let us say that they were legitimately scheduled and there was no debate about that. It then becomes a question of police and next of kin having access "should they need it", and the question becomes: What is the definition of need. I might very well say, "I am a police officer in Moree. What I need in order to police my community properly is a list on my desk of everybody in Moree, everybody in my police command, who has been scheduled because I do not have the time and we do not have the equipment out here for me to do that on a case-by-case basis.

I simply need to have that information. I need to have a list in the police station of everybody who has ever been scheduled so that I can respond accordingly." I could say, "I am a relative. I need to have that because this person may very well go off and spend money." Well, they may well be spending money because they hope that members of their family will not get their hands on it at some stage. Who will judge the question about who "needs" access to that information and in what circumstances?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You want to.

Mr PUPLICK: No. I want to have, if anything, the Parliament properly address the question in relation to access to things like health records and clearly stating the circumstances under which access should be granted and the terms and conditions. I am certainly opposed to the blanket approach which says a police officer or "a relative"should have access to information about people "when they need it" as if that were simply an open invitation for people's records to in fact be public documents.

CHAIR: The current Health Records Act does overcome those concerns?

Mr PUPLICK: It overcomes them in large part. It will be dependent upon the making of some codes to support the internal architecture of the rent scheme.

CHAIR: The rents and the MOUs that go on between the departments which even for forensic patients has caused some concern.

Mr PUPLICK: I have seen, in terms of some of the evidence to the Committee—I think it is from the Police Association—the criticism about the MOUs with the department either not being effective or not being acted upon. I have to say I think the health department in New South Wales by and large has done a very good job in terms of attempting to deal with the vexatious questions of how they manage their health records. People who want access to information who are told that "Sorry, you can't just have it by asking", always think the MOU is no good.

CHAIR: The MOU goes to a whole lot of other issues. The Police Association was more concerned about the interagencies working together rather than sharing information. The issue that Mr Chesterfield-Evans was raising initially though has significant importance. In other words, if somebody is scheduled and goes into hospital and the relatives are not told when that person is coming out. This is raised in the circumstance where many of the relatives are asking that that they be made like a secondary guardian where when a person is scheduled they lose control of their own ability to decide certain things but when they come out of hospital they are not well, in the judgment of many—not just the relatives but even the health professionals will say they are not well when they come out—and then they come out with varying forms of plans for care which many of those plans are just discharge and they turn up at the door of their relative whom they see as almost a like a guardian.

There was evidence yesterday from a particular woman of a child of hers who gets scheduled but becomes a voluntary patient halfway through. So that the relatives know that the person is in hospital but they are not told when the person is coming out. Then they have got to pick up the pieces a month later. How do you overcome that? The intimate arrangement, I suppose, between a person who is mentally ill and a carer, is the minute they go into the system they stop being consulted, talked to, taken any notice of, and when the patient is discharged they do not get told they are being discharged and what plans there are. Yet they are expected to be the carer.

The Hon. JOHN JOBLING: Pick up the caring again.

Mr PUPLICK: With respect, Mr Chairman, I think that is a question properly addressed to somebody who is a mental health professional.

CHAIR: The issue of privacy is the issue I am raising with you. For privacy reasons the mental health service does not contact the relatives unless the patient says they can. While that is proper, is there a way that people who are legally competent but still ill can have this default guardianship? You can have a formal guardianship—that is one thing—and they can go through that process, I suppose, of becoming the formal guardian, but that is a very difficult situation and something that may be a bit heavy.

Mr PUPLICK: I guess, Mr Chairman, the question of patient autonomy has never been an easy one and it is not just in the mental health area, there are people who are not mentally ill who refuse to take their medication and as a result are either dangerous or likely to become a burden on the health system because they are simply noncompliant and in many instances they are noncompliant because they are not particularly competent to understand and to be compliant. The question of establishing a system whereby people who are judged to be incompetent or less than adequately competent to manage their lives but not so incompetent as to require the full machinery of the public guardian to be brought to bear, is really the essential question.

One could start with probably the definition of the 60 percent of people who are in prison who probably fit that category to begin with, let alone those who are simply within the confines of the schedule mental health system. I do not know that anybody, and least of all myself, has adequately addressed the question of people who do not have the level of competence to manage everyday life which becomes more and more complicated in terms of the things that you have to do in order to survive adequately in the 21st century societies like ours, including interaction with the health services and the justice services.

You will certainly find that there will be a whole series of debates about whether in fact if you put the ruler across the entire spectrum of our society you did not produce certainly a very undesirable outcome in terms of the particular racial groups, in terms of people of particular backgrounds, who are more likely to be in those sorts of situations. But at the moment privacy legislation and privacy practice has given patient autonomy the primary focus when it comes to balancing a series of judgments. Now if as a community we want to impose some override on the question of patient autonomy where the person is in fact not under guardianship or probationary or forensic control—what I might characterise as sort of being on health parole—where you have got to report to somebody and do certain things otherwise there are certain consequences, that is a very large public policy debate which is certainly worth having.

CHAIR: It comes down to simple things like the real estate agent or the housing department not telling a carer that the person is not paying rent and just evicting them. In other words, somebody may have come out, the plan has been put in place for supported accommodation in a housing department house with mental health workers looking in from time to time, and the person simply does not pay the rent. The housing people go along and say "You have got to pay the rent". They do not pay the rent, they get booted out on the street and then they get discovered by a relative. The housing department cannot even ring and say "Joe Blow hasn't paid the rent". That is the difficulty of not having a secondary guardian idea.

Mr PUPLICK: And then characterises those people who do not pay the rent because they are mentally unwell, those people who do not pay the rent for other reasons, those people who do not pay the rent because they are having a drug and alcohol problem. This is the circularity of it. You want the real estate agent to inform the relative that they have not paid the rent and it is probably a mental health problem, can something be done about it?

CHAIR: No, I want the mental health team, who will be aware of this, to be able to contact a relative and say, "They have not paid the rent". In other words, the official carer, I suppose, is the New South Wales community mental health service but the real carer may well be a family member who is hovering around doing all the bits on the sideline but do not get told that the rent is due and for want of $50 they are out on the street.

Mr PUPLICK: This then brings in the question about what information is the landlord or the real estate agent going to have?

CHAIR: The mental health worker will be aware of it because they will see all the letters there and the person will say, "They want the rent or they are going to kick me out". The mental health patient may even say that. So the mental health worker will be aware because the patient has told them. Unless the mental health worker can ask "Can I tell Auntie Flo?"Then they cannot pass that information on.

Mr PUPLICK: Quite the contrary. If the mental health worker says, "Look, Chris, you are obviously having problems, you have not been able to pay your rent. Can I phone your mum and have a talk to her about it?" I can say yes or no. If I say yes, what is the problem? If I say no, why should my autonomy be overridden? That is the worst of all possible situations in terms of the Nanny State, is it not?

CHAIR: We have not discovered that the mental health service actually asks the patient whether they want the relatives contacted to say they are going out of hospital.

Mr PUPLICK: Well, they can do that quite easily.

CHAIR: We have not discovered yet whether or not that is part of the protocol on the discharge. It may be that they are not told simply because they do not ask if they can be told.

Mr PUPLICK: The thing about privacy is that it simply says in terms of this information "Do you want this information shared? Can I tell somebody?" If you say "Yes please, I am very grateful. Please tell my mum I am coming home. Please tell my relatives that I am being discharged. Please tell them that I cannot pay the rent", then there is no problem at all

The Hon. JOHN JOBLING: But you tend to get the feeling that once they cease to be either scheduled or a voluntary patient they are released into the community and it is almost as if there is a void. I gain a feeling that some of the carers at that stage use the terms of privacy to say "No, we cannot go any further or do anything". So consequently whilst the patient is still unwell in medical terms, they are highly likely to regress and come back into the system at great expense. It is for the want of a follow-up, a contact, the ability of somebody to do something—equally with patient consent if it is available—but just somebody to be there to call in from the working team. All this just seems to stop at a point and this is what a lot of people are concerned about, as to how we get around that.

Mr PUPLICK: That actually is quite simple. You get around that by the whole question of asking patients or individuals whether in fact they want some help or access to follow-up services and the community has to face up to the fact that there is a cost or potential cost to the community involved in those step down processes. It is exactly the same issue as occurs when people are discharged from prison: open the gates, shake their hand and basically sort of say "See you in six months" or whatever it happens to be.

The Hon. JOHN JOBLING: Sadly that is the proposition. I am not sure, Mr Chairman, that we have actually got any evidence that indicates that this sort of procedure is being followed at discharge.

CHAIR: That will be a question for the mental health team. In other words, are you caring and concerned enough for your patient to ask the question "Would you like me to let Auntie Flo know you are coming home?" We do not know that that is the case or it is not the case. They may well ask and the patient may say no and therefore the person would have no right to be told, but if they do not ask the question it is a completely different matter, is it not?

Mr PUPLICK: Absolutely. One of the things about the electronic health records system as proposed is that we have found on a number of occasions that the disjunction between people being discharged from parts of the health system and their primary carers, is the general practitioners, being properly notified which has not been as satisfactory as it should have been. That has been one of the arguments about having a system of electronic records so that in fact proper notification to general practitioners or to referring health-care providers is something which will be done automatically.

CHAIR: Should it not be a matter of them saying, "Do you want me to notify your general practitioner about this admission?" If it is automatic that would be a breach of privacy, surely?

Mr PUPLICK: No, there is a requirement on institutions that where a person has been referred to an institution, to notify the person who has made the referral that the discharge has occurred.

CHAIR: Is that a regulation or is that simply a practice?

Mr PUPLICK: I think that is a regulation.

CHAIR: It is well noticed in breach if it is. It is a practice that is in the patient's best interests but again should that not be subject to the patient's compliance? It is good public health.

Mr PUPLICK: If it is a matter which is only practice and not provided by any of the Department of Health guidelines, then I understand in most hospital systems it has been a practice that where a patient has been admitted through the activities of a medical practitioner, the practitioner is advised when a patient is discharged from hospital.

CHAIR: Again, should that be subject to a tick and a flick when they leave? Say they come in from a car accident and there was a discharge to care by a GP and there may not be a follow-up plan; it may be a straightforward return to the fracture clinic next week and that is it.

Mr PUPLICK: That is not a case where somebody has been referred to a hospital by a practitioner.

CHAIR: What is the difference between a patient who is referred by a general practitioner and a patient who comes in off the street because they have been cared for by a practitioner for 40 years and they have a hypoglycaemia attack because they took too much insulin? Would you not notify the GP?

Mr PUPLICK: No, not without consent.

CHAIR: Should they give consent for all of the record on discharge even if the GP does refer them for care?

Mr PUPLICK: I have not had the opportunity to examine the patient consent form which you sign when you enter hospitals, but I presume it includes that the practitioner who referred me to the hospital will be told what treatment I have had in the hospital and that that will become part of the medical record of the person who sent me here in the first place. It would be bad medical practice if it did not.

CHAIR: That may well be bad medical practice but that does not mean it is not against the Privacy Act?

Mr PUPLICK: I think you are falling for the three-card trick of elevating the NSW Privacy and Personal Information Protection Act to doing a whole series of things it does not purport to do. People have been coming along, not only to parliamentary inquiries but every time someone wants to be uncooperative, whether they be in the private sector, the public sector or wherever, in the course of the last couple of years they have been able to stand up and say, "The Privacy Act stopped me from doing it." That is just nonsense.

CHAIR: I am not trying that one at all. I am trying to draw an analogy between things done automatically as part of the admission and patients should be aware that—it is an education process which is required of informed consent—and things that are not automatic. In other words, some material will go to the GP that is nominated by the patient and others will not. That goes to the whole area of admission to a psychiatric hospital or a public hospital for other care or it might be a psychiatric admission in the middle of an admission. If a patient is referred for a particular problem the GP under the current arrangements will get automatically the record. If in the middle of that they develop a mental illness as part of that, they will get that record too?

Mr PUPLICK: If that is part of the treatment that is provided which is then relevant for the ongoing treatment that the general practitioner is providing. In the system of electronic health records, of course that record will be entered into the patient record in terms of the hospital procedures and admissions.

CHAIR: And there will be an audit trail for who accessed it and so on?

Mr PUPLICK: Yes.

The Hon. JOHN JOBLING: Page 4 of your submission deals with implied consent. Under the recommendations you have highlighted a statement that there is a higher level of uncertainty on the part of non-government agencies [NGOs] in receipt of government fundings as to which, if any, legislation or regulation cover their services. You further deal with contractual arrangements with State agencies exempting MPPs contained in the Privacy Act and that it is assumed that the State Government will bind those agencies. Would you amplify on that?

Mr PUPLICK: This is a matter which has particularly concerned me in my other capacity as President of the Anti-Discrimination Board. As a specific example, there was a church-based organisation which received funding from the State Government to provide crisis accommodation services and then specifically excluded gay people from accessing those services because that was contrary to the beliefs of the church organisation. In other words, they took public money to provide a public service, that is crisis accommodation, and then denied that to a particular group of whom they disapproved in a way which would have been utterly unlawful had they been a public sector agency but because they have an exemption as a religious organisation they committed no breach because there was nothing written in their contract with the State Government requiring them to provide services on the same legal basis as those services would have been provided had they been provided by a public sector agency.

It is my belief that with the increasing contracting out of government services, or services which are perceived to have been government services—indeed when you are contracting out police services in this particular instance, it seems to me that it ought to be a matter of principle that no government service should be contracted out to a provider unless the provider is required by the terms of the contract to provide the service with due regard to legislation such as privacy legislation and anti-discrimination legislation, as would be required had they continued to be a public service provider.

The Hon. JOHN JOBLING: I understand where you are coming from with that specific example. Are you aware of any other NGOs relating to, particularly, electronically linked data and patient data where there has been a breach?

Mr PUPLICK: We have not got to the stage where that information would be available to such organisations but you may recall in your own area some instances in which providers of employment services who were contracted with the Commonwealth as well as with the State then ran into a degree of difficulty on the basis of not being prepared to employ "people who were not Christians" in the provision of advice to the unemployed.

The Hon. JOHN JOBLING: I turn to implied consent and what an NGO can do in that regard. Is your submission based on anticipating what you think could happen? Can you give me further details to support the recommendations on page 4 of your submission?

Mr PUPLICK: It is in that sense a matter of principle. I do not address the question of whether government services should be contracted out or not. That is a debate about which I do not legitimately have an opinion in this capacity, but I am of the opinion that where a service is contracted out, the rights that people have—and that includes the rights to the respect and protection of their privacy and about who can access information about them—should be exactly the same in terms of the operation of the non-government provider as it is of the government provider.

The Hon. JOHN JOBLING: You say that agencies in private sector which are contracted to a State agency are exempt from the MPPs contained in the Privacy Act. Again, I presume you could supply the Committee with a number of examples?

Mr PUPLICK: Yes. I would be happy to take that question on notice and give you a number of specific examples.

The Hon. JOHN JOBLING: It is important that we understand whether that is one-off, anecdotal, factual or an anticipatory view that is being expressed.

CHAIR: I may be able to help. The Privacy Act anticipates that the Minister may regulate to require private sector agencies to comply with the Health Records Act at some stage in the future. It has been put off because of cost and determining how the Health Department itself will do it. Mr Jobling is asking about NGOs which are funded for supported accommodation, for example, and whilst I take your point about anti-discrimination, if they are providing supported accommodation for mentally ill patients or patients who have mental illness, their access to the record is a matter of some concern which was not necessarily addressed by your answer. What information should supported accommodation people have, because they are providing a non-clinical service really? They supply rehabilitation, housing—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a question of degree, if they are getting people to take medication as part of that support. The assumption is that only medically trained people will give medication. In a supported accommodation context that may be an unreasonable and even silly assumption.

CHAIR: Often in those circumstances the medication is dispensed by the pharmacist into little packets and that is supervised by mental health workers in the field but how much information should those people have about the circumstances or the condition of the patient?

Mr PUPLICK: Unless there has been any amendment to this section—and I am working of a draft copy of the Health Records Information Privacy Bill—a health service is defined to include the following: whether provided as public or private services, welfare services necessary to implement any of services referred to in the paragraphs above, which include medical, hospital and all the others, or a service prescribed by the regulations as a health service for the purposes of the Act. So that is possible to say here is a welfare service or a health service being provided for the care and support of persons who are mentally ill and as a result ii is a health service for the purposes of this legislation and as a result appropriate people have access and appropriate people have degrees of access and the necessity for an audit trail to be established for that purpose.

The Hon. JOHN JOBLING: It is the audit trail that Mr Puplick is really emphasising—that it must be clearly there.

Mr PUPLICK: They can be brought within the definition of a health service given that both of those sections of that definition—I am not sure whether there were any changes to that in the final form in which the Parliament has dealt with this—

CHAIR: I will be asking Professor Raphael this question on Monday, and I have told her that. It refers to the changes to the Privacy Act and the delay in access to care and the steps that need to be taken to ensure that that does not happen. Does the bill itself overcome those difficulties?

Mr PUPLICK: I believe the answer to that is yes. The bill was preceded, as you may recall, by the report of the Ministerial Advisory Committee on Privacy and Health Information entitled "Panacea or Placebo?", which was presented to the Minister in December 2000. It involved very extensive discussions with representatives of mental health services, not just in terms of Professor Raphael, whom we had specific discussions with, but also with a number of other consumer groups and others in relation to mental health services. It is important to recall that this is a piece of legislation from the health portfolio;

it is not an Attorney General's bill written exclusively from the point of view of the Privacy Act and integration. It is a Health Department bill. So at the end of the day all of the material that was approved by Cabinet was material that was submitted to it by the health Minister, and it is because it was regarded as entirely consonant with best practice and with the requirements of the Health Department that the legislation was in the form in which it was presented.

CHAIR: Timely and accurate access to information currently is a real problem. That will be overcome effectively and with proper privacy protections only once we have an e-record.

Mr PUPLICK: Once we have a more integrated system. We already have very extensive electronic records in some places—for example, central Sydney. At Royal Prince Alfred the electronic health record is already a well-developed and sophisticated tool. That is not the case in other parts of the system. I do not think it would be fair to say that electronic health records are going to be available for everybody in a comprehensive and best practice situation for five to seven years. It will take quite a lot of time to get the electronic health record system up and running. But what we do have under the health records legislation now is the framework in which that can go forward. The question now becomes the architecture of it. We have some time between the passage of the bill and the commencement of the legislation to get some of those questions right.

I do not see that there will be a short-term automatic improvement in the question of timeliness. I do believe that eventually that problem will be addressed, and in some areas it will be addressed more quickly than others. It will continue to be difficult in the mental health area because the question of patient consent in relation to mental health will be, along with sexual health and reproductive health, the most difficult matter to manage in terms of striking the balance between the need of the medical authorities and people providing medical services to have access to information and the rights of patients to withhold that information, particularly from practitioners that they do not know. They might have a quite different view about what should be accessible by their general practitioner and a totally different view about what should be accessible to someone else around the place, least of which would be the police.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that effectively they would be signing for whatever health service was reasonable, and referred to an audit of that. If the health service said that it is reasonable that forensic patients and scheduled patients who are admitted to a psychiatric facility shall, unless they opt out, have their next of kin notified at the time of their discharge—let us say that that is a policy of the Health Department or the institution—would that then be covered within the Privacy Act as being a health service as delivered under the protocol under which we deliver it?

Mr PUPLICK: I think that that sort of thing would not be simply a matter of a health authority indicating that it was simply its opinion therefore it did it. The health records information privacy legislation provides a mechanism whereby people can make complaints about the breach of their privacy. If a complaint were made it would then be up to the processes under the Act and eventually up to either me or the Administrative Decisions Tribunal to determine whether there had been a breach of privacy. What would be looked at in those circumstances would be the reasonableness with which a policy decision had been made.

However, I would expect that before the legislation came into effect codes of practice would have been developed. They are contemplated and required under the legislation but those codes of practice, which would be developed between my office and the Health Department or the providers of health services, would have attempted to address those issues in a way which would then give some guidance in that area. Quite clearly, the recommendations that would come out of this inquiry would have a very persuasive effect on government and on me as Privacy Commissioner about what issues should be taken into account in developing those codes.

CHAIR: Have you seen what is called the MHOAT form? It is the new form for all patients who have contact with the mental health service. The practitioner or provider of the service has to fill out this assessment form, which runs into some 34 pages. Have you seen a copy of it?

Mr PUPLICK: I am delighted to say at this stage that I have not.

CHAIR: It is aimed at providing de-identified information for collection purposes, outcomes and so on. It is a huge form that takes people about 45 minutes to fill out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are complaining about it. It is about 37 pages long.

CHAIR: It is a quality measure that has been put in place by the department. It is a major report that has to be filled out on major contact by the mental health teams. MHOAT stands for mental health organisation assessment tool. Would you normally see forms like that? Would they come past you?

Mr PUPLICK: That is variable. Some departments are a little more assiduous than others in submitting forms to us and asking for our opinions. I have not seen that particular form. But if it would be of assistance to the Committee I would be perfectly happy to receive a copy and offer any comments that might be relevant. I might take the opportunity to provide the Committee with information about just what the claims about material being anonymised, delinked or de-identified actually mean and how easy it is to reconstruct, even from aggregated data, specific information about individuals in the health system.

CHAIR: Especially in small populations.

Mr PUPLICK: Particularly in small populations. The moment you have a small area postcode and you start to add questions about gender, age, number of family members and occupation it does not take very long to reconstruct things. It is quite easy. When you look in public service annual reports and you see how many officers there are with a salary above a certain level—

CHAIR: It is you.

Mr PUPLICK: That is right.

CHAIR: I understand that. They have to have approval to collect information and to summarise information, if you like. Most of it is designed for planning purposes, for major aggregates. But where you start to use the processes for individual targeted research that is where it gets more difficult. I do not know what they are going to use MHOAT for. It would be interesting to see. It is in paper form and therefore much less easy to protect than in an electronic form as part of the unique identifier. In relation to NSW Health client data linkage, CDL, and the access using the health information exchange, which is available to the staff of all area health services, how do you ensure that when an area health service has all of its information there for its number crunching and reporting and so on that bits do not flow out of the health information exchange to a nurse on ward 3 about a relative of hers in ward 8?

Mr PUPLICK: You cannot.

CHAIR: Except that she has done it?

Mr PUPLICK: You hope that you can identify that she has done it but in many instances—this is exactly the same situation as you get with the difficulties of national DNA databases and police exchange—if people are seeking information in a way in which they personally do not want to be identified, most people have friends within the system who are prepared to assist them in finding out.

CHAIR: If the patient complained that the Auntie Flo rang up and said that she heard that the patient was in hospital, and that was because a cousin in another ward saw the name on the admission list, how do you avoid that sort of breach except by codes of practice?

Mr PUPLICK: At the end of the day it is impossible to avoid those situations. People may see somebody going into a hospital admission area and sitting down and filling out a form. A wardsperson may tell them they saw that person's friend up on whatever ward it happened to be. Data in that sense, wherever it is, however securely you want to hold it, is never 100 per cent secure. There is no such thing as secure data anywhere in the system with an absolute guarantee. All you can do is try to establish as best as possible an audit system whereby access to the actual detailed record, the health record, as distinct from a list of admissions or as distinct from anecdotal—people seeing each other around the place—is capable of being audited and capable of being controlled.

CHAIR: Should we all be more aware of another person's privacy? If I see Amanda Fazio lying in a bed next to somebody else when I am visiting in hospital as an ordinary person and I ring up

Meredith Burgmann and say, "I saw Amanda in hospital today" that would not be breaking any law, but should we all be more aware of people's privacy?

Mr PUPLICK: We should all be more aware of people's privacy in that respect. Yet we also bring to bear some judgment about whether it is in the best interests that Meredith be told. Where we avoid unpleasant consequences is that if you have not told the Whip you are going to get into real strife.

FRANCIS JOHN WALKER, President, Schizophrenia Fellowship of New South Wales Inc., 85 George Street, Parramatta, and

ROBERT GEORGE ILAHI RAMJAN, Executive Director, Schizophrenia Fellowship of New South Wales Inc., 85 George Street, Parramatta, sworn and examined:

CHAIR: Will you each tell the Committee your occupation?

Mr RAMJAN: It is always a difficult question, but it is probably administration.

Judge WALKER: I am a judge.

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

Mr RAMJAN: As a representative of the Schizophrenia Fellowship of New South Wales.

Judge WALKER: As President of the Schizophrenia Fellowship of New South Wales.

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

Mr RAMJAN: Yes.

Judge WALKER: Yes.

CHAIR: If you make a submission to this inquiry, do you wish it to be included as part of your sworn evidence?

Mr RAMJAN: Yes.

Judge WALKER: I do.

CHAIR: If at any stage during your evidence either of you should consider that in the public interest certain evidence or documents you make wish to present should be heard or seen only by the Committee, the Committee will be willing to accede to your request. However, you should be aware that the Legislative Council may overturn the Committee's decision and make the evidence public. Mr Ramjan, would you like your submission, which is identified as No. 245, to be part of your sworn evidence?

Mr RAMJAN: Yes.

CHAIR: As the Committee has been going on for a while and there has been certain material in the press, would either of you like to expand on your submission or make any comment before we begin?

Judge WALKER: I would like to make some comments but we would prefer to do questions and answers as particular value will come from that. We are very grateful to the Committee for the opportunity to give evidence today. As I said, we would prefer to spend our time answering questions. However, there is one subject upon which we would like to make some brief remarks, and that is your first term of reference relating to the Richmond report. I never cease to be amazed at how many people who tell me that the Richmond report is the cause of the crisis in mental health care we have at the moment. Most of those people have never read the report. Most of those people do not realise that only 208 people ever came out under the Richmond recommendations, and most of the studies of that show that they got on perfectly well.

The fact is that at that time most people were institutionalised and did not get out. The problems in the system today relate to the 1983 Mental Health Act, not the Richmond report, but it is very good for bureaucrats to demonise David Richmond and make him a scapegoat for the problems in the current system. Having said that, I could also say that deinstitutionalisation was a process that started in most developed countries in the 1950s and the 1960s. Australia trailed behind the rest of the world, not introducing it until the 1980s. But it is a process that has worked moderately well around the world, and it certainly was a process that did work far better than the previous system. The problem with the Richmond-style deinstitutionalisation, which is community care at the moment under the 1983 Act, is that governments of all political persuasions have failed completely, in my view, to provide adequate resources to look after the people in community care.

Australian governments are incredibly mean when it comes to funding mental health. Our budgets in round figures are less than half that provided by all developed countries in the world that we would compare ourselves to—sometimes much less than half. Certainly, our budget is half that of the United Kingdom, Canada, Ireland, New Zealand or America—the sort of countries we would like to compare ourselves with. So we are putting about 50 per cent of the resources that those countries put into mental health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you speaking nationally or for New South Wales?

Judge WALKER: No, I am talking nationally. We do not have the New South Wales figures. I suspect that New South Wales is a bit up on that, particularly recently, but I do not know. If we were spending twice our current budget, then I think a lot of the problems about which our organisation complains would disappear overnight, but there would still be some. Richmond missed out on one thing in his report because he was not prescient, and that was the huge flood of drugs into our country that occurred at about the time of that report and thereafter. That has led to a substantial increase in mental illness. It has also led to a substantial increase in what we call dual diagnosis, that is, people with mental illness who are also drug addicts. That is a major problem in our society because it is not being treated. The health system refuses to treat people with drug addiction; the drug rehabilitation people refuse to treat people with mental illness so you have almost no treatment of that very large group of people in the community with dual diagnosis.

But there are those—and no doubt they have made submissions to your Committee—who believe that life in the 1950s was perfection. They look through the rose coloured glasses at their childhood, and they think that is what they would like to return to. Of course, they are supporting submissions to go back to the very large mental institutions that Billy Sheehan got rid of in the 1950s. I think they conveniently forget what was wrong with those institutions. Our mental health asylums were concentrated in the Sydney metropolitan area. Country New South Wales received almost no mental health services as a result of that. All the financial resources were going into the city. Relatives had to put their family members with a mental illness in city institutions; they seldom got to see them. It suited a lot of people. Unfortunately, sometimes for very good reason, there are a lot of families that do not want to have anything to do with their relatives who have a mental illness, and would like to see them out of sight and out of mind.

They represent part of a small lobby group out there. But people forget the nature of those institutions that caused governments to be horrified by them and to close them down. The inquiry into Rozelle was the inquiry that set that in train. We had institutions that were characterised by very large numbers of mentally ill people being totally sedated. They walked around, they lived a zombie-like existence. They were easy to control. Industrially, it was a very easy place to run. I think a lot of people look back to those easy times, when looking after people with a mental illness was quite a simple thing because they were like zombies, and if they were not you had straitjackets and padded cells to deal with them. There are still a few padded cells left in the State, despite the fact that there should not be. But in those days they were a very common occurrence.

Not only that, these large institutions provided a great deal of clinical material for medical practitioners who wanted to make a name for themselves by experimenting in the field of mental illness, and there was a great deal of involuntary medical experimentation at the time. There was a great deal of psycho-surgery, electric shock treatment of people, and coma therapy. A whole series of very bad things were happening to people against their will. Basically, the inmates had no rights, they had no identity, and they had no hope. So that is the sort of institution that people want to bring back, and that is why we are opposed to it.

I am not saying that we do not have a problem with people in community care. Obviously we do; there is not enough. About 80 per cent of people get on fairly well in community care, except when they come to the crisis in their condition. As you probably know well by now, most mental illnesses present with periodic or intermittent crises. Usually it is full of suicidal ideation and often hallucinations and delusions. It is when those crises happen that I think the current system is breaking down to a great degree. The proper level of care is not being provided to families and to the patients at that point in time.

I have included in the material a speech I recently made on our criminal justice system because I think the truth of the matter is that those who want to go back to the institutions do not need to want; we already have them. We have a de facto system of institutions in New South Wales. It is called corrective services of New South Wales. Some 4,000 people are currently incarcerated in our prisons who have had a diagnosed mental illness. There are 90 hospital beds to deal with those 4,000 people. Nearly all of them get no medical treatment whatever. They are cared for by prison warders and the kindness of their fellow inmates. A great many of them—as many as probably 1,000— go into psychosis. They are not treated. How you run a prison system when you have people with delusions, I do not know. They are very difficult people to deal with in the medical context. They are probably impossible people to deal with untreated, and that is a very bad situation.

Something has to be done about that. In the speech I made I set out a large series of recommendations. They are not mine; they come from medical experts around the country, particularly Victoria, about solutions that might be made, firstly, to improve the prison system, the way it operates, and, secondly, to do something about getting a lot of those people in gaol with diagnosed mental illness out into secure or medium-secure medical facilities around New South Wales. But I will not go into that. I simply say that we have recommendations that I think should be of interest to the Committee, and perhaps you might look at them.

CHAIR: Would you like to table your speech?

Judge WALKER: Yes, I am tabling that in the kit.

CHAIR: First, I accept, from the other evidence we have received, much of your analysis. The only problem was that, of course, many of the drugs that allowed for community-based care only came around in the 1950s, the 1960s and certainly the 1980s. For example, lithium was an Australian discovery in 1949 and did not get to America until 1979. That exited a large number of people with manic depression who were highly difficult to treat, except being totally zombied almost. Without lithium, many people like that would still be totally zombied in some sort of secure environment, because it is probably the only truly effective, simple treatment.

Judge WALKER: By the way, the same applies to schizophrenia, particularly with the very modern drugs.

CHAIR: Exactly, and certainly with fewer side effects. The other issue about the Richmond report, which is still ongoing, is the issue of disability and people with major intellectual disability. There are still 2,500 people like that in institutions, and there is a 10-year plan to solve that problem. People have not been critical of Richmond himself or the Richmond report but surely of what comes from that, because it is only a report to government for government action. The issue of governments over time has been the constant—of the 300 submissions we have received, nobody has demonised Richmond himself. Certainly, the evidence we have received is that governments of the day should have taken much better note of what was happening around the world, realising that it would be more expensive, not less expensive, to care properly for people in the community, in terms of both the drugs and the care.

So you are right, and putting it in context we have slipped behind in Australia and certainly in New South Wales. That is identified with the changes that happened in Victoria and in Queensland. Later this month we will be visiting Victoria to look at its forensic service as well as its mental health, particularly its community mental health services, because we identified early in the piece, and many people have drawn it to our attention, the level of funding and the way in which it is funded in the other States. We are aware also of the health Ministers getting together to produce the national mental health plan and policies, and the Commonwealth's involvement in the funding of many of those initiatives.

But I do agree with you that we are well behind and we have to catch up. The areas I wish to discuss today—and other members of the Committee will have others—is the issue of non-government organisation [NGO] funding, the issue of forensic services, the drug and alcohol issues, and the issue of Long Bay and the plans for Long Bay. The issue of NGO funding is particularly problematic in New South Wales because we probably have the lowest funding of all the States in terms of the proportion of this State's budget that is spent on NGOs. If we increase our funding from a bit less than 1 per cent of the budget to the 9 per cent that might be found in other States, where would we best spend that money? I do not mean which organisations, but which services would then be, if you like, privatised?

Mr RAMJAN: There are a few things to say about this. To provide some perspective, New South Wales has always been a poor funder of non-government organisations, so this is not something that has come about in the past 10 or 15 years. We have been shocking and it always peeves me to say that Victoria has always been better than us. I do not like having to say that, but it has always been the case. Victoria has always been better in funding mental health services and in the way that it has dealt with non-government organisations. The other thing I should say is that there is no question that funding to NGOs should be increased in the mental health area, but if there is a sudden influx of money to the non-government sector, that would probably destroy a number of organisations. They would not have the infrastructure nor the expertise. There are a lot of very good people in a lot of NGOs currently who are very committed and who are definitely cheaper than other services that could possibly be provided. That is something else that needs to be addressed.

CHAIR: It is not the price, it is the quality. Where would we best spend our money?

The Hon. AMANDA FAZIO: Let him answer.

CHAIR: Okay. I accept that.

Mr RAMJAN: It has to be a staged introduction of increased funding. If we are looking for the best bang for the buck, our membership, and we have surveyed our membership a number of times and it is approximately 4,500 currently, has told us that the critical issues are permanent and secure accommodation.—and there is lots of research evidence that would validate that and I would say that if we can provide somebody with a secure home, then mental health will improve or at least stabilise so that they will have less acute episodes—and rehabilitation. To answer the question in a slightly indirect way, one of the misperceptions about people with mental illness is that they cannot improve. There is absolutely no question that most people who have a mental illness can improve with the right sort of clinical support and rehabilitation.

That is clearly underlined by the research of Courtney Harding in the United States and who tracked people over a 30-year period. Rehabilitation is an area which does not bring an instant reward back to New South Wales as such because people who effectively undergo rehabilitation start paying tax to the Federal Government, not to the State Government, but it alleviates some of the expenditure that the State Government has to spend on acute hospital and maintenance services. Another thing to say about it is that at the moment the funding, from the perspective of the Schizophrenia Fellowship and a number of other NGOs, is fragmented. If we are a statewide organisation, our core funding should come from the Department of Health—from the State Centre for Mental Health—with ministerial approval.

At the moment we have to track funding through various area health services. The Schizophrenia Fellowship, which is definitely a statewide organisation, receives its funding from the Northern Sydney Area Health Service and we are accountable to Northern Sydney Area Health Service. That means that if we want to do a community development project on the North Coast that is looking at establishing a rehabilitation service in the area, we have to go through the Northern Sydney Area Health Service which has no vested interest in the North Coast. We are currently developing projects in the greater Murray area and technically we should be getting our funding through the Northern Sydney Area Health Service. It does not make a great deal of sense for it to happen in that way. Where should you best spend the money? Accommodation is the first thing and rehabilitation is the next. They are areas in which the non-government sector has a long track record.

The Richmond Fellowship of New South Wales and the After Care association are organisations that have been providing, at the very least, supported housing for a very long time. They predate any Government housing in this State through the Department of Health, and they have a level of expertise in providing that. As somebody who declares having been on the board of After Care and the Richmond Fellowship, I am able to say that that gives me a close knowledge of how they operate. The Schizophrenia Fellowship is currently developing housing programs. There is a level of expertise and Richmond Fellowship was the first organisation in Australia to run a residential therapeutic community that had an 83 non-return-to-hospital rate.

CHAIR: Yes, we have had them in already.

Mr RAMJAN: They are not so much running therapeutic communities now but that is because there has been a turn in the way that the department and the Government of New South Wales views the concept of therapeutic communities. I think the words have changed a bit: they are now called psychosocial rehabilitation units, which is fine.

CHAIR: But I can tell you that the big issue for them is that they get $10,000 per annum for clients whereas if they go to Department of Ageing, Disability and Home Care [DADAHC] for someone who has a disability, then they get $70,000. They are a non-government organisation that does not rely upon the Government to provide things, except for a house. They have to look at what they can afford to provide and it is $10,000 for a mental health patient and $70,000 for a client of DADAHC.

Mr RAMJAN: And functionally, the disability may be equivalent.

CHAIR: Exactly. That is the point. Having said that, if you are looking at permanent and secure housing and rehabilitation to achieve socialisation and employment, which I presume would be part of it, that relies enormously upon a proper, responsive community-based mental health service, does it not?

Mr RAMJAN: Absolutely.

CHAIR: So you cannot do any of those things, and you could not possibly at the moment put large amounts of money into the non-government sector to do any of those things, without massively improving the community-based mental health service.

Mr RAMJAN: Not necessarily. Sometimes the tale can wag the dog. The Schizophrenia Fellowship established a Clubhouse Pioneer social rehabilitation program in the northern beaches as part of the Northern Sydney Area Health Service.

CHAIR: I opened it.

Mr RAMJAN: Of course you did, and we have photographs of that. I can tell you that we are eight years down the track from that having opened. When it first opened there were some serious concerns from the Government mental health service about how it would integrate. It is now a very integrated part of the service, but the great benefit from that has been that a number of people with mental illness on the northern beaches and who were disaffected with the Government's mental health service or completely out of contact with it for other reasons are now linked in.

CHAIR: That is right.

Mr RAMJAN: They are now part of a much better integrated networked service that is giving them better outcomes. It might also please you to know that eight years down the track over one-fifth of the members of Clubhouse have returned to open employment.

CHAIR: That was part of the aim, but again, the community mental health service has got to be the key to ensuring success. We have already identified that Housing is very good at providing housing.

Mr RAMJAN: No problems at all. We can get as many houses as you need.

CHAIR: Housing has done a spectacular job, but to make it permanent and secure you have to have not just willing workers and keen volunteers or a non-government organisation, but you also have to have the support of the community mental health team.

Mr RAMJAN: Yes.

CHAIR: That is the biggest single factor identified by people who provide supported examination, such as the Christian Fellowship and the Dean Miles housing group and others. They have said that they can get the house easy, they can identify the clients, and they can put them in proper housing and so on, but their access to getting continued management of those patients from the service is just very poor.

Mr RAMJAN: My personal experience is that when these sorts of facilities set up, the mental health crisis teams and care teams seem to think that that is not their problem.

CHAIR: That is the end of it?

Mr RAMJAN: Yes, and they leave them alone. I think that the Salvation Army has had a similar experiences in its attempt to deal with dual diagnosis. Once they set it up, the assumption was that they could run it and the mental health team would not bother sending a crisis team out simply because someone is acting up. That seems to be the big problem.

CHAIR: In other words, you are concentrating on spending our money in NGOs on non-clinical services. Are there any clinical services that could perhaps be taken out to the non-government sector that you have identified, given your long experience in this area?

Mr RAMJAN: With adequate funding the expense of other countries tells us—it has never really been tried here—that the non-government sector can provide clinical services as well. Certainly some of the chapters of Narmen in the United States are providing some clinical services. The difficulty is caused here with the Disability Services Act constituting a barrier to providing multiple services to the same client through the same agency, but in the United Kingdom some Clubhouses are providing a range of services.

CHAIR: Do you mean that they are having live-in psychologists, live-in social workers and so on?

Mr RAMJAN: They might. In fact our Clubhouse here, although we do not press the point, is providing a clinical service in that members of Clubhouse are encouraged, not obliged, to develop an individual service plan which definitely has a clinical basis to it. It is not a black and white division. In Washington DC virtually the whole of the mental health service is run by a non-government agency because they found that that was the best and most efficient way. That non-government agency is based on what is known as the Green Door Clubhouse, so that is one clubhouse that has over 200 staff providing virtually the total community-based clinical service to Washington DC. The hospital services are still separate.

CHAIR: What about things such as advocacy? That is something that is needed in this State and it has been identified in other countries. The British National Mental Health Act will have advocacy as a responsibility under its provisions. Could advocacy go to a non-government organisation?

Mr RAMJAN: Yes. I did not mention that and I guess I probably would never think to because it is a given.

CHAIR: It is what you do all the time.

Mr RAMJAN: Yes.

CHAIR: I know, but in terms of individual advocacy—not advocacy for a group of people.

Mr RAMJAN: Absolutely, and even, on occasion, legal advocacy. I cannot remember whether this concerns the Act because it is dimming into the past, but I was involved in establishment of the first representation of people who were going before the magistrate and who had been detained involuntarily in hospitals back in the seventies. My recommendation as an employee of health services research was that it not be a legal service because it broadened this out a whole lot and allowed people with expertise in mental health, which would include other consumers and carers, to be involved in the advocacy for those people in the legal context as well.

CHAIR: Legal advocacy is embedded in the Act itself for very specific purposes.

Mr RAMJAN: Yes it is.

CHAIR: But the whole issue of other advocacy is to make sure that an individual gets the services because an individual may not even identify that they need a service.

Mr RAMJAN: They might not.

Judge WALKER: Particularly not the people we represent.

Mr RAMJAN: Absolutely not.

Judge WALKER: There are legal tensions in the system. If you are an NGO which is funded by a government, requiring the Minister's goodwill, the moment you start organising a large number of suits in which the Minister is the defendant and which really affects the Minister's administration, you are putting pressure on your relationship.

CHAIR: We have already done one of those inquiries into the Department of Community Services.

Judge WALKER: I must say that we do not have a problem, although sometimes we get pretty blatant about what we say about Ministers. We do not seem to have trouble. We got on very well with Peter Collins and we get on very well with the current Minister in that regard, despite the fact that we encourage people to take law suits against the Government. Maybe there should be protection for NGOs who want to be true advocates and speak fearlessly.

CHAIR: It may be that we need to set up an advocacy service as part of Richmond Fellowship or Schizophrenia Fellowship as a side branch. There seems to be a need for advocacy and whether that is done by a commissioner similar to the Privacy Commissioner or whether it should be a role for an independent government person to advocate or whether it should be a role for a non-government organisation are all questions to be considered.

Judge WALKER: I think that non-government organisations have got to be advocates.

Mr RAMJAN: One of the things that is a great difficulty is that you are, to a degree, beholden to the hand that feeds you. The Schizophrenia Fellowship has been able to be more potent in its advocacy in the fact that it raises more than two-thirds of its funding independently. We certainly get some government funding, but more than two-thirds we raise ourselves.

CHAIR: You also have guaranteed long-term government funding, put in place by Refshauge.

Judge WALKER: But it only lasts for the goodwill of each government.

CHAIR: But it got you going and it set you up, which was its aim. That is what was put to previous governments and to the current Government.

Judge WALKER: We are not complaining, but other NGOs do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that advocacy groups have to be separate from other groups because of that problem of funding?

Mr RAMJAN: It depends on what kind of advocacy you are actually talking about. There is a difficulty. If you look at the layers that currently exist you will see that there is a potential difficulty in some of the consumer advocates being employed by the area mental health services that they are working for. That has some difficulties that could surface. I am not saying they have surfaced, but they could surface.

CHAIR: But they are more liaison officers?

Mr RAMJAN: They can do significant individual advocacy. We have two projects going, or they are in start-up phases, at the moment that provide advocacy for carers. One of them, under the Caring for Carers program, will provide it in four areas throughout New South Wales. A second project is operating in a different area. They are under our auspices, but they are funded with government money. So you could have some things running through a non-government agency. Another model is the Intellectual Disability Rights Service, which is independent and which has a board. That board is made up of people who may sit on other intellectual disability groups who come together to administer the Intellectual Disability Rights Service, so there is a degree of independence there.

CHAIR: The Hon. Dr Arthur Chesterfield-Evans is identifying the difficulty that exists for an advocacy group that is also providing a service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am referring to two NGOs that are both being funded by the Government. It is one thing to fund such a body, but it is another thing to fund it in the hope that it provides a service.

Judge WALKER: The trouble with separating it is that often what you want to be an advocate about is the service. You really want to be an advocate for your professional services. To separate it to me seems to be an artificial thing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the client is not happy with your service and you are the advocate, that is a problem.

Judge WALKER: That is a big problem.

CHAIR: Perhaps NGOs should be funded separate from government, such as the Commonwealth-funded advocacy services. We could con the Commonwealth into providing advocacy. That might solve the problem of the provision of services by the State, and the Commonwealth would provide the advocacy service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would be great if you had different Federal and State governments.

CHAIR: Given that there is a mental health plan which is agreed to by all Ministers, otherwise it will not be put in place, all States would have to comply with this plan in one way or another. Advocacy does not seem to be part of it.

Judge WALKER: For individuals there probably needs to be an advocacy service. But I still think that NGOs, which are lobby groups, ought to be able to be advocates as well. I think you need both.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So are you saying that they should be systemic advocates? In some of the disability areas a lot of emphasis has been placed on the difference between a systemic advocate and an individual advocate. Do you think that they should be done by the same body?

Judge WALKER: I think there should be two systems of advocacy. There should be a general system and NGOs should have the right to be advocates. NGOs do not always agree with one another. The reason you have this proliferation is that there are different views among NGOs as to how the system should be run. That is only natural. If you start to create uniformity you will lose the creative forces that are trying to get reform in society.

CHAIR: I do not think that the New South Wales Government would establish the Schizophrenia Fellowship tomorrow.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: From my understanding of Council of Social Service of New South Wales figures, we are spending one-third of what Victoria spends—less than one-third of the national average—on community based services. Victoria is spending twice the national average on community based services. That represents six times the amount that is being spent in New South Wales on community based services, if those figures are correct. Obviously, if that is the national model, that is the model to which we should be aspiring. As part of that spending, Victoria is spending—and I cannot remember the figures exactly—a much greater amount than New South Wales on NGOs.

Mr RAMJAN: Their funding is 11 per cent of their budget, which effectively is 22 per cent of our budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the difference is about one-sixth of the amount?

Mr RAMJAN: At our last national council meeting our equivalent organisation in Victoria reported that the Victorian Government was up to around 11 per cent of their mental health budget going to the non-government sector. If theirs is nearly double ours—and I am not sure about this—11 per cent of their total mental health budget goes to the non-government sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The difference is about six times. I think ours is 1.7 per cent.

CHAIR: New South Wales is spending less than 1 per cent of its budget. Our budget is lower than Victoria's budget per head. Therefore it is a vastly more than six times; it is more like nine times.

The Hon. AMANDA FAZIO: What is the point of the question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The point of the question is whether or not New South Wales is going to get to Australian best practice and increase its NGO sector by six times. You said earlier that it should be staged because you could not find competent people to fill those positions in time. In what area should those NGOs be put? How does one decide on the NGOs and how they are to be balanced in the community? Should they be area-based organisations that have branches mostly in the housing sector? There are a lot of possibilities.

Judge WALKER: I think we have answered that question. We have said where we think our priorities are. They may not be our priorities. For example, if there was a large a sum of money for housing, I do not think we would be wanting to run the housing side. We are advocates for people. Often in housing situations you have managerial problems and you have conflicts of interest. People act out and they have to be removed from housing. We do not want that. We want to be on what we call the consumer's side. We do not want to be the bad guys.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not asking you that question as members of the Schizophrenia Fellowship; I am asking you to represent the NGO sector and to take a sectorial view.

Judge WALKER: Our view is, first, housing and, second, rehabilitation. That is where the money ought to go if we are to get the best results.

CHAIR: But you do not necessarily want to run the service?

Mr RAMJAN: Part of your question was how it should be structured—whether it should be statewide or whether it should be local. If we start saying that it should be one or the other, we are cutting out excellent examples of one or the other. I remember talking to Michael Wooldridge. We were looking at establishing some pilot rural clubhouse programs. I asked him whether he had a preferred place for them to go. He said, "Yes." I thought, "Okay, here is the political imperative", and it was. His answer was, "Where they will work. Put them where they will work." That I think is how we have to view this. Which organisations can do it? They may be big and they may be small. There are some good small NGOs about the place.

NGOs can be quite accountable. Often they can be more accountable than government services. So you can have a look, see the track record and see the success of a particular NGO. To make a non-government service work—and I look at Pioneer with great pride—it requires a number of things. But links to the local community are a critical factor in making it work. Pioneer works because it is a good model, because it has good links in the local community and now because it has established good partnerships. We should be looking at the factors that will make a service work and not say that it will be State or area based. We want what will get us the best outcome. I do not think that it is that hard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What if we said that we wanted a staged degree of support, from supported housing to institutional care, with grades inbetween and with a number of full-time equivalent staff visits each week for each client or whatever? Do you think that putting that out to tender for individual areas is the way to go?

Mr RAMJAN: In some circumstances. There may not be an absolute right way to go. So flexibility in the way things happen is what will get better outcomes at the end of the day. A tender process can be very good and can get you good outcomes. A tender process can mean that an organisation that has greater resources can do a better tender than an organisation that has a better chance of succeeding.

Judge WALKER: Look at the unemployment rate and the crisis that that is in because of the tender process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure.

The Hon. JOHN JOBLING: I note that you state in your submission that the Schizophrenia Foundation in New South Wales is one of the largest mental health NGOs. I do not know whether you heard some of the evidence given by an earlier witness relating to the question of implied consent and NGOs complying with the Privacy Act. Is there a high level of uncertainty on the part of non-government agencies in receipt of government funding about what legislation or regulation covers their service? A view that was expressed to us was that agencies in the private sector that are contracted to a State agency are exempt from the national privacy principles that are contained in the Privacy Act as it is assumed that the State Government will bind those agencies in the provision of the Privacy and Personal Information Protection Act or the State's privacy laws. What are your views in relation to that issue?

Mr RAMJAN: The part that I can comment on is the access to information. Again, a range of situations exist, but there are a few absolutes that cannot be denied. For most people, their family is their natural support network. No family is perfect, but families are the best natural support network that people have available to them, for all the disharmony and conflict that may happen. Your mother, father, brothers and sisters are the people with whom you have a clear relationship. In many cases with people with a mental illness it is the family that provides the care on an ongoing, day-to-day basis. They are there 24 hours a day, seven days a week.

I was one of the co-consultants with the National Review of Carer Views—carers of people with a mental illness—that was funded by the Federal Government for Carers Australia and the Mental Health Council of Australia. What came through crystal clear was that the carers are the prime providers of service and that some of the services that they are providing, if you look at them closely, are really clinical services. So a lot of our carers have expressed the view strongly that they cannot provide their care role, either in a loving or in a semi-clinical way, without some basic information, which is often denied to them.

Tying into that, the Schizophrenia Fellowship was contracted by NSW Health to develop a clinical practice guideline for the treatment of schizophrenia. I have a few copies of it here to leave with you. This issue came up there about privacy. It is an issue that has two sides to it. The person with the mental illness has a desire for privacy. The carer has a need for information. We had four committees—researchers, clinicians, carers and consumers. We sat the four committees down together and said, "How do we resolve this issue?" We actually did a role reversal. The carers were arguing the case for the consumers about privacy and the consumers were arguing the case about carers' need to know information.

Out of that it became pretty clear that a lot of the guff that goes on about confidentiality is not a real issue within the context of legislation and withholding information. A lot of consumers were able to say that if it enhanced their mental wellbeing they would want their carer to know certain information. They would obviously want a lot of information private, but basic information about their treatment plan, the medication they were getting, when their appointments were, should be information that was passed on. I have a couple of other things to say about that.

CHAIR: That would require the health service to actually ask the patient or the client whether they wanted the information passed on.

Mr RAMJAN: There is another issue that comes into that. If the person with the mental illness is not in a situation to make informed decisions at the time, then the guardianship legislation comes into play and the carer is clearly the person responsible. So the person responsible clearly has a right to know.

CHAIR: If they are a voluntary patient and they have been discharged and for all sorts of reasons they say "Don't tell mum or dad ", they may not mean that simple stuff such as when the next appointment is and so on, but the health service takes it to mean "Don't tell them anything at all" and they do not bother letting a relative know, which is what you are concerned about and what your carers are concerned about and what they might be concerned about systemically. But individual patients can be very tricky people and individual families can be very tricky. The onus must be left, therefore, to the health service to discover what they want told and what they do not what told in a fairly forensic way.

Judge WALKER: If you are a parent you may have a different view, and I was twice. I found myself totally frustrated and very angry about the total lack of information. I never managed to get any explanation out of a psychiatrist ever about the nature of the disease. I had to find out for myself. I had to educate myself. I got no support at all at any stage over a long period of time, and nor did my family. Of course the families are often in just as much crisis. It is a very terrible thing, this schizophrenia disease. It has a massive impact upon family relationships and to be left in a vacuum is a very frightening thing for a family.

The disease, of course, presents with symptomatology that is delusional, often extremely delusional; these people live in an unreal world and you could get no information at the time when the my son was in terrible delusions. He had five voices talking to him constantly year in, year out, and he had a total lack of sense of reality for large periods of time, but never once what I able to persuade a medical practitioner to assist me as to what the nature of the problem was or what should be done about it. Not only that, he was extremely paranoid and he feared any part of his medical record getting out because he knew that the CIA would get it and he knew that aliens with laser beams were likely to use that information to hurt him. Yet that was the excuse used to keep my family in the dark.

There needs to be uniform legislation on privacy. There is a desperate need. It was on the agenda when I was attorney general and that is a long, long time ago. Joh Bjelke Petersen would never allow any form of uniform legislation. The companies legislation only came about because John Howard and myself got together and agreed, did a deal. But that has changed and I think there is a desperate need for uniformity, not only in this area. Care orders are another thing. People cross borders these days. You are up in Tweed Heads and you have got a care order on; you cross into Queensland and then it disappears.

CHAIR: The current Minister has regulated to deal with Victoria and Queensland. I saw that quite recently in the Gazette.

Judge WALKER: There are a lot of these areas and privacy is one of them where there should be a uniform set of laws across the country.

CHAIR: New South Wales has done it and we have proof of the target legislation. We have just had Chris Puplick in front of us—you probably heard some of his evidence. The issue of the patient not giving consent is the significant issue. Where you have a person who is paranoid and even though they come out of hospital they are still not well, are they competent? This is the whole issue of whether they are competent or incompetent at various stages, to use non-threatening language. How does a mental health worker overcome those problems to let the real carers know what they need to know?

Judge WALKER: I never had any problem with crisis care teams. They always told you what they thought. It was the medical profession where I had a problem.

CHAIR: They would be offending against the Act. They probably did not understand the Act as much. They would be offending unless they had clear consent. But I wonder how much they bother to press to get that consent. If they find the person is not competent to answer the question, do they then go to the Guardian and say "This fellow or this woman needs guardianship orders to the relatives so that we can tell the relative they are going to be caring for them"?

Judge WALKER: It is a very complex way to deal with a day to day situation. If you had to keep running off for guardianship orders every 10 minutes you would never get anywhere.

CHAIR: What other solution is there though if your son says "Don't tell him I am coming home" and he is discharged and the next you discover he is on the streets in King's Cross and you are angry because they should have told you?

Judge WALKER: They will not tell you he is on the streets in King's Cross anyway, even though they know it. They will not tell you that.

CHAIR: That is true, but you discover that and you are angry that they have not told you. Unless they have actual consent or they have the guardianship order to give you for information, what other way is there of having a secondary guardianship, some step down form of guardianship?

Mr RAMJAN: That may already exist. There are two things. There is the legislation in the Guardianship Act that says there is a person responsible and that person responsible can be involved in medical decisions and medical information.

CHAIR: That is if you already have a guardianship order.

Mr RAMJAN: No. The guardianship order is the formal side of it. You do not need a guardianship order if there is a person responsible who can make the consents and who can deal with the information. You do not need a guardianship order. I should declare I sit on the Guardianship Tribunal and I was involved in putting the Act together. You do not need to have a Guardian appointed. A Guardian appointed may be required to convince the health authorities of the legality of the person responsible, which is really unfortunate. It just means the health authorities do not understand the concept of "person responsible". But the Act actually provides for a person responsible who can hear the information and make the decisions if the subject person is not competent to do it themselves.

CHAIR: Can I tell you if it was that simple it would not be a problem. If you have a patient in front of you and you know that behind that person sits a carer, a mother or a father, and you say to the patient "Will I let Mum and Dad know you are coming home?" and they say "No", you cannot look over their shoulder and say "Mum and dad, he is coming home".

Mr RAMJAN: If they are not competent to make the decision—

CHAIR: You have got to make that decision.

Judge WALKER: That is their duty under the Mental Health Act. That is the doctor's duty. District Court judges complain to me all the time that they make orders saying people are incompetent, they say they are a danger to themselves or are a danger to the general public; they then send them into the health system who will immediately discharge them into the community where they kill someone or they do some damage or they kill themselves. That is something that happens every day of the week. They are prepared to make that decision to overrule a judge's decision, a seriously taken judicial decision, they are prepared to do that, yet they are not prepared to say "This person is incompetent. He is delusional. He is suicidal. We are going to ring the parent and tell them that he is up the Cross trying to sell his body".

CHAIR: That is because the judge gets advice from the newly created forensic service or the judge sends the person out from the court to get an opinion under, I think it is section 28. But having got that advice the judge then says "I am not going to hear this case until this person is competent" or whatever; they then send them to the mental health service and they use a different set of guidelines about whether they are going to be admitted to hospital or not.

Judge WALKER: What I am saying is they are not legal guidelines, they are their own guidelines. The Act has a very specific guideline there, they are a danger to themselves or they are a danger to the public. That is the test.

CHAIR: If the judge can make that judgment on the basis of advice, I mean that happens all the time; a GP makes a decision on a schedule 2, sends them up to the Caritas Centre; the treating psychiatrists there say for various reasons, no beds, they are overstretched, etcetera. etcetera., "You are not sick enough to be admitted and scheduled", and they send them out again. Whilst they may not be competent to live a normal life and do all of those things, in the judgment of the people there, or because of their resources, they will not admit them. It is a separate issue. If you say to the person then "Do you want mum and dad notified?" so you can go to that sort of carer arrangement, it depends upon the advice. If they are not competent then you have got to go to the guardian to appoint a person to make decisions on their care. If I see somebody in a car accident who is unconscious and they are 19 you cannot automatically go to mum or dad. Mum or dad can be advised, however the Guardianship Board has to be advised, do they not?

Mr RAMJAN: No, not necessarily.

CHAIR: That is the change in the Act.

Mr RAMJAN: If there is a car accident, that is a good example. A car accidents, traumatic head injury, the person is semiconscious, not unconscious, and in the process of that there is either an objection to treatment happening from the semiconscious person or a confused state that is not allowing that person to give a consent. In any other area of health the treating doctors would go to the person responsible. If they can find a person responsible they will go to the person responsible. They will only go to the Guardianship Tribunal if they are clear that there is a real objection to the treatment being presented.

The Hon. JOHN JOBLING: The point that was made that we have drifted away from a little bit is the patient has received treatment, whether they are scheduled or voluntary; they are at a discharge point and it is at that discharge point where they have been adjudged on medical evidence and assessment that they are allegedly competent to go back into the real world. The point that was being made was at this stage it appears unless they consent to their parents being told, they are just discharged, possibly with a treatment plan, and they vanish out into the big wide world. The parents only discover later, when they either turn up on the doorstep, or they are involved in something that brings them to the attention of the police or by some other means, and there just does not seem to be a way to get around that, that the carer per se, or the family member who wants to care is actually notified on a formal basis. It just does not happen that way.

Judge WALKER: You would think that it would be easy to get an interim order situation the same as you can get a warrant from a judge; if there were someone in the health care system you could contact and say "I think we really ought to tell the parents in this case", and you have an interim order. If the person wants to challenge it there is a judicial challenge to it later but at least at that time the parents are advised and may be able to save the life of their child.

CHAIR: We need to change things to get that done but I think you are right about that.

Mr RAMJAN: Just before we move away from this, there are two quick things I want to say about the privacy side of it and confidentiality. There was, a couple of years ago, draft model mental health legislation put out for national adoption. There were a couple of clauses that we submitted for that which I understand were in the draft model mental health legislation that provided means for carers to get access to information and when the person they cared for was being discharged from hospital if they were the ones who were going to be providing the care post discharge. My understanding is that those clauses in some form or another have been adopted at least in Victoria, I think the Northern Territory and Western Australia. So legislatively some things can be done.

There is a nice quick way around it which we identified out of that workshop that we held in the clinical practice guidelines and that is for the carers to be involved pre-discharge so that the discharge planning is done with the carers and then they are already part of the process and you have set up an integrated care model. That was something that was agreed to by all of the stakeholders: the consumers, the carers, the mental health workers who were present, and it is what actually happens in the intellectual disability field. In the intellectual disability field when individual service plans are being developed they are developed with all of the key stakeholders there. If the carers, the family, are providing real care they are involved in the development of that individual service plan. Rather than leave it to the final moment—"We are going to discharge Johnny in 10 minutes, do we tell the parents or not", the parents are involved at an earlier stage and they are part of the planning for discharge. That is actually in the clinical practice guideline.

CHAIR: We will check that.

The Hon. AMANDA FAZIO: Reference was made earlier to whether there should be expanded funding for non-government organisations. A number of people who have given evidence before the inquiry referred to the problem of the seemingly artificial boundaries of the area health services within New South Wales. If there were to be an increase in funding for non-government organisations, would you support that being done within area health services or a statewide planning and funding program to try to ensure a consistency of service provision across the State?

Mr RAMJAN: There are two avenues of funding for non-government as it currently exists. It could come from head office or from area health services. What I think would be the most desirable way to deal with it would be for the large increase to come through a centralised system but for area health services to still be in a position to contract non-government agencies to provide services within their catchment, so you would have two phases. In some ways that makes a bit of sense. One of the terms of reference is the mix of mental health services in New South Wales. Apart from mix, mental health services are not consistent across the State. It depends on where you live what quality of service you will have access to.

In some areas where they have become involved in the provision of accommodation services, they are now seeing that is not part of their clinical task, so they currently, within the area health budget, are putting money into providing accommodation services and some areas are starting to acknowledge that that is not their job. Their job is more clinical and they want to contract that out. It could operate at both levels. Existing funding to area health services could be allocated to NGOs to take on tasks that the area sees as important but if there is enhanced funding for non-government, that should come from somewhere centralised and hopefully be sprayed in some even way across the State so that people in the rural and remote areas do not miss out, as they have in the past.

Judge WALKER: I want to say something that is very political. There are a lot of area health services that are antagonistic to us as an organisation. They tell us quite bluntly that Ministers come and Ministers go but they will be there forever and we may be able to persuade Ministers to assist us with funding for particular projects, but rest assured that unless we come to terms with them and not the Minister, then we will not be getting any further assistance once that Minister goes and they persuade the next one. Some areas simply do not agree that we ought to be in the business and will not fund us in any shape or form. We are at North Sydney, not because we want to be there because we would have preferred to be centralised, but we are there because they were tremendously empathetic and supportive of us and that is how it has developed. That is the problem with individual area health services, which are bureaucracies within themselves, with their own budgets and their own set of priorities. We do not find that a satisfactory arrangement. We cannot get any service in Newcastle, for example, yet it is one of the biggest areas in the State. We have a little bit going at the moment and we have had to fight to get that. That is the sort problem we have.

The Hon. AMANDA FAZIO: I think it is probably more widespread across New South Wales bureaucracy, not just in health. That issue needs to be dealt with separately.

CHAIR: Mental health is currently going through a process of making its funding population-based, like all other funding, and trying to mainstream mental health in that regard. The problem is they then have to spend the money through the area health services. Whether you can keep non-government services funding back and let the Minister decide on political advice or advice from the Centre for Mental Health or not, the issue is that they will operate within the area health services so whether you get funding to operate a service in the Hunter, operating that service still depends on those linkages to the government sector. Even if it is funded centrally it will not overcome the problem unless you change the whole thinking in the areas to look at providing those services through the non-government sector. It simply cannot happen, can it?

Judge WALKER: If you are on the ground and you have a lot of people working on the ground you often get the community being so supportive of what is happening and they put pressure on the area health service. That happened in the New England area and it has been very successful because of the tremendous community support. There was a change of view by the local area health board and things have improved out of sight, so it can happen if the community wants it.

The Hon. AMANDA FAZIO: Some people have said in submissions and evidence that a solution to some of the problems would be greater promotion and awareness campaigns around mental health issues so that people are more aware of when to refer family members and so on if they are exhibiting signs of illness or unusual behaviour, and also in terms of community acceptance of people with mental health issues. Do you support that or do you think the money would be better spent elsewhere?

Mr RAMJAN: There is no question that mental illness is misunderstood, even though it is one of the biggest catchments of illness that we could possibly have and there is no question that some impact can be made. "Beyond Blue" is demonstrating that you can certainly change the way the community views one mental illness, depression, although admittedly it is an easier one to deal with because depression is something that everybody can understand and everybody has at least felt sad. "Beyond Blue" is having some impact. I live at Summer Hill and when the Richmond implementation was happening Summer Hill was the second most saturated suburb for people out of institutions in the country, not because of Richmond but because of previous people coming from various institutions.

I grew up in Lewisham, Dulwich Hill and have been in Summer Hill for 18 or 19 years, and in the whole time I have been there the only violent thing that has happened with regard to a person with a mental illness was one of our local boardinghouse people was a chronic beggar and was kicked to death in the local park by a couple of people, supposedly from the pub but nobody was ever arrested. That is the only incident of violence but most people in Summer Hill think that people with schizophrenia especially, are violent, dangerous people, so the perceptions are not good and when you try to integrate people into the community and open up channels between members of the community who have mentally ill children, it is very difficult.

Awareness has great value beyond just changing community attitude. I know we are taking a long time but it is really important on how awareness can have an impact. About 10 or 12 years ago I spoke to our local rotary group of 35 men. During the warm-up part of it one guy said, "There is nobody here with any involvement with mental illness. We have one fellow with a child with autism and a couple of fellows with children with asthma but nobody with mental illness." I looked around and there were five fathers who had a son or daughter with schizophrenia. It was a really good rotary club, very social and supportive, but they could not talk to each other and so they were isolated. Awareness will have an impact on that is well. People will become more able to say, "My son, daughter, sister has a mental illness."

If you look at research on outcomes with awareness campaigns there is no question that the thing that gets the best change in attitude and behaviour is direct contact. It means not doing the glossy television, newspaper or magazine advertisements. They are an important subsidiary but should not be the prime place to spend the money. Paying people to go to the clubs and do the talks and training consumers and carers to be public speakers and throwing them out at the community and having direct contacts so that within a couple of years you have maybe 10 per cent or 20 per cent of the population that have had direct contact with somebody with a mental illness as the public speaker.

The basis for that is the Canadian Disability Awareness Campaign, which ran for over two or three years. They spent a fortune on advertising but the real place they got impact was direct contact. That was a while ago so there will be evidence beyond that. My view is partially evidence-based and partially a prejudice I have that you are going to change. They found that they could change purported attitude by doing the electronic and paper stuff but the behaviour actually got worse. People learnt how to get the right answers but their behaviour got worse, but by direct contact you have a change in attitude and behaviour.

Judge WALKER: I chaired the Federal Government's media and communication committee for a number of years and we did the big health campaigns on stigma. We did a lot of research into that. The biggest problem we found was that American television, the Hollywood product that is coming out, had a much greater influence on people's views about mental illness and how it should be dealt with than anything we could do. If the programs were to be effective they had to be repeated for each generation. In America the word "schizophrenia" is immediately associated with homicidal maniacs because that is the way it is presented on television and it is a very hard stigma to overcome.

We really have to get out into the community constantly in a more on-the-ground, practical way rather than running the glossy television, radio and newspaper campaigns. Governments like to do that but the reality is that they are not that effective. We need to run campaigns and most of all we need to convince GPs that they should know something about mental illness because a great many of them know absolutely nothing. They do a six-month course at university and most of them are so out of date that they are not much use at all.

They know nothing about the medications. When they prescribe medications they are the wrong ones or the old-fashioned ones dating back 20 years. I am not saying it is everyone because some are very good but our experience is that GPs need to be educated greatly. That is probably one of the great problems about mental illness, early intervention is vital with schizophrenia and there are not many GPs who have the first idea how to diagnose it, to see the signs and to get people to specialists quickly so that they might intervene, thereby saving a great deal of time and trouble. Early intervention seems to work, there are a lot of signs that it does and it could be very valuable. I think we need to run big campaigns into the medical profession to try to get them behaving better.

CHAIR: It is your estimation that if you have a dual diagnosis you go to one but you will not get treated unless you get treated by the other and you fall through the crack. It has been identified that drug and alcohol funding and mental health funding are quite separate. They did not used to be. When you were in government before they were not separate. When did they get separated and why?

Mr RAMJAN: It was probably about 1972.

CHAIR: Do you remember why?

Mr RAMJAN: Because it was a worldwide trend more than any other reason. Other jurisdictions around the world had succumbed to the argument that they were separate. There was a time when a whole lot of things were caught under psychiatric services—intellectual disability, drug and alcohol, dementia—there was a worldwide trend at that particular time.

CHAIR: Yet Richmond did recommend in 1982 that a combined unit be set up. Such a unit did exist at Rozelle and it quietly disappeared about four years ago.

Mr RAMJAN: Cedar?

CHAIR: Yes. There was a direct recommendation by Richmond to identify that issue in 1982 yet for some reason we have closed down a unit that was there.

Judge WALKER: I can give some insight into it. One of the problems with treating someone who has both a mental illness and an addiction is the true, tried, tested and successful ways of treating alcoholism or drug addiction, that is, the Alcoholics Anonymous plan—all these steps to enlightenment, which is very Buddhist in its approach, but it is just about the only way that these things seem to work at the moment. The difficulty is that it is a plan that requires insight into the nature of the condition. Most people with schizophrenia have no insight into their condition. They really believe that little green men are coming at them with lasers. It is very hard to get the necessary insight. It also requires tremendous self-discipline and control, which is very difficult. People who have a mental illness do not have much discipline or control. They cannot because they are living in an unreal world half the time. They are not really able to. What I am saying is that the true and tried system of getting people off addictions seems to conflict with a mental illness, and they have not come to grips with that problem.

CHAIR: Unless you can stop people taking marijuana you can never control their medications for control of their schizophrenia. It is the issue of the dual usage of marijuana amongst people who have serious delusional and psychotic episodes.

Judge WALKER: There is no doubt that there are strong links between the taking of marijuana and schizophrenia.

CHAIR: I am not saying that one causes the other.

Judge WALKER: There are not a lot of links between addiction and marijuana. The addiction I am talking about is heroin, amphetamines, that sort of thing.

CHAIR: But if you can control that with a methadone program you have some chance of getting control of the other illness. While ever one is episodic and the other one is not you cannot control over. That is why you need to treat both at the same time. How many people who are in our psychiatric institutions are on methadone? Not a lot.

Judge WALKER: I think it can be done. What I am saying is that it has to be done with new ways, and I do not think enough thought is going into the best way to deal with this dual addiction problem.

CHAIR: We are also really interested in the forensic issue. The Monday before last we went to Long Bay, Mulawa and so on. We spent the whole day doing it. What absolutely staggered me—it really brought it home—was that forensic patients are in prison garb being looked after by prison officers. At least there is a correctional health service these days which is under a board and it has a different area health service. You may be aware that the department has a plan to build a secure hospital on the same site but outside the walls of Long Bay. There will be a secure hospital. It is planned to have in that facility difficult to manage people who need high security from the community, forensic patients and difficult to manage people who are prisoners but who have a mental illness, and to take back into the prison itself a prison hospital for lumps and bumps and the sprained ankles and so on. Is there any impediment that you can see to changing the facility they have at Long Bay—you have some experience of what happens out there—into that sort of service tomorrow?

Judge WALKER: I do not know how many beds there are at Long Bay. It is less than 90 because there is only 90 in the whole New South Wales system.

CHAIR: If you take 30 out for prisoners who have an illness you get 30 back. They are planning to make it a 120-bed facility. Getting rid of 30 prisoners will give them an extra 60 beds. The issue is whether we can get rid of the prison officers tomorrow and replace them with Chubb Security.

The Hon. AMANDA FAZIO: Or would you want to?

CHAIR: You do want to because you want it to be a health facility and not a prison facility.

Judge WALKER: We believe in secure facilities for people who have committed violent crimes. We believe in it because it is political reality. The public is simply not going to accept letting those sorts of people back out into the community on any short-term basis. We believe they ought to be there, and we also believe that the facilities ought to be small and decent places to live in, not your usual harsh prison environment. These are people with serious illnesses. We think they ought to be all over the State. You can put them next to a prison. I do not care where you put them.

CHAIR: The question I asked is not that. It is: Should they be looked after by Health or should the prison guards be prison guards?

Judge WALKER: This is a personal view: I think they should be looked after by a team of health care workers. Some of the team should include police officers because there is a need for joint services. The Victorians are starting to do it now. They are starting to get multi-discipline teams with police officers involved. I do not think prison guards are the appropriate people. I think the police service ought to be involved in this. They do it in the Drug Court. They are starting to integrate. But I think it ought to be a health environment. I do not think it should be a prison environment. That is why I would not agree with that. That is my personal view. I do not know what Rob thinks about it but—

Mr RAMJAN: Having been out there, I know my mental health suffered just being in the environment. I do not know how somebody who does not have a sentence but whose release is reliant on being mentally well again becomes mentally well in that environment. It is a frightening place to be.

Judge WALKER: The greatest tragedy is in the women's prisons. Something like 60 per cent of women prisoners have a diagnosed mental illness. They have usually got drug problems as well.

CHAIR: Ninety-four per cent.

Judge WALKER: Yes. You have dual diagnosis in extremis. Many more women are in prison now than have ever been. There are probably more women in prison now than in the convict days as a percentage of members of the community. The reason is drugs. That is where large numbers of female crimes evolve from. They are out there in the prisons. They usually have a mental illness as well. That is where I feel the greatest tragedy is occurring.

CHAIR: We were staggered to find that they have only just got this information recently. This has been going on for a long, long time. Yet the actual information gathered is very, very recent. They were all very keen to tell us about this wonderful new information. You would have thought that for planning purposes in how to treat people this would have been part and parcel of a corrections health service.

Judge WALKER: In that speech of mine I make a lot of comments about what they should be doing in the prisons but I think we should take a lot of these people out of the prisons and put them around the State in small facilities.

CHAIR: Arthur wanted me to ask you this question. Looking at the spread of health funding for hospital-based services and for community-based services, including NGO services, what do you think the split should be and what is the split in other jurisdictions that you are aware of?

Mr RAMJAN: It varies quite a bit. Spending on mental health services varies all around the world. In, I think, New Hampshire in the United States 12 years ago they were spending $168 American per capita on mental health services, which today makes our spending anywhere in Australia looks sick. The peak time for people in psychiatric hospitals in New South Wales was 1961 or 1962 when they held 12,700 people. Projecting from what we know with the current rates, that would probably mean that at least 90 per cent of people with a serious mental illness were still in the community. When that discharge of people between 1962 and 1965 happened there were no community services for them to go to. It is that new. We are not 40 years away from that.

Hospital services are expensive because they have the medical side to them. There have been targets in different jurisdictions to have a 50-50 split between hospital and community. You might have the resources to follow up on this. In the southwest counties of England—Devon, Exeter—they came up with a formula when they were doing their deinstitutionalisation about 10 or 15 years ago at a similar time to the Richmond implementation here. I am sure their mix was much less to hospital than it was to the community. It would be interesting to see how they have managed this far down the track.

CHAIR: I remember that not a long time ago when you had your index admission for schizophrenia you would be there for three months and then you would spend the next six months also at Macquarie Cottages before you went home. You would have home release, weekends and that sort of stuff. But these days that is not available—the medium-term, long-term care. I suppose you could almost say it is institutional care, although they were in small cottages. They now seem to be in hospital for two weeks and then go home.

Mr RAMJAN: I think the average is well under two weeks.

CHAIR: No, for the index admission it is longer. But it is not very long. Then there is the post-admission—starting to understand what it is all about, getting you stabilised and all that sort of stuff. If you do not do that you end up with a revolving door, which happens more and more. That is why you need more and more beds. So if you could do more in the community or you treated the first things earlier that would require much more community-based services or less acute admission services but more money outside.

Judge WALKER: My sources tell me that a hospital bed will cost $200,000 per year and a gaol cell $60,000 a year. And that is why you have a lot of trouble convincing Treasury officers at budget sessions to—

CHAIR: But how much do community-based services cost per year?

Mr RAMJAN: It depends which ones you are looking at. You just referred to the early intervention stuff. If it is done properly, early intervention costs a bit of money. There is some evidence, not compelling yet, coming through that that does lead to a better prognosis. To that end I have brought this book along. We will need to get it back but we can leave it with you for you to have a look at. Hopefully, when you are in Victoria you will go to have a look at Epic, the service there that I understand was the first real early intervention service established in the world. It has been copied in other countries. It is intensive but it gets good outcomes. If you can have that intensive early intervention and get good outcomes there are savings down the track. So it is worth the investment, although it takes a while to realise.

CHAIR: Would you say that mental illnesses such as schizophrenia, a chronic relapsing condition, are treated as well as asthma or diabetes by NSW Health?

Mr RAMJAN: Comparing it in the level of treatment that is available?

CHAIR: Yes.

Mr RAMJAN: I would have to say that I think mental illnesses generally—schizophrenia specifically—as far as I know are probably the worst treated health conditions, not just in this State. I struggle hard to think of a health condition that consistently for the length of time—you can go back as far as you like—has been misunderstood and not properly addressed. You can go back as far you like. Part of that is historical, and we did not know a lot of things. But in the last 20, 25 or 30 years a lot more information and research has become available and we know a lot more. We would not treat people with heart problems the way we treat people with mental illness.

CHAIR: I saw the figure yesterday from the research that was put out in the newspaper. Are they the sort of figures that you are comfortable with? Would you expect that one in six people who die who have schizophrenia die from suicide, and that 84 per cent of the people with schizophrenia who died last year died of suicide?

Mr RAMJAN: The 84 per cent I am not sure about; the 9 to 15 per cent of people with schizophrenia committing suicide is a well-established figure. It has been established for a long time. It may be slightly higher because of coronial findings of misadventure rather than suicide. Wherever you place it, I have no doubt that schizophrenia is a fatal illness for a significant number of people who develop it.

Judge WALKER: Particularly young teenage men.

CHAIR: Did you see the newspaper articles yesterday about the report?

Mr RAMJAN: I have actually brought a copy of that report to leave with you.

CHAIR: And that coincides with your own experience? You have been in this business for a long time.

Mr RAMJAN: I have not had a chance to read the whole lot of it. There are some parts that were reported in the paper that we would definitely disagree with. The Herald said that there were 37,000 people with schizophrenia. That is clearly wrong. What they are talking about is that at this instant in time there are 37,000 people who have schizophrenia that is intervening in their day-to-day living in an acute way. There is a hell of a lot more than that. Most recent research is suggesting a figure of 1.5 to the 3 per cent of the population having schizophrenia. From very personal experience, my mother-in-law went for about 35 years without being identified. She had treatment in the early 1950s and then disappeared into the back blocks of Sydney and would never appear on any statistic as somebody with schizophrenia. But she had it and she was hallucinating and delusional right up until she died.

That figure is clearly wrong. A better document in its accuracy and veracity is this one which we will leave with you. Assen Jablensky is one of the principal authors of this. He would be one of the top three or four epidemiologists in the world. That is only on University of Western Australia figures. It is Western Australian figures but they have had a much better data collection system than just about anywhere else in Australia. There are figures in there that are very powerful. One thing we would push hard is that with mental illness, especially schizophrenia, it is the whole person who is being dealt with, not the psychiatric symptoms. When you look at this, you are looking at a range of health problems that are consequent or in partnership with the mental illness that can actually have an impact on the symptoms.

I think I might have spoken with you before but in a different context, and I should say it here. A very simple thing like oral hygiene, looking after a person's dentition, can have an impact on the psychiatric symptoms that they are exhibiting. And what are we doing about that? When somebody's teeth are bad and infected, their symptoms will be worse. There is some research done by dentists that show that—not by the psychiatric area but by dentists—when you treat the poor teeth you get better symptom outcome. We should be looking at the whole person because there are a lot of simple things we could be doing that would alleviate the human suffering of the person with the illness and the carers who are standing there trying to assist.

Judge WALKER: We think there is some political hyperbole in those newspaper reports.

CHAIR: That is the stunning thing. We would be interested if you have done any sort of summary of that research. Spinning is always the difficult bit of selling reports to make them a bit more accessible to the newspapers, but the reality is what we have to try to deal with.

Judge WALKER: We do not think they are completely untrue. We think the figures are slightly exaggerated.

CHAIR: In my view, the Government is mainstreaming mental health so that it looks like any other part of the health system. When we build wards, we build the mental health ward there, the drug and alcohol section there and the main part of the hospital here and we hang the emergency department off to the front. When somebody comes into the system they go to the emergency department; the mental health team comes up and has a little look, and that is all that has a look. Nobody else has a look at them, just the mental health team, and then they go off to the mental health place where they are found to have other illnesses, such as pneumonia or something else. If they come in with pneumonia and they are delusional or whatever they get admitted to the medical ward and you hardly get somebody from this ward to come up to this ward to see them. Is this an issue that constantly appears amongst your people?

Mr RAMJAN: I preface this by saying that I have worked in health all my life. I would not want to work in an accident and emergency ward. I do not think they are places where you can succeed, just because you never know what is going to happen. So I preface it with that. The complaints we get are serious complaints, and they are complaints about people having to wait four hours, 12 hours before anybody does an assessment. In some ways that is an understandable situation. If you work in accident and emergency you are used to blood, visual injuries, something that you can actually see or feel immediately. Somebody who has come in with a carer because they are a bit psychotic and who looks like they will be able to sit quietly in the corner while you deal with other things can get ignored, and by the phone calls we get they do get ignored and they can sit there for lengthy periods of time. The consequence of that, in some cases, is that the person with the illness will become so agitated or frustrated that they leave—

Judge WALKER: Or behave very badly.

Mr RAMJAN: —or behave badly and be arrested. In some circumstances they will get arrested, even when they leave, and in some circumstances they may die through misadventure, not necessarily suicide—

CHAIR: Run across the road.

Mr RAMJAN: Yes. We have a few things we will leave with you. We have one of these for each member of the Committee, which has our submission and some policy papers that we have used at various times.

Documents tabled.

(The witnesses withdrew)

Dr MICHAEL ROBERT GIUFFRIDA, Director of Forensic Psychiatry—Westmead-Cumberland, c/- Cumberland Hospital, P O Box 7118, Parramatta BC, 2150; and

Dr BRIAN MICHAEL BOETTCHER, Senior Staff Forensic Psychiatrist, Bunya Medium Secure Unit—Cumberland, P O Box 648, Wahroonga, sworn and examined:

CHAIR: The Committee will resume to swear in the witnesses and begin to take the witnesses' evidence as discussion which will be adopted when a quorum is formed. In what capacity are you appearing before the Committee?

Dr GIUFFRIDA: In a private capacity.

Dr BOETTCHER: As a private person.

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

Dr GIUFFRIDA: I am.

Dr BOETTCHER: I am.

CHAIR: Dr Giuffrida, you have not forwarded a submission to the Committee?

Dr GIUFFRIDA: No.

CHAIR: Dr Boettcher, you have made a submission to the Committee, so would you like to have that taken as part of your sworn evidence?

Dr BOETTCHER: Yes, I would.

CHAIR: Have you received a summons under my hand to appear before the Committee today?

Dr GIUFFRIDA: Yes I have.

Dr BOETTCHER: Yes I have.

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 to the Committee should be seen or heard only by the Committee, the Committee will be willing to accede to your request, but you should be aware that the Legislative Council may overturn the Committee's decision and make that evidence public. Dr Boettcher, my understanding of your submission is that it is a public submission.

Dr BOETTCHER: That is right.

CHAIR: Before we begin to ask questions, I wonder whether either of you would like to make any comments to us in expansion of a submission that we have received, or for any other reason?

Dr BOETTCHER: I would.

CHAIR: The Committee is now quorate. I declare the swearing of the witnesses and formal questions and answers to be part of the Committee's proceedings.

Dr BOETTCHER: I would like to state right at the beginning that I believe that the mental health system has been degraded to a terminal state in a wilful, deliberate and negligent manner by professionals who know better. I thank the Committee for the opportunity to make an oral submission. As well as my own written submission I have contributed to several other written submissions under the Association of Practising Psychiatrists and the forensic branch of the Royal Australian and New Zealand College of Psychiatrists. As the Committee will see from my curriculum vitae, I worked at Mulawa women's prison in 1994.

More recently I worked in Corrections Health in the Long Bay prison hospital, Bathurst, Parramatta and Silverwater prisons. I have also had experience in working as a senior consultant psychiatrist in an integrated community and hospital setting in the UK, Queensland and New South Wales. In the year 2000 I was the Director of Forensic Psychiatry in north Queensland and in 2002 I was the clinical director of psychiatry in the Wentworth area for a time. I am now working as a forensic psychiatrist for the Westmead-Cumberland hospital at the Bunya Medium Secure Unit. Bunya is one of the two medium secure units in New South Wales whereas the UK has hundreds of them.

CHAIR: The other one is at Maitland, as it not?

Dr BOETTCHER: Morisset. It is my belief, as well as the belief of many of my colleagues who have worked overseas, that New South Wales is 25 years behind the UK and Queensland in the development of ethical forensic mental health service. Both Liberal and Labor Governments have overseen this disgraceful situation but they have had nothing to respond to as there has been a lack of leadership from the forensic mental health services. It was indeed very difficult to make any progress against the iron grip that Corrections has on mental health in prisons. In response to media attention, especially from the *Sydney Morning Herald* articles and the announcement of a parliamentary inquiry, that there have been some hurried changes. It is worth thinking about the reasons why Corrections has been so resistant for so long to the development of the mental health services.

Professor Carolyn Quadrio was forced to resign due to the lack of progress and support in the development of such services and the generally contemptuous treatment she received from Corrections Health. It was she who instigated the survey which showed the fact that 30 per cent to 40 per cent of prisoners suffered from mental illness in New South Wales. The final straw for Dr Jonathan Carne and myself came when it was suggested that 40 mentally ill male prisoners be placed in a wing of Silverwater with no nursing supervision. We both resigned rather than oversee such an antitherapeutic imposition. There is no adequate hospital treatment for women and Dr Giuffrida will address this further. Little has changed in New South Wales since I worked in Mulawa in 1994 and saw a such disgraceful treatment of women prisoners that I complained to the Minister for Women.

I was subsequently treated as a whistleblower by Corrections Health. However, when I left, the number of psychiatric nurses had increased from one male nurse to an additional six female psychiatric nurses. An example of the inhumane treatment of prisoners was when I saw one female prisoner in a cage which was being hosed out with her still in it. These cages were like small monkey cages previously used at Taronga zoo that had been removed because they were considered inadequate for animals. Inhumane practices still exist and Dr Giuffrida and I will be trying to move disturbed women to Bunya Medium Secure Unit in order to treat and protect the women prisoners from staff and other prisoners. There are no other facilities to properly treat and protect women and men prisoners with mental illness, and in any case Bunya is a rehabilitation facility, not an acute psychiatric ward.

This means that many men and women remain dangerously psychotic and are not treated in prison. I am perfectly sure that, should the public become aware of the situation, there would be an outcry as it goes against every instinct of humanity. The biggest outrage is that this has been allowed to continue for so long. In my view, the law should deal with the people responsible. Corrections Health is the most dysfunctional organisation I have ever seen. In relation to general psychiatry, the Committee has heard extensive evidence that there has been an acute beds shortage in New South Wales which has developed over some years. With the introduction of a parliamentary inquiry and the threat of industrial action by doctors at Cumberland Hospital and Penrith hospital, various promises have been made and a few beds have been opened up. However, it is a very dangerous situation and deaths have resulted. I believe that Dr Barclay is compiling a report about those deaths which I gather number 11.

Many more have been written off as suicides or have been held to be due to some physical illness that has been suffered over the years, as was done in the deep-sleep deaths in Chelmsford. I find the similarities impressive and frightening. Besides the need for acute beds, the real shortage for many areas however are for the following types of beds: supervised psychiatric beds in the community as in Victoria, psychogeriatric beds, child and adolescent beds, and rehabilitation beds. If these were to be supplied, the acute bed shortage would be considerably eased. I heard only yesterday of a plan to provide some of those beds, but such plans come 10 years too late, and at what cost to our sons, daughters and older folk? In the Nepean Hospital there are approximately three to six patients over 65 and from three to four adolescent patients under 18 and any one time. This unit of 30 acute beds should have 80 by any civilised standards.

To support this contention, I point to an area that is demographically similar to the Wentworth area, namely, Ipswich in Queensland, which has 34 beds for 170,000, and Nepean Hospital which in the

Wentworth area has 30 beds for 300,000. Warnings of serious problems by New South Wales senior psychiatrists about dwindling bed numbers have been ignored for many years, and they were being ignored when I first arrived back from Queensland. When I also complained about the lack of acute beds I was told that I had beds on the brain. There is a disturbing separation between the Centre for Mental Health and front-line psychiatrists and registrars that I did not see in Queensland, or in the United Kingdom for that matter. There is a dictatorial attitude in the Centre for Mental Health. It was obvious to blind Freddy that to place increasing numbers of patients in the community had to come to an end, or patients would die and suffer as they have.

It is no wonder that other States have considered New South Wales a basket case for many years because of this deficiency in most areas of mental health. I would like to respectfully suggest that the inquiry look closely at Queensland because I feel that that system leads the world. I would briefly like to give you a taste of how the system works. Soon after I arrived in Cairns from the United Kingdom in the year 2000 I admitted a very psychotic patient and began treatment. Some days later I was told that he had serious assault charges against him and I was instructed by nursing staff to report this to Brisbane. Brisbane told me that he was now a restricted patient—that is the category they called it—and to ring the courts who, to my surprise, cancelled all court hearings and placed the matter in the hands of the mental health court.

That took the patient out of the adversarial criminal justice system and the corrections system and placed him firmly into the health system and an inquisitorial court system. Patients are treated for their mental health in a secure section of the district mental health court and staff have to write the reports. If there are any problems on clinical grounds they are transferred to Brisbane forensic hospital and the new forensic hospital in Townsville. Other specific areas that I am concerned about include the fact that there is only one nurse in the Parramatta region for the whole of New South Wales who runs the forensic community services. That creates a problem for people on conditional release.

In Queensland, the forensic community mental health service supervises general community services or case manages very difficult patients and supplies them with a consulting service or, as I said, a case management service. They will go out to Mount Isa, for example, and they will have 10 of the patients who are on the restricted list. They will go through those lists with the nurses and they might see some of those patients. The other thing is the general lack of adequate rural mental health workers. I have spent some time—10 years actually—going to Young and supplying them with a consultant psychiatric service.

The other thing is the lack of adequate indigenous mental health workers, which I witnessed in Queensland. Here there does not seem to be anything effective. In Queensland you do not have to worry about Aboriginal people. The workers take over, they are fully aware of medication and are very well trained. I mention the fact that the world is homing in on the treatment of precursors of criminal behaviour in the hope of reducing the crime rate—there is evidence that that can be done—in certain groups of children with particular symptoms in an effort to prevent incidents of mental illness. New South Wales will be left behind in this. Clinics in Scandinavia and Canada are doing a lot of research which is showing that this is effective.

CHAIR: Did you see the series on deinstitutionalisation that was shown on the SBS last month?

Dr BOETTCHER: No, I did not see that.

CHAIR: The SBS had a one-hour program on forensic matters. Doctor Giuffrida, would you like to make a statement before we ask any questions?

Dr GUIFFRIDA: Perhaps you could deal with Dr Boettcher first as I am speaking about a separate area.

CHAIR: I refer to the issue of forensic patients. You are aware that we went to Mulawa, to the Silverwater complex and to Long Bay. What stunned me at Long Bay was the fact that forensic patients were actually in prison garb, indicating that they were prisoners. Is there any reason why the facility at Long Bay—there are plans to replace that facility in 2005—should not remove the prisons service and replace it with NSW Health?

Dr BOETTCHER: Yes. Professor Blueglass was the father of forensic psychiatry. What you just said was his big point 30 years ago or more—to get the mentally ill completely out of the prison system. He lobbied hard at Westminster and got them into a building next to the corrections building, which is what they are planning to do at Long Bay. He found that that did not make any difference. The effect of having the corrections people around was very bad. He ended up putting it on the other side of Birmingham to get right away from corrections. I think it is a big mistake.

CHAIR: So the plan at the moment, which is to build on that same bit of real estate but readjust the walls, will not solve the problem in your view?

Dr BOETTCHER: No, absolutely not.

CHAIR: Given that they have taken a policy decision to have forensic patients and other high security patients who are not forensic patients dealt with together in a new and better designed building, as an interim measure could we not replace prison guards with Chubb Security or NSW Health security?

Dr BOETTCHER: Absolutely. That is exactly what is done in Queensland and it works perfectly well. They have outside perimeter care and they do not set foot inside it unless there is an emergency.

CHAIR: Is that the appropriate place to treat people who have a mental illness but who are prisoners, because they are quite separate people? Forensic patients are not prisoners. However, forensic patients and prisoners can be both as unwell as one another. Is that the sort of place where you would treat such prisoners, or should there be a mental health service inside the prison as well?

Dr BOETTCHER: I think it is quite inappropriate to have anything to do with corrections.

CHAIR: Once they have been through the courts and the courts have decided that they are prisoners, should prisoners be in prison and be cared for, or should they be cared for by NSW Health while they are prisoners?

Dr BOETTCHER: By NSW Health, absolutely.

CHAIR: Currently the arrangements with Corrections Health is that it is part of NSW Health. What is the problem with that? Corrections Health is an area health service, just like the Children's Hospital is an area health service. What is wrong with the current arrangements?

Dr BOETTCHER: They still have corrections officers and the atmosphere of corrections around them.

CHAIR: But they are prisoners. If they go to Prince of Wales Hospital as acute patients they are guarded by prison officers, are they not?

Dr BOETTCHER: Yes, they are.

CHAIR: So what steps have to be taken for us to reach a stage where mentally ill people and mentally ill prisoners are treated without the stigma that you are talking about?

Dr BOETTCHER: They have to be treated by NSW Health, just as they are at Bunya. We have some dangerous people at Bunya and we manage them quite adequately.

CHAIR: They are not guarded by Prisons Health?

Dr BOETTCHER: No, it is all NSW Health, as is done in other States.

CHAIR: These are people who have been sentenced?

Dr BOETTCHER: Yes.

CHAIR: I am not talking about forensic patients; I am trying to separate the two. Forensic patients and prisoners are different categories of people.

Dr GIUFFRIDA: They are all forensic patients in Bunya, except those who have come to the end of their limiting term and who have been made continued treatment patients.

CHAIR: Fair enough. I understand that. You can have a patient who is quite psychotic but who has been found guilty by the courts and sentenced to a term of imprisonment. Equally, you could have a patient who is psychotic, who is found not guilty because of mental illness and who is a forensic patient. They are separate groups of people. Currently we treat them all the same. If we change what NSW Health is planning—it intends to take forensic patients out of that—what about the care of people who are mentally ill who are in the prison system? How will we look after them?

Dr BOETTCHER: Anybody who is mentally ill, in particular the seriously mentally ill, should not be cared for by corrections officers.

CHAIR: To get to that stage we have got to intervene before they receive a sentence, which is what I am referring to. Because if we cannot intervene beforehand and they are sentenced by a court they become prisoners. That is the law. If they are going to be prisoners then they are going to be treated separately from other patients because they are prisoners, like if they have got a broken leg or they have diabetes, no difference. So how we going to intervene beforehand to get the happy Queensland situation?

Dr BOETTCHER: Queensland has changed it all.

CHAIR: Could you explain that to the Committee?

Dr BOETTCHER: It is illegal to have a mentally ill— particularly a seriously mentally ill—person in a prison.

CHAIR: Even if they are sentenced?

Dr BOETTCHER: Even if they are sentenced, they have got to be removed and placed under a special order into usually the forensic hospital. If not, then the district secure unit, but usually the forensic hospital.

CHAIR: At once they become well again they go back to prison?

Dr BOETTCHER: Yes, if the forensic psychiatrist looking after them feel that they are now able to cope back in the prison then they go back.

CHAIR: So it is not just a matter of court diversion, it is a matter of changing the law in terms of where they get looked after if they are mentally ill, whether they are a prisoner or not?

Dr BOETTCHER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your evidence you talked about a Blueglass report. We have been unable to locate this. It was mentioned in the NAP submission and the staff here were not able to find it.

Dr BOETTCHER: I have got a copy at home.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you can give us a reference we could probably find it. Where did it come from?

Dr BOETTCHER: I do not know where it came from.

CHAIR: It would have a title.

Dr BOETTCHER: I would have to have a look at it. I could certainly give you a copy.

The Hon. JOHN JOBLING: Dr Boettcher, in your opening comments you made a specific reference to a report by a Dr Barclay. Just to assist the Committee and those who might not understand or have met the good author, can you tell me a little bit about Dr Barclay to start with please?

Dr BOETTCHER: Dr William Barclay was the director of mental health when I was training and was a benign dictator and psychiatry brand very smoothly. Ever since then, after he left, things have slowly slipped.

The Hon. JOHN JOBLING: What is he doing it now?

Dr BOETTCHER: He is in private practice and he approached me at the college conference in Brisbane about four months ago and asked me if I could help him get one particular report of a patient who had left the hospital and killed his wife; he and his son, or daughter— I cannot remember which now— had killed the mother.

The Hon. JOHN JOBLING: As I understand it you indicated the report was— I think I am paraphrasing you fairly— was commissioned after there were about 11 deaths or something of that nature.

Dr BOETTCHER: That is right. He said he had sent for off at that point to the Minister, I presume, and he had nearly completed another three and he had four to do after that but he could not get the last four files at that point. He has probably got them by now.

The Hon. JOHN JOBLING: When, to the best of your knowledge, do you believe this report would have been commissioned? When would it have started?

Dr BOETTCHER: I heard about it in about February, I believe.

The Hon. JOHN JOBLING: That is February this year, I take it?

Dr BOETTCHER: Yes, a roundabout that time.

The Hon. JOHN JOBLING: A report like this sort of thing is obviously from a pretty serious inquiry. Who would be normally the person who would commission such a report? Have you any idea?

Dr BOETTCHER: The director of mental health, Dr Raphael.

The Hon. JOHN JOBLING: So Dr Raphael would in fact be the commissioning one. Over a report like that would there be any other causes that might have caused the inquiry to have been commissioned, do you think?

Dr BOETTCHER: I do not know really.

The Hon. JOHN JOBLING: Would Dr Barclay be the sole person in charge of undertaking the inquiry and report or is it the sort of report where you have multi people?

Dr BOETTCHER: It would have been a committee I would have thought from the health Department who would have requested the report from Dr Barclay because of his vast experience.

The Hon. JOHN JOBLING: Sorry I sound a bit ignorant in this field. I am just trying to come to grips with it. So a committee in mental health with the approval of the director, Dr Raphael, would go to Dr Barclay and say "We want you to look into something"?

Dr BOETTCHER: I would have thought so, yes.

The Hon. JOHN JOBLING: What sort of team would there be and how would they put together the brief for such an inquiry? Would there be a brief?

Dr BOETTCHER: The Centre for Mental Health works in a funny way. It is a bit like a Victorian court with the courtiers all floating around the outside. I would say that, at a guess, Beverley Raphael has suggested it to one of the courtiers who would have gone off and organised the committee and asked Dr Barclay to do the report.

The Hon. JOHN JOBLING: I presume it is completed at this stage to your knowledge?

Dr BOETTCHER: I would have thought so. If he had been given the files he would have completed it quite rapidly.

The Hon. JOHN JOBLING: It would not be a cheap thing to do, would it, if there are 11 cases or however many there are, it would have to be a fairly expensive little exercise?

Dr BOETTCHER: He would spend quite a lot of hours considering the seriousness of some of these murders and so forth. It would have been quite an expensive operation.

The Hon. JOHN JOBLING: Would they make an inquiry of the coroner and seek files from him, do you think?

Dr BOETTCHER: I would think he would need all the reports he could get: the police, the coroner, anything he could get his hands on for this.

The Hon. JOHN JOBLING: He would have to have some authority then to get the coroner and police to release reports to him to show that he is genuine or it is a government directive. Is that the way it works?

Dr BOETTCHER: That is right. He would need that authority.

The Hon. JOHN JOBLING: Would he do it on his own or would they establish a team to go with him?

Dr BOETTCHER: No, he would do it on his own.

The Hon. JOHN JOBLING: That would be part of his normal costed job or do you think there would have to be an allocation of funds to enable this to be pursued?

Dr BOETTCHER: It would be expensive so there may well have to be an allocation of funds for him to do it.

The Hon. JOHN JOBLING: When you say expensive what, $100,000?

Dr BOETTCHER: It could be $800 to $1,000 each, I would have thought. That is each one times 11.

The Hon. JOHN JOBLING: So we are thinking in the realm of $10,000 plus which obviously should be able to be funded somewhere in somebody's budget. If you were to look for a costing where might we commenc looking to see where the money came from?

Dr BOETTCHER: The Centre for Mental Health.

The Hon. JOHN JOBLING: It is interesting because we have heard about it but we have not been able to track it down.

Dr BOETTCHER: That is a real shame because I think it is vital.

CHAIR: The issue of suicides is another issue. We are trying to find anywhere where there is any information about people who may have suicided either whilst under care— that means whilst under a community treatment order or in an acute facility or a lower-level mental health service. Is there anywhere we could find those figures?

Dr BOETTCHER: I would have said the Centre for Mental Health would keep figures like that inevitably. I do not know what Dr Giuffrida thinks.

CHAIR: In terms of forensics do you deal with children who are forensic patients?

Dr BOETTCHER: No, I do not.

CHAIR: Is there a forensic service for children?

Dr BOETTCHER: No, there is not.

CHAIR: Do you get involved with court advice where the judge is hearing a matter, whether it is for bail or remand or whatever, and they seek advice from the court? Is that commonly done?

Dr BOETTCHER: About children?

CHAIR: About adults?

Dr BOETTCHER: Yes. I have done a lot of that sort of stuff with Dr Giuffrida.

CHAIR: At that stage the patient may be admitted or not admitted to hospital?

Dr BOETTCHER: Normally in private practice you see them but they are not often admitted to hospital at the point where you see them.

CHAIR: Say for example you see someone who is frankly psychotic and they have come out of Parramatta courthouse where they are up on remand; they have been arrested yesterday, the police have taken them off to Cumberland hospital; the doctors there did not think they were bad enough to be a committee at all they did not have any beds or whatever; they go back to the police Jail; they get taken to the magistrates the next day; the magistrate says "I want an opinion"; you give them an opinion and you think they should be admitted, what happens then? Does that happen?

Dr BOETTCHER: You would see them in prison at that point.

CHAIR: You see them in gaol?

Dr BOETTCHER: Yes.

CHAIR: They have not got to prison yet, they are just in gaol. They are in gaol before they get to remand, so you see them in the gaol?

Dr BOETTCHER: I have not done that. It has always been the in the gaol, in a remand centre.

CHAIR: So they go to their first hearing in court; they are psychotic. What happens if the police have taken them off somewhere and they would not be admitted but they are still obviously out of it?

Dr BOETTCHER: Well, privately you would have little say but you would be giving the opinion that they should be treated in the forensic hospital at Long Bay.

CHAIR: If they send them off to Bunya for an opinion from a government psychiatrist from Parramatta they would not take them out to Long Bay they would not necessarily take them to a private psychiatrist, would they?

Dr BOETTCHER: They sometimes ask for a private opinion, yes.

CHAIR: That is a visit to a remand centre. I am talking about the gaol. . I am talking about before they get to the hearing at all.

Dr GIUFFRIDA: I think the remand centre is the gaol.

CHAIR: It is the only gaol. So there are no police cells at Parramatta?

Dr GIUFFRIDA: Yes, there are police cells in the courthouse but that is not known as the remand centre.

CHAIR: When they get arrested they do not take them to a remand centre, do they? If they get arrested in the streets they go to police cells. In the police cells they are acting up. The police identified this under section 24, or 23, they take them off to Westmead hospital and they get triaged there and the mental health people say "No, not sick enough. Send them back to the gaol". They are still in the gaol before they do their presentation to the magistrates Court for malicious damage, for example. The magistrate just looks at the person and says "This guy is out of it" because magistrates are not stupid, and the police say "Yes, we took him off to Parramatta and they said he is a bit out of it but he is not sick enough to be admitted". What happens then?

Dr GIUFFRIDA: Almost invariably if it is a serious matter the person will be bail refused and will be remanded in custody.

CHAIR: Then they are taken on to Silverwater. So they are still out of it, they are psychotic, they are not bailed and they go to Silverwater. Is that where you first see them?

Dr GIUFFRIDA: Yes. They would then be triaged again by the health screening people; they would probably be seen by a mental health nurse who would make an appointment for them to see the visiting psychiatrist at the next session.

CHAIR: So here is this psychotic person who has caused malicious damage or obstruction to traffic or whatever and for the next three days after they are arrested they are then taken off to a hospital, not admitted, then they go to Silverwater where they are gaoled for three days before somebody gets around seeing them at Silverwater. How long does it take on average for somebody to see them at Silverwater?

Dr GIUFFRIDA: I could not give you the times on that. At Mullawa it would take three to ten days.

CHAIR: So for three to 10 days somebody who is psychotic is sitting out at Silverwater or Mullawa— it is a woman we are talking about, is it not?

Dr GIUFFRIDA: Yes.

CHAIR: Because you deal with forensic tests on women. So it is 7 to 10 days, they are out of it, if I can use that expression, for 10 days before anybody gets to treat them?

Dr GIUFFRIDA: At Mullawa at least they are usually seen quite quickly by the risk intervention team, or the mental health nurses acting on their own, and they have a psychiatrist on-call. They can make their own assessment and they can consult with the psychiatrist on-call and seek appropriate medication to be given.

CHAIR: They get medicated before a psychiatrist sees them?

Dr GIUFFRIDA: Yes.

CHAIR: So the psychotic woman causing obstruction screaming at traffic and picked up by the police could end up being treated, on advice over the phone, by a mental health nurse at Mulawa?

Dr GIUFFRIDA: A mental health nurse consulting with a psychiatrist, yes.

Dr BOETTCHER: If they take the medication. If they refuse medication there is a real problem.

CHAIR: If they refuse medication, so they are not scheduled at this stage and they cannot be forced to do so, what happens then?

Dr GIUFFRIDA: There is really nothing you can do.

CHAIR: Can a doctor not schedule them and send them to Bunya?

Dr GIUFFRIDA: The only way of ensuring that they have medication, if they refuse it, is to write two schedule 3 certificates. Those certificates then go to the Centre for Mental Health, to the chief health officer, who signs the orders and they become a forensic patient at that point and they can be transferred to Bunya.

CHAIR: How long does that take?

Dr GIUFFRIDA: There is a waiting list. At any one time there is usually about three to six women on the waiting list to go.

CHAIR: If this the sort of thing that should be happening in 2002?

Dr GIUFFRIDA: No.

CHAIR: What should be happening?

Dr GIUFFRIDA: We need more beds for males and females in freestanding forensic hospitals outside of prison facilities.

CHAIR: Given my scenario of the woman causing a delay in the traffic, who is approached by the police, fights with the police and is taken off to gaol, what should happen from that point, when the police have reason to believe she is off her head?

Dr GIUFFRIDA: They should be assessed as quickly as possible and there needs to be a good mental health team available and a unit within the gaol where they can be assessed by a multidisciplinary team.

CHAIR: Do you mean police cells or gaol?

Dr GIUFFRIDA: In both places. There ought to be court liaison services available in each of the local courts so that people can be diverted from courts and gaol to appropriate mental health facilities, whether that is in a hospital or in the community.

CHAIR: Would that be a forensic service or the sort of thing you would expect any mental health crisis team to assist the police to do?

Dr GIUFFRIDA: Every team should be able to do that.

CHAIR: If I am a policeman and I have a problem I should be able to ring up the mental health people and say that I have someone in the cells or in the paddy wagon and I want someone to access them because I think they are off their head?

Dr GIUFFRIDA: Yes, that ought to be the case.

CHAIR: That is not currently happening.

Dr GIUFFRIDA: There are two court liaison services that ran over the last two years, one based in the central local courts and the other at Parramatta. Certainly in the case of the central local courts that was working quite successfully. I think you have heard evidence from Dr Jonathon Carne on that and that has been a successful model. The proposal now is to set up another nine court liaison services together with a clinical nurse consultant in each of those courts, with psychiatrists on call.

The Hon. JOHN JOBLING: But you would need to access them for drug and alcohol, mental illness or a combination of both at that stage? You may have two totally different sets of assessment teams?

Dr BOETTCHER: I set up a court liaison in Townsville. They can do that. A competent nurse running it should be able to do that. If he or she is having problems, that is when the forensic psychiatrist gets called in.

The Hon. JOHN JOBLING: In New South Wales we tend to have a drug and alcohol system of assessment and then assessment by a mental health team. From what I have heard and seen I am beginning to draw the conclusion that they do not always work together. Is that a fair assessment?

Dr GIUFFRIDA: I am not sure that I would agree with that. The mental health professional should have, and usually does have, the skills and competence to assess the person in all of those respects in regard to inherent mental illness and the other complicating factors such as drugs and alcohol.

CHAIR: What happens in Sydney? We have heard evidence from police, which I have no reason to doubt, that four paddy wagons pulled up at the Caritas Centre with four patients inside each with a police officers standing beside them, either awaiting or getting an assessment. They fill in a special form for an assessment. There are no beds so they are carted off somewhere else or they are told that the patients do not need to be admitted and should go back to the cells at Bondi or where ever. The police have told us clearly that even though they think somebody is affected by drugs they are told they are not interested. The patient may be suicidal, running through the traffic, jumping off buildings or whatever but they are just told they are out of it because they have taken ecstasy, marijuana or heroin.

Dr GIUFFRIDA: The real issue, if they are mentally disordered within the meaning of the Mental Health Act—and that does not necessarily exclude drug and alcohol intoxication and the behavioural effects of that—is that everybody should be assessed on the basis of their mental disorder regardless of the aetiology of it.

CHAIR: What can we do to ensure that if someone presents in that way, that they are treated for their mental disorder or at least put in a place of protection for themselves or others, to prevent police having to drag people around the State if they are admitted or wait with four police wagons—the only ones that maybe available—with people in the back or police tied up inside the Caritas Centre waiting for someone to be assessed. Blind Freddie can tell if somebody is out of it, can they not?

Dr GIUFFRIDA: No, I think it is quite complex. It is also a question of the reality of the system. You only have so many resources available to you. If you are an admitting doctor in an admission centre and you have only two or three beds available over the weekend, you are going to narrow down or give priority to those people who are unequivocally mentally ill within the meaning of the Mental Health Act and for whom you can provide effective and rapid treatment.

CHAIR: If you are Mr Burdekin, would you agree with the statement you have just made? Do not people have a right to care if they have an illness that requires that care?

Dr GIUFFRIDA: I think all people have a right to appropriate care but it is still the reality that psychiatrists have to make decisions.

CHAIR: I am talking about someone who cannot look after themselves, who are a danger to themselves or others—they are not reasonable, rational people but they get turned away.

Dr GIUFFRIDA: I think those sorts of people ought to be admitted if they have a mental illness within the meaning of the Mental Health Act and they are a danger to themselves or others. Those people should be admitted.

The Hon. JOHN JOBLING: If you are the admitting physician on the weekend when you have only two or three beds, do you keep turning patients away until you get somebody who meets the requirement or do you admit the first three and the rest miss out? How do you make that sort of judgment with only that number of beds available?

Dr GIUFFRIDA: You do not admit everyone. It is not appropriate to admit every person who is brought into a hospital by the police on a section 24 certificate. Some people are brought into hospital who are just behaviourally disturbed as a function of their intoxication from alcohol and who may well settle down over the next few hours. If the police think that person has some associated medical condition, they can take them to the casualty department of the hospital, but I do not think it is appropriate that we try and admit everyone who develops some sort of behavioural disturbance in the community.

The Hon. JOHN JOBLING: If you get a couple in early who appear to have a condition that is both mentally and drug-related and you admit them, no matter what happens from then on, there are no beds, full stop. If someone comes in with a particular serious condition you either have to throw somebody out or decline the rest?

Dr GIUFFRIDA: What you do at the moment is ring around every other hospital in New South Wales.

CHAIR: There is a new system for that.

Dr GIUFFRIDA: That system is not working at the moment.

CHAIR: Isn't it?

Dr GIUFFRIDA: I was advised by Dr Gilhotra yesterday at a meeting of the staff of specialists at Cumberland that in his view the system was not functioning.

The Hon. JOHN JOBLING: Did he say why?

Dr GIUFFRIDA: There are all sorts of difficulties. This is the so-called bed management system.

CHAIR: Yes.

Dr GIUFFRIDA: There are various reasons why it has not been working. One is that the situation in any admission centre changes so quickly and those changes are not always posted immediately on the computer, on the surveys. By the time you look at a computer and see that there are two beds at Rozelle Hospital and you ring up and say that you want one of those two beds, you find that those two beds have been filled. There are other reasons but that is the most obvious one. The system does not work with an immediacy that is necessary for it to do so.

The Hon. JOHN JOBLING: What sort of failure rate are you likely to encounter by the inability to fill beds on a fairly regular basis? How serious is this problem?

Dr GIUFFRIDA: At the moment it is extremely serious and I would have assumed that you have been informed of that by other witnesses.

The Hon. JOHN JOBLING: We are trying to get a cross-section of views. I presume the weekends are the busiest and you have this problem?

Dr BOETTCHER: Most weekends this happens.

Dr GIUFFRIDA: Two years ago one could say that by 3.00 p.m. on a Friday afternoon there would be no beds available in Sydney or out of Sydney. Now, in the last few months, that situation is occurring almost on a daily basis.

The Hon. JOHN JOBLING: What extra numbers would be needed to overcome the problem either on weekdays or the weekend? How many do we need to alleviate the problem?

Dr GIUFFRIDA: There has been a lot work done on what is regarded as the ideal number of acute, subacute and long-stay beds for any particular community.

The Hon. JOHN JOBLING: Take the Sydney area generally as a guide?

Dr GIUFFRIDA: I think we need at least 20 acute beds per 100,000 basically and then you would need back-up long stay rehabilitation beds.

The Hon. JOHN JOBLING: How would you apply that to the other side of the sandstone curtain, the country end, with one-third of the population but huge distances? How would you structure something to meet the demands out in that area?

Dr GIUFFRIDA: I am not quite sure what you are getting at.

The Hon. JOHN JOBLING: If you are looking at 20 beds per X thousands in Sydney, how would you deal with the needs of the country areas and what would be the minimum size to make the facility functional?

Dr GIUFFRIDA: I think that anything less than 20 beds really not functional. You have to have an effective, full-time multidisciplinary team. You need at least full-time psychiatrists, full-time registrars, social worker, occupational therapist, psychologist, and to justify that number of full-time people you have to have a minimum of 20 beds.

The Hon. JOHN JOBLING: So you would need a fair number of nursing staff to back it up. Three shifts a day?

Dr GIUFFRIDA: Yes.

The Hon. JOHN JOBLING: What other staffing would you say?

Dr GIUFFRIDA: For those numbers you would need about 28 to 30 nurses available on your roster.

CHAIR: I have never been to the Caritas home but we have heard a lot of evidence about it. There must be patients in there who are just people who have decompensated from their schizophrenia and who are admitted there for a couple of weeks to be re-established on their care or whatever. In the middle of the night you are getting all these new people screaming and shouting and carrying on being admitted right through the night. You might even be woken up yourself by someone saying, "We were thinking of sending you home tomorrow at 10 but would you mind going home now at 1 a.m.?" That happens.

Dr GIUFFRIDA: I am not aware of that.

CHAIR: We have received evidence that that happens.

Dr GIUFFRIDA: I have not been aware of that happening.

CHAIR: In a city the size of Sydney should there not be a couple of acute admission places where you can take people and be certain that they will have a bed—the right sort of bed? It happens every day. It is not like a meningococcus outbreak; this is a constant feature of Sydney life. The cops could take someone there knowing that there is a team of people there who are there only to receive these sorts of people. It can then be sorted out the next day.

Dr GIUFFRIDA: We are both probably old enough to remember the old Darlinghurst reception centre.

CHAIR: Exactly.

Dr GIUFFRIDA: In the good old days—the bad old days—everyone was taken to Darlinghurst and admitted. There was guaranteed admission. You never ran out of beds. The next day they would all be bussed off to the sandstone mental hospitals along the Parramatta River.

CHAIR: That is right. Surely that sort of system would be more effective, efficient and less concerning to all the other existing patients at St George or wherever. There are mental health hospitals throughout the metropolitan area. There are acute admission centres throughout country New South Wales. The Minister has just opened new ones at Tweed Heads, Coffs Harbour and Taree. There are new admission centres all over the place. The previous Government built them all over the place too. In a 40-bed unit at Blacktown suddenly the cops roll up with somebody screaming and shouting and that means that 40 patients will be disturbed by a new admission. In court liaison terms, forensic terms, we are trying to pick these people up before they get into the gaol system, the corrections health system or the court system. The police do not want to put people in gaol who are mentally ill. They have said that to us. How can we stop people getting into the gaol system who, with their behaviour, are screaming out for mental health care?

Dr GIUFFRIDA: I am sorry, that is simply so broad a question I do not know that I could begin to answer.

CHAIR: We need a new system. The system we have now is clearly not working for anybody—for the patients who are mentally ill, for the people who are committing offences because they are mentally ill, for the police and for the community at large. We need a new paradigm. There must be paradigms elsewhere that work. I would be surprised if there are not. What we have now is not working.

Dr GIUFFRIDA: We do not want to go back to the bad old days of the Darlinghurst reception centre. We need a model of comprehensive, integrated community mental health services so that each community should have all the components of an effective mental health service.

CHAIR: So where are they now?

Dr GIUFFRIDA: Over the last 18 years we have seen the devolution of the fifth schedule hospitals. They did provide for a continuity of care in the sense that they had acute unit beds and then various ranges of accommodation on the hospital campus with rehabilitation facilities and ultimately cottage-type beds and a more domestic arrangement. We argued that when I was a member of the Barclay committee from 1988 to early 1990. The Health Department at the time provided for a whole range of accommodation in those fifth schedule hospitals. They have now become the core of the rehabilitation beds still available in New South Wales. But there are simply not enough to provide for the new chronic patients. Twenty years ago people believed somehow, naively, that we could prevent people going on to develop chronic forms of schizophrenia with all of the disability and chronicity that one would see with chronic cases. But that was not to be so. There are still people who develop very virulent forms of schizophrenia who require long stay rehabilitation services of the kind that are now only available in a few fifth schedule hospitals that still stand. And some of those are in danger of being closed.

CHAIR: So when we build all these 20-bed or 30-bed units in the country we should also be looking at step-down care for those communities as well?

Dr GIUFFRIDA: Exactly. Otherwise the acute units simply get blocked with long-stay patients waiting for a rehabilitation bed in a hospital far away. At any one time a unit might have three, four or five such people who might stay there for months on end.

CHAIR: So if they get discharged without that rehabilitation care, as they are now, and end up in the street they then become part of the gaol system and come back in as acute gaol patient. This is a problem that the police identify. This is not my view: they have said that in their view they are default mental health workers.

Dr GIUFFRIDA: And the custodial officers have become the nurses.

CHAIR: If there are no further questions on that area I would like to turn to your specific area of expertise and what is happening at Mulawa. Would you like to make an opening statement?

Dr GIUFFRIDA: Yes. I understand that I was summonsed here on the basis that I previously gave evidence to the Select Committee on the Increase in Prisoner Population, Issues Relating To Women. Dr Chesterfield Evans was a member of that committee. Certain surveys that have been done are still relevant to what I have to say today. Perhaps if I could draw out from a couple of documents, statistics that I think are still very pertinent. There are two surveys. One is the inmate health survey, which was conducted by Tony Butler for the Corrections Health Service in about 1999. There were 132 female inmates at Mulawa. An alarming number of patients were shown to be seriously mentally ill: 50 per cent of the patients surveyed stated that they had received some form of treatment or undergone assessment for an emotional or mental health problem by a psychiatrist or a psychologist at some time in their life, and 36 per cent had previously been admitted to a psychiatric unit or psychiatric hospital. That is a very interesting figure.

A little more than a third of these women had actually been in a psychiatric hospital. Fifty-four per cent stated that they had thought about suicide at some time in their life. That is a very alarming statistic when we have to assess people continually coming into the prison system with the knowledge that 50 per cent are likely to be considering suicide. If they have ever had thoughts of suicide at some time in their life then the time they are going to develop those thoughts again is when they are back in custody. Over 55 per cent of suicidal thoughts of females occurred over the previous year. So these were recent episodes. Over 10 per cent of suicidal thoughts occurred in the previous month. Approximately 30 per cent stated that thoughts of suicide had increased since incarceration, as one might expect.

Approximately 10 per cent had greatly increased suicidal thoughts since imprisonment. Thirty-nine per cent had previously attempted suicide, which I think is an extraordinary figure. Again, if you are ever going to be at risk again this is when it was going to happen: Within the first week or two of coming into gaol there is a very greatly heightened risk of attempted suicide. Twenty-three per cent had deliberately self-harmed or injured themselves at some time in the past. They represent a group of extremely disturbed women, often with severe borderline personality disorder, who often have a long history from early adolescence of cutting or slashing their arms and swallowing various objects and doing rather nasty things to themselves. Approximately half of the self-harm incidents reported occurred in the community, 40 per cent occurred in the prison. About 10 per cent had self-harmed in both of those settings.

There are a couple of things in the report of the select committee I ought to correct. It referred to the Mulawa annex as a six-bed inmate unit for patients who required more intensive nursing supervision. It has been assumed that this unit has the facilities of a hospital. I think I need to point out that there is no hospital at Mulawa. Many magistrates believe mistakenly that there is a fully fledged psychiatric hospital at Mulawa to which they can safely remand mentally ill women knowing that they will get full and proper treatment. Nothing could be further from the truth. Neither is there a medical hospital there.

CHAIR: There are no inpatient beds whatsoever?

Dr GIUFFRIDA: No. It is not an official hospital.

CHAIR: What happens to a patient who has sprained an ankle?

Dr GIUFFRIDA: Anyone who develops a medical emergency goes straight to Westmead or Auburn hospital casualty department.

CHAIR: If they are admitted to one of those hospitals they then have to be supervised by a prison officer?

Dr GIUFFRIDA: Yes.

The Hon. JOHN JOBLING: So what is at Mulawa is principally a cell with fewer sharp edges and perhaps a door through which the person can be viewed 24 hours a day?

Dr GIUFFRIDA: Women that are judged to be a risk to themselves are put in what are euphemistically called safe cells. I think the Committee has viewed some of these. They are the very last place on earth that I would place a woman who was severely depressed and who was having thoughts of suicide. This is isolation for a start. It is totally antitherapeutic.

CHAIR: But this is where they are put now?

Dr GIUFFRIDA: Yes.

The Hon. JOHN JOBLING: We saw them.

Dr GIUFFRIDA: I think that members of the Committee can come to their own conclusions.

CHAIR: Generally speaking, the Committee made the observation that the women's facilities were vastly worse than the men's facilities at Silverwater.

Dr GIUFFRIDA: Yes, as you saw for yourselves. The secure cells in the Mum Shirl Unit at Mulawa are fairly horrendous. The previous select committee certainly thought that was the case.

CHAIR: Do you want to make any further comments?

Dr GIUFFRIDA: On that report, at that time there were six forensic beds. The Committee recommended that the number increase. I did increase the number to 12 forensic beds at the Bunya unit.

CHAIR: This is the Bunya unit, which is part of Cumberland Hospital. It is not at Mulawa.

Dr GIUFFRIDA: That is where forensic acquittees were sent from gaol.

CHAIR: That is OK for Sydney. Where is there in Goulburn—

Dr GIUFFRIDA: There are no other forensic female beds in New South Wales. There are only those 12 beds at the Bunya unit at Cumberland Hospital, and previously there were only six.

CHAIR: Where else are women imprisoned in New South Wales?

Dr GIUFFRIDA: Emu Plains is the major facility. A unit of 50 something beds has opened at Berrima. I think there are 15 beds in Grafton gaol.

The Hon. JOHN JOBLING: Windsor is on the drawing board.

Dr GIUFFRIDA: Windsor is on the drawing board, and there are some beds at Broken Hill.

CHAIR: If I were a woman prisoner at Grafton where would I go if I were mentally ill?

Dr GIUFFRIDA: If you are mentally ill in Grafton they send you down to Mulawa. Anyone who is mentally ill in those other prisons is usually sent back to Mulawa.

CHAIR: What will the treatment at Mulawa offer them? Seriously, if you go to Mulawa, where is the treatment you can get at Mulawa?

Dr GIUFFRIDA: Effectively, we provide an outpatient clinic. I go there now two full days a week. Another psychiatrist goes half a day. We have a psychiatric registrar who is coming in 2½ days. So at least the psychiatrist input there is pretty good. They could see someone almost every day of the week.

The Hon. JOHN JOBLING: Between you, though, it is basically a Monday to Friday service, not a seven-day service.

Dr GIUFFRIDA: Yes, it is a Monday to Friday, daylight service, with a small team of mental health nurses who are extremely experienced, very highly skilled and greatly dedicated but small in number.

The Hon. JOHN JOBLING: So if you are going to be transferred there, it is most likely to be Monday to Friday, nine to five. If it is outside those hours, would you wait until the next Monday?

Dr GIUFFRIDA: No. You could be transferred at any time of the day or night.

The Hon. JOHN JOBLING: But it is going to be outside the psychiatric nurse. There will not be anybody there to see you; there are no specialists available.

Dr GIUFFRIDA: No.

CHAIR: Some of these psychiatric teams should be classified as nurse practitioners, should they not?

Dr GIUFFRIDA: Yes. They are certainly working in that capacity. Indeed, they are highly skilled people.

CHAIR: The guy from the forensic service at Port Macquarie who gave evidence is clearly operating as a nurse practitioner.

Dr GIUFFRIDA: Yes.

CHAIR: What is the problem with the reclassification of some senior psychiatric nurses? What is the problem with them being called nurse practitioners and operating in that relatively independent role?

Dr GIUFFRIDA: I think they come under a special Act, do they not?

CHAIR: Yes, but is there a problem from the psychiatrists' point of view for these people to be acting in this independent role?

Dr GIUFFRIDA: Not for me. I would love all of them to be classified as nurse practitioners.

CHAIR: Because that is what they actually work as, do they not?

Dr GIUFFRIDA: They do for me, yes. They are making full independent assessments of seriously mentally ill and mentally disordered women.

CHAIR: And the appropriate role for the psychiatrists is to be a consultant.

Dr GIUFFRIDA: Yes. It is more than a consultant because we do more than a consultant assess. We provide ongoing treatment.

CHAIR: Sure. What sort of support do you provide to the nurses themselves as people? Do they come to you and say, "We have a problem with this patient"? How do you look after them themselves?

Dr GIUFFRIDA: Probably mostly by providing a quick assessment service to them, being able to take the patient into treatment, recommending appropriate medication, giving advice about how they might be best managed.

CHAIR: The stress in that job must be pretty high for these professionals—

Dr GIUFFRIDA: I think so.

CHAIR: —when they see what they need and they see what they can provide. In other words, the difference between the standard that they think they should be treating them at and the standard of care that they are giving must be a huge stress for them.

Dr GIUFFRIDA: Yes.

CHAIR: How do you manage that stress?

Dr GIUFFRIDA: How do I manage it with them?

CHAIR: Yes.

Dr GIUFFRIDA: We do not have time to do anything but see and treat patients. We do not have the luxury of being able to sit down and contemplate where we are all at in terms of our own personal difficulties in coping with those situations.

CHAIR: This has been raised by other community mental health teams and the need for a consultant just for them.

Dr GIUFFRIDA: Yes.

CHAIR: Otherwise there is the burnout and the stress on the staff that then leads to lower quality care for patients and also a loss of job attractiveness and therefore a problem with recruitment.

Dr GIUFFRIDA: Yes.

CHAIR: Would a service like that be of value for recruitment or retention? I do not mean to ask that in a leading way, but it occurs to me that this is one of the great stressors.

Dr GIUFFRIDA: Yes. Ideally, you would have a comprehensive mental health assessment unit available with a multidisciplinary team. It is not enough just to have the psychiatrist and the nurses. You need a fully fledged team.

CHAIR: So there are no social workers.

Dr GIUFFRIDA: There are welfare officers on the custodial side but they do not necessarily deal with the social work type issues that we need to address.

CHAIR: These are parents of children.

Dr GIUFFRIDA: Yes. Overwhelmingly they have children.

CHAIR: So they need a social worker as much as they need a nurse, surely, to be certain that their kids are being looked after and that sort of stuff.

Dr GIUFFRIDA: Yes.

CHAIR: And occupational therapists?

Dr GIUFFRIDA: Yes and psychologists.

CHAIR: Psychologists, all of those people, and they are not part of the team at Mulawa.

Dr GIUFFRIDA: Not in health, no. There are psychologists who work for corrective services but they are in two different realms, health services—

CHAIR: That is exactly the point. Surely this is a health service, not a corrections service.

Dr GIUFFRIDA: Yes. I think there are a number of people like myself who think the clinical psychologists and psychologists should be part of the health service rather than part of the custodial service.

CHAIR: If we got what you wanted, which is a diversion process, then these people would have access to all of those services as part of NSW Health.

Dr GIUFFRIDA: Yes.

CHAIR: Why has Corrections Health, which is part of NSW Health, not seen fit to provide those same services as it would if I were a patient at Casino, Ballina or Lismore?

Dr GIUFFRIDA: I am afraid I would have to refer you to the board of Corrections Health.

CHAIR: Okay, but that is obviously a problem. Do you deal with the male patients at Silverwater?

Dr GIUFFRIDA: No, other than to do assessments for court.

CHAIR: Dr Boettcher, are you in the same position?

Dr BOETTCHER: Before I resigned I was dealing with male patients.

CHAIR: Tell us about the position of male patients at Silverwater?

Dr BOETTCHER: They get assessed by psychologists and people.

CHAIR: Are the psychologists owned by prisons health?

Dr BOETTCHER: Yes.

CHAIR: They are owned by Corrections Health.

Dr BOETTCHER: Corrections Health, yes. They are not a very happy bunch. The sort of things you were saying about the support that these people should be getting, they do not get ongoing education or the sort of things that make for a happy work force. They do their job and get out. The male patients are assessed and do have access to a number of psychiatrists who have persisted in coming there but it is very unpleasant. I got fed up with that, and so did Jonathan Khan. The atmosphere, the close downs, the lockdowns that occurred where you suddenly have no access to prisoners. These people are locked up for 16 hours I think it is in the nights. I think the women are also locked up for that period of time with no access to medical help.

CHAIR: I think it is only 12 hours for the women.

Dr GIUFFRIDA: It depends on the staffing available. If they are short of staff they get locked down.

CHAIR: Yes, but I think we were told 12. The difference between women and men was 12 versus 16. We saw a bus arrive with some people and they come in huge packets because it is a transit centre. I was impressed by the process of each of them being interviewed. But are the timing and only one person to see them to make all those judgments the problem?

Dr BOETTCHER: It is a very hit and miss affair, whether or not somebody who is psychotic is picked up. Admittedly the psychologists are pretty good picking up. The real problem occurs when somebody refuses medication and there is nothing you can do about it. You can go into any yard—I do not know if you saw them when you visited—and nearly always you can pick out psychotic patients who are not being treated. That is the real problem. What do you do with them then? When I used to see them I would make them forensic patients and put them on the waiting list for the forensic hospital at Long Bay, but often there would be 25 people on the waiting list and it may be weeks before they got over there.

CHAIR: Would the Bunya unit take them as well, or is it only for women?

Dr BOETTCHER: Bunya is not designed for acute patients; nor acute women, for that matter.

Dr GIUFFRIDA: The Bunya unit has 12 beds for women and they are usually fairly acute when they do come there. They are people who may be on the mend.

CHAIR: Are they guarded by NSW Health or by prisons health?

Dr GIUFFRIDA: It is only health. The 12 male beds are all for males from Long Bay hospital who are forensic patients who are in a rehabilitation program.

CHAIR: So they are medium security.

Dr GIUFFRIDA: Yes.

CHAIR: But they are looked after entirely by NSW Health.

Dr GIUFFRIDA: Yes. I wonder whether I can continue with the sort of submission in relation to what I raised before?

CHAIR: Yes.

Dr GIUFFRIDA: I mentioned that there were two surveys. There was a second survey done in 2000, known as the SIDI survey, which is a structured interview which was done on 169 female admissions at the time. This was very significant because it showed that there were marked indicators for psychotic illness in 13.6 per cent of the women. If we translate that into absolute numbers, it meant that there were about 40 women on this basis at any time who were likely to show evidence of a psychotic illness. I find in fact that we see between 30 and 35 women at any one time who would satisfy the criteria for the international classification of diseases or DSM4 for a diagnosis of psychotic illness, including schizophrenia. That is easily the most common diagnosis, but we also see people with bipolar affective illness, usually presenting with a manic psychosis—which I might say is often the reason why they were put in custody; as a result of their manic illness they got into trouble in the community.

We see people with psychotic depression, delusional disorder and drug-induced psychoses. That is an increasing group. The inducing agent are the rampant forms of crystal meth available in the market and the high octane cannabis or hydroponic cannabis that is readily available. There were other significant measures of serious psychiatric disorder, including a rate for the indicators of major depression of 46 per cent, which is interesting because that rather accords with the survey that was done a year or two earlier by Butler.

CHAIR: Is that in addition to the psychotics?

Dr GIUFFRIDA: They may be co-morbid. You can be psychotic and still satisfy a criteria for a major depression. So the whole population satisfied those indicators. That figure is very interesting because it also coincides with the approximately half of the population of the prison at any one time on an antidepressant or an antipsychotic drug. Again, it is a very consistent pattern between two surveys, our own survey of the use of medication and our own indicators of actual diagnosed psychotic and major depressive illness. But there is a little more, too.

In addition to those, there are a range of anxiety disorders, including panic disorder, of 10 per cent, which is very interesting because in the normal population, using the same SIDI test, it was less than 0.6 per cent of the population. Here we have a group that is hugely overrepresented for a range of anxiety disorders: 10 per cent with panic disorder, 90 per cent with generalised anxiety disorder and a very interesting group of 5.5 per cent who showed indicators for obsessional compulsive disorder. I must say that that is something that I would not have expected. You would not think that people who commit the types of crimes that get them into jail would be particularly obsessional. We tend to equate that with people who are rather anxious and inhibited, such as the compulsive hand-washers, checkers, and women who would have half a dozen showers a day, and so on. We see them as a very aberrant group compared to the general population. Serious substance abuse is rife with a rate of amphetamine use of 45 per cent. The drug that is the most likely substance to be present as a cause of drug induced psychosis is used by 45 per cent of women.

The Hon. JOHN JOBLING: That is just purely amphetamine on its own, or what percentage of that is likely to be amphetamine plus one other?

Dr GIUFFRIDA: Yes, amphetamine analogues.

The Hon. JOHN JOBLING: What about the polycocktail types of drugs?

Dr GIUFFRIDA: Yes, for example 45 per cent use amphetamines and 53 per cent used opiates. But almost all of the ones who used opiates used amphetamines, so in all these cases we are seeing polysubstance abuse. The common cocktail is of course opiates, heroine, amphetamine and its analogues, benzodiazepines and high octane cannabis. I say that because the cannabis that is being used now is far more potent than was available a few years ago.

The Hon. JOHN JOBLING: So there has been an upward trend?

Dr GIUFFRIDA: Yes. Another group which the survey did not show up but of which we see a great preponderance are women with a thoroughgoing post-traumatic stress disorder with a very intense flashback experiences. These almost always relate to childhood sexual abuse and adult sexual and physical abuse, mostly by partners. These are people who have often contained their post-traumatic stress symptoms by the use of these drugs. When they come into the gaol, suddenly they are withdrawn from all of these and they get a sudden rush back of all of their stress disorders, reliving all the experiences, terrifying nightmares and all of the reliving experiences with flashbacks during the day, and they become extremely suicidal.

CHAIR: All of these things would be evident when they go through the court process?

Dr GIUFFRIDA: Yes, very much so. It is the period while on remand that people are most disturbed. Often, once they have gone through the court process and they are sentenced, then they will settle down. It often builds up in the days prior to going back to court.

CHAIR: In Queensland, this would be exactly the time they would be diverted?

Dr GIUFFRIDA: Absolutely.

CHAIR: That would not solve a lot of problems, but it would certainly help these people a lot more rather than having people being medicated in their cells at Mulawa.

Dr GIUFFRIDA: Yes.

CHAIR: Which is effectively what is happening?

Dr GIUFFRIDA: Yes. Lastly on the statistics, much has been said about co-morbidity of psychiatric disorders. I have given you some indication of that. What we often see is not dual but triple and quadruple diagnoses. A common combination is a woman with a developmental disability or brain damage, personality disorder traits, drug abuse of a polydrug type and then ultimately presenting with a drug induced or other psychosis. A very common presentation is someone who has had several previous episodes that have been diagnosed as personality disorder and drug induced psychosis but who ultimately presents with typical characteristics of process schizophrenia; in other words, they have an inherent, underlying schizophrenic illness as opposed to merely having the drug induced form.

CHAIR: What about if somebody attempts suicide?

Dr GIUFFRIDA: The most common thing we see is women self-harming and the most common form is slashing their wrists, their arms, and their legs sometimes, and beating their head against walls. There was one case of a girl who would regularly do so to the point where she would concuss herself. We have women who repeatedly swallow objects and who have to be taken off to hospital. We have women who, not too commonly but from time to time, try to hang themselves. As indicated by the statistics, a considerable number of these people have in the community attempted suicide in a quite serious way, often by hanging, or by taking potentially lethal cocktails of drugs. Many of the believed accidental overdoses of heroine in the community were probably in fact at least in part intentional suicides.

CHAIR: While you are looking after some of this people who are not bailed, how many people who are bailed go through the same process? You have got the subset who are not allowed bail, but in women who are on bail and who have the same sorts of court appearances but for different crimes, perhaps, how many of those would have the same sort of problems?

Dr GIUFFRIDA: I am afraid I cannot tell you. I do not have any numbers on that. I do not see them.

CHAIR: So what happens if you are bailed and nobody will do an assessment of you before you go to the court?

Dr GIUFFRIDA: There is no routine for doing so, unless you are identified as needing that assessment by the participants in the court process and where there is an existing court liaison service.

CHAIR: The classic case is a woman picked up for shoplifting who has to make a court appearance. She is arrested by the police, charged and she goes to court. Many of those women will have an underlying depression or a serious mental illness.

Dr GIUFFRIDA: Yes.

CHAIR: But how does the court find that out? Is it because the solicitor gets information and presents it to the court as part of mitigation, or what?

Dr GIUFFRIDA: Commonly it is in fact the solicitors.

CHAIR: Who ask for the opinion?

Dr GIUFFRIDA: Not only ask for the opinion, but who often recognise that the person is quite ill and needs to see a psychiatrist for treatment. They are often referred to a private psychiatrist who also practises in the community health centre. Often it is a combination of treatment but, yes thank you very much, we need a report as well.

CHAIR: To what extent would a forensic service across the State for both people on remand and people not on remand be a highly expensive exercise?

Dr GIUFFRIDA: Of course it is expensive exercise—there is no way round that—but I would argue that it is cost effective because there are enormous costs in keeping people in gaol or in psychiatric hospitals or in forensic hospitals.

CHAIR: The Committee received evidence in Port Macquarie that although the Commonwealth-funded trial in Port Macquarie is now completed, the Mid North Coast Area Health Service is not only going to continue but will also put it into Coffs Harbour and Taree. That indicates to me that there must be a cost benefit or at least a quality improvement for that service.

Dr GIUFFRIDA: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One of the prison officers at Mulawa was saying that the women are a lot worse than he had ever seen them and he had been working for 25 years. He said that they had looked at the shape of the dunnies in terms of sharp edges, the bars, and the need to put in perspex doors so that the prisoners could be watched at all times, and the need to have more cells of that type than before. He also said that sometimes he had to sit there doing nothing, more or less just watching the person. His suggestion was that things are a hell of a lot worse than they have ever been. Is that right?

Dr GIUFFRIDA: Yes. There are some statistics to back that up. I understand that as of last year there has been a 66 per cent increase in the imprisonment rate of women in New South Wales over the previous five years. First of all, there is a greatly increased number. When I started in 1995 at Mulawa there were 160 women on any day, but now there are 280 or 300, so it is overcrowded. The crimes for which women are remanded in custody now seem to be more serious. It was rare to see a woman charged with armed robbery, but now I see people coming in on armed robberies all the time. There is a greatly increased incidence, as indicated by the previously mentioned polysubstance abuse. These substances are more potent. They are more likely to have medical and psychiatric complications with those substances, not the least of those being drug induced psychoses. My impression is that we are seeing a lot more disturbance in women, particularly in various forms of self-harm, but also violence between inmates in the gaol situation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I will come back to that question, but the question I was actually asking was directly related to self-harm cells, or safe cells as they call them.

Dr GIUFFRIDA: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The prison officer was saying that he had never seen anything like what happens now in his 25 years of prison work. The determination of self-harm and the degree of active despair, if you like, was greater than he had ever seen it previously.

Dr GIUFFRIDA: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you speak about the change in the degree of insistence on self-harm? Are women more depressed now than they have ever been? Is it true that a lot more of them are self-harming? Are there statistics on that? If so, can you speculate as to why?

Dr GIUFFRIDA: I have given you some statistics, but just increasing the total number of people will obviously also proportionately increase the number of self-harmers. I have indicated that we have a very consistent statistic of around 50 per cent of women coming into prison with a depression that would qualify on the criteria for a major depressive episode and a higher rate of past and current self-harm episodes. It is not surprising that one would see that there is an increase in that number.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is drug use associated with more self-harm, particularly in the drying-out phase?

Dr GIUFFRIDA: Yes, in both the intoxication and the withdrawal phase. It depends on the different types of drugs. These women often use a combination of stimulants such as amphetamine on the one hand and sedatives such as opiates and cannabis on the other hand. What often happens is that the effect of the amphetamine is longer lasting so that if they started to develop the kind of drug induced paranoid psychosis that you see with persistent amphetamine abuse, that will often continue long after they have come into gaol even though the amphetamine has been stopped. It will not have the kind of protective effect of heroin which actually works a bit like an antipsychotic. Just taking someone off heroin will bring on the psychosis or the anxiety or the depression and make it more intense.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that they were in for a lot worse types of crime and that there are a lot more armed hold-ups. It has been painted to us that the problems with women are social and that the problems of men are custodial. In other words, it is hard to keep the men in, but the women have had social problems and the ones who are in for armed robberies are generally cockatoos for their boyfriends. Is that true, or do you think they are actually doing more crimes themselves?

Dr GIUFFRIDA: It is interesting. The women that I have seen convicted of armed robberies certainly give you that story, that they were the driver or the cockatoo, as you say. But they always seem to be in a victim role in the relationship. They usually have teamed up with quite psychopathic and almost invariably violent standover boyfriends who, they say, have forced them into these sorts of activities.

Often they are dependent on those same males to supply funds for their drug use. So it becomes kind of interwoven with the partner in their crime, for a variety of reasons.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is to do with an ongoing cycle of drug abuse but also of personal abuse. Does the personal abuse relate to the increase in drugs, or have there always been people who were abused from childhood who went on to find abusers? Have the incidences of that changed?

Dr GUIFFRIDA: I am not quite sure what you are getting at.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am trying to look for reasons for the changes in the populations and the way in which they behave so that we can find some preventive strategy. We all agree that the number of drugs has increased.

Dr GUIFFRIDA: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously some people become dependent on unsavoury people because they need drugs?

Dr GUIFFRIDA: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am trying to separate them from the people who, presumably, before drug use was rife, were abused as children and who sought out abusers. Has the incidence of that changed?

Dr GUIFFRIDA: I can only say that the women I have seen in that sort of relationship have almost invariably been subject to childhood psychological, physical and sexual abuse. They have then gone on to have a series of partners who abused them in exactly the same way, and they have become abusing or dependent on various substances.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it more common?

Dr GUIFFRIDA: I guess that particular permutation associated with armed robberies is something that I did not see seven years ago but I seem to see it with great regularity now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That may be drug related. If they were abused before they did not go to gaol for armed robbery.

Dr GUIFFRIDA: Exactly, yes.

CHAIR: We heard evidence early in the piece that the most toxic people to deal with in mental health are those who have a combination of mental illness and drug abuse. Those people, who are in the acute hospitals, are the most difficult ones to deal with.

Dr BOETTCHER: Some of the most violent people I have ever seen have been on this high octane cannabis.

CHAIR: But here you are dealing with these people in a prison environment without all the other assistance that is available?

Dr GUIFFRIDA: Yes. It is even more complicated than you say because the most toxic group are those that we see quite regularly—women with dull normal intelligence, or developmentally disabled in the borderline intellectual range—who may or may not have in addition to that some past history of head injury, who have been diagnosed as having a personality disorder, or at least who have the traits of that, and often the borderline and antisocial traits. They then abuse a range of different substances and they have repeated episodes of psychosis. They then ultimately go on to a typical natural history of the development of schizophrenia. That is a monumentally difficult group.

CHAIR: How many people in Mulawa have real developmental disability [DD] and mental illness?

Dr GUIFFRIDA: I could not give you the numbers, but I think we are talking about probably five to 10.

CHAIR: What range of services are available for them?

Dr GUIFFRIDA: No facilities are available for developmentally disabled women. They tend to be just kicked in with the mad and the dangerous.

CHAIR: Is that the case in other jurisdictions, Dr Boettcher?

Dr BOETTCHER: Yes. They are a very ill-treated group in the prisons.

CHAIR: Across the world?

Dr BOETTCHER: No, not across the world.

CHAIR: In other jurisdictions?

Dr BOETTCHER: I thought you meant in the male area.

CHAIR: No.

Dr BOETTCHER: No, they are separated out. They are treated in health facilities like any other DD and they are separated out from the acute psychosis, et cetera.

CHAIR: Part of the Richmond report recommended that the developmentally disabled be separated from health?

Dr BOETTCHER: Yes. They are ill treated by prisoners and by staff.

CHAIR: Of course, that applies also to males. Is there a separate area for the developmentally disabled?

Dr BOETTCHER: At Long Bay.

Dr GIUFFRIDA: But there is nothing equivalent for the women. They are just dumped in with everyone else, which I think is grossly inappropriate.

CHAIR: It is recognised as inappropriate for men, but it is not recognised as inappropriate for women?

Dr GUIFFRIDA: That is true. They are amongst the most tragic cases that I see—seriously developmentally delayed women who have behavioural problems and perhaps intermittent psychotic episodes.

CHAIR: What happens when they leave prison? They are some of the most damaged people who then have to be picked up by a community mental health service. What happens when they are discharged? They are often on parole, are they not?

Dr GUIFFRIDA: Yes.

CHAIR: They have parole conditions to live with, they have to re-establish their lives and they have these serious mental illnesses and drug problems?

Dr GUIFFRIDA: One of the reasons why we desperately need a community forensic mental health service is that, by and large, the ordinary psychiatric hospitals do not want these sorts of people. They do not want you if you are DD, with a bit of behavioural disturbance and intermittent psychosis.

CHAIR: And many of the housing departments will not take you if you have been in prison.

Dr GUIFFRIDA: Yes. The hospitals do not want women with personality disorders, schizophrenia, and drugs. You will get 72 hours and then you will be out on your ear.

CHAIR: Would a forensic mental health service fix that?

Dr GUIFFRIDA: I think it would go some way towards fixing it. I think a forensic mental health service that sees the same sorts of people in the court system and in the gaols would have a deeper and better understanding of the difficulties that they have and, over time, it develops a skill in dealing with them.

CHAIR: One of the big issues is the revolving door issue—an issue that was established by the Standing Committee on the Increase in Prisoner Population—not just for the prison system but also for mental health services. Those who are admitted for 72 hours are back in again or they are picked up by police for acting out or whatever.

Dr GUIFFRIDA: In the prison they call them the frequent fliers. They are the people who just keep on recirculating between the mental hospitals and the gaol. They spend virtually no time free in the community. They just bounce from one service to another.

CHAIR: So then the halfway house idea, or the step-down care from prison, if you like, is equally important?

Dr GUIFFRIDA: Yes.

CHAIR: The other issue that was identified in recent legislation by the Government is the change to the Bail Act, which involved a presumption against bail for people who have offended frequently. That would impact on these women.

Dr GUIFFRIDA: Very much so.

CHAIR: One of the things that was referred to in the Attorney General's speech was the creation of bail hostels. Have you any evidence of bail hostels being set up?

Dr GUIFFRIDA: I do not know of any. They may well be. I just have no knowledge of them.

CHAIR: We held out some hope for those bail hostels. Often these women have nowhere to go. They have no fixed abode. Would that sort of supported accommodation help to keep people out of Mulawa and out of the corrections centres?

Dr GUIFFRIDA: There is no doubt that if we had a greater range of accommodation options other than being in prison or being in a mental hospital, we would do a great deal better than we are doing now. Supervised hostels in the community for this particular group of people, staffed by highly skilled and, hopefully, dedicated people, might serve to reduce the revolving door. The group of people that are probably most in need of that are this group with developmental disability, with intermittent behavioural disturbances and psychosis. I am not saying that they are easy and that they would be more easily managed in a hostel; but we would do a good deal better than we are doing at the moment.

CHAIR: That would require a major increase in funding for community mental health services, would it not?

Dr GUIFFRIDA: Yes.

Dr BOETTCHER: I supplied a service in the United Kingdom—a hostel-type arrangement like that. It was a bit of a hell hole as there were not enough staff. So there were just a whole lot of criminals mixing together and exchanging notes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They might as well do that in the community as they might in the gaol.

Dr BOETTCHER: If it was properly staffed, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Psychiatrists are leaving the system because they are unhappy with it. Is that a big problem? I have heard it said—not in evidence here—that psychiatrists are unhappy to work in Corrections Health because the culture is so antitherapeutic. Is that right?

Dr BOETTCHER: That is right. There are no facilities for training and no encouragement is given. You do your job and you get out. That is the main aim. There is just an awful feeling about it. People are not encouraged to do research or anything like that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We are really working with the wrong model.

Dr BOETTCHER: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is why they left. If Dr Guiffrida is still there he would be the last of the Mohicans. He obviously is unable to deliver the services that he would otherwise deliver? Is that right?

Dr GUIFFRIDA: My wife thinks that I am seeking a higher place in heaven.

CHAIR: You probably deserve it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If I have correctly read your submission, you want to adopt the Queensland model holus-bolus? It is an excellent model, we should simply grab it from over the border and throw it in.

Dr BOETTCHER: It works very well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that a fair summary of what we should do?

Dr BOETTCHER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Guiffrida referred earlier to personality disorders. Psychiatrists have argued over whether or not that is a psychiatric diagnosis. Some people say that you are hard-wired wrongly, it is refractory treatment and it is a judgment and not a diagnosis. Yet people in the criminal justice system tend to think it is a psychiatric disorder, and psychiatrists tend to think it is a developmental thing. What can be done for it?

Dr GUIFFRIDA: I have had wonderful discussions with Ms Lee Downes, the Superintendent at Mulawa, about this. The problem that she has is with the personality disordered people. She wants me to get all of them out the prison while I am getting the formally mentally ill schizophrenics out of prison. She says that they are no great problem, that they take their medication and that they settle down. We are not necessarily treating the personality disorder per se. If you have a borderline personality disorder, you have a many-fold increase in the incidence of a whole range of other psychiatric disorders—a whole range of panic disorder with agoraphobia, obsessional disorder, major depressive illness, substance abuse of every kind, and so on. So it is not the personality disorder by itself that we are necessarily treating; it is all these other conditions that are much more likely to be present. If you do that, if you treat these other conditions, then often the behavioural problems associated with the personality disorder become less of a problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is she distinguishing between the ones you are interested in, the schizophrenics and those with a personality disorder, who presumably have psychopathic or antisocial personalities or whatever they used to be called—the ones who spontaneously hit you because they think you are bad because you our male or whatever? In other words, they learned the wrong lesson, like a dog that always bites. Is that a fair analogy of the situation? Are they really therapeutic? Is she right in saying that you can do something about them?

Dr GIUFFRIDA: I can only go back to what I said. Personality disorders are, by nature, an enduring set of traits which are remarkably resistant to any sort of intervention but often they become less toxic if you treat their comorbid conditions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They usually have comorbid conditions? Most of them have comorbid conditions?

Dr GIUFFRIDA: Invariably.

CHAIR: We have to conclude. I thank you very much for the extended time you have given us today. Obviously this is an issue which is of great importance to mental health care in New South Wales and the changes that may need to be made. You will obviously get your *Hansard* which will take you a bit of time to wade through. If there is anything you think that we have not understood even though you have tried to make us understand, have another go at it. If there is anything you think we should have known that you did not tell us because you did not think of it at the time please let us know that and we will include that as part of your evidence. We may come back to you again when we get to the stage of writing recommendations to see whether or not we have got it all wrong or got it right. Thank you very much for your time and your expertise.

(The witnesses withdrew)

(The Committee adjourned at 4.01 p.m.)