REPORT OF PROCEEDINGS BEFORE

SELECT COMMITTEE ON MENTAL HEALTH

INQUIRY INTO MENTAL HEALTH ISSUES IN NEW SOUTH WALES

At Sydney on Friday, 14 June 2002

The Committee met at 10 a.m.

PRESENT

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

The Hon. Peter Breen
The Hon. Dr A. Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. J. Hatzistergos

ATTENDING MEMBERS

The Hon. Jan Burnswoods
The Hon. I. W. West

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IAN ANDREW BALL, President, Police Association of New South Wales, 154 Elizabeth Street, Sydney, and

SANDRA SOLDO, Researcher, Police Association of New South Wales, 154 Elizabeth Street, Sydney, sworn and examined:

CHAIR: Mr Ball, are you conversant with the terms of reference before the Committee?

Mr BALL: I am.

CHAIR: Are you happy to take submission No 254 under the name of Sandra Soldo as part of your sworn evidence?

Mr BALL: I am

CHAIR: Ms Soldo, are you conversant with the terms of reference before the Committee?

Ms SOLDO: I am

CHAIR: Are you happy to have the submission you have written for the Committee No 254 as part of your sworn evidence?

Ms SOLDO: I am.

CHAIR: If either of you consider at any stage during your evidence that, in the public interest, certain evidence or documents you may wish to present should be seen or heard only by the Committee, the Committee will be willing to accede to your request. However, you should be aware that the Legislative Council sitting as Full Council may overturn the Committee's decision and make that evidence public.

This submission, in my judgment, is a very good one. I apologise for the press release in which I said the Committee thought it was a very good submission when that was my personal view. At this stage the Committee members may agree that I should not have used their name in the press release in that way. I am aware that this submission comes from the gathering of information from a large number of people; and a number of police officers have assisted and to them I extend the Committee's thanks.

Mr Ball, would you like to make an opening statement before we ask questions?

Mr BALL: In the 25 years I have been in policing I do not think I have seen a worse situation in terms of mental health in this State. A direct result of the failure over the last 20 years of anyone to implement the Richmond Report in full has resulted in a whole range of social issues being cast upon police officers that are not police officers' roles. Worse than that, it is placing sick people in a terrible position, a position that is unacceptable to any right thinking person. Other than that I rely on our submission.

CHAIR: Ms Soldo, would you like to add to that?

Ms SOLDO: No.

CHAIR: There are recommendations at the beginning of your submission. Could we walk through some of the important issues such as de-institutionalisation? We are aware from other evidence that, certainly in the last few years, the combination of drugs and mental illness has become a significant issue with more very toxic, very violent, dangerous people out there. Is that an observation that the Police Association of New South Wales would confirm?

Mr BALL: I find the prevalence of substance abuse certainly increasing but, in terms of this Committee's discussion, I need to make very clear that we are not advocating the re-institutionalisation of

the mentally ill. That has to be clearly understood. Police officers do not have a difficulty with being first point of contact. That is quite natural. It is obvious we would be the most appropriate people to be the first point of contact, but we are finding more and more people in a situation where they are adversely affected by some sort of substance. The problem becoming more difficult to deal with is what we do with them.

CHAIR: We might come to that. The first part of your submission goes to the issue of de-institutionalisation and you say that, although the institutions were sanctuaries, they were often more like prisons.

Mr BALL: I misunderstood. If we go back many years to the wonderful places called Callan Park, Gladesville, Rydalmere and Parramatta, because I only had experience in the metropolitan area, they were awful. As a much younger person I could not comprehend why we were putting people into those institutions, they were awful. They secured them, locked them in, and there was all sorts of stuff happening. If one was cynical one would say that patients were being abused. The reality was that was not good enough, they were prisons. The problem today is we have criminalised mental health because there is nowhere else to put people.

CHAIR: You make the comment that these people stop taking their medication and sooner or later they end up this is after the institutionalisation - running foul of the law. You point out many of these people went out of the institutions and became homeless.

Mr BALL: We have so limited a resource available to us but we have to do something with these people. We have a duty of care to people. We get litigated against every day on duty of care. Here we sit. We have a problem: Where do we take people? Where do we put people? How do we care for them in some real way so that they are not out in the streets? The reality is that people are getting charged with criminal offences where really we should be applying another section to take the opportunity to deal with psychiatric illness. We cannot do that.

CHAIR: What is your understanding of the duty of care a police officer has to a person who is breaking the law and who appears to be mentally ill?

Mr BALL: First, police officers have discretion so they are entitled to take action in a criminal way or not. That is a common principle. The situation in terms of our duty of care is that once people come under our notice police cannot just take a black and white view: A criminal offence has been committed. I often think about a lady many years ago, the wife of a Minister of the Church, who walked into a shop in the western suburbs and stole an extremely expensive dinner set. It weighed about 23 kilograms. We charged her. I do not believe that anyone can forget they are carrying 23 kilograms of dinner set out the door of a shop without paying for it, but that poor woman had to be charged and prosecuted and had to create a defence because she was sick.

I do not believe she stole anything. I think she said: I need some attention, I have some problems. I had to do something. I could not take her anywhere. I was not going to put her into Parramatta Ward 22. What could I do? I am not a doctor, I am not a psychiatric nurse, I am not a mental health professional, I am a policeman. What can I do? I had to put her before the court. It became a farce really because that poor woman never got any help.

CHAIR: At page 5 of your submission you mention the memorandum of understanding between your service and other services which is the framework of how you are to interact with New South Wales Department of Health. You have some fairly strong words to say about that. What is the reality of that memorandum of understanding?

Mr BALL: It is not working.

CHAIR: Is it not working at the local level or at the highest level?

Mr BALL: The problem in the world today is that we can have heads of agreement or memoranda of understanding, but the fact is that it has to work. It has to translate at a local level; it has

to translate to the constable in the truck. Governmental heads can sit together and say: Yes, we agree to do this, this and this, but the fact is that if that is not happening, for whatever reason, at the local level then it cannot work.

We are in a situation at some places, for example, where we have people at 3 o'clock in the morning with nowhere to go. We have no place to take people. We have no help coming from the New South Wales Department of Health. We have them trying to abrogate their responsibilities. For example, with the movement of people out of secure institutions they will actually ring us and say: You go and get them. Well, hang on, these are sick people who have walked out of a secure health facility. Surely a mental health crisis team should be the first point of call. It is not, it is the police.

CHAIR: Again there is quite a fair effort - I cannot remember which page it was in your submission - dedicated to those searches.

Mr BALL: Of course.

CHAIR: Sandra, you might help us, on what page is that issue raised where you talk about the large number of call-outs that you have, searching for people who have absconded?

Ms SOLDO: Page 11.

Mr BALL: Patients leaving hospitals.

CHAIR: That is a considerable drain on your facilities, is it not?

Mr BALL: Particularly in the country. The fact is that in every 24 hour police station in this State we have first response agreements and those first response agreements are based on calls for assistance. The reality is that these jobs take us off for hours and hours and hours, which reduces our capability to respond. That is the fact of it.

CHAIR: In a country area they might be the only police that are available.

Mr BALL: Well, if we go to Bourke Police Station, there is one car on.

CHAIR: Now section 24, this where you take people to the health service because you believe that it would be beneficial to the welfare of the person who is committing or has recently committed an offence that they be dealt with in accordance with the Act rather than otherwise in accordance with the law, in other words the Mental Health Act?

Mr BALL: Yes.

CHAIR: What is your experience of taking people to Health under those circumstances?

Mr BALL: I think the submission sets out a whole range of case studies for you to consider.

CHAIR: These are the examples at the back?

Mr BALL: Sure.

CHAIR: Yes.

Mr BALL: But I will give you a couple of personal examples where I have been at a western suburbs police station where I have seen our members take to hospital people who are clearly mentally ill or clearly in a situation where they have attempted self-harm, and either our people are required to stay with them or we are told that these are behavioural issues, they are not psychiatric issues, therefore there is nothing mental health experts can do for them. That does not solve our problem because our problem is that these people are going to go back.

I was thinking about a lovely elderly lady that I once had some experience with. She was a widow and her son was mentally ill, that is a simple explanation of it. That lady could not cope. He was misbehaving to the extent where he was actually, I think, slowly wearing his mother down to death. It was clear that he had committed an offence when he put a hole in the wall of his mother's house, but he was not well, and mum did not want him charged with anything, she wanted him looked after in a proper health facility. We wheeled him off to this particular hospital.

CHAIR: Had she tried to get the crisis team?

Mr BALL: Indeed, and there was no answer. We go to the hospital and finally get the health crisis team out to him and are told that it is a behavioural issue. This is a man who had a history of psychiatric admissions. It is not behavioural; the man is sick.

CHAIR: But, when you get to the hospital, could you just walk us through the issue raised in your submission on page 8 about the length of time that you may have to wait to get an assessment under section 24.

Mr BALL: As we say, it takes between two and four hours. Now the fact is that we should not even be there. If, for example, we find a person wandering at large, then sure, we will convey them to a hospital, but that should be the end of our responsibilities. Police officers of this State should not be placed in a position where not only do they have to find them and take them to the hospital, but then have to stay with them until they are assessed. That is unacceptable. Why?

CHAIR: This is one of the nub issues of the inquiry: At what stage should there be a transfer of duty of care, which is what you identified earlier, and if you transfer that duty of care early, for example upon walking in, if the person is violent, dangerous or whatever, do you have a duty of care to look after that person until the health teams have organised some other form of protection for themselves or for the patient?

Mr BALL: I would actually argue that our responsibility should end - and I am not really fussed about the process after this, that will be a matter for other experts who quite frankly will be involved in an area of work that I have no knowledge of - when we walk in the door, fill in a section 24 notice, tell the people what the circumstances are upon which we have found this individual, and then we should leave.

CHAIR: There has been a transfer of most of the reception facilities to general hospitals, which is part of the Richmond Report, and that is rolling itself out well and many of the metropolitan hospitals now have mental health assessment teams at the emergency departments.

Mr BALL: We raise in our submission an example of two female officers secured in a room with three mentally ill male patients in a general hospital situation. That is the point we are trying to raise. You are right, the local hospital should have a secure mental health facility; it has to have more accredited people capable of dealing with it. The hospitals have to have the opportunity of being able to secure people, but they do not. In some of our hospitals we have security guards working, but they cannot look after the mentally ill, they did not find them, so what is happening is that our people are being required to stay there because you cannot leave mentally ill people who may or may not have a propensity to violence with one or two night shift hospital nurses and maybe a wardsman. That defies logic.

CHAIR: It is a matter whether the health service provides that support and that security or whether the only two police in the local area do it for four hours.

Mr BALL: Well, violence begets violence and the problem is, when police officers end up in punch-ups with mentally ill people, that is as may be, that is going to happen, but the fact is that the next time any police officer in this State has an activity with that same mentally ill person, guess what is going to happen? In fact that person is going to get into a punch-up not because they are mentally ill but because they are frightened of what is about to come, because they may get re-institutionalised, so it has that long down-the-road effect. I do not think that it is appropriate for police officers to be something special because a person who is sick is violent.

I do not like to run back all the time to anecdotes, but I have never forgotten a 17 year old boy who told a police officer he could fly and the police officer said, "I bet you can, mate", and agreed with him and agreed with him and agreed with him on everything that individual said because, quite frankly, the police officer knew no other way. He thought that that was the best way to handle that individual. The problem was, three days later, I picked him up off the car park after he had flown 17 floors straight down. Cops are not trained to deal with this. You were talking about violence. Schedule 2s are being used willy-nilly, not because people are violent but because it is the cheap option. It is cheaper to chuck someone in the back of a police truck and convey them to a facility from a local hospital than it is to have a purpose-built resourced vehicle and team to deal with a sick person.

CHAIR: If I could pursue the section 24s: It is an ordinary person in the street judgment, the discretion that you have, but if you take them to a hospital and they say, no, this person is not mentally ill, what are your options then?

Mr BALL: Well, we have probably a couple of options: (1) Do nothing and say, good, see you later; (2) if some form of offence has been committed, perhaps charge them, and again, as you have pointed out, it is a judgment issue here because sometimes there may be sufficient proof to perhaps charge somebody - it does not mean you are going to get up at court, if you know what I am saying.

CHAIR: Yes.

Mr BALL: And the third option is for the police officer to carry on and try and force people to take some other action. Of course, the fourth option is to go back to where you found them.

CHAIR: Yes. If you take them back to the police station and you charge them and you are still concerned about their care, you can access your doctor, can you not, the doctor, a local doctor, that the police have to check people going to be locked-up?

Mr BALL: No.

CHAIR: You do not have a government medical officer?

Mr BALL: No. I am sorry, certainly in the country they do. In the metropolitan area, no. If we have a person in custody who is sick or has been injured or, for example, is bleeding for whatever reason, the normal process is that you would get an ambulance and convey them to the local hospital for examination. In the country where they do not have a 24 hour hospital, for example, it is quite common that you would call out the government medical officer, but certainly not in the metropolitan area.

CHAIR: So you would have to accompany that person to the hospital?

Mr BALL: Yes.

CHAIR: And then you get tied up in the emergency department where you wait for four or five hours.

Mr BALL: Indeed.

CHAIR: But having got the doctor to see them or the hospital to see them, if the person then has a schedule 2 written by the government medical officer in a country town or in a public hospital emergency department and they say it requires police to accompany, what is your experience of taking people with schedule 2s to a hospital?

Mr BALL: Well, once you have a schedule 2, once you arrive at the designated hospital, you hand over and that is pretty much the end for us. Schedule 2 is for general admission into a psych hospital. The problem is, of course, that a lot of people walk out two days later.

CHAIR: The evidence we have received in your submission is that sometimes they say the person is not mentally ill.

Mr BALL: Okay, we go to a hospital. The doctor signs the schedule 2. We go to the psych hospital and the psych hospital then does its own assessment and says "See you later". Well, quite frankly, once we have delivered them off a schedule 2, we leave.

CHAIR: So you do not wait around?

Mr BALL: No, if we have a schedule 2 that says take him to a psychiatric hospital then we do that.

CHAIR: Jean Lennane, in her evidence to us on 31 May, talked about taking them to a psychiatric hospital. She said:

> *The police really are currently being used as de facto travelling psychiatric units because they are landed often with taking people not just to a particular unit, but around the State looking for a bed.*

In other words, you turn up at, say, Prince Alfred Hospital with a patient under schedule 2 and they say: We don't have a bed, we're on our computer right now - because there is a new computer system - we have found a place in Tamworth, please take him to Tamworth.

Mr BALL: And they have tried many times to do that. Probably the best example I have is from Eden to Kenmore, from Eden to Goulburn, where we had to change the ambulance service at this half-way spot.

CHAIR: This was in a paddy-wagon, of course?

Mr BALL: Well, no, that was done in an ambulance, which is even worse in my view because there are far more dangerous things in the back of it but, going back to your original question, we do shop around, we have to shop around, because you cannot leave sick people out in the general domain. We will shop around.

CHAIR: What do you mean by "shop around"?

Mr BALL: Find a bed.

CHAIR: You have a schedule 2 in your hand to go to St Vincent's and they say this fellow is mentally ill--

Mr BALL: Well, the schedule 2 is signed by another doctor.

CHAIR: That is countersigned then at that place.

Mr BALL: No, the schedule 2 is signed by a doctor at a facility to convey someone into a psychiatric institution. You go there and the institution then does its own assessment. Quite often they will not have beds.

CHAIR: That is the point.

Mr BALL: Yes. For example, Parramatta used to have I think 26 wards. I would stand corrected as to how many there are today, but there would not be anywhere near that. Rydalmere has gone. If Parramatta has not got a bed then you are looking at Rozelle, you are looking at a whole range of places to find a bed for someone. If they have not got a bed we cannot just leave them there and Health has not got transport facilities, so we end up having to shop around. I have to say, to be fair to the people at the institutions and certainly the staff at the institutions, they are so helpful because they understand the difficulty. In fact they are quite disturbed at the situation.

CHAIR: So you get to a place and are told: We have no beds; sure, this guy is mentally ill, we will try and find a bed, would you hang around with the person in the paddy wagon until we find a bed

and would you then cart the person off to that bed? I mean it is not handed over to them then, it is not handed over at that stage?

Mr BALL: No, and in the metropolitan area we would convey. In the situation you have outlined, off to Tamworth, we would not do that, there is no way we could do that.

CHAIR: We heard evidence recently that there used to be mental health ambulances but they do not exist any more. Do you remember those?

Mr BALL: I do not remember them specifically I might be too young for that. It is interesting when you think about this. I was at a hospital near where I live recently and I watched an ambulance come in with patients. Sitting in the ambulance bay was a patient transport vehicle used for medical people, not psychiatric people. I do not remember the old psychiatric patient ambulances, but we are advocating that; they should be staffed and available at most metropolitan hospitals.

CHAIR: When you turn up with someone and there is a need for that person to be transported around the city or the State, that should be done by a professional trained group of people rather than in the back of a paddy wagon?

Mr BALL: Exactly. I referred before to the use of violence. Let us be clear about what it means for a sick person to be in the back of a police truck and driven around this city in the middle of winter: They are prisoners. I do not apologise for the police not putting them in the front because there is far too much gear in the cabin that could present a problem. The problem is that, once people are in the back of the truck being transported around the city, the next time the police have something to deal with, what is in their head is: I end up in the back of the police truck being driven all over the countryside; so the next time they come in contact with a police officer we have a problem.

CHAIR: It is not just a couple of minutes?

Mr BALL: No, it could be hours.

The Hon. ARTHUR CHESTERFIELD-EVANS: You said there were four options when you came to this situation. It seems you are saying that the option of treating them as a mental health person is much more troublesome than charging them. If the police officer says: I will go along this mental health route, he is effectively creating a large amount of work?

Mr BALL: When you exercise your judgment not to take someone's liberty for the purposes of a court but to take their liberty for their health, it takes a bit of soul searching. When we make that decision I do not know that we create a lot of work for ourselves other than transportation issues and getting into arguments with people, with other agencies. Of course the other side is that we have also taken our operational people off the road.

The Hon. ARTHUR CHESTERFIELD-EVANS: In a sense you are making a decision that you are going to spend a lot of time trying to get treatment or help for this mentally ill person or you are giving up half a shift or however long it takes?

Mr BALL: Certainly.

The Hon. ARTHUR CHESTERFIELD-EVANS: So there is an incentive not to go along with that option? You would rather try and catch burglars or try and make society safe?

Mr BALL: I think that is probably right because you are under enormous pressure to get the jobs done. There is an enormous expectation in the community today that within one second of a phone call you are going to have the police at your front door. That is not possible. The reality is, when we are in this situation with some poor devil, we are off the road, which means we double any of our response time. In most cases on night work we have halved our response capabilities. You are right; we are off for some considerable hours.

CHAIR: For example, if the Committee were to recommend once you go to a hospital with a person then you can transfer the duty of care to the hospital, what would there be to stop abuse by the police to dump their problems on the health service? I put that because it is something we have to consider.

Mr BALL: Let us go back some years, pre-Richmond Report, where the police could well do that. Indeed I remember a famous police case where Detective Sergeant Phillip Arantz was placed into a psychiatric hospital. There was nothing wrong with him other than that he told the truth a rather interesting concept when you think about it these days.

What would stop the abuse? When you take the decision to deal with a person for whatever reason, arrest, summons, to have them treated or obtain a place to take them, you take that decision based on your circumstances. I would have thought if police started to abuse their ability rather than charge them and put them before the court that would be quickly detected in discussions between the mental health professionals and local area commanders or our external oversight bodies.

The fact is you do not just dump people in psychiatric hospitals. You form a view that people are not well and take the appropriate action. If I, as a police officer, did abuse the process because I was lazy, I am going to last about 30 seconds because the first thing that is going to happen, if a person is not sick, they are straight out the door and the problem is back at the front counter or back at the circumstance where you found it. I do not think you can say that people would abuse the process.

CHAIR: I am going to the other side. Currently you are a victim of the circumstance of health not having enough acute facilities or not being able to handle the numbers of people. What actions do you think senior police should take against New South Wales Department of Health to ensure health pays its part under the memorandum of understanding? In other words, they cut their cloth to suit the needs too. If their beds are full they say: We cannot take this person. You are then left with a mentally ill person in a police cell. What action can you take?

Mr BALL: That might be a matter for mental health professionals. The reason there are not enough beds is because it has all been cut back. You mentioned before there are facilities in many of the bigger hospitals for care. The fact is that the period in which patients are kept in those facilities is too long. If they need long term care there should be capabilities elsewhere.

You cannot keep people in a local hospital psychiatric unit for a lengthy period because the problem is still coming in the door. There needs to be a short-term, a mid-term and a long-term facility. The short-term should only be roughly 24 hours, then out of the local hospital into a proper care facility. Obviously the longer term is a matter for other people.

I have to confess I am a little reluctant to say you need to have every metropolitan hospital or every hospital in New South Wales with a psychiatric unit with X number of beds. I could not answer that.

CHAIR: A recommendation of the Richmond Report was to return care of mental health to community based facilities such as Lismore Base Hospital and so on, so mental health is mainstream rather than specialised.

Mr BALL: It went beyond that. Richmond said people can lead productive lives in the community but a "community" does not mean just a hospital, it means residential care with support facilities available full-time, places where you can ensure people continue to take their medication and, if they do not, an appropriate regime can be put in place.

CHAIR: What is your feeling about the adequacy of community mental health care facilities?

Mr BALL: I do not know the statistics but I would have a dollar that our community health capability is nowhere near sufficient and I am careful with the dollars I punt. Schizophrenia, for example, can be managed through a whole range of treatment. I am not a doctor, I am a policeman. Schizophrenia can be dealt with and people can get on with their lives if they are looked after. We can

put people into the community and make sure they lead productive lives. More importantly, forget the rest of the community, we can make sure that they can have a decent life. They are not getting that opportunity now.

I was here the other day watching the budget speech. There is a chap who comes into both Houses. He is a homeless person and I do not know if he is just homeless or sick, I have never spoken to him. I watch him all the time and I think to myself: What support network has he got? If he wants to live out in the street, that is fine. If he wants to set up a tent in the front yard here, that is all right too, but what is his support network? Is there one out there, and is there an adequate one out there? The fact is that there is not because our community health people just do not have the numbers. You have to feel sorry for those poor devils because they want to do the job.

CHAIR: If they were getting that support and they are mentally ill they go into the acute service. Say you go to a situation where there is an affray in a home and it is perfectly obvious that one of the people might be mentally ill. There are two questions: (1) How do you find out if they are mentally ill? (2) When you decide that they might be mentally ill and you call the mental crisis team because you think, well, they are not really breaking the law at the moment but you think there is obviously a need for the mental crisis team, what happens then?

Mr BALL: I will give you a real case study. The question you ask is: How do you determine someone is mentally ill? You apply the test of a reasonable person. I have walked into a particular house; an affray certainly had occurred and I have formed the view that this young man was mentally ill. I do not call the mental health crisis team because they are all fighting among themselves, so I have to convince him to come with me so that we can see if he is all right.

CHAIR: Have the people you have gone to see often themselves called the mental health crisis team before you get there?

Mr BALL: Indeed, that goes to part of your assessment. Quite often that will not have been the case. The difficult one is the first contact where you go to a job, see someone and form a view that they are mentally ill. I personally do not call the mental health crisis team into people's homes.

CHAIR: No, but have the people themselves called the crisis team?

Mr BALL: In some cases they have; in some they have not. This might be the commencement of the illness. I referred earlier to an elderly lady who had been trying to get the mental health crisis team to come out and deal with her son. She could not get them to come out. In fact she was advised to ring the police.

CHAIR: Do you believe that Health has a duty of care to people who are under care like that, where mum is looking after the person, to come when mum calls?

Mr BALL: I guess they do. We refer in our submission to the number of police shootings in this country. The last couple here in New South Wales involved mentally ill people. I think that speaks for itself.

CHAIR: There was one last Friday in Canberra.

Mr BALL: I want to make an observation about that: I do not think anyone quite realises the effect that that will have on the police officer because I will tell you now that the vast majority of police officers involved in those situations become sick themselves, because all you ever see for the rest of your life is taking someone's life.

CHAIR: I asked a question yesterday in the House of the Minister, because I knew you were coming today, about the care of police officers following such incidents. Are you comfortable with the services being provided by the service to the officers who might end up with post traumatic stress disorder following such an event?

Mr BALL: No, it is an absolute disgrace and I will tell you why. I will give you a really good comparison. You might recall some years ago there was a major bus crash on the Pacific Highway where a large number of people were killed, an absolutely awful situation.

CHAIR: The Grafton one?

Mr BALL: There were two of them.

CHAIR: Yes, Grafton and Kempsey.

Mr BALL: Yes. It is really interesting. When those situations happen, along come the counsellors, along come the various people, welfare people, and they deal with a major incident like that. In an academic study, I was talking to an investigator involved in one of those bus crashes and he said: It was really good, they came along and they spoke to me and they did this and they did that and we never saw them again. But he said: The real problem was that I had done 130-odd fatal accidents before that and I did another 100-odd before they realised that I wasn't travelling real well and the problem is I have been in the police service for 25 years and never been debriefed. Never ever been debriefed. I was moved out of an operational area into a non-operational area as a result of some personal difficulties I was having. I was not getting debriefed, I was a senior fellow at a police station with a major hospital in the area and because I was the senior fellow out on the road I got the dirty jobs. Never been debriefed.

CHAIR: As a result of the Grafton bus accident one of the policemen actually committed suicide, did he not?

Mr BALL: Grant East attempted several times and he killed himself in Brisbane, an absolute frigging indictment, and I am sorry I have used the word "frigging", I wanted to use something else. The fact is that his offsider is just as sick. Police officers in this State are not debriefed. They are not adequately cared for. Right at this minute at Westmead, for example, there is a police officer identifying the body of a deceased person, and it may well be an elderly person. I read a wonderful death notice the other day which said: Died of the effects of age. I think he was 99, a lovely old police officer who we were hoping was going to last until September and be the first one we have seen turn 100. Died of the effects of age. I often think to myself about the effect at this moment that that is having on that young constable, whoever it is, at Westmead at the moment who is identifying whoever the dead person is, whether it is an aged person, a cot death, a road accident, a murder, whatever. I often wonder what is the effect on that person when they walk out of the mortuary having done the identification for the government medical officer who is about to do the post-mortem. I wonder what is the effect on them when they walk out into the sunlight at the back of the morgue at Westmead in terms of what is going through their heads, because we do these every day. Our members do this every single day and there has never been an adequate focus in the police on looking after the welfare of the cops who have to deal with all of this stuff. It is really awful for our people and, unfortunately, we have seen much in the media and in other places of people carrying on about the amount of sickness in the police service, but let me tell you: They do not come out and do what my blokes do.

The Hon. PETER BREEN: Can I ask you a couple of questions about the link between drug abuse and mental illness? You said at the beginning of your remarks that in 25 years of policing you have not seen a worse situation than exists at the moment with regard to the mentally ill and then went on to say that there is a prevalence of substance abuse which is adding to the increased problems with regard to mental illness. Do I assume that you believe that there is a direct link between increased substance abuse and the rise in crime rates?

Mr BALL: I think it would be pretty safe and I am sure that there are more expert people than me that could tell you that a large amount of crime is directly related to particularly alcohol abuse, particularly the anti-social type crimes. I do not think it is any secret that heroin addicts, for example, are out doing break and enters every day. In fact there are people in this State, in this country, in this world, who make an enormous sum of money. Forget selling the drugs, don't worry about that just for a minute, think about the people who are doing all the receiving of all the stolen property. It is quite amazing. If I find the devil who knocked off my Whipper Snipper, I'll have him, because that was a good Whipper Snipper, but I know it has been sold for $20 in the pub down the road. It cost me a fortune.

The Hon. PETER BREEN: What if that person is apprehended and there is a question as to whether he or she is affected by drugs or is mentally ill. How do you deal with that?

Mr BALL: Again, the vast majority of the mentally ill people that you will come into contact with will not be stealing things generally, it will generally be property damage, that type of thing, and I used the example before of the lady who stole a dinner set. You form pretty quickly a view about people's state of mind at the time.

The Hon. PETER BREEN: But it can be drug-related.

Mr BALL: Of course it can.

The Hon. PETER BREEN: And once they have got over the drugs they could be okay again.

Mr BALL: Some mentally ill people are prescribed medication and they will overdose on that prescribed medication, for whatever reason. I think there is probably a link between them all, but I do not know that we - or that I certainly - can necessarily say that there is a direct link for every mentally ill person with substance abuse.

The Hon. PETER BREEN: Just before the Olympics the Government passed a law that provided for the police to detain a person who was intoxicated and the definition of "intoxicated" was extended to include people affected by drugs. Have you any experience of that legislation? Do you know whether or not the police are detaining people on the basis that they are affected by drugs, even though they might not have committed an offence?

Mr BALL: Personally I have had some experience detaining people affected by various substances, yes.

The Hon. PETER BREEN: And the same principle would apply to people who are mentally ill presumably. If they are doing something that is inherently dangerous or you believe that they are about to commit an offence--

Mr BALL: We have direct power. Section 24 gives us that power.

The Hon. PETER BREEN: Yes. Would you be in a position to say whether police officers are detaining those people, even though they have not committed an offence, in order to protect either the public or protect the people themselves?

Mr BALL: There is a great reluctance by police to put people who have not committed an offence but who are affected by particularly drink - and that is obviously the more prevalent case - into cells.

CHAIR: Because they die there, do they not?

Mr BALL: Exactly right, and having had that pleasure let me tell you it is the absolute last thing. It is really interesting: We all have a vision of the old station sergeant, the big gruff chap at the desk. He does not exist any more, they are generally much younger, but the last thing they will take into their cells is a drunk because it is just so fraught with danger for everybody. I have to say in answer to your question I have not seen a lot and I have no personal experience of having put someone into a cell who had not committed an offence who was, in my view, under the influence of a drug, other than in the case of driving under the influence of a drug.

The Hon. PETER BREEN: Could I assume that the same principle applies to someone who is mentally ill, that is, the police would be very reluctant to take them into custody if they had not committed an offence?

Mr BALL: Indeed, yes, and quite the reverse. We would do just about anything not to put them into a cell. I mean you would never put a mentally ill person into a cell who had not committed an offence. In fact if you had to, if you were placed in a situation of having someone in custody who had maybe committed an offence, you would do all you could in terms of bail.

CHAIR: When a situation arises where somebody is running in and out of traffic and they are obviously mentally ill, they have not necessarily committed an offence--

Mr BALL: Many people are delusional. With appropriate intervention and some commonsense, many of those sorts of people can be dealt with fairly expeditiously.

CHAIR: Recommendation 8 is one that I am particularly interested in teasing out a little today, if I could:

> *The Association recommends that police be provided with up-to-date and accurate information by the Department of Health in relation to mental health issues. This could take the form of a national health database for identification purposes in relation to storing and updating of an individual's name and medical history.*

We are in the process of debating the Privacy Health Records Bill in the Legislative Council. Have you had any discussions with the Privacy Commissioner about this matter as an association?

Mr BALL: No. We have had some correspondence in regard to what I view as a related issue from a policing perspective. At this very moment we cannot record or broadcast the health status of any individual. So, for example, if we know that person A has hepatitis C or has AIDS or whatever, we are not allowed to broadcast that. If my car crew has a person in custody, we cannot put that over the air.

CHAIR: But you could put over the air, for example, who should be treated with rule A precautions. Can you not do that?

Mr BALL: There is a whole range of things you could probably do, but what we have been told is we are not allowed to inquire about the health status of any individuals and we are certainly not allowed to record them. For example, when I arrest person A and person A says to me, "Get away from me, you mongrel, I've got AIDS", and I confirm later that he has in fact got AIDS, I am not allowed to record that.

CHAIR: How do you confirm that?

Mr BALL: You do it generally through families and stuff like that.

CHAIR: But you cannot access their health service record?

Mr BALL: No.

CHAIR: So you have people in your cells and you are concerned that they may have a medical history, your only recourse is to call in a doctor or take them to a hospital to get them assessed?

Mr BALL: Yes.

CHAIR: How could this database work with the current privacy laws that we have in this country?

Mr BALL: It cannot.

CHAIR: I am aware of the Canberra situation where the person was shot in the neck just last week because it was all over the news while I was in Canberra on Friday.

Mr BALL: Yes.

CHAIR: There was again a call by the police: Is this person a mentally ill person, because it would change the way in which the police went about--

Mr BALL: The other problem and the dimension that has not been thought of or you have not asked about, you probably were going to, is the transitional nature of many mentally ill people. They do not just confine themselves to one geographic area. The New South Wales system is not compatible with the Victorian system. I have to actually make some inquiries by telephone to find that out. What we are advocating is that there should be a national database where we can access information about the mentally ill. That is what we are saying. How that would work, it would require, I would imagine, quite considerable legislative change and I actually think that it would be a terribly difficulty thing to do, but it does not change our view.

The Hon. PETER BREEN: Could you envisage something along the lines of the DNA database, the CrimTrac database?

Mr BALL: Something along those lines could perhaps work. I think we just want to find something and, quite frankly, we look to this Committee and we look to many others to help us here.

The Hon. PETER BREEN: We had a problem I think just yesterday or the day before with the CrimTrac database in the Northern Territory case.

Mr BALL: Indeed, and can I tell you the really disturbing part about that: We knew there was incompatible legislation. We went to the Federal Government in November last year and let them know: Look, you've got a problem. We've got this incompatible legislation that has placed us in a position where we can't trade. We can't trade information. Nothing has been done about it. We needed overarching Federal rules to enable us all to deal with it. When DNA first came into this country the first thing out of the Police Federation was: We must ensure national consistency of legislation. It took us 100 years to get national motor traffic legislation. We told them right from the start: If you're going to use DNA, you've got to have compatible legislation. It has not happened and look at the problem it has created.

The Hon. PETER BREEN: If we do the same thing with regard to people who are mentally ill we have to get it right and it has to be consistent across the country.

CHAIR: There are agreements across the borders.

Mr BALL: Of course, but my point is, in terms of the mentally ill, we are not asking that we know the ins and outs of their illness. What we are asking is just tell us that these people have some problems so our members can be a little more aware.

CHAIR: In recommendation 11 you talk about the need to have the mental health teams able to respond in physical call-outs outside Monday to Friday. I thought they were a 24 hour service.

Mr BALL: Supposed to be. We are just asking for more - and we are not asking for more police, we are asking for the capability of sufficient mental health crisis teams to respond and to get out and do those jobs rather than be in a position where the cops have to do it as their de facto team.

CHAIR: The recommendation that cross-border transfers of the mentally ill be urgently addressed, is that a significant issue or simply a resource issue?

Mr BALL: In terms of completeness it is a significant issue because, for example, we have many towns along the Murray River and along the northern border where there are very good facilities just across the road. It is interesting, if I break my leg I will go to a hospital - it does not matter which State it is in, it does not matter if it is just across the bridge, I will go to it. I think we gave the case study in our submission of a person who was sick but we had to travel hundreds of kilometres for many hours because they had to go to a New South Wales health facility. Why?

CHAIR: I think in fact there have been quite recent regulation changes that might have dealt with that.

Mr BALL: Our group put this together a month ago. I hope it has.

CHAIR: You also look at the issue of the 000 calls where I think the record was 400 calls in one shift by an individual. You would have to be not mentally ill, you would have to be really dexterous to do that.

Mr BALL: Re-dial buttons are quite amazing. It is like the radio competitions, I do not know how anyone gets on to them. They hit the re-dial. The point though is that it does two things: It ties up very badly the 000 system, which is under great pressure. More importantly, it demonstrates that someone has a real problem and they need some help.

CHAIR: You cannot trace those people, can you, using Telstra?

Mr BALL: Yes, we can.

CHAIR: We have heard a lot of evidence about people with mental illness or depression or whatever you like calling life-lines. Do you get those sorts of calls to police stations, where somebody just wants to have a chat?

Mr BALL: I take great pride in the fact that sometimes people actually walk into a police station just to have a chat. They see it as a place of safety. Yes, you regularly have phone calls from people who just want to have a yarn. They are lonely people, they are not mentally ill, just lonely, and good police, smart police, have a chat to them.

CHAIR: Give them a cup of coffee and let them sit there and watch?

Mr BALL: Yes. If you go into most police stations now there is a television in the foyer. I actually had a family spend the night. We offered them beds, but the kids were too frightened, they thought the beds were going to be in a different part of the police station. They had a broken down car, I was not going to put the kids in the cell. Dad I was thinking about.

CHAIR: Police training is a vexed issue because there is so much for a policeman to learn in so little time. What about the issue of ongoing training in dealing with mentally ill people?

Mr BALL: There has been quite some contribution into police training in terms of mental health and that has come from a number of coronial findings. You can do all sorts of things in terms of police training. My argument is, no matter what you do, our training should be about one thing and one thing only and that is the identification of when a person is ill and to know what the process is after that. Our role is not to be treating people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You talked about the problems effectively when you were filling-in, doing jobs that the mental health system ought to be doing. Can you quantify that a little? What percentage of total police time would be taken up doing these things and how big a problem is it in the whole scale of things?

Mr BALL: I cannot quantify it. It is very dependent on a range of things: For example, your location. Some of the country locations may not see this on a regular basis. You come into the inner city and it is a very, very common occurrence. It is very hard to quantify.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would it be two per cent of police time or ten per cent of police time or how much? Could you guess?

Mr BALL: I can only guess on my personal experience and I would estimate probably one per week in the metropolitan area. How that equates into time, I am a policeman not a mathematician.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that one hour, four hours?

MR BALL: A couple of hours, two or three hours.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Two or three hours out of 40 hours is a big percentage.

Mr BALL: That is right. Like I said, I am not a mathematician.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you could not say in relation to across the State?

Mr BALL: No, I would not be game, but I suggest that it would be significant.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would that be available from police records? Do you fill in log sheets of how you spend your days?

Mr BALL: I am representing the Police Association of New South Wales, I do not have access to the police force records.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that, but, for example, many people who are working in industry say they spent three hours on this job and two hours on another job. Are those figures submitted as part of your pay data? Would this be able to be quantified? Would we be able to get that data?

Mr BALL: What you would be able to obtain from the police force is the number of mental health interventions we have had through our COPS system. You would then have to compare that to all the other incidents.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would not have the times they took?

Mr BALL: No, you cannot. From my knowledge of the system, no, you would not be able to drag times out.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Assuming I can get that, can you give me a ball park figure of how much time each intervention takes?

Mr BALL: It depends if you put them into custody; it depends if you take them to a hospital; it depends if you do nothing. If you are talking about the classic case: Turn up; mentally ill; take them to hospital, that adds up to four hours per shift.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. What is your average, in your experience, though? I mean obviously there are some where you do not do anything and some which take four hours.

Mr BALL: Sometimes you turn up and say: I told you, you get back inside, and that is the end of it. It is two minutes. Sometimes it is the whole shift. I am sorry, but I really cannot quantify that, it is just a bit hard. I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Coming back to the question of privacy and mental health, that is obviously a vexed question. Has that been taken up with the Privacy Commission at all?

Mr BALL: Not by us, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there were a lot less police involved in mental health that would take the pressure off the need for that, do you think, or would you still need it for the odd case?

Mr BALL: We have never had a difficulty being the first point of contact for people. I think that is probably important. The police are out and about dealing with responses. People commit offences; people cause self-harm. We have an emergency capability. I think we should retain that, certainly the first response capability.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure.

Mr BALL: I take on the Chair's view in terms of, well, if that was available, we would also have to be very careful about how we monitored people's performance in regard to mental health, but I would like to see us get a hell of a lot more out of it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Information?

Mr BALL: Yes. We might do 2,000, 5,000 mental health interventions in a year. I do not know how many we do, but let us assume we do 5,000. It might be only one or two that end up in people's lives being taken, but the reality is that people's lives are being taken. Police should be given information. If I go to a domestic dispute I can find out if there are firearms licensed to the premises, I can find out if people have apprehended violence orders on them and I can find out if people have criminal convictions. I can find out a whole range of things to prepare myself for how I am going to react and what resources I am going to commit, but I cannot find out - you are quite right. With mental health there is a real privacy issue, but from a police officer's perspective I think we should be able to find out. Schedule 2 is the best example I can give you. Most mentally ill people are not violent, yet we are always getting these schedule 2s because they may be violent. Well, I might be violent too.

CHAIR: But is that not just because the health service does not want to transport them, they want you to transport them?

Mr BALL: I rest my case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have been a GP in GP land and I have been called and I have written schedule 2s, so it is looking from the other side of the fence here. If you answer a call in the middle of the night to a place that is distant from a hospital, you can ring an ambulance, but if the ambulance did not come or whatever you might write a schedule 2. I have always found that ambulances come, from a practical point of view, quicker than anyone else so, if there is no violence, the ambulance is usually pretty good, but the ambulance officers are often a bit frightened, so would you do a schedule 2. Mostly, from my point of view, when I was writing schedule 2s - this is nearly 20 years ago - they said, well, write the police and we won't ring the police unless we need to and in most cases - I do not think in any of the cases where I have not rung the police they have ever been needed because the ambulance people were very reasonable about the non-violent ones.

Mr BALL: And indeed, ambulance officers have considerably more training than police officers. Ambulance services are notorious for their practical ability to implement stuff. You raised the issue of the GP writing a schedule 2. We are not suggesting for a minute-

CHAIR: They should not tick the box that says they need the police.

Mr BALL: That is the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, but when you do fill it in, if you are not going to stay in that house for however many hours it takes for the matter to get resolved and the person does not want to go, then that is the dilemma you are in. If you call the ambulance they will be standing there with you. Then the person might want to go. What do you tick then?

Mr BALL: So what you do is you tick the box so that the police can drag them out. Why? That is our whole submission. Our whole submission is that it is not for the police to turn up and be the storm-troopers and drag sick people out of houses. Let me go back to your point. Let us assume you are a GP writing out a schedule. Most people, as a first point of contact, we would help. We would help in that circumstance, of course.

CHAIR: You are often there first?

Mr BALL: I actually agree that the ambulance officers are normally first, but that is only because the police are smarter. I think the point is that, if you use the schedule 2, there has to be a real belief that people are violent. That is not the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly if they need treatment and do not want it, that does put the doctor in difficulty?

Mr BALL: Our whole submission is that the police should not be dragging them out if they do not want to go. There should be a purpose-built vehicle and suitably trained professionals to come and do whatever has to be done, not the police.

CHAIR: Can I take you to a couple of the examples at the back which are absolutely horrendous. It amazes me that you can have evidence that the mental health team are visiting somebody fortnightly to give them an injection, and I think example number 10 is the best example, where they are regularly visiting this person in his filthy hovel with no food, maggots and ants all over the place, and the police are somehow asked to accommodate and care for somebody like that rather than the mental health team who come and visit on a fortnightly basis and just walk away. Is this an unusual case?

Mr BALL: It is common. I actually think the best example in our submission is example 12. I think that demonstrates, so beautifully to me, what is wrong in the whole system. I think that is the best example in the whole submission.

CHAIR: This was the issue you were talking about, this little old lady said she did not want to go and she was violent, waving a walking stick.

Mr BALL: A 72 year old woman.

CHAIR: But the issue of duty of care is taken up by example number 10.

Mr BALL: Yes.

CHAIR: And the other example of the Aboriginal person threatening neighbours, where there is constant contact but no care?

Mr BALL: That is right. The trouble is that the police are expected to care.

CHAIR: Well, you make the point that you are the default system when everything else fails, but you are probably the least well trained in that area?

Mr BALL: That is right.

CHAIR: We will put the transcript uncorrected on to the web site when Hansard has completed it and you will get a copy, if you would like to correct that and send it back to us. If there is anything that you think we may have misunderstood or you may have misunderstood and you would like to make further submissions to us, we would be delighted to see you. We may ask you to come back or contact you again to test some recommendations we may make in the report, because we want to make recommendations which are practical and which will advance the situation.

Mr BALL: Sandra Soldo, my researcher, has done an excellent job of putting this submission together. We would be really happy to put a group together to assist, if we can, to try and get something better for these people.

CHAIR: Yes, the list of names of police officers who assisted is quite outstanding

(The witnesses withdrew)

(Short adjournment)

RODNEY THOMAS BRABIN, Registrar, Mental Health Review Tribunal, 26 Oaktree Grove, Prospect, and

MICHAEL JOHN STERRY, Lawyer, Deputy President, Mental Health Review Tribunal, 108 Louisa Road, Birchgrove, sworn and examined, and

DUNCAN CHAPPELL, Lawyer and Criminologist, President, Mental Health Review Tribunal, 20 Clifton Lane, Balmain East, affirmed and examined:

CHAIR: Professor Chappell, you have read the submission prepared by Rodney Brabin?

Professor CHAPPELL: I have.

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

Would you like to take us through the main points or do you have a presentation you would like to make?

Professor CHAPPELL: I have a presentation and opening statement I would like to make. As usual, the technology I think might be challenging us here, but I can simply speak to my notes. I have brought copies of our statement and tables.

CHAIR: We may proceed without the presentation and, if we have time, we can go through it later.

Professor CHAPPELL: Dr Pezzutti and Committee members, thank you for inviting the Mental Health Review Tribunal to testify before the Committee today. I am accompanied by Mr Michael Sterry, who has been a deputy president of the tribunal since 1990, and also by Mr Rodney Brabin, who is the registrar of the tribunal and who was appointed to this position earlier this year.

I myself only assumed office as president in April 2001. Since that time I have been seeking to initiate a substantial refurbishment of the tribunal. The need for this refurbishment was confirmed by an independent appraisal made of the operations of the tribunal in November and December of last year by Ms Ruth Cotton of Mandala Consulting. The conduct of this review was agreed between the tribunal and the Department of Health as a result of representations made by me both to the minister and to senior management of the department.

I would like to take the opportunity today, in what I very much intend to be a succinct opening presentation without the ability to show it to you on PowerPoint, to tell you about this refurbishment and provide you with more detail about the nature of the tribunal's work in both its civil and forensic jurisdictions. Before I do so, I would like to indicate my gratitude to both the minister and the department for their strong and ongoing support for the tribunal. Upon being made aware of the problems which did confront the tribunal both the minister and the department have responded in a very positive way.

The Mandala Consulting report, in its final version which was submitted to the tribunal in January of this year, noted that the tribunal was "facing a number of challenges in terms of its physical facilities, its organisational structure, its systems and processes and its financial and human resources. The tribunal has experienced an almost tripling of its workload of hearings since its first full year of operation in 1991, without any budget enhancement in direct recognition of this increase".

The tribunal has responded to these challenges and it is a time of great change in the way in which we are conducting our core business as an independent--

CHAIR: You were cutting some corners fairly dramatically, were you not?

Professor CHAPPELL: We were indeed, and I am happy to describe them but I think they are in our written submission.

I think it is important to remember that we are an independent quasi judicial body, and that, in the broad context of the protection of human rights, the tribunal is a review body of the type envisaged by the United Nations in its principles for the protection of persons with mental illness and for the improvement of mental health care. Principle 1 of those United Nations principles provides in part:

> *Any decision that, by reason of his or her mental illness, a person lacks legal capacity and any decision [made] in consequence of such incapacity ... shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law.*

I think it is also timely to recall that the United Nations principles apply as well to persons serving sentences of imprisonment for criminal offences or who are otherwise detained in the course of criminal proceedings and who are determined to have a mental illness. Principle 20 states in part:

> *All such persons should receive the best available mental health care.*

CHAIR: Does it say that they should be treated in a mental hospital?

Professor CHAPPELL: It does.

CHAIR: It says they should not actually be in prison at all?

Professor CHAPPELL: I go on to quote:

> *Domestic law may authorise a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.*

I think that is the point you are making.

A review body like the tribunal can only perform its functions, however, if it is adequately resourced. The Mandala Consulting report has made it quite clear that in recent years the tribunal has not been funded adequately and, as a result, the quality of its decision making has declined. The tribunal's ability to pay for the services of both its small full-time staff and for its much larger part-time professional membership has been constrained increasingly while its workload has been growing relentlessly. That situation has now begun to be addressed. As a result of the Mandala Consulting report, budget enhancement funds for the current financial years totalling $364,000 have been provided by the department. Negotiations are still being conducted about the level of recurrent funding which is required to permit the tribunal to operate in an effective and efficient manner.

In addition to this injection of funding, approval has now been given for the tribunal to relocate in late 2002 to new premises which are being provided within the grounds of the old Gladesville Hospital. For the first time in its comparatively short history the tribunal will have available appropriate hearing facilities in which to review cases in both its civil and forensic jurisdictions.

Change is also under way in the area of membership and staff. A new deputy president position has been created and filled and this new position is going to be of particular assistance in handling forensic patients' reviews which are required to be conducted each six months under the provisions of the mental health legislation.

A restructure is also occurring of the staff within the tribunal. There has been an upgrading of the position of registrar and two new senior team leader positions are about to be advertised and these will give new direction and momentum to both the civil and forensic operations of the tribunal. Additionally, a recruitment program is under way for the appointment of new part-time members in each

of the categories which are provided for under the Act, that is, lawyers, psychiatrists and other qualified persons.

A review of procedures for dealing with civil matters is also under way. As will be seen shortly, civil matters form by far the largest portion of the tribunal's workload.

I now turn to that workload. There are some attached graphs. Turning to what is the seventh slide, you will see in the graph that the total number of hearings conducted by the tribunal since its inception have more than trebled. In the last calendar year, 2001, a total of nearly 7,000 hearings of all types were undertaken by tribunal panels in the civil and forensic jurisdictions.

Of the civil hearings undertaken in the most recent period you will see that the largest number involved community treatment and community counselling orders, although there were also more than 2,000 reviews of involuntary patients held in various hospitals around the State.

Another important aspect of the tribunal's civil hearing load concerns the review of applications for electroconvulsive treatment therapy or ECT. There were also a number of situations in which the tribunal was asked to give consent to surgical or other involuntary medical treatment for patients who lacked the capacity to make decisions on their own behalf.

CHAIR: Is that over and above where the guardianship rules apply?

Professor CHAPPELL: Yes.

CHAIR: Because the guardianship deals with millions.

Professor CHAPPELL: Yes. We deal with only a very small proportion and often they are extremely difficult ones. I am sure the guardianship ones are too.

CHAIR: Can the guardian deal with people who are mentally ill?

Professor CHAPPELL: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is not counting the disabled ones as in intellectually, developmentally delayed, sterilisations?

Professor CHAPPELL: Yes. There might be dual diagnosis, of course, in such situations, but I think there were only something like a few over 20 of the actual surgical operations to which we had to consent and few of them were obviously ones that the Guardianship Tribunal had not had--

Mr BRABIN: The Guardianship Tribunal cannot consent to people who are under schedule in hospital. If they are in under the Mental Health Act then this Act has precedence.

CHAIR: Or forensics?

Mr BRABIN: Yes.

Professor CHAPPELL: As we have indicated in the tribunal's written submission, perhaps the most sensitive, difficult and controversial area of the tribunal's jurisdiction relates to forensic patients. There are only a comparatively small number of our overall patient load, approximately 250 at the present time, but their numbers have also been increasing at a significant rate over the life span of the tribunal, as the graph shows.

The different categories of forensic patients are also shown in the table displayed. You will see that the majority are persons who have been found not guilty on the grounds of mental illness of some type of crime. In most instances, and regrettably so, the crime is most likely to be murder or a grave assault. There are also a quite significant number of transfers from prison into hospital of persons who are found to be suffering from mental illness and who require treatment.

CHAIR: Separate from the cause and effect relationship.

Professor CHAPPELL: Yes. You can see in that year 53 were transferees and that is taking a snapshot at a particular point in time, but obviously they are a shifting population.

CHAIR: Do they disappear from your care the minute their gaol term finishes?

Professor CHAPPELL: Yes, if they are transferees.

CHAIR: But the other forensics do not?

Professor CHAPPELL: No, they do not, it is only the transferees.

Mr STERRY: And the tribunal has a power within the period of six months before the end of their sentence to make them a continued treatment patient.

CHAIR: Yes, but you cannot hold them in gaol?

Mr STERRY: No.

CHAIR: What are informal transferees?

Professor CHAPPELL: They are people who are awaiting transfer from prison to hospital and often there is a significant waiting list of people who require treatment because of acute psychoses or other mental illness and there is not a bed there for them, so while they are waiting we informally review them as required under legislation.

CHAIR: The waiting time to get into Long Bay is how long from the place at Silverwater?

Professor CHAPPELL: Into the hospital?

CHAIR: Yes.

Professor CHAPPELL: It can vary significantly and I am not in a position to say precisely, but it may take weeks, it may take a few days, it often depends upon what is assessed to be the level of unwellness or whatever of the person involved, but it can be quite a significant period.

One perhaps less well-known aspect of the tribunal's work is that relating to fitness and limiting term patients. These are patients who come under the jurisdiction of the tribunal as a result of being found unfit to be tried either by the Supreme Court or the District Court acting in their respective criminal jurisdictions. They often involve cases of significant complexity and difficulty.

CHAIR: Could I clarify that: They only get involved with you after they have been found by a court - in other words, there can be lots of people who are mentally ill sitting at Silverwater waiting for trial or going through the process, and you do not even know about them until they have actually been found not guilty or guilty by reason of mental illness, et cetera, by a court?

Professor CHAPPELL: That is so. In some instances, the nature of their mental illness may have been identified at an earlier point while they are on remand, in which case they may have been transferred into the hospital and then become a forensic patient by stint of that transfer, but there are others who we do not hear about until they are actually brought to our attention, as they are required to be, by the court after they have been found unfit to be tried.

CHAIR: So they could be, while waiting for this trial of murder, sitting at Silverwater or somewhere for two and a half years before you get to see them?

Professor CHAPPELL: It is unlikely that we would, if the person was acutely unwell, not already have them in a hospital setting and would be reviewing them as a transferee under section 97 of the Mental Health Act, but it is possible that some people are not brought to our attention until such time as the court itself finds that they are unfit.

The Hon. PETER BREEN: Professor, are these sections that are referred to, 16 and 24, sections of the Mental Health Act?

Professor CHAPPELL: That is the Mental Health (Criminal Procedure) Act, yes, and under those sections, in fitness matters, after a finding has been made by the Supreme Court or District Court - it has nothing to do with magistrates, it is only in very serious matters - of a person being unfit to be tried, the court has to refer the matter to the tribunal. We have responsibility then to decide whether they are likely to become fit within a period of 12 months and we have to notify the court to that effect. There are some other complexities that I will not go into. Once the matter goes back to the court, there may then be what is called a special hearing, with which you are probably familiar, where the attorney and Director of Public Prosecutions will determine that it is necessary to decide, on the facts available, whether or not the person who is believed to be unfit has actually committed the act that is alleged to have been committed. If it is found that they have they then set a limiting term, notional sentence as it were, and then they have to again refer it back to the tribunal and we then have responsibility under section 24 of the Mental Health (Criminal Procedure) Act to decide whether that person is suffering from a mental illness or, if not, from a mental condition which is treatable in a hospital setting. We then notify the court of our finding on those matters and it is for the court then to decide what happens to that person.

CHAIR: So they all have now a limited term?

Professor CHAPPELL: Not all, no. In fact it is a matter of discretion on the part of the attorney as to whether or not a person is in fact brought for a special hearing before a court. It may be decided, for example, to drop the charges if a person is found unfit. It will obviously depend very much upon the gravity of those charges and whether it is felt appropriate to do so.

CHAIR: How can you be not guilty by reason of mental illness and then have a limiting term put on you?

Professor CHAPPELL: This is a different situation.

CHAIR: There are two groups, one where they actually committed a crime but they are not guilty by reason of mental illness. If they are not guilty by reason of mental illness, how can they get a limited time for any order to come under your jurisdiction?

Professor CHAPPELL: There are two different circumstances. Some people are brought before the criminal justice system charged with an offence and it is determined on the basis of psychiatric evidence or whatever that they are not in fact able to defend themselves - I am talking in general terms - at whatever trial they are going to confront. It is at that stage that they may be found to be unfit to be tried. On the other hand, there are other people who are capable of briefing counsel, able to appear in the trial process and participate themselves, but who are found nonetheless not to be responsible because of their mental illness for the act with which they were charged. In those cases the verdict is not guilty on the ground of mental illness. In the other case it is simply that the person is unfit to be tried and a limiting term may or may not be set.

CHAIR: Extraordinary.

Professor CHAPPELL: It is extremely complex and I am trying to simplify it a little, but yes.

CHAIR: Phillip Arantz held in Callan Park.

Professor CHAPPELL: Yes. These are the fitness cases and, as I say, I bring it to your attention because in a sense we are acting at the level of the Supreme Court and District Court in the way

we are asked to perform this function, and it is a very important one but at the same time one which takes up a considerable amount of time even though numbers are not very large.

CHAIR: Do you deal with matters like whether a police officer is capable of appearing before the court or a royal commission for reason of mental illness?

Professor CHAPPELL: No, we do not. One thing I would like to point out to you from the table is that, in the first five months of this year, we have had 20 patients who have come under our purview under these two sections. If you look at the year before, there were only 32. We are projecting a very significant rise in the number of the cases that we are being asked to look at which are being referred by the Supreme Court and District Court.

Finally, I thought it might be of interest to show the Committee where the forensic patients are located who are the subject of review by the tribunal, again a snapshot as at 7 June. You will see that the largest number are detained at Long Bay Prison Hospital; others are in the corrections system and there are also patients held at a number of other hospitals around the State. 65 patients are under conditional release in the community.

I hope that my brief presentation has been of assistance.

CHAIR: I am astonished that mentally ill patients are being held in prison. How can we justify, in 2001, having people needing treatment for their mental illness being in a prison?

Professor CHAPPELL: I can only refer to the United Nation principles which I have mentioned and also to the national principles that have been presented for the treatment of people in the forensic system nationally - I am sure you are aware of those principles - which again indicate that people who are mentally ill should be treated in hospital.

CHAIR: Is New South Wales the only State where you find people who are mentally ill in a prison rather than a hospital?

Professor CHAPPELL: I cannot answer that question.

CHAIR: You do not talk to your mates in other States? Each State has something like the tribunal, have they not?

Professor CHAPPELL: The tribunal is unique in one sense, that we tend to deal with forensic patients when in some other jurisdictions often the forensic patients are dealt with at the level of the Supreme Court or District Court, or whatever the level of the court is, and referred back to the original sentencing judge to be reviewed. There is no common model across the country.

CHAIR: Most of the other States have a forensic psychiatric service.

Professor CHAPPELL: Yes.

CHAIR: Which we do not have in New South Wales.

Professor CHAPPELL: We do not. In our submission we have drawn the Committee's attention to the Victorian system, which we have visited and which we believe represents a good model.

CHAIR: In Long Bay Prison Hospital there simply are not 93 beds, to my knowledge.

Professor CHAPPELL: Well, I cannot speak for the precise number.

CHAIR: There are not 93.

Professor CHAPPELL: From memory, I think there are something like, I have been told, 110 beds overall in the hospital for mentally ill people, subject to correction by those who run that service, of

which, as you can see, an overwhelming proportion are occupied by forensic patients, that is 93 forensic patients there at any one time or at that time, 7 June, with a waiting list to get in.

CHAIR: Obviously on the Mental Health Review Tribunal - you are all lawyers because you have to chair the hearing - you have a large number of professional psychiatrists and community people. Have they actually gone to visit Long Bay and Silverwater?

Professor CHAPPELL: As you know, Chair, the panel that hears all reviews in the forensic arena is chaired by either the president or one of my two deputies and we also have on each panel a psychiatrist and another qualified member. Obviously all of those panel members go to Long Bay Prison Hospital and other sites where people are held to conduct hearings, so we are very familiar with the situation that faces those patients.

CHAIR: When you go out to Silverwater or Long Bay how often do you find a person simply in a lock-down situation?

Professor CHAPPELL: We see them obviously in a hearing room setting. "Hearing room" is a euphemism, I have to say; we operate in some very difficult situations. If you have time I invite you to attend one of our hearings to see how they do proceed. I think that would be quite helpful for you to understand the circumstances. They are obviously brought to us by the corrections staff or, in the case of the Long Bay Prison Hospital, by the health service people working there. We do not see them in their cells, although I have visited independently the areas where these people are held and am familiar with the conditions under which they are detained.

CHAIR: How many are at Silverwater? That is not mentioned on the list.

Professor CHAPPELL: Silverwater would be among that group of 20. I cannot answer how many of those were actually there.

CHAIR: That is the prison, but what about the remand centre where people can be held for months, years?

Professor CHAPPELL: That, I am afraid, I cannot answer without taking on notice. Of the 20 listed on that date, 7 June, I could give you a breakdown of where they actually were held.

CHAIR: Do you think that we should recommend a change of the tribunal's powers to include people who are detained rather than just sentenced?

Professor CHAPPELL: In what sense?

CHAIR: Well, a person who is in prison is imprisoned. I mean you get some people in prison because they are being detained or awaiting trial. Then you get the people you see who are declared by a court. There are a lot of other people sitting out there, waiting in prison. Do you think we should leave that to the Human Rights Commissioner or do you think we should have some supervision by an organisation like yours?

Professor CHAPPELL: We of course do, to a certain extent, have that supervision already because when a person is transferred into the mental health system, that is into the hospital section, they become a forensic patient, if they are already detained, whether on remand or actually a sentenced prisoner. The people that we do not see are the people who are mentally ill and who are receiving various forms of treatment within the correctional system from the correctional health service, but who have not been flagged for transfer into the hospital. They are not people who we see at all at this stage.

CHAIR: 53 has to be a gross underestimate from the evidence we have received so far and they are the ongoing forensics that you have, are they not?

Professor CHAPPELL: They are.

CHAIR: We are led to believe 400 is the turnover per week at Silverwater of which a large number will have mental illness. That is a large number that we are talking about, certainly not 53. We are talking about that sort of number a week that need some sort of assessment.

Professor CHAPPELL: Not all of them, of course, are people who necessarily require treatment in a hospital. If you are looking by analogy at the community, it is rather like people who are involuntary patients who are scheduled for treatment within a hospital setting and we review that as part of our function in the civil area, or people who are treated in the community. I suppose the people that you are looking at, who you are asking should we have review powers over, in a sense are in the community, but in the prison community, not the free community.

CHAIR: Where our covenants say they should not be if they are mentally ill?

Professor CHAPPELL: If they are mentally ill, they should be treated in a hospital, that is correct. They are only mentally ill within the context of the Mental Health Act and there would still have to be a determination of that nature.

The Hon. IAN WEST: That relates to slide 13, the current locations of forensic patients?

Professor CHAPPELL: It does indeed, yes.

The Hon. IAN WEST: Is Kenmore still open?

Professor CHAPPELL: Kenmore is definitely open and it has only recently become a hospital that is receiving forensic patients. It is receiving only those, though, who do not require a high level of security.

CHAIR: So they are the ultimate step-down, like Macquarie Cottages?

Professor CHAPPELL: It is not quite that because they can be held in what is a locked ward, but it is not one of the high security psychiatric hospitals for forensic patients.

CHAIR: What is the cause of the rise in the number of mentally ill people that you are seeing? This is something the police and many other people have noticed, that there has been a rise in the number of people who have mental illness who come into contact with the police service, the prison service and the court service.

Professor CHAPPELL: I can really only speak from personal observation here rather than from my role as the president of the tribunal. I think it is a reflection of a number of things. One of them certainly is the de-institutionalisation process and the fact that many people who were mentally ill and kept in institutions are now left, and properly so in my view, in the community. They also, of course, require the resources and to be able to be treated in the community, and often those resources are not available to them and they then get picked up by the criminal justice process and are put back into institutions.

CHAIR: Because they are homeless?

Professor CHAPPELL: Often homeless, often without the basic supports that allow people to function effectively in the community, whether it be social, economic, family or other.

CHAIR: When you have these 65 people out in the community, how can you be sure that they are getting the support and treatment that you order as a condition of their release? How can the people of New South Wales be sure that, when you have a forensic person in the community, that person is getting the support they need to live within the conditions that you have set?

Professor CHAPPELL: I was talking more generally.

CHAIR: I know, but I am now going in particular to the people that you should know about. How many of these 65 people who are not guilty by reason of mental illness, some for quite serious crimes - how can we be sure they those people are getting the level of support in the community that they need to live in the community, de-institutionalised from prison?

Professor CHAPPELL: They clearly are people for whom strict conditions have been set as part of the release mechanism. Those are conditions which are recommended by the tribunal and which are approved, as you are well aware, by the executive process. The responsibility for the actual delivery of the service to those forensic patients rests with the community health professionals who are attached to the various area health services.

There is undoubtedly a stigma attached to being a forensic patient and also uncertainty about the nature of their offending behaviour and anxiety about it at the level of the area health service, quite apart from the review mechanism that we have at the tribunal. I think that one of the difficulties we therefore experience is that often people in the community health system are not necessarily very happy about having to supervise forensic patients and often do not have either the training or resources to do it. It is for that reason that we believe strongly that there is a need for a Statewide forensic system, as in the Victorian system, where experts who are attached to the Statewide forensic service are able to provide support and back-up to their professional colleagues in the community with difficult patients and difficult forensic patients.

This is done on an informal basis in this State at the moment by a number of dedicated people who provide that type of back-up, advice and support, including the Tribunal. Again, we have pointed to the fact in our submission that we do not believe we have the legal authority to supervise and manage those patients in the community. That is not our responsibility, nor I think should it be, but there is a need clearly to define whose responsibility it is. I think in the long term that has to be a responsibility assumed by a Statewide forensic service.

CHAIR: Can you legitimately organise the conditional release of a forensic patient where you are not certain that the conditions can be fulfilled? In other words, would it be irresponsible of you to release somebody into the community where you are pretty sure that the community mental health services are so bad that it is not going to happen?

Professor CHAPPELL: We simply would not do that. We are aware enough of the pressures and strains that are out there in the community settings on the area health services and community health services and we would not release a forensic patient back into that community, or recommend it, unless we were satisfied that there were those services available.

Often it is extremely difficult to identify those services and in fact people will stay in detention, in one of the hospitals, awaiting the sort of service that is needed for them in the community and often because we cannot identify a suitable place for them to go.

CHAIR: Do you have a signed-off deal with the department or with the community health service before you release them?

Professor CHAPPELL: As you would with a civil patient, you would have a treatment plan. We would identify that plan, we would look at it and we would query it, if necessary. It is only after all of that has been done as part of our tribunal review mechanism that we would then recommend to the minister that a person ought to be conditionally released. Obviously there is no infallibility on any of our parts here, but I think in general, up until now, we have had a pretty good track record at large in terms of people who have been released back. Obviously there are breaches, but in most instances they are relatively minor ones and when they do occur again we have identified that often there is a quite draconian outcome that those people have to be put back into Long Bay Prison Hospital, sort of go back to "Go" and start again, and it can take a long time then for them to get back to the point where they were.

CHAIR: The reason for asking those questions in such a style is that, if you have trouble getting somebody with a CTO, who is a forensic in the community, cared for, and being certain about it,

how do you think a parent feels about their son or daughter coming out of a hospital and getting the same care and treatment in the community?

Professor CHAPPELL: I can only speak directly from the difficulty that we have with forensic patients and it is an issue obviously that needs to be addressed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that there is the odd breach, in a sense, but how confident are you when you give a CTO with a treatment plan that it is actually carried out in the long term according to that plan, that the plan actually is adhered to, resourced and carried out?

Professor CHAPPELL: Are you talking now about the forensic patients?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those 65.

Professor CHAPPELL: Yes. Well, as you know, the legislation requires us to review all forensic patients each six months, and we do that and, if necessary, we will review them more frequently. There may be an indication that a person is perhaps not complying. We may convene a special hearing and bring that person in with their case manager, we will review the situation and decide what we are going to do, but it is a matter of, I suppose, discretion as to how we do that and at the moment the tribunal is actually probably providing what might be called a de facto parole service, which we have no authority to do - legal authority, in my view - and case managers will call our forensic case manager at the tribunal or call one of us and say: We are having some difficulty here, what do you think we should do? We try and give advice and so on, but in the long term that is, in my view, a function that should be performed by a forensic service which is not simply one operating within the various area health services, but which has Statewide responsibility and Statewide expertise.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is preferable surely that you do this than that it is all rolled up in the parole model? It is fitting that the mentally ill forensic patients have a different service and a different model than the routine paroled ones?

Professor CHAPPELL: We do not want to be a parole service, nor do I think that is the appropriate way to look at it. It is the health system that we are talking about here and health monitoring. If they were in the community and on a community treatment order it would be the same sort of situation, but we are here talking not about a community treatment order, we are talking about a conditional release to which there is a lot more clout. If you breach a condition of this release you can be ordered back to hospital or you can be ordered back to comply with those conditions. If you fail you can be breached and go back, as I say, inside usually Long Bay Prison Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How effective are the CTOs? How many people go back from the CTOs? I suppose what I am trying to find out is how many people can be treated in the community even for forensic things, because obviously the number of beds versus the amount of community support in the State is one of the things this Committee has to consider and obviously, in a sense, you are a microcosm of the worst case people or dangerous case people.

Professor CHAPPELL: We are.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you can keep them in the community with CTOs being complied with then presumably that figure or better than that could be achieved by community support vis a vis the hospital systems.

Professor CHAPPELL: Well, you might I suppose say that there is probably closer supervision of the forensic patients, for obvious reasons.

CHAIR: They are not all violent, of course.

Professor CHAPPELL: They are not, no, and that is one of the things I overheard the president of the police association say. They are not. There is a presumption that they are all violent, but they are not. Obviously they have on many occasions committed very serious crimes, but once

medicated, treated, they are not violent and not a threat, and in fact probably less a threat than the untreated or people who are coming in through the civil process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have drifted off my question which was: How many of them are successfully treated through CTOs and remain not breached, the CTOs do not break down?

Professor CHAPPELL: I would say a very large proportion. The number of breaches each year is quite small. I cannot give you a precise figure at any one time, but I would say that of the community patients that we have at any one time there might be two or three who we are watching very closely and there might be a breach every two to three months, something of that nature.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is only a few percent?

Professor CHAPPELL: It is a very few percent.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So community treatment works in a high percentage, over 95 percent of cases?

Professor CHAPPELL: I would say that it is very successful.

Mr STERRY: It is a conditional release, it is not a CTO. It is an important difference because the conditional release is much stronger than a CTO. We can basically put any conditions that we want in that conditional release. In a CTO you cannot. Also one of the conditions of a conditional release order is that, if required and requested by their case manager, they will present themselves to hospital. Now in a number of cases where we are very close to a breach situation quite often we want that person assessed and assessed quickly and that is one process that we use to do that. We get them presenting back to the nearest hospital, mental hospital, and they are assessed there and we can better then assess the situation and look at the situation. In a number of cases we are not able to do that but, in the cases where we can do that, that stops a lot of people being breached and sent back in to the Long Bay Prison Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have heard about the need for more assertive treatment - I think that is the term people use - when they need an intermediate situation, I presume, between your directed treatment and CTOs; in other words, where the CTO remains not optional. You would be the model for that, would you?

CHAIR: It might help if I just confirm that a CTO is simply a community treatment order saying thou shalt take these pills on a daily basis. The sort of orders these guys can give is: Thou shalt take those pills on a daily basis; thou shalt be seen weekly; thou shalt not drink alcohol; thou shalt not smoke marijuana; thou shalt not leave this town; thou shalt not go to this place. They are much more stringent and they have a much more stringent way of following those up, so it is not the same as a CTO, nothing like a CTO.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, I understand that. I am teasing out the difference in the grading of it.

Professor CHAPPELL: The better analogy I would make I think is with the parole system really.

CHAIR: Yes, it is exactly the same as the parole system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But assertive treatment which is requested by the forensic psychiatrist is, in a sense, somewhere between a CTO and where you are, is it not, and they are asking that a State forensic service carry that out.

Professor CHAPPELL: We are talking now about people who are within the framework of the criminal justice system rather than people who are simply civil patients or--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, I think the point the forensic psychiatrists are making is that these people who have not got into the prison system or the legal system or the forensic system yet, but who are flagged as being likely to, will need more assertive treatment and effectively the system has to bite the bullet, if you like, in terms of civil rights and have what has been called assertive treatments, in other words forced compliance treatments, in order to stop other events happening, either suicides or whatever.

Professor CHAPPELL: Well, I assume that that would also be part of a court diversion program, that you would identify these people at the level of charging and decide that they were better treated through the mental health process than being put through the criminal justice system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But suicides would still be treated by that assertive system, even though they were not likely to come in touch with--

Professor CHAPPELL: Yes, and they would be even in the broader community because if they were suicidal presumably they would be able to be scheduled and then could become involuntary patients.

The Hon. IAN WEST: When you are doing a review of a breach of a CRO can you give us an indication as to whether or not, because you are assessing the breach of a person as opposed to the community's ability to support that person, there are occasions where you feel that you are providing - I would not dare say false imprisonment - accommodation for those particular people who at times you think may not have failed due to their own abilities?

Professor CHAPPELL: Well, I think that when people are conditionally discharged out into the community as forensic patients obviously we have talked about how we seek to monitor and ensure that they are succeeding in that community setting. One of the problems I think is that there are not necessarily many options that are left between, on the one hand, trying to get compliance and, on the other hand, having to get them back into, let us say, Long Bay Prison Hospital. There are not enough stepping stones on the way. It might be much better perhaps to get them into supported accommodation or into a group home or something of that nature. Often it is extremely difficult to find that sort of facility and someone that is going to take a forensic patient in that circumstance. Here community safety often prevails over what might be in the best interests of the individual and we always have to weigh that up and we might decide that, in the best interests of community safety, unfortunately that person has to go back into this maximum security setting. Now hopefully at some point when we do have new hospital and other forensic facilities, which we understand may well take place soon, that situation might change.

CHAIR: Five years.

Professor CHAPPELL: At the moment it is unfortunate that so often people have to go back into Long Bay as the only option.

The Hon. IAN WEST: Are you able to give us a very rough estimate as to percentages of people you find in that sort of situation?

Professor CHAPPELL: Well, I think I said earlier that it is a very small percentage that actually do get breached and sent back. I would say overall it is probably somewhere in the five percent range, something of that nature, indeed one of the things that I think should reassure the community that forensic patients, once they do get identified and treated, have a high success rate in terms of rehabilitation. Obviously some will have to be kept in very secure facilities for a very long time. Some people will probably be there for the rest of their lives, unfortunately, but overall the rate of recidivism is low.

CHAIR: I am glad that issue has been raised because the single biggest issue that I think we have identified is the failure to provide rehabilitation - not just accommodation, but socialisation, education, employment - for people who have been de-institutionalised, for people who are mentally ill, the young person of 17, 18 or 19 who has schizophrenia who goes through the whole process. Because of the failure of that, on the evidence we have so far, they end up committing crimes. Is that one of the

reasons - without putting words into your mouth - that there has been a rise in the number of people you are seeing, as a criminologist?

Professor CHAPPELL: I think that is undoubtedly the case, and there is obviously a strong correlation between criminal offending and socioeconomic conditions and circumstances, which includes mental illness and other things you have referred to.

CHAIR: What about adding to that picture the toxicity of illicit drugs and/or alcohol?

Professor CHAPPELL: That is something certainly we have not talked about up to this point. There is no doubt that the so-called dual diagnosis of mental illness and illicit drug use is pretty lethal.

CHAIR: Or even alcohol.

Professor CHAPPELL: Yes, it can often be a lethal combination. I will not go into the issue which is cause and effect, but I believe there is significant evidence now that increasing numbers of people are coming in to the criminal justice system who have significant drug problems as well as a mental illness. They represent a very difficult challenge for treating and, in the longer term, rehabilitation.

CHAIR: Dr Jean Lennane spoke to us about drug and alcohol issues because that is now separated from mental health and it was in the 1980s. She said that you are much more likely to be hurt, killed or murdered by someone who is mentally ill today than you were 20 years ago when community based mental health services were better. Is she right or wrong?

Professor CHAPPELL: That is a research question, but my general answer, I would have to say as a criminologist, one of the things that gives you a measure of the gravity of incidents committed by people with mental illness is the homicide rate. If you look at the homicide statistics nationally, which have been monitored for over a decade by the Australian Institute of Criminology of which I used to be director they show that there is no apparent variation in the number of people coming into the homicide statistics who are mentally ill or identified as being mentally ill over that time frame, so I would have to question whether or not her statement is correct.

CHAIR: I am going to tell you a brief story. There was a family down the road from us at Richmond Hill in 1983 who decided to sell their property. Their son was released from Morisset where he had been held for five years as a forensic patient for serious assault while mentally ill. He was released to the parents and he came home to find the parents were selling their farm, because they were elderly, to move into a house. He caused a major ruckus with the developers, threatening them with a crowbar and so on while he was on conditional release. The mental health team came; the mental health team went away. They had their house built across the road from us. We had three children, my wife pregnant with our fourth. The old man came down the hill: You two are doctors - my wife and I are both doctors - you have to do something about our son who is causing my wife a great deal of harm.

My wife rang the mental health team. They came out, the police came, took him away and then released him after giving him his Modecate - he was not taking his medication - and a couple of days after Christmas he stabbed his parents to death and shot himself. They are not the only two, there are two others from the northern rivers. There was the lady who caused trouble on the Concorde and the other two murders at Byron Bay. These are in my vivid memory from Lismore. That was before the Mental Health Review Tribunal came into existence, but the same system held of careful consideration, back-up teams and so on. That was 20 years ago. Is it different today?

Professor CHAPPELL: Those are tragic circumstances you describe and you have personally experienced. I could tell you one or two personal stories myself, but by focusing on individual cases you can distort the situation, I am afraid. I again come back to the homicide monitoring program. It shows the rate of homicide in this country over the last decade or more has been relatively stable; it has not been going up and down. The proportion of people who are mentally ill in those statistics is relatively stable as well. How many of those who turn up are repeat offenders, I cannot answer. Every now and then someone does re-offend, but overall the track record is good in terms of handling forensic patients both

within the system and outside as far as recidivism rates are concerned. I do not see that as a significant risk issue.

Mr STERRY: Can I say that 20 years ago, in 1983, that would have been a release on licence system, which is basically done on the recommendation of the medical superintendent.

CHAIR: A good Salvation Army man.

Mr STERRY: Well, yes, I think we both know who that was. These days, of course, they would come through the tribunal and be part of the evidence that the tribunal would review. Health care agencies have been set up under the 1990 Act and they did not exist before.

CHAIR: That is true.

Mr STERRY: Because we have had forensic patients on conditional release in the system for the last ten years, there is much more expertise in the area generally regarding forensic patients than there was before.

The Hon. PETER BREEN: Professor Chappell, I want to clarify the description or definition of forensic patient, if I may. I think you indicated that a person already detained, whether on remand or sentenced, and referred to a mental hospital becomes a forensic patient within the prison system. My concern is that the numbers are extraordinarily small: 247 against a prisoner population of around 8,000. There has been evidence to the Select Committee on Prisoner Population from the Department of Corrective Services that 13 per cent of all prison inmates have intellectual disability, 21 per cent have attempted suicide and 40 percent meet the diagnosis of personality disorder. I cannot understand the disparity in those figures between people who are identified as suffering from mental illness and those that are classified as forensic patients.

Professor CHAPPELL: Yes, I suppose the core number in terms of your question are the ones who have been transferred in to Long Bay Prison Hospital from the existing prison setting where they have been identified as having a mental illness. Not just that, though, but they are people who require treatment for mental illness within a hospital setting.

The best analogy I can give is if you are someone who is mentally ill in the community it may be decided that you can continue to be quite adequately medicated or treated in whatever way in the community without having to be put into a hospital either voluntarily in involuntarily. The people we are now talking about being transferred out of the prison system into the health system or Long Bay Prison Hospital are people who are acutely unwell and who really can only be dealt with in that hospital setting and have to have constant supervision and medication, as they would if they were in the community, they would also be in a mental hospital.

The Hon. PETER BREEN: So if an inmate who was not classified as a forensic patient, for example, had a psychotic episode and was treated by prison staff who are not trained to deal with mental illness, the person's illness has not been identified in the prison system, on anecdotal information that person would be placed in solitary confinement until they got over their psychotic episode. Do you have any evidence to suggest that that is how people are dealt with who are not classified as forensic patients?

Professor CHAPPELL: No direct evidence, no. All I think I can say to that is that there is a waiting list for people to get into the Long Bay Prison Hospital and that it can be a significant waiting list. That means people who are presumably identified as being acutely unwell and need treatment in a hospital setting for that illness.

The Hon. PETER BREEN: Given the numbers that I gave earlier, there must be a huge number of people throughout New South Wales in prisons other than the Long Bay prison complex who do suffer mental illness and who are not being properly treated. Would you agree with that?

Professor CHAPPELL: I cannot talk about whether or not they are being properly treated. All I can say is that there are obviously a large number of people within the correctional system who are

mentally ill in varying ways. I think that is uncontroverted. The question of whether or not they should be treated in a hospital like Long Bay Prison Hospital is something that has to be determined by assessment of those people based on whatever correctional health service assessment mechanisms are in place. As a result of those assessments there are, as you can see as at 7 June, 20 people in the general prison population who were identified as needing hospital treatment. I cannot really go beyond that, I do not know what else is happening out there.

Mr STERRY: Correctional health services staff, as I understand it, are present in the majority of prisons, if not all prisons. They have both psychiatrists and nurses who are on call and available in situations like that and who can treat that person, with their consent, in relation to giving them medication and anything that is appropriate. Obviously, if they feel that they are in a situation where they are not consenting and they do need urgent treatment, then there is the schedule 3 process through the Mental Health Act which will then put them on line for transfer to Long Bay Prison Hospital, or Cumberland if it is a female.

CHAIR: What the question is going to is, if they are mentally ill, they should be in a mentally ill place, not in a prison with mental illness treatment.

Professor CHAPPELL: I do not disagree with that, but I am just saying what is happening.

CHAIR: That is not what should happen.

The Hon. PETER BREEN: The Chair is partly right. What I was really leading up to was the point at which those people begin to appear in your statistics and it seems to me that that is such an extraordinarily low number that there ought to be a better way of classifying prisoners who do suffer mental illness, who have not been described as forensic patients but are in a category which separates them from the rest of the prison population and identifies them as being at risk. Do you have any idea about how that might be done and whether it would achieve any desirable outcome?

Professor CHAPPELL: I think that we can only say in general terms that we recognise that there are a large number of people within the correctional system who are suffering from mental illness who require treatment for that illness. It may not be necessary to treat them in a hospital setting. It could be, as my colleague, Mr Sterry, has indicated, quite possible for them to be treated in the general prison population. I suppose in an ideal world you might say that they all ought to be in hospital rather than prison, but I suppose also there are a certain number of people who unfortunately will have to continue to be detained in prison and treated in that context.

The risk is that the people who are acutely unwell are still not able to get into treatment mechanisms and there may be situations where it is decided that, because there is such a long waiting list, they will just try and do their best in the general prison population, not scheduling them and waiting for transfer in to the hospital but treating them nonetheless in that population. They are I think the people who need to be identified and there should be facilities available for them, and I think there need to be more facilities than we have at present.

I am reminded by the registrar that the situation is particularly acute in terms of women. Women have to put up with gross conditions. I am on a committee which is reviewing the Mum Shirl unit at Mulawa and that is where a lot of acutely unwell women are at the moment held, receiving treatment, who should be in a hospital. I think that women are in a particularly bad situation.

The Hon. PETER BREEN: In that context, the Select Committee on the Increase in Prisoner Population was informed by the Department of Corrective Services that 39 per cent of the female prisoner population had previously attempted suicide; 23 percent are on psychiatric medication and a staggering 73 percent have been admitted to psychiatric or mental health units. I have to make the point these people ought to be classified in some way to cover this huge gulf that exists between the prison population generally and this extraordinarily low figure of 247 forensic patients. Do you agree with that?

Professor CHAPPELL: I do agree, yes.

The Hon. PETER BREEN: I spend quite a lot of time at Goulburn Correctional Centre and I notice that patients who suffer from other kinds of illness, physical ailments, are treated very well: They have little bags of pills that they are distributed; the staff generally - medical staff and prison staff - ask about their health, "Have you taken your pills" and this sort of thing. If you have a physical illness it seems that you are very well looked after in prison. If you have a mental illness, you are not looked after at all.

Professor CHAPPELL: I would not say that is the case, but I think certainly there is a need for many more resources to be devoted to providing the sort of treatment required for people who are acutely unwell within the correctional system and who are mentally ill.

CHAIR: There is a revolving door of mentally ill people who go in and out of prison, they go out of prison into homelessness, they are picked up by the police and go back into prison, this revolving process that has about a yearly cycle. What about all those people? You do not go anywhere near any of them.

Professor CHAPPELL: We do not, we do not see those. They are the shorter term stay people.

CHAIR: It would be good if they could commit something really decent because then they would come under your care. If they really committed a decent crime rather than petty crime, like throwing bricks through windows or causing an affray or running up and down the street naked or something, then they go in and out of the prison system, but if they did something really decent they would get proper care, would they not?

Professor CHAPPELL: Well, there are some people, and again coming back to women we see, I think many of the women have committed relatively minor offences and they are on that revolving door and they are identified as being mentally ill in some cases and we therefore do see them. Getting them off that treadmill and putting them into some decent care situations is extremely difficult, but they should not be dealt with in the prison system, they should be dealt with elsewhere.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You obviously have some difference of opinion with regard to the prison system. How many people do you think should be released or you recommend to be released that are not released? Are your recommendations always acted upon and, if not, why not and who intervenes?

Professor CHAPPELL: As you indicate, we recommend only so far as the forensic patient status is concerned to the minister and we are obliged to give written reasons, which we do, for our decisions. There are a proportion of cases, and we do something like between 500 and 600 reviews a year, I think the last figures I saw suggested that in about 20 matters last year there were requests made of the legal advisers for the persons whom we were reviewing for further information by the minister before deciding on a recommendation. There have been very few instances, since I have become president, that I can recall where there has been an outright rejection, I think at the most perhaps two or three matters where the recommendation was not accepted.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the person stays in gaol although you have recommended that there be an alternative?

Professor CHAPPELL: Well, questions tend to come I think when we may recommend that a person should be released conditionally back into the community perhaps directly from Long Bay Prison Hospital or from another secure setting without a staging process - in other words, we are not stepping down the different levels of security - and my impression would be that those, whoever they are, who decide on these matters would like to see staging going on through the process rather than perhaps a direct release. Now that is not something that I think we should be unduly concerned about. I think that community safety is an issue here and there is always the concern that one has, weighing up that, whether or not a person should progress more slowly than might be desirable under ideal circumstances. While the system is as it is - and I have to point out that the national principles that I mentioned earlier suggest

that political process should not be involved in decision making and that means, in a sense, that the governor's pleasure situation that we have, the old remnants of that within the State, is not at least the espoused principle that these national draft documents suggest - there are always going to be some second views and second opinions. I think we work with that, we live with that and that is the way it is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the lack of staging the reason why you are overruled?

Professor CHAPPELL: It may be, but that is I think the one area that I could identify as being possibly where there might be difference of view with those who make the ultimate decision as to what is to be the outcome of a tribunal's recommendation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said there were a lot more people in prison than should be, or psychiatric people in prison than should be. Do you think that you are under-identifying people and you are really only dealing with a subset?

Professor CHAPPELL: Well, we are not asked to identify them. They come to us. In other words, they are identified and that is how we get jurisdiction over them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But from the Honourable Peter Breen's statistics it is likely that there would under-referral.

Professor CHAPPELL: I think my response to that question earlier was yes, I think there is under-referral and there are people who should be in the hospital system who at the moment are in the prison system, but that reflects the pressures that are there on the hospital beds that are available to deal with mentally ill people in the corrections system.

CHAIR: I am aware that you make recommendations to the minister, the minister almost invariably agrees with them--

Professor CHAPPELL: He does.

CHAIR: If the minister does not agree with them you all resign, but they then go to the executive council where government has a say. Now there was a plan when Andrew Refshauge was minister to give the final decision to the Mental Health Review Tribunal and that was a recommendation of the tribunal under Dr Hayes. I think Government and Opposition both saw it differently, because otherwise we would be handing over to the Mental Health Review Tribunal the entire responsibility for when somebody could go home. I am drawn to one example which I would like you to perhaps think about: A person who might take marijuana and has a schizophrenia type reaction to that, commits a serious crime or a series of major crimes like murder, is picked up - not running away - and is clearly mentally ill at the time. Three days later, clearly perfectly sane. Clearly still in prison today. What do you do about that situation? You keep recommending release and the Government keeps saying no.

Professor CHAPPELL: Well, there are probably some situations, some patients, where there may be fundamental disagreement about what should happen. I think it is more likely to be people who are suffering from severe personality disorders than from mental illness, and as we all know that is an area of intense controversy and difficulty. I would like to refer you to principle 12 of the principles for forensic mental health that are up for public consultation at this moment. Judicial Determination of Detention and Release: Decisions to detain, release or transfer mentally ill individuals found not guilty or unfit for trial because of mental illness should be made by courts or independent statutory bodies of competent jurisdiction, not by a political process or the Governor in council. I happen to agree personally with that view.

CHAIR: Okay. I know you have been working under difficult circumstances, you have cut corners recently and hopefully this new funding will fix it up, although I think it is simply going to keep you with your nose barely above water. Can you see any solution, rather than the tribunal's solution that we have, which does two things, firstly, ensures community protection but, more importantly, makes sure that the person gets the proper level of treatment and the proper level of freedom. I mean we have been

concentrating a little on containing, but how many people at Kenmore, Cumberland, Macquarie, Morisset, Rozelle and in fact Long Bay should not be there and should be, because of their mental state and the judgments that you make, in a house somewhere or back at university or doing a job or playing football?

Professor CHAPMAN: I think while the system is the one that it is there is probably more likely to be an erring towards extreme caution in release decision making and that people who might well be able to be safely put back into the community under conditions may well be kept in more secure circumstances than they really need to be. If there were an alternative mechanism for the review - and I am talking only now of forensic patients - it would be a review mechanism that would take it out, as I have already indicated, of the present system into the principle--

CHAIR: So that requires legislative change.

Professor CHAPMAN: It does and I think, wearing another hat, it may well be something that needs to be looked at in a law reform context and possibly moving towards some sort of specialised court which has jurisdiction not only to make the decisions about unfitness and the other matters but also to make determinative findings about release with powers to monitor and bring back people.

CHAIR: Would that be analogous to the serious crimes--

Professor CHAPMAN: Serious offender review?

CHAIR: The parole system.

Professor CHAPMAN: Well, it would be more akin to parole.

CHAIR: The Government has no say in that, does it?

Professor CHAPMAN: No, it does not, but it does in the Serious Offender Review Committee. It only recommends, it does not have determinative function. How that would be set up, I cannot speak directly to that, but I think it is something that needs to be looked at. I said "wearing another hat". I have recently been appointed as part-time commissioner to the New South Wales Law Reform Commission and I know that that commission has had in the past a look at this area, but perhaps it is time to revisit it.

CHAIR: Yes. It was attempted by Andrew Refshauge back in 1999 and got scuttled.

The transcript will be put on to the web uncorrected. It will only be corrected after you have seen it and sent it back and you are happy with it. If you think we have taken your answer incorrectly, because of subsequent questions, or you have not answered a question, on reflection, as fully as you would like, please send us anything you would like to add. We may come back to you at a later time to test some recommendations we may wish to make because we want to make the recommendations sensible, practical and workable, not stupid, so we might come back to you for advice on some of the recommendations we make and we would appreciate it if you could give us your advice when we ask for it. Is there anything more you would like to say today?

Professor CHAPPELL: Just to thank you for listening patiently and also allowing us to appear to give this testimony.

CHAIR: You are a very important part of the process.

(The witnesses withdrew)

(Luncheon adjournment)

ALLAN CALA, Forensic Pathologist, Department of Forensic Medicine, 42-50 Parramatta Road, Glebe, sworn and examined, and

ELLA SUGO, Forensic Pathologist, Department of Forensic Medicine, 42-50 Parramatta Road, Glebe, affirmed and examined:

CHAIR: Dr Sugo, in what capacity do you appear before the Committee?

Dr SUGO: As a professional who examines cases which have presented before the mental health team.

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

Dr SUGO: In general terms, yes.

CHAIR: Dr Cala, you are conversant with the terms of reference?

Dr CALA: Yes.

CHAIR: Would you like the submission you have made to be part of your sworn evidence?

Dr CALA: Yes.

CHAIR: Your submission is confidential because names are given.

Dr CALA: There are names, but particularly some of Dr Sugo's cases are still before the coroner and unfinished.

CHAIR: If you consider at any stage during your evidence that, in the public interest, certain evidence or documents you wish to present should be seen or heard only by the Committee, the Committee would be willing to accede to that request, but you should be aware that the Legislative Council may overturn that decision and take the evidence in public.

Could you walk us through why you sent us this submission and what the submission shows, please?

Dr SUGO: During our line of work we come across a lot of cases where either the victim, the deceased or the perpetrator has actually been before the mental health team in one aspect or another and we have been struck by the fact that these people have been flagged in some way as needing mental health care and had sought that care, either by themselves or by their next of kin or other family member, and in spite of that circumstances continued and people actually died as a result of that.

CHAIR: Either they have died or someone else has died?

Dr SUGO: Someone else has died, that is right. We have been struck by the fact that, if these people had been flagged as requiring this service, why is it that things were allowed to continue?

CHAIR: Are you able to identify, when you deal with these people, either the victim of one of the mentally ill people or the mentally ill person themselves, that they are official forensic patients under the Mental Health Review Tribunal?

Dr SUGO: What do you mean?

CHAIR: Well, that they have been found not guilty by reason of mental illness or for some other reason declared by a court to be not capable of defending themselves and therefore they have been declared either by the Supreme Court or District Court as being a forensic patient.

Dr SUGO: I think we are actually seeing cases in the very early stages, which is the time of death, so often the findings come later on.

CHAIR: So you are not certain. What strikes you about these? Do you get the full medical record of the person or the perpetrator?

Dr SUGO: It depends on the cases, but we do endeavour to try and get past history on the deceased as much as we can. Some of that information comes to us up front in a P79A which is completed by police officers at the time of someone dying. We subsequently request medical records and look through those medical records to get more information. Often there is additional information in the medical records, for example, that tells us that these people have made contact with mental health teams.

CHAIR: You have no trouble accessing those records?

Dr SUGO: No.

CHAIR: Will the new Medical Records Privacy Bill make a difference? You have not seen the bill, I suppose?

Dr SUGO: No, I have not, but our cases are coronial cases and we are putting a report together for the coroner, so we request the coroner to subpoena the medical records, which is what happens.

CHAIR: If it is not a mentally ill person who dies but a person that you are examining for the coroner whose death may have been caused by a person who is mentally ill, how do you get the medical records of the perpetrator?

Dr CALA: Most of the time we do not. It has been my experience in the eight years that I have been at Glebe that we do not, or on very rare occasions, get the medical records. We ask the police to give us certain information about the psychiatric background of that person, but most of the time we are not privy to the medical records, if they have been admitted to a psychiatric facility or have been seeing a private psychiatrist or whatever.

CHAIR: So your inquiries are about the body that is in front of you really?

Dr SUGO: That is right.

CHAIR: Do you look at the perpetrator as part of the coronial inquiry?

Dr CALA: No, we leave that to the police. I have tried over the years to delve into that aspect a little bit closer, and not to say that the police tell me not to do that, but the feeling I get is that that is more an investigative part of the police work rather than anything that I should be concerned about, which is basically investigating the death of that person.

CHAIR: Most of the cases you have here are people who have committed suicide or, as a result of their actions, have been taken out by somebody, whether it has been a police shot or somebody defending themselves?

Dr CALA: Well, I have not mentioned those sorts of cases. The nine that we have mentioned are people who suicided who had been to at least one psychiatric facility.

CHAIR: We will come to that. There are others you have investigated who have come to their death because of some other person's actions, not suicide?

Dr CALA: That is right. For example, one of my cases was the mother of a mentally ill young man who had schizophrenia and was increasingly delusional and thought his mother was satan and, despite calls to the mental health crisis team to come and review the situation urgently, she unfortunately was knifed one evening by this fellow, so I did the post-mortem examination on that woman.

CHAIR: Of the people who die who are mentally ill, how many of them die by other people's hands, not their own?

Dr CALA: They would be the minority.

CHAIR: Small numbers?

Dr CALA: Yes.

The Hon. PETER BREEN: I think what you are saying is that many of the people that you see and that are referred to in the case studies are victims of people who are mentally disturbed who commit murder?

Dr CALA: Yes, that is one aspect of the cases that we gave in our submission, that is right.

The Hon. PETER BREEN: I do not think there are cases of people who are themselves killed because of an indirect link to mental illness.

CHAIR: There are - suicide.

The Hon. PETER BREEN: Apart from suicide.

Dr CALA: They are not murder victims.

The Hon. PETER BREEN: No.

Dr CALA: Not in the cases that we have presented. I am sure if I look back over the records there may be some, but, in answer to Dr Pezzutti's question, they would be a minority.

CHAIR: Shot by the police or somebody defending themselves against an attack by somebody like that, you would see them?

Dr CALA: Yes, we would see them, but I have not mentioned them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You only had the police account of the example you gave where the woman was killed by her son. You did not have the mental illness history of the son as a medical history?

Dr CALA: Not as a document that I could read, no. For example, in that case, the son was known by the local mental health team. The police went and got the records from that mental health team, I think questioned them verbally in relation to that person--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And then you saw the police records of that?

Dr CALA: Yes, or discussed it with the police in relation to his diagnosis and so on.

Dr SUGO: Another thing I would like to clarify is that the cases we have given are examples. There are definitely a lot more cases that would come before us. These were just some readily accessible examples that we had at the time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Obviously from the point of view of privacy or civil liberties there may be implications to you having access to the medical histories of people. Do you think that the lack of history of the people around your cases impairs your work at all?

Dr CALA: No.

Dr SUGO: No.

CHAIR: We have a situation where the latest evidence we can get of suicides in New South Wales officially from Beverley Raphael is 1996, nothing since then, because she says that there is some doubt about whether or not a person has suicided and the only people who get to be suicides officially are those declared to be so by the coroner, so you are the only people who know at least all of the official suicides but not necessarily all of the suicides. Is that correct? In other words, there would be an awful lot of people who die, particularly over the age of 80, where there might not be a coroner's inquest, there might not be any suspicion of suicide, but the only counts that are made are of those people who are declared to be suicides by the coroner.

Dr SUGO: I think at the present moment actually, if someone dies in the community, the police investigate that death and Crime Scene actually attends that death as well and what they are looking at is looking at the scene and making some assessment. It is true, though, that if a medical practitioner, for example a general practitioner, is satisfied with the death and is keen to issue a death certificate, that is basically the end of the matter, so I guess the onus is back on the general practitioner who issues the death certificate to be happy that it is a natural death.

CHAIR: Sure, but if you have a 25 year old who dies at home, that would almost always become a coroner's case. Is that right?

Dr CALA: I would expect so, unless there is some well-documented history.

CHAIR: AIDS or something?

Dr CALA: Leukaemia or whatever, and a GP or some doctor has been looking after them regularly.

CHAIR: Why is there some reticence to release the figures, do you think, on suicides in New South Wales?

Dr SUGO: I was not aware that there was a reluctance to release the figures.

Dr CALA: Do you mean by the coroner or by other government agencies?

CHAIR: Other government agencies.

Dr CALA: I do not know that I can answer that. I have spoken directly to the coroner--

CHAIR: Not about the number of suicides, but the number of suicides where mental illness is a factor?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There seems to be a problem getting figures on deaths within the ambit of mental health services.

CHAIR: Yes, if they are under the care of mental health services, under a schedule in hospital or out of hospital under direct care, under a CTO or something like that.

Dr SUGO: Is that reluctance coming from the mental health people? I do not know if it is coming from the coroner.

Dr CALA: In any event, if those people have died by their own hand, then those deaths, whether those deaths are reportable to the coroner at Glebe or go to Westmead or elsewhere, should all be reportable to the coroner. No doctor should be able to sign a death certificate if he or she thinks that suicide has occurred because that is an unnatural death and it should be reportable to the coroner.

CHAIR: The coroner would issue the number of suicides, but the issue is how many of those people are under the direct care of the department in terms of the Mental Health Act, either in hospital in a facility or under direct care on a CTO?

Dr SUGO: I think deaths that are occurring within an institution, if it is a scheduled bed, become a coroner's case, I mean they should anyway, so those cases are flagged by the coroner and I think those figures would be readily available. I think we do not formally note in our reports, for example, where we find a story of the fact that the person has been in the care of a mental health team. We may mention it in our report, but we are not officially flagging that, we have not been asked to flag that.

CHAIR: So a person who walks out of the Missenden centre at Prince Alfred Hospital where they are meant to be under secure protection and jumps over The Gap or onto a railway line or off the Anzac Bridge may not be notified in your report?

Dr SUGO: Well, it will be described in our report and the coroner is usually very interested in holding inquests into those deaths, but there is no formal way of notification, if you like, or really collecting those cases or collecting those figures. It could be done, but at the moment it is not being automatically collected.

CHAIR: So that is why Beverley Raphael may have trouble in releasing what she would call accurate figures.

Dr SUGO: Well, that is probably it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is in the text, in a sense, but it is not in a box in the database.

Dr SUGO: Well, yes.

Dr CALA: I think that is quite right.

Dr SUGO: It is as simple as that.

CHAIR: Well, that is why she is having trouble releasing the figures because she is not certain that they are accurate.

The Hon. PETER BREEN: Could I make a point about that: We have seen in another inquiry that the Corrective Services Department has suggested that 39 percent of the women population in prison has previously attempted to commit suicide. That is a clear statistic based on the information that they collect in corrective services. I am interested to know whether a comparison can be made of a statistic like that in the work that you do. For example, you have suggested that 50 cases are suspicious out of 250 to 300 post-mortem examinations that you do each year. I would be interested to know what proportion of that 50 cases represents suicides?

Dr CALA: Cases that are called "suspicious" are homicide cases. That is just our jargon for homicide. A suicide would not be regarded as suspicious.

The Hon. PETER BREEN: Are you able to say what proportion of the 250 to 300 would be suicides?

Dr CALA: I think about 20 percent of the ones I do. I might see a skewed population because I am more senior than some of my other colleagues and I tend to do perhaps suicide and homicide cases rather than natural cause deaths which might be delegated to junior staff, so I would see, I think off the top of my head, about 20 percent, and Dr Sugo may be the same figure.

Dr SUGO: Probably yes, but it is a significant part of our work, these suicide cases, definitely.

Dr CALA: For example, yesterday at Glebe, of eight cases, three were suicides. That is 37 percent. It may be none on one day out of ten or it may be four out of seven or something like that, it is variable on a daily basis, of course.

CHAIR: What about train jumpers. There must be some pressure brought to bear by relatives if the coroner is not absolutely certain that they are suicides to have an open finding on whether they are suicide or not?

Dr CALA: Although the coroner is the one who ultimately decides on the manner of death, we do provide a lot of input into what we think has been the manner of death. So far as railway accident ones go, from my own point of view, if somebody has a clear history of depression, for example, at most railway stations in Sydney at least there are video cameras and we have documentary evidence of people seen to get up from a seat and then run in front of a train, people who have maybe left a suicide note and gone to a station or something like that, where there is clear evidence that they intended to take their own life and the post-mortem findings confirm that, that is that there are no other findings of any significance, they were not murdered and placed on the railway tracks or something like that, I would be quite happy to give the manner of death in that instance as suicide.

CHAIR: How many of the train ones, though, would be not suicide?

Dr CALA: Very few.

Dr SUGO: Small number.

CHAIR: Most of them are suicide?

Dr CALA: The vast majority, almost 100 percent would be suicides. I have never encountered a homicide and very few accidents, and they would be industrial accidents.

Dr SUGO: Or graffiti artists from time to time coming to grief.

Dr CALA: Yes, from time to time, that sort of thing.

CHAIR: You have given us some examples of which I think there are 15 or 16 and they are all slightly different.

Dr CALA: Yes.

CHAIR: Can you just describe the sort of differences and your concerns about those cases?

Dr CALA: Well, there are some concerns that I have. As Dr Sugo has intimated, these cases, from our point of view, also represent the end of the spectrum. They have obviously resulted in somebody's death, but I think in quite a number of these cases I believe that the deaths might have been preventable. I have concerns in a number of areas. I think some of the deaths outline cases where people have been looked after by their family members for a considerable period of time, they have had a long history of psychiatric illness and, put bluntly, they have been mucked around by the mental health system, they have gone from doctor to doctor or from one health facility to another requesting treatment, they might have been admitted for a short period of time and then released because they have not been able to be kept, but nevertheless their psychiatric illness has been getting worse, so they might have been becoming more delusional or more violent towards family members or other people, other members of the public, and ultimately either they suicide themselves or, even worse, they kill a family member or somebody else.

My feeling is that in many of these cases the deaths might have been preventable if affirmative action had been taken to admit these people, keep them in hospital for a period of even 72 to 96 hours rather than overnight, because I do not really think that in that situation you get a good idea of what psychiatric state somebody is in, and then after that period evaluate them, make an assessment as to whether they need to be kept in or not, look at the social factors going on with that person, the family background, how the family is coping and, if need be, either keep them in longer if you have concerns as to whether they are a harm to themselves or to others, and if they are not and you are satisfied then release them.

CHAIR: There is a very fine judgment though between someone who is mentally ill where you can forcibly detain them and a personality disorder where this can be an attempted suicide or "I am going to commit suicide" or "I am going to jump off that bridge" can be defined as attention seeking. It is a very fine, difficult judgment that some professionals have to make. If they are mentally ill it is very easy. Some of them may only be kept for a short time and are then discharged, and that can be a problem, but for some of them where they are not mentally ill it is difficult for the health system to take full responsibility and care or even lock them up. When you do your inquiries, how many are mentally ill or how many are personality disorders?

Dr SUGO: I think we see a lot of people with a diagnosis of depression.

CHAIR: That just hides personality disorder, does it not?

Dr SUGO: I do not think it necessarily does and I think if you have a personality disorder it does not mean you cannot get depressed. I think it is probably towards the end of the road for many people with personality disorders. What often I find very, very hard dealing with these cases is when you go back and review the notes and you see someone who, for example, is admitted with a suicide attempt and is scheduled and is reviewed within 24 hours, is asked, "Are you suicidal", the answer is "No" and they are released.

CHAIR: And they do it.

Dr SUGO: And they do it. Now I cannot believe that someone attempts suicide, is scheduled for that and in the next few hours is no longer suicidal and ready to be discharged.

One of the examples I have is the murder/suicide of a man who overdosed and was found in his car outside his unit. He was admitted for that, he was noted to have homicidal unease as well as suicidal, but within hours was assessed as: No, he did not really mean that, he says he is a Christian, he would never do that. He was allowed home and subsequently murdered his wife, within hours. At the post-mortem he still had his ECG dots from when he was in hospital from his over-dose.

Maybe we need to look at things a little longer than "No, I am no longer suicidal" and taking that on face value, which I think is what we are tending to do. We see that quite often. They are admitted, they say "No, I am not suicidal", they are discharged and they suicide.

CHAIR: There is a fair pressure on those beds, is there not?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is hardly the point, though, is it?

Dr SUGO: I guess there is going to be pressure in the graveyard if it is going to continue like that. There is going to be pressure somewhere along the line.

CHAIR: How many of the people who come under your jurisdiction have absconded from a place where they are currently being treated?

Dr SUGO: A small percentage, but they are there.

CHAIR: And they are under schedule 2?

Dr CALA: Some are, but some are also voluntary patients.

CHAIR: The others are simply people who have tried to seek care but have not been successful or do they just do it out of the blue?

Dr CALA: Yes.

Dr SUGO: Some do it out of the blue, but there is often a history of depression. If you go to the P79A you will see, yes, he has been depressed, or yes, she has been depressed.

CHAIR: That is the old retrospectoscope, which is probably the best vision you ever get, but where there has clearly been indication that this person will commit suicide, the family has said to the doctor, the nurse, the mental health team, "I am really worried about Joe/Jeanette", and nobody takes any notice.

Dr SUGO: Well, in this case the lady actually pleaded for him not to be discharged, she was seriously concerned for her safety and he was discharged.

CHAIR: Do you think we should include any change to the Mental Health Act to allow the relatives to have some say in the discharge plans or treatment plans?

Dr SUGO: Well, I think often it is the next of kin who know the patient very, very well and probably a lot better than a psychiatric registrar or a crisis team who assesses the person in a half to one hour interview when the person is actually putting up a pretty good front because they do not want to stay there, they want to go. They have something they want to do and, if they stay there, they are being put off from doing it. I think people that know the person very well at least should have some input into the assessment.

CHAIR: Currently, unless the person gives consent, the law does not allow the relative to be contacted or even consulted because that is an invasion of the person's privacy. You cannot discuss one's medical condition with another, if they are adults.

Dr SUGO: I think that is a problem because at the same time we are saying, all right, you cannot have any input into whether this person is kept in hospital or not, but you can look after them because we are sending them home. I think that is a bit of a double standard.

Dr CALA: I think the family should be more involved in the eventual assessment. When it comes to decision time as to whether someone should be allowed home or not, I think they should be consulted. In some cases the right to privacy issues should not be ignored, they should be considered, but I do not think they are overriding.

CHAIR: What are the other types of examples that you are concerned about?

…….

CHAIR: The 42 year old woman who attempted suicide by jumping off a cliff.

Dr CALA: Yes.

CHAIR: She was prevented from jumping, taken by the police to a teaching hospital, assessed and released to the care of her husband, the following morning she told her husband she was going for a walk and disappeared.

Dr CALA: Yes.

CHAIR: What lesson can we take from that?

Dr CALA: This woman was found at The Gap on the other side of the fence and was ready to take a jump. Some passers-by saw her, hopped over the fence and called the police. The police took her to Prince of Wales Hospital. If someone is found at The Gap on the other side of the fence I do not think you need to be a psychiatrist to say that it is probably likely that this woman really intended to take her own life. Looking back, she had a history of depression and had been seeing a psychiatrist and so on. To be seen by a resident doctor, as she was, and discharged within several hours of almost making what would have been a very successful suicide attempt, in my opinion, is pretty cavalier.

CHAIR: She just says, "I am going for a walk", and her husband says "Fine".

Dr SUGO: I think this highlights another issue which is really important and which Allan and I have discussed before: The care, the monitoring, is thrust back on the family. You get situations where the family are told: Go home, but don't take your eyes off her, will you? What happens when the person actually succeeds in committing suicide? Whose fault is it? Is it the person who for five minutes took their eyes off her? How is her husband feeling in the situation knowing that he let her go for a walk? The doctor said she was all right, she was allowed to go home. Now the blame is going to be on the husband who should have kept a closer eye on her. I do not think that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The marriage may not have been too good and that may have been why she was depressed. There are plenty of people with bad marriages who keep going along.

Dr SUGO: That is right.

The Hon. JOHN HATZISTERGOS: Do we not need more facts here?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is illustrative, though, of a problem.

The Hon. JOHN HATZISTERGOS: It could be illustrative of something and it may not be. I do not know I could draw too much out of it. I do not know anything about the circumstances. If we are trying to lay the blame at some authority-□

CHAIR: I think it is just illustrative.

The Hon. JOHN HATZISTERGOS: I think it is more than illustrative. It is attempting to suggest, as do a number of these examples, that there is some authority which ought to have taken a greater level of responsibility in the circumstances than it did. That partly depends upon what all the facts are. It is difficult, on two or three sentences, to make that judgment. It may be that the doctor or whoever it was at the hospital was cavalier and should have taken further action. There may have been reasons why the doctor could not or should not have or why the judgment of the doctor in the circumstances may or may not have been appropriate. On the other hand, it may be that the husband had some circumstances which led him to believe that everything would be okay, I do not know. It is difficult to form those sorts of judgments from what would seem to me, with the greatest respect, fairly sparse information that we have been provided. Are you able to put more flesh to it?

Dr CALA: On that particular case I have the report, I could have a look. In fact I could give you the whole file and you can have a look and see what information was available to me.

The Hon. JOHN HATZISTERGOS: I would like to look at it, if you are prepared to make it available.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems to me that this is the case that we often have in the legal situation where people ask for "beyond reasonable doubt" for individuals and will not draw a universal conclusion. That is why public health never gets a guernsey. Each case is demanded beyond reasonable doubt and then, because each one or a large number fail on beyond reasonable doubt, you draw no conclusions from the mass of evidence. If you take the tobacco analogy and the way society has dealt with that, that is the way: Each case has to be beyond reasonable doubt, so we never draw any conclusions, so we never take any public health action. In terms of resources of public health, if you took that line that you want absolute proof of every case here, you would not do anything about mental health services, would you, or you may not, whereas if you said what is the most likely probability of all these cases and what should be done about that, you would obviously come to a far more action-demanding conclusion than you would if you want beyond reasonable doubt for each case and are reluctant to act until you have that.

CHAIR: There are two scenarios. She is found like that, she is taken to Prince of Wales Hospital and the doctor does one of two things. He says, look, she is really unwell, but we have not got a bed, bring her back next Thursday, or he says we think she is just attention seeking, just give her hot soup and a bit of a cuddle. Two scenarios: (1) The doctor agrees that she is not mentally well but has not got a bed, "please keep a close watch on her", and (2) the doctor does not think she is mentally ill, thinks she is just attention seeking, take her on a holiday.

The Hon. JOHN HATZISTERGOS: That is right, but just looking at this file - and this is the sort of issue that I am talking about - this woman was taken to the psychiatric unit of Prince of Wales Hospital. It is believed that she was assessed as being non-suicidal and she was released. It is one thing to say that a person is released because there are inadequate resources when she is suicidal. It is another thing to form a view about her that she is no danger to herself and therefore to release her. What I am saying is that, if it is the first thing that applies, then yes, there is a case made out that something should have been done on a resource basis to ensure that that person was properly attended to, but it is a bit rich to run around blaming lack of resources when, assuming there are resources available, the person is diagnosed as being non-suicidal--

CHAIR: What they are saying is that she was assessed by a junior doctor as being non-suicidal.

The Hon. JOHN HATZISTERGOS: It says the psychiatric unit of the Prince of Wales Hospital.

CHAIR: That is right, but see who the reviewer was.

Dr CALA: I do not know, but they were clearly wrong in their diagnosis.

The Hon. JOHN HATZISTERGOS: You might take the view that that was negligent.

Dr CALA: Well, that might be the case.

The Hon. JOHN HATZISTERGOS: That happens a lot in medicine.

Dr CALA: Yes.

The Hon. JOHN HATZISTERGOS: People form wrong opinions. But it is one thing to say that a judgment is formed that a person should be released because, even though they are in danger, there are no resources to keep them there, and it is another view to say the person is mis-diagnosed and released. People are diagnosed all the time, sometimes incorrectly, but we try and avoid those sorts of errors.

Dr SUGO: I think in the cases we see you will see examples of both.

The Hon. JOHN HATZISTERGOS: All right.

CHAIR: I think also the Mental Health Act requires that a person be treated in the least restrictive circumstances.

Dr SUGO: That is right.

CHAIR: In other words, if there is a balance of doubt, you are meant to give the balance of doubt to give the maximum freedom with as much care as possible, so that if you are faced with a situation: Is the person suicidal or not suicidal? Will I keep her here compulsorily or will I take the other option and say she is not suicidal and therefore it does not go on to her insurance records and a whole lot of other things? The least restrictive is send her home. I mean there are these things at play.

Dr SUGO: Sure.

CHAIR: But, as I said, there are two interpretations that I got from those stories 1 and 2.

Dr SUGO: I think there is a third one, which is I think the one we do see, which is the fact that the person is scheduled successfully and they are admitted and then, within a short period of time, that person says, no, I am not suicidal, and that person is released, and that period of time is often very short, very short indeed. This is where I am saying you cannot be standing at the edge of The Gap one minute and not be suicidal the next. These people are deeply depressed.

CHAIR: Unless she was simply attention seeking, which is what the doctors are saying.

Dr CALA: Well, I do not know that they are saying that.

CHAIR: She is deemed to be not suicidal.

Dr CALA: She is deemed to be not suicidal, but, like I said, I think they have erred in diagnosis. I think she clearly was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If I can comment here as a person who has worked for a considerable time in casualty and intensive care units, the pressure on the doctor to find that people are what the resources are able to do is quite high. If you are deciding who should go into an intensive care unit and you have not got enough beds, you are inclined to say that this person can manage without when otherwise, if there had been enough beds, you certainly would not have said that and I would imagine that the same thing applies when looking at psychiatric beds. I can speak more authoritatively on deciding who should be in intensive care units and who should not because I have spent more time in that area, but certainly the pressure on the doctor to say that that person can go out because someone else has to come in is very high and it is a very strong doctor and one who is not tired and so on who resists all those pressures.

The Hon. JOHN HATZISTERGOS: There was no evidence in this particular case that that is what motivated the diagnosis.

CHAIR: But there is no evidence to say that that is not the case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a systemic problem, though, of lack of resources, lack of beds, and that will not be written in the notes.

The Hon. JOHN HATZISTERGOS: Well, I am getting through the notes and I will come back to it, if I can.

CHAIR: That issue is a constant juggling issue, but you see the end result and declare that to be a suicide. The retrospectoscope is a very powerful tool and the forensic pathologist is a much more powerful tool than just about any MRI or CT scanner or anything.

Dr CALA: Well, not if you ask a clinician.

CHAIR: The pre-mortem diagnosis is nowhere near as good, nothing like as good, as the post-mortem examination, which I do not think we are doing nearly enough of to confirm pre-mortem diagnosis. However, what does the next case bring to us?

Dr SUGO: Have you got another example, Allan, or something that just highlights a slightly different case?

Dr CALA: The first one that I brought up was from 1995, a 37 year old man.

CHAIR: Which case number?

Dr CALA: Paragraph 7. The story that I got rather was that he had a recent history of paranoid behaviour, was hearing voices and becoming delusional, thought that the Russian and the Polish mafia were attempting to kill him. He had recently overdosed on anti-depressant tablets. That situation of

delusional behaviour and paranoia was not getting any better. He was taken to the nearby hospital, which coincidentally happened to be Prince of Wales Hospital, and was released about two days later for reasons which I am not privy to. A couple of days after that - it may have even been a very short period of time after that - he telephoned his mother and said that he had just murdered his wife and daughter. Police eventually located him as his mother from Copenhagen rang Sydney police and he was located and found in a bath having tried to slash his wrists. So here is a fellow who, in my opinion, is clearly in need of urgent psychiatric attention with delusional behaviour and paranoia and so on, who is taken to a hospital and released and the consequence of that release is that, unfortunately, he in all likelihood has murdered his wife and daughter and tried to take his own life, gets admitted to hospital and then a couple of days after that does take his own life.

CHAIR: Certainly in that situation I would hardly believe that it would be two days before anti-psychotic treatment would be effective. It takes longer than that for the anti-psychotic to come on board and work, it would certainly take more than a week. To be released after two days when he is still psychotic or paranoid and having hallucinations or delusions is interesting.

The Hon. JOHN HATZISTERGOS: I would like to come back to this case. I cannot find the person's previous history of depression that you referred to. Are there some doctor's notes? This just seems to be the coroner's file or the forensic file.

Dr CALA: Yes, that is our file, that is what we have to work on.

The Hon. JOHN HATZISTERGOS: We do not have any material from the clinician who examined her at Prince of Wales Hospital?

Dr CALA: No.

Dr SUGO: The coroner would possibly have that information.

The Hon. JOHN HATZISTERGOS: Nor do we have information as to her pre-existing depression, if there was any. We do not have that material. That material would be fairly critical.

Dr CALA: Well, it might be, but this case is from a couple of years ago and I cannot remember the exact details of it, but nevertheless, even if she had never been depressed before and this was her first bout of depression, it seems like a serious bout of depression that this woman has.

Dr SUGO: The way in which we deal with that information is there should be attached to that report a form which is labelled P79A which is compiled by the police and that is where our first lot of information comes from. If they have been in the hospital in the recent past we request the medical records from that hospital and we examine those records. I tend to photocopy some pages from it, but I do not always do that.

The Hon. JOHN HATZISTERGOS: What is the form called?

Dr CALA: P79A.

The Hon. JOHN HATZISTERGOS: I have that here.

Dr SUGO: Yes.

The Hon. JOHN HATZISTERGOS: That is just the report of death to the coroner.

Dr SUGO: That is right.

Dr CALA: But on the second page it should have the synopsis of the events leading up to the death.

The Hon. JOHN HATZISTERGOS: Yes, but that is just a description given by a constable of police.

Dr SUGO: That is right.

The Hon. JOHN HATZISTERGOS: It is not the primary record.

CHAIR: Does that say she was admitted to Prince of Wales Hospital?

The Hon. JOHN HATZISTERGOS: It says that she was taken by police to Prince of Wales to be assessed.

CHAIR: What Dr Sugo says is that they then request the records from Prince of Wales Hospital.

Dr CALA: If any exist.

The Hon. JOHN HATZISTERGOS: Well, it certainly names a doctor - I will not name the doctor, but it certainly names a doctor - and it says that the doctor advised that she be driven home and that was complied with, but there is nothing indicating--

CHAIR: His seniority and what assessment he did.

The Hon. JOHN HATZISTERGOS: It does not indicate what his assessment was.

CHAIR: You would have to have the hospital records to find out more about the doctor.

The Hon. JOHN HATZISTERGOS: You would need to find that out and that would then tell you how and in what circumstances the doctor exercised the judgment to release the woman.

Dr SUGO: That is slightly outside our area. The coroner is actually responsible for all the other investigations. Our examination is basically the post-mortem examination.

The Hon. JOHN HATZISTERGOS: I understand that, but the issue gets down to this: Is every person who is apprehended by police in circumstances where it may be thought that they are taking their lives to be treated as a person who should be assumed to be suicidal and placed in institutional care?

Dr SUGO: Yes, it is one of the requirements.

The Hon. JOHN HATZISTERGOS: And monitored for a period. Is that what you are saying? This could have been attention seeking, we do not know.

Dr CALA: We do not know. I do not think it was, but in any event the police will take them to the nearest psychiatric facility and I do not think there is any obligation to compulsorily admit them, but I think that they are certainly assessed by whoever the doctor is for that unit and an assessment is made as to whether they are suffering from a psychiatric illness and if a diagnosis can be made it usually is and then a decision is made as to ongoing management, are they admitted or not admitted, and then if they are not admitted, released to the family or whoever.

The Hon. JOHN HATZISTERGOS: Have you seen any information other than this information about this woman?

Dr CALA: I think at some stage I might have seen the medical records from Prince of Wales Hospital, but it is from a couple of years ago and I cannot honestly recall.

The Hon. JOHN HATZISTERGOS: Well, I am just wondering because you made a statement earlier that troubles me and that is that you stated that it appears that when she went to the Prince of Wales Hospital she was treated in a somewhat cavalier manner?

Dr CALA: Yes.

The Hon. JOHN HATZISTERGOS: There is nothing here that I can see that supports that view. It may be that there is other information that I have not seen, but there is nothing here that indicates to me that she was treated in a cavalier manner.

CHAIR: Let's go back a step: Say for example your wife was picked up at The Gap and you have absolutely no reason to believe she would do that and the phone call you had was from the police saying "We have just taken your wife to Prince of Wales Hospital, she was found on the other side of the fence at The Gap". You would rush to the hospital and there you would be reassured by the junior doctor or the senior doctor that she was not suicidal, take her home. I do not think that I would be very happy with that sort of level of care. Assuming that there had been no previous history, assuming your wife had been perfectly normal, had done the shopping, taken the kids to sport, I would be very unhappy with an assessment done like that or over a two hour period without observation, without deep questioning, the person says "I am not suicidal", she goes home and two days later she is dead.

The Hon. JOHN HATZISTERGOS: I agree with all of that.

CHAIR: How do you think you and your family would feel?

The Hon. JOHN HATZISTERGOS: I would agree with all of that if that is what happened, and you would want to know why it happened, but here we have a situation where the woman is sent home. In fact the husband, for whatever reason, is told apparently that she wanted to go shopping and is comfortable with allowing her--

CHAIR: Because he is told by the doctor--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not recorded that he is comfortable.

The Hon. JOHN HATZISTERGOS: He allowed it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is recorded that he allows it.

The Hon. JOHN HATZISTERGOS: He is comfortable because he allowed her to do it. The argument that has been put is that these doctors in these places are under enormous pressure to release people and therefore people in circumstances such as this unfortunate woman are taken to hospital, a view is formed about them and they are released in circumstances where they should not be. That is one view and you would be critical of the system if that is what happened. Then we have another view and that is that she was misdiagnosed, the view was formed that she was perfectly okay when in fact she was not, and she was released. That is a criticism that you could make of the person or practitioner at the psychiatric unit who assessed her and I do not know what you can do about that apart from ensuring that you have a more competent person to carry out that work, but if it is a different--

CHAIR: But there was a third scenario.

Dr SUGO: I think there is a third scenario.

CHAIR: The third scenario was that the registrar is under enormous pressure, which we got from all the people last week, huge pressure; all the beds are full, you cannot take this person, you have looked at the bed state and the closest bed where she might fit is at Parramatta, and they say thank God she has a husband and this is the first time she has tried to commit suicide.

The Hon. AMANDA FAZIO: You are jumping to amazing--

CHAIR: But she did commit suicide.

The Hon. JOHN HATZISTERGOS: I just feel that you need all the facts and I know Arthur keeps saying this is lawyer's speak--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, it is.

The Hon. PETER BREEN: Mr Chair, can I ask that you direct further questions to the witnesses? Dr Sugo has a third scenario which may be different to your scenario.

Dr SUGO: I actually have a fourth scenario because you gave the third one. I think the fourth one is that there are limitations to the way in which people are assessed and if someone says "I am not suicidal" it is very, very hard for someone to override that and say, well, look, I am actually still a bit concerned about you, I think I will keep you under schedule for another 24 hours. I think that is a problem that is faced if people are very adamant and say, look, I am not suicidal, I would like to go home. What can you do then? If you are not allowing input from other people that are intimately concerned with that person, like the next of kin, who know that person better and are still concerned, then you may be put in a situation of releasing someone who you may have reservations about releasing, so I think that is our fourth scenario.

Dr CALA: And there is a fifth scenario. The fifth scenario might be, and this is hypothetical and I do not know because I do not know all the facts, but this woman is very determined to kill herself, she is depressed, she is fed up with her husband and life in general and going to The Gap and doing this was a genuine suicide attempt. Unfortunately for her, or so she thinks, the police have stepped in, she knows that she is going to end up at a psychiatric hospital and she gets taken to Prince of Wales. She knows that to get released all she has to say is, "I am not suicidal any longer", after a two hour chat with the doctor. The doctor will release her because she says to the doctor, "I am not suicidal any longer", knowing full well that she is and that by her being released it is going to put her back out into the community without any safeguards or anything placed upon her or any prevention strategies in place to prevent her from killing herself, she knows full well what she is going to do, she goes home, she says to her husband, "I am going shopping", lies her head off, knows that she is going to jump off the cliff or go and drown herself or whatever, and I think that is a reasonable hypothesis as well.

The Hon. JOHN HATZISTERGOS: They are all reasonable hypotheses, all I am saying is that it would be useful to have additional information so that we know which one applied in this particular instance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would say more resources would be helpful.

The Hon. JOHN HATZISTERGOS: But if you are going to deal with the problem I think it is important to--

CHAIR: Well, the police were serious enough--

The Hon. JOHN HATZISTERGOS: I think it is a bit premature to draw conclusions.

CHAIR: The police were concerned enough to do a section 24 admission to hospital.

Dr CALA: Yes.

CHAIR: The fact that the hospital did not follow up with a section 22 is something that the police were highly critical of in this morning's evidence. I do not know frankly whether more should have been done or not, but the issue is that here is a person with a two hour admission for assessment, that is it, and then they go home. And the doctor might only have been with her for five minutes in that two hours. That is the problem.

The Hon. JOHN HATZISTERGOS: I am just saying that we should have a little bit more information to draw conclusions.

CHAIR: You can have 100 cases like that and draw no conclusions because you never ever know all of the facts. You can never get into the mind of a person who is dead. You can describe the death notices, but you cannot get into the mind of the person who is dead.

The Hon. JOHN HATZISTERGOS: But I think you can get the facts.

Dr SUGO: I think you will find that the coroner actually has a lot of those facts already and where we find cases like this we often recommend that the coroner follow these cases up and investigate the cases and those cases are investigated by the coronial investigators.

The Hon. JOHN HATZISTERGOS: Presumably the doctor would be asked to make a statement.

Dr SUGO: Yes.

The Hon. JOHN HATZISTERGOS: Presumably you would get the clinical records of the Prince of Wales Hospital psychiatric unit?

Dr SUGO: We would have seen that actually.

The Hon. JOHN HATZISTERGOS: You would ask the husband what happened?

Dr CALA: Yes.

The Hon. JOHN HATZISTERGOS: You would get a pretty good picture of where the fault in the system lies.

Dr SUGO: All of this information comes out during an inquest.

CHAIR: Let's go to paragraph 15 briefly: The deceased 16 year old boy had a 12 year history of psychiatric illness. He had been seeing a psychiatrist but was not taking any medication. His stepmother was finding it increasingly difficult to cope with him as he had been assaulting family members resulting in calls for help to the police. His stepmother had fears that this boy would suicide or attempt to kill others. Calls for help to psychiatrists were often not answered, but ultimately the psychiatrists suggested that the police be called each time the boy was violent. He incised his wrists and was taken to a hospital but was discharged. He went home and hanged himself. He was found unconscious and taken to hospital where he died several days later from the effects of cerebral hypoxia due to suicide (hanging). That is not an uncommon occurrence where people get the razor blade and you have these thin little strips across the chest, or a doctor I know who stabbed himself, tried to adrenalise himself with a needle in the chest. He is still alive, but I mean attempted suicides are attempted suicides. If they are unsuccessful today, well, they do it tomorrow, but the numbers are not there to say you do it today, if you do not get any treatment you are going to do it tomorrow. I mean this is the risk management process, is it not?

Dr SUGO: I actually prefer the term "self-harm" to "suicide". I think it is quite good because it will cover cases like slashing wrists where it may not necessarily be fatal, but I think they are all manifestations of the one thing, so I actually prefer that term to "suicide".

The other thing which I wanted to point out is that the determination that some people have to commit suicide is absolutely amazing sometimes. The lengths to which people will go, the way in which it is a cold, calculated procedure, it can be incredibly elaborate with safety mechanisms in case something fails, that something else will take you out and stuff like that, so to think about people committing suicide as only being people who are deeply depressed and hardly able to do anything I think is quite wrong.

CHAIR: Some rational people just do it.

Dr SUGO: That is right, and there are people who are depressed but are still able to take great lengths to make sure that it works.

CHAIR: It is not illegal any more to commit suicide. It used to be illegal, did it not?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

CHAIR: It is not illegal any more. That is progress.
The Hon. JOHN HATZISTERGOS: It is illegal for someone to assist you.

CHAIR: Yes, but it is not illegal if you commit suicide yourself.

The Hon. PETER BREEN: The point of your evidence, though, is that there are not sufficient mechanisms in place to properly assess these people and to take some kind of intervention in their lives to make sure that they get proper care. That is what you are saying.

Dr CALA: That is right. Certainly that is a point that we are trying to make.

The Hon. AMANDA FAZIO: What would you like to see happen? I know people just throw in the words "resources" and "funding", but so what, you can have resources and funding, if you do not use them effectively you will not actually achieve anything.

Dr SUGO: That is right.

The Hon. AMANDA FAZIO: What would you like to have happen to somebody who has exhibited some tendency to self-harm who is brought by the police into a psychiatric unit at a teaching hospital. In an ideal world, what would you like to have happen to that person?

Dr CALA: Well, obviously a competent assessment, and I think that goes without saying, that whoever assesses them is in a position to be able to do that in a fully competent manner, and in some of these cases I accept that that may not have been the case, but if the assessment is made and that person is deemed to be a genuine suicide risk, at risk of harming themselves or even others, for example the case that Ella described, then I would hope that there are sufficient resources in that particular area of the city or of the State where bed availability is not a factor as to whether or not they are admitted. If the doctor who does the assessment is of the belief that this is such a serious threat that this person has made, the admission should be done virtually automatically without any impediment.

The Hon. JOHN HATZISTERGOS: For how long? This is the difficulty. We had this MP in Victoria who took his children with him and tried to kill himself and his children in the car. He was assessed and eventually released, a few days elapsed and he took his own life. I understand from what you are saying that some of these people are very good at masking their intentions.

Dr CALA: Well, like this one, he might have been very good at that.

The Hon. JOHN HATZISTERGOS: Yes, he probably was, and convinced all the doctors that everything was fine. I mean how do you know when a person is not well enough to be discharged or do you need to keep them in indefinitely?

Dr CALA: No, you certainly do not do that. That is where I think experience and skill as a competent psychiatrist comes into play, but I do not think that I can answer that question as to how long they should be in hospital for. I do not have a set time period. I do not think that it would be the case that I would say at 48 hours you are then able to decide whether that person is fit for discharge or not. I think it obviously depends on the case, it depends on the background of the patient, whether they have had previous suicide attempts, what the family background is like, and by interviewing the family as well, seeing what the home situation is like, seeing what the back-up is with the general practitioner, and these are complex things it takes time to examine, so I think probably at the very least to be able to do a competent assessment like that might take 48 to 72 hours. I would be surprised if it took more than 96 hours.

The Hon. JOHN HATZISTERGOS: Are there any other jurisdictions or places where they do these forms of assessments for 72 or 96 hours that you would regard as competent that we should be looking at?

Dr SUGO: I do not think we really are in a position to answer that.

The Hon. JOHN HATZISTERGOS: Who does this better than we do?

Dr CALA: Sadly, I do not think many areas do it better because if it was knowingly done better and the statistics were there to prove it I am sure that many people would have seized that method by now.

The Hon. AMANDA FAZIO: If you had somebody and you did the full assessment and at the end of 96 hours they were still suicidal, but they were rational about being suicidal, would you then see that you had a role to stop that person from harming themselves or would you see that as being their right if you believed that they were rational?

Dr CALA: As a medical practitioner, whatever your views are on euthanasia and so on, I think you have a duty to maintain life and I think, even if you think that person might be very rational in making that decision, you should do everything you can to prevent them from taking their own life.

Dr SUGO: We were asked how long, and I do not want to be funny or anything, but I think as long as it takes. Some people might be able to be assessed quite promptly, but other people you might need to do more assessments, more time to do an assessment. I do not think you can in any way set an arbitrary figure that is going to fit everybody.

I think the other thing that we are probably under-using is people that know the patients probably a lot better than their psychiatrists do, and that is really the families. One thing that does come out when we review the records and stuff like that is the plea from family members for attention and often the people are being taken by the mum or whoever it is, like in the case of the young boy, that mother went to great lengths to try and help that boy. She phoned the doctor time after time and the call was not returned. I have seen a letter that she wrote, it is in one of her medical records, expressing her concern about the fact that she tried so hard to get attention and it failed, so I think there is actually a source of information there that we are not using and that is those people who are directly bearing the front of these people who are out of control.

The Hon. AMANDA FAZIO: We had evidence from other people on other days of hearing about the need for family members to be treated in some formal way as advocates or contact people for their family member who has a mental health problem and there are all the privacy issues involved and other things like that, but it seemed that it would be a good idea if they could be formally somehow linked into the system.

Dr SUGO: I think so.

The Hon. AMANDA FAZIO: Have you got any suggestions about how that might happen or the way in which we could better use the resources of the family knowledge?

Dr SUGO: I do not know, it is something I have not thought about, but I know that with the change to the mental health care the family has been asked more and more to help look after these people and I think part and parcel with that should be a consultation process where they can feed back to us as to how things are going and, if they are concerned, I think we should listen to them.

Dr CALA: I think a lot of the time the onus of responsibility of care and supervision of the mentally ill has fallen on to their family, there is no doubt about that, and I do not know that many people are in the best position to be able to do that. They have other family members and jobs, the rest of their life to worry about, not just this one person, but if you get away from perhaps stigmatising and looking at it as a mental health issue, if this was, for example, heart disease and your father presented with a heart attack I would be very surprised if the doctors treating that person did not involve the family in the

rehabilitation of that person, involve them in aspects of care, even dispensing medication and that sort of thing. I think you have to be sensitive about mental illness, there is no doubt about it, it is different from diabetes and cancer and so on, but I think in the right circumstances if you get to know the family reasonably well - and that again takes time, it cannot be done in a five minute consultation - I think they can be involved, even to a large extent, in caring for their loved one.

CHAIR: Can I go back to this case that is interesting. Who is Dr X?

Dr CALA: She is a medical officer at Glebe.

CHAIR: Well, she writes: I am concerned with the fact that she was released from the psychiatric unit at Prince of Wales. I believe she was assessed as being non-suicidal; however, events proved that assessment to be incorrect. I believe persons expert in the field should have a look at their assessment process - the Prince of Wales assessment - to ensure that best practices are followed. It is interesting also that in these notes she was found to have Venlafaxine in her blood. I assume that is an anti-depressant?

Dr CALA: Yes.

CHAIR: Whether that was prescribed there and then or she had been on that for some time - I assume she had been on it for some time.

The Hon. AMANDA FAZIO: Why?

CHAIR: Because in the two hours that she was at Prince of Wales it is unlikely that they would have shoved her on to that drug and she would have had this level of blood concentration. It takes time for it to build up, you do not get hit hard. That is quite a reasonable level, that is a therapeutic level, is it not?

Dr CALA: Yes.

CHAIR: So she had been having that, so she was known to be depressive and she was in Prince of Wales, and here is Dr X saying that the recommendation to the State Coroner's Court, to Sgt Y, is: I believe persons expert in the field should have a look at their assessment process to ensure that the best practice is being followed. So there is a concern and she is from the Institute of Forensic Medicine.

Dr SUGO: From our department, yes, it has changed names.

CHAIR: That is just more evidence, I mean I have not got her medical records here. History: Major depression.

The Hon. JOHN HATZISTERGOS: But that is not a primary record. Where did it come from?

Dr SUGO: It comes from a direct observation.

The Hon. JOHN HATZISTERGOS: How? What? She is dead.

Dr SUGO: No, from medical records that we have access to.

The Hon. JOHN HATZISTERGOS: That is why I would like to see them.

CHAIR: You would have trouble getting them.

Dr SUGO: If we write something in our report it is because--

Dr CALA: It is because we have read it in the medical records and if somebody says "Major depression", we take that on face value as being true.

Dr SUGO: That is right. There is no way we can do a mental state examination.

CHAIR: The evidence you have given today will be put on the web site uncorrected. We will send you a copy of it so that you can correct it. If you think that we have misunderstood and you would like to give a fuller answer or you read an answer and you think it should be improved upon, would you please let us know separately rather than just correcting the record. We may come back to you at some later time if we are going to make some recommendations as a result of your input or for other reasons and I hope you would be happy to assist us if that were to be the case.

Dr CALA: Certainly.

Dr SUGO: Absolutely.

CHAIR: I do appreciate you coming in, thank you very much. We may in fact be asking you for some statistical information.

Dr CALA: If there is any statistical data that you want retrieved that we are able to get, I would be very happy to bring that along at some future time.

CHAIR: Do all of the cases in New South Wales come to you?

Dr CALA: No. We only deal with the eastern two-thirds of Sydney.

Dr SUGO: And country.

Dr CALA: Not for suicides.

Dr SUGO: Not for suicides, no.

(The witnesses withdrew)

(The Committee adjourned at 2.50 p.m.)