THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON MENTAL HEALTH MEASURES MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART, ON THURSDAY 19 MARCH 2009.

INSPECTOR MARK MEWIS, TASMANIA POLICE, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thanks for coming along, Mark. We are recording the procedures and they become part of the public record, unless you wish to say anything in camera. You can make that request to us and the committee will consider it. As far as speaking to the media if they want to speak to you afterwards, we are more than happy for you to speak to them but just to not relate to specific issues that we might talk about in the committee.

Mr WILKINSON - Even if you agree

CHAIR - Mark, we are focusing particularly on the legislative framework that enables us to deny someone their civil liberties when they have a mental health disorder that requires treatment. We can hospitalise them without their consent for treatment. The reason we have asked you to come along and talk to us is that we know that the police are often involved with these patients as they have some issue in the community and come to the attention of police. They are brought to the hospital and sometimes they are admitted and sometimes they're not, but because of their very close involvement with police we thought it was important to see from your perspective how you feel the system works; if there are challenges or issues that maybe the legislative framework has an impact in. We appreciate you are not involved in issuing orders to detain someone, but we are aware that you are involved in spending time with patients until they are assessed. Would you like to give us a bit of overview of your role and the challenges you experience in managing patients who fall under this area?

Mr MEWIS - Yes, certainly. Persons suffering from mental illness provide a fair challenge to Tasmania Police, particularly because we are the only 24-hour seven-day service to some degree, and I think that that in itself is a challenge for us. We would prefer to see less intervention by the police and more intervention by health solutions.

Mr WILKINSON - What happens interstate?

Mr MEWIS - To be honest, I really couldn't tell you in any detail. I suspect that there would be 24-hour services in probably some of the larger metropolitan areas interstate. The adult health community team have extended their hours from what they were some time ago but generally it still only extends to about 10 p.m. Often, with the sorts of people the police have to deal with, it is much later than that or early in the morning when the issue arises. I suppose that would be the first thing that bugs us.

Mr MARTIN - For the record, could you run through how you'd deal with it in a normal situation?

Mr MEWIS - There is no normal situation. It really is event-specific, but I suppose the sort of scenario the police might deal with would be people threatening self-harm and bizarre behaviours such as running down the street naked waving things in the air, yelling at passing traffic and that sort of behaviour. Police are of the view that if the person is a danger to themselves or to others, then police have the power to act, of course, to take them into temporary custody and take them to the hospital for an assessment to see whether in fact they do have the parameters of mental illness in the definition.

The scenarios can range from somebody inside a private home causing or threatening to cause harm to themselves, to a public environment in a public place and any other number of combinations. It really amounts to people who are acting bizarrely or what would otherwise be out of the norm, but perhaps not on the verge of committing offences or such that the offence is seen as voluntary or whether they are incapable of making the decision to commit those offences.

Mr MARTIN - Where would you take them?

Mr MEWIS - We take them to a primary admission centre in the regional hospitals in the three key geographical areas - in other words, the Launceston General Hospital, the Royal Hobart Hospital and North West Regional Hospital.

Mr MARTIN - There has been some evidence produced to us that they might stay at the hospital for a few hours and then they are back on the street.

Mr MEWIS - That is one of our concerns, yes. If I go back a step, quite often one of the things that happens is that we will take someone to the hospital for assessment. The legislation provides for the detaining of that person for a maximum of four hours per assessment and we find that quite often that four-hour period is well and truly reached, which means that our police officers sit there and retain custody of that person for this amount of time.

CHAIR - The police are required to sit with them for that four-hour period?

Mr MEWIS - Yes, until such time as they have been assessed.

CHAIR - That must create some challenges, staffing-wise, for you?

Mr MEWIS - It does, very much so and particularly if those police officers have come from a regional area. For example, if they come from an area such as Huonville or one of the outlying areas where they may be the minimum police presence in that area at that time. Nevertheless, they are still required to stay with the person until they have been assessed.

CHAIR - That is the still the case is it?

Mr MEWIS - That is still the case.

Mr WILKINSON - Is that legislation though, Mark, or is it just custom?

Mr MEWIS - We would like to see the legislation reflect the fact that once we present them to the primary admission centre for assessment, the health authorities then take

responsibility. The Northern Territory and the ACT both have legislation that quite clearly states that the primary admission centre will take responsibility for custody of the person once they are presented. At the moment that is not the case here; our people will sit there for anything up to four-hours until that person is assessed.

Mr WILKINSON - If you did not have that duty to stay with them, and if they were assessed and then put back out on the street, should you be notified? It would seem to me, the answer would be yes because they might be creating dangers to others?

Mr MEWIS - Yes, we should be notified. In some cases we are and in many cases we are not.

Mr WILKINSON - How would that happen then if you lost control by handing it over to somebody else and then once they were assessed to be okay to go back into the community at night or early morning?

Mr MEWIS - It would not be too difficult for the hospital to advise us through our primary communications that this had happened. But what happens regularly - and this is a concern to us because police officers are not medical practitioners - is that when we take someone for assessment we have to make the best judgment we can at the time of whether we think those people are a danger to themselves or others, then they are released some time later and we have to go and deal with them again. There have been scenarios where we have people who are threatening self-harm or are suicidal and perhaps standing on a bridge threatening to jump. We have taken them in for assessment and three or four hours later they are back out on the bridge

Mr MARTIN - What happens then?

Mr MEWIS - We take them back again for assessment and sometimes they will be taken in from an order or sometimes there might some alternatives. We try to seek the least intrusive model we can - whether there are family or friends who can intervene. But one of the issues with current legislation is that the mental illness definition is so defined that it does not take into account people who are suicidal, and that would probably be one of the main scenarios that we deal with on a regular basis.

CHAIR - The definition in the act is that is has to be serious to be considered a mental illness, so if someone is having a relationship break-up or whatever and then ends up on the bridge or even jumping, they might not even have a history of any mental illness. Is this what you are talking about - these people?

Mr MEWIS - The history is the key issue. If there is no history then they are not taken to be mentally ill in terms of the definition. I made no comment about the definition because that is a matter for clinicians but as it stands at the moment the proposed changes to the new legislation would include some reference to temporary or continuing states and I think that would probably alleviate some of those problems. Having said that, at least two State jurisdictions that I know of have legislation that specifically refers to people attempting to commit suicide. It says that where a person is threatening self-harm or harm to others, or has attempted suicide within the last 48 hours or appears to be intending to attempt suicide, then the police can take them into protective custody for the

purposes of assessment. We do not have that, so it is really down to the clinician to determine whether the attempted suicide falls within the definition of mental illness.

CHAIR - If the definition does not change to include those sorts of scenarios, you are no better off?

Mr MEWIS - No, not at all. In fact, as I said, the definition as it stands at the moment does not work.

Mr WILKINSON - Am I right in saying that in a number of instances you would come across the people have not had any prior history but something that has happened in their life has caused them to think, 'I don't want to be here any more'. These are the people who are at risk of this?

Mr MEWIS - Very much so.

Mr WILKINSON - So what you want to do is take them to the hospital, and once they were taken to the hospital and handed over to the medical authorities, they would be assessed. Still, even if they are assessed and classed to be not at risk, a person without any medical knowledge would ask how can they be not at risk now when they were at risk two or three hours earlier. What do you do then?

Mr MEWIS - I think what should happen, and what probably does not happen to the degree that we think it ought to, is that there should be some follow-up intervention by health authorities. Quite often we will present these people to the hospital and they will be assessed and found not to fit within the definition of mental illness. We are contacted because we have responsibility then under the act, under our memorandum of understanding, to take those people and transport them - basically have responsibility for them if they are found not to have a mental illness. This is okay, but there is no follow-up in terms of their needing some sort of support. It might not be an intervention in terms of the Mental Health Act, though. It could be an intervention in terms of alcohol and drug support, or some form of counselling support or whatever, and we find that invariably does not happen.

Mr MARTIN - At 3 a.m. when that situation occurs, what do your officers do with them?

Mr MEWIS - We try to find some alternatives for them. In many cases they will settle down after a time and so forth, and we then try to find family, friends, some sort of support mechanism for them if available. Quite often they don't have any, and largely our hands are tied as to what we can do with them. If we are still of the view at that time of the morning that they are a threat to somebody, we will take them back into custody or take them back to the hospital, unless of course they have committed an offence and we can deal with them that way.

CHAIR - Getting involved in that side of it, trying to engage family or other people who may be able to direct them to the various avenues of support, was that the role of the healthcare provider? In my mind the role of the police is to deal with people who are creating a disturbance in the public arena or in a home. If in the view of police they need medical treatment then you would take them there, and then they get released and they are back out there and you pick them up again. Do you really think it's your role as

police to be looking for those other support services for them or is that someone else's role?

Mr MEWIS - No, but as police we engage with the community on all sorts of issues for all sorts of reasons, so I wouldn't see it as outside our role but health authorities should be the primary service provider in that instance. I think it would be reasonable to say that after hours we become the default service provider rather than the secondary service provider.

CHAIR - Is that predominantly because there's a lack of services available at that time of day?

Mr MEWIS - Yes.

CHAIR - What sorts of services do you think could be implemented - bearing in mind we don't just have the Hobart area; we have the whole of the State to consider with smaller populations - that could alleviate some of this?

Mr MEWIS - I don't know that it's my position to make a comment. It is probably for the health authorities to make that determination but it would certainly assist us if there was an intervention team of some description that operated 24 hours a day to alleviate exactly those problems.

Mr WILKINSON - That would be the ideal, wouldn't it? It would seem that if you saw a person about to take their life, and you took that person into the hospital and a couple of hours later the hospital gave them back to you, it would be better for that person to go to an intervention team where they could be counselled, be talked through their problems. Alternatively, as a result of further information, they might then resubmit them to the medical authorities and say, 'I know you've come out and said that that person is not a problem but after fairly lengthy discussions with them we believe they are because of *x*, *y* and *z*' and then get the medical team to assess them again.

Mr MEWIS - Yes, I would agree with all those scenarios.

Mr MARTIN - Is that what happens during the daytime now?

Mr MEWIS - It does to some degree, perhaps not to the degree that we would like. We don't have any firm figures on it but I suspect the difficult times that we have would be after-hours times. During the day there are opportunities for us to follow up with alcohol and drug people. Again, it seems to be that we do that in certain circumstances rather than the health people do. Realistically, the police should only intervene when it really becomes a matter of public safety or safety to the individual. Beyond that we really shouldn't be involved. The general principles of human rights state that police are a last resort in intervening with people suffering mental illness, for a whole range of reasons. Our preference would be that that was the case on all occasions.

Mr MARTIN - Are there sufficient services after hours so that police should not be forced into a role they shouldn't be in. Is that okay now or is it a problem?

Mr MEWIS - It is difficult for me to answer whether or not there are sufficient services. During the day I suspect there are, but I think the issue is that if a person is brought in for an assessment, day or night, in relation to a mental illness, if they don't fit within that parameter then the default position is to give them back to the police rather than to seek those additional services.

Mr MARTIN - So that's a problem 24 hours a day?

Mr MEWIS - In my view it is, yes.

CHAIR - If you have the intervention team you talked about available 24 hours a day, they would assess the person but then access the services or keep them in overnight until these services were available during the day. That would be the role of that team.

Mr MEWIS - Yes. I would go one step further and say that at 3 o'clock in the morning, in certain circumstances where there are reports of people or a person acting strangely or bizarrely that would appear to require some form of assessment, then a health intervention team could attend in the first instance. We would attend if there were some threat of danger, of course, but not in circumstances where there is no immediate threat of danger.

CHAIR - Someone walking down the street naked is not really creating a problem.

Mr MEWIS - No, not necessarily, but we would be called to attend because there is nobody else to attend. Nine times out of 10 we would take that person for assessment, but a health intervention team could make that assessment virtually on the spot to some degree and provide some sort of intervention role, which may be other than taking them in for assessment; they may have some other option that they can use that the police do not have.

Mr MARTIN - It must put enormous pressure on your staff to deal with these mental health situations considering they are not medically trained? Do they receive any training?

Mr MEWIS - We do have training. Our recruits are given some training but it is more about identifying a person suffering from mental illness, the key indicators and obviously in the legislation and their powers and how to deal with it. Mental Health Services have, in the past, provided some training out in the field. We had what are called district training days once a week in each of the areas which combine a whole range of training and from time to time mental health have provided us with some training on those days for our infield police. That does not happen that often.

I think, largely, our people do a very good job, given the circumstances that they face, particularly at all hours of the day and night, and the fact that they are not trained specifically to make diagnoses.

Mr MARTIN - That is certainly what I have heard, anecdotally. We have heard nothing but praise for the police.

CHAIR - Mark, can you give us a bit of an indication of the amount of time this takes up, particularly the after hours? What percentage of your work force's time is taken up dealing with people in this category?

Mr MEWIS - I really could not tell you. We do not keep very good records in relation to dealing with people with mental illness. Our command and control system, which governs our incident reports and how they are dealt with, simply records generally what the incident was first reported as. So it could be a disturbance or it could be anything and it is not until police arrive that there is an identification that mental illness is possibly involved. To cut a long story short, our data capturing does not simply capture that. I would not hazard a guess, it varies so much.

Suffice it to say that when we do it, it takes a fairly big chunk out of our time - particularly if you take travel into consideration. For example, if the police take someone into protective custody at St Helens they have to go to the Launceston General Hospital. So you have all the travel -

CHAIR - So it is not just going to the local police station. This means significant distances to be travelled in these regional areas?

Mr MEWIS - Yes, because the major hospitals are the only ones with the facilities to deal with the assessment.

CHAIR - So in Circular Head you would not go to the Smithton Hospital?

Mr MEWIS - No.

CHAIR - No, you would go to Burnie?

Mr MEWIS - The primary admission centres are designated under the act or in the schedule or the regulations; I am not 100 per cent sure, but they are quite clearly specified. So, we have no other alternative but to take them.

Mr MARTIN - You mentioned before the example of Huonville and at 3 a.m. the situation occurs and they bring you up to the Royal Hobart Hospital. I imagine there would not be too many officers on duty at 3 a.m. at Huonville?

Mr MEWIS - No.

Mr MARTIN - Just the two?

Mr MEWIS - Yes.

Mr MARTIN - So what happens then?

Mr MEWIS - That area would then have to be covered from the nearest available police unit or on a recall basis. So, in Huonville's case it would be Kingston or a recall of Huonville police or a recall of Geeveston police or -

CHAIR - A recall of off-duty officers?

Mr MEWIS - Yes, off-duty officers. Or, if there was a Kingston unit working, a Kingston unit would attend. But, yes, it takes the on-duty police resources out of that area.

CHAIR - Do you have any idea from your data how often this happens, that you need to back-fill in that way?

Mr MEWIS - No, I do not.

CHAIR - I am just thinking about the cost of it, Mark. Is there a quantifiable basis for the argument of putting in place the intervention team that you talk about? Obviously it would cost money to establish a 24-hour intervention team but this could be offset against the costs that would not be spent on police time and travel time and all of that. Is there any way that you could get some of that information through your data or is it just not possible?

Mr MEWIS - It would be very difficult. Largely there would be some anecdotal evidence but that would be about it because we simply do not record it. One of our submissions to the committee has been that we would like to see more recording of people who are brought in for assessment at the hospital end.. One of the reasons we are keen to do that is to ascertain those who are brought in and not put on order versus those who are because they could inform us as well.

CHAIR - We are talking to the Department of Emergency Medicine heads in both areas, so that is something we can ask. As far as you know, they don't keep that data?

Mr MEWIS - As far as I know, they don't. If they do, we certainly don't see it.

Mr WILKINSON - Are you able to get their medical records when you go there and sit with them, which would assist you in deciding whether they are going to be a danger upon their release?

Mr MEWIS - No, not as such, but I think the information lines are fairly informal on those occasions. Quite often the people who are dealt with in this manner are known to the people at the hospital and to us, so there is usually a history of one form or another exchanged between the nurses and the attending police, but not formally, no.

Mr WILKINSON - Unless you get their authority, I suppose their medical records wouldn't be open.

Mr MEWIS - There are a lot of privacy issues.

Mr WILKINSON - That's why if you get their authority it is okay. But in relation to the medical records unit, probably it would be closed down after hours as well?

CHAIR - They're always accessible. You can always go and pull a file.

Mr MEWIS - The memorandum of understanding that currently exists, and which is due for renewal, states that we can exchange information in crisis situations. If you can imagine a siege situation, where we have someone who has been previously diagnosed or is a

patient, the medical authorities under the MOU will provide us with information in as far as it is restricted to what dangers we might face - for example, if they have an aversion to authority figures or to people dressed in blue or whatever it may be and it is relevant to that situation - that information would be exchanged. But largely it isn't on a day-to-day routine basis.

Mr WILKINSON - Should it be?

Mr MEWIS - I think it would assist, yes, particularly if we have some police who don't know the subject and have had nothing previously to do with them. Certainly if there were critical factors that would affect the safety of our members we would be extremely keen to have access to that information.

CHAIR - You would need to restrict it to that because the fact that they had some other illness, some other health matter that was irrelevant to your management of that person, there would need to be a fine line in regard to disclosing information.

Mr MEWIS - It would be difficult but, again, there are problems with things such as addiction to alcohol and drugs. The current definition talks about a person who doesn't fit within the definition of mental illness based on alcohol or drug intoxication alone but sometimes if there are drugs or alcohol involved then that would seem to be a factor in determining that they don't have a mental illness, even though they previously have been diagnosed with a mental illness. Our knowledge of that would mean that we would be in a better position to argue the fact that just because they are intoxicated on this occasion doesn't necessarily mean that it's not a mental illness that is still playing a fairly significant role in this event. I suppose there are circumstances where that information would be of assistance to us, but I agree it would be a very fine line in protecting a patient's privacy and allowing police to have access to certain information. At the moment I think that exchange works reasonably well.

CHAIR - In relation to drugs and alcohol, often it is very hard to tell if someone is intoxicated on whatever substance it may be or whether they have a mental illness. Do police have to make a determination at all? I know you don't have to apply the meaning of 'mental illness' under the act, that is not your role, but it must form part of the process of your assessing someone's need to be put in a cell to dry out for a while or taken to the hospital?

Mr MEWIS - Yes, very much so. We have to make a determination whether the person is simply drunk and committing offences and behaving badly or intoxicated by some other drug. Again, our people are fairly experienced in determining that in that they deal with drug- and alcohol-affected people regularly and so they are reasonably good at making that determination. When there are issues of comorbidity where more than one factor is in play, obviously that is a lot more difficult for our people. What can happen, for example, is that there will be a subject who police know has previously been diagnosed with a mental illness, perhaps on a number of occasions, and is involved in an event that could be seen as bizarre behaviour or whatever, but also happened to be drunk at the time. Our argument is that the drunkenness should not preclude the fact that they perhaps still need an assessment, depending on what they are doing. If they are simply staggering down the street and not really causing any sort of problem -

CHAIR - Tying to find their way home.

Mr MEWIS - Yes, it is not something that we would intervene with, or we certainly would not intervene with it via this legislation. If they are waving swords around and are naked in the middle of the street and they have a previous history of mental illness, the fact that they are also currently affected by alcohol should not, in our view, preclude them from undertaking an assessment. We are told from time to time that these matters are episodal and that is understandable, and that is why to my way of thinking the proposed definition, because it talks about temporary and continuing and so forth, tends to cover off on some of those issues.

Mr MARTIN - Would it fix the problems you are talking about?

Mr MEWIS - It won't fix all the problems. It will certainly be a significant improvement on what there currently is, but of course it will largely depend on the standing orders issued by the proposed Chief Psychiatrist. My understanding is that it is proposed that the Chief Psychiatrist would be in a position to issue standing orders and practice directions on how the definitions apply. I think the proof of the pudding will be in the eating in terms of how that occurs. In other States, for example, they have a separate definition of mental illness, but then there is an alternative definition of mental disorder or dysfunction, which provides for probably a lower threshold and talks about bizarre or unnatural behaviour. It means that someone who might not fit the precise clinical definition of mental illness but is still acting bizarrely and strangely can still be taken by police for an assessment.

Mr MARTIN - I am really concerned about the amount of police time that is taken up on this. I am concerned that there are no records available to try to analyse how much of your police resources are taken up on this issue. We had an example - and I don't want to identify the person in open committee - of what you were just talking about, of one who does not fit the definition and therefore is not kept in the hospital, yet his father has given evidence to this committee that in one two-week period the police were called five times. How common is that?

Mr MEWIS - Common.

Mr MARTIN - That really is common, is it? So this situation in Huonville could happen five times in two weeks down there?

Mr MEWIS - Yes, and I know personally of instances where that has happened. I can recall an incident - and I don't want to give too much detail, for obvious reasons - where a person acted very strangely on a number of occasions and caused quite a lot of fear in the community. He had been diagnosed with a mental illness, and then was not because it was seen to be drug-induced, and yet we were told on a number of occasions to search his house and find evidence of drug use because it was clear that was causing the problem. We had no power or authority to search his house for drugs, and we certainly had not found any drugs when we had attended on that occasion, but that person was regularly taken to the hospital for assessment and was regularly given back to us some time later. I am talking about swinging swords above his head and threatening people on the street at 3 a.m. yelling quotes and scenes from battle movies and all sorts of things, all behaviour that the average person in the street would think was quite abnormal.

Mr MARTIN - And you are expected to do something about it.

Mr MEWIS - Yes. We are not clinicians but my understanding from the police that attended was that they did not see any obvious evidence of drug use or that it was drug-induced. The other issue, of course, is that the diagnosis will often depend on who attends at the time, so we have had situations where the Adult Community Health Team have attended a situation where they have said this person needs an assessment and is clearly showing signs of mental illness and in fact has been in our system before. We have taken that person to the hospital. They have been assessed as not having a mental illness and given back to us an hour later, despite the fact that the trained community health team have just two hours previously said that they did have a mental illness. So there is a lot of ambiguity about the diagnosis on a regular basis.

Mr MARTIN - It is not uncommon in a situation like that where you could deal with them five times in two weeks or something?

Mr MEWIS - It is not uncommon for us the deal with them five times in a day in some cases. We could extract some data, but the reason it is difficult is that we might not hear of that person for six months and then, all of a sudden, that individual becomes a major issue over a two-week period and then fades away again. Often with the recorded reports that we get the link is not always that obvious, particularly if different police are dealing with it.

Mr MARTIN - If this committee were to recommend that the police keep records of this to analyse what percentage of your time was taken up, would that be possible to do?

Mr MEWIS - It would be. It would simply mean that we would have to develop a reporting mechanism for capturing incidents specifically related to mental illness or that we believe are related to mental illness, because after the assessment they might be found not to be mentally ill. But at the moment given the way we record our events it would be difficult. We could go through it manually over a period of time but it would be difficult to substantiate any firm data. We could offer some data but it would be difficult to offer distinct data. But it would not be beyond us to introduce some form of recording system to capture that.

Mr MARTIN - If you implemented a system today, would it be time consuming?

Mr MEWIS - To implement such a system?

Mr MARTIN - Yes.

Mr MEWIS - Of course, we would prefer to avoid any additional administrative work on our people attending these incidents. So we would have to give some thought as to how we captured it. I would have concerns if you introduced yet another form for our police to fill out at the scene. But there are ways that we could move around that through our command and control system, which captures all the incidents we attend. We could perhaps make some amendments to that. I certainly would not be prepared to commit to it without further advice from our corporate management group. But I think it would be quite feasible for us to do it, yes.

Mr WILKINSON - You have your own psychiatrists or psychologists full-time at the police?

Mr MEWIS - Yes.

Mr WILKINSON - Have you, at times, had to call upon them or are they strictly in relation to the police?

Mr MEWIS - My understanding is they are strictly for staff and to my knowledge they have not been used for anything external. But I could not be sure whether or not advice has been sought, particularly in high-risk situations such as searches, where we will seek advice from psychiatrists or psychologists regardless of whether the person has a history or not because it obviously assists in negotiations with offenders and so on. I think our psychologist has been used for that from time to time but certainly not with a routine patient or a routine subject.

CHAIR - Taking the issue of the intervention team a little further, we have had some evidence that there may be some benefit for any patient who presents, whether they come in with the police or a family member brings them in or they present themselves to the Department of Emergency Medicine, to be provided with an advocate pretty much up-front and who could be part of that intervention team in that setting. That advocate would be able to assist that person - whether capable or incapable of making decisions. Would that be a person who could perhaps relieve the police of their duties so that police could leave once the person had been received by the Department of Emergency Medicine staff? Would that be an option?

Mr MEWIS - Yes, I think that would be quite a good option. One of the issues, of course, is safety and security, so there will still need to be some safety procedures in place. But I think that would be a good option.

CHAIR - Safety and security for staff and other patients in the unit?

Mr MEWIS - Yes.

CHAIR - Is it appropriate then to have security personnel - who would benefit from a bit of skilling, as your police officers get, in mental health disorders - that could fulfil that role?

Mr MEWIS - Yes and there already are some but they are limited in number. That would be our preferred model - that we would hand over responsibility at the time and that their safety and security would be undertaken by the hospital, obviously through a third-party security person. There would need to be sufficient to address any situation that might arise because sometimes these patients might calm down quite significantly once they are in custody with the police, but then they might fire up again or react to different events that might occur at the hospital, if they are told, for example, they are going to go to another room. That may spark a reaction and so the security would need to be constant, depending on the nature of the patient. Not all people that we deliver to the hospital are violent, but the large majority have shown some propensity to violence otherwise we wouldn't be intervening.

CHAIR - So you're saying that the majority of people you are involved with in taking them to the hospitals have a tendency to violence?

Mr MEWIS - Yes.

CHAIR - Would people having a mental health crisis but who are still able to think rationally and are not threatening to kill themselves or harm anybody else normally come to your attention, or would they get there some other way?

Mr MEWIS - No, we deal with those people. I suppose I am thinking of after hours really when some form of violent behaviour is usually the norm. If we get some indication after hours that somebody is not looking after themselves - I am trying to think of a scenario that might fit - generally we wouldn't become involved. For example, during normal hours where somebody was not capable of looking after themselves or was spiralling downhill. Mental health authorities would deal with that and probably would only call on us if there were an issue of safety. After hours, we would probably be more inclined to pick up a couple of those cases.

CHAIR - So that is the role for the intervention team, and it wouldn't require your attention if that was in place?

Mr MEWIS - Yes, that's right.

CHAIR - Do you have any comments you would like to make in closing, or any recommendations you would like to suggest?

Mr MEWIS - I would like to reinforce a couple of points. We would like to see a change in the definition to ensure that it encompasses persons threatening suicide and bizarre behaviour on a temporary basis. We would like see a handing over of custody and if that were legislated it would give us firm ground on which to operate much better and would free up our resources. Operationally, though - perhaps not for legislation - we would like to see better opportunities for following up patients who don't meet the assessment criteria but are clearly in need of some form of intervention other than police intervention. We would like to see that firmed up so that that support and intervention was provided.

CHAIR - Thank you for your time. It is good to hear from the coalface, so to speak.

THE WITNESS WITHDREW.

Dr JOHN CRAWSHAW, CHIEF EXECUTIVE OFFICER, WAS RECALLED AND RE-EXAMINED, AND **PROFESSOR MARK OAKLEY BROWNE**, STATEWIDE CLINICAL DIRECTOR; AND **Mr CHRISTOPHER FOX**, SOUTHERN REGIONAL MANAGER WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Thank you for coming along. I am sure you are aware of the terms of reference of the committee, that we are focusing on, particularly the legislative frameworks, the protective legislation for people with mental illness. The committee is well aware of the review of the Mental Health Act that is ongoing. To start off, we would like you to give us a bit of background as to where you fit into the service delivery area. Whilst we don't necessarily expect you to comment on the legislation as it exists or how it might be or what the way forward is, we would like to hear from you how it is applied at the workplace, what challenges that presents, if it does, and a variety of issues from various sectors of people using the services - community services as well as in-hospital services. There will always be varying views on how that works, or doesn't. We would like to hear from each of you how you see it and what your role is within Mental Health Services.

Prof. OAKLEY BROWNE - I was recently appointed to the position of statewide Clinical Director of Mental Health Services. My understanding was that this is a new position within the service, which has principal responsibilities for clinical governance - that is, the quality and safety of the care provided to patients within the service. I started that appointment on 2 February and I am getting on top of the position and its responsibilities and duties, including the proposed mental health legislation. My previous responsibilities were within the State of Victoria. For five years I was clinical director for mental health services in the Gippsland region of Victoria. More recently, for the last three years, I was professor and director of the Monash centre for rural and indigenous health. Prior to the last seven years in Victoria I worked in New Zealand as an academic psychiatrist. So my experience in terms of mental health acts has been shaped by my experience in New Zealand and more recently in Victoria.

Mr FOX - My name is Chris Fox. I am the Southern Area Manager for Mental Health Services, which means I have overall responsibility for the operation side of Mental Health Services South. I have been in this position for almost six years. My background is in nursing and prior to working in this overall manager role I was team leader for Inpatient and Extended Treatment Mental Health Services, which includes PICU at the Royal Hobart Hospital and the Millbrook Rise facility at New Norfolk.

Dr CRAWSHAW - I suspect that you know my role but, as people would be aware, I wear many hats. I am CEO for Mental Health in the statewide services and have overall operational control. I am also the Chief Forensic Psychiatrist and am specifically responsible for the operation of the forensic sections of the act. I am also a consultant psychiatrist.

Mr WILKINSON - So you've got a bit on, John?

Laughter.

Mr WILKINSON - We have just heard - and it has always been a bit of an issue for me - what often occurs is that if people are carrying on in a bizarre fashion in the early hours of the morning, the police are called to attend. If the police attending believe such people are a risk to themselves, they are taken to the hospital and the police are required to stay with them for up to four hours for the assessment. They then may be told that because they do not fall under the definition 'there is not much we can do with you', and they are given back to the police who are then left with the decision of what to do with them. How do we overcome that problem?

Prof. OAKLEY BROWNE - It is also problem in the other two jurisdictions I have worked in - Victoria and New Zealand. It is not unique to Tasmania. There are a group of people who behave in a way that causes concern to the community and the police but who would not meet the criteria of the Mental Health Act in those other jurisdictions. There is then an issue as to how you manage the situation.

Mr WILKINSON - Should the definition as we have it change to ensure that these people who are acting in a very bizarre fashion - let us say they are on top of the bridge and want to jump off - in two or three hours' time they might have calmed down. It is a lot of responsibility for yourselves to say that they are allowed back out into the community. That might be the case though, and the police are saying they are back out on the bridge as soon as they can get out. We have had that example.

Prof. OAKLEY BROWNE - I cannot talk about specific examples, but I think if a person is actively seeking to harm themselves, and in a short duration of time they try to do it again, then I would be surprised that they had been discharged, actually. I would expect them to be given the benefit of a further period of assessment in a more secure environment. I don't think broadening the definition of 'mental disorder' under the act will change that problem.

Mr MARTIN - Why?

CHAIR - You can look at conditions of a temporary nature such as someone who has found out that their husband or wife has left them, they are in a bit of a financial crisis or whatever, and their reaction is to think that life is not worth living so they will go and jump off the bridge, but they have no history of mental illness, they were not previously depressed even. The definition as it stands says they have to have serious distortion of perception or thought, or serious impairment or disturbance of the capacity for rational thought, and on it goes. Everything has to be serious. That is a serious incident, but it is temporary. If they can get good support and counselling they may well realise that life is actually worth living and work through some of these problems. Under the current act - this is the point we are making - that situation is not allowed for, to detain them and provide them with treatment to the point that it does not stop them going back out to the bridge half an hour later when they leave the hospital.

Prof. OAKLEY BROWNE - I think that is not a common situation, to begin with. Most people who are actively trying to harm themselves would meet some criterion for mental disorder. The legal definition of disorder is actually fairly broad and can encompass most disturbances in behaviour, perception, thinking and mood. What happens is you get variable interpretations sometimes by commissioners about that disorder, about whether those criteria apply, and some people would apply a more stringent

interpretation and some a more liberal interpretation. I tend to think that if someone even has a very transient disturbance in behaviour associated with marked disturbance in mood - and I expect that someone who has had that sort of personal circumstance and was trying to harm themselves would fit those criteria - that they would have disturbance in behaviour clearly because they were trying to harm themselves. They would have disturbance in mood, I would think, because they would obviously be very upset in some way or another, so even that transient disturbance -

CHAIR - But it comes down to interpretation of what 'serious' is, doesn't it?

Prof. OAKLEY BROWNE - Yes.

CHAIR - It has certainly been brought to my attention that there are some psychiatrists - and not the one across the table - who suggest that personality disorders are not mental illnesses. That means that when someone has a personality disorder, if they come in when that particular psychiatrist is working they will not be admitted, whereas if they come in when someone else is on who has a different view about that, they will most likely be admitted.

Prof. OAKLEY BROWNE - Yes, there is variable interpretation, and that is one of the problems with the current act. I would hope that the new act, associated with teaching and training of clinicians as to how to interpret the act, would lead to lesser variation. But I think people with personality disorders would meet the criteria of the legal definition of the act, particularly at those times when they are extremely distressed and disturbed. It would be unusual that you would see someone with a personality disorder who at the time does not also meet some other criterion for a mental disorder. Quite commonly people with personality disorders also will meet criteria for mood or anxiety disorder or substance-use disorder, and it is within the context of a life stress or difficult circumstance that you get self-destructive behaviours. In those circumstances I think you would look at the act and see if they met the criteria and I would be surprised if most people did not.

The current act is a bit clunky, if you forgive the expression, in the sense that it does not fit well with current, modern clinical practice and processes. It places an emphasis on place of containment rather than on treatment per se. In the other jurisdictions I have worked in you would have other options in your therapeutic armoury. You would not need necessarily to admit a person, but you could require them to receive treatment, so you have treatment under an outpatient order, for instance, or a community treatment order.

I think part of the problem of the current act is it does not give the clinical team a range of options that they might wish to exercise in a circumstance like that. They can only really admit or not admit, whereas there might be other options which would provide the person with support, follow-up and appropriate treatment and also some degree of control if that were necessary.

Mr WILKINSON - After hours, is there an intervention team available for counselling or any other service that is required within Tasmania?

Mr FOX - Yes, there are currently intervention teams available after hours in the south and the north, and one is about the commence in the north-west. That is a seven-days a week service in the south that currently finishes at 11 p.m.

CHAIR - It is not 24 hours then?

Mr FOX - No.

CHAIR - Can you describe how that intervention team works, what they do?

Mr FOX - The intervention team consists of clinicians who are based in the community. In Hobart the intervention team comprises two clinicians who are based at the Peacock Centre, which is in North Hobart, one clinician who is based a Gavitt House in Glenorchy and one clinician who is based at Bellerive Quay. When contact is made, and frequently those contacts come through from the help line, the clinicians respond to that contact based on assessed needs. Typically, someone on the bridge, the scenario that was referred to, would be given a CAT 1 response which is an immediate response, emergency service is required and Mental Health attends, if at all possible or if requested by the emergency services. Sometimes we are not. If we are, the staff who received the call would go to the bridge and meet the police and the ambulance there.

Mr WILKINSON - What would happen? Would that person be taken to the hospital to be assessed?

Mr FOX - In the scenario of the person being on the bridge, I would imagine that invariably the person would be taken to hospital but there would be other scenarios where that may not be the case, depending upon presenting circumstances.

Mr WILKINSON - During that time leading up to assessment police have to remain with them, haven't they?

Mr FOX - That is correct.

Mr WILKINSON - Do you think there is a necessity for that or should they be passed over to security within the hospital?

CHAIR - Or the intervention team on the bridge?

Mr CRAWSHAW - I think there is a difference between where we are currently and where we hope to be with the changes we are proposing in the new legislation. I will make some general comments with respect to that and remind you of comments I made last time I was here.

First, one of the things which we see would help with variable interpretation is not simply training but also the capacity to write clinical guidelines. We are intending that the chief civil psychiatrist or the chief forensic psychiatrist, such as myself, could provide guidelines to assist clinicians in making some of those judgment calls because we certainly recognise that it can be very difficult sometimes to make the judgment call. If we can provide them with guidance as to how to respond, from a legislative point of view, that will greatly assist. As I said, this is not necessarily because they are trying to

do the wrong thing, they are trying to place their clinical understanding within a legal context. As a forensic psychiatrist, it is something that I am used to but it is not necessarily something that I would expect all clinicians to be able to do to the same degree of facility that I have.

Mr WILKINSON - What happens in other States, do the police have to wait with these people?

Dr CRAWSHAW - If I can come onto the second part of the question. Second, we are trying to be much clearer about what happens when someone is taken into protective custody and what happens in terms of the handover process with respect to protective custody. There will always be times when, because of the risk associated, the police or the ambulance service may well need to assist our clinicians. There may well be times when we can facilitate more of a health response rather than a police response. It really has to depend upon that risk and working with the police. One of the things which we are trying to be clearer on, in terms of our thinking with the drafting of the new legislation, is to be clear about what happens when, say, the police bring them into the hospital and they allow for the capacity to be handed over clinically, without the police necessarily having to wait.

That there are legislative components and then there is the service component. I think that the extended CAT function has been really only developed in the last 18 months to two years, hasn't it?

Mr FOX - Yes, in October this year.

Dr CRAWSHAW - What we are seeing is the rollout of different types of service options which then in turn, regardless of the legislation, give us a better range of options. We are in the process of integrating the services within the south so that the community and the hospital mental health services function more effectively together. That again gives a greater range of options with respect to how we manage people.

Part of Mark's role is very much about trying to raise the overall clinical governance of those services and to look at how we manage some of these risk processes more effectively. That is why, for instance, this clinical director has been appointed in the north-west and the north, as part of that process of trying to assist our services to make more appropriate responses than people may have perceived in the past.

That is not to do with legislation. Legislation gives us the framework on which to work but what we have to do is actually look at the service delivery options because - and I repeat what I have said to you before - legislative response is the last option in involuntary treatment options or involuntary admissions to hospital.

We would vastly prefer to be able to work with people on a voluntary basis.

Mr WILKINSON - Does the legislation allow you to do that now?

Dr CRAWSHAW - There are parts of the legislation that are unclear. There are parts of the legislation which in one interpretation tends to look more cross-sectional rather than longitudinal and therefore we are trying to change some of the definitional sections to

make it clearer that you can take into account a wider range of factors when you are making your assessment

In answer to your question, we have current legislation, which I agree with Mark is quite clunky and does sometimes produce responses that may not be seen as helpful. We are trying to look at how we map new legislation that allows a continuum of care approach and also looking at a longitudinal approach with respect to the person.

Prof. OAKLEY BROWNE - I could state in support of my senior colleague that going back a few steps in terms of the response of the person who is on the bridge, it used to be considered that an admission of itself was not a treatment so the intent was to intervene in a way to increase the likelihood that a person would get to a state where they were better able to manage their lives and be less of a risk to themselves.

Admission may be part of a treatment package. So admission may allow certain types of interventions to occur which allow you to get to that end point. But it may be possible to deliver the treatments without admission but also needing some sort of control.

In other jurisdictions they have moved away from the emphasis on place of treatment, in-patient or community, to the idea of a compulsory treatment order which gives you a great deal more flexibility about how you will deliver treatment.

In Victoria I was involved with a number of cases. For a while I was Deputy Chief Psychiatrist in the State of Victoria and we often got involved in the Office of the Chief Psychiatrist with very complex cases that were high risk, often-repeated, self-harm type of cases that caused a great deal of anxiety amongst the community, the family and the treating team.

With those people who had those sorts of problems it often meant mapping out a very detailed treatment plan and involved various care and service providers contributing to that plan.

When a person acted in a way that caused concern, with self-injurious behaviour, they might be assessed but they might not always be admitted. Part of the plan set criteria for when it was appropriate to admit and when not. At times admission doesn't help. It may actually exacerbate in the medium to longer term that type of behaviour, and other responses may be more appropriate.

I do not know if that helps.

Mr WILKINSON - We have had evidence of a situation such as the one involving a fellow called Terry, who is classed as having a personality disorder. He is a big strong fellow, extremely big and strong. It has reached a stage where, because of his age and strength, his parents could not look after him. They call for assistance, he goes to the hospital, where they say, 'No, you do not fit the criteria, off you go.' Immediately he is back out on the streets or wherever causing disruption, there is a call from the community and the police then go and get him. Then it is back to the hospital - no, he does not fit the description, so out he goes.

Mr MARTIN - The police have had to deal with him five times in two weeks.

CHAIR - They said they had situations like that five times in one day.

Mr WILKINSON - He is putting his hands up and saying, 'What can I do, what can I do?'

Prof. OAKLEY BROWNE - I cannot speak of the specific instance there but what I would expect to happen in a case like that is that the various services involved with that person - and it would be usual that multiple services were involved: police, housing, social services et cetera - would sit down and have a meeting about the most appropriate management plan, how they would each contribute to that, and map out what should happen if the person presented. That plan would include other responses, besides just in-patient admission - which may not be the appropriate response.

CHAIR - But letting them back out into the streets would not be the most appropriate response either in situations such as that, would it?

Prof. OAKLEY BROWNE - If the person was going straight out to harm themselves, no, but if the person was not regarded as of immediate risk to themselves then the in-patient team might have no choice in that, under the law. They cannot retain a person -

CHAIR - Yes, I appreciate that. When we are talking about the intervention team, the fact that it is not a 24-hour service is a failure, probably, of the system. From the police point of view and from what we have heard from other witnesses, most of these crises occur in the middle of the night after 11 p.m. and before 7 a.m. The alleged time of most need is when that service is not available, so how that service works during the day may be different from how it could work after 11 p.m.

Can I get you to explain a bit more about what you actually do, what the role is, how you provide that community care or whatever it is for this person who presents, regardless of the severity of their illness or what they are actually suffering at the time. Also going on from that, do you suggest that expanding it to 24 hours would be a benefit?

Mr FOX - Mental Health Services does have a 24-hour service that is available for mental health emergencies - that is the mental health help line, which is manned 24 hours a day, seven days a week. Whoever contacts it - and it is quite often the police - gets a clinician on the other end of the line who would provide advice in a scenario such as that. At this point in the south we do not have the capacity after 11 p.m. to provide an on-ground response. The data we have of presentations after 11 p.m. until 7 a.m., from a strict financial or budgetary perspective would indicate that the cost of having staff in place for what may very infrequent presentations or scenarios would potentially outweigh the benefit in having that service there.

CHAIR - Is it possible to get statistics, or numbers from the help line, as to how many calls they get, what time they get them and how long the calls take? Obviously some calls can be quite short calls, others could require quite a degree of engagement. Is it possible to get that information so we can look at the time frames?

Dr CRAWSHAW - We would have to take that on notice. We certainly could provide some breakdown of statistics.

Mr MARTIN - Going back to the issue that Jim raised, and I think we were referring to this particular example, we have had a number of witnesses - it is not just the one - saying much the same thing. I will refer to the same one because I know you are familiar with it, Kevin, from what you indicated last time you were here.

Dr CRAWSHAW - As Mark said, I am constrained in the terms of what I can say.

Mr MARTIN - Yes, and I do not want to go into certain detail, but in order to highlight what we are concerned about, as a layperson I am struggling with what seems to be conflicting evidence about the hospital policy and the definition of mental illness. So can I just quote from this particular submission of the parent of this one person?

Mr CRAWSHAW - Yes.

Mr MARTIN - 'The Royal Hobart Hospital policy taken word for word from an e-mail response to a complaint by me a few days ago is - and I quote:

> The hospital's policy is not to admit "patients who primarily suffer from a personality disorder and for whom a brief period of time in hospital is unlikely to produce any therapeutic benefit".'

Then quoting further from the parent:

> 'The community mental health support option available to my son and people with similar illnesses is the mental health crisis line - the 1800 number. This is a process similar to the Department of Emergency Medicine - that is, are they diagnosed with one of the five major categories of mental illness? If the answer is no, then are they psychotic? If the answer is no, then the conclusion is they do not qualify for treatment and help at either of the hospitals and the only community option which is available to them is the Health 1800 number.'

So he then surmises that there is a whole category of people with severe mental illness suffering in the community with no support options available to them. That seems to be borne out by evidence we have just had from the police, where in one two-week period the police had to be called five times. I asked the police inspector whether that is common and he said it is very common and in fact sometimes they can be called out five times in a day. There seems to be this group of people who have fallen through the net somewhere. That group of people is concerning me and I do not quite understand how this is happening. They seem to be people who need help for themselves personally, for the families who are suffering incredible distress and also for the wider community.

Dr CRAWSHAW - I really do not want to discuss the specifics because -

Mr MARTIN - No, I am using it as a question.

Dr CRAWSHAW - I do not have any permission to do so. Again, I come back to some of the comments that Mark was making. One of the issues for me is not simply to rely on a diagnosis but to rely upon the functional level of dysfunction - the level of disturbance in someone's life. The way that the current Mental Health Act is written and certainly the way some people apply it means that there is much more of a cross-sectional focus as

distinct from a longitudinal focus. We are trying to clarify that within the new legislation.

The other part about that is that there have been some disjunctive points between what the community services provide and what the hospital services provide. That is part of why we are integrating the services in the south so that we close off some of those cross-over points so that we have continuing care. The whole focus of the new mental health strategic plan is to move towards assertive case management, which is about people such as the sort of individual you describe or other people who have severe levels of fluctuating distress.

Mr MARTIN - Even if assessed as not falling into one of the five major categories?

Dr CRAWSHAW - I do not think it is simply a matter of diagnosis. In the services delivered for people who have severe mental illness, diagnosis is one component that needs to be considered. The other part that obviously needs to be looked is what are the consequences for that person and their life in terms of the level of dysfunction and disability that illness produces. Quite typically within the forensic context clients do not simply have one diagnosis. They have multiple problems in their lives which lead to a final common pathway. At any given time it is not so much about making the diagnosis as about trying to sort out what is going on in their life and how to provide them with the appropriate level of response.

Part of what we have been trying to do is improve the quality of the services that we deliver. Part of that is having the right clinical governance structure in place. That is principally why we have appointed Mark, to have a good hard look particularly at people who have very challenging problems. These problems are not just challenging to the community and family and to police; they are also sometimes very challenging to our staff in terms of trying to walk a fine line between rightfully encouraging autonomy in the individual while acknowledging that they are causing distress to others. How do we walk that line between providing as much autonomy in their life as we can versus acknowledging the distress that it causes to carers and others? Again, that has to come down to clinical guidelines. You can't write rules around this because each case is different.

The other thing of which you may not be aware but we certainly use this in highly complex cases, is an agency collaboration strategy where we pool together what we call the key coordinators, the senior managers of the likes of Housing, Mental Health, the hospital and so forth, so that we can try to plan across the system more appropriate interventions. Certainly some of the cases which may be prompting your questions, I am aware that is what we have been attempting to achieve.

In terms of comorbidity in problematic individuals, which is the other question that you raised with respect to police, we really need to have a proper approach to dealing with that.. We have been fortunate to recruit some senior clinicians who now have the capacity to enable us to start addressing the comorbidity issue. For instance, a psychiatrist in the south of the State, who is jointly trained in addiction medicine and psychiatry, will be starting to move that one forward. I have had to get the resources - and I do not mean this in terms of dollars - to get the senior clinical staff employed so we can then start the next phase, which is to really drill down to how we develop it. As you

would be aware, that is part of why we had the alcohol, tobacco and other drug treatment services review and why we had the budget announcement which has enabled us to employ some of the staff who are now starting to come on board, so we can really start to address that. It is also part of why I have both Mental Health Services and Alcohol and Drug Services now as part of my bailiwick so that we can start -

CHAIR - So you can review the alcohol and drug act as well?

Dr CRAWSHAW - We certainly believe we need to review the alcohol and drug act and just where that sits within the protective legislation and whether, as in some other States, we need another alcohol and drug act or whether another piece of legislation, such as the guardianship act, could pick up some of those issues.

Mr WILKINSON - Will the work you are doing now cater to individuals with cases similar to those we have been putting to you to allow more an inclusion process for that type of person into the system than there is at the moment?

Dr CRAWSHAW - Firstly, if I can make it clear, having worked in more than one jurisdiction - and I am sure Mark will bear this out - these people are highly challenging for any service to respond to because they do not fit easily.

Mr WILKINSON - I understand that.

Dr CRAWSHAW - If you look at the mental health strategic plan, you will see that is based and predicated on assertive case management, which is really the only way to start to resolve some of these problems and also on building solutions around the individual rather than just relying on one size fits all. That requires skilled clinicians. So the changes which Mental Health has been going through over the past two to three years and the changes that the Alcohol and Drug Service is now going through is predicated on our being able to build a much more robust system around the management of complex clients.

I am not saying that I will completely resolve every problem that comes up. I am well aware that some people have very challenging issues that need to be addressed. But what we are trying to do is build the systems that will enable us to respond in a more rapid and appropriate manner. Part of that is about training and part of that is about putting the right senior clinical leaders in place. We are fortunate that now we have most of those senior clinical leaders in place, which is necessary to change the system.

CHAIR - What you just described in that quite extensive answer is a system that is providing for a continuum of care within the system, which I firmly support and I think you probably know my views on that. Also, it will contribute to the reduction of the risk of people falling through gaps where they do not fit a particular definition or framework. What you have described to me is a perfect reason why we should be looking seriously at legislation that incorporates all these decision-making powers under one act rather than two.

Dr CRAWSHAW - I would hesitate to say that that would not solve the problem, because in fact where other legislatures have attempted to do that they have still needed some of the Mental Health Act legislation.

CHAIR - Only in specific areas though?

Dr CRAWSHAW - Possibly only in specific areas, but certainly from my perspective it is not the legislative solutions, it is actually the service system solutions. A lot of what we need to do is not necessarily predicated on having the right legislation. It is having the right clinical systems in place. What we do need is a lot more clarity within the mental health legislation to enable us to provide direction and assistance to clinicians in their making of decisions, and that is not capacity process, that is about us being able to provide clinical guidelines and standing orders which actually assist us in assisting our clinicians with their decision-making processes.

CHAIR - So you could be accused then of saying it is all about the doctors and the medical staff who need - and I agree - clear direction because this is a very sensitive area, and it is an area fraught with danger in lots of ways, so it is not unreasonable to have that. Then we have the other side of the coin, which is the human rights side, of ensuring that people's rights are not impinged upon. So we come back to the whole argument of capacity again. How do we prevent people falling through gaps if we don't have a united approach?

Dr CRAWSHAW - The task of not just doctors but also other skilled mental health professionals in the system is to really understand how you balance civil liberty issues or human rights issues and mental health treatment issues, and it is not simply about capacity. It is about how you actually walk that often very difficult tightrope between the two systems to ensure that we act appropriately when things reach a crisis, but then back off when that level of protection is not needed. If you look at the international covenants, what is quite clear is that not only do you need the right processes and support systems, but you also need the protective legislation to ensure that there are not any potential abusers of the system. You need to have checks and balances in the system and there needs to be external scrutiny and review of those processes. I certainly believe that the current level of review in the system from a mandated legislative point of view is inadequate, which is part of why we are going through the legislative reforms. There needs to be appropriate checks but equally important for me is that we have legislation that enables that continuum of care. I believe that the fluctuating nature of most people with mental illness is such that we need somewhat different legislation than the normal capacity guardianship legislation. Interestingly, as I said to you last time, that seems to have been the view that most other jurisdictions have come to for much of the same sorts of reasons.

CHAIR - Taking that one step further, if you are going to provide appropriate care for people, it needs to be provided in the right place at the right time - and the same principle applies whether it is mental health or other health. If someone with a mental health condition, such as the sort of cases we have mentioned, becomes homeless for some reason, or their accommodation cannot be mandated to provide the most appropriate care for them, then that is part of the package of their health care. If someone is homeless, rather than go and get food they are more likely to mix with people who have gone off on drugs or alcohol, and then they are going to accompany them to the ATM on pension day to pay for the drugs or alcohol they have already had. Thus it becomes a downhill spiral. So unless we have a system that encompasses all those areas of their life, it must

fit into that treatment spectrum even though it is not treatment as such. Are we missing the boat here?

Dr CRAWSHAW - I would agree that without what I would call appropriate social support - and that includes housing and meaningful day-time activity that gives structure and purpose to their life - and without appropriate social networks, we are actually not solving anyone's problems, so all of those are part of what I see modern mental health care as being about. That's part and parcel of what we would expect our case managers to provide when they are doing assertive case management. Having said that, I must add that that's actually a significant challenge in terms of getting people to change the way they work. It's also a significant resource cost for us because it means that it's a very intensive way of working.

From an organisational and system point of view, it's why I spend quite a bit of my time talking to my Human Services colleagues about how to provide cross-service systems solutions, such talking to Housing people about how to facilitate our patients through the housing process; talking to Youth Justice and other people about how to provide continuums, reaching agreements about how we will work together for better client outcomes. Really, that's about system solutions, not simply about legislation.

Mr MARTIN - John, for anyone who's ever been involved in government and bureaucracies, this is the frustration. Most of the social issues we deal with, come up against the solo mentality of government that is quite often a barrier to coming up with a holistic solution to problems, dealing with the causes of problems rather than the effects of them. You are trying to address that. Are you going to succeed in addressing it? Can you give us confidence that you're going to succeed? Do you have the support within government to do it?

Dr CRAWSHAW - I certainly believe I get a very fair hearing from my CEOs and other senior directors within the agency. For instance, recently I have been working with Mercia in terms of the Housing things, looking at how we can find different sorts of solutions. I believe that the mandate which I had is very much about trying to see how the services are provided to find solutions in Health and Human Services, and equally about how those two parts of the agency assist me in finding solutions for our clients.

You may be aware there has been a longstanding agency collaboration strategy which was designed simply to address some of these cross-agency people. Chris has been an active participant in a number of the agency collaborative meetings to try to solve it, and I have to say, having sat on the overarching body, I think that solutions have come to be found which previously weren't being found. In the time that I've been in Tasmania, I see that as a major shift in terms of how people have been working, and that people have been working in a more collaborative and integrated fashion.

Mr MARTIN - How long has that been in place?

Mr FOX - Only about three or four years.

Mr MARTIN - At your level, do you see that it's working well?

Mr FOX - For the more complex cases, yes.

Mr MARTIN - So there shouldn't be people falling through the gaps?

Mr FOX - I think people will always fall through the gaps. If we come back to what we spoke about before, mental health clinicians are often called to attend situations with either current clients or unknown clients where the person who's made the call, which may be Emergency Services, assumes it's a mental health issue, but when our clinicians get there it actually isn't a mental health issue, it's violence, burglary, someone has brought drugs onto the premises, or a whole number of other issues. That sometimes leads to frustrations for Emergency Services.

Emergency Services - Police, for instance - then take the individual to the Department of Emergency Medicine and get a response that unfortunately this person doesn't meet the criteria of the Mental Health Act and the situation isn't a mental health situation. From our perspective, I suppose what I'm saying is that there will always be clients in Mental Health Services who will appear to fall through the gaps. I don't think they're falling through the gaps because we haven't provided them with the treatment their presenting circumstances require, they're falling through the gaps because some other things are happening, and the Mental Health intervention is not an appropriate way forward for them.

Dr CRAWSHAW - I guess that's why I was saying to you that part of the work we've been doing in the last 12 months is trying to close off some of the systemic issues. But as I am sure you are aware, addressing system issues -

Mr MARTIN - Very difficult.

Dr CRAWSHAW - takes time, but I have to say that I am personally pleased with some of the responses I have received from some of my senior colleagues.

Mr FOX - In scenarios where it may not be a mental health issue but they are a known client of ours normally, because it has been communicated by the police that there is no mental health issue, then it would be expected that the case manager who was responsible for that client at some point in time would make contact with the other agencies involved and discuss it. Whilst this particular circumstance might not have been due to an exacerbation of mental illness, they would ascertain whether there are some underlying problems in terms of security of tenure of housing, financial oversight or so on that we can work on together to move that forward.

Dr CRAWSHAW - The other comment I would make is that it is not just Health and Human Services we are talking about.

Mr MARTIN - No, not at all.

Dr CRAWSHAW - It is Education, it is Police and it is Justice. We are in the process of setting up some of those cross-government processes so that we can have a more, if you like, whole-of-government response. It is not just government services, it is also the community sector services. As you would be aware from your previous role, it is also local government services. For me the challenge which I am working at is how to get all

of those people understanding what part they play in the provision of good mental health in the community.

Prof. OAKLEY BROWNE - This may sound somewhat pessimistic but even with the best service and the best inter-service cooperation, there will still be a group of people who cause real concern to the community because of aberrant and disturbing behaviour, but that behaviour is not best seen as a result of a mental disorder. That is a very big problem for all communities and different jurisdictions have tried to respond to that in different ways.

In the UK, for instance, specific legislation was brought in to deal with that group of people who do not have a mental health problem but principally may meet the criteria for however you define a personality disorder and they have other problems - for example, repeat sexual offenders. Legislation was introduced to try to manage that group of patients to be re-introduced into the community. That was very controversial and still is controversial. Civil libertarians would take a very different view about that solution than we might.

Mr MARTIN - Is the British solution to lock them up or something?

Prof. OAKLEY - Yes, essentially.

Dr CRAWSHAW - They are a dangerous and severe personality disorder group.

CHAIR - Where do they lock them up? What sort of facility are we talking about?

Prof. OAKLEY BROWNE - They have a special facility, I have forgotten what it is called.

Dr CRAWSHAW - They are either sitting within the prison system or what they call their three special hospitals.

CHAIR - Secure hospitals, obviously.

Dr CRAWSHAW - Well, they are almost like prisons.

Mr MARTIN - Without being found guilty of a crime.

Dr CRAWSHAW - There are all sorts of ethical and legal implications. It is not for me to criticise another country but I would hope that Australia never heads down that path. That is the extreme of going one way in terms of trying to solve the -

Mr MARTIN - We are certainly not advocating that.

Prof. OAKLEY BROWNE - When you evoke the Mental Health Act, it leads to an abrogation of a whole range of civil rights of a person. If I place you under the act, I can take you away, put you in a room by yourself, make you have injections that you do not want and take medication that you do not want.

CHAIR - Even if you have the capacity to refuse them?

Prof. OAKLEY BROWNE - If you meet the criteria for the act, yes. In Tasmania it is slightly different because we have the Guardianship and Administration Board involved, as well. It is quite a major restriction in your rights so it is not something to be undertaken casually. Getting the balance right between protection of people's natural rights and making sure that their interests are served and also protecting the community is a fine balance. Sometimes people may behave in a way which causes concern to the community but do not meet the current criteria for the act. It is their right to behave in a way even if we regard it as self-destructive and problematical. I do not know if I am explaining that.

Mr MARTIN - Yes.

CHAIR - There is a group of people who are clearly a challenge, they are square pegs in round holes really, aren't they? Not being a mental health professional I am a bit limited in my knowledge in that area, but when you get people in this situation it is hard to tell which box they fit in so to speak, and a lot of them do not fit in any box. They might need lots of boxes, I do not know.

Mr MARTIN - If they are causing a problem they need to be in a box.

CHAIR - Yes, some box somewhere. You have to find a box that is right which is the challenge. We have heard from the Police it provides challenges for them if they pick a person up who is behaving in a way that the community does not deem as acceptable. It may be as simple as being naked in public or it might be something quite destructive. They take them to the hospital, they are required at the moment to stay with that person up to four hours until that initial assessment and then they have to make a decision one way or the other. The police don't seem to be fully aware of the role the intervention team plays. What if they were able to take over management of that patient rather than the police being the ones who have to be responsible for them at that time, even if after four hours it is deemed that admission is not the most appropriate treatment - and I accept that that quite often would be the case? Clearly this person still needs some help and support. Is there some way that this intervention team could have a facility - not to lock them up in a secure hospital - that could provide that transitional care, so that that person can be more fully assessed even though they don't meet the criteria to have their rights taken away at this point but still need some support?

Dr CRAWSHAW - I think the current legislation makes it difficult for all involved. I fully understand the frustration of the police at having to sit around for four hours. They are some of the elements that we are trying to address in the re-draft currently with the Parliamentary Counsel. We are clearly looking at the capacity for the police to hand over the custody within the hospital setting so that we continue to provide a health intervention. We are looking at assessment orders which would allow us, as Mark was suggesting before, to have people who continue to require observation and so forth, not necessarily simply in hospital but also that they may need to be followed up within the community and to have a graduated response.

CHAIR - Clearly the Department of Emergency Medicine is not the best place for some of these people.

Dr CRAWSHAW - No. The range of treatment options is clearly a system issue, which is what we are working on in terms of our service redesign. Mark has described the extreme if we have legislation that doesn't have sufficient protections in it. In terms of the new legislation we are looking at having at least two levels of protection. One is that the office of the chief civil psychiatrist or chief forensic psychiatrist is able to do quality assurance activities in making sure that the system is functioning the way it should do and to provide clinical guidelines in standing orders that regulate things.

CHAIR - Is that independent of the service delivery?

Dr CRAWSHAW - Yes, that is independent. That is more Mark's role in terms of his clinical governance giving the capacity for him to provide guidance to our clinicians in a more structured way. The second is making sure that there are more review mechanisms built. Currently the initial orders are not subject to any necessary reporting or review by the Mental Health Tribunal. CCOs do not have to be reviewed until quite some time after the event, and often a number of them are discharged before they even get to the tribunal, whereas we are trying to shorten that time frame so that there is a much more immediate review. We also want that review not simply to be around detention but about having adequate treatment plans in place and whether it makes sense. What we are really looking at in the new legislation is what I and Mark are used to elsewhere, which is to focus on treatment solutions as distinct from detention solutions, which is the big frustration that we currently have. I have certainly had clinicians in this State explain to me their real frustrations of having to do a hearing for detention, which is the CCO, and another hearing order for treatment, and the two things are sitting disparately and not producing a good clinical outcome, and certainly not producing a good civil rights outcome.

Mr FOX - Clinical staff on the ground would also struggle, I think, in the scenario of attending situations where, whilst the person is disturbed, it was apparent the disturbance was due to alcohol or drugs. In other words, it is not clearly a mental health issue. Also, a lot of those situations often have a high level of risk attached so there may be four or five police officers needed to get the person to an assessment centre. We wouldn't have the numbers on the ground for mental health staff to then step in and take over that role, and we probably don't have the training that the police would have in dealing with what can be very overtly aggressive people.

CHAIR - Rather than tie up police time, particularly when you have a police officer who has come from a remote area where you do not have a lot of police presence in those towns overnight - so they have to back-fill in some way - once they have delivered that patient to the hospital and handed over the custody of that person, could we use security officers who are trained in mental health awareness or whatever rather than having police? Then you have your mental health advocate or whoever to provide help and support for the patients themselves.

Dr CRAWSHAW - There are potential solutions which we can look through and certainly we are talking with the police as we are drafting the new legislation to a enable appropriate transfer. There are some situations where both they and we have acknowledged that they will always have to be involved because it is a matter of safety. There are other solutions where we would want to move the person out of police or justice care back into health care as soon as possible. As I said to you I think last time,

we are fortunate in this State that we do not have the incidence, which I have certainly experienced in New Zealand and other States have experienced, of people who are not mentally ill but have taken ice or some other stimulants and made themselves extremely hostile and dangerous.

Tony Lawler says that is a very low percentage of presentations, nothing like what his colleagues report on the mainland.

Prof. OAKLEY BROWNE - I am aware in some jurisdictions there have been deaths of people being transported while in the care of police and also in the care of security. I think there needs to be very careful thought about the level of training that people have when they are responsible for transport or physical containment of a person and the methods they use.

CHAIR - The same can be said of the medical and nursing staff as well.

Prof. OAKLEY BROWNE - The deaths have been more common not with medical health providers but with other agencies that have been involved.

Dr CRAWSHAW - While the current legislation does not provide much guidance in this regard, that is certainly some of the things that we are trying to address as part of the rewriting of the legislation.

CHAIR - Can you explain to me the role of the intervention team in the hospital? We talked about what happens out at the bridge, for example, but what happens once that person arrives in the facility where they are getting assessed?

Mr FOX - The primary role of the intervention team, or the CAT team - Crisis Assessment and Treatment - is to manage crisis scenarios in the community, respond to crises in the community and provide intensive support medication. There is a whole range of tasks they do in the community. When they attend a scenario where the presenting situation based on their clinical assessment indicates that the person should be taken to an assessment centre, then they would take the individual to an assessment centre. We have some agreed forms in terms of information that we hand over and then they would hand over that individual to the assessment centre. They would stay around for as long as the assessment centre indicated they were needed. Sometimes that is a longer period and it has been a quite a number of hours. Sometimes it is actually quite short, a known client or a person that might present two or three times in a week.

CHAIR - So they do not actually discharge that person to your care? They do not say this person does not need admission or admission is not the most appropriate treatment here so the assessment team can work with them now to look at accessing this service or that service or to follow up?

Mr FOX - They do not discharge directly to the assessment service. The EDs can contact the relevant community team, usually through the help line, and indicate that someone has presented at ED, that they do not meet the criteria for admission but they certainly do meet the criteria to need to be followed up in the community within a set period of time, and that may be two days. Then that referral goes through to the relevant community team and the relevant community team ensures -

CHAIR - So you do not have a role in that as the intervention team?

Dr FOX - The intervention team are attached to community teams; we have a population-based model. It may be the intervention team that sees that person in those two days, it may be a case manager; it really just depends. If a person is presented to hospital and the triage nurse saw them, then the consultation liaison registrar saw them and they determine they do not need admission at this point but being followed up in the community in a short period is quite an acceptable pathway for that individual, then the referral would come back through to the community team. It would be given a category 2, which is within two days, and the community team would ensure we saw them within two days.

Dr CRAWSHAW - I think that one of the problems for Chris is that we have had a division of labour, as it were, between the inpatient service and the community service. With the decision to amalgamate and integrate the two, we should be able to start to close off some of those gaps. We are in the process of appointing a clinical director overarching the services in the south.

In the north and north-west, it is usually the CAT function of the community team that actually goes into the hospital, does the assessment and liaises with the respective hospitals. That is what we want to see happen here.

Mr MARTIN - In relation to the Peacock Centre and the changes that were made, which I think was before your time -

Dr CRAWSHAW - Certainly.

Mr MARTIN - I can remember your predecessor was very involved in it. There were a number of meetings - very controversial at the time.

We had evidence criticising the change. Can you explain exactly what the change was and whether the changed circumstances have provided an adequate service compared to what was being provided?

Mr FOX - I was the southern area manager and ultimately oversaw a lot of that reform. Prior to October 2006, in the south we had six community teams; we had three five-day week case management teams who basically saw people for longer-term treatment, worked office hours Monday to Friday. We had a CAT team, a crisis assessment and treatment team, which sat at 4 Liverpool Street, which is basically opposite the Royal Hobart Hospital, and took emergency calls and provided a crisis response in the community, albeit to a relatively confined geographical area because the resourcing level was not very high, so they did not go much beyond the metropolitan area.

We had a mobile intensive support team, which provided seven-day week case management and intensive follow-up to long-term chronically disabled clients and we had a rehabilitation team, because rehabilitation for some reason, philosophically at that time was not seen as core business of every mental health clinician, it was seen as a specialist role that a particular team provided.

The major issue that we found -

Mr MARTIN - What happened to Peacock?

Mr FOX - The rehabilitation team and the mobile intensive support team used to both sit at Peacock, one on each floor.

The major problem we found with that system was that there was a whole number of silos - that if a person who was being five-day week case managed required crisis response after hours, then that team would have to negotiate with the CAT team for that crisis response to happen, with no actual guarantee that it would happen. If a person was deemed to require intensive support, which was seven-day week case management via the mobile intensive support team, apart from the fact that the books of that team were closed and it was very hard to get into, you would still have to negotiate the person to get into that team. What we found was that a whole number of clients were in suspended animation, for the want of a better word. They were discharged from one team - or they no longer met the model of care or the resourcing requirements of one team - but they could not get into or they hadn't been picked up by the other team.

So the decision was made, following the completion of a strategic plan and a lot of data and so on, to put in place a population-based model where basically - I will use the example of the Clarence team, if I can - if you live on the eastern shore you are the sole responsibility of the Clarence and Eastern Districts Adult Community Mental Health Service seven days a week, 16 or 17 hours a day. If you need rehab, that team manager is your rehab; if you need crisis support, that team manager is your crisis support.

CHAIR - I am really pleased to hear that.

Mr FOX - It is a much better service because from a client perspective it is a one-stop shop and there are no silos. Most of the feedback has been very positive around the changes. I am not saying that those services did not provide a good service to clients, and hence some clients would still like to be provided a service by MIST because they were provided from a broader community perspective, from people moving between different services.

CHAIR - To keep it a whole person.

Mr FOX - Yes.

Mr MARTIN - I suppose the criticism is that it used to act a little like a drop-in centre, somewhere they could go to -

Mr FOX - Yes.

Mr MARTIN - and that service no longer exists.

Mr FOX - Yes, the Peacock Centre had a couple of additional services attached to it, one of which was called the community activities program, and it was probably almost the old asylum-type model, where a specialist mental health service didn't just see itself as being responsible for the clinical care of the client, but they also were responsible for activities

for that client, they managed the money of those clients, they managed cigarettes, they managed housing, they managed the whole gamut of a person's life. Under our new model of care we believe that the primary responsibility of Mental Health Services is the specialist mental health intervention, and there are some CSOs that are well qualified, well resourced and, research will say, do those things very well. The community activities program that was briefly attached to the Peacock program was outsourced via a request for tender process, and Langford Support Services picked it up. They have a long history - I think 20-odd years - of providing disability support and community programs, and our feedback in the seven or eight months since it went across has been very positive.

Mr MARTIN - Have you measured that in some performance indicator-type way, or is it just anecdotal?

Dr CRAWSHAW - We are in the process of doing a major evaluation of our three major organisations that provide psychosocial support and residential rehabilitation, so the answer to your question is we are doing it properly in terms of evaluating.

Mr MARTIN - That is what I wanted to know.

Dr CRAWSHAW - It is what I need to know as the person who has to write the contracts. What Chris is describing is in fact the model which is seen as best practice in most modern jurisdictions. It is certainly the process which I went through in New Zealand, and I would agree with Chris that it actually resulted in an improved client outcome overall. It is not to say that one or two people may not have felt upset because they lost some of the personal contact that they might have had with one or two individual clinicians, but overall it actually produced a significant improvement and a greater diversity of resources. The other thing that worries me is that if you try to force everyone into a one-stop narrow framework you are not acknowledging individual difference and individual need. Whereas, if you have a range of community sector providers, who actually by and large do a very good job and can do some things in a different way than what we can do as professionals, you get a greater level of diversity. This has enabled us to look at other sorts of options. For example, currently we are looking at how we can support people in getting back into work and that is a significant process. So it enables us to focus on solutions as distinct from monolithic services.

Mr MARTIN - The review when it is done, will that be public?

Dr CRAWSHAW - Most of the reviews we do end up public, as I am sure you are aware. I don't believe in secret squirrel stuff.

CHAIR - When do you intend to have that done?

Dr CRAWSHAW - I am not sure off the top of my head. It takes as long as it takes.

CHAIR - Has it started?

Dr CRAWSHAW - Yes.

CHAIR - It has started, so it is under way.

Dr CRAWSHAW - Yes.

CHAIR - We have a couple of questions we would like to ask in camera, so we just ask if the room could be cleared.

Mr RANDOLPH WIERENGA, PRESIDENT, POLICE ASSOCIATION OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - If you were to make recommendations to the committee, what would you suggest? I know our terms of reference are fairly specific in relation to the legislation, but we do have other matters entered into there to and we are looking at how the application of the legislation framework either works or does not in view of various stakeholders.

Mr WIERENGA - I am not sure how you are going to address the actual working on the coalface, but certainly the definition of mental illness or the ability to detain people for their own safety needs to be broadened to some degree so that the sad as well as the mad can get some treatment. The doctors who are dealing with the patients at the emergency departments need to be trained in their responsibilities to a greater degree than seems to occur now.

The proposition of having assessment teams available on a continuous basis should seriously be looked at.

Mr DEAN - Is the detention side of things at the hospital another area that needs to be considered?

Mr WIERENGA - Certainly. There needs to be some way of expediting those matters.

CHAIR - Admitting patients, do you mean?

Mr WIERENGA - When police present with -

CHAIR - At the initial?

Mr DEAN - Also of relieving police, I would suggest.

Mr MARTIN - I asked this question this morning and it is of considerable concern to me, given I know some cases and evidence has been given that police sometimes have to deal with the same person five times in a fortnight and sometimes five times a day and the huge pressure on police resource because of that. Is there a measurement of that?

Mr WIERENGA - No.

Mr MARTIN - I did ask this morning whether it was feasible to put in a process and the answer was, yes. Do you think that would be worthwhile or would it be too time consuming?

Mr WIERENGA - Certainly.

Mr MARTIN - Not too time consuming?

Mr WIERENGA - I do not know the nuts and bolts of IT but I would have thought that this type of task could be recorded electronically in the amount of time consumed.

CHAIR - I guess it comes down to what data you want. I think what we as a committee would be interested in, is how many of these people are there that the police are involved in - on the assumption that it could be a mental health issue because you cannot always be sure and it is not the police's job to make that diagnosis - how many end up not being considered as fitting the criteria of mental illness and how much time each interaction takes. Some of them could be quite quick and some of them might take four hours or more and eight hours if you have to drive them back again.

Mr WIERENGA - The only way you could do that now is to commence some kind of survey work and obviously you do not have the time to do that.

CHAIR - No.

Mr DEAN - It is done in relation to domestic issues and there are some questionable situations there from time to time of whether it is domestic or whether it is something else. They capture that data pretty well and they can assess police time taken in the handling of domestic issues.

Mr WIERENGA - That is probably because there is a much more formal report process in place in relation to domestic issues. The reporting process in relation to mental health patients or possible mental health patients, as far as the police are concerned, is almost nil in terms of the paperwork trail.

Mr DEAN - There needs to be a quick answer there.

CHAIR - What the committee would be most interested in is the amount of time, which is money, tied up when there may be other ways of effecting the most appropriate support and treatment for these people. If you looked at the cost that you could remove from the police budget and put it into the mental health budget to provide a support process, then maybe that is a better way of spending your money.

Mr WIERENGA - All I can say is that usually these incidents are resource intensive and not of short duration but that is a generalisation and I know it does not help you too much.

CHAIR - But it sounds pretty right. Thanks Randolph for coming in and providing your evidence.

Mr WIERENGA - Thanks very much.

THE WITNESS WITHDREW.

Dr MILFORD McARTHUR, CLINICAL DIRECTOR, DEPARTMENT OF PSYCHOLOGICAL MEDICINE; AND **Dr TONY LAWLER**, DIRECTOR OF EMERGENCY MEDICINE, ROYAL HOBART HOSPITAL, WERE CALLED, MADE THE STATUTORY DECLARATION, AND WERE EXAMINED**.**

CHAIR (Ms Forrest) - Thank you for coming along, gentlemen. We have had a lot of evidence during the committee's hearings, even though we are specifically looking at the protective legislations that direct the care of patients with mental illness, particularly serious mental illness. We have had evidence about people's interactions with the front-line services, particularly the Department of Emergency Medicine, where the whole process kicks into gear at times. We want to hear from people at the coalface, how it works in practice, what the challenges are. We have talked to the police as well, who often bring the patients into those areas. Could you identify issues that you think that the committee should be aware of and what you think the most appropriate legislative framework would be in relation to that? Could you give an overview of where you work, your background and then how you see the whole issue?

Dr McARTHUR - I have been a doctor for 34 years, four years in the hospital, 10 years in general practice in town. About 20 years ago I retrained and have been doing psychiatry since then. Foot the last three-and-a-bit years I have been the director of the Department of Psychological Medicine. I have mostly been a clinician rather than an administrator, so I see patients.

Dr LAWLER - I graduated from the University of Tasmania in 1995 and trained in emergency medicine. I have been a specialist since 2002 and since November 2006 I have been director of the emergency department here. That is a department that sees about 42 000 patients per year. It sees all types of patients - paediatric, medical, surgical, obstetric and gynae, mental health - and has over 100 nursing staff. It has 12 senior doctors, 14 training registrars and 10 duty doctors and supportive clerical and allied health and ancillary staff. The hospital is a tertiary referral centre for the State, so we see quite a few transfers and retrievals from other parts of the State as well.

CHAIR - Including mental health?

Dr LAWLER - Yes, including mental health.

CHAIR - You are the only unit that has a psychiatric intensive care unit?

Dr McARTHUR - No, the Spencer has an HDU, which is the same thing. Launceston has one as well.

CHAIR - Why would you receive a transfer from the other regions? If they were full, perhaps?

Dr McARTHUR - We certainly do if they are full. We tend to be better staffed and we offer further opinions, if that is required from treating teams - mostly in the north-west, but occasionally Launceston.

Dr LAWLER - I guess the other common instance would be one of repatriation. If patients from the south, north and north-west require hospitalisation, the initial phase may occur there but eventually the patient may be repatriated to the Royal Hobart Hospital to be closer to family and services. The reason the emergency department might be involved in that is as a holding or screening area because we need to be clear that patients who are transferred from other facilities that they are physically well and stable prior to transfer. Especially when transfers occur overnight or out of hours, they may well come via the emergency department rather than a direct ward-to-ward transfer.

CHAIR - Can you give us an overview of how both of you feel about the current legislation - being very conscious, of course, that there is a review of the Mental Health Act going on at the moment and has been for a number of years, and we are told that we are getting very close to a draft bill, but we will believe that when we see it. There have been some suggestions that the way of the future is a more comprehensive generic capacity-based legislative framework that incorporates the powers of the Guardianship and Administration Act and the Mental Health Act. This is one of the reasons we are looking at this issue, and you may have views about that, but I am just interested in how you find it works at the coalface and what issues there may be.

Dr McARTHUR - It probably does not matter to us how many acts there are. The problem for us is the implementation of them. If we have to have two hearings in a short period of time for one patient it is very distressing for the patient. They find the hearings quite onerous. They usually take at least an hour and occasionally quite a lot more. So if we could deal with permission or authority to detain a patient and treat a patient with one hearing that would be of benefit, I am sure, to the patients rather than having to subject them to two.

CHAIR - This has been an issue that has been raised in a number of areas. In my mind it is quite logical that you would have one hearing to detain and treat, because why else would you detain somebody if you did not want to treat them, in most cases? We are also looking at issues of accommodation, managing their finances and some of those other social issues that these patients often have, because if you don't have adequate accommodation for a person then the treatment may not be a success because they might not be compliant with it, you might not be able to contact them to initiate the treatments or whatever. So is there a place for even a broader framework, a more inclusive framework that enables those sorts of decisions to be made at the same time?

Dr McARTHUR - Certainly the guardianship act, I understand, currently can direct where someone lives, so that would tend to be part of the whole process. It would be a shame to leave that out.

CHAIR - But that is a separate issue. That is not done under the Mental Health Act, it is under the guardianship act.

Dr McARTHUR - Yes. As you know, to admit someone under an order it takes a lot of people to see the patient and to line up and to all agree. It can actually take five people to get someone past 72 hours, three of whom are doctors, two of whom are authorised officers. We don't always have those resources easily and quickly available. We have to get resources in and doctors to see patients, and that is just to get us to the stage where we are legally able to detain the patient if we think that is the appropriate thing to do, and

of course that does not allow us any treatment options at all except under the emergency conditions.

Mr DEAN - Is this what you are talking about when you talk about the number of hearings? Just explain to me exactly what you mean by the number of hearings that you have to go through currently as it is now.

Dr McARTHUR - If a patient comes into Tony's department they will often be placed on an IO or initial order. There will be an authorised officer and a doctor who will do that. That gives us 24 hours, then we need another doctor with special expertise in psychiatry to sign off to allow it to go from 24 to 72 hours, and then to get the patient onto a CCO we need two doctors and an authorised officer. It makes a total of five, and then the Mental Health Tribunal has 28 days from the initiation of that order to have a hearing and make a ruling on the hearing and decide, but that is just to detain the patient. It is not to allow us to treat the patient with any medication.

Mr DEAN - That was going to be my next question. In between that there is the treatment order and everything else that is necessary and required, and does that normally necessitate others involved in that process as well?

Dr McARTHUR - Yes, another hearing, another board. The Guardianship and Administration Board would have to then give permission.

Mr MARTIN - So what change do you recommend?

Dr McARTHUR - What we would like to do is to have one hearing and one tribunal allowing us to detain and to treat, rather than having to go to one to detain and a second one to treat.

CHAIR - That is what the recommendation of the review is. I am fairly confident we will see those changes in the new Mental Health Act; I do not think that is really in question.

Dr McARTHUR - When you think of how many acts there are it is just as well.

CHAIR - The other issue which has been raised by a number of people is that because there are 28 days for the Mental Health Tribunal to review an order, often patients are discharged prior to that. Many orders, if you look at the Mental Health Tribunal reports you will note that many of those orders are never reviewed at all. Effectively - and I do not suggest this is happening - you could have hundreds of orders placed on people that are never reviewed and perhaps are not really appropriate. That is the risk, is it not?

Dr McARTHUR - Yes, that is a risk. I do not believe that happens but yes, it is a risk.

CHAIR - No, I am not suggesting it does but there are suggestions that we need to have an earlier review of those orders. Would you support that?

Dr LAWLER - The alternative is to have a longer period between the 24 and the 72, so rather than have a review earlier after the 72, once it is extended would be to extend the 24 to 72 period. Beyond 72 hours, I think that carries with it significant risks. I think the

earlier review is the process that would remove a good many of those inappropriate and unpoliced orders.

Mr DEAN - Can I go to the first stages when a patient is brought into the Department of Emergency Medicine? What is the actual process with, say, the police bringing a person in? Please take us through the process.

Dr LAWLER - It depends on the manner of presentation, whether the patient presents in a voluntary sense or they are brought in under protective custody.

Mr DEAN - If we can deal with the one brought in under protective custody.

Dr LAWLER - From my understanding of the circumstances, a patient brought in under protective custody can be kept for four hours and during that time needs to be assessed by staff within the emergency department. If a patient is brought in under protective custody we automatically assign them a category 2. All of our patients are categorised according to physical and mental health stability and also the capacity for deterioration.

Mr DEAN - Does that determine how you would deal with them, the response?

Dr LAWLER - That determines the order in which patients are seen.

CHAIR - Category 2 means they can wait a maximum of -

Dr LAWLER - Ten minutes. They should be seen within 10 minutes. Our benchmark is 80 per cent of category 2 patients are seen within 10 minutes. Over the last month, I think 87 per cent of our category 2 patients were seen within 10 minutes.

CHAIR - Does category 2 include other patients, not just mental health?

Dr LAWLER - It does.

Mr DEAN - Is that a common position in the public hospital systems throughout the State or does it just apply to Royal Hobart Hospital?

Dr LAWLER - I cannot speak for the practices in Launceston, Burnie or indeed in other departments. I know that for many years our practice has been that patients, whether they are potentially violent or potentially disruptive, if they are brought in under the care of a police they are a category 2 priortisation.

CHAIR - There have been claims that there is a feeling amongst police when they bring such patients in they are pushed well down the list of priorities. This means the police are expected to remain with them and provide that level of support for up to four hours because they effectively may have to take them back to where they came from, which could be the LGH, St Helens, Queenstown, wherever.

Dr LAWLER - I can't speak for the feelings of the police on that. I do know that the patients who come in are accorded a category 2 priortisation and are seen before category 3, 4 or 5 patients. Every endeavour is made, as with chest pains and respiratory emergencies, to see them within 10 minutes.

CHAIR - Do you have data that can clarify how many patients are brought in under protective custody, how many voluntary patients come in and what time frames they are seen in or can't you break it down that far?

Dr LAWLER - We have data collection at the point of arrival and that includes referral source. I would have to check whether we have a category for those brought in by police - I can certainly provide that to the committee.

CHAIR - It would be good if you could do that. We are having trouble getting a handle on how many such people there are.

Dr LAWLER - Sure.

CHAIR - The issue for the police is how long it ties them up.

Mr MARTIN - Did you say that everyone brought in by police is dealt with as category 2?

Dr LAWLER - Patients who are brought under protective custody, we take out of that issues such as requiring blood testing for drugs or alcohol or intoxication assessment.

Mr MARTIN - They are all category 2 and dealt with within 10 minutes.

Dr LAWLER - Patients who are brought in by the police with potentially destructive or violent behaviour under protective custody are accorded a category 2 priortisation.

CHAIR - Are you aware of police bringing in patients with mental health disorders who are voluntary? I think the majority would probably be in protective custody, that's why the police are called.

Dr LAWLER - Yes, but there are patients to whom the police are called and they are escorted in. They are not in custody but they are escorted as a logistical exercise more than anything else.

CHAIR - So they would not be category 2?

Dr LAWLER - If they were potentially violent or destructive they would be a category 2. But frequently those patients who are not brought in under protective custody are presented to the triage nurse and may go to the waiting room.

Mr DEAN - What is the expectation of your department when a police officer brings in a patient in custody and they are given a category 2, so they are to be attended to within a 10-minute period? In other words, do you expect the police to remain there in a security role, protection role?

Dr LAWLER - Not unless the patient is determined as a particular risk. We have patients who are particular risks, have presented armed threats and we have a couple of patients - and I am clearly not going to go into specifics - who on occasion we will have received forewarning that the last time they were in it took six police staff to restrain them. At times such as that we would have a professional discussion with the police and try to

determine what level of support is required at the time. Our department's policy is that in accordance with the category 2 prioritisation we would perform a rapid sufficient assessment to determine whether the patient is at risk and whether the person satisfies the criteria for placing them on an order. When they are placed on an order it is our responsibility to keep them in hospital. It is not the police responsibility to keep them in hospital and at the time they are placed on an order my view, and I believe the view of the hospital, is that the police are released to return to their duties.

Mr DEAN - So the police are expected to remain there until such time as a determination is made as to whether or not an order is going to be made?

Dr LAWLER - I believe so, yes.

Mr DEAN - On average, how long could it take for that assessment process to go through to an order being made?

Dr LAWLER - The majority of patients brought in by police under these provisions are not difficult to assess in terms of whether they need to be restrained under the Mental Health Act initial order. They can be quite rapid and that is done on the basis of the history from police, and that is a vital part of the assessment; the history as can be obtained from the patient; a mental health examination which includes anything from orientation and mood through to an assessment of thought and speech patterns; and also a determination as to whether we believe there is any intoxication, through alcohol other drugs, or any other type of organic problem, be it an illness or an injury. If there is a belief of intoxication or illness or injury then we are moving away from the Mental Health Act and into common law provisions for detention. Under the Mental Health Act it can take experienced emergency doctors - and we always have someone with at least four years of experience in an emergency department, registrars who are training in emergency medicine or consultants who have at least seven years' post-graduate experience, and anywhere up to 30 - so to make an assessment of whether the patient presents a risk to themselves or others can take minutes.

Mr MARTIN - One of the issues we have been dealing with since this has been put before us is that there is a category of people suffering from a form of mental illness - that is, personality disorder - who have fallen through the gap. They are taken to the hospital and current hospital policy is not to admit a patient 'who primarily suffer from personality disorder who over a brief period of time in hospital is unlikely to produce any therapeutic benefit'. In assessing them, if they are not diagnosed as having one of the five major categories of mental illness and they are not psychotic, they are not admitted. Is that a fair summing up?

Dr McARTHUR - Not many people are turned away. Our figures don't show that. I know that this is a particular case that you're talking about and obviously -

Mr MARTIN - Without going into the details.

Dr McARTHUR - In generalities, one of the problems with that case, and more generally, is that we have a difference of opinion between say family members and the patient. We get caught then with patients telling us one thing and family members telling us another thing, and perhaps the police telling us a third thing. We have to make a very rapid

judgment about the best thing to do at the time. We often get incomplete information - sometimes it is wrong, it is often in the middle of the night - and it is obvious that we do our best to make a determination. What you are referring to is our capacity to certify such a patient under the Mental Health Act and force them into hospital.

Mr MARTIN - Yes. I must say I am quoting from one specific example which you are obviously familiar with. I am doing that because it is typical of other cases in evidence we have also had.

Dr McARTHUR - So you are talking about compulsorily detaining someone against their wishes?

Mr MARTIN - Yes.

Dr McARTHUR - To do that we have to comply with how we best understand the Mental Health Act.

Mr MARTIN - Right.

Dr McARTHUR - I guess as we best understand it such a person would not fall under the Mental Health Act to be forced against their will to be admitted into the hospital.

Mr MARTIN - What I have just read out, is that -

Dr McARTHUR - That is not a person who wants to come into hospital; we are talking about someone who does not want to come into hospital.

Dr LAWLER - There is certainly no hospital or departmental policy. Through my work in the emergency department and with the in-patient psychiatric services there is certainly no policy that determines a gate or that bars admission for patients with personality disorder or even patients with a purely personality disorder. Assessments are made in the emergency department, and following referral to inpatient psychiatry services, on the current state of a patient and how that overlies any chronic mental health issues they may have. We assess the capacity they have to make decisions about the appropriateness of admission, the responsibilities and powers we have under the Mental Health Act, and also there has to be an assessment as to whether a stay in hospital would be of therapeutic benefit to them.

So a patient will present and an assessment will be made at the time as to whether there is a professional opinion on any therapeutic benefit from admission. Incorporated into that, as Milford has mentioned, is that it is at a whole other stage if a patient presents as not wanting to come into hospital or if a patient is brought to hospital not wanting to come into hospital. I am familiar with the case as well and, as Milford has said, for patients who present with primary personality disorder and who want to be admitted to hospital it would be, more often than not, that admission occurs rather than admission being rejected.

CHAIR - Is that because treatment and admission is in their best interest?

Dr McARTHUR - Yes.

Dr LAWLER - Well it is multifactorial as well because in terms of providing treatment to that patient they cannot be considered in isolation. You mentioned about the impact of accommodation problems on treatment; there are also the impacts of the relationship with family members, with accommodation issues, with case managers and health practitioners outside of the hospital, and those things can often require clarification.

Mr MARTIN - The case I am referring to, how common are cases like that? Is this a very isolated one or is it a common case?

Dr McARTHUR - From a clinician's point of view our most difficult situation is where we think a patient should come into hospital and the patient is declining to come into hospital. That is always our worry, especially if there has been some kind of risk or suicidal thinking or something of that order, and of course in the context of the mental illness. Lots of people who come in who do not have a mental illness. So that is always our biggest and most difficult decision to make.

Mr MARTIN - Can you articulate in layman's terms how you make that decision?

Dr LAWLER - Chronologically they will present to us first. As has been mentioned already, they may come in police custody, they may self-present or they may be brought in by a family member or a support individual. We would see them, assess them, and if we determine that they present a risk to themselves or to others, or would benefit from more specialised psychiatric input from a registrar or a consultant, then we would make the referral to inpatient services.

CHAIR - That consultation would occur in the DEM initially?

Dr LAWLER - That is right.

CHAIR - Then the psychiatric staff will come to the DEM and then what?

Dr LAWYER - One of the initiatives that we have adopted over the last six months is that we have appointed a registered psychiatric nurse who is present in evening shifts because that is the time in which we have the gross preponderance of mental health presentations. They not only provide one-to-one nursing care with those individuals but also, obviously, they develop their own skill base to provide some education and training for the rest of the department. So even within the emergency department, which is, by necessity, a generalist service, we have an area within the department that has, for a significant proportion of the week, specialist psychiatric nursing exposure. It is a fantastic addition.

Mr WILKINSON - It is only new, as I understand it?

Dr LAWLER - That is right.

CHAIR - It is only in the Royal at this stage.

Mr DEAN - That is going to the question that I was going to ask. It has been suggested to us that perhaps some of the hold-up in this process within the DEM has been because of a

lack people within that area with psychiatric experience and background to make proper determinations and assess and work with these patients. In other words, the staff working there do not have that capacity. That has been a breakdown of the problem. What is your view on that?

Dr LAWLER - This is an issue that is commonly raised about a great many types of health, both physical and mental, in terms of having staff who are learning in a teaching hospital in a teaching environment. It is affiliated with the university and there is a need to be exposed to all types of presentations. Having said that the process of an emergency department is an optimisation between providing the best access to required specialist care but at the same time provide a screening point to ensure that referrals are or are not appropriate.

There are places elsewhere in Australia where all mental health presentations are to a separate facility. Now that raises some concerns, certainly amongst emergency physicians, and I would suspect psychiatrists, because there are a significant proportion of patients who present with an initial triage or basic assessment of mental health problems, which is a very broad group. However, on subsequent thorough assessment they end up being an alcohol or drug illness. There are a great many illnesses that mimic some of the presenting symptoms and signs of mental health problems or head injury.

CHAIR - Acute pancreatitis?

Dr LAWLER - Acute pancreatitis for one. Anything that can cloud the consciousness of the patient can be misinterpreted as a mental health problem. So it is important to have a set of circumstances, like the emergency department, wherein you have a generalist approach in order to ensure that no life-threatening or inappropriately missed diseases are neglected.

CHAIR - Terry just wanted follow a chronology from when they are seen by mental health staff in the DEM.

Dr LAWLER - Or seen by the emergency department staff and then we would make a referral to the mental health services.

Dr McARTHUR - That depends a little bit on what time of the day it is. During the day we have staff on site but we do not have enough registrars at the moment to run registrars in the hospital 24 hours a day, so the registrars go home and are called back in of a night. We also work them the day before, that night and the next day. So we are obviously very worried about what we are doing but at the moment that is the best we can do.

CHAIR - Have you asked for more staff?

Dr McARTHUR - Yes.

CHAIR - And the reasons you have not got them?

Dr McARTHUR - Well, we cannot recruit staff.

CHAIR - So there are positions available but recruitment is the issue.

Dr McARTHUR - Yes. We lost four psychiatric registrars to the service last year and we have not replaced one of those.

CHAIR - Four registrars.

Dr McARTHUR - Four registrars left the service. Two went interstate, two left us and we have not been able to recruit a single one so far.

Mr MARTIN - Do you know why they are leaving?

Dr McARTHUR - There are a lot of reasons. It is a difficult job. I would rather than be a psychiatrist than a policeman - I think that is probably more difficult - but there are difficult jobs and that is one of them.

Dr LAWLER - This is not a shortage that is isolated to Hobart or even to Tasmania.

Dr McARTHUR - No, it is Australia-wide and includes New Zealand as well.

CHAIR - So if the registrar is called back in, the time of day makes a difference on how it works.

Dr McARTHUR - Yes, and because Tony's staff are so senior, the registrars would often take the advice of the emergency physicians. But they would make their own assessment. They would usually admit the patient by this stage. The number that are turned away is low. If they do turn someone away they certainly have to ring one of the consultants, who may or may not come in.

CHAIR - Does it happen on every occasion whether a patient is not admitted?

Dr McARTHUR - Yes, we ask our registrars to ring a consultant and discuss with the consultants.

Dr LAWLER - I should say that discharging a patient who has been initially assessed by the Emergency Department as warranting admission, and then referred to a psychiatry registrar, that is a big step. We bill that here as a big step, that a patient has been assessed possibly by the Mental Health Crisis Team, certainly by the nurses and the doctors in the Emergency Department, then referred. To actually make a decision that is counter to that is a big step and that is why the insistence on a consultant.

CHAIR - I guess that then it comes back to the question of how many patients who are then assessed by the DEM staff and not referred to the Department of Psychological Medicine are discharged.

Dr LAWLER - We were discussing this, and we thought that the figures were in the realm of about 12 a day who are seen in the Emergency Department. We would say that between six and eight are referred and, of those, four to six would be admitted.

CHAIR - We have had evidence of a couple of situations where people were discharged, and we did not actually drill down to at what point they were discharged, whether they had

been referred to the psychiatric team or whether they had been assessed by the DEM staff and then a decision made to discharge. People have gone home and then successfully suicided, which obviously is distressing for everybody involved in the whole contact with that particular person. We have also heard of the suggestion that patients are not admitted because there are not beds for them. They can't admit them so they have to send them home.

Dr McARTHUR - We got some information in the last few days. We actually are full again today. We are full in our PICU-HDU- with eight patients, and 34 patients in the open ward. But unfortunately we ask Tony to keep the patients as they sort of bank up and he kindly does that, so we sometimes have patients having to wait in DEM until we can discharge someone from our inpatient unit to get them back out.

CHAIR - Are you saying that really does not happen?

Dr McARTHUR - We do not say to anyone 'You need to come in but we can't take you, so go away'.

Dr LAWLER - In that respect with your Mental Health referrals, as we do with cardiology or respiratory, general medicine, or surgery, if a referral is indicated on the basis of need then it is indicated regardless of bed status. We make the referral and, as Milford has mentioned, in a number of instances that will lead to patients staying in the Emergency Department for some time, but that is after initial assessment. This is not waiting for assessment. It is after initial assessment and mental health referral.

CHAIR - So what support do those patients get while they are waiting?

Dr LAWLER - They receive full nursing supervision. They are watched as any other patient in the emergency department is. They are kept either in what we call the seclusion rooms, which are our mental health assessment rooms, or one of the consequences of bringing our psychiatric nurse online is that we have also cleared out the three cubicles next which can serve as an overflow cubicle, because we have a significant proportion of patients who come in with, for instance, suicidality and have taken an overdose of medications that renders them unassessable and we treat them as medical patients. So they might come in at 8 p.m. having taken an overdose of Valium, for instance, and we will keep them in the department until the morning, because calling Mental Health Services or calling inpatient psychiatry services is really a waste of time because they cannot make any decision to detain or release until then, and we have those three cubicles that can then to a certain extent act as a psychiatry overflow area or mental health area overflow -

CHAIR - With medical or mental health -

Dr LAWLER - With mental health patients, or the so-called medicalised mental health patients. A significant proportion of those patients in the morning, once they have overcome their sedation or torpor induced by their overdose, will be assessed again by the medical staff in the morning, which includes not only the registrars that have come on, but also staff specialists who have had significant experience in emergency medicine, and a risk stratification process is employed. Various factors come into play: the fact that it was an acute episode or a situational crisis or an emotional argument, that there is

remorse for the episode, that they have clear plans for the future. By plans I mean there are things that they have to do and people they have to see and strict follow-up mechanisms are employed. Those patients, once they have come in overnight, have settled in the morning and received support overnight may well be appropriate for discharge in the morning.

CHAIR - Just one other instance that was raised and it may well be quite an isolated instance, I do not know. We were informed of a patient who was basically refused treatment because they were known to the department and obviously had previous dealings with them. It is my understanding that in any public hospital we cannot refuse treatment to anybody.

Dr LAWLER - There are so few instances in which that might be a factor that I am almost getting into specific cases that I feel uncomfortable doing.

CHAIR - Okay.

Dr LAWLER - We have to balance, though, the welfare of the patient clearly with the welfare of the staff and there are patients who in the past have demonstrated violent, particularly violent, threatening homicidal behaviour towards the staff and that is when they presented with non-mental health-related issues.

Mr MARTIN - Perhaps we could do this in camera before we go any further with this particular question.

CHAIR - Do we need to go any further?

Mr DEAN - Not on that. I do not know whether we do or not but just a couple of issues. You mentioned before about the assessment process for these patients. Because of some evidence that came out in another committee yesterday on the same subject, do you think that there is a place in the system for people who present with a perceived mental health problem - either in custody by police or voluntarily or a member of the family or case worker - being assessed in a separate area. In other words being assessed in the psychiatric ward areas of the hospitals. I am not quite sure what you call your ward down here, ward 1E in Launceston for instance, rather than going through the DEM area?

Dr LAWLER - We have discussed this in the past as well about a separate streaming facility and we would have all medical, surgical, paediatrics, obstetrics, gynaecology in one area and mental health would go through a different part of the hospital. That carries with it the risk that of patients who present with what is perceived or assessed as a primary mental health disorder there are a significant proportion who end up, as I mentioned earlier, with an organic problem be that a head injury, be that an infection or end up as drug affected on the final assessment. I guess a concern I would have is for the benefit of teasing out the streams you would lose that safety mechanism of catching those individuals because of assessment by a generalist doctor.

Dr McARTHUR - We would feel the same too. There is a small percentage of patients who look like they have a mental illness who in fact have encephalitis or meningitis or a brain tumour or something and of course we would have them on our ward for a couple of days

before that became obvious and that might be all the time that is needed for it to be a disaster.

Dr LAWLER - One of the important aspects of the psychiatric admission is that there is a reliance upon the medical staff in the emergency department to medically clear the patient, which is to say by our assessment of their vital signs, a physical assessment, whatever blood tests or x-rays are required which may go so far as requiring a CT scan, we determine that there is no medical reason that precludes this patient being transferred to the ward. It is almost universal that psychiatry registrars will expect that and I think that is entirely reasonable.

Mr DEAN - Do you believe then that in a very obvious case of a mental disorder and where there is a history with that person into psychiatric assistance and support and it is very obvious what is going on, there is a case for that person to be taken into another area for the assessment process and so on rather than going through the DEM area where very clearly the evidence will be that they are going to be admitted?

Dr LAWLER - Interestingly enough my experience in dealing with inpatient psychiatry services professionally is that patients who present very frequently with obvious mental health disorders are the ones that they are actually more keen to have a physical clearance on because they are the ones that you assume every time they come back is the same as the seven or eight times before. We call it the error of availability. It is a nice, easy, available diagnosis. I take your point, and it may well come from the method of screening we use, but in the emergency department a main focus is on flow. We clearly have a focus on the resuscitation and treatment of the critically ill, on the support of the patient, but also on flow. We are resource limited, as everyone is and the sooner we can get a patient assessed, diagnosed and referred the sooner we can get them to the place where they need to be. When we see a patient with a suspected primary mental health presentation, we will make a rapid but thorough assessment to determine whether that is the likely cause, and we will make a referral to Mental Health and do our physical assessment in parallel.

Mr MARTIN - Going back to my question on whether some people are falling through gaps in the assessment et cetera, I accept what you have said. We have heard evidence provided by family members of patients, probably four or five of them, and it is supported by comments made by the police this morning. For example, one family member in the case we were talking about, without identifying the person, in the space of two weeks the police had to go five or six times. I put that to the police this morning and they said that sometimes for some people you have to go five or six times in a day. As a layperson, I have difficulty understanding the police having to keep going back five or six times a day. Obviously, there is a problem with such people. How can he not be assessed for admittance if he is going to continue?

Dr McARTHUR - Hopefully the person was assessed for an admission. If people thought that patient has a mental illness that requires compulsory admission - which is I guess what you are talking about - then they should be admitted, but if people think that they -

Mr MARTIN - But the police were saying it is a commonplace occurrence that they have to keep going back to deal with the same people a number of times, and sometimes five or six times in a day.

CHAIR - They claimed that they did not fit neatly into the definition of mental illness under section 4 of the act -

Dr McARTHUR - Yes, to do with compulsory admission, I think we are talking about. I actually requested that the person stay in hospital but he declined, but because I did not believe, and subsequently a series of other people did not believe, that it was appropriate to force the person to stay in hospital, the person was allowed to go.

Dr LAWLER - Taking the general case, I understand that there are individuals to whom the police have called on frequent occasions and often they are left with little recourse but to bring them to hospital. The frequency with which they are called does not give us a mandate to detain them against their will, and that is the unfortunate thing.

CHAIR - Because the act does not allow for that.

Dr LAWLER - Not if they do not satisfy the conditions of the act for a detainable mental illness.

Mr WILKINSON - Leading on from that, what should happen to them? It would seem to me that there should be a team you could contact made up of counsellors, whatever, psychologists -

CHAIR - The intervention team, it has been called.

Mr WILKINSON - the intervention team, yes, and pass that person to that team for that team to then give the proper care.

Dr LAWLER - I think this works very well for individuals who are seeking that nature of treatment. There will always be a group of patients who are brought to us frequently and want nothing to do with us. I can understand that to a certain extent, nobody wants to be in hospital. If they present on assessment to possess the insight, the understanding of their situation, the consequences of their decision, they are not detainable and once they are not detainable they want nothing to do with the treatment that we have to offer.

CHAIR - There is no guardianship order on them or any other, so you are stuck.

Mr WILKINSON - So what do you do?

Dr McARTHUR - We try hard to engage them in the hospital environment and then we try hard to get them engaged in the community mental health services.

Dr LAWLER - I have to say we are very sympathetic to these comments because we do exactly what they do. As far as I understand from what you are telling me, they do not have the legislative option of holding these people in custody.

Mr MARTIN - No, that is right.

Dr LAWLER - Neither do we.

Mr MARTIN - That is our predicament as a committee, that there seems to be a gap with this group of people who are causing distress to themselves, potentially dangerous to themselves, having enormous impact on the family members and the wider community as well and no-one seems to be doing anything.

CHAIR - They have not committed a crime so they are not a forensic patient and they do not meet the criteria under the act.

Dr McARTHUR - They are not certifiable.

CHAIR - Yes, that is right.

Dr McARTHUR - If you do certify them and force them into hospital that would be a huge step and then you can imagine how it would be very hard to regain rapport with patients once you have done that sort of thing. It is very difficult.

Mr MARTIN - I suppose that brings up the other personal dilemma I am having in this committee, the balance between civil liberties, which I have a tendency towards myself, and this other situation with people. Are they the best judges? What are your views on that?

Dr LAWLER - Without a doubt. You have already heard described the long and tortuous process in obtaining an order beyond 72 hours. We tend to work in much tighter time frames. We all have a patient who presents as violent, disruptive, causing clearly a great degree of angst to those around but also a real physical threat to themselves. We have to make a decision on how best to manage them and that may well be to place them on an initial order. It may well go further than that to restrain them by the use of medication. That is an enormous step for us, removing their liberties or depriving them of their liberties to the extent of actually sedating them -

CHAIR - Do you use chemical restraint?

Dr LAWLER - We do.

Dr McARTHUR - Much safer.

Dr LAWLER - I believe the evidence is that mechanical restraint has much more significant and longer lasting psychological impact than chemical restraint; but that is the big step. That is not something that is taken lightly. We have a great deal of attention to the safety of that. We have very highly trained staff, both orderly staff who provide the necessary restraint because there needs to be physical restraint while the pharmacological, the medication-based restraint is occurring. What we call code black medications, simply because that seems to be a term that is widely used, we have a great deal of training for our medical and nursing staff in terms of completing those measures safely.

CHAIR - Are your staff trained in code black?

Dr LAWLER - We have a requirement that all of our senior staff, that is the nursing staff who are likely to be acting in a team leader aspect, are trained in code black and all of the

orderlies who respond are trained in the code black response. In fact, we have a code black response team.

Dr McARTHUR - I have the figures here for the last 12 months - there were nearly 1 000 code blacks in hospitals which is a huge number, compared to when I started 20 years ago.

Dr LAWLER - That code black does incorporate a number of things, including code black medication, which is the process of pharmacological sedation I described earlier. It also includes code black escort, which is, I guess, a preventive measure. If we are taking a patient who is on an initial order from the Department of Emergency Medicine to the Department of Psychological Medicine or more commonly to the PICU-HDU they will have a code black escort, they will have someone with them. They won't be sedated, they won't be restrained but they will have staff with them almost as a show of force.

CHAIR - They know what they can do.

Dr LAWLER - That is exactly right and so that is incorporated in those figures. Also incorporated in those figures would be code blacks against patients who are generally on the ward or visitors or members of the public, which unfortunately is not unheard of.

CHAIR - How many of those would be visitors?

Dr LAWLER - I do not know that that level of data is kept.

CHAIR - Okay. Similar to in a maternity ward, I reckon.

One of the criticisms that has been levelled at the DEM communication aspect is that the police say when they bring in someone in protective custody, they are assessed and then deemed to be suitable for discharge, the police may well have left the unit by that stage. The police are not informed, and maybe that is an issue, because they are the ones that often have to go and pick up five times in a day, or there may be other reasons they are interested in the discharge because they may have committed a crime and they want to follow up with them as well.

Dr LAWLER - Sure.

CHAIR - Is there a policy around that?

Dr LAWLER - I must admit that as Director of the Department of Emergency Medicine I have never received a communication that that is desired. That would have been good to know, and we can certainly do that.

CHAIR - The recommendation from the police was that they were notified prior to the patient being discharged, just so they were aware they were back on the street. They may not have an interest in them in a police sense, but they would then know they are out there and they are known to the police as potentially requiring attention.

Dr LAWLER - There are points of friction, and frequently they are around such issues as patients who are being brought in to be assessed for mental illness. I believe on the

whole we have an excellent relationship with the police. I was not aware of a concern about being informed of patients being released. There is sometimes a degree of confusion around the status of patients who are being looked into for crime, about whether they are under arrest, if brought in under custody and then placed on an order, if that order is discharged what is their status. As far as I can tell, as a practitioner who has been working with these systems for a little over a decade, if a patient is released into our custody and then discharged from an order, my understanding is that they are free to go. That is my understanding.

Mr WILKINSON - That would be right. They are not in custody. The police have given it away.

CHAIR - But is it still good communication that you notify the police that that patient has been discharged because they had an interest in their admission, or is that a patient privacy issue that is overstepping the mark?

Dr LAWLER - These are the confusing issues.

Mr DEAN - The concern of some police is - and I take the example of myself and people when I was there - with regard to a person who is alleged to have committed a criminal act but is also displaying signs of some mental health issue or problem and is brought into the system. An example given to us was that that person, after being treated and so on by the hospital, was then returned I think five hours after that treatment. The person was let loose, as it were, and the police were wanting obviously to interview that person in relation to an alleged criminal activity and behaviour, but were not notified by the hospital. It seems to me that that could be a breakdown probably from the police as well, who ought to be saying to your senior personnel there that there is an allegation of some criminal activity here, so on release -

CHAIR - Some of this was evidence given in camera.

Mr DEAN - Yes, but I am taking it from my own experience. I am using my own personal experience here. Maybe there is a breakdown here where the police should talk to you and you would then notify.

Dr LAWLER - Yes. Poor communication is always going to lead to poor care, and I agree with you entirely. If we were aware that that was an expectation of the police we would comply with that, and if it is in keeping with the practice of this committee I will take that on board.

CHAIR - Certainly talking to the police is probably not a bad idea.

Mr WILKINSON - It would be a fair conclusion to make from the Royal Hobart Hospital's point of view that if the police handed a person over to the Royal Hobart Hospital to carry out any treatment they deemed appropriate, that the police believe that that patient at that stage was not going to be any risk, otherwise you would think the police would still be with that person under arrest, because it is what happens in relation to a number of matters that police remain with them in relation to blood tests or matters like that. The police have the power, as Ivan would know, to stay with them, and if anybody were deemed to be a danger they would not let them out of their sight.

CHAIR - Just to clarify that point, it may not be that they are considered a danger, but then they go back home and create problems within the home environment. There may not be a danger in a mental health sense, and they may not require treatment in a mental health sense, and they certainly do not require detention otherwise you would have kept them and admitted them involuntarily if necessary. But the fact is that some of these people go back out, they are not suicidal, they are not posing an immediate threat to themselves or others -

Dr LAWLER - I would go back to your earlier point that if the patient has been discharged - and the police are discharging their duty of care clearly in bringing a patient to us - once we have assessed the patient is not requiring detention and they are fit for discharge, we have discharged our duty of care.

Before, I guess, coming up with any firm policy we would have to negotiate with both sides. I would really like to explore the privacy issue in relation to a patient, once discharged and if they are not under protective custody with the police. What right do we have to communicate the information in that circumstance?

CHAIR - With regard to the question privacy you have to be sure you were not stepping over boundaries there.

Dr McARTHUR - You are obviously well aware of the privacy thing, but if we thought there was still some risk we would still notify the police and we do notify the police that we are discharging someone from the ward even though privacy may be a worry. If there is some risk to someone else we would still warn.

CHAIR - So if you were discharging someone who you were concerned might harm somebody else then you would notify in those circumstances?

Dr McARTHUR - Yes.

Mr WILKINSON - There would be no bar to your doing that, would there, because that would just be normal practice I would imagine. It is like a doctor writing to the transport department to say Jim Wilkinson is not a fit and proper person to hold a licence and therefore the licence is taken away. It is the same type of thing, isn't it, on a different scale?

CHAIR - Then they give it back to you after a designated time.

Mr WILKINSON - No, you have to prove you are a fit and proper person.

Dr LAWLER - We take great pains to ensure the status as best we can. We have had instances in the past where patients have been brought in not under protective custody but under arrest for alleged criminal acts and they have been unconscious and intubated in ICU. There have been discussions about whether the fact that they are in a medically induced coma means that they do not have to have someone with them and we contend that is not the case. Their medical status if they are under arrest should dictate that they have an escort at all times. So we endeavour to be very clear on the status of patients.

Again, I am not sure whether I am in a position to take instances such as the communication process and explore them.

CHAIR - There is no reason why you can't.

Mr DEAN - Can I explore a different area? How much input have you had in relation to the current review into the act?

Dr McARTHUR - I have had a moderate amount of input. There are not many of us clinicians there but we get invited to go to the meetings and we go when we can but they are very time consuming and it is very hard to find half a day to go so we try to get updates from the various people who go and do it that way rather than go ourselves. It is hard to have the time to specifically go but my colleagues do tell me what is happening and we get the reports and various updates about what has happened. Also, we are able to put submissions in. I have put a submission in and other people have put submissions in so we have some input but not as much as we would like.

CHAIR - Will you get a chance to review the draft bill when it comes out?

Dr McARTHUR - I would assume so.

Dr LAWLER - I was asked for input as Director of Emergency Medicine but also as a State counsellor for our College of Emergency Medicine so we had both an operational and a professional capacity to provide input and I would similarly hope to be able to look at the draft when it is released.

Dr McARTHUR - It is very important that clinicians are involved because often things that have happened there on the coalface -

CHAIR - Administrators do not always understand the clinical application. Is that fair comment?

Dr McARTHUR - I won't comment. I am nearer retirement.

CHAIR - We are almost out of time. We did ask if you could provide data related to the number of people who are brought in by police both in protective custody and not. I was wondering if you could also provide figures, if you have them, of the number of people who present and they are not admitted or they are turned away?

Dr LAWLER - Not admitted and turned away are two very different things.

Not admitted means not requiring admission. Turned away I would say indicates wanting to come in but for whatever reason it is determined that is not in the patient's best interest, which also has to be balanced against the interests of staff and other patients. I am not sure that I could necessarily get data on the number of people who are discharged against their own wishes.

CHAIR - So that information may not be available?

Dr LAWLER - That is not something we tend to collect.

CHAIR - So the number of people who you do not admit who are brought in in that manner by police would be?

Dr LAWLER - My understanding is that we can drill down to getting the number of patients who are brought in by police and from there a breakdown of those who are admitted and those who are discharged from the emergency department.

CHAIR - That would be helpful. Thank you.

Mr MARTIN - I would not mind going in camera to finish off.

CHAIR - There are a couple of matters that we were discussing at a previous hearing which would be best heard in camera to allow a more free and frank discussion, if you are willing.