THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON MENTAL HEALTH LEGISLATIVE MEASURES MET IN THE CONFERENCE ROOM, 4TH FLOOR, HENTY HOUSE, LAUNCESTON, ON MONDAY 23 MARCH 2009.

Ms CORAL MUSKETT, DIRECTOR OF MENTAL HEALTH SERVICES, **Dr JENNY TUDEHOPE,** CLINICAL DIRECTOR OF MENTAL HEALTH SERVICES, NORTH-WEST, **Dr PAUL PIELAGE,** DIRECTOR OF EMERGENCY MEDICINE, LAUNCESTON GENERAL HOSPITAL, **Dr MANILALL MAHARAJH,** CLINICAL DIRECTOR, LAUNCESTON GENERAL HOSPITAL, AND **Dr ALASDAIR MacDONALD**, DIRECTOR OF MEDICINE, DEPARTMENT OF EMERGENCY MEDICINE, LAUNCESTON GENERAL HOSPITAL, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Welcome. I assume that you have had a chance to look at the terms of reference of the committee. The committee's focus is particularly on the protective legislation around mental health. During the course of our inquiries we talked to a number of groups and individuals who have varying views on the best way forward. We are very cognisant as a committee of the review at the moment of the current Mental Health Act and that there will no doubt be some changes with that. This is not to undermine that in any way or to stymie it or slow it down or anything like that. We are trying to look to the future as to which is the best way forward.

There have been suggestions that we need more generic, capacity-based legislation that encompasses the powers of the Mental Health Act and the Guardianship and Administration Act as well so we are looking at that as well as the broader picture. During the course of our hearings we have heard a number of comments and concerns, I guess, about how the legislation impacts at the point of service delivery. That is why I have asked for people involved in the service delivery area to come and provide some evidence to us about that. We have talked to police who are often involved in bringing patients to the Department of Emergency Medicine. We have talked to other staff at the Royal about how they process through the DEM to their Psychological Nursing Department there. So we want to hear from your perspective - I know Jenny is from the north-west - how you find it works up here in the north and the north-west of the State, what challenges you particularly face, whether you think the legislative framework should be changed and how it should be changed to meet the needs of yourselves as health professionals but also for the patients you care for.

Because there are quite a few of us and Hansard is recording this it would be good if just one person spoke at a time. It makes it a bit easier for Hansard. That includes us on this side of the table. Also remember that the committee hearings are covered by parliamentary privilege so if you do talk to the media after this event you can talk more broadly about the topics you have discussed but not refer to specifics of what evidence you have given to the committee. If you have any questions about that, please feel free to ask.

Before we start, could you each give a description of what your role is within Mental Health Services just so we know which area you are coming from. We will start with you, Coral, if that is all right?

Ms MUSKETT - I am Coral Muskett. I am the statewide Director of Mental Health Services and have been since 2001. Prior to that I started nursing in 1976. I did my mental health first at Royal Derwent Hospital and then did general at the Royal Hobart Hospital. I have worked across a range of settings, mostly inpatient, in my nursing career but also I have taught at university on secondment. Probably most particular to this I managed Ward 5A in 1994 up until 2000 and amalgamated wards 5A and 6A into the DPM in 1998. I also spent three months living in Launceston in early 2006 when the task force was first set up, just coordinating and being part of leadership and support for Ward 1E at that time.

CHAIR - So you are currently based in Hobart?

Ms MUSKETT - I am based in Hobart and I clock up a lot of miles.

CHAIR - Dr Pielage, would you like to give an overview, please?

Dr PIELAGE - I am the Director of Emergency Medicine with the Launceston General Hospital. That about says it all.

Dr TUDEHOPE - I am Dr Jenny Tudehope. I am the Clinical Director of Mental Health Services in the north-west of the State. I am originally from Victoria. I have been in the north-west for about 24 years. I do clinical work. Across all the fields I have worked in inpatient, outpatient, I currently do some clinical work in child and adolescent mental health and also in adult community mental health and I am doing my director work as well. This is a new position. I am the first person in this position. It has been nearly six months.

CHAIR - Medical Director just for the north-west?

Dr TUDEHOPE - Yes, just the north-west.

Dr MAHARAJH - I am the Clinical Director for the north, covering both Ward 1E and the outpatients. My background is a limiting factor because I have only been here three months. Prior to that I came from New Zealand where I spent 15 years and trained as a psychiatrist and continued working there. Prior to that I was a general practitioner for 12 years. At the moment I have inherited the issues that have been part and parcel of the mental health system in the north but I am clearly very optimistic about the way that is going.

CHAIR - When you were in New Zealand, what role did you fulfil?

Dr MAHARAJH - I was a consultant psychiatrist specialising in diagnosis, mental health, and alcohol and drugs.

Dr MacDONALD - I am here in part because up until today I was unaware whether Paul was going to be able to be here. My role is the Director of Medicine in the Emergency Medicine Department. Paul is under the medicine umbrella and in that context I was coming to offer some continuity in case Paul wasperhaps would not be available. I have been in and out of the Launceston General Hospital since the mid-1980s and I have fulfilled roles up to and including Acting Director of the Emergency Department at one stage. I have had a long experience but my presence probably is not quite so necessary now that Paul has been able to come.

CHAIR - I will start off with when patients present to the Department of Emergency Medicine and then we will get to when they are admitted to the psychiatric areas and how is that is managed. You probably can't speak for the North West Regional Hospital, although, Jenny, you may have some comment to make about that. We have had evidence from the Royal Hobart Hospital DEM about how they manage their mental health clients down there and we are keen to hear how it works here and how you feel it is working considering the demand on the Department of Emergency Medicine here.

Dr PIELAGE - We get a lot of mental health patients and we also have people with drug and alcohol problems which often overlap. There is often a combination of the two issues in the same patient. The numbers increased rapidly in the early years of this decade and have been very stable the last four years. It has not changed at all.

CHAIR - That is the number of presentations?

Dr PIELAGE - Yes. Numbers are always a little bit rubbery because of the way you define what is mental health, drugs and alcohol. It went up about 60 per cent between 2000 and 2005 but has remained constant ever since. Most of the patients turn up outside normal office hours - in other words, only about 30 per cent of patients turn up between 9 a.m. and 5 p.m. Monday to Friday.

CHAIR - This is mental health patients?

Dr PIELAGE - Mental health and drug and alcohol, yes.

Mr WILKINSON - You say that in 2005-06 there was a marked increase?

Dr PIELAGE - No, between in 2000 andto 2005 there was a marked increase and since then it has plateaued.

Mr WILKINSON - Is there any reason for that increase?

Dr PIELAGE - It is hard to define because probably a lot of it is happening outside the hospital with perhaps reduced mental health services. There was certainly a reduction in the number of psychiatrists, for example, in Launceston at that time and I suspect that had a role to play. I don't really know totally but it seems to have found a new level.

Patients arrive, they are triaged. The conditions of people presenting are very variable. Some people who arrive want to see someone from the mental health team and someone else may be unconscious from an overdose or lacerations. There is a whole range of

presentations so they are triaged accordingly. They should be seen by medical staff, their medical or surgical condition worked out and stabilised, and they are then referred to the Mental Health Service as appropriate. We do have a rule that all self-harm patients are referred.

CHAIR - Is that actual self-harm or threatened self-harm?

Dr PIELAGE - Threatened self-harm usually are referred. The rule is for actual self-harm, so it applies if you have taken an overdose or you have lacerated yourself or whatever, and that has been the rule since 1992.

CHAIR - Have you afforded these patients a category?

Dr PIELAGE - They are all triage categorised, yes.

CHAIR - We were told at the Royal they categorised all mental health clients who came in by the police as category 2.

Dr PIELAGE - I would have thought that would be mostly the case, yes. I cannot say for certain without looking into that. The ones who are brought in by the police are usually fairly florid in some respects. We do have various problems with this.

First of all the police bring them in. Some of the patients the police bring in do not really have psychiatric illnesses, they are either drug affected or alcohol affected. Often there is no overt psychiatric complaint. They are often aggressive, abusive, destructive, threatening - very difficult sorts of patients. We do not have the security to deal with these people very often. The police end up having to stick around for a while. There are not many police in the middle of the night. It is a major impost on them and a major impost on us and it is very difficult.

The mental health services in the north have for many years been deficient. There is a deficiency of psychiatrists within the hospital system and outside the hospital system. There has always been a long-term general shortage of psychiatry registrars in the hospital system so we function very differently from the Royal Hobart Hospital in that there is a community mental health team which was originally set up to service patients in the community but which has taken on the role of first call for patients in the emergency department largely, historically, due to a lack of psychiatry registrars.

Mr WILKINSON - How many are you short, Paul?

Dr PIELAGE - I cannot answer that; it varies all the time. The numbers of psychiatrists and registrars and the directors of psychiatry have changed so much and so frequently over the last five years that I have no way of keeping up. It has been constant change. It is very difficult; money is on a five-year contract, I believe, and I am drawn to that because then at least I know whom to talk to.

At once stage we had alternating directors of psychiatry who were doing a month about and it was just impossible.

CHAIR - Also I think the north was providing services to the north-west at times as well.

Dr TUDEHOPE - Occasionally, but not on a regular basis. It was just when our services were even more poorly supplied than north. If beds are full in the inpatient unit we can send them on to 1E and vice versa.

CHAIR - Do you get some transfers from the LGH through to the Spencer Clinic?

Dr PIELAGE - Yes.

CHAIR - Is that on a bed-needs basis?

Dr PIELAGE - Yes, and we also have transfers to the Royal Hobart. The last year or so there have not been nearly as many transfers as a couple of years ago. I am not sure why that is but there have been fewer direct transfers out of the ED.

CHAIR - Just getting back to a point you made a moment ago, the challenge in defining what mental health illness is. This is a matter that was raised by other witnesses and by the police. It is certainly not their job to diagnose a mental illness but they are called in to escort people into the hospital. Then there are some who fall through the gaps, those who do not seem to have a mental illness but are affected by drugs or alcohol and it is hard to tell because of the state that they are in at the time whether or not they have a mental illness. Is this an issue and can we resolve that? It seems that there are people falling through the gaps who then leave hospital.

We were given a scenario of police picking up someone wanting to jump off the bridge in Hobart. They bring them into hospital, they are assessed and then discharged and then the police are called back because they are on the bridge again. Do any of you have a comment to make on that?

Dr TUDEHOPE - They are very difficult.

Dr MAHARAJH - With regard to the LGH and the north, certainly it is problematic. I think the one particular issue about it is the use of drugs and alcohol and historically there has been a pedantic rule of the blood alcohol level being less than 0.05 before Mental Health can be called in.

CHAIR - Is that still the case?

Dr MAHARAJH - We are trying to bring some commonsense into that now. We have a new policy that is in draft and should be in place in a few weeks about police attendance at DEM and how we as mental health and clinical staff in general look at this in a commonsense, practical and logical way so that if someone comes in, even if the level is above 0.05, we are now able to work with clinical staff who might give an assessment. We work with them to see whether they can give advice on the phone or come in because we accept what the police have always maintained, that there are many individuals who may have that level but be fully competent to do an assessment.

To my knowledge in the past people have fallen through the gap because of application of the rule, but we are hoping to change that.

CHAIR - Do you think that will be enough on its own? If you change the rules around that, the 0.05 being the cut-off for having that assessment, do think that will fix it or are we still going to have patients who could fall through a gap? When you look at the current definition in the Mental Health Act everything has to be quite serious before it is treated as a mental illness. Will that be enough just to change the policy in a hospital?

Dr MAHARAJH - No. I think the policy brings some commonsense to it because we know that individuals, under the influence of drugs and alcohol, can present with high risk which will be detected, so keeping to the rule of the 0.05 but also making sure that we can assess them. If we cannot assess them the DEM has the containment policy that will allow them to protect and look after the client and in a while to make the medical assessment and wait for the blood level to lower so they are in a position to attend to an assessment. That policy is there.

The reason for us looking at this again is that police resource is very valuable and for them to wait six or eight hours for us to do an assessment is really not on. We have been in consultation with the police and hence this policy that we have drafted so that we can respond earlier and be able to detect risk and illness earlier and then make the necessary arrangements either for admission or to treat the condition they have come with at the LGH.

CHAIR - Did you want to make a comment about North West Regional in that regard?

Dr TUDEHOPE - Just to add to what Dr Maharajh has said, in practice that will mean that emergency department staff will often be left with a very drunk person who might appear to be suicidal or mentally ill and they will let them sleep it off until morning when the psychiatric staff will be called in to assess. That works fairly well. Sometimes it is not so much a matter of testing the blood alcohol level but seeing how the patients are behaving themselves.

CHAIR - So do they sleep it off in the DEM?

Dr TUDEHOPE - Yes, unfortunately.

CHAIR - So how does that work at the LGH?

Dr PIELAGE - Yes, exactly the same. We are very grateful if they sleep it off. It is much better than bouncing around the wall abusing, shouting, wandering and threatening. Some of these patients are very difficult and often they are just drunk. They are merely inebriated but when they are assessed by the mental health team when they have sobered up we might find they have a significant psychiatric illness.

It is very difficult because we cannot hold them. If they want to walk out it is difficult because they are not under arrest and they are not under an interim order and we cannot hold them; they can leave.

CHAIR - There should be another avenue for these people then, do you think?

Dr PIELAGE - There should be. If they are quietly drunk, asleep on a park bench the police do not do anything. They only bring them in if they are causing trouble and the trouble continues. Often there is no real medical or psychiatric underpinning to it, apart from the fact that they are stoked up on some sort of drug or alcohol.

Mr DEAN - Doctor, if I could just put this to you: if a patient is brought in by the police or whoever and they have made an attempt to commit suicide, for instance slashed their wrist or what have you, they are attended to until they are assessed. There is not anywhere in the legislation that you can keep them until they are actually assessed as having a mental health issue and where they can be retained. So at any time up until then they could get up and just walk out. Is that the case?

Dr PIELAGE - If they had obviously done something you might be able to stretch it and put them on an order to hold them.

CHAIR - An interim order?

Dr PIELAGE - Yes. The legislation is very vague sometimes. It is very difficult. If you put them on an order it does not necessarily allow you, in my understanding, to treat them.

Dr TUDEHOPE - That is correct.

CHAIR - Just to detain them, yes.

Dr PIELAGE - But you cannot treat them. People get very confused by it. I get very confused by it. The ones that are really difficult are those that the police bring in who are, say, drunk who say they want to commit suicide. That is a guaranteed ticket not to go in the cells. I they just mention the 's' word -

CHAIR - The police cannot take the risk.

Dr PIELAGE - Exactly. Ideally they should be in some sort of a cell or something where they cannot do any harm to themselves but to do that they need to be supervised. I suspect the police do not have the resources. Quite frankly we do not really have the resources either because some of these people are quite aggressive and violent.

CHAIR - At the Royal they have two seclusion rooms within their DEM and three bays set aside where they employ a mental health nurse in the evening shifts to meet the police with the patient, and to basically take over responsibility and care for that patient, up to a point of course. There are some patients who need extra manpower around.

Dr PIELAGE - And that is the issue here.

CHAIR - Yes. Has anything been considered like that at the LGH to alleviate that problem with them being quite disruptive, potentially at risk of self-harm and separating them from the rest of the patients in the DEM?

Dr PIELAGE - It usually requires a bit of manpower, which is the problem. The whole security, manpower type issue is the problem, particularly after hours, which is when these things almost always occur. In terms of seclusion rooms, if you lock someone in a room then the requirements for observation and everything go up absolutely dramatically. Again it is a huge staff resource. The risks are much higher once you lock people in.

CHAIR - Here you do not have a mental health nurse that -

Dr PIELAGE - No, we do not.

CHAIR - That is what they do at the Royal.

Dr PIELAGE - The Royal has a few things we do not have. We lack security staff. Our mental health service does a good job with very limited resources but we certainly do not have a mental health nurse in the department 24 hours a day.

CHAIR - Do you think that would help?

Dr PIELAGE - It probably would.

Mr DEAN - If somebody presented, say, at the Launceston General Hospital at 11 o'clock or midnight on Saturday night, who would actually do the assessment of that person to determine whether or not they should be on an interim order or what have you? Who would make that decision?

Dr PIELAGE - The medical officer in the emergency department.

Mr DEAN - A medical officer. And how many medical officers would there be in the emergency department at that time?

Dr PIELAGE - At 11 o'clock? Probably four.

CHAIR - You have a senior?

Dr PIELAGE - There will be a senior who may be a registrar. At 2 o'clock in the morning, mind you, it will be down to two medical officers, or even at 1 o'clock in the morning.

Mr DEAN - Two only?

Dr PIELAGE - Two only.

Mr DEAN - To do all the other work plus the assessments?

Dr PIELAGE - Exactly. We would like another one but we do not have the funding.

CHAIR - You do not have the funding?

Dr PIELAGE - No.

CHAIR - What about nursing staff level at that time?

Dr PIELAGE - Nursing staff is much better but once you start having patients who require one-on-one or two-on-one nursing you start to feel it because it creates a deficiency elsewhere in the department.

CHAIR - Do you think there are benefits to having perhaps a mental health-trained nurse as well as a general nurse - in the same person if you can get it - employed in those settings? Then that nurse could undertake other roles depending on the demand in the DEM at the time but also provide that increased supervision and observation of mental health clients who may require that.

Ms MUSKETT - I think there are definite benefits these days when you look at the incidence and prevalence of mental illness and probably not just mental illness because when I last reviewed the figures from the Royal Hobart Hospital in DEM and the reasons for presentations the drug, alcohol and substance abuse presentations were the ones that were really escalating too so that is probably your skillset that traditionally has not been amongst emergency nurses that probably is long overdue.

There are limitations, though, to what a nurse can do for some of the clients that end up in the Emergency department and are very difficult and dangerous to manage. The average age of mental health nurses in Tasmania is 51 and they are usually about my stature. Regarding placing them and making them responsible for caring for those sorts of clients, the sole responsibility of one person of course is never going to work.

I do not whether you have read the latest discussion paper from the Hospital and Health Care Reform Commission. It has identified that not just emergency departments but increasing the mental health literacy of primary health-care staff is a national priority because when you look at the incidence of mental illness, the cost of mental illness and treating depression alone are higher than what it costs the community in Australia for coronary artery disease and asthma and yet people talk about them as though they are primary physical illnesses. We train our staff to deal with those in primary care settings but we have not kept pace with training staff to deal with basic recognition and assessment of mental illness and mental health issues.

Mr WILKINSON - Are we able to get a copy of that document that you have just spoken about?

Ms MUSKETT - It is on the Commonwealth department web site but we will get you a copy of it. It identifies a number of critical issues across the whole of the health sector, including the decreasing work force, and it is not just mental health nurses that we have problems attracting; psychiatry is a difficult area, to attract people across the whole of that profession - medicine, psychology, social work. COAG had tried under the COAG reforms to redress some of that with some of the better outcome measures, giving GPs extra training, cognitive behaviour, therapies to deal with the less severe mental illnesses.

It also talks about the fundamental issues like mental health representing 13 per cent of the total illness burden across Australia but only traditionally attracting on average 7 per cent of funding for services.

CHAIR - This broadening out of mental illness awareness amongst GPs and other staff is one aspect. Do you think there is a benefit of having nurse practitioners in mental health areas to provide a more focused attention in areas like the DEM and other areas where they do present?

Ms MUSKETT - That is why we have been excited. We are going to be the first of the services in the Department of Health and Human Services to have mental health practitioners.

CHAIR - Will they be located in DEMs and places like that?

Ms MUSKETT - We have been having a look at where they are ideally located and in the north and north-west while we have not advertised the positions, we are ready to go with those advertisements. It looks as though we are probably going to attach them to the crisis assessment functions of the community teams in those areas because the problem is the capacity to respond to crisis. I do not know of many clinicians who would respond to crises in the community with some sort of backup and if that is just nurses, social workers and the other people who are on the team then when they get to a crisis they themselves still do not have the capacity to treat; you still have to get somebody into a treatment or an area where an medical officer or potentially a nurse practitioner can prescribe some form of treatment. So there are some limitations.

Mr DEAN - I want to go back to Dr Pielage. Is it fair to say that with the difficulties you have with staffing numbers during the early hours of the morning and so on it makes it very difficult for you to carry out all the assessment processes for somebody who may well be brought in by the police for assessment under the Mental Health Act? Does that restrict your ability to perform those tasks?

Dr PIELAGE - It certainly puts a lot of stress on the department. It depends on the patient but a patient who is creating difficulties because of bad behaviour, yes that is a major problem for the department. Sometimes we need to get the psychiatry team in in the small hours of the morning just so that we can make a decision about the patient and which way they go. Do they get admitted, do they go home, do they go to the lockup or whatever? They are very difficult to manage, restrain and control in the department. If you jump on them and drug them into insensibility then you have to wait a long time for them to wake up and the mental health team do not want to talk to patients who are drugged into insensibility so it just postpones the evil moment. It also carries risks so we do not like doing that.

Mr DEAN - My next question then is whether a patient being presented by the police for a mental health issue at, say, 2 o'clock on Tuesday, Wednesday Thursday, Friday afternoon, is likely to receive a quicker assessment, go through the processes faster than somebody being presented at 2 a.m. on Saturday morning or Sunday morning?

Dr PIELAGE - I do not have hard data but I would probably say yes.

CHAIR - Would they be less likely to be alcohol affected though?

Dr PIELAGE - Yes. Thirty per cent of our patients come in nine to five, Monday to Friday. The system really has to work after hours. The bulk of what happens is after hours. On weekends it is in the evenings and the small hours of the morning. There are not many patients that are brought in by the police in the middle of the day.

Mr DEAN - I was going to ask Coral a question. With that being the situation, and as the Director of Nursing you have a responsibility, I take it, for where nurses are and what they are doing to some degree, I suppose. Do you see an issue there in your area for the appropriate number of nursing staff and add-ons, say, during the wee hours of the morning in these areas?

Ms MUSKETT - I will just clarify that. My position is more about strategic policy and direction, so operational line management I do not have a responsibility for. Just as a general system response to that, we are having difficulty attracting people who want to do mental health nursing. It is the same issue for nursing across the board. People make lifestyle choices these days and when they have young families those choices do not usually involve working shift hours in the middle of the night and looking for child care, which is very hard to get. Those sorts of things do not make nursing particularly attractive to a lot of people these days.

There is a lot of evidence to show that if you do work across those hours and work night duty over a long period, it is not good for your health. So these difficulties come up when the bulk of patients are presenting at a time when people least want to be available. You have heard evidence about the numbers of psychiatric nurses being trialled at the Royal Hobart Hospital, but that is for an afternoon shift. The majority of those people are actually knocking off and going home at half past 10 at night too. I do not know the statistics for the north but most who present with major mental illness in the south tend to present with specific and identifiable mental illness problems before that 11 o'clock at night period. Then they start to tail off again. So I am not sure.

Dr PIELAGE - That is correct. In terms of those who get admitted there is certainly a bit more of a bias towards daytime presentation. I think it is 40 per cent of those who get admitted come during office hours.

CHAIR - Does that come back to the fact that they are not probably under the influence of drugs or alcohol as much and so it is easier to assess them and do all those things?

Dr PIELAGE - Yes. Often the ones that come in during hours just come in and say, 'I want to see the mental health team.' Quite often they are regulars who are known to the system.

CHAIR - They identify the fact that they are having a crisis or whatever?

Dr PIELAGE - Yes. The really difficult management problems tend to be after hours.

Dr TUDEHOPE - Just to make a comment about the way patients coming to DEM with mental health problems are managed: the DEM staff initially triage them and the RMO will see them. During normal working hours we have a system where the registrars from the inpatient area will go and assess them when they are called. They usually have to be seen within an hour. After hours we have the on-call staff; so you have first on call. Our system in the north-west is different from that of the north and south. We have only two registrars so we couldn't have them on call in a non-stop roster. So we have other seniors; they could be nurses, social workers or a psychologist who can also do that first on call. They see the client and assess them and then call the psychiatrist, who is the second on call.

CHAIR - So, bypassing the registrar on that occasion? The registrar is sleeping?

Dr TUDEHOPE - Well, the registrar takes part in that roster as well, during the week.

CHAIR - Oh, I see. So, it's three in one then, basically.

Dr TUDEHOPE - They're mostly only on one night a week or something like that because they have long day hours and they really couldn't be on call two or three nights a week because that would mean they would be up half the night assessing patients then they can't get to work the next day. Then that first on call, after assessing the patient, calls the consultant for discussion and reviews as to what further action occurs.

We've just introduced a CAT team, which is a crisis assessment team. That's going to take over a lot of the function of the on call and do a short-term follow-up of up to two weeks of patients who present to them; we hope to reduce admissions in this way because, through intensive care in the community; they can be visited every day or two if necessary. So they've had a psychotic break but are not considered to be requiring hospitalisation and they can be closely managed by that team.

CHAIR - What hours of work?

Dr TUDEHOPE - They're going to take up that evening work on an evening shift, so they will be managing a lot of those people who present after hours in crisis.

CHAIR - So, not overnight; just the evening. Or does evening extend into the night?

Dr TUDEHOPE - No, I think it extends to 11 p.m. but the rosters are just being introduced so I'm not sure.

CHAIR - That's all right. So, who's on the team, then?

Dr TUDEHOPE - There will be five staff. There are three nurses, a consultant psychiatrist and a social worker.

CHAIR - Right. Is anything being implemented at the LGH along those lines?

Dr MAHARAJH - It's a slightly different system. During normal working hours the DEM is covered by the CAT team and if there is greater need then a consulting liaison team will come in.

CHAIR - After hours or during the day?

Dr MAHARAJH - During normal hours. That is made up of the consulting liaison registrar, who is full-time, the consulting liaison nurse, who is full-time and me - I am part-time consultant. During after hours we have the crisis team who work until about 8 o'clock and thereafter the consultant and first on-call is available. So if there's a call the registrar will go up until 10 p.m. After 10 p.m. the consultant is called. If an admission is required, the registrar comes in and does that. So we have it pretty well covered, which is slightly different from the north because of limited numbers. We have certainly our full complement of registrars plus a house surgeon who will go on rotation, so we have one in six.

CHAIR - So, any one of those professionals could put the patient on an initial order?

Dr MAHARAJH - Yes.

Mr MARTIN - One of the doctors -I think it was Paul - made comment about the lack of resources at LGH. Is that a lack of expertise over a long period of time, and is that due to a lack of finance or the inability to recruit staff?

Dr PIELAGE - I'm not working in the department of psychiatry but my understanding is it's inability to recruit.

Mr MARTIN - Right. So the financial resources are provided but you just can't recruit people.

Dr PIELAGE - It's my understanding that over the last 15 years or so that has been largely the problem - the inability to recruit and retain. Sometimes you recruit but you don't retain. At the same time there's been a gross diminution in the number of psychiatrists out in the community as well, with age and outward migration taking their toll.

Mr MARTIN - I was about to ask the reason for that, so it is a combination of ageing and migration out?

Dr PIELAGE - Yes.

Mr MARTIN - Is there a reason for the migration out?

Dr PIELAGE - Spouses get jobs elsewhere or whatever. Of course one of our psychiatrists is incarcerated.

Dr MAHARAJH - May I comment?

CHAIR - Yes, feel free upon that note.

Laughter.

Ms MUSKETT - Could we just qualify that was a private sector psychiatrist.

Dr PIELAGE - Yes, we are talking about the private sector.

CHAIR - I would also like to hear Dr MacDonald's view because being there a lot longer you may have another slant to put on that.

Dr MAHARAJH - I think historically, yes, there have been problems but of late we seem to be working at our full complement, whether that is using a locum psychiatrist or waiting for one to be reinstated. Clearly we are utilising all our FT positions at the moment. I think that is probably one of the reasons things have changed over the last six months. I would like to say the last three months, but probably over the last six months. We are getting a greater interest of people wanting to work in Tasmania. I rejected three registrars this morning and there are two consultants who want to come but one has to be extremely selective so that we do not repeat the mistakes of the past. We are taking a very cautious approach to this. We would rather wait and make a good selection than hire someone and have great difficulty in getting rid of them because they become toxic to the system.

Mr MARTIN - My next question was going to be whether there is any strategy in place to address it. Obviously something has gone right. Is that because of a deliberate strategy?

Dr MAHARAJH - I think the answer to that is complex. There has been a large amount of instability in the system because of the lack of clinical governance and direction. I think that with my coming in three months ago with some degree of permanency and very rapidly being able to put in governance structures - and that has moved very rapidly - we are starting to see the stability coming back to the system. I think when people from the outside view that then it forms a basis for attracting staff, where they see it is a place that you can work in, a place that has some promise. I think that has made a difference although the time has been very short. But the word spreads. I think even in the community there has been a sigh of relief that now we have some permanency in the job so that we can start putting a governance structure and policies in place that will stay and will not be changed every time there is a weather change or a change of director.

Mr MARTIN - As a lay person, I would have thought it would have been pretty obvious that you need stability in this position.

CHAIR - And continuity of care for the patient.

Mr MARTIN - Yes. The northern members probably have a better idea of the history than I do but why was it not the case before?

Dr MAHARAJH - It is difficult for me to answer that but perhaps others here with long experience such as Jenny can shed some light on that.

Dr TUDEHOPE - I will make a few comments. In the north-west - and this actually applies to the north also in many ways - in years past the public services were really run by a

dedicated few who'd been there a long time. They were hard-working, very supportive units with reasonably good morale. Of course that started to fall down as they got to retirement age. Salaries were low; they had not caught up with mainland States. It is almost impossible to attract people and we had no area management unit of our own. We were run together with the north and north-west. Clinical directors did not exist so the doctors were employed in limbo, in a vacuum. They did not have any support. There has been a massive change in the last few years recognising those situations. After those long-term doctors left and retired we were existing with locums and people who were coming here really just to meet immigration requirements often. Once they were met they were off to the mainland where salaries were better. That really has changed.

Mr MARTIN - So the salaries have been increased?

Dr TUDEHOPE - The salaries have now increased. They are commensurate with most mainland States. That has made a massive difference. People want to come. Opportunities for education and further training have improved. Launceston now has a very good registrar training program. We have dedicated area management units to get all the policies functioning correctly and dealing with complaints. We had no complaints system in the past. We had no system for analysing what was going wrong. All of these things have improved significantly over the last few years, and it is a concerted effort by the head office in Hobart and, for instance, in certain areas such as child and adolescent services, better funding for more staff from the National Mental Health Strategy. They were very poorly staffed in the north-west. They only had about five staff and they are up to 11 now. So there have been very significant changes in the way it has been managed and run. We did not even have a medical establishment until nearly a year ago, we didn't know exactly how many consultants and medical officers we needed for our population. We have not had it worked out. So all of that has been resolved, and I am very impressed with how we are moving forward - in the north-west at least.

Mr DEAN - Having said that, is there good reason to look at bringing the two together, bringing Mental Health and the hospitals together, rather than having them separate as they currently are? It would seem to me that there is every reason for us to look that way. I have always failed to understand why we have had the Mental Health setting separately to the hospitals and simply only having a room in that -

Dr TUDEHOPE - Yes, it has just been the Cinderella.

Mr DEAN - Yes. Do you wish to comment on that, Doctor.

Dr TUDEHOPE - The inpatient areas operate with a memorandum of understanding with the regional hospital, and that in many ways equalises treatment and staff conditions. The patient is managed in a seamless way if they are moved from a psychiatric ward to a general ward or things like that. But we do have a lot of other specific services like older persons services, child and adolescent services, and community clinics.

Mr DEAN - That is why I made the statement.

CHAIR - But the alternate view would be that Mental Health Services really should be based in the community, because the majority of inpatients with Mental Health are best managed in the community. Only a small percentage are actually managed in a hospital setting.

Dr MUSKETT - When I managed DPM we were actually funded by Mental Health Services with a memorandum of understanding through the Royal. That changed in 2001 at the time I moved into the position that I am now in. If you become part of a global hospital budget then the hospital has opinions about priorities, and often funding will be taken from Mental Health areas to put into priority areas - things that are seen as desperate needs for the whole of hospital, so it is not quarantined. So from the time the budget transferred across in the Royal we have been pushing that multidisciplinary teams are critical to Mental Health Services and people with mental illnesses but, because of the difference in priorities, the psychology position, the dedicated occupational therapy position, no longer exist on DPM. Those are the sorts of risks that you run if you put a mental health budget into a hospital setting and don't quarantine it.

You are right - the majority of clients live the majority of their lives in the community. It has been part of the Burdekin Report recommendations that Mental Health Services stand alone, that they have a quarantined budget, and that they become community-focused. One of the big pushes has been to actually close hospital beds and open up many more community services and early intervention services based in the community to stop people ending up in inpatient services. So I think making Mental Health Services part of the hospital is probably the wrong focus and philosophy. Mental Health Services needs to be a community-based service, and that tertiary end of it is a very small end of that wedge.

CHAIR - I just want to ask Dr MacDonald to give a bit of a longer-term view.

Dr MacDONALD - I can only endorse the comments that have been made by others. We did have a system in years gone by which was very key-person dependent within the Department of Psychiatry and we lost some of those key people for various personal reasons as much as anything else. We had a system that had private sector dominance and the changing workplace and work force requirements has meant that we have moved much more towards a public-sector dominant-type service. With that we have now achieved critical mass with the number of psychiatrists in the north and that has allowed us to run a much more attractive service. Retention and recruitment in general is dependent on having a critical mass of staff that allows you to have established and sensible rosters for the changing medical work force. The 24/7 doctor is no longer part of the new medical work force. We were key-person dependent on those sorts of people and as they left replacing them with a single locum often was a recipe for further deterioration of the service. With more appropriate resourcing, recognition of that and at the same time the process of understanding that you needed to get a critical mass of individuals there before they would stay, we have been in a much stronger position.

I think we now have a work force, from a medical perspective particularly, in psychiatry in Launceston attached to the public sector that is sustainable and will grow. It will grow because we now have a good training product, opportunity to train and retain in the long run our own trainees. That is what has worked in all the other disciplines in so much as

once we are able to train cardiologists, nephrologists, psychiatrists et cetera there is much more likelihood they will form links with the community and, although they may not stay here for the entire training, some of them will return and that stands us in much better stead in the long run from a work force perspective. We need to learn to appreciate that there is a critical number required and if you drop below it then you find recruitment very difficult. For a number of years during the early part of the 2000s and in the late part of the 1990s we had dreadful difficulty because we had dropped below critical mass and it wasn't attractive to anybody to come.

While I am addressing some of those issues around work practice in the emergency department, we are looking at model change to allow us to do some of those things as well so that we do recognise that resources should be there 24 hours a day, seven days a week.

CHAIR - And mental health resources.

Dr MacDONALD - And mental health resources, but it is linked with all the other things. When you comment about waiting times at 2 o'clock in the morning it is not an emergency department entirely for mental health. Those times that you talk about and ask, 'Do they have to wait longer at 2 o'clock in the morning?', yes, they do have to wait longer at 2 o'clock in the morning because of the general demands. We are looking towards changing the model which sees us able to meet those demands more effectively. But, again, we have to have an attractive work environment with enough work force and enough opportunity to work hours that are acceptable to the current medical work force. That process takes some evolution but it is well down the track now.

CHAIR - Do you have a view about how the crisis intervention team should work, what hours they should work and the nurse practitioner project within mental health?

Dr MacDONALD - I think from our perspective the changes in the resourcing from a medical and nursing perspective in intervention has meant - this is my feedback from the emergency department, and Paul may correct me - that particularly in the last three months things have looked up quite significantly. From that perspective, we are not unhappy with the way the system is currently working. Paul, the nursing staff and the mental health staff meet on a weekly basis to look at issues. In fact, the tone of those meetings has moved to a point where most people are largely satisfied with the current interaction between the emergency department and Mental Health Services. Twelve months ago that was a very different picture. With adequate resourcing there has been a major improvement in the service.

CHAIR - What about with the police then? I think Dr Pielage was saying that police officers stay for many hours, particularly when you have an aggressive and disruptive patient. Obviously that's a big issue for police; it ties up their resources, particularly in the middle of the night and if they've had to come from, say, St Helens with a patient and then stay on to transport them back and they are the only police officer on duty in that town they have to backfill it somehow.

Dr MacDONALD - I'm not suggesting the situation's perfect and there is no doubt that we don't have the critical mass of security staff within the hospital - and they're not likely to

have in the foreseeable future - that can manage aggressive patients with the same deterrent value that the men or women in uniform can. It's not ideal, I agree, but those patients can only be assessed once they're ready to be assessed and they're not always ready to be assessed immediately, for a variety of reasons that have already been alluded to. In that context the system isn't perfect.

CHAIR - Is it the role of police to stay with them in that case or is there a place here perhaps for some of the attendant staff, usually men, for the orderly roles to be trained up?

Dr MacDONALD - We're certainly not resourced to have that sort of attendant staff available to do that role, nor are they trained for that role.

CHAIR - Would that be an appropriate way to move forward, do you think, to actually train some of the staff who could help. Obviously when no patients requiring that sort of attention are in the DEM they could be doing other things such as turning patients in the night and a whole other range of duties that attendant staff have. Could they be multiskilling and providing that extra level of service?

Dr MacDONALD - There's no doubt that having large male attendants or otherwise in the emergency department has some deterrent effect but, as I say, there's always going to be a boundary beyond which police officers are much better equipped to handle those situations and have deterrent value than somebody who is actually trained as a hospital orderly.

Mr WILKINSON - There's nothing new there.

Dr MacDONALD - No.

Mr WILKINSON - This was the case 20 or 30 years ago.

Dr MacDONALD - Exactly.

Mr WILKINSON - So, what's the difference now?

Dr MacDONALD - Sorry, I'm not quite sure what you mean.

Mr WILKINSON - What I am saying is, there seems to be a problem now, from the evidence that we have received in relation to restraining these people that can be aggressive and can be obviously quite dangerous; I can't see the difference between the dangers now as opposed to in 1950, 1960 or 1970.

Dr MacDONALD - I see what you mean. What we're finding is that each of the work forces are much more constrained than they were in the past. Other people are probably much better able to comment, but the resources available, the number of police on a shift; everybody's working closer to the margins and in that context once there might have been somebody they could have sent up to spend much of the evening in the emergency department. When I worked in the emergency department in the 1980s it wasn't unusual to have the police around the emergency department but I don't think they had the same demands on their time as they do now. The whole system has changed.

Mr WILKINSON - So, that's the big difference that you can see?

Dr MacDONALD - Yes, that's my perception.

Mr DEAN - Deinstitutionalisation, I think, has created those further problems hasn't it -

Mr WILKINSON - I was going to mention that.

Dr PIELAGE - Yes, the deinstitutionalisation and reinstitutionalisation of the mentally ill into the forensic facilities and prisons; we certainly get that and we've had patients who've deliberately done things and damaged things so they could go to prison because they prefer prison to the real world. If you go back far enough in time before the inquiries into deaths in custody, a lot of the aggressive drunks would have been in the cooler.

Mr DEAN - Handled by police; the police handled them all.

Dr PIELAGE - They would have been handled by the police. In the morning they would hopefully have been semi-sober, they would have been charged and sent home. But after those inquiries the whole focus changed and hospital became the first port of call. Also, I think it's been quite clear that the number of people coming in late at night and in the early hours of the morning has increased disproportionately. I think our whole community lifestyle has changed; we now have all-night television, people are up all hours of the night and the increase in patient numbers after midnight over the last decade has increased much faster than the increase at other times of the day. I think there has been a shift in when people turn up. Obviously shifts in drinking hours and all these things tend to push these events later and later into the night.

Mr WILKINSON - And the resourcing decreases.

Dr PIELAGE - Yes.

Mr WILKINSON - You have a resource decrease and a consumer increase. Is that right?

Dr PIELAGE - That's one way of putting it, yes.

CHAIR - They also don't go out until later in the night.

Dr MAHARAJH - I think we also need to be cognisant of the fact that in relation to the orderlies you talked about, we legally can't detain someone; the police have that power and we don't.

CHAIR - Without an initial order.

Dr MAHARAJH - Without an initial order, but we can't be putting everyone on an initial order, so that is a huge restraint and it is certainly an infringement of the person's rights if we were to detain them without any legal basis, as the police can.

Mr WILKINSON - Can I ask another question in relation to that increase? Have you noticed a marked increase because of consumption of drugs now? Years ago, as far as criminal work was concerned, it was more because of alcohol. Now there seem to be more drugs out in the community and the drugs are more powerful than they were. Has that meant that there are now more people in trouble from time to time psychiatrically as a result of the ingestion of drugs?

Dr PIELAGE - The very big increase in the early part of this decade has plateaued off. It has really plateaued off pretty much across drug and alcohol psychiatry - there hasn't been a huge increase in the past few years. So far we have been spared the potent amphetamines, such as ice, that have been seen into some of the mainland hospitals, where in places such as Royal Perth Hospital they are actually an appreciative percentage of all patients coming in. It causes them immense grief. We just haven't had that yet and I hope it goes out of fashion before we get it because we are singularly ill-equipped to deal with that. That requires huge resources. I know people at the Royal Perth, I have seen video from security cameras of these sorts of patients. The number of people you need to control and restrain them we just don't have. It would be a huge problem for us.

Mr WILKINSON - With the drugs as well, that causes an increase in adrenalin, and as I understand it, an increase in strength and therefore there are these problems with people who are able to properly quieten them down if they start to play up. Is that correct?

Dr MacDONALD - Very much so. There are still isolated cases from our perspective. The change in the culture of drinking later has been a much bigger impact on us than any form of illicit drug use. They are isolated cases worthy of comment when they come in and they are something that gets discussed the next morning because they occur so rarely.

Ms MUSKETT - The affluence of youth, I believe, has probably contributed to that change in drinking patterns, the fact that most of our young people are clearly more cashed up these days compared to 30 years ago.

Mr WILKINSON - If you were given the opportunity to fix a problem, what would you do? If you believe there is a problem, and resources are a bit better now so far as medical staff is concerned, it would seem, what else would you do to make it a system that you would be extremely proud of?

Dr TUDEHOPE - One comment at a practical level - and in speaking with the DEM staff in the north-west - is that there is not a secure room in which to put these extremely agitated, disturbed or aggressive patients. An actual secure room would be very helpful. Getting a highly-resourced CAT crisis assessment team operating, which we are in the pathway of introducing, is important.

CHAIR - Isn't it important to have that after-hours as well, though?

Dr TUDEHOPE - Yes.

Ms MUSKETT - With respect to the crisis team, we are going to buck up against the fact that, for eight hours out of 24, people may be twiddling their thumbs. There may be

better resource-utilisation patterns such as the capacity to have a call-out roster for those non peak periods because we know it is really difficult to get people to work consistently in some of those shifts. It is not just those with young families. The majority of people my age have parents they cannot leave with a carer.

CHAIR - Do we have any idea of the level of demand? There comes a point where you are paying on-call staff. You pay double time when they come in for at least four hours - I think that is probably still the case. There must be a point where that is not economical and to have someone working and potentially assisting in other areas of the hospital in other services would be more economical. Do we know what the demand is after hours?

Ms MUSKETT - Only because it was given to me today before I came up. I know that of the number of category 2 referrals through the help line in the south for the previous three-month period, there were only eight calls after 7 p.m.

CHAIR - It is not huge, then?

Ms MUSKETT - No, it is not huge. The south's population is probably half the population of the State.

Mr DEAN - It would be interesting to see if those figures are similar in Launceston.

Ms MUSKETT - I know that you are getting the statistics for the help line. While they do not capture all of the referrals at the moment from the north and the north-west, certainly the number that they are capturing is much higher than that. It would be those category 2 referrals for which you would expect some assistance in dealing. The 'respond-within-two-hours' category 1 cases are usually taken to an emergency department by an emergency service because they have been that florid and problematic in a community setting.

Dr PIELAGE - The problem with that is whether the Royal Hobart Hospital's emergency department uses the help line or, when it gets the patients, does it just go directly inhouse for assistance? That is my understanding. We still do not use the help line a great deal for psychiatry. We do for child and adolescent problems but not for adult psychiatry. It just interleaves another layer in the process which is time-consuming and sometimes difficult. I really do not think that some of these patients need to be in emergency departments, certainly the ones who are just fuelled up on alcohol and are aggressive and stroppy. It would be very nice if there were somewhere else they could go because they are really not a medical problem.

CHAIR - Like a drying-out centre of some sort?

Dr PIELAGE - Yes, but where they can be observed - that is the key. They are not really an emergency department problem. We have women, children, old people- all sorts of people - in the emergency department and if someone is ranting and raving, stomping around, hitting things and yelling obscenities at the top of their voice, it is really not an appropriate environment in which to have sick people reasonably close by. We cannot put them far away in the emergency department because we have to observe them. We cannot put them in some dark, back corridor away from everything because we have to

look after them and observe them. Some of these patients are not really compatible. They are not ill, they are not mentally ill, they are drunk.

Mr MARTIN - Would police be able to make that judgment call? Whether someone was -

Dr PIELAGE - I think for a lot of them, they probably can. Some of them we might have to make the call and then they are taken away. The point is they do not want them in the lock-up because they cannot observe them even though that is probably the best place. Sometimes they are very nice to us and take them away and we are extremely grateful for that.

Dr MAHARAJH - If I can make a comment, from my own New Zealand experience. New Zealand police have a safe room on the monitors that is observable from the front desk so that if somebody who is really drunk cannot be assessed they are put in the room and observed. The room is specially built for that purpose. It works extremely well. At any point when they do sober up, no matter what time it is, the call is made for an assessment. I think it really works well.

CHAIR - Are they brought back to the hospital for the assessment at that point or does the team go out to them?

Dr MAHARAJH - If it is within the hours of the crisis team, which is before 11 o'clock, the crisis team goes out to them. If it is after then the police bring them in.

CHAIR - Do you think there might be a better way of resourcing it to improve the police budget to enable that sort of facility in our major centres, whether it is attached to hospitals like at Burnie Police Station, Launceston and Hobart?

Dr MAHARAJH - I have seen it work, and work very effectively.

CHAIR - I say those three areas because those stations have more than one police officer at night as opposed to little country ones. Effectively if the police officer brought a patient from St Helens to the LGH and was told by the medical staff that they were just drunk, they could sleep it off, they could take them to their room at the Launceston Police Station , and then the St Helens police officer could go back to St Helens and leave them there?

Dr MAHARAJH - May I qualify that? Because of the unpredictability of the intoxicated patient, they may have hit their head and be suffering from a neurological injury. A general practitioner is always called in to do a physical.

CHAIR - Yes, in hospital?

Dr MAHARAJH - No.

CHAIR - In the police station?

Dr MAHARAJH - Yes.

CHAIR - That would only be in the absence of having an assessment in the hospital, wouldn't it?

Dr MAHARAJH - Yes, that is right.

CHAIR - If the police took them straight to their police station then the GP would be called.

Dr MAHARAJH - There is a GP affiliated to that police station would be on call. He or she would authorise arrangements, come in and do a physical and make sure that we are not seeing pre-coma instead of drunkenness, which brings in the safety factor.

CHAIR - The GP would have a fairly good knowledge of mental health disorders as well?

Dr MAHARAJH - Generally, yes.

CHAIR - On the issue of the increasing demand - and I think, Jenny, you might have mentioned it - do you think that some years ago when people were considered drunk and were put in the lock-up for the night, there was an under-recognition of mental illness at that time as well? Could it be that more people who were locked up when they were drunk possibly had a mental illness but that was not recognised?

Dr TUDEHOPE - I think that could be the case. Ivan Dean might be able to answer this better. There seem to be more reports of disasters happening in those situations where police had to take it on their own shoulders and then the fellow died in the night from whatever.

Mr DEAN - The police do the assessment charge and they go through a list of questions that they answer. At the end of that there is a waiting system placed on it, and if it is believed during that waiting system that they could be suicidal or there could be something else the matter, that is when they take them to the hospital. They are required to do so, they have no option but to take them to the hospital system. If they are not thought to be suicidal then they can either take them to one of the sobering-up homes or place them in a cell and keep them under very close observation. But the police handle only a very small number of the ones you get..

CHAIR - But having the situation where the GP comes into the police station and assesses a patient would remove that onus from the police officers, wouldn't it?

Dr MAHARAJH - Yes. It would not be fair to put that on them, but I must also add that police officers get mental health training too. They have quarterly training in general mental health conditions.

Mr MARTIN - We have had evidence that there is a category of people with, say, a personality disorder who are turned away and not admitted - certainly in Hobart anyway. It may begin with an event in their lives and police have to be called to take them to the hospital but they are not admitted because they do not fit into the top five categories of mental illness. The interpretation of the definition under the act does not allow them to be admitted, and they are discharged because they do not voluntarily stay. We have heard evidence from a family member that with one patient police were called five times

in two weeks, and then we heard from police that sometimes they were called as often as five times in a day. Has that group of people fallen through the net? Is this a problem in Launceston?

Dr MAHARAJH - I think that those with personality disorders are a very difficult group of people with very difficult problems, and what has been traditionally the case is that they present multiple times, with multiple self-harm attempts, which places a lot of stress on the staff, who can become complacent at times and herein lies the risk. What we have tended to do is to work closely with DEM and the hospital, and for those that present multiple times we are attempting to have management plans for them which are placed in DEM, so that if they were to appear there is a coherent plan of action that staff can utilise instead of just turning them away. It is a difficult process, and we are only at the beginning of doing that, so the more chronic ones have those plans. We are in the process of looking at all the plans that are present to make sure they are updated. These are initiatives that are happening at the moment, but clearly historically they are a very difficult group of clients and one that we will not pretend does not pose a huge challenge to most mental health services. Having said that, I point out that they are a needy group, they have very difficult lives, they have issues that most of us would probably never dream of. We simply don't have the services to cater for them. In an ideal world most of these clients would be sent to an outpatient department, dialectical behaviour therapy would be given, they would have multiple support which all amounts to resources and availability of trained staff, both of which certainly we can't loudly say that we have, but they are our priority and I think Paul would agree that together we are working very hard to help these individuals.

Mr MARTIN - At the moment, for the reasons you have said, they really are falling through the gap. They are a problem to themselves, their family members and the wider community, the police, yourself and your staff. It just seems an urgent priority to me.

Dr TUDEHOPE - As Dr Maharajh says, we know the appropriate and best treatment for people with borderline personality disorders. One particular type is a combination of what we call dialectical behaviour therapy and individual therapy. Ideally it occurs often several hours a day, every day of the week and -

Mr MARTIN - All hours of the day.

Dr TUDEHOPE - It's a day program and it's very intensive; it requires two or three therapists and a group of maybe eight patients. It may go on for eighteen months or two years sometimes and to date we haven't had the resources to do that. It would be wonderful to be able to do so as various staff are trained in it.

Dr MAHARAJH - Research has shown that dialectical behaviour therapy does work and it does work effectively but it is, as I said, costly to train people, costly to run and very resource intensive.

CHAIR - For these people, do you think having adequate resourcing in this area is the answer, or do we need legislative change as well that can provide an avenue to treat these people involuntarily where necessary?

Dr MAHARAJH - Research has shown that coercive treatment does not work and that using the Mental Health Act is usually in the longer term not productive. Short-term use to contain risks is useful but in the longer term it does not allow the person to take responsibility for themselves. That's what dialectical behaviour therapy does; it allows them to examine their thinking; it allows them to change their thinking, get into new patterns of thinking and develop new skills to deal with dialectical ways of coping with life because of the lack of skills and the problems they have had.

Ms MUSKETT - In an ideal world you would try to eliminate some of the causes that result in those sorts of personalities that fracture people so badly that they act out in those ways. We would be supporting families so there weren't marriage break-ups, so that they weren't sexually and physically assaulted at young ages and the sorts of things that really create long-term scars on people's psyche. They are the sorts of things that potentially would be just as good an investment - teaching people those parenting skills, improving assessments and that recognition of when things are going wrong for very young children.

Dr MAHARAJH - My wish list would contain a dialectical behaviour therapy.

CHAIR - What sort of money are you talking about? Any idea?

Dr MAHARAJH - It is expensive to train the individuals who would practise it.

CHAIR - Can nurse practitioners be trained up in this area, for example?

Dr MAHARAJH - They are mostly nurses and psychologists. Virtually anybody can be trained in it, with some degree of medical training but it is a skill-based training. It is well described by Marsha Linehan, who started the process, and there are workbooks and once the people have gone through the training they can effectively deliver the service.

CHAIR - Do they use it in New Zealand?

Dr MAHARAJH - They use it in New Zealand. There are studies that have come up in New Zealand where it has worked. I know that it has worked in Waikato and in Hamilton where they have a service running and the results have been quite promising.

Mr MARTIN - Is there any data within Tasmania or northern Tasmania in particular with the numbers of people we are talking about?

Dr MAHARAJH - I could not give you that. I am not sure whether Coral could give it to you.

Ms MUSKETT - No, but I suspect you could probably get some sort of indicative idea from the last of the National Mental Health and Wellbeing surveys. That data is three years old, but it has only just been released. The problem is personality disorder is such a catch-cry. We see people with borderline personality disorders and they are probably the most distressing for staff, because with them comes the most risk to themselves so they are the group that are likely to suicide. But the other spectrum of that is people who act in such abusive ways now that they are a risk for everybody else too, and some of the

dialectical behaviour therapy and things with that group have not been as effective as with borderline personality disorder. The genesis of 95 per cent of people with borderline personality disorders is sexual abuse, so again if you can get to the cause and to the preventative stuff early -

CHAIR - If we could prevent all these things, it wouldn't matter whether it was mental health or anything, we would be right. We would not have half the people presenting at DEM, would we?

Ms MUSKETT - The problem with mental illness is that there is probably a genetic and organic cause, and for some reason people's brain chemistry starts working in ways that are very different. Getting that back to working normally will fix it for people. But for people with personality disorders it is the exposure to those traumas that really does damage to the way that they see and interact with the world. So there are two different ways of management, really.

Dr PIELAGE - I don't think we have a huge number of patients that turn up at the ED with personality disorders, but the ones we do have are frequent attendees. Dr Maharajh has indicated sort of obliquely that admission is not necessarily a good thing for these people and does not actually help the process, so that the reflex of turning them into inpatients does not actually help and can reinforce the bad behaviour.

Mr MARTIN - But at the moment they are at least taken back home to repeat the cycle.

Dr PIELAGE - That is what happens, and the way is to try to use forms of psychotherapy to break that repetitive cycle, but being an inpatient very often actually reinforces the bad behaviour. You don't get a positive benefit out of it. It is very hard, because often staff in the ED think 'if only they would admit them we wouldn't have to keep on seeing them every second day', but in actual fact approaching it a different way will work better. We have already seen evidence of this over the last few months, and we have been working quite well with the Department of Psychiatry on this issue with various patients, and we are seeing positive results. That does not mean they are cured, but we have seen significant positive results, reduced attendances etc., and much less stress on the staff. We have management plans for various people, and they work. It does not mean we have 100 per cent success, but -

CHAIR - We should not be designing out Mental Health Services around the convenience of a facility, should we, or an organisation? For the convenience of the police we should not admit patients if that is not in their best interest.

Dr MAHARAJH - It is a clinical call.

Dr PIELAGE - Sometimes we do things because we do not have other resources available. For example, the police bring patients to us because they do not have resources available. We keep them in the ED or they get admitted because there are not other resources available. That happens all the time. We have to deal with problems with the resources that we have.

CHAIR - If you can point us in the direction to avoid that need to act from a lack of resourcing approach, then surely the outcomes will be better.

Mr MARTIN - Changing the subject again slightly, I suppose the issue I am struggling with most as a layperson is in the wording and the thrust of the act. We have heard evidence provided by family members that they are locked out of the care programs for their loved ones, and the issue seems to be the rights of family members versus the privacy rights of the individual, the client. I really am struggling myself with that issue. Do any of you have any comments on that?

Dr MAHARAJH - I would like to comment on that. The first is the act itself. The act does not make a provision for inclusion of family members whereas in other countries, particularly where I come from, it is mandatory to have family informed the moment someone is put under the act.

Mr MARTIN - In your view?

Dr MAHARAJH - I think that is very useful. I think it is not always possible but there is room at least within 12-24 hours to include family. That is the first point. The second point is that we have been lacking in the degree to which families and consumers - I will call them consumers - or clients have been involved in the process of their assessment and treatment. I think that moves are underfoot for that. I know that there is a draft carer and family participation policy coming up. So I think that is an area that we are lacking and we have to face that. We are now making moves to see family as extremely valuable because we only see these individuals for a short time. Families live with them. So they are really the experts on what is happening and they shoulder the burden. That is worldwide. All literature on family input shows that they carry the burden of illness. We send clients home to their families. We only make provision for a small number of people. So that is an area that we need to be looking at and working on. I think, as I said, we are making progress towards that. With the drive coming from John Crawshaw and all the governance structures that we have replaced, I am hopeful that we are moving in the direction. Coral, would you like to comment

on that?

Ms MUSKETT - Mani is exactly right. We have a signed-off consumer carer participation framework which we can give you a copy of. We are embedding things like knowledge of the management plan and discussion with the family as part of a routine process and policy for inclusion. The difficulty is that under the current act family only legislatively can be involved to give substitute consent when the person is not able to give consent and people can be very, very ill and still able to give informed consent about their treatment. So it is a fairly narrow legislative framework that actually approves and condones the involvement of family in treatment decisions around a client. Whereas some clients are so ill and, while they can still make decisions about themselves, they would benefit very much from family inclusion. The PIP act has always been a difficult act to interpret.

CHAIR - Have you found that to be a barrier?

Ms MUSKETT - The PIP act has been a definite barrier for people that still retain the capacity to make informed decisions about their own care and who they want involved in that care and if they do not want families then you haven't got a legislative framework to go outside of that. The only time you can go outside of that is if someone can no longer give informed consent and then you can involve family -

CHAIR - So it is only when they lack capacity then that you can use that?

Ms MUSKETT - At this point in time.

CHAIR - So do you think that needs to change - that even for people who are quite ill but still have capacity, the family can still be involved in that decision-making process? That seems to be a big issue at the moment.

Ms MUSKETT - I do not know that involvement in the decision-making process is even a primary reason that we would do it because a lot of families are not given any strategies to know how to manage people. Anybody these days that has any reasonable level of Internet access can find a lot of their strategies on-line. Why we cannot sit down and discuss with families, 'these are the common problems associated with somebody who may have this and these are the ways that you might manage their condition.'-'

CHAIR - So this is the privacy act that is stopping you doing that?

Ms MUSKETT - It is the way that it has been interpreted.

Mr DEAN - Every piece of legislation should have a commonsense section in it.

Ms MUSKETT - Yes. We know that some of the -

Mr MARTIN - That is a really important point. So you are saying that it is not a problem with the act but the way it has been interpreted? Can you amplify on that?

Ms MUSKETT - Potentially the privacy act does say that a person has the ultimate right to decide what happens with their information. A lot of staff will say that is the letter of the law, and it is. A lot of staff. I mean, there are lateral and fairly innovative ways that you can move around that. Most people know that their family member has a mental illness so they themselves could provide a lot of their strategies and you can talk to people in general terms about how you might manage things.

CHAIR - It that just what side-effects to look out for with the drugs they are on? Things like that?

Ms MUSKETT - Yes. The privacy legislation has made it difficult for a lot of people to know exactly where they stand and what they can do. The consumer-carer and family participation framework is clarifying some of that. Some of the policies that are coming out of that will tell staff what they can do without breaching privacy and mental health legislation at this point in time.

CHAIR - Just to wrap up; we are slightly over time but does anyone want to make any closing comments in relation to the information or the topics we've covered, particularly with regard to legislative change you think is necessary or any improvements that could be into the future.

Ms MUSKETT - I would like to make two. One of the big downfalls, and I saw it time and time again when I was doing clinical practice and managing the acute unit at the Royal, was the lack of capacity to treat. I think it is very difficult for clinicians to detain people and not be able to treat them fairly early, especially when we know that all the evidence these days shows that the earlier you get in and intervene, especially when people have a major mental illness, the better their outcomes are. It is much easier to reverse some of that brain chemistry the quicker you get in and the less length of time that that actually exists. That's my first point.

My second point is that there is quite a lot of talk about combining the guardianship legislation and the provisions of that act and the Mental Health Act. I think that there may be some fundamental problems with doing that if we are just looking at the generalised capacity to consent. It's been probably eight or nine years but I don't think it's changed a lot - some of the sickest people that were coming in were very depressed; they had made decisions about taking their own lives against the background of the death of a spouse or something else; they still retained their capacity to make an informed consent about those decisions but we didn't want to treat them because you would know full well that that was probably the outcome if you didn't actually treat the underlying depression.

So if you just have a generalised order that specifically looks at capacity then we are going to miss giving treatment to some of those clients that would probably benefit from it and desperately need it because it's not about capacity.

CHAIR - I guess one other side of that is that one of the roles of this guardianship board is looking at the accommodation and financial management for the person and those other areas that often form a very important part of their overall health and wellbeing. One view has been put that if those matters are considered under one legislative framework then it makes it easier to have a holistic approach of care for someone with a mental health disorder, or another disability for that matter. Do you not see there are benefits in that?

Ms MUSKETT - Personally, I don't. Some people with and during mental illness do have a significant amount of psycho-social disability that does make it difficult for them to make decisions about their finances, about living and what they prioritise. I think that is a separate issue and should be separate from mental illness and its treatment. You are looking at a very specialist skillset, it takes very specialist knowledge to know whether in fact somebody should be treated or not treated. Whereas some of the living arrangements and such things are more peripheral and more an issue of a whole population rather than just people with mental illness.

Dr MAHARAJH - I would just like to add, as a psychiatrist, the manner in which the act is currently formulated where a person can be incarcerated but not given duty of care, our first principle is to do no harm but to incarcerate someone and not treat them and see

them go through the stress, I think is a huge harm. Therefore, it is that area of the act, particularly, that causes problems for me as a clinician in carrying out my duties as a doctor.

CHAIR - I think we can feel fairly confident that the review is addressing that but we will have to wait and see when we get a draft bill. It certainly has been noted and looking at the discussion papers and things like that, I see that it has been identified so hopefully we will see that, at least, as one of the changes resulting from the review of the act. I certainly accept that point.

Dr TUDEHOPE - I would like to make one further comment from a Child and Adolescent Mental Health Services point of view, which treats children up to the age of 18 and adolescents, teenagers. On hospitalisation - there is no child and adolescent inpatient psychiatric bed in Tasmania and in the south they've just managed to get a small service going but no dedicated beds but at least it's better than it was. So if we have to admit an under 18-year-old we'd have them specialled at vast cost and kept separately from the often very disturbed adults there. It still can be a trauma to them actually being hospitalised. Even if they are very ill themselves with acute schizophrenia or whatever it is, the experience of hospitalisation can still be traumatic to them. There is a proposed eight-bed adolescent unit in Hobart, and I strongly endorse that.

CHAIR - That is on your wish list near the top?

Dr TUDEHOPE - Yes. They do need specific facilities for themselves.

CHAIR - Thank you very much for your time. We appreciate your input and your expertise in the area.

THE WITNESSES WITHDREW.

Dr ERIC THORNE RALPH RATCLIFF WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks Dr Ratcliff.

Could you give us an overview of your background, experience and what your role is within the college at the moment and how you see the protective legislative framework?

Dr RATCLIFF - I've been engaged in the practice of psychiatry, at least some of the time, since 1965 and have been a consultant since 1974. I was in charge of the regional service here in Launceston for a number of years until 1985 and I've been in private practice since. I am here representing the Tasmanian branch of the Royal Australian and New Zealand College of Psychiatrists. I have been a member of the committee of that branch for about 30 years and chair on a number of occasions. I've been a member of the council of the bi-national college for 14 years and chaired a number of communities of the college over the years. So I have had a great deal of national, bi-national and State involvement in -

CHAIR - You've seen some legislative change in that time.

Dr RATCLIFF - Yes, a great deal.

CHAIR - It would be good to have your perspective on that.

Dr RATCLIFF - I've had a lot of experience of the old act, a lot of experience with the new act and I've developed some very definite ideas about how I reckon it should go.

CHAIR - We'd like to hear those.

Dr RATCLIFF - Well, I think you've probably seen a copy of the college's submission to the drafting committee.

CHAIR - Yes.

Dr RATCLIFF - I was the editor and principal author of that so that would include a lot of views but the first on the wish list is including the provision for involuntary treatment under the Mental Health Act. I know you've discussed this already and it has been brought up before. Anything to do with non-consensual treatment should be included in the act; I think that's essential.

CHAIR - In the Mental Health Act?

Dr RATCLIFF - For the reason that's already been stated by others - if a person is involuntarily detained in a hospital, and the hospital is for no other purpose but treatment, it's very wrong that there should be any impediment to the appropriate treatment at that point. I think it's essential that that be removed from the guardianship act and included in the Mental Health Act.

Mr MARTIN - We have had some other evidence provided by advocate groups, for example, that argue against that and the rights of the individual to decide what happens to his own body should be paramount. That's what I'm struggling with.

Dr RATCLIFF - When people are admitted involuntarily they're often not in a condition where they can make a reasonable judgment about what's best for their own body. One of the problems is that when somebody is acutely ill they're certainly not thinking of what the detriment to them will be over the next 20 or 30 years. In the case of an illness like schizophrenia and to a lesser degree bipolar disorder a person may come to very serious harm down the track as a result of a misjudgment made at the outset.

There is now very good evidence about the importance of early treatment, particularly in schizophrenia, for the ultimate outcome. So a short-term enunciation or an absolute principle that people have that absolute right is very much against their interests.

Mr MARTIN - There must be a balance somewhere between those two opinions.

Dr RATCLIFF - I think the balance has always got to rest on the reasonable judgment by those acting in good faith. Advocacy groups are very prone to the idea that somehow there's an evil conspiracy on the part of the professionals, the multinational drug companies, the Government and various others to somehow do harm. There is no evidence for this at all. A lot of the fashion in mental health legislation, which has influenced even our Tasmanian legislation, has arisen from concerns about, for example, what was happening in the Soviet Union about 20 years ago.

CHAIR - Isn't that a realistic fear, though? I know it is going back some time but if the pendulum\ has swung too far the other way where you detain and treat, even when a person has capacity, but does not fully comprehend what is in their best interests, as you suggest. Are we on a fine line there?

Dr RATCLIFF - We are always on a fine line there, but so much of the existing act is predicated on the idea that something has got to be done acutely and over a short period of time, whereas we are generally dealing with conditions which will influence a person's life for the rest of their days and place a very great burden on their carers as well. So I think it must be a mitigated judgment. I know that there are these concerns, but they are theoretical concerns. I am talking about the practicalities of dealing with real people in real situations. I have had the opportunity to follow some of them for more than 30 years and can see just what does happen.

Mr WILKINSON - If that is the case then should there be a second opinion provided as well? In other words, your opinion is this should be done, and there be another opinion to say 'yes, I fully agree with the sentiments of Dr Ratcliff'.

Dr RATCLIFF - Yes, that is almost provided in the act, isn't it, apart from the first few days. Certainly in the middle of a long weekend in high summer you might have trouble getting an authoritative second opinion within 72 hours, so there should be a reasonable judgment in good faith that can be made within that short time but, yes, a second opinion is appropriate. The question, though, about second opinions is to what extent they are independent. The old act used to require that one of the certifying doctors not be on the staff of the hospital that was receiving the patient, and they were not permitted to be a

partner of the other certifying doctor. So there were provisions against collusion, which came from the old British act. Now, strangely, there seems to be no concern about collusion, and if the second opinion comes from a bright young registrar with a fairly heavy consultant on top of them, how independent is that opinion?

CHAIR - So what safeguards do we need then to avoid people being inappropriately treated?

Dr RATCLIFF - I think the risk of being inappropriately treated is very, very low. It is very high in the agenda of advocacy groups, but I think it is an extreme rarity. But to do something about it I think is very difficult with a small pool of people. Here in Launceston, for example, if a second opinion outside the hospital was required, there would only be me to do it, because all the other consultants in private practice in the town are working within the hospital for part of their time.

CHAIR - It would be a problem on the north-west coast too, wouldn't it?

Dr RATCLIFF - It would be an extreme problem there, getting an independent opinion. So I think we have to trust that although technically it may not be an independent opinion, we have to say two good opinions in good faith are about as good as we can do.

The second was in the definition in the act of mental disorders which in the current act excludes alcohol and drug-related mental disorders. The problem about that is that comorbidity is the order of the day now, and often in an acute psychiatric situation it is difficult to know whether this is a drug-related one or a mental illness in its own right, or some mixture of the two. Therefore the definition of mental illness for the purposes of the act should include mental disturbance which may be due to alcohol and drug use. If that can be excluded by reasonable assessment within a reasonable time, perhaps it might only relate to the initial order, not necessarily to a continuing order.

CHAIR - So you can tell whether they are still drunk or not, is that what you are talking about?

Dr RATCLIFF - It is not merely drunk, but -

CHAIR - Or be under the influence of a drug or other substance.

Dr RATCLIFF - Or under the influence of a drug, yes, because those effects can be fairly lasting. I think it is wrong to include in the definition what you think might be wrong when you may be wrong about that.

Mr WILKINSON - I have read some studies on people who abuse marijuana, especially now with marijuana being grown in the way that it is grown - it is much more potent than it was. That can spark off a reaction within the brain which causes a psychiatric episode. Would that not be under the present act classed as an alcohol and drug disorder?

Dr RATCLIFF - Yes.

Mr WILKINSON - Therefore you are unable to treat that person even though that person is suffering from a mental disorder as a result of the ingestion of drugs or alcohol.

Dr RATCLIFF - Yes, if there is reasonable certainty that this was the case then it would be excluded under the present act.

Mr WILKINSON - Which is ridiculous.

Dr RATCLIFF - Which is ridiculous because with marijuana, for example, you may have an ongoing episode of psychosis that may last for some days or longer. You may have a person in whom it triggers a major disorder which goes on for months or even for the rest of their life. You do not know what that will be on day two.

Mr MARTIN - Doctor, I am not sure whether you were present when I asked the previous witnesses about the category of people who have a personality disorder not caused by drugs or alcohol who fall outside the five main groups of psychological disorders. At the moment, the interpretation of the act is such that they are being excluded from treatment.

Dr RATCLIFF - Yes, that is right.

Mr MARTIN - What is your opinion on that?

Dr RATCLIFF - If they have a personality disorder which from time to time produces manifestations more like a mental illness, I think they should come under the provisions of the act. But I think it would be inappropriate for them to come under, say, community treatment divisions and be placed under the act long term. Certainly it is appropriate for them to perhaps be involuntarily admitted in certain circumstances until we are sure what is going on. In other words, a diagnostic assessment period would be appropriate. Then, when we have a fair idea that it is an ongoing personality disorder, other provisions need to be made.

Mr WILKINSON - That is number two, the definition.

Dr RATCLIFF - Yes.

The third is that the act, as I have said already, encourages a cross-sectional view of patients. It is very much concerned with how they are now and for optimum treatment for these people it is important to encourage a longitudinal view of the patients and recognise that these episodes are sometimes life-long or intermittent and occupying very large amounts of the person's time, disrupting their lives at fairly regular intervals. The act is very much concentrated on the situation at the time of admission and then only secondarily after that. Part of that is that dangerousness to themselves or others has been the major criterion for admission involuntarily. In my view, need for treatment in the absence of insight is very much more important in terms of the long-term wellbeing of the person. The act needs to embrace philosophically the recognition that the sort of conditions it is dealing with most of the time are ones which will be long-term issues.

CHAIR - I will go back to the other point to clarify where you spoke about the relation to the patient's with personality disorders. We heard evidence from the previous witnesses and also in Hobart that often admission to a psychiatric unit is not the best option for those people. You said you did not believe they should be on the longer-term community treatment either.

Dr RATCLIFF - No.

CHAIR - What do you see is the way to deal with these people who seem to be a group that falls into a gap, who do not really fit anywhere?

Dr RATCLIFF - I would say that when we are seeing such a person for the first time, when we get very grossly disturbed behaviour that you can get in some of them, usually in adolescents or round about then, there needs to be the opportunity to make a reasonable assessment. But I think the pressure on hospital services means we tend to troubleshoot in every crisis that these people have. They are very frequent and the crises are grossly disturbing to others because they often involve self-harming behaviour. There is a suicide risk but they are not suicidal in the technical sense, so that is not their main aim. What they do to themselves is to relieve tension, to manipulate others to seek help. They display a range of behaviours like that which lead them to do dreadful things to themselves which are horrifying to other people and they say, 'That person must be really crazy and they should be put away.' But the crisis abates within a certain length of time. When people like that present every week or so, admission is not appropriate if a good assessment has been made. Converse to that, it is a serious problem if somebody says of somebody who is behaving like that, 'They are just one of those' and they have not been assessed in the past. There needs to be the opportunity for a good initial assessment and thereafter the treatment plan. It is not appropriate to involve coercion.

CHAIR - Do you think that is happening and has it in the past? You have had long experience. Do you think that now we are doing that better or are we doing it not as well as we did years ago?

Dr RATCLIFF - I think it varies. It depends very much on how robust the admitting officers are, generally.

CHAIR - Are you talking about the admitting officers in the DEM or the admitting officers in the -

Dr RATCLIFF - Whoever governs the decision as to whether they are admitted or not. Some people are so concerned about the potential suicide risk, that they will admit them every time, in crisis. But that works very much against their long-term management.

The difficulty is that public mental health services have not generally been able to provide the degree of continuity in treatment that these people need. The problem is that they will get a new locum every six months in Launceston, a new registrar every three months and the management of these people involves very long-term involvement with one therapist. We need some means of getting appropriate therapists who are prepared to hang in there for a long time.

CHAIR - The continuity of care is a really important part of management for these people.

Dr RATCLIFF - It is a really important part. That is right.

Mr WILKINSON - When you talk about therapists, are you talking about psychiatrists or others?

Dr RATCLIFF - In this case, the number of them required in the community means they could not be psychiatrists. I carry a fair load of such people and so do all my colleagues. I think psychiatrists are needed as backup and supervision of other people and they need to deal with the too-hard basket of these people.

Mr WILKINSON - Who are these other people, are they psychologists?

Dr RATCLIFF - They could be psychologists. They could be psychiatric nurses. They need to be very well trained and very well supervised because these people are a heavy load.

Mr WILKINSON - Do we have such people within Tasmania?

Dr RATCLIFF - We have people who are capable of being trained in this but there are very few who are capable of taking it on. It is an area where the stress is very great and the caseload has to be reasonably small and there has to be plenty of backup for a person.

CHAIR - Is that an issue, the lack of support for these people? As a mental health nurse I am thinking, I could do that but it is tough.

Dr RATCLIFF - When they say, 'I could do that', you ask them whether they are prepared to do that for three years because that's what's needed.

CHAIR - That is right. For me to do that for three years, I would expect to have a great degree of backup from my colleagues and also a low number in my caseload.

Dr RATCLIFF - Yes.

CHAIR - Is that not possible with the current staffing that we have?

Dr RATCLIFF - It is not possible with the current staffing. It would be very difficult to achieve. The other problem with it is, there was a great deal of comorbidity, meaning they are drug dependent as well.

CHAIR - Are we talking about the patients?

Dr RATCLIFF - The patients.

CHAIR - Just checking.

Dr RATCLIFF - In general. Drug comorbidity is fairly high and there may be other issues as well.

Mr WILKINSON - Does that exacerbate it, the problem with drugs?

Dr RATCLIFF - Yes. Drugs have a number effects. First of all they produce behavioural changes and then they produce mood changes. They inhibit the capacity of a person to learn new ways.

CHAIR - In your years of experience have you found that drugs have had an increasing impact on the prevalence of mental illness as well as its severity?

Dr RATCLIFF - It is an enormous difference. There were authoritative people saying in my, say, first 20 years in psychiatry that schizophrenia as a condition first appeared around about the end of the eighteenth century - perhaps like AIDS did in our time. No-one knew what caused it but there were good records of people with bipolar disorder right back to hyprocratic writings from the ancient Greeks. Good descriptions of schizophrenia only started to turn up towards the end of the eighteenth century. It was clearly epidemic in the nineteenth century, which was when the big mental hospitals were built all over the world.

CHAIR - What drug came on the market at that time? Was it something like that or don't we know?

Dr RATCLIFF - We do not know. Then it began to decline in incidence and severity in the 1960s and 1970s. People said 'I think this epidemic is fading, it is going to go away one day'. Then came cannabis and now the incidence has gone up like a rocket and the severity has gone up because if a person was schizophrenic and keeps using cannabis it is very, very difficult to get them into remission. So the illness has become more chronic, more severe, more spectacular in its initial manifestations and probably more common. The evidence is accumulating that early use of cannabis in teenage years is probably one of the high-risk factors in producing schizophrenia.

The difficulty with schizophrenia is that there is clearly a hereditary vulnerability to it. About one in 10 of us have the genes that make us vulnerable to schizophrenia but most of us do not get it; something else has to happen to fire it off and cannabis is clearly one such agent. There may be many others.

CHAIR - So back in the eighteenth century is when it first started?

Dr RATCLIFF - Yes.

CHAIR - There may have been something that initiated that incidence, are you saying?

Dr RATCLIFF - There may have been, but we do not know what caused it. There are many theories about it. For example, it was discovered about 20 years ago that what season you were born in governs your risk of getting it.

CHAIR - So which month is the dangerous month?

Dr RATCLIFF - If you are in your mother's tummy in the winter time in a temperate climate you are at higher risk of getting schizophrenia, so somebody thought maybe it is a common virus.

CHAIR - It is funny how these theories develop, isn't it?

Dr RATCLIFF - It is not proven but there are still people investigating the possibility that there may even be some influenza viruses that are the trouble, that they affect the foetus in 15 to 20 years' time. We don't know but it is a peculiar finding, isn't it?

CHAIR - It is, yes.

We were a little bit side-tracked there.

Dr RATCLIFF - So encouraging a longitudinal view and dangerousness are not to be the criteria but the need for treatment is to be the criterion. Of course, many of these people are distressingly and quietly becoming psychotic but they are not dangerous to themselves and they are not dangerous to others in the direct sense. What they are dangerous to is their own future.

CHAIR - You need to remove that implication of dangerousness being a factor.

Dr RATCLIFF - It is not explicit in the act but it is very much implied and it is very much part of the way it is interpreted. People who have worked with acts overseas where that is insisted on tend to interpret our act in that way as well. So the push has all been towards that being the only criterion.

CHAIR - Have you worked in other countries too?

Dr RATCLIFF - No, I haven't.

CHAIR - You are aware what -

Dr RATCLIFF - Only in the north island, in Victoria.

Laughter.

CHAIR - Okay, it is probably far enough to go anyway.

You said the concept of dangerousness was in the British legislation. Is it still in the British legislation?

Dr RATCLIFF - I think it has been to some extent amended but that is where we got it from.

CHAIR - Are you aware of any country that is removing that from their legislation and basing it more on the need for treatment rather the risk of dangerousness.

Dr RATCLIFF - I think it has been canvassed almost everywhere because of the recognition that this does not work. But to what extent it has been enacted elsewhere I do not know.

Another point that the college made was the amount of resources devoted to the dubious, unnecessary scrutiny of Mental Health Services. You may remember that when the act was first being drafted there was a proposal to have a person called 'the patient's friend', which assumed that all the professionals that were treating them were their enemies. So we objected very strongly to the use of that term which was being advocated.

So official visitors and that sort of thing, yes. The idea that everybody is hostile to them except this nice person who holds their hand is a very troublesome thing.

Mr WILKINSON - And who has no training in the area as well.

Dr RATCLIFF - Exactly. There are so many ways of scrutinising practice within hospitals. All of them have committees looking over everybody's shoulder, everybody's professional bodies looking over their shoulder. We do not need layer after layer of expensive resources to look for malfeasances that do not happen, or very rarely do.

CHAIR - So how do you think that is best managed? I think that there is a need for oversight .

Dr RATCLIFF - There is.

CHAIR - Because of the history. We have had some unfortunate times in recent history at the LGH and others. How do we ensure that there is adequate oversight without being totally pervasive?

Dr RATCLIFF - This is not a college position. Personally, I have been thinking for some time that the Mental Health Tribunal, instead of being a body that sits only occasionally on cases that are put to them, should be in almost continuous sitting and that they should be given other duties. That should include regular inspection of not only public facilities but also there should be an inspectorate of registered accommodation for the private and the voluntary sector, or non-profit sector, for where patients actually live.

In other words it is no longer possible to run a very cheap, very nasty boarding house with very poor care.

CHAIR - Are you saying that happens?

Dr RATCLIFF - Yes, of course it does. That is those who have somewhere to live. My proposal would be that the tribunal has a role which is almost across-the-board continuous inspection of the whole system.

CHAIR - The official visitors undertake an aspect of that role currently. Do you see them as being an addition to the function of the official visitors or they would not be needed?

Dr RATCLIFF - I have nothing against the individuals involved but I think there are problems with the way that the thing has been set up - they are permitted for instance to view patients' records but they cannot understand what they are looking at, they do not understand what the issues are. I think having lay people in that sort of situation is a big hole in the privacy act; it is just not a good way to do it. It just looks a good way from the point of view of some advocacy groups who see that as having some sort of independence. Whereas in fact they may very well be independent but they are also in a degree of ignorance that is not appropriate to the work they are doing.

CHAIR - Obviously to have the Mental Health Tribunal as you suggest, and I can see the potential validity in that, would be a resourcing issue and a cost and the bucket of money is only so big. Are the official visitors paid do you know?

Dr RATCLIFF - Yes.

CHAIR - They are, right. So there would be that consideration obviously.

Dr RATCLIFF - Yes there is.

Mr WILKINSON - But that oversight body would act in accordance with its own discretion and therefore be able to look into a number of different things at its own discretion which is, I would think, a safety valve to ensure -

Dr RATCLIFF - But it has a capacity to develop experience over time.

Mr WILKINSON - Sure it does. And it has the capacity because there is a number of people involved, whereas in what we are talking about there might be only one or two involved..

CHAIR - There are three on the Mental Health Tribunal. There is a consumer represented on the Mental Health Tribunal too. You have your medical professional, your legal professional and chairman.

Dr RATCLIFF - It is an additional reason why we do not need the extra layer.

Mr WILKINSON - Are we down to number five or are we still on number four.

Dr RATCLIFF - It is just number five. I boiled three and four together.

CHAIR - Okay.

Dr RATCLIFF - Number six covers a more recent matter that has been raised. Under the act, if somebody is refused admission they are entitled to a second opinion. The problem is where to find that second opinion and how independent it would be. I was asked to raise the issue of the usefulness or otherwise of that particular provision. It probably falls most heavily in the case where one of the people with a borderline disorder who has just slashed their wrists in nine places is taken to DEM and is told to go home again, and we will see them next week. That is the sort of place where it happens, and how you get appropriate additional opinions -

Mr MARTIN - As a layperson, I wonder why you need a second opinion.

Dr RATCLIFF - It is provided for in the act.

Mr MARTIN - Yes, but as a layperson I cannot see why there would be a difference of opinion.

Dr RATCLIFF - No, that is right.

CHAIR - In your experience, if someone did present to a DEM in such a state having made a clear attempt on their life, whether they had a personality disorder or they were just really depressed - had a marriage break-up or whatever and had a short-term depression with sudden onset and no history - would it be normal to detain that person until you could get some appropriate support around them, rather than to say 'We have stitched up your wrists and we have pumped your stomach and now you can hop on home'?

Dr RATCLIFF - If it is a clear attempt on their life I think they would always be admitted, but they are not clear attempts on their life. They are acts of self-harm which are not intended to do more than what they do.

CHAIR - A gunshot wound to the head is a clear attempt on their life. What is a clear attempt on their life?

Dr RATCLIFF - That is a very clear attempt on their life.

CHAIR - It doesn't always work, though.

Dr RATCLIFF - No, it doesn't.

CHAIR - Unfortunately it often leaves a big mess rather than -

Dr RATCLIFF - I have seen several cases of manipulative parasuicide by gunshot, so you have to assess what is going on. Many years ago when I was working at the Launceston General Hospital we did a two-year survey of all the people who presented with intentional self-harm, attempted suicide or whatever, and we looked very carefully at all of them. The casualty officers said, 'These people keep coming all the time. Every Friday night these same people turn up and they have taken an overdose and we pump them out'. We found out that was not the case. The cases are so similar that busy casualty officers thought they were the same people. Certainly there were repeaters, but they were a minority.

CHAIR - He gets thrown into that bucket, 'Oh, here's another one'.

Dr RATCLIFF - Yes. The danger of the act has to be kept assessed. There have been a number of ways of looking at how this should be done. One is that for the extreme repeaters you provide services but you detach that from the act, so that when they have cut themselves they are sewn up if necessary and are told 'You have your appointment on Wednesday', so that continuity is maintained. In Edinburgh they some years ago decided that they would deal with this by taking every act of self-harm very seriously, as if it was suicidal. They put them under the act, they put them in hospital and they stuck them there whether they wanted to be there or not. The boyfriend had been round with flowers and all was wonderful again, but they were still there for five days whether they liked it or not. It was considered to be a useful deterrent, and they produced some evidence that in treating it over-seriously you did not lose the ones who were serious, and you deterred the ones who were not.

CHAIR - They didn't want to stay in hospital five days.

Dr RATCLIFF - Yes, it is very boring.

Mr MARTIN - Where is the balance?

CHAIR - Exactly. We cannot afford to do that either.

Mr MARTIN - Even the cry for help is that; it is a cry for help.

Dr RATCLIFF - Sometimes.

Mr MARTIN - Wouldn't they always be a cry for help?

Dr RATCLIFF - No, not always.

Mr MARTIN - What are they?

Dr RATCLIFF - A lot of borderline people who cut themselves particularly or do painful things to themselves, tell me they get a build-up of tension, and when they have cut themselves and see the bleeding then they feel better. Other people do it in other ways. They spend money they cannot afford and hurt themselves that way. When you bleed it worries people. Some of it is simply a discharge of tension.

Mr WILKINSON - More than the bank balance bill is.

Dr RATCLIFF - That is right.

CHAIR - That is bleeding of another sort.

Dr RATCLIFF - For some it is a cry for help, but if we set up services for these appropriately then after proper assessment they will get the help. The thing is that the help is not controlled by what they do. The help is there all the time.

CHAIR - It is their way of easing pain, isn't it - an emotional pain?

Dr RATCLIFF - It is their way of easing pain. Yes, emotional pain.

CHAIR - We see that as strange because that is not something that, I know, I would do because I do not like physical pain myself.

Dr RATCLIFF - Yes, that is right.

CHAIR - I would steer clear of that but other people find that a way of dealing with their emotional pain.

Dr RATCLIFF - Most of the cutters do not feel the pain. There is anaesthetic for a while and then it starts to hurt. The discharge or tension is very brief but it comes to a peak and they do that. Overdose is a bit more complicated. That tends to occur on Friday night, in the premenstrual week, after a row with the boyfriend or where there is a lot of grog. The act is often premeditated for a very brief period.

CHAIR - What about the moon? Does the moon play a part?

Dr RATCLIFF - Possibly.

CHAIR - There is anecdotal evidence about the full moon.

Dr RATCLIFF - I live near the middle of Launceston and the level of noise on a bright moonlight night is considerably higher right through the night and the number of bottles around the house is raised considerably higher. There are other intervening factors.

Coming back to how we find this balance, I think in making a good diagnostic assessment to decide that this person is not deeply depressed and a high risk of suicide, that they have other problems which we need to deal with in a different way. We need to know which ones we are dealing with rather than saying that suicidal or self-harming behaviour is 'one size fits all'. That is not reasonable.

Mr MARTIN - We really need to trust the judgment of the clinicians?

Dr RATCLIFF - We are stuck with that all the time.

CHAIR - Do you have a view on the dialectical behaviour therapy that the other witnesses were talking about?

Dr RATCLIFF - It is certainly one of the well-recommended ways of dealing with not very comorbid cases. Certainly with early intervention, early in their careers is a very useful way of doing things. When they have dissociative symptoms, a drug problem and a number of other things happening at the same time it is a much longer-term process.

Mr WILKINSON - In relation to your fifth point, what should we do?' What do you believe by way of a recommendation would assist?

Dr RATCLIFF - With?

Mr WILKINSON - The matters that you have been raising in your fifth - no, sorry - sixth point. Is there anything we can do legislatively?

Dr RATCLIFF - Legislatively, I think it is just a matter of being careful within the definitions in the act and that it is provided for. I think there are grounds for the initial order having a less stringent definition than a continuing treatment. At the moment they both have the same criteria, which I think is a mistake.

Mr WILKINSON - I hear what you are saying. We are probably focusing on it a bit too much because it is just one of a number. In relation to the personality disorder that does not get across the line, does not get the initial treatment maybe because the initial treatment should not occur because it may be non-beneficial, what do we do for those people to assist them in what is obviously a distressing time for them but especially, I think, for their family seeing it happen day in, day out?

Dr RATCLIFF - I suppose the essence of personality disorder is that the people around them suffer more than they do. The pressure on carers is going to be considerable.

Mr WILKINSON - Can we help at all with the legislation or can we put forward a recommendation that is going to assist those people?

Dr RATCLIFF - By including a good assessment phase on first presentation and then providing enough services somehow for the ongoing load. I could not guess how many

people are really involved in this. We only see the most severe ones, and because of the lack of resources generally it is only the tip of the iceberg that has been dealt with, the ones that are so insistent, and they use multiple services. They are very costly really to the community overall. It is not just Mental Health and psychiatric services, they use an enormous amount of social services, police services and court services.

Mr WILKINSON - Is it something that will continue in their life forever, or will there be a time when this starts to die away?

Dr RATCLIFF - Without early intervention it will last through most of their young adult life. It tends to fade with time and maturation. They do tend to grow out of it.

CHAIR - The issues around the Privacy Act that were mentioned by a previous witness, are they issues that we need to visit here? Particularly as you said the family of these people are often the more adversely affected, and they are the ones that feel they need that information about their loved one's condition to enable them to at least have some understanding and try to cope with it. So is the privacy legislation that we have currently in place an issue and do we need to look at that at all?

Dr RATCLIFF - I think sensible clinicians pretend it isn't there quite a lot, and when somebody has brought someone along and they are obviously with them, there are a number of ways around it: interview them with the person, and you don't just shove them out the door without giving some advice about where things are at.

CHAIR - So some general information as opposed to specific information related to their loved one?

Dr RATCLIFF - Yes.

CHAIR - There are ways around it.

Dr RATCLIFF - Yes.

CHAIR - You can meet the needs.

Dr RATCLIFF - But, as someone said, sticking to the letter of the law we can't do it, but you must do it.

CHAIR - We did receive evidence from the mother of a young girl who was 13 when she started self-harming, cutting in particular, and overdosing on a number of occasions, and she claimed that she was unable to get any information about her daughter's condition, the medication she was on, even though she had to get the script and go and fill it and then administer the medication to her daughter. Is that a usual situation, would you think?

Dr RATCLIFF - I think it is somebody taking an extreme view of the privacy legislation. I think there are some people who deal with children and adolescents who are very strong on the idea that the parents are probably one of the chief pathogens and therefore you must not involve them.

CHAIR - Even though that parent is the sole care provider for that child?

Dr RATCLIFF - Yes. That attitude is uncommon, but it does exist. I am sure there should be quite a reasonable involvement of those who are involved in the direct care of the person, but it always has to be assessed. With psychotic patients we have people who are deluded about their relatives.

CHAIR - You do tend to hear different stories from each side.

Dr RATCLIFF - Yes. Or we get destructive information, sometimes mendacious information, from relatives who are trying to achieve a certain result.

CHAIR - So there needs to be some protection against that too.

Dr RATCLIFF - There needs to be protection against that. So information going to and from carers needs to be a matter of careful judgment to assess what the relationship is. People may present as the carer and they are not**.** Somebody else is.

Mr DEAN - So you are reasonably satisfied with the privacy legislation in that regard?

Dr RATCLIFF - I think it is highly protective, but I think it is written and promulgated in a way that makes people over-value it and not do sensible things.

Mr DEAN - I think that is very clear from the evidence coming out to us, that people are interpreting that it does restrict them.

CHAIR - Others are finding a way around it.

Mr DEAN - They should not have to, though. They shouldn't have to find a way around it. It should be written in fairly clear English that there are certain circumstances where you ought to be able to consult with the mother, father or husband or wife.

Dr RATCLIFF - Yes, that is right. Generally you seek the patient's permission to do that and you do it, but sometimes you won't get it.

CHAIR - It must be difficult when you have a particularly manipulative partner, whether it be the male or the female partner, where the patient is really dominated by that partner and is fearful of going against their wishes. It must be a big judgment to make as the treating clinician.

Dr RATCLIFF - That is right. It often is.

Mr WILKINSON - But a good, experienced clinician should be able to make that judgment, should they not?

Dr RATCLIFF - Yes. They should indeed.

Mr WILKINSON - There is nothing we can do about that.

CHAIR - No. I am saying it is not easy.

Dr RATCLIFF - The other place where the shoe pinches of course is in privacy legislation governing patient's access to their records where much depends on information from others which might impair the relationship we have achieved. .

Mr WILKINSON - That is an important area, is it not?

Dr RATCLIFF - It is very important, yes.

Mr WILKINSON - What happens now in relation to that and what should happen?

Dr RATCLIFF - At the moment generally it can be withheld but released to someone they nominate.

CHAIR - Like a lawyer or someone?

Dr RATCLIFF - Like a lawyer or someone like that.

Mr WILKINSON - And that is the way it should be?

Dr RATCLIFF - Yes.

CHAIR - So if I was the patient who wanted to see my medical records but it was deemed not in my best interest to do so and I got Jim to act on my behalf and seek my medical records - and he is not a psychiatrist and he does not have a lot of knowledge in that area - because I was trying to determine whether I had been misrepresented or mistreated or whatever, how can I rely on Jim to provide that information if he is the one that accesses the records? I am not going to be able to understand it myself, either.

Dr RATCLIFF - I think a person who takes that role would have to be in a position of being able to come to you and say, 'They really were not trying to poison you. There was no conspiracy to' -

CHAIR - And Jim, as my lawyer, would check with the clinician and have it checked with another clinician.

Mr WILKINSON - That happens on a number of occasions where they state, 'Please, do not state what the report says because there is a number of adverse comments made by a parent' and they want the parent and the child to still have a good relationship. But that might falter if the -

CHAIR - I appreciate that.

Dr RATCLIFF - Yes, there needs to be a clause that allows for commonsense in good faith.

Mr WILKINSON - That is right.

CHAIR - The reasonableness test. Do you have any other further point then, Dr Ratcliff?

Dr RATCLIFF - I think they are the most important ones really. It is a matter of resourcing. I do not know if you are considering the existing plans for accommodation and that sort of thing.

CHAIR - It is not specific within the terms of reference but it is part of the health and well-being of people with a mental illness. So if you would like to make a comment on that you are most welcome to.

Dr RATCLIFF - I am thinking in terms of the issue of whether residential institutions, for instance, should be private, whether they should be in the not-for-profit sector, whether they should be directly government-funded. There are issues beyond the economics of this. The fashion now is to privatise everything. Certainly in the realm of geriatric care that is proving ever more disastrous. In the mental health area it has been disastrous from the word 'go'. I think there needs to be a lot of reconsideration. In Tasmania we became involved in very gungho deinstitutionalisation when we were not ready for it. The paradigm is that if you have an institution, no matter how old and grotty it is, if you can screw a plaque to it and have the Minister for Health unveil it it will be painted every so often, it will be staffed.

But if you set up an establishment like a community mental health team, somebody goes on maternity leave and the Government is short of money so they are not replaced. So a service that starts off being a 24-hour service becomes a 9 to 6 service and then it stops working on weekends. We have seen this attrition. We have seen attrition in terms of numbers and in terms of working hours. That happens all around the world and wherever a mental health division consists of people it will disappear by attrition in times of economic difficulty. Whenever there are bricks and mortar, no matter how undesirable, they will be maintained.

CHAIR - You still have people in them though, don't you? You still have to have people inside the bricks and mortar?

Dr RATCLIFF - Yes, or using them.

Mr MARTIN - So you are not saying deinstitutionalisation is a bad thing but that the services were not being provided -

Dr RATCLIFF - I'm saying that it was taken too far too fast without setting up the appropriate provisions. The appropriate provisions were promised and set up initially, but they invariably disappeared in the way that I said. Until we can find a way of screwing plaques onto people and having Ministers for Health in Parliament I do not see how we can do anything about it.

CHAIR - Maybe we need the Minister for Health doing it.

Mr MARTIN - Do you think it has improved in the last few years?

Dr RATCLIFF - No, it has got worse.

Mr MARTIN - You think it has been going downhill?

Dr RATCLIFF - Yes.

Mr MARTIN - It is a disgrace if that is the case.

Dr RATCLIFF - It is. I think in general the quality of the people doing the work has gone up, but their numbers have gone down, or the amount of time they are available has gone down.

CHAIR - So what facilities in Launceston are we talking about then?

Dr RATCLIFF - We are talking about the community mental health team.

CHAIR - Yes, but what do you have in Launceston?

Dr RATCLIFF - Just that.

CHAIR - Just the one service?

Dr RATCLIFF - Yes.

CHAIR - Is there residential accommodation?

Dr RATCLIFF - The residential varies. The next thing is the respite unit at Rocherlea. They are busy trying to close the Longford one. When they closed Royal Derwent each region in Tasmania was going to have a small unit for the residue of people whose best quality of life is institutional and not attempting to struggle in some sort of allegedly independent life.

Mr MARTIN - It never happened, did it.

Dr RATCLIFF - Here they got their act together and they happened to have the old Toosey nursing home available, so they refurbished that and that became Howard Hill Centre. It really worked very well for that core of people that were really not capable of existing independently. Nothing was done in the north-west. Nothing was done in the south. They used the rump of Royal Derwent until it could go on no longer, and then they built Tyena and so it went. But unfortunately in terms of government provision it has again been centralised in the south, contrary to the policy of past years where it was to be decentralised so that people could be near their relatives.

Mr DEAN - Doesn't surprise us at all.

Mr MARTIN - Is there a document that shows the history of what has happened since the closure of Royal Derwent?

Dr RATCLIFF - I don't think there is any single document, no.

CHAIR - There is an inquiry that is before the Community Development Committee that is looking at that start.

Dr RATCLIFF - Yes, it has become fragmented. It used to be a matter of the annual report by the Mental Health Services Commission, but now it has all been chopped up and you will find the information you will get you will have to scoop up from Housing and from all the Health facilities as well, and probably from the courts and the police.

Mr DEAN - You are absolutely right with deinstitutionalisation. We were never ready for it. I was commissioned to do a report for the Police Department when they were talking about it, and the very observation I made was that the Police Department were not ready for this and could not and would not be able to manage it. That is in fact what happened. The police got themselves into all sorts of trouble and problems, and some would remember the infamous case in Hobart where police were involved with a person who had been recently deinstitutionalised and was thought to be causing other problems on the street and the police used force -

CHAIR - Overzealous, were they?

Mr DEAN - Overzealous, and a number of police were charged as a result of it and so on.

CHAIR - It is probably an opportunity to make a submission to the Community Development Committee related to those matters, I would think. It would be good to have a view on that.

Dr RATCLIFF - Yes. It certainly needs to be a policy that is driven by the needs of people rather than the needs of the accountants, I think.

CHAIR - Thanks for your time, Dr Ratcliff. Do you want to make any further closing comments?

Dr RATCLIFF - No, I don't think so.

CHAIR - It was good to have all sides of the arguments.

Mr WILKINSON - Are we able to get you back, if need be?

CHAIR - Get Dr Ratcliff back?

Mr WILKINSON - Or even by phone, because that was very helpful as far as I am concerned.

CHAIR - Would you be willing to meet with us again if we need to?

Dr RATCLIFF - Yes, certainly.

CHAIR - Thanks very much.

THE WITNESS WITHDREW.