EDUCATION AND HEALTH STANDING COMMITTEE

REVIEW OF WA'S CURRENT AND FUTURE HOSPITAL AND COMMUNITY HEALTH CARE SERVICES

INQUIRY INTO THE ADEQUACY AND APPROPRIATENESS OF PREVENTION AND TREATMENT SERVICES FOR ALCOHOL AND ILLICIT DRUG PROBLEMS IN WESTERN AUSTRALIA

TRANSCRIPT OF EVIDENCE TAKEN
AT KATANNING
MONDAY, 21 SEPTEMBER 2009

SESSION TWO

Members

Dr J.M. Woollard (Chairman)
Ms L.L. Baker (Deputy Chairman)
Mr P.B. Watson
Mr I.C. Blayney
Mr P. Abetz

Hearing commenced at 1.30 pm

DAVEY, MS LYNETTE JOY
Psychologist,
examined:

DOUGLAS, MR ROBERT
Executive Manager, Community Development, Baptistcare,
examined:

The CHAIRMAN: On behalf of the Education and Health Standing Committee, I would like to thank you for your interest and your appearance before us today. The purpose of this hearing is to assist the committee in gathering evidence for its inquiry into the review of Western Australia's current and future hospital and community healthcare services, and also its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and drug problems. You have been provided with a copy of the committee's specific terms of reference.

The Education and Health Standing Committee is a committee of the Legislative Assembly of the Parliament of Western Australia. This hearing is a formal proceeding of the Parliament and therefore commands the same respect given to proceedings in the house itself. Even though the committee is not asking you to provide evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. As this is a public hearing, Hansard officers are making a transcript of the proceedings for the public record. If you refer to any document or documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we proceed to the questions that we have for you today, I need to ask you a series of questions. Have you completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes at the bottom of the form about giving evidence to a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIRMAN: Do you have any questions in relation to being a witness at today's hearing?

The Witnesses: No.

The CHAIRMAN: Shall we start with Lyn? As a private psychologist, you can talk to us about the needs, both in terms of what you see as hospital and community services. Also, as a psychologist, you really will cover both of the reviews, because I am sure you will deal with some people in the area who will have mental ill-health problems because of alcohol and drug use. Shall we start with the hospital and community services perspective first and how they link and if you see any deficiencies in how they link, and staffing? Then maybe from the hospital and community healthcare services we could look at alcohol and illicit drug use, and you could look at those separately.

Ms Davey: The hospital and community services: as a private practitioner, my service is in Narrogin. I primarily work from Narrogin three days a week and come to Katanning six days a month. I also visit Kojonup and Boddington. My referrals come to me under the Medicare Better Access program, and that is a GP referral, and that allows my clients to have 12 sessions with me over a 12-month period. With that, I deal with whatever the situation is that they have been referred to me under.

The CHAIRMAN: With that Better Access program, is that for any form of —

Ms Davey: Anybody. They have to have a diagnosed mental health illness to come to me. That can be as simple as anxiety—if you call anxiety simple, but it is probably simple to treat—to schizophrenia bipolar and the really severe ones. The difficulty I have with the severity of cases is that it is very difficult for me to case manage because I am a counsellor. I do liaise with Mental Health and people who have severe mental illnesses, and they case manage and I counsel.

The CHAIRMAN: So you work with their case manager.

Ms Davey: I do. I do not do a lot of that, but there is the interaction between Mental Health and myself. There is a drug and alcohol service in Narrogin. I do not get a lot of that, but it is often linked in. The anxiety and depression episodes are because of the drugs and alcohol. Again, I have referred to the drug and alcohol service for them to actually look at what they can do. We have co-shared some people—not a lot, but some people.

The CHAIRMAN: How does the co-sharing work? Would you still see them for the 12 designated times but try to tuck so that they are actually getting more assistance?

Ms Davey: Yes.

The CHAIRMAN: Did you say that were 12 occasions over 12 months?

Ms Davey: Yes. After the sixth consultation, if we agree that they need more, they then go and have a review with their GP and that then gives them another six, because this is all Medicare funded. That is the avenue it goes through.

The CHAIRMAN: Are you at 100 per cent capacity with referrals in three places? Are we in need of more psychologists in the area?

Ms Davey: I think Mental Health is very stretched, because that is the avenue that they have had. There is no other private psychologist in Katanning or Kojonup or Boddington that practices. In Narrogin there is one other private psychologist. Again, I think we are full. It has taken me probably 18 months. I have been out in private practice now for three years, but it took me 18 months to actually set my business up where the referral process was to the point were I am saying that I do not need any more in a day; I am stretched to capacity, especially when I travel. When I travel I come down and start at nine and finish at 4.30-five, and that is a full day. The next day you have got to do all the bookwork. As you know, the paper trails we have to leave are very full on, and it takes you a day to process what you have done in the day you have been out.

The CHAIRMAN: So really you are at capacity then.

Ms Davey: Yes, I am now. Since January this year it has just gone like that. Again, I think because there are six doctors in Katanning and I work from the doctors' surgeries, so I can liaise with the GPs on a regular basis, the GPs, especially in Katanning, are very happy to handball on, because I allow an hour for each session. They do not have an hour for each client. Again, if it is just to offload and be a supportive counselling service, that is an availability they have got in me.

Mr P. ABETZ: How long has the Medicare-funded arrangement been in place?

Ms Davey: It started on 1 November 2006.

Mr P. ABETZ: So it has been going for a few years already.

Ms Davey: Yes. Again, because it was put in place it allowed me, because I am not a clinical psychologist, to go out in private practice, which has been an advantage for me as well.

The CHAIRMAN: You say you treat everything, but with that, what are the major causes of illness?

Ms Davey: Anxiety and depression would be the major ones. That then links into often the economic situation and what is happening, especially with farming. There is no salary. You are dependent on world markets for what you are going to get. That is all impacting. A lot of farmers are trying to spread their wings and buy more land et cetera. When you do your budget it looks fine, and then hit a bad year. Whether this will be a good year or a bad year, I do not know, but that all impacts. A lot of the kids here are in boarding places. In Narrogin-Katanning we have got boarding houses, because a lot of the other centres have only got to year 10. The kids have got to board somewhere in Perth or a major centre. You are looking at the cost of sending children away for all these sorts of things. Most parents want their kids to have a good education. These are all things that impact on our everyday being. We cannot just go down the road and find another school. That would be the biggest thing in this area, I think—anxiety and depression.

[1.40 pm]

The CHAIRMAN: Is that anxiety and depression across all ages?

Ms Davey: Absolutely.

The CHAIRMAN: The member for Albany, one of the other members of our panel, has been particularly concerned about the number of suicides in the Aboriginal community. Are you finding —

Ms Davey: I do not have a lot of Aboriginal clients but, yes. You asked about all ages. I am seeing children as young as nine and 10 who are quite severely anxious and depressed. They are not Indigenous children; they are white children.

The CHAIRMAN: One of the other things we have been looking at is children's assessment and readiness for school. Have you found any relationship in terms of when they should have screenings for hearing and eyesight. We are finding that a lot of children are starting school behind the eight ball because they cannot hear or see properly. That then spirals. If it is not picked up in those early years, they get further and further behind. With the nine and 10-year-olds you are seeing, have you noticed any pattern in difficulty with learning with them or would you say again it is really across the board for all children that age? What do you think are the major determinants of children that age who need help?

Ms Davey: I think boys have it much more difficult than girls do. You can branch out into things like dyslexia, ADD and ADHD in that learning forum.

The CHAIRMAN: When you say that boys have it much more difficult, how is that?

Ms Davey: Because a lot more boys are impacted on with dyslexia, ADD and ADHD than there are girls. If, in a classroom situation, children are not learning, they become disruptive so they are further banished because they are not learning, but they are not learning because they have a learning disability. It is often not picked up. Again, teachers are stretched to maximum anyway. It just becomes like an umbrella: they are disruptive because they are not learning and they are not learning because they have a disability that has not been picked up. Boys are much more susceptible. If you look at statistics and research of the people who are diagnosed with dyslexia, 70 per cent of that population are male. As I said, a lot of the educational services do not, I believe, understand what is happening for these kids. Again, it is a time factor. If there are 30 kids in the class and two are not learning, you will concentrate on the 28, would you not? It definitely has an impact.

The CHAIRMAN: When it is a learning disability that is possibly caused through a mental health problem, what other referral options are there for you within this area to help those children who have learning problems catch up to the other students?

Ms Davey: Mental health does not touch ADD or ADHD people, so, again, it is down to private psychs and/or the school psychology services, which are stretched as well. As I said, it becomes a tightrope for people trying to get the best deal they can for their children. Unless you move to Perth and have access to places, I do not know what other avenues are available.

The CHAIRMAN: I think we have covered the service part. It is the GP, to you.

Ms Davey: Yes.

The CHAIRMAN: Would some of the people here need to go to Albany? Are you supported in your services by people from Albany?

Ms Davey: No, because I am a private practitioner and I am not part of the mental health service. My situation is very different because you are not part of the health system; you are basically on your own.

The CHAIRMAN: For the scheme you just spoke about —

Ms Davey: The better access scheme.

The CHAIRMAN: That allows you to bulk-bill Medicare.

Ms Davey: I do not bulk-bill because I charge the gap payment, which is a bit of a contentious issue. I charge the gap payment because I feel that when you are encouraging people to be responsible for their health, when it is a freebie, it does not matter, so I charge the gap payment. I am continually behind the eight ball on that because the Medicare system is archaic. We are in the process of getting online, but we are not online. The GPs are, but allied health people are not. Because we are not online, cheques go back to the client and I am reliant then on the cheque coming from the client. We have a transient population. People change phone numbers and it has been quite difficult in some cases to get the money for my consultations. I could bulk-bill but it is a two-way situation there.

The CHAIRMAN: We might give you a break for a moment, Lyn, and move over to Rob for a minute. We received your submission last week. We are trying to prioritise needs and the gaps in the area. Would you like to tell us what you see as the priority for those needs and gaps?

Mr Douglas: I guess from our point of view, we are a not-for-profit organisation, so we recognise our role specifically working as a recovery service for people with mental illness. Those people are usually referred to us through the state community mental health service.

The CHAIRMAN: The mental health caseworkers refer to you.

Mr Douglas: That is correct, yes, and we deal with people over the age of 18, so it is quite specific in that sense. We have only two part-time recovery workers, so, I guess from our point of view, we see a huge need but without the capacity to actually effectively meet that need. Our role is to work alongside people who have a mental illness and support and help them in their recovery. There are always far more people ready to be referred to us who we are not able to take. I think Lyn might have referred people to us, or has the ability to do that, as well as from the community mental health service.

The CHAIRMAN: Do have you a refuge-type area for people?

Mr Douglas: No; it is a one-on-one service. We have a drop-in centre in Narrogin and in Katanning.

The CHAIRMAN: Is that open?

Mr Douglas: That is open one day a week. People come in and have the ability to do whatever they want to do, basically. Sometimes they sit and have a chat and a cup of coffee or whatever. Sometimes we arrange craft activities or something, depending on their particular needs or interests. We have run workshops in daily living skills, cooking, budgeting, how to deal with issues that arise in our lives. Sometimes it takes the form of a sort of educational-type thing. Sometimes it takes the form of an activity. Sometimes it is just about being there with some other people. It is very much governed by the people's particular needs at that time.

Mr P. ABETZ: Who are you actually targeting with the services you provide?

Mr Douglas: I guess our target is governed by our contract, which is for people over the age of 18 with a severe and persistent mental illness.

The CHAIRMAN: Do you rely a lot on volunteers? Do people who work with you have to have a baseline qualification?

Mr Douglas: Over the years we have not had a huge turnover so there has not been a real problem in that. But our goal has always been to not look for a person with qualifications necessarily but someone who has the capacity to relate to people and work well with people. We are not a clinical service; we are a recovery service so we think it is more important that we have people who have the right nature and ability to work alongside people and to develop relationships and understanding with people. Then when people join us, we provide training for a range of things whenever there are training services available.

[1.50 am]

The CHAIRMAN: What is the age range of the people who can utilise your services?

Mr Douglas: It is from 18 years of age onwards. I guess we have had people who have been in their 50s and 60s. Most of the people who we have supported probably have been between 30 and 50—around that age. It is fairly open—from 18 up.

The CHAIRMAN: Is it word of mouth or mainly through the mental health caseworkers that people come to you?

Mr Douglas: It is mainly through the caseworkers. Our contract requires that people who come to us need to have a caseworker. We try to keep it at that level. If somebody who has not got a caseworker comes in, we then need to try to make sure that they do have someone.

The CHAIRMAN: We noticed in another area that there is a big hole when it comes to teenagers. What happens with teenagers in your area?

Mr Douglas: From our point of view, although our contract is for people over 18, there is a clause in the contract that allows us to take people over the age of 16 provided that they are living as an adult. In other words, normally they would not have any other support base. Basically, we would be able to take a homeless person. Contractually, that is all we are able to do in that area.

Ms Davey: Again it comes down to the education system. A lot of kids change schools, whether it be at the end of year 7 or the end of year 10 and after year 12 they go to Perth for their tertiary education. There are not a lot of jobs in rural areas for kids. A lot of kids just go to Perth. Regardless of whether they can get work, the big thing is that they need to go to the city to see what is happening in the city. Of course, the parents feel that that is the time when they are trying to spread their wings. I suppose it is a pit stop whereby kids are trying to be independent, but they really need some adult supervision to assist them. There is not a lot for kids to do in country towns anymore. The youth clubs and the things they had 30 years ago just do not seem to be around now, or if they are around they are not attended. I am not quite sure what the avenue is to actually helping these young people if they are not into sport. If they are into sport often they are part of a very cohesive group, whether it be the boys with their football or whatever. If they are not into sport, and some of them are not, I guess they live in isolation.

The CHAIRMAN: Rob, you suggested a crisis care facility in Narrogin. Would you explain how the crisis care centres operate and specifically why you need one in Narrogin and not Katanning and other towns?

Mr Douglas: The centre that we operate in Geraldton is a four-bed house that we lease from the Department of Housing. We man that 24 hours a day through state health department funding—through the mental health office. Basically, people are referred through the community mental health service, again through caseworkers.

The CHAIRMAN: Is that four bedrooms for four people or for four families?

Mr Douglas: It is for four individuals.

The CHAIRMAN: Therefore, it is not a family oriented centre?

Mr Douglas: No. It is a service for individuals. Sometimes people come there on a respite basis, if you like. The situation at home might have become quite difficult and they go there to give other family members a break for a couple of nights. Often it is about some relief for the hospital. The hospital is not able to take someone, so we are able to take them for a couple of nights and provide the hospital with some relief there. Sometimes we have people who are just passing through town who seem to find their way there as well. The reason it was raised in Narrogin—it sort of came from a number of local people who had shared with our staff that they felt that there was a need for that kind of service. To be honest I have not actually heard the need expressed for that kind of service in Katanning. There could well be, but I am not aware of it. However, the service in Geraldton, which is a fairly large town compared with Narrogin, is not 100 per cent full all the time. Financially it is quite difficult to operate it efficiently. Several rooms are empty more often than not. From a financial perspective it would probably be difficult to operate in a place like Katanning. There is a need there for that service, but you would not necessarily be able to treat it as a financially viable service. Finance and need are two separate things.

The CHAIRMAN: What would be the running cost of such a crisis centre in Narrogin?

Mr Douglas: You have got me on that one. I have done some work on that.

The CHAIRMAN: Do you happen to have any idea how much it costs in Geraldton?

Mr Douglas: We do have those figures available.

The CHAIRMAN: Would the running costs be lower in Narrogin?

Mr Douglas: Not necessarily, I think the cost would be the same in all towns because it is about how much it costs to employ staff and to meet the running costs of that kind of service. I think it would be the same.

The CHAIRMAN: If you have already done that business plan and you have that information, it would be interesting to see what those figure are. I will leave that for you to decide whether you can provide those figures.

Mr Douglas: I would be prepared to.

The CHAIRMAN: Let us look at mental health as a whole. Three years ago it was said that one in five people would suffer from mental illness. Now they are saying that 45 cent of the population will at some stage throughout their life suffer mental illness. You have said today, and it has been drawn to our attention by other people, that there is a particular problem with suicides, which is caused by anxiety and depression. Over the past five years have you seen an escalation in the area? Have you needed in the past the services that you need now?

Ms Davey: That is a good point. The need has been there. The other thing is that people are becoming more aware and perhaps more vocal about the fact of being unwell. There is still a huge stigma attached to being mentally unwell, because a person is considered to be off to see the shrink. That stigma is still there. In saying that, it is becoming more common for people to speak out and

say, "I need help here." Again, there is good and bad in the media. A guy from over east has been speaking to groups about depression because he has suffered with it. The group things really work well because they are actually accessing a lot of people in one hit.

Again, if people have to travel 100 kilometres and get kids babysat and all the rest of it so that they can attend a program, they just do not do it. Programs have been targeted at country woman because they are isolated. I recall one program that country woman were encourage to attend because it would help them, but it was a three-day course. Country women do not have the time to do that. They would battle to do it if it was for only one day. Again, I think education is still the best avenue that we have to get this out there to the community.

The CHAIRMAN: Fiona from the hospital suggested that you needed to have a health promotion officer to deal with this area. The committee recently went to the eastern states and while driving along the road every 20 kilometres we would see a "beyondblue" sign giving directions of where to go for help. Did other members notice that; I did?

[2.00 pm]

Mr P. ABETZ: Yes, it was in your face.

The CHAIRMAN: Yes, and it seemed at the conference that a lot more was being done in the east for people who may have depression.

Ms Davey: But again, perhaps that is to do with population; the population is bigger in the eastern states than in Western Australia. Also, distances are much greater here than in the eastern states—perhaps not in Queensland. The distance from here to the Kimberley is huge. I am not sure whether that is part of it. For me, it is about getting people who want to be in rural areas. I feel that has been a huge downfall for the health service and for clinicians per se because the new graduates who come out after completing their degrees are very enthusiastic but have never lived in rural Australia before. After six months or so they say they are going home because it is ridiculous. I do not know what we can do about that. I think it a huge downfall that the people who come to rural Western Australia do not understand the culture. They find it too isolating and too difficult and give up and go home.

Mr Douglas: I think your question about how long this has been going on is important in the sense that this has been happening for a long time. I think that one of the things that may be happening perhaps more amongst Aboriginal people—although I do not know if it is more—is that there appears to be a greater level of drug use. The combination of drugs, alcohol and mental illness, taking into account child abuse over the years and dysfunction over the years, makes it very hard to say which came first—the chicken or the egg. I do not think that we can say which came first, but we can say that a whole range of things appear to compound on each other. It would appear that increased drug use—when compared to a few years ago—is further compounding the problem.

The CHAIRMAN: I want to ask both of you this question in relation to that drug use: could you list four drugs, in terms of the damage they cause to the individual and to the community, that need to be addressed by way of priority? What would be the first drug on your list? We are looking at, for example, alcohol and illicit drugs.

Ms Davey: Alcohol would definitely be up there because it is legal and you do not have to go undercover to get it. Possibly marijuana would be pretty close to the top of the list and even perhaps speed because that is readily available—dexamphetamine and the like.

The CHAIRMAN: What about you, Rod?

Mr Douglas: I would have said the same. I do not have sufficient local knowledge on that, but that is how I understand the case to be.

Ms Davey: Members of the Indigenous population referred by GPs consistently do not keep appointments. I do not babysit. I do not phone up and ask them where they are because I figure they have to be responsible for where they are at. DNAs are the most frustrating thing for me.

The CHAIRMAN: Did not attend.

Ms Davey: Yes. They do not come. You have allowed an hour for the consultation but they do not rock in. A big part of the problem is the lack of mobile phone coverage, and the changing phone numbers and a transient population. Also, they need to admit that they are unwell and that they need help.

The CHAIRMAN: Some of the elders have actually spoken about the need to get Aboriginal people to take responsibility for their own health.

Ms Davey: That is also a problem; the elders of today do not appear to be the same as the elders of 20 years ago. A lot of the elders are not respected today. This whole breakdown of Aboriginal communities also impacts on what is happening to the younger generation.

The CHAIRMAN: Returning to the issues of alcohol and drug use and mental health, Peter and I have looked at the cannabis review which details the number of acute admissions and chronic admissions related to cannabis use. It also looks at the cost to our healthcare system. I will ask Lyn to respond first and then Rob. You have said anxiety and depression are very big problems in this area because of economics, but what proportion of your clients have mental ill health as a result of their alcohol and drug use?

Ms Davey: Not a lot for me; probably, maybe, two per cent. However, in saying that, a lot of these people are so unwell that they are in the mental health system—they are not part of my criteria.

The CHAIRMAN: If we look at a continuum of health, your patients are at the higher end of the continuum rather than the lower end that is represented by alcohol and illicit drug use problems.

Ms Davey: I think it is about those people who have, with a bit of a push from their GP, got to the point that they need to do this. It is not that they have to do it. It is about choice. I think that is an important concept. The frustration for most clinicians, whether they work in mental health or not, is the fact that people self-medicate. They have their antidepressant medication or anxiety or whatever medication and then they use illicit drugs or alcohol and say, "But it is not working." That is a huge conundrum for the whole service. Again, I am not sure what we can do about that.

Mr Douglas: I would not say that there is necessarily evidence that alcohol and illicit drugs are the cause of the mental illness. It is probably outside our ability to determine that. However, we have identified that probably 95 per cent of our clients have some problems with alcohol or drugs of some sort.

Mr P. ABETZ: Interestingly, I have done a bit of homework on the drug situation. Graylands Hospital records indicate that 40 per cent of all admissions through its emergency department are directly related to drug use. The difficulties with marijuana use in particular are the very long-term mental health issues: even if someone stops taking the drug today, they can still experience emerging major mental health issues six months later. It is a huge issue to contend with. You have indicated that there seems to be increasing use of drugs in the Aboriginal community. Will that continue to put pressure on mental health services in your area?

Mr Douglas: Yes, that is right.

The CHAIRMAN: Rob, is the $375 000 funding the total of your government funding? I am interested to know how your funding is made up. If there was a crisis centre, would you tap into state funding, commonwealth funding, local funding or lotteries funding? How does that work for such a centre? How does it work firstly for your group as a whole—that is, for Baptist Care?

Mr Douglas: I have mentioned $375 000 of funding over three years.

The CHAIRMAN: A minor point!

Mr Douglas: That funding is specifically for the great southern recovery service contract. We now have additional contracts for the crisis centre in Geraldton—that is, for our psycho-social support service in Geraldton and for our independent living program in Geraldton. Basically, we have four programs funded through the state health department.

[2.10 pm]

The CHAIRMAN: As part of the submissions, my impression of what the state health department actually were saying was really that they could not survive without the non-government organisations providing assistance to people who had mental ill health; the reliance on that support was very high.

Mr Douglas: That is correct. Of course our argument is that it is not enough, and possibly if that were funded then I think that that would probably ease some of the government system as well.

Mr P. ABETZ: What sort of analysis is done of the benefits that flow from this kind of service that you are able to provide? Are you able to quantify the benefits of that in some way or is that very difficult?

Mr Douglas: It is difficult to quantify that. I guess that where we have identified it is in terms of some of the things that we have achieved where we have worked with individuals. For instance, we were able to get a number of ladies to end up going to TAFE in Narrogin. For the first time they actually undertook some studies, learnt how to use computers and after that, a couple of them said that they wanted to go on and learn some other things, so they then went on and did some other studies. The women were in sort of middle age, I guess, who for the first time in their lives had got to that point where they were able to really build on some things in their lives and to build self-esteem, and it required us to work alongside them very closely, and to work with TAFE, to help them do that sort of thing. The results are significant I guess in that sense. One of our support workers spent quite some time working with some women around self-esteem and helping them with putting on makeup, and when they went out shopping to look for clothing with colours that matched and things like that that they had not really thought about before. Those women got to go away feeling really good about themselves because of how they looked and felt, and it is that kind of thing that has a really profound effect on people, which is part of what we try to achieve. A clinical service is about clinical stuff and that is really important, but this is where I see the non-government service is able to take it to that next level, if you like, and to really work alongside people and help them to achieve self-esteem, to learn skills and to be able to find ways of feeling good about themselves that enable them to continue to recover and grow.

Mr P. ABETZ: Is that mainly mental health recovery or is there also drug addiction recovery?

Mr Douglas: No, it is mainly mental health.

The CHAIRMAN: Lyn, I am going to give you and Rob a couple of minutes. We have veered on to lots of things that we wanted to ask you about but there may have been some things that you wanted specifically to bring to our attention today. Therefore, I ask you each to maybe summarise and if we have not looked at those areas, maybe flag those areas for us.

Ms Davey: I am not sure about the flagging of different areas. I just want to let you know that I am also a trained telephone counsellor, which has been also implemented from the University of Melbourne as a research project. I sort of go from Hopetoun up to Brookton and because I am in Katanning or Hopetoun sometimes some of my clients come up for a consultation, but in the intermediary months I phone them and we have a 50-minute phone consultation, which appears to be working well because it takes a bit of the pressure off that they have to come 500 kilometres for a consultation. Another thing that I have is a contract with the great southern division of GPs under the better outcomes program, which again is the same referral process but the criterion to get into the better outcomes program is that you cannot afford to pay the gap payment. That is also working

quite well, depending on funding. I am a consultant for Carers WA, which is for people who are caring for whoever. To be a carer you need to be registered with Carers WA, which costs you nothing but they also supply a support service for you as in phone counselling and they pay for five sessions to do with anxiety and overload to do with the caring of people. I am a Prime site consultant as well—same employees that are government employees. I do their consultations in this area. The fourth one I have just signed up for is PPC Worldwide, which is the old EAP—the employee assistance program—and any employee can access that counselling service if they are having stress, anxiety and depression problems.

The CHAIRMAN: And in your spare time?

Ms Davey: I am a mum and I have five grandies! However, that works well at the moment.

Mr Douglas: There are a couple of things that we have identified. One is in relation to the government mental health services—or health services generally, I should say—that is, I think it was a couple of years that there was no rehabilitation officer attached to mental health in Narrogin. That was quite a significant role because —

The CHAIRMAN: What is the difference between a rehabilitation officer and a caseworker in mental health?

Mr Douglas: As I understand, the rehabilitation officer works with the caseworkers in terms of really helping those people in the next stages.

The CHAIRMAN: Therefore, a caseworker is for a more acute level and then they move on to rehabilitation.

Mr Douglas: Yes. The non-government services would normally work fairly closely with the rehabilitation officer in terms of being able to identify the next sorts of steps that need to be taken. There was no person for a number of years and I understood they ended up recruiting someone from England, I believe, so currently there is a rehabilitation officer. That has been a great thing but for a long time there was not anyone and, from our point of view anyway as a non-government organisation, we really recognised that it was hard to find people to talk to because the case managers were just so busy. From Katanning's point of view, that is particularly a problem. I understand at the moment there are three people employed in Katanning under community mental health, and our clients who have dealings with them generally feel that they are not really looked after. I do not think that is a criticism of the people but rather a criticism of the lack of resources to enable them to do their job well and efficiently. In addition to that, Katanning hospital does not have the service for people with mental illness, so people with a mental illness who go into hospital in Katanning would be sent to Albany or Perth. Again, from the point of view of our clients, they have expressed that they do not feel supported in that situation. Fortunately, Narrogin does have a couple of beds, so it is marginally better but not ideal.

The other gap that we have identified is in relation to families of people with a mental illness. The funding that is available for mental illness is always for the person. However, the families have to provide support and care; they are the ones who do the worrying and often end up with a mental illness themselves or anxiety of some sort. Basically, I suspect they go to see Lyn, but really there is very little in the way of support for people, whether it is partners, parents, siblings or children, with the huge pressure that they are under. There are no services for these people. Possibly, it is hard to quantify and say who they are or what the problem is, but they are the people who we come into contact with on a regular basis.

Mr P. ABETZ: So there are no support services of that type at all in Katanning and Narrogin?

Ms Davey: I have had clients with ageing parents and basically they have put mum or dad in hospital for two or three nights, but you cannot do that in Narrogin because it is an acute-care hospital, so again it is about juggling the balls in the sky to get the best deal that you can. It is quite

difficult when there is a single person caring for this person because they do not get any respite at all.

The CHAIRMAN: Up in Perth, Rotary has been doing a wonderful job in going around to different metropolitan areas and inviting all the non-government organisations to involve the community to talk about what services they can provide. Obviously, they cannot do that here because it would be you and Lyn and I think that there would be trouble coming to see you!

It is interesting that no-one has mentioned that rehab officer before. I am aware of the case managers but I am not sure. It sounds like a role that would be very useful not only down here, but also in the metropolitan area, so I am surprised that I have only just come across that role. I do not know that we will have an opportunity to ask but we —

Mr P. ABETZ: I think they come under different names. I know Bentley Hospital in Perth has a system so that when somebody is discharged, they have a —

The CHAIRMAN: But that is discharge planning.

Mr P. ABETZ: Sort of community links —

The CHAIRMAN: No, rehab is not —

Mr Douglas: This is still pre-discharge.

Mr P. ABETZ: The rehab officer works in the hospital. I thought they worked with them after the crisis sort of passes to some extent and they help channel them back out into the community and help them to find their feet and find appropriate support and so on. That is how I thought it worked.

Mr Douglas: Yes, I think you are right. I think they work right across the board and possibly more when they are not in hospital than when they are.

The CHAIRMAN: It might be worth us following up on that in Perth.

Mr P. ABETZ: Bentley Hospital has what I think is called community link or some name like that, which —

The CHAIRMAN: Is that for mental health patients or general?

Mr P. ABETZ: Mental health, yes.

The CHAIRMAN: It would be good to find out about that.

In that case, I thank you for your evidence before the committee today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections must be made and the transcript returned within 10 days from the date of the letter attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should, however, you wish to provide additional information or elaborate on particular points, please include a supplementary submission for the committee's consideration when you return your corrected transcript.

Once again, thank you both very much for coming.

The Witnesses: Thank you.

Hearing concluded at 2.22 pm