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 ALBANY
FRIDAY, 11 SEPTEMBER 2009

SESSION FIVE

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 2.08 pm

MISSON, MS MELINDA JANE
Team Manager, Great Southern Mental Health Service,
WA Country Health Service, Great Southern,
examined:

CANNON, MS MARCELLE
Regional Manager, Great Southern Mental Health Service,
WA Country Health Service, Great Southern,
examined:

MILLAR, MS SUZANNE JUNE
Regional Manager, Aged Care,
WA Country Health Service, Great Southern,
examined:

GALANTINO, MS NATALIE FLORENCE
Service Coordinator, Silver Chain, Great Southern,
examined:

MARKOVS, MR ANDREW
Manager, Men's Resource Centre,
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 health-care services, and its inquiry into the adequacy and appropriateness of prevention and treatment services for alcohol and illicit drug problems in Western Australia. 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. 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. This is a public hearing, and Hansard will be 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 Witnesses: 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: We are a bit late in starting, so we will probably be able to give you only 10 minutes each. We are hoping today to identify where the gaps are in health care services in this area, and how those gaps can be filled. I am going to ask you to try to present those gaps in terms of priorities, and the committee will interject. As I have said, you will probably have about 10 minutes each, so if you start with something that is a low priority, we may not get to your high priority issues. We will start with Melinda and Marcelle. Thank you.

Ms Cannon: Did you want a summary of the services that are already being provided?

The CHAIRMAN: Yes, but in giving that summary, you have 10 minutes, and we need to find out what those needs and gaps are.

Mr P.B. WATSON: We are mainly worried about the shortages, not the things you are actually doing at the moment.

Ms Cannon: Okay. Just to give the background, we are talking about ambulatory mental health services today. We do not manage the inpatient mental health unit, so if you require any information on that we will have to get that for you at a later date. The Great Southern Mental Health Service provides a specialist treatment service for people with mental illness across the lifespan, so we look at zero through to 65 plus. We are a little bit different from our colleagues in WACHS Great Southern, because we cover the southern wheatbelt as well in mental health services. The population is about 71 000, and that is in about 75 000 square kilometres.

The CHAIRMAN: Are you able to provide us with a map showing your geographic area?

Ms Cannon: Certainly.

The CHAIRMAN: Thank you. In relation to that, when you show your area, can you also show for WACHS how the mental health units are distributed?

Ms Cannon: We certainly can. Specialist treatment is psychiatric assessment. We provide medication and management. We do counselling and things like cognitive behavioural therapy and other psychosocial interventions, case management and psycho-education for family members as well as the person with the mental illness, and rehabilitation and recovery programs. We also try to cover as much of the continuum of care as possible, so that is consultation and liaison, and specialist advice to the emergency departments and district hospitals across the region. That is for acute psychiatric presentations as well as if someone comes in with a physical health problem and there is a co-morbid mental health problem. That secondary care may be either an assessment and providing support to the general practitioner about their management, or it may be just advice to the GP without seeing the client. We also spend a lot of time supporting transfers of people to Perth inpatient psychiatric facilities. That is more for our Katanning and Narrogin-based staff, because in Albany most people will come to G ward—the inpatient unit—but for others in the upper parts of the region, they are being transferred to either Bunbury or Perth. So that is our staff supporting those clients.

The CHAIRMAN: Why are they transferred? Is that because your region or your area is closer to there than it is to here?

Ms Cannon: Yes, primarily—it is closer to home. We will at times have transfers from Katanning to Albany hospital, so that is much of a muchness from there.

Mr P.B. WATSON: Marcelle, are you happy with what is provided in G ward? Could more be done in G ward? I think there are nine beds?

Ms Cannon: Yes. We have nine inpatient beds. We work very closely with G ward. I think in terms of the management of people close to home, G ward does a really good job of that. What would be fantastic is if we could get inpatient child and adolescent services closer to home, because people do have to go to Bentley if they are under 18. You are probably aware that mixing children and adults in a psychiatric acute facility is not a very good thing.

The CHAIRMAN: In relation to that, with the plans for the new hospital, would you see that as being run as two separate units? Are you saying that it would be a good idea to have two separate units—

Mr P.B. WATSON: It is not in the forward plans.

The CHAIRMAN: —one for adult mental health and one for child and adolescent mental health?

Ms Cannon: I think the reality of the population is that we are looking at the design features and whether we can have swing beds that are designed in such a way that they could be used for either psycho-geriatric or child admissions so that we can use the staffing mix and the specialist staffing mix.

The CHAIRMAN: So that is on the drawing board, is it?

Ms Cannon: That is part of what we are building in, yes. We have put to the design team that that would be ideal.

Mr P.B. WATSON: Has there been an increase in child mental health problems—statistically?

Ms Misson: I think what we are seeing is our presentations are more complex and more acute.

Mr P.B. WATSON: Because of drugs?

Ms Misson: Well, I would be making an assumption, because I do not actually have the data to support that. I think there are various reasons, one of which might be an increase in drug availability and drug use, but there are also other issues such as the more transient nature of families generally in modern society. The feedback from the CAMHS team is that they are actually seeing far more acute presentations. Also, I hate to use the word "chronicity" in relation to children and adolescents, but we are seeing also more chronic issues, such as the emergence in increasingly younger people of what might in an adult be diagnosed as a personality disorder.

Mr P.B. WATSON: I have had a primary school teacher say to me that in preschool they have children with anger management problems and mental problems through obviously the mother having been on drugs or on alcohol when the child was born. Is this showing through in your statistics?

Ms Misson: We do not usually provide anger management, because anger management is not actually a mental health intervention. Anger management is more of a psychosocial behavioural intervention. DCP would probably be more capable of giving you those statistics for the region. I am not trying to avoid the question. I just do not know.

Mr P.B. WATSON: That is okay. It is just something that has come up and I am wondering if it has flowed through to you.

Ms Misson: As I said, we are seeing far more acute presentations. That is probably across the age span of the CAMHS clients. We would receive referrals for children as young as one year or 18 months on occasion.

The CHAIRMAN: The statistics would be there somewhere in terms of the increase in services required for children and adolescents. Who would keep those statistics?

Ms Cannon: I am trying to think of the best way of getting that for you. We could probably look at the number of clients over the years. Some of that is to do with the data collection system, where some of the data is not particularly robust. I was just looking at our breakdown for one financial year, where for the zero to four age group we saw 15 kids, for the five to nine age group we saw 128 kids, and for the 10 to 15 age group we saw 272 kids.

The CHAIRMAN: Which year was that?

Ms Cannon: That was 2006-07. That data was better than for 2007-08.

The CHAIRMAN: Is it possible to get us the data for 2008-09 so that we can see whether the number has increased or decreased?

[2.20 pm]

Ms Cannon: We can probably give it to you with the rider that some of the data is not particularly robust. It will probably give you a sense of comparison from there.

Mr P.B. WATSON: If you are getting them at zero to four, when you look at the end of what Andrew is there, it will put huge pressure on there.

Ms Cannon: One of the things is that we have a fairly well-connected service with the school psychologist and the child health nurses down here. In terms of early identification of young people, I think it is a fairly good system down here. Again, that may inflate that we are seeing some people earlier and who are more amenable to change then. They are some of the things to keep in mind in terms of the numbers.

The CHAIRMAN: Those statistics are quite amazing. I would not have imagined that you would be seeing quite so many children.

Mr P.B. WATSON: They are the ones you get to see, not the ones slipping through the system.

The CHAIRMAN: We have spoken to people in Perth. I did not think to ask those questions about those age groups. It would be useful if you are able to get us that later comparison.

Ms Cannon: We have a person at WACHS head office who might be able to pull some of that data. If you are looking at whether there is a trend in increases in the age groups of children being seen by specialist mental health services, we can get that.

The CHAIRMAN: It would be wonderful if you can get us some further information.

Ms Misson: Do you want just the data for this region in terms of WACHS?

The CHAIRMAN: It might be interesting to see whether that is across the board and a whole societal problem.

Ms Cannon: I know that in the Kimberley and in the Pilbara, because they have not had staffing, they have not seen the children. That has been one of those things that makes it look as though children are not needing services. We were thinking that we do not know what happens with those kids if we are seeing this many down here because they have not seen the children. We will get you a summary.

That was triggered by us talking about supporting client transfers. We also provide support with crisis assessment and intervention for people having an acute psychiatric episode. As I said, there is recovery and rehabilitation. That is probably one area we would like to do more of. I guess when you are a generic service like ourselves, you have to prioritise clinical urgency, so that support to ED presentations or psychiatric emergencies, which is fairly labour intensive, or transfers tends to take up a fair bit of resource.

The CHAIRMAN: In the metropolitan hospitals, they have a mental health nurse. I am trying to think of what the position is—liaison or something.

Ms Cannon: ED liaison?

The CHAIRMAN: In the emergency departments. Do you have that here?

Ms Cannon: No, we do not. I guess that would be an area that I think, for mental health in WA, it would be good to get agreement on service models for their ED in terms of psychiatric liaison support. Nationally, a number of different models are based within the community mental health service that provides service into the hospital. Others are employed by the hospital and by the ED and can do generic ED work as well.

The CHAIRMAN: Particularly when it is such a big hospital.

Ms Cannon: That would be from a state perspective, because it is done differently across WA.

The CHAIRMAN: Because you are from WACHS, can you let us know which hospitals associated with WACHS and the regions do have those psychiatric liaison people?

Ms Cannon: The south west region does, so Bunbury hospital does. I do not think the smaller district hospitals do. I think it is just the regional resource centre. In the goldfields, the community mental health team has on-call ability to provide support to the ED. In the mid-west it is the same sort of thing; they have some people who can give some after-hours support.

The CHAIRMAN: Is that on-call specific to some regions rather than being across the board?

Ms Cannon: No, it is not consistent. For some of the places, it is the hospital that employs the ED liaison; in other places, it is the community mental health team staff that extend the service. Both models exist, but there is not a lot of research to show which is the best.

The CHAIRMAN: There is one or the other in all hospitals?

Ms Cannon: I am not sure about the Kimberley. There would be, in the regional resource centres, some kind of service offered by community mental health, all based in the hospital of some nature. I think it would be good to make that more robust. The recovery rehabilitation in places such as Victoria is very much non-government organisation driven. It is an area we see people benefit immensely from if we can work in partnership, and that is an area we would like to see more of.

Ms L.L. BAKER: Will you comment on the capacity in the NGO sector to do that work at the moment?

Ms Misson: I am going to put it very bluntly and say the NGOs are actually in an unenviable position. When they have time available, it seems that the time available is because they have not been able to staff. When they are fully staffed, it seems like all the time they have is gobbled up. We are aware that they are playing a constant juggling game. Either they have hours and no staff or they have staff and no hours.

Ms L.L. BAKER: If you put a figure on it, would you say it is a 30 per cent capacity gap or what?

Ms Misson: The NGOs would probably be better placed to comment on that. We definitely have more referrals and more client need than the NGO capacity can match.

Ms L.L. BAKER: That is the figure I would be really interested in getting from you.

Ms Misson: We would not have that figure in terms of their capacity.

Ms L.L. BAKER: How many knock-backs do you get? I am assuming that from what you said, when you refer clients, they are not able to take them all.

Ms Misson: Sometimes it is not a matter of referrals; sometimes it is a cutback of service to clients we have already referred to them. Sometimes it is, "Look, we can do service A, so we can provide some groups, but we can't provide service B", which might be things like transport and welfare. I am not sure whether the NGOs keep track of that data in seeking renewed funding, but there is a definite gap. It is bigger than just a slight gap.

The CHAIRMAN: Thank you.

Ms Cannon: The other area is psychiatric disability support. These are people who have long-term disability because of their mental illness—so things like house cleaning, cooking, gardening, being able to maintain those daily living activities. A lot of services will not take mental health clients, so sometimes we have, I guess, quite specialist nurses doing cleaning-type activities because they are the only people who will help. Services that are designed with psychiatric support in mind are not using a specialist resource for that.

The CHAIRMAN: We have to move on to Sue. If we do not get a chance to come back to you, Melinda, we have some supplementary submission sheets and we really would appreciate it.

Mr P.B. WATSON: What mental health problems do those zero to four children have?

Ms Misson: We would probably need to pull it. Some of it may depend on how they are classified. We do not really like giving children damaging labels. Often it is categorised as an adjustment issue, a family crisis or something like that, simply because to give a child a label is something that tends to stick.

Mr P.B. WATSON: At that age, struth—scary.

The CHAIRMAN: We might move on to Sue.

Ms Millar: I will give you some background with what we do for aged care across the region. It covers the community aged-care services, plus acute, plus residential care right across the region. Everyone is aware that our population of the elderly across the region is increasing. In the past 10 years it has increased by 9.5 per cent. We are looking at 52 500 people over the age of 65-plus in the region. There are 6 651 over 65s in the HACC target group. Out of that number we have only 2 462 receiving HACC services.

The CHAIRMAN: There are 4 000 people who are eligible for HACC, but are you not able to provide HACC services because of funding?

Ms Millar: No, not the funding. I think it is the need—whether they will accept the program. Some people might have been assessed but they have declined the program. This is with the community aged-care packages as well. It is up to them. You cannot force a program on them.

[2.30 pm]

Mr P.B. WATSON: Are there reasons why, Sue, that the program is not acceptable to them?

Ms Millar: I find in Albany that the services—and nothing against Silver Chain or any other provider—under the HACC funding just seem to go in a radius from the centre CBD, whereas actually HACC funding is allocated to LGA; that is, your postcode. Outlying areas like the ones under health—and they pick it up under their MPS so they can cover that LGA locality. But I just found it quite interesting in Albany when I was doing the old role.

Ms L.L. BAKER: What is an MPS?

Ms Millar: Multipurpose service—I will come to that.

I will just go through the residential care places that we have throughout the region. Under WACHS, under our multipurpose services, they cover community, acute and residential all under the one umbrella; we have 45 high places and 37 low places and they offer respite for the elderly, as well. The NGOs within Albany and also Katanning—we have an NGO residential facility sitting in Katanning and Kojonup—there are 129 high places and 229 low places so that is your level of care whether it is high nursing care or like hostel low care.

The CHAIRMAN: What is the need in those areas both in terms of general aged care places and dementia places across the region? We would like to know about aged care in terms of high dependency and low dependency and then dementia. What is the need now and what do you envisage the need will be in five years' time?

Ms Millar: I think that the dementia-specific is increasing; over the five or six years that I have been here it certainly has increased.

The CHAIRMAN: Are you able to give us the statistics?

Ms Millar: Yes, I could pull that.

The CHAIRMAN: Could you give us the statistics both across the region for aged care places that you have for high dependency and low dependency now, and whether there are gaps in the current places for the current need now? You have mentioned that the population is going to increase in this area over the next five to 10 years, so could we have what you anticipate we will need in five years' time and in 10 years' time. Could we also have statistics for not only high dependency and low dependency, but also dementia patients? I have just been amazed at the number of people who are suffering from dementia. That is a big scale going up and therefore it is going to be a big problem. How many dependency units do you have? Where do you have units for people with dementia across the region? From the statistics that you have from here, again, what do you see as the need in the next five years and in 10 years' time?

Ms Millar: Yes, that will be fine. The facilities, NGOs and that some of them actually provide a whole dementia wing within their facilities, and with the MPSs we have like Mt Barker that has an actual residential facility for dementia-specific residents. We set up an aged care unit here that actually came out of one of the reviews that was done and it was included in our foundations document for future planning for aged care—that is, the WACHS foundation. It was also developed through the 2003-2008 state aged care plan and it was to set up aged care units in each region through WACHS.

The CHAIRMAN: I think we would also be very interested in receiving a copy of that because that report would probably also have some future planning as well.

Ms Millar: It has; yes.

The CHAIRMAN: Therefore, we could see what your statistics are like in comparison with what they planned and what you know has happened with population to what the real needs are.

Ms Millar: In setting up the aged care unit we brought ACAT—the aged care assessment team—in under us; the home and community care project officer; my position, which was a new position; and the national action plan coordinator, and that actually formed part of the aged care plan as well. That was to introduce the long-stay older patient initiative and education on aged care, as well. Currently, our unit has 7.21 FTE but that is to cover the whole region, so we do keep pretty busy.

The CHAIRMAN: How many would you like to have?

Ms Millar: I have one FTE coming; I am just waiting for the money to come down from the department.

The CHAIRMAN: You have one FTE coming but what is your wish list?

Ms Millar: My wish list would probably be for another two FTE.

What we are trying to implement, especially with the models of care coming out from WA Health, is our team that we need to pick it up. It is the same as the safety and quality information bundles coming out from WA Health, as well. Myself and one of my other team members, we act as clinical leads for the whole region as well, so we are doing quite a few dual roles—anything with age or "A" comes to aged care.

The CHAIRMAN: You have two minutes now, Sue.

Ms Millar: Okay, sorry.

Other programs are: the older patient initiative; we are running the residential care line on a pilot, we do not have any recurrent funding for that and it would be good if we could do. With the

residential care line, the residential facilities can call into the hospital or we can send a nurse out to the facility. That is to prevent unnecessary ED presentations, but our funding has ceased on that.

The CHAIRMAN: There is going to be some COAG funding in that area; whether your aged care unit taps into that or whether Natalie through Silver Chain might be able to tap into that is something.

Ms Millar: The last lot of funding stayed in the metro; no funding came out to the rural areas, even though there were two —

Mr P.B. WATSON: Note that city members.

Ms Millar: — rural areas—Geraldton and us in Albany—that were running the program. We got nothing out of any of the COAG funds.

The CHAIRMAN: But did you put in?

Ms Millar: Yes, it was put in.

We had a transitional care program and we had a visiting geriatrician service as well, but I am trying to secure ongoing funding for that to remain.

I will quickly talk about our gaps. We need suitable programs and suitable facilities for the younger disabled with challenging behaviours; they always seem to manage to get either left in a hospital system in an acute setting or they try to push it onto aged care to have them admitted into a residential facility, which is not suitable for the other residents. That is my big beef. Other gaps are dental health services across community and residential. Allied Health, I daresay you heard from Sandra and them, is lacking the physio, OT and podiatry services for the elderly. A psychogeriatrician visits, we have an application in for funding for that but we still do not know whether we are successful in that and in the application for the recurrent for the geriatrician. I think what would be a big help here, as well, is rehab in the home like they have it in the metro area. They were going to introduce it to Geraldton and Bunbury but we have sort of like missed out again down here in the funding.

The CHAIRMAN: Natalie, would you like to start with your wish list and then describe your services afterwards to ensure that we get to your wish list?

Ms Galantino: I would prefer to do it the other way round because it sort of meshes in—is that okay?

The CHAIRMAN: Yes, that is fine.

Ms Galantino: Basically, Silver Chain in the great southern provides multiple services and programs. It usually means that we operate within about a 25 kilometre radius of the CBD, but as we said, that is dependent on the postcodes and there are three that basically govern us and then the MPS sites tend to pick up what comes past that boundary. We have had instances where we have both shared a client who sits right on the boundary and that has actually been quite successful. As you are probably aware, we —

The CHAIRMAN: Sorry, just with those boundaries, can we have a copy of Silver Chain's regional boundaries as well? It is just that everyone seems to have different boundaries; there does not seem to be much of a liaison between one and the other.

Mr P.B. WATSON: Do you go up as far as Jurien Bay?

[2.40 pm]

Ms Galantino: If you take the remote sites, it is from Walpole to Eucla to Shark Bay. There are 11 remote sites that are sort of on the outskirts. However, for the Great Southern, we basically operate within a 25-kilometre radius of the CBD. We have multiple funders who provide funding for us to deliver different programs. HACC, the home and community care program, would be the biggest

component of what we deliver in the region and that is inclusive of domestic assistance, social support, respite, personal care and nursing. PEP, the personal enablement program—I am not sure whether you are familiar with that—has certainly been one of the successes for the region. Also, there is allied health, which has an OT and a physio who basically deal more with clients who are housebound; they cannot get out to access other allied health community programs.

We also have state-funded clinics—the wound clinic and the continence clinic. Part of the continence clinic is also the CMAS program—the continence management and advice service. Basically, the continence clinic would be the largest component of services within those two clinics. We have about 200-odd clients. Certainly, there has been an increase in the continence needs of people in the community. That does not extend only to Albany; people within the whole great southern region can access that clinic.

The CHAIRMAN: In the past a person suffering from incontinence who got commonwealth assistance for incontinence pads could not get assistance from the state. Now people can get both. With them getting both, does that meet the need or are there still people —

Ms Galantino: I think you will find that it actually covers them for the full 12 months of the financial year. The extra $480 from CMAS certainly seems to achieve that. I have not had the continence adviser tell me otherwise. We have been fortunate with the continence clinic, because it provides a need that we have identified in the region. We have had a good partnership with WACHS, which has brokered us to provide continence services to the upper great southern. We have now extended the CMAS program to the upper great southern for this financial year as well, with WACHS providing us with a clinic room in Katanning. That is quite good.

We also do the Department of Veterans' Affairs. The veterans home care program includes nursing, respite and personal care—pretty much the same services as can be accessed under HACC. We also provide a palliative service—a 24-hour, seven days a week service—which WACHS brokers us to provide in the community. We also have the commonwealth packages. We have 71 community aged care packages; 15 extended aged care at home packages—EACH; and five EACH dementia specific packages. All those three areas of packages are completely full and we have a waitlist for EACH and the EACHD. Now there is also another provider in town, and hopefully we will be able to forward that waitlist once it has received the funding to basically roll out their packages. That would have been one of our identified gaps, especially the EACH and EACHD packages. We are talking about people with very complex needs. We have found that the funding for the EACH and EACHD packages is certainly sufficient to provide them with the care that they need to remain in their home.

Ms L.L. BAKER: For the sake of Hansard, could you tell us the full name of what you just referred to?

Ms Galantino: Yes. EACH is the extended aged care at home package and then there is the extended aged care at home dementia specific package.

As I said, we found that the funding is sufficient for EACH and EACHD packages, but not for CACP. Obviously, the community aged care packages are more for the virtual hostel-type clients, whereas the EACH are more the residential, high nursing home-type clients. We are finding that there is a vast gap between the CACP and EACH. There almost needs to be another tier. If you look at it in regards to hours instead of dollars, you are looking at providing someone with five to seven hours' worth of care at home under a CACP, and under EACH they are between 16 and 20.

The CHAIRMAN: That is the question. In the metropolitan area someone can get up to $7 000 for support services or up to $12 000, and then $32 000 or something plus. How does it work here for those packages? Are there set levels?

Ms Galantino: There are set levels. You are basically given a commonwealth subsidy for your CACPs and the same for EACH packages. When you look at it, a CACP breaks down to about $35

a day of care; that is how much is allocated to a client. It then jumps up to about $118 for an EACH package. That is quite a vast difference.

The CHAIRMAN: What happens then?

Ms Galantino: Basically, what ends up happening is that if you have a client on a CACP and you know that their care needs are increasing, you would put a referral through to ACAT to assess them for a higher care package. However, that higher care package must be available—an empty package for them to fill. In the meantime, they end up becoming high-care users under the CACP until an EACH package becomes available. We have tried to transition those clients. The sooner you identify them and start that transition, the better it is for you. It actually ends up that the CACP budget goes into deficit, because you have high-care clients under a CACP.

The CHAIRMAN: What are your waiting lists?

Ms Galantino: For CACP, none; for EACH, we have eight; and for EACHD, we have two.

The CHAIRMAN: Does that apply annually?

Ms Galantino: This is only the third year that we have had the EACH packages actually running. I suppose that we have not seen a long-term trend for me to be able to comment on that. We are seeing even more with the HACC-type clients—basic homecare-type clients—is that there a lot more of them with things like dementia and Alzheimer's. It is very hard to maintain the amount of care and coordination—especially coordination—that they require to remain at home. Those are the types of clients who almost need that other tier between a CACP and EACH package. One of our suggestions would be twofold: a low-level CACP and a high-level CACP, something along those lines.

The CHAIRMAN: What would you suggest for a high-level CACP?

Ms Galantino: For me personally, somewhere that sits around 10 hours of care per week and has a good amount of funding allocated for the coordination more than anything else. One of the key things that we have seen is a gap across all services. We tend to find that, because the packages of care that we deliver in the community have got that coordination aspect sort of assigned and funded within that program, they are more successful programs; whereas when you go down to the basic HACC services and even palliative—one of the suggestions that we have is maybe packages of care for palliative—they are the types of clients who move in and out of funding programs because their needs change. One minute they might be terminal or unstable and the next they are in remission and are back on to HACC services. They move in and out and get caught up in that stream of different funding and different criteria. Maybe a flexible package of care that can cope with their changing needs might be a possible solution. That is one of the suggestions we have.

One of the other things about gaps—I heard you refer earlier to liaison nurses within the hospital—is that one of the pitfalls for us down here is the lack of discharge planning, or community admission, for a better term. They need to start looking at the language if they really want to try to engage people in that process. Discharge planning can actually become quite a cumbersome process in itself. I know that Silver Chain in the metropolitan area has liaison nurses. The feedback that we have had is that that actually works quite well within the metro area. It is something that we have seen is really lacking since the role of discharge planner from the local hospital has been removed.

Ms L.L. BAKER: When did that happen?

Ms Galantino: I think it was mid last year, 2008.

Ms L.L. BAKER: Why was that?

Ms Millar: We are looking at the discharge planning at the moment. It is on the agenda for next week's meeting.

The CHAIRMAN: I do not think that is an aged-care issue. We have spoken to some of the nurses today.

[2.50 pm]

Ms Galantino: No. It is driven more by individuals instead of being something that is actually sustainable. It is people ringing up and going, "Hi Nat. This is the client. This is their whatever. What program do you think they'd be best suited to go into?" It just needs to be a bit more of a sustainable solution for it to work really well for good outcomes for clients. We have had quite a few clients that have presented to Silver Chain and would have been perfect candidates to access something like a PEP program, but they have to be in a hospital prior to being referred for that program, and then what you can actually provide them does not actually fully meet their needs as something else would have if it had occurred initially from within the hospital.

The main goal is that there is a seamless transition for clients between different funding programs and services. As much as we almost like to think that that actually does happen on the ground, it certainly does not, probably for a multitude of reasons. There are a lot of different community providers that can provide services or different programs for clients, and they can certainly be on one, go into hospital and then they come out on to another one which might be short term, and then they come back on to us. It is just making sure that that is a seamless transition for them. One of the things I know we have talked about before—I am sure I am not the first to suggest it—is along the lines of the patient health records, so that the client is actually engaged in that process and they can take the information with them and they are engaged along the whole pathway. That would certainly be something that we would like to see progressed, along with, I suppose, things like the MMEx. I do not know if you are aware of that.

The CHAIRMAN: No.

Ms Galantino: I knew you were going to ask me, and for the life of me I cannot remember what it stands for! It is an exchange of information which is encrypted, so that you share information to prevent duplication. I can send something to Marcelle from mental health about a client. It is an electronic form of sharing confidential information about clients. The aim is, through the managed health networks down here, that that would basically link up all the providers so that you prevent that duplication, so you are not asking the same assessment questions and then I am. Why there has not been a huge uptake from a lot of people in regards to that is because, for us, we have already got electronic client information systems in place, and it does not complement what you actually already have to collect your own data and people end up duplicating. I might send something for you and then I have to download it and put it into my system as well. If they can somehow get that whole system to merge and be a bit more cohesive with what people have actually already got in place, it would be the most valuable tool for everybody to use, not just for us as organisations, but definitely for the clients not being asked the same things so many times over.

The CHAIRMAN: We have to move on to Andrew.

Ms Galantino: Can I just do one more, please?

The CHAIRMAN: One more, but anything you have missed you can give us by way of supplementary information.

Ms Galantino: I have just one more that we see as a gap. I get a lot of phone calls about younger clients who have been hospitalised for whatever case—it might have been an MVA or they have multiple fractures—and they are not eligible to access community services like HACC because they do not have an ongoing functional disability. They almost need to have a certain package of something that deals with those clients from 20 to 45—they are about the age bracket—those clients end up becoming longer term in hospital or have to go away for family to be able to look after them for a certain period of time. Unfortunately, we get quite a few calls which I have to basically say no to for accessing services.

The CHAIRMAN: Thank you. We will look into the MMEx.

Ms Galantino: Medical messaging exchange.

The CHAIRMAN: I am sure people are looking at that in terms of the privacy act and where it will fit in, but it does sound like it will be a very good system.

Ms Galantino: It is fantastic.

Ms Millar: The Department of Health and WACHS have got a contract with the MMEx system now. So you will be able to get information from either the Department of Health or the area office because it has gone across the Department of Health now.

The CHAIRMAN: Are you involved in that at all, Sue?

Ms Millar: Yes, we have been trialling it.

The CHAIRMAN: Sue, in your role for WACHS great southern, could we ask that you follow up on that for us and provide us with that information on the MMEx by way of supplementary information? Andrew, over to you. You have 10 minutes, so give us your wish list first.

Mr Markovs: Help me please, Janet, because Natalie has already thrown me. I have to make a comment on MMEx. I am aware of it as well from various corporate and business hats. It is a fantastic tool. Because I am not a government employee, and I will get back on to task in a second, I would go so far as to say—you will call me out if I am saying the wrong sort of thing already—that I was fairly intimately involved with all the players in one of the recent tragedies in our hospital. I am talking about Kieran. From my reading of it, if MMEx had been in place, that boy should not have died because if the doctor looking after him, Andrew Knight, a colleague of mine—among the other people who are basically colleagues, because I fit in the middle between these guys and the consumers—had known that that boy, Kieran Watmore, suffered from apnoea, simply by clicking on to that confidential network, I would have felt much better.

Firstly, I appreciate being here. I am very conscious of making that a strong point. As someone who comes from the NGO sector, I basically started the Men's Resource Centre myself with my own money four years ago. Ongoingly, it is still basically a one-man show. I think that, in itself, my appreciation of being here is one of my suggestions that I would like to be noted. I would love to think there are more opportunities, especially for small NGOs, to actually speak with decision makers at a local government, state government and federal government level. I do that because of my own —

The CHAIRMAN: Andrew, you know that we have a great advocate here on our panel for NGOs.

Mr Markovs: I know; exactly.

Ms Galantino: We are an NGO as well—Silver Chain.

Mr Markovs: Yes. Nat's boss is on the board, interestingly enough, of the Men's Resource Centre. One of the main reasons for our efficacy is we have people such as the regional manager of Silver Chain on our board.

I am going to try to do two things: one is to be brief and succinct and second is to wear two hats. The two hats is probably my first cue. I am not a schizophrenic, but I was diagnosed with clinical bipolar depression quite a number of years ago. Peter pressed another button very early on when he spoke about G ward and what it is like to be in there. So I am going to wear that hat for maybe four minutes and four minutes as the manager of the Men's Resource Centre. I am doing a *United States of Tara*; I am going into my consumer hat.

I, like lots of males—mostly males, I have found with my work—found myself at a critical situation where I fell into dysfunctionalism. My initial diagnosis was possibly depression; however, I very quickly went into alcohol and drug abuse and suicide ideation. The more of a high flyer you are in the corporate world, such as I was—my first degree was in architecture and I spent many years in

film and television around the world; hence the vulnerability—meant that I had even further to fall and far greater implications that you already know about, such as shame and embarrassment. My experience in Albany—I am no orphan in this; in fact, I hear this story over and over again from the consumer end—was abysmal and it still happens nowadays. To some extent that has to be pointed at the system—at the health system and at the practitioners. I work with GPs on a daily basis. I mentioned earlier one of the GPs involved in the tragic coronial inquest. I know him very well, so I am not going to single anyone out there. He is probably one of the better ones. The GPs that I work with in my own personal capacity as a consumer of mental health basically do not give a damn about mental health. I have questioned them at different times. Among the material I may have given you—otherwise, I will leave some for Tim—I run community mental health forums. I have become a bit of a lay—expert is probably a bit too egotistical—commentator on men and depression. One of the hardest things to do is to get a GP to turn up to one of these information evenings. The only way you can get a GP to turn up is if it is done through the division of general practice and they are being paid their fee. I am not naïve; I realise that GPs are in business. However, I will give some other examples. I am not here to give compliments. I do not think you want to hear that. I can give lots of compliments. I am here to maybe make constructive feedback to you that is realistic.

The Better Outcomes in Mental Health program was a wonderful initiative by the Howard government. I think it was $1.9 billion. There is so much confusion surrounding those sorts of programs in Albany that we almost need a directory equivalent to a telephone directory for practitioners, agencies, departments, consumers sometimes, and well-intentioned organisations like the Citizens Advice Bureau et cetera to navigate through this plethora of schemes, projects, pilots and services that we have in this region. That is partly because I think Albany's demographics are such that we do get a lot of pilot programs, so it is a double-edged sword. I am very, very appreciative that we get them. We were one of the first areas in Australia to get headspace, which is probably one of the most exciting mental health programs ever in the history of Australia. By the way, I work very closely with the beyondblue board and organisations such as that. Things are changing, but in Albany, as a consumer—I am still wearing my consumer's hat for one more minute—I probably went to six doctors and was fobbed off by three of them with samples from their drawer: "Why don't you take this for a month and come back?"

The CHAIRMAN: Andrew, you are not going to have much time wearing your other hat if you keep going.

Mr Markovs: And I will stop in 30 seconds on this one.

I was told by one GP in this community, "Could you just take these and come back in a month? I've got serious patients in the waiting room." As I mentioned earlier, that led to drug and alcohol abuse and that path that I deal with in my work role.

I have now put on my work hat. The Men's Resource Centre nowadays is fairly generously funded by the Western Australian health department. It almost was not in existence today and I will tell you why in a short summary, leaving maybe one minute to sum it up. When I first started it with my own money four and a half years ago, there was nothing like this in Albany to help someone who was in my situation. No GP in this community ever mentioned there was the Palmerston drug and alcohol service team. It was never mentioned once. I found it by accident after I had already had a couple of suicide attempts. Our organisation was set up by me to sort of fill this gap. The gap is that we have thousands of consumers on this side; on the other side we have thousands of health professionals across the whole range. There is no-one meeting the two up in this sort of community. My background is basically marketing and public relations type areas. What we do is actually act as the broker in between. We have now developed a reputation as probably Australia's leading men's shopfront health resource. Most of the other ones like us operate out of one little room at the back of some sort of hospital building.

The CHAIRMAN: Is there a women's resource centre in Albany?

Mr Markovs: There is a women's refuge in Albany, which we work very closely with. In fact, we were there yesterday and presented them with some presents for their birthday. I am working very closely towards the realisation of a men's refuge. With a bit of luck, in six months, courtesy of Troy Buswell, we will have one. However, an organisation like ours is, I think, one of the best recommendations I will be able to leave you with, because we sit between the two. We are eminently accessible; we are in the CBD of Albany. We took over an old shoe shop with big windows, and people see us and they know we are here. I have made the suggestions on a national front as well in terms of the best thing to do is to have a shopfront. We were, and still are, tossed between health and community services. McGinty and McHale regularly played tennis with us, unfortunately. Nowadays, we have a very good relationship with both McSweeney and Hames and we appreciate that. While I am here, just for 10 seconds, we have had fantastic ongoing support from our very effective local member, politics aside. It is very important to have that for an NGO like ours to be effective. We have to leverage off everyone we can. We leverage off our local chamber of commerce, and we leverage off our relationship with the GP division. Some of the products we develop are health checks, depression management for men booklets, and anger management for men booklets. They are used by the main GP division in Victoria throughout all their branches in Victoria. In the Western Australian Department of Health, no-one is interested. As far as I know, there is one man—I never seem to get a return email from him—who has got the slightest responsibility for men's health in the WA health department—Senkham Boutdara. His boss is Susan Leivers; she does not return emails either. There is no-one else that I know of, in my four years involved at a local level. I also sit on the board of the Men's Advisory Network, the prime group in Perth. I also sit on the national group. In WA there is nobody who is basically interested in this area. Kim Hames has taken an interest because of the runs we have got on the board. So, hopefully, from here we can keep going forward. But there is a huge, huge gap in the area where we work. Certainly, putting my consumer's hat back on for a minute, things are getting better. We are closely involved with Marcelle in the development of a local consumer action group, and, hopefully, they are going to be all around WA. Consumers of mental health here are definitely still second-class citizens. I point the finger at GPs, who often are far too busy with other things, or the actual bureaucracy of the department where wheels turn slowly and the squeaky edges might be crisis housing. For example, I think we should have a crisis paramedic team down here to cover our region. We had six suicides in Narrogin. We had four in Albany. These areas are not even touched yet.

The CHAIRMAN: I apologise that we do not have more time. You each play a very important role. Because we have cut you short, if there are things that you would like to have brought to our attention, could you please provide them by way of supplementary information? 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 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. Thank you once again for coming.

Hearing concluded at 3.05 pm