LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH

(Reference: budget 2002-2003—service delivery)

Members:

MS K TUCKER (The Chair)
MR B SMYTH
MS K MacDONALD

TRANSCRIPT OF EVIDENCE

CANBERRA

THURSDAY, 28 MARCH 2002

Secretary to the committee:
Mr D Abbott (Ph: 62050490)

By authority of the Legislative Assembly for the Australian Capital Territory

The committee met at 2.05 pm.

LYNNE PEZZULLO was called.

THE CHAIR: Thank you for coming to talk to the committee. This hearing is being broadcast. It's a public hearing. If you're not comfortable with that at any point, you could let me know if you think there are issues of confidentiality or whatever. These are legal proceedings of the Assembly and have privilege attached to them. That means there are some protections for you in what you say, but it also means that we ask you to take that situation seriously and see that there is a responsibility there for you as well. I would ask you to state your name and capacity in which you appear before we begin.

Mrs Pezzullo: I'm Lynne Pezzullo. I'm spokesperson for Abortion Grief Counselling Association, and I'm a consultant health economist.

THE CHAIR: Would you like to address the committee?

Mrs Pezzullo: The proposal we've put before you is a proposal to establish a therapeutic counselling service for women and men in the ACT and surrounding regions whose lives are adversely affected by their decision to abort. It's currently an area of unmet and growing health need in the territory.

Our submission addresses four main considerations. First and foremost is the rising incidence and prevalence of PAS throughout Australia. The sorts of clients we have on the 1300 line Australia-wide have a variety of symptoms. Some present with trivial presentations, and one or two counselling sessions over the phone is usually sufficient and adequate in those situations, although calls range between 20 and 90 minutes.

There can, on the other hand, be quite severe cases. We have a lot of clients who are suicidal, who have depression, who have developed eating disorders, sleeping disorders, substance abuse, relationship disorders, numbness, ambivalence, anger, guilt, shame, anxiety, panic attacks and so forth. The therapeutic counselling required is often longer, and face-to-face counselling is usually extremely beneficial in those cases.

There isn't a funded service dedicated to this particular need in the ACT at present. Our phone line suggests that the prevalence in the ACT is in line with published prevalence figures, which range between 10 per cent and 87 per cent, so it's quite a broad range. On the conservative side, we received, for example, 31 calls in December, which would suggest a prevalence of 200 to 300 in unmet need in the region. We would be looking to have a presence in the ACT which would address that unmet need. There is no other dedicated service publicly funded within the ACT at present.

The currently funded services are not necessarily geared to providing the targeted counselling that's required for affected women. A lot of our clients are quite reluctant to return to the termination provider and will hesitate to go there. Many might have gone to a pregnancy counselling service before making a termination decision. They will tend to go back to the counselling service as opposed to the termination provider. That isn't always the best either, because the counselling services aren't always geared to providing

post-abortion counselling. They are often pre-abortion counselling or decision-making counselling services.

The Abortion Grief Counselling Association, on the other hand, has been around for 18 years. It's a professional organisation. It has trained and dedicated professional people who in many cases have empathy with the women concerned, who often are very concerned that they are going to be judged. I think it's important that a service is provided where that judgment isn't something which is faced.

The final issue I raise is the current inadequacies in diagnosis and treatment of PAS. A lot of women will also go back to their general practitioners, and they won't necessarily receive a targeted diagnosis, because PAS is not necessarily well known within the community. AGCA would like to increase awareness and therefore be able to receive referrals from GPs within the ACT region. Part of the budget, you will note, is directed towards publicity and awareness of the condition within the ACT.

THE CHAIR: Thank you. I didn't quite follow what you were saying. The 10 to 87 per cent statistic was related to what?

Mrs Pezzullo: To the prevalence, the incidence, of PAS within the population of women who have had terminations.

THE CHAIR: Where did that figure come from?

Mrs Pezzullo: There are two figures. One of them is the 87 per cent figure, which is from the 1994 UK Parliamentary Commission of Inquiry into the Effects of Abortion on Women. The 10 per cent figure is the Zolese and Blacker reference of 1992, "The Psychological Complications of Therapeutic Abortion", listed in the *British Journal of Psychiatry*.

THE CHAIR: That was the 10 per cent?

Mrs Pezzullo: That was the 10 per cent. But both of those are addressed within the submission. They're listed on the first page of the submission.

THE CHAIR: I just want to understand what you're saying. You seem to be saying that you think it's necessary to have this particular targeted counselling service because there is empathy with the women concerned. They were your words. Are you suggesting that general counselling services available in Canberra are not able to deal with a woman who has a problem after having had an abortion; that there's a problem with empathy or lack of professional standards in the current counselling profession here? Is that what you're saying?

Mrs Pezzullo: I think that it is one of the issues. The important thing is that the women be able to receive counselling from people who have a really solid professional understanding of the clinical need. That's certainly true for AGCA counsellors. I don't know that it's necessarily the case in general counselling service provision. It's a targeted area. It's like post-traumatic stress disorder was in the mid-1970s to early 1980s, when it wasn't recognised. War vets would present with various symptoms, and it wasn't treated as a well-established condition.

MR SMYTH: Why can't Lifeline do it?

Mrs Pezzullo: A lot of the spillover is going to Lifeline and others. Our case is simply that the requirement is for very dedicated sorts of grief counselling procedures. Those involve things like moving towards acceptance, going through various stages in the grieving process, having someone who is able to come and do things with the client, in many cases having ceremonies, and a whole spectrum of services which wouldn't normally be provided through an agency like Lifeline. The other issue is that perhaps part of the role of AGCA could be to better inform other counselling services so that there is a greater understanding of the specific needs so that referral can be made to the appropriate agency.

MS MacDONALD: Can you tell me about the training of volunteers that takes place?

Mrs Pezzullo: Quite a large manual has been developed for training. It would be part of our objective, if funding was granted, to have that as a publicly accredited program of training and then to deliver training throughout Australia on the basis of the training that's currently—

MS MacDONALD: That has been developed how?

Mrs Pezzullo: The manual has been developed on the basis of American expertise in general. Philip Ney—I don't know if you're aware of him—is an expert in this area in the US. We've based a lot of the training regimes on information, manuals and things that he has produced. He has also visited Australia a few times and provided training sessions, information sessions and seminars for counsellors.

MR SMYTH: Your submission says that you're already operating on the 1300 line at full capacity. Is there any understanding of how big the problem might be?

Mrs Pezzullo: One of the things we would also like to do with public funding is to establish a firmer database. But, as I said, the data that's collected rather sporadically at the moment suggests that we're operating at the lower end of that prevalence, around 10 per cent. For the ACT we have data for just a few months, one of which is December 2001, when there were 31 calls from the region, from Canberra and surrounds.

Being a health economist who loves data, I would dearly like to get a lot better statistics. An important consideration is that at the moment we are quite unaware—and in fact the authorities are unaware—of the extent of the problem. It would be really good to collect the data, and a central organisation would be well equipped to do that.

THE CHAIR: Are a number of the phone calls coming from the same women? Are they all new calls or are they from people seeking counselling again and again.

Mrs Pezzullo: As I said, we don't have definitive data on that. Certainly some of the calls are follow-up calls, but I couldn't give you an exact proportion for each. Sometimes the reason for that is that the client doesn't necessarily want to be identified, particularly on the first call, so then they—

THE CHAIR: But you can ask, "Have you called again?" It doesn't have to be—

Mrs Pezzullo: Thirty-five per cent is an estimate of the percentage of anonymous calls. I would say that probably one-third are one-time-only callers and the rest are people who call more than once.

THE CHAIR: A number of submissions have been made to this committee about the need for counselling. You're saying a third are one-time callers but you're not sure.

Mrs Pezzullo: Yes. We would like to verify that.

THE CHAIR: You say that there's a rise in incidence of post-abortion syndrome. What evidence do you have for that?

Mrs Pezzullo: The evidence for that is that originally the supply was not stretched and now the supply is definitely stretched. It's obviously way below demand, and there's a high unmet need when we're referring to other agencies and unable to take calls.

THE CHAIR: Just so I'm understanding properly, your claim is that general counsellors in the ACT aren't able to understand the clinical need?

Mrs Pezzullo: There is a general lack of awareness and lack of ability to address the specific clinical need in this case, yes.

THE CHAIR: And you know that because that's what you say you've been told by people who call you?

Mrs Pezzullo: Certainly, the clients have said that they have, in some cases for years, been to various GPs and to various counselling services and never had a diagnosis of PAS. They've been treated for a lot of symptoms, and in many cases treated quite well, but when the root cause is not being addressed there's often not progress, and it's important to—

THE CHAIR: So do these women say to the counsellor that they've had an abortion but that's discounted? Is that what people are telling you?

Mrs Pezzullo: Sometimes they do and sometimes they don't. Certainly, when a client first sees a health practitioner, they will tend not to mention the abortion, and that makes it quite difficult to diagnose.

THE CHAIR: But clearly if they're ringing you they've got to the point where they've decided it's an issue?

Mrs Pezzullo: Yes. Once again, they don't feel judged if they mention it. They are not scared to mention it, and that's important.

THE CHAIR: I think it's quite a serious complaint about current professional standards, to be honest. I'm interested to know whether you've taken that to the Health Complaints Commissioner or followed that up. That is a serious issue of professional conduct.

Mrs Pezzullo: I suppose the way that we are following it up is to try to get specific funding. Rather than moving through a complaints procedure, it would seem more appropriate to properly fund the specific service.

MR SMYTH: I heard Lynne saying that it wasn't necessarily that the current treatment is inadequate but that it was not meeting the specific needs that need to be addressed with PAS.

Mrs Pezzullo: Exactly.

THE CHAIR: I'm sorry, the words were: "They don't have a solid professional understanding of the clinical need." I think that's about standards.

MR SMYTH: I think it's about understanding a specific condition. I think it's says in the submission that it is simply the treatment of symptoms rather than treatment of cause.

THE CHAIR: If you're talking about counsellors and psychological services and you're saying that people don't have empathy and judge, then I think that's an issue for the profession. I think it is as serious as that.

Mrs Pezzullo: I might clarify that. It may not be a problem with the profession. It's a problem in the perception of the clients. Their perception is that they may be judged. Whether or not they're going to be tends not to affect the decision they make to go to those places.

MS MacDONALD: The line operates how many hours a day?

Mrs Pezzullo: It's 24 hours.

MR SMYTH: What currently happens with the lack of face-to-face counselling? Where would you direct clients?

Mrs Pezzullo: That's a good question. In different states and territories different services are provided. In the ACT the line is directed to three or four services. I could follow that up and make sure. I wouldn't want to name one on record that was incorrect.

MR SMYTH: That would be fine.

THE CHAIR: Thank you for your submission.

Resolved:

> That, under standing order 243, the evidence received today in this public hearing be authorised for publication.

AINE LOUISE TIERNEY was called.

THE CHAIR: Welcome. Thanks for addressing the committee. Thanks for the very comprehensive submission. Before we commence, I need to inform you that this hearing is being broadcast. If at any point you don't want it broadcast, you can let me know. These are legal proceedings of the Assembly and, as such, privilege attaches to what you say, but we ask you to take that responsibility seriously as well. That protection comes with a responsibility which I know you're aware of. Could you state your name and capacity in which you appear before we start, please?

Miss Tierney: I'm Aine Tierney. I'm a committee member on the ACT Mental Health Advisory Council.

THE CHAIR: Thank you very much for coming to speak to the committee. I don't know that we've had that happen before. I think the advisory committees have been more attached to a minister. Have you given submissions to committees before? I didn't chair the health committee before.

Miss Tierney: Not that I know of.

THE CHAIR: It's great. I welcome it. Would you like to address the committee?

Miss Tierney: A lot of us on the council work in mental health areas and have identified gaps. Part of the reason for having the consultancy was to see whether other people in the sector had the same sort of feeling, and to substantiate what we'd already individually seen ourselves. It seems to have done that. It's been very good.

Miss Tierney: If people leave hospital when they're really not quite stabilised, there's a higher incidence of readmission within a short period without that kind of support. Sometimes people go home and they've got the stresses of having run up rental arrears if they're in ACT housing. That's incredibly difficult to deal with and of course impacts upon their mental health, and they end up back in hospital.

THE CHAIR: The case of the gentleman who had to go to Goulburn with dementia is coming up over and over again because it's such a sad thing for the family that they're separated. There has been a suggestion from the family that we could look at more innovative models of aged care. I imagine this fits into the group you're talking about. Do you think these sorts of innovations can apply to aged care as well, to people who have problems with dementia and so on?

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Miss Tierney: A lot of people who are trained in aged care aren't necessarily trained in mental health. It's a big area. You've got people in nursing homes who've got mental health issues, but they've also developed dementia, incontinence or Parkinson's disease. It's an area that needs to be looked at quite carefully.

THE CHAIR: Dementia wouldn't fit into the normal category of mental illness. What would you call that? Where does that fit if we've got to have boxes?

Miss Tierney: It's not a mental illness per se.

THE CHAIR: No, it isn't.

Miss Tierney: My mother has dementia. I hope it's okay for me to say that. Some of her behaviours are quite distressing and remind me of behaviours that are common in a client who's got a mental health issue. But she didn't have a mental health problem to begin with. It's a deterioration of the brain. It's a disease more than something that comes from a chemical imbalance.

THE CHAIR: Nevertheless, would you say that these sorts of innovative approaches are appropriate for whatever, wherever the box?

Miss Tierney: As long as people were adequately skilled if they're going to step in and care for that person. It is like dual diagnosis. They need to be trained in both mental health and drug and alcohol addiction issues.

THE CHAIR: There are questions of use of medication and the institutions.

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Miss Tierney: I can speak from personal experience as well as work experience. A person may find a counsellor who might do CBT, which is cognitive behavioural therapy, but may not be comfortable with that person. When you're going to speak to someone about your issues, you need to feel safe and comfortable and be able to identify with that person. If there's any kind of cultural issue, you need to move on and find another counsellor. There are not that many counsellors who are specifically able to deal with issues of personality disorder. Rape crisis counselling is a specified area. I believe that youth who go in for counselling need to be able to feel comfortable and identify with the counsellor. I would feel that it does need to be somewhat specified for the client's safety and comfort.

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MR SMYTH: Something that's topical is sexual abuse of children. For many of them, many years later it's exactly as you say—some of the other symptomatic layers of the onion skin are revealed. When the person treating you recognises the sum total of what you're saying, it may lead you in an entirely different direction. That's the horror of mental health. Some of it is so unclear.

Miss Tierney: Post-traumatic stress disorder is something that people who've been sexually abused develop. People who've been through an armed robbery or through a horrific car accident can develop PTSD. It's not just people who've been in a war zone. That's the difficult thing with that issue. You might front up and say, "I went through this situation." It's not necessarily identified straightaway that you've got a long-term chronic issue that needs to be counselled.

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THE CHAIR: Sometimes the phone isn't answered.

Miss Tierney: That's right. There were examples of the phone not being answered.

THE CHAIR: That's not good for a crisis phone line.

Miss Tierney: One of the carers groups we talked to had got through to the switchboard—I think it was the Canberra Hospital—and they'd been put on: "If this press 1. If this press 2." They had someone who was in a crisis situation. They were from a non-English-speaking background. They couldn't quite understand what the options were. In the end they had to call someone from the Schizophrenia Fellowship who could speak English and who knew about it. They came over. They then contacted the thing. There was this incredible process. The whole thing was incredibly stressed. The consumer was in a very bad way throughout that whole process. If the person hadn't been able to get on to this mate, I'm not quite sure how it would have resolved.

There are quite a number of examples of problems, particularly in relation to shortage of numbers of staff and the need to make sure that people are trained adequately in some of the ways of moving down from the crisis point. Examples were given of the crisis team coming in and using language which escalated the situation instead of reducing it. So really good training in terms of those sort of other mechanisms—

THE CHAIR: You mentioned the police and corrective services. There's meant to be a protocol. There's meant to be a kind of training and understanding. What's wrong? What's going wrong there?

Miss Tierney: I didn't get time to investigate it. That's one of the things that did come up. There was a whole range of things that indicated to me there was a need to have a better mechanism for liaising between carers, consumers and the police. The mechanism that's there at the moment doesn't seem to be fulfilling what you'd hope. I'm not sure if you've got a more up-to-date view about that.

THE CHAIR: But there's also the face-to-face contact in crises in the community, the issue of how police are handling situations.

Miss Tierney: I was at a situation where someone was having a mental health crisis. The police and the CAT team were called, and the police arrived before the CAT team. I advised them not to go into the situation until the CAT team arrived. But they ignored what I said. Then there was an assault which could have been prevented. The person who

was in the situation and who assaulted the police went through a terrible time for several months afterwards having to deal with the legal side of it, feeling unsupported and feeling the shame of having not been mentally well at the time but responding because of fear.

Certainly there is a need for a better understanding by the police not to proceed into a situation. They need an understanding and knowledge of mental illness and an understanding that somebody with schizophrenia is in the fear state or that somebody with bipolar may be aggressive but it's the illness, not necessarily that they're an aggressive person who is deliberately being—

THE CHAIR: A danger to anyone else?

Miss Tierney: Yes, that's right.

MR SMYTH: I was at a barbecue on Saturday night where there was a police officer, a mental health worker and me, the politician. We'd all dealt with the same person from different angles. Yet because of privacy legislation, and I think flaws in our current mental health legislation, all of us at various times felt excluded or disempowered in our ability to help. It wasn't until the person had crossed a certain threshold that the CAT team was called in. It wasn't until they crossed another threshold that the police might turn up. It was when their carer arrived that one contacted the politician and we were brought into it. Some of those issues do have to be addressed, because there are frustrations among the mental health workers.

I know that there's frustration among police officers, who don't want to be mental health workers but unfortunately are often the first or last port of call. They have frustrations when they take people with an obvious mental health problem to the hospital. They're assessed and let go almost immediately, because either the unit's full or they're not bad enough to be put in the unit. The police then bear the brunt, because they say, "We'll be back tomorrow night and the next night."

How desperate does it have to get? I know this is a budget consultation, but where do we take people into some sort of protective custody for their own good?

MS MacDONALD: That's been coming up in some of the other submissions as well. If it's not an acute case, where do the people go for care, not necessarily acute care, so it doesn't escalate?

Miss Tierney: Some people end up in refuges which are already. I don't think I need to go over that. Part of it is just stigmatisation. If a person is able to say, "I've got a mental illness and sometimes I become unwell," and tell various authorities so that it's on the record, they can get support that is respectful. That would break down a lot of barriers.

MR SMYTH: That would be great, wouldn't it?

Miss Tierney: Yes. It's very idealistic, though.

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THE CHAIR: Great. Thank you.

The committee adjourned at 3.13 pm.