STANDING COMMITTEE ON PUBLIC ADMINISTRATION

"LIFE MATTERS: MANAGEMENT OF SELF-HARM IN YOUNG PEOPLE"

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 31 MAY 2006

Members

Hon Barry House (Chairman)
Hon Ed Dermer (Deputy Chairman)
Hon Matthew Benson-Lidholm
Hon Vincent Catania
Hon Helen Morton

Hearing commenced at 11.19 am

SILBURN, PROFESSOR SVEN ROBERT
Chair, Ministerial Council for Suicide Prevention,
C/- Telethon Institute for Child Health Research, examined:

The CHAIRMAN: Welcome to everybody, including the witness and the people in the public gallery. There are a few formalities to go through first. On behalf of the committee, I would like to welcome you to the meeting. You have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Professor Silburn: Yes.

The CHAIRMAN: These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you refer to during the course of this hearing, for the record. Please be aware of the microphones and try to speak into them. They are not for amplification; they are for recording purposes. I remind you that your transcript will become a matter for public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised it should not be made public. I advise you that premature publication or disclosure of public evidence may constitute contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Would you like to introduce yourself and make an opening statement to the committee?

Professor Silburn: Thank you. My interest in being able to testify here really comes from a couple of roles that I have had in this area. Firstly, I chair the Ministerial Council for Suicide Prevention which reports to the Minister for Health and all other ministers on the cabinet subcommittee for social policy. Our council advises state government, maintains epidemiological registers on suicide and deliberate self-harm hospital admissions and coordinates the efforts of government and community organisations in reducing self-harm and suicide. It also has a service role in providing training for service providers and seeks to advance community and professional understanding of suicide and its prevention. The second reason that I was interested in appearing here is that I was the chief investigator on a National Health and Medical Research Council investigation of all deliberate self-harm admissions to Perth teaching hospitals in the early 1990s and that study looked at investigating whether enhanced care in the hospital and community follow-up of deliberate self-harm admissions could reduce suicide or reduce rates of re-attempt and health service utilisation. We studied some 650 young people under the age of 25, and we followed all of them through the state's epidemiological registers. That study demonstrated that more active hospital intervention, particularly pre-discharge planning and follow-up, could significantly reduce subsequent mortality and rates of deliberate self-harm and also improve the rates of mental health follow-up care in the community.

Two of the co-investigators on the study were Dr Hugh Cook and Dr Tom Hamilton, who were both members of what was then the youth suicide advisory committee, which subsequently became the Ministerial Council for Suicide Prevention. Hugh Cook and Tom Hamilton together led efforts within their respective colleges; that is, the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists. This led to those two colleges coming

together to produce this document, "Guidelines for the Management of Deliberate Self Harm in Young People," jointly authored by the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists.

Following that, we were approached by the Auditor General in 1989 or 1990. He was interested in doing a performance audit of what was happening in emergency department management of deliberate self-harm, because it provided a window into how the pointy end of mental health care and the emergency departments were interfacing with one another, and because there was a defined standard of care he was interested in looking at a performance audit. He asked if our committee would support him in developing the methodology for how that performance audit should be carried out. One of the issues was that medical practitioners were very unhappy about having their clinical practice audited, but if that could be done with the support of the colleges and the professions, they felt that that provide a more accurate understanding of what was going on. In fact, the Auditor General employed Hugh Cook and Tom Hamilton to do the clinical audits of case notes. They played a very important role in the first performance report by the Auditor General.

I was therefore very surprised when our council was not consulted at all in the second performance report. We felt that we did have a perspective and some of the data that we had about hospital management could really have been useful in that performance report. I think that was a disappointing aspect of the second performance report. I have some comments I am able to make about the second performance report, and I am able to speak in more general terms about the state's approach to suicide prevention, and to answer any particular questions that the committee may have.

The CHAIRMAN: Thanks, Professor. How would you like us to address you?

Professor Silburn: Sven.

The CHAIRMAN: Thank you. As the chairman, I will ask a series of core questions, but the other members may come in with other questions related to some aspect. I am sure they will have some other questions at the end.

The first question you have mostly answered, I think. Perhaps you could provide the committee with an overview of the Ministerial Council for Suicide Prevention - its history and functions. You did this at the beginning, but in terms of its history, how long have you been in operation?

Professor Silburn: The council has been in operation for the last three years as a council; prior to that it operated as a committee, reporting to the Minister for Health since 1989. For the first 12 years of its operation, its focus was primarily on youth suicide prevention, but more recently, as we become aware that the age group with the highest rates of suicide and the highest numbers of suicide is actually people in their late 20s and early 30s, we have broadened the mandate so that it looks at suicide prevention across all ages. That now includes prevention of suicide among the elderly, which is becoming more of an issue.

The CHAIRMAN: What is the composition of your council? Who are the members?

Professor Silburn: The current membership is listed in the document that I tabled, which is the annual report for 2004-05 of the Ministerial Council for Suicide Prevention to the Honourable Jim A. McGinty. On page 7, you will see there is currently a small board, which I chair. It includes Jane Brazier, Director General of the Department for Community Development; Professor John Finlay-Jones, who is Assistant Director at the Telethon Institute for Child Health Research; Tony Fowkes, who represented the Western Australian Association for Mental Health and Association for Relatives and Friends of the Mentally Ill; it was Dr Aaron Groves, but now Dr Peter Wynn Owen represents the Department of Health; and Mr Michael Perrott is the member who represents the National Advisory Council for Suicide Prevention. We then have a series of working groups which include representation from most government departments, which have some involvement with this area, including Police, Corrections, Education, Health and Community Development.

[11.30 am]

The CHAIRMAN: You have tabled that annual report and there is another document that you might care to explain, or will that come into questioning later?

Professor Silburn: When I attended the meeting of the committee where Keith Wilson was testifying there was some comment made about the availability of up-to-date statistics. What I provided here is really quite a general overview of what the current situation is in Australia and in WA, and what the issues are for youth. The documents indicate the importance of self-inflicted injury as a major cause of injury death but also a very expensive cause of injury morbidity; areas of the state that have most immediate needs; and Aboriginal suicide and the approach the state has taken in its approach to prevention. I have outlined two particular approaches. One is a high risk approach that looks at the very pointy end of the problem, which is addressing the immediate needs of those people who are in acute distress and who need immediate intervention. The other approach is really a much more long term approach that aims to reduce the proportion of people in the population who become at risk for suicide through mental health problems and vulnerability to stresses in their lives. That then concludes with a description of the role and history of the council. The final page just reports the current situation in terms of how the council is about to be restructured and the particular funding difficulties that we have experienced this year. It contains a very general comment about what we hope to do over the next couple of years.

The CHAIRMAN: Thank you very much. That document, I am sure, will be referred to in some of the questions that I subsequently ask. The committee's inquiry, as you would be aware, focuses on management of deliberate self-harm in young people and, more specifically, what progress has been made towards implementing the recommendations of the Auditor General's 2001 report "Life Matters - Management of Deliberate Self Harm in Young People." Do you have recent figures on the incidence of deliberate self-harm and suicide in young people? Has there been any reduction in the incidence of deliberate self-harm and/or suicide in young people in recent years?

Professor Silburn: The most complete recent figures that we have are up to the year 2003. The way in which suicide statistics are recorded is that when a death occurs it is notified to the State Coroner. A process of investigation is undertaken by the police and the state forensic service. Once the coroner has made a legal determination of the cause of death and made a ruling, that case can then be determined as suicide. Sometimes that process can take two or three years, so the latest year that we have complete figures for is 2003. Preliminary figures are sent to the Registrar General and those are the figures that are reported by the Australian Bureau of Statistics. Our figures are the gold standard but there is quite significant volatility in the official figures reported by the ABS because sometimes those are artefacts of the build-up of cases. It only takes the coroner to have long service leave due and you can get a whole lot of cases of suicide that get shifted from one year into the next, and you can get these artificial spikes in the figures; so that the figures we have for 2003 are the most accurate up-to-date figures. That shows that for young people under the age of 20 there has been a continuing decrease in rates of suicide but there continues to be an increase in the rates of young people 25 to 29, and that high rates are continuing in the 32 to 34 age group. The rates of suicide in Australia peaked in 1999 and in the chart on the first page you can see that there was a significant reduction up to 2001. The WA figures match those fairly closely, this is for all ages, and in fact there has been a further reduction for 2002 and 2003. We are actually making some progress, we believe, when you look at the big picture, but there are certain groups who are sort of standing out as being particularly needy.

Hon ED DERMER: Just to confirm with you, the figures you are referring to are the ones based on the year in which the suicide occurred as opposed to the ABS figures which are based on the year in which the coroner made a finding?

Professor Silburn: Yes, it is the year of death.

Hon MATT BENSON-LIDHOLM: On the graph that you have provided, it would appear as though there are peaks and troughs. What sort of analysis is being made of the reasons behind those peaks and troughs? I look at them and I see, obviously in terms of rates increasing, 1981, 1985, 1989 and then 1999 being significant years. Is there any analysis of that particular trend?

Professor Silburn: There have been some analyses conducted. I would caution that while there are significant numbers of suicide, as a percentage of the overall population it still remains a fairly rare event, so there is always some volatility in figures for where you have the occurrence of something that has a low base rate. However, I think there is no question that the improvement in the country's economic position has made a difference and that there is an association between unemployment and employment opportunities and suicidal behaviour. But at the same time I think the nation's efforts in suicide prevention really only kicked in around 2000 and that the reductions we have seen are actually beyond what one would have expected from what has been attributed to the benefits one would see because of improved employment opportunities.

Hon MATT BENSON-LIDHOLM: Taking on board though one of the headings you have in your briefing paper with regard to geographical variations and also the fact that you said high rates continue in the higher age group, representing part of rural WA, and given the sorts of issues that occur in terms of finance and seasonal conditions in agricultural regions, there is obviously something there as far as I am concerned. Representing these people I would like to have a look at those figures more closely for myself to see what sort of information I can deduce from that pattern.

The CHAIRMAN: Did you want to respond to that comment?

Professor Silburn: We are actually in the process of producing an updated monograph that gives the most current figures and it includes a breakdown by each of the state's health regions, so that would give you the regional profile and you will see what the regional trends have been within any particular region.

The CHAIRMAN: Just on the figures, and this is transgressing a little, it seemed that in the Auditor General's 2005 report, I am not sure whether you can call it a criticism but an observation was made that there were not recent figures on suicide made available to him. When we had officials from the Department of Health with us we put that position to those officials and they said, "Well, he didn't ask us."

Professor Silburn: No, he did not ask us either and I think that was a real surprise. It certainly seems to me that the report was very much a once over lightly report; that it could have gone into a lot more depth, I would have considered.

[11.40 am]

Hon ED DERMER: The 2005 report?

Professor Silburn: The 2005 report - in comparison to the 2001 report. A particular omission that surprised me was that the performance review did not extend to any of the country areas. It was only confined to the metropolitan area. We made very particular recommendations about country services particularly because hospitals and country services are staffed largely by general practitioners, most of whom are in private practice but operate under contract with the Department of Health. The importance of having clear hospital guidelines as departmental policy we felt was most particularly needed for country hospitals.

The CHAIRMAN: When the Auditor General was asking the Department of Health for information on this general area, would you not have expected the Department of Health to provide these figures if it had them?

Professor Silburn: Again, I am surprised that they were not asked. If they had been asked, we would have provided those figures to the Department of Health and to the Auditor General.

Hon ED DERMER: That is within the understanding, that I think you explained today, that the best available figure to date is that for 2003?

Professor Silburn: Exactly.

Hon ED DERMER: Each particular year you have that three-year lag looking backwards?

Professor Silburn: What we do have, and what there is access to, is fairly current information about deliberate self-harm admissions, through the hospital morbidity data system. For the last eight years our council has also instituted a data monitoring system in all of the teaching hospitals in Perth, specifically around the management of deliberate self-harm. We do not just want to know how many there were; we actually keep a minimum data set of the extent to which enhanced care is being practised. The Auditor General did look at that information in the first performance report. By not contacting us, we would see this as a major deficiency in that report.

Hon ED DERMER: Those reports on self-harm, the statistics are independent of the coroner?

Professor Silburn: Yes.

Hon ED DERMER: It is logical that you have more up-to-date figures on self-harm than you would on suicide?

Professor Silburn: Exactly. The Department of Health's purchasing contract with the hospitals meant hospitals had been provided with deliberate self-harm social workers to assist in the emergency department. A condition of their being provided was that they should keep information about the hospital management of these cases. We have good information from the teaching hospitals as to what is the current practice, what is the level of pre-discharge planning, and what was the level of assessment that was carried out. We have seen that as a really important tool in maintaining the adherence of good standards.

Hon HELEN MORTON: Sven, are you saying that each hospital was provided with a social worker to monitor and assist specifically deliberate self-harms?

Professor Silburn: Exactly.

Hon HELEN MORTON: Are you aware of those social workers there doing that work now? When was that?

Professor Silburn: It has been implemented since 2000. They were first funded by clinical health goals and standards money. Initially, our council provided the funds to the hospitals and they were accountable to us. Subsequently, that has been taken over by the contract management section of the Office of Mental Health, and a requirement is that hospitals must deliver these statistics each year. The hospitals have continued to do that. There is a cost associated with keeping records of these things. We had hoped that that would be streamlined by the psolis system coming on line, which will make that a much easier process.

Hon VINCENT CATANIA: Is that hospitals across regional Western Australia as well?

Professor Silburn: No, just the metropolitan area. It is certainly something we would like to see implemented in all the regional hospitals, as a quality assurance tool.

Hon ED DERMER: One of the difficulties, of course, is there are always various tangential questions that arise from what you are saying. One of the areas I particularly want to focus on is progress since the first Auditor General's report on the implementation of the recommendations. I think the Chairman had that in his questions, but I wonder if you could provide us with a little bit more on what progress you believe has occurred?

Professor Silburn: In terms of making sure that the department knew that these guidelines were to be implemented as a matter of departmental policy, the then director general Mike Daube went on record publicly and said that this was departmental policy, and through the departmental notification processes all hospitals were on notice that they should be implementing this as

departmental practice. The Office of Mental Health set up a working group to look at the implementation of the Auditor General's recommendations. I must say that that group really has made very slow progress, I think because of some of the pressures experienced in the Office of Mental Health; many meetings were cancelled and it was not pursued as the matter of priority that it deserved. However, placing psychiatrically trained nursing staff in the emergency departments has been a very good initiative. From everything I have heard about that clinically and from what I have observed first-hand, I think that has made a very significant difference to the speed with which cases are processed. The triage process has improved. I think the Auditor General felt that more could be done, but that has been a very significant step forward. The extent to which that is happening around the state is variable and it is really dependent on the availability of suitably trained staff to perform that role.

The recommendation about hospitals developing protocols with the local service providers has again been implemented with variable success. There are some areas where that is working quite well. Fremantle is a good example, where there are good linkages developed with primary health care services, and the GP group has taken a more active role as a first-line mental health service provider and point of referral to more specialised services. I think that has been a very good initiative. We certainly would like to see more of that happening. Something that has not been done as actively as it should have been is for hospitals and community mental health services to develop local protocols about what the expectations are regarding timely referral and the case management processes. That can be driven at the local level, and it really requires a stronger imperative from the Office of Mental Health to make that happen. That can only be driven within the Department of Health. It does require linkage with other community agencies and other community services. That is something that we would like to see the regional directors pursuing much more actively.

Hon ED DERMER: Is that an area restricted by a lack of availability of suitable personnel?

Professor Silburn: I think that certainly has been an issue and there is no question that the emergency departments and the mental health system have been under extreme stress because of funding constraints. You have two systems that are under strain; where they overlap you really do get the greatest likelihood of breakdown in the level of care.

The CHAIRMAN: You have covered a couple of the questions I have here. The Auditor General raised specific concerns about integration of hospital and community-based services. The phrases he used were "continuum of care" and "preventing patients from falling through the gaps". What else needs to be done, in your view, to improve that area?

[11.50 am]

Professor Silburn: There have been continuing problems with, for example, child and adolescent mental health services and adult community mental health services in allocating priority appointments to people being discharged from hospital or to people who are acutely suicidal. These services are very busy and they have long waiting lists, but when people need acute care there needs to be a greater capacity to deal with these emergency cases. There is a point when you can catch people in the period of crisis where you really can make a major difference in the ongoing course of care, and if you miss that opportunity, two things happen; one is that there is a much greater risk for deaths or further self-harm, and the opportunity to engage people properly in treatment that is going to lead to a long-term stabilisation and recovery is lost. Improving that capacity for that emergency response and immediate post-discharge response should be a much higher priority for child and adolescent mental health services and adult mental health services.

The CHAIRMAN: Do you feel there has been an improvement in that quality of care at that point?

Professor Silburn: I think again it has been variable. Certainly, if we were to compare it to how things were 10 years ago, I would say it has vastly improved, but I do think there is a long way to

go. There is a lot more that could be improved and it does require further resources, but it also requires more assertive leadership with those priorities.

Hon ED DERMER: You referred to 10 years. If you look at the date of the first Auditor General's report for the period in which that was being compiled, has there been an improvement since then?

Professor Silburn: I think there was an initial improvement for the first couple of years and what we are seeing is that things are stalling, and it really is through services being overstretched. Something that has been brought to our attention as a council as we do a lot of work around the state, training professions, agencies, school psychologists, prison officers and so on in the need for early identification and referral and the sorts of problems that need referring, is that often it is very difficult to get the appointments when you need them. We have had representation from the university counselling services that they are dealing with much more severe cases now than they ever did previously and that they are constantly frustrated at the difficulty they have in getting prompt referrals for cases that they consider to be real priorities. It really is an issue of service capacity.

Hon ED DERMER: Is this a matter of an increasing demand as much as a restriction on supply?

Professor Silburn: It is both and I think that there needs to be increased demand. One of the effects of the hospital intervention study was to increase mental health care utilisation, and that is a good thing. Those people were much less likely to die and they were much less likely to be readmitted for further self-harm.

Hon ED DERMER: So it is difficult to asses whether the total number of people needing care is increasing or whether a larger proportion of those who do need care are actually seeking assistance?

Professor Silburn: It is not an either/or situation. There is actually evidence that the rates of mental health problems in the community are increasing and we have that from a number of sources. Rates of depression based on longitudinal studies has occurred in all developed countries around the world basically since the 1950s. We have seen steady increases in rates of serious mental health problems, particularly in teenagers, and those serious problems are occurring at earlier ages. That is a true increase, an almost fivefold increase in the rates of depression.

Hon VINCENT CATANIA: Is that due to the increase in awareness of mental health - the programs that were put in place by the Auditor General's report?

Professor Silburn: It is more than that. It is related to the fact that a lot of young people in their formative years are being exposed to a greater number of significant stressors at the time their brain is developing. The highest rates of mental health problems are occurring in developing countries, and particularly countries that have experienced social chaos. The fallout we will see from places like Timor is just astronomical. Developed countries are experiencing this because of all the changes in modern living, stresses, technology, and family life. All of that is a major issue. There are hypothesised reasons for this including quite systematic changes in the diet of whole populations with the industrialisation of food production and systematic elimination of particular nutrients that are important for the developing brain and good mental health. I think we can assume with a lot of confidence that the increased rates of problems are a true increase. There is also increased awareness and we would see that that is a good thing because these are problems which if caught early are much more amenable to assistance and recovery if they are dealt with early rather than letting them fester and become much more entrenched and difficult to deal with.

Hon ED DERMER: Have you had an opportunity to study the Senate select committee that reported in April of this year on mental health?

Professor Silburn: It is an enormous document and I must admit that I have scanned it and read the bits that particularly interested me.

Hon ED DERMER: We do have the advantage of very diligent staff providing us with very helpful summaries or something similar. One of the things that struck me was the incidence of what they referred to as a dual diagnosis linking mental concerns or psychiatric disorders with substance abuse. I would be interested in your thoughts, and it may be an intuitive thought, on particularly the end of the question - is it a matter of people who have psychiatric weaknesses being inclined to substance abuse or is it a matter of substance abuse aggravating or initiating psychiatric problems, or could it be an element of both?

Professor Silburn: We have the opportunity of looking at that systematically. The Alcohol and Drug Authority commissions us to do some research into the drug and alcohol use patterns of all youth who commit suicide in WA, and we have access to blood toxicology results and information from the coroner's files as to the drug use history of people who had committed suicide. We also look at the other data that is around on drug use in school-age people and the national surveys of drug and alcohol use. There is no question that some of the increases that we have seen in suicidal behaviour in young people is directly attributable to the increased proportion of young people who are using alcohol particularly, but also cannabis, and that the more recent strains of cannabis are much more potent than the cannabis that was around 15 to 20 years ago. The toxic levels of cannabis in people who had committed suicide surprised us. We could see a clear relationship in the proportion of suicides of young people involving cannabis where cannabis was detected in significant levels. In fact, it was much steeper than the increase in the rates of use. So the periods when rates of youth suicide increased were paralleled by very sudden increases in cannabis use, and there are two issues with that. One is that prolonged cannabis use certainly triggers depressive disorders and schizophrenia in young people, or exacerbates them when they have that predisposition. However, the other thing that our data showed is that acute intoxication is really the major problem and that a lot of the impulsive suicides that come out of the blue, as it were - in fact, the greater majority of those - were associated with very acute intoxication. It did not matter which substance it was, acute intoxication diminishes judgment and increases impulsivity. If you put those two together you are much more likely to have an impulsive suicide which, if the method is lethal, will be lethal.

Hon VINCENT CATANIA: So are you seeing an increase in young people trying out these forms of illegal drugs and an increase in suicide because of that?

Professor Silburn: It depends a bit on the drug. The cannabis story is that cannabis now is as frequently used or tried by teenagers as is tobacco. The problem arises when there is very regular use. If people are using regularly - that is, more than once a week - their risks for mental health problems and suicide just go up. If they are using just occasionally, like every few weeks or once a month, we do not see any of those increased risks.

Hon HELEN MORTON: Getting back to some of your comments about discharge planning, I was really interested in the comments about the funding constraints. I have been in Parliament when the minister has made it clear that this year's mental health recurrent budget was underspent by $14 million. It would seem that in terms of a recurrent situation there was money that was underspent by a considerable amount across the board in both community-based services as well as inpatient services. It is really hard to know if that is the case - and it is the case, because the minister actually made that clear statement in estimates hearings - where the problem is because it would appear to me that that funding constraint is not there. Why is it that we cannot get decent discharge planning? I know from people who have made contact with me that there is sometimes a four to five-week waiting time for them to be seen by a community-based organisation that is going to be providing their ongoing support in the community. What is it that is stopping those things from happening in that window of opportunity if that is such a significant factor in terms of managing that person's problems more effectively?
[12.03 pm]

Professor Silburn: It is very distressing to hear that there was unspent money in the mental health budget. Our council has experienced a major reduction in capacity because some of the money that we have had in the past from corporate sponsorship and national funding has stopped this year, so we have actually reduced capacity. We have made representation to the state government for over 18 months now, anticipating that this would occur, and, despite promises being made, those have not been delivered on. That has caused us to lose some very good expertise in our council. We have not been able to retain very experienced people who have been running some of our training programs, and it has really reduced our capacity to respond to emergency situations that can arise. To address your question about why pre-discharge planning and community follow-up has not developed as much as it should, I think it really must boil down to failures in administration in not making sure that those priorities are properly represented in the budget planning processes. Two things are needed to improve that: one is that there does need to be continued pressure and advocacy to identify when gaps in services arise, as this can lead to very tragic situations that have enormous consequences for the family and the community generally; and that there are standards of practice which should be maintained and monitored. If this was in another area of medicine, say surgery, and the proper standards were not being adhered to, the health system would put itself in a very vulnerable position for litigation. It is only a matter of time before that happens.

Hon HELEN MORTON: I am very interested in the capacity for non-clinical people to assist in providing support in some form or another for people when they are discharged from hospital. The example I can give is something like a health and ageing care-type service where they are not untrained in that they have certificate III or certificate IV training of some sort or another. But there seems to be a desire to require people to have specific mental health training to provide any form of community-based support for people once they are discharged from hospital. My understanding is that quite frequently families just want someone to be there with them for a couple of hours a day, or to take them shopping, or to do some of those things in the home etc. I know there are some services like that, but I just want to know whether you feel that if that side of it were increased significantly it would make a difference to capturing those people in that window of opportunity, straight after discharge?

Professor Silburn: Yes. I think there is good reason to believe that that would be helpful. In 1990, we did a trial of something similar. The Samaritans provided a person who had some level of training that particularly could assist - this was to try to deal with the problem of unattached youth, young people who might have no capacity - to drop in on them and physically get them to their appointments. The reason that people were not taking up follow-up care is that they had no means of getting to their appointment, or it was all too difficult. They could call around and say, "How are you going? You've got an appointment coming up tomorrow, do you want a lift?" Things as simple as that we found could work. It was very difficult to sustain because the hospital services were very reluctant to deal with someone from a community agency coming in to the emergency department. I think if it were set up where there was confidence in the level of training and there was some sort of accountability process, then that could work. That is certainly something our council would like to investigate further.

The CHAIRMAN: These are very interesting and wide-ranging issues. I would like to get through some of the core questions relating specifically to issues raised by the Auditor General, and then I am sure members will have things to add to that. Do you have a comment on the Auditor General's finding that access to appropriately qualified staff to deal with deliberate self-harm patients was particularly problematic in regional areas?

Professor Silburn: A lot is being done to try to improve the availability of mental health practitioners in country areas. I think the other states are doing much better on this front than WA. In New South Wales and Queensland, I know that clinical psychologists, social workers and psychiatric nurses are taking on that role. In terms of the kinds of risk assessments that need to be made on admission, prior to discharge and on follow-up, those practitioners can conduct equally

valid and helpful mental health states examination and risk assessments. I think it is a matter of training, and it is a matter of multidisciplinary team procedures. I think that the new generation of psychiatrists are much more open to working in those sorts of teams, and looking at their special role as psychiatrists being used in a much more focused way for the areas which are their very particular areas of expertise, particularly medication and more complicated mental health assessments.

Hon VINCENT CATANIA: Regional Western Australia has a problem attracting people from the general professions and there is a lack of professionals in those areas. Mental health is no orphan. The resource sector suffers the same sort of lack of skilled workers. Do you see that as being quite similar - finding people to go to regional WA?

Professor Silburn: I think that is an issue. It is interesting that other countries have addressed that problem in other ways. The United States and countries like South Africa have looked at training clinic psychologists for some of those roles, with an additional year of training, particularly in psychopharmacology, and that is one of the means by which they have solved that problem. That is something I think will inevitably happen in Australia. It is just a matter of time.

Hon MATT BENSON-LIDHOLM: You mentioned New South Wales and Queensland - I cannot quite quote you, but I think you said that they are doing better than we are here in Western Australia. Queensland is an interesting case in question, because of the demographics of the place and the distribution of population. What sorts of things are they doing in their more regional, rural and remote areas that we are not doing here? How are they addressing those sorts of issues? Particularly, Queensland does have a significant Aboriginal population, and there is probably a fair amount of leakage into Queensland from places like Alice Springs. What are they doing?

Professor Silburn: Queensland has in the last few years developed a state plan for suicide prevention. They have allocated something like $2.5 million for that purpose to do an equivalent thing to what our council does, but they particularly put money into regional areas to get mental health teams that may not be headed by a psychiatrist but may be headed by other professionals who have mental health training, and link them up with networks. But again, the demography of regional Queensland is very different to WA. You have bigger concentrations of population. WA, I think, is much more challenged by the very remote spread.

Hon MATT BENSON-LIDHOLM: Going along those lines and looking at Aboriginal rates that are mentioned in some of the materials that we have here, and given those sorts of figures, we really do need a specific unit focus on Aboriginal suicide rates, because the figures that Hon Ed Dermer and I were looking at last night in the house were woeful. Is there a specific unit which is, or could be, involved in this sort of thing?

Professor Silburn: Our council was involved with setting up a working party that looked at a state response to Aboriginal suicide prevention. That included a lot of initiatives being made. Some of the money that came from the link-up service from the "Bringing Them Home" report and the "Bringing Them Home" counsellors was earmarked specifically, and many of those counsellors were trained by us in suicide prevention. There were a whole range of initiatives across different government departments that were directed to what each department could do to reduce suicide. There does need to be some regional capacity. We are in the process of re-establishing that committee. The problem in Aboriginal communities is that there is a very high likelihood of clustering where there are social contagion factors. A death in a very small community can have huge ripple effects, and in some of the clusters that we have seen in the East Kimberley - previously around Bidyadanga, Broome and the Dampier Peninsula - were some very big spikes, which had settled down. There was an immediate need to get north-west mental health working in much better collaboration with the Aboriginal medical services. Traditionally, they have not collaborated well, and it literally took community leaders to drag in the Aboriginal medical service people, by saying, "We cannot let our children continue dying." There has been, I would say, a very big improvement

in that collaboration in the West Kimberley, but the issue in the East Kimberley, around Kununurra and down around Halls Creek, does require a much more focused effort and those communities desperately need to be supported. We used to have an Aboriginal staff member. We no longer have that because the commonwealth money for that staff member stopped. We had set up the possibility of training a new member at the request of people in Halls Creek and we had negotiated with all the Aboriginal senior elders, particularly with the men in that area. That was all set to go but we were not able to proceed because the funding ran out and we did not have the financial capacity to send anyone. It had to be addressed in other ways.

[12.16 pm]

Hon VINCENT CATANIA: Since there is a large population of people who are working in the resource sector and a lot of people who are flying in, flying out, working longer hours and being away from their partners and families, do you see the resource sector assisting in mental health as much as they could do considering the high suicide rates that exist in the resource sector and mental problems that result from that?

Professor Silburn: Our council was very fortunate in getting a good partnership with those at Woodside Energy. They provided around $400 000 to the council over a five-year period and their interest in doing that was because of their awareness of the situation. We are currently trying to get grant funding through the Australian Research Council and are seeking other mechanisms to collaborate with the resource sector and with unions on what we can do in apprenticeship training and in the industry itself to address some of the stress issues and the support needs. It is particularly important for the young men on their own in very isolated places and where there are the risks of heavy drinking and so on, to give them some life skills to cope with that and to have the mental health literacy to know when they are getting into trouble or one of their colleagues is getting into trouble, and to have avenues to address that before it becomes a major issue. That is an area that we would really like to progress.

Hon ED DERMER: I wanted to get your view on the possible solutions to the problem of finding appropriate personnel for the service delivery. When you refer to Queensland and New South Wales enjoying more success I wonder if one of the reasons for that is that their populations are more decentralised, and whether the prospect of finding the very rare person who has the vocation to be, say, a psychiatric nurse and getting them out of Sydney or Brisbane might be easier than attracting such a rare and vital staff resource out of Perth. Do you have any suggestions you might be able to make in terms of finding a greater total number of appropriate staff and also encouraging them to go into areas where they are most needed? Is the absence of staff the real bottleneck on the service delivery that we would like to achieve?

Professor Silburn: One of the solutions is likely to come through the university training sector and something I would really urge the government to consider is the possibility of scholarship schemes or bonding arrangements. The increased cost of university study with HECS is enormous. You could provide real incentives to people to work in service areas like remote country practice, rural and remote medicine, Aboriginal health and mental health in these areas. Scholarship schemes like that would pay dividends. The training opportunities that exist in these areas are enormous. You are never going to get the depth of experience that you are likely to get as a practitioner in Port Hedland or Derby, just because you have to deal with everything. I think the universities could play a much more active role in supporting that happening and creating a culture where this is the best experience they are likely to get.

The CHAIRMAN: Because our inquiry focuses on the Auditor General's report, I will focus on a couple of specific matters that the Auditor General raised and then we can branch into general questions. The Auditor General observed that although most hospitals have the services of an Aboriginal liaison officer, these officers are not specifically trained to deal with deliberate self-harm patients. Do you have a comment on that?

Professor Silburn: Yes. That is something that could very easily be addressed. Our education and training programs have trained psychiatrists, accident and emergency nurses - all sorts of professions. We have a gatekeeper training for professionals and we have adapted that gatekeeper training for Aboriginal people. That is something we could do almost immediately with funding. We could run training and advanced skills programs for those Aboriginal liaison officers. The other issue with Aboriginal liaison officers is that they have to do everything and in some of the hospitals like Princess Margaret Hospital for Children they are having to do so many things. At Royal Perth Hospital very often the Aboriginal liaison service is just simply not used because the people are too busy or they cannot find them or they are busy working on something else. There really does need to be a proper examination of what is an appropriate Aboriginal liaison service presence in relation to the population need for that hospital.

The CHAIRMAN: A key focus of the mental health strategy 2004-2007 is recruitment of mental health nurses and psychiatric registrars in emergency departments. The Auditor General raised some concerns about this approach, given the chronic shortages in the mental health nursing work force as well as difficulties with recruitment and retention. Are there alternative models of care that should be explored with health professionals? I think this semi-relates to Hon Helen Morton's earlier question.

Professor Silburn: Yes. I think the range of mental health professions that could be suitable for that situation needs to be broadened, particularly to include clinical psychologists. However, I do think that Hon Helen Morton's suggestion about using other community members and training them to provide that support role as the home and community care model is definitely worth pursuing.

Hon ED DERMER: You mentioned accountability in that context earlier. Can you tell us a little more about that?

Professor Silburn: If you are having a service like that, the clinicians in the hospital need to be confident that when they call on that service a person can be found, that they can rely on the service, that they can have some confidence in the knowledge and skills of that person and that there are clear communication lines; that the person is not going to get out of their depth and will know when to consult and ask for help when they need it. Those are processes that you can work through. They certainly have to operate in a lot of regional areas where, because there is nobody else around, community members just step into the gap.

Hon HELEN MORTON: In the performance indicators around the community and mental health services there was a performance indicator target of 65 or 75 per cent of people who had to be seen within the first two weeks of discharge. That seems like that was a long time out of discharge. I can understand why you do not have a target of 100 per cent, because some people do not even live in the area that they are seen in, etc. However, the target is that 74 per cent should be seen within 14 days of discharge and 60 per cent seen within seven days by a community-based public mental health service. That seems like a low target to me. Also, a fortnight out was too far out for my liking.

Professor Silburn: I would agree. When we did our intervention study we managed to get 85 per cent of people seen within 48 hours and that is just because we mobilised people to say that this is what has to happen, and we had people in the hospital driving it to make sure it did happen. It can be achieved but I think that unless you actively monitor these things, the programs drift, and with the high turnover of staff, the corporate knowledge of what is the correct standard of practice tends to disappear; so this is the reason that you really do need to have clearly spelt-out protocols. Something the Office of Mental Health is working on is a very brief two-page checklist of the actions that need to happen. I am not 100 per cent sure of where that is up to but I could check with Peter O'Hara to see if he knows. That was something that was seen as being a very simple tool that would enable some of those things to be followed through.

Hon ED DERMER: Are there trained people available to make that possible?

[12.25 pm]

Professor Silburn: The trained people are available in community mental health clinics, providing they have a system that can prioritise who needs to be seen. They have a huge caseload of people who are coming in for regular maintenance appointments, prescription renewals and things like that. They have to get through that. At the moment, they usually allocate one day for urgent new cases. I would argue that to deal with this end of the problem, that capacity must be expanded. People are there, it is just a matter of how the community clinics are allocating their priorities.

Hon MATT BENSON-LIDHOLM: On the issue of recruitment and retention that The Chairman started the discussion with, and perhaps even following on from what Hon Vincent Catania has said, with respect to skills and expertise shortages in other employment areas, are wages and salaries the issue? Are we attracting people from overseas? Do we have a recruitment plan in place there? I do not mean poaching people from New South Wales and Queensland, but certainly, in terms of the building trade and things like that, everyone realises that New South Wales is slowing down. The problem is that if they come over here, they need to bring their tent because there are no houses. What are we doing with respect to recruitment and retention? Are wages and conditions appropriate? That is a very political and pointed question, I know, but I think we need to look at all scenarios.

Professor Silburn: The public sector psychiatry has great difficulty in competing with the rewards that are available to psychiatrists in private practice. That is a continuing problem. That is a matter of supply and demand. I do think that all of those psychiatrists in private practice have received their training in the public system and I think that the public sector should make a much greater demand on the professions, particularly in their training years, in seeing that there is some mechanism to get those skills, particularly earlier in people's careers.

Hon MATT BENSON-LIDHOLM: The point about bursaries and scholarships is an excellent one, because certainly if you go back, dare I say, to the dark past when certain members here were bonded to the education department, it certainly kept us in the system for a few years. The problem was that after that some of them found this place and others turned to the private system and all sorts of other things. I think that is an excellent point that you make about scholarships and the like. I think that has a lot of potential.

Hon ED DERMER: I was asking about the coincidence, if you like, or the issue of the drug use, substance abuse, and increasing demand, and it leads me to wonder to what extent is the gap in service delivery a product of limited resources? Is it more a case of the increase in demand being such that with appropriate will, policy and resources the system is failing to keep up with increase in demand?

Professor Silburn: There is no question that both of those reasons are true. I do think that it highlights the need to broaden the traditional ways of doing things. I think that there is increased importance in general practitioners as the usual first point of contact for people who are in difficulty. We recently did a study with men, trying to understand why they are so reluctant to access mental health services. We did a study of a few hundred men who had actually been suicidal, half of whom had sought professional help and others who had got through on their own. What was very interesting is that of those who had sought help, almost all had gone to a GP for their first point of contact, but they were bitterly disappointed with how they were dealt with. They had a very short period of time that they were seen and they were ushered out the door and pointed to connect with some other service. Increasing the capacity of GPs would provide a better level of care to those people. They can do that by scheduling longer appointments and they are reimbursed by Medicare for longer consultations, but the general public does not know that. Men had very particular views about the service they got from their health services and views about how that would make them much more accessible and amenable to men using those services. There are things that services could do to make them more attractive and usable at earlier stages of problem

formation, rather than at the more difficult stage. There is no one single solution. It is going to require whole-system change, because the problem is not going to go away. It is likely to increase.

The CHAIRMAN: That could be an issue even in our electorate in the south west. The coastal towns, by and large, are serviced well by GPs, but other towns are not serviced very well at all. For instance, Manjimup has two GPs. There is obviously a severe physical time restriction there for them to deal with issues like this.

Professor Silburn: Before I forget, I think there is another potential solution. The mining industry has demonstrated that you can have fly in, fly out services. There is no reason you could not have mental health services provided, not only just on the fly in, fly out basis. I have done fly in, fly out clinics in the Pilbara and Geraldton. It is one thing to go there for a day, see a whole lot of cases and then come back home to do all your follow up by telephone; it is quite another matter to go up, be in a hospital for 10 days and then come back in the same sort of way that the mining sector does. I think that is something that could be very attractive, particularly for single people.

[12.34 pm]

Hon VINCENT CATANIA: Fly in, fly out is one of the contributors to mental health, so it is a bit of a catch 22.

Hon ED DERMER: So you are visualising them seeking each other's assistance?

The CHAIRMAN: Are there any other general questions? Mr Silburn, we have covered a lot of ground. Would you like to say anything in conclusion by way of summary or rounding up?

Professor Silburn: No. I think this is a very useful focus for public administration. I think it is one of the pointy ends of the health system and throws a lot of the problems into high relief and demonstrates where some of the solutions need to be found.

The CHAIRMAN: In direct reference to our terms of inquiry - that is, the Auditor General's comment - do you have a summary comment in terms of the Auditor General's treatment of this issue?

Professor Silburn: Again, I was disappointed with the level of investigation and the fact that that did not include country areas. It would be my hope that the Auditor General revisit this area again in the future and that there is a fuller investigation throughout the state.

The CHAIRMAN: Thank you very much for your time. Your comments have been very useful.

Hearing concluded at 12.35 pm