STANDING COMMITTEE ON PUBLIC ADMINISTRATION

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

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 3 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 11.31 am

WILSON, MR KEITH
Former Chair, Mental Health Council of Australia, examined:

The CHAIRMAN: On behalf of the committee I welcome the public and media in attendance, and in particular Mr Wilson. Mr Wilson, you will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Mr Wilson: 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, and please be aware of the microphones and try to talk into them. They are for receiving information rather than amplification. I remind you that your transcript will become a matter for the 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 a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Briefly, this issue arose as a result of an Auditor General's report originally produced in 2001 and followed up by a subsequent report in 2005. As part of the committee's terms of reference we have a constant dialogue with parliamentary officers, such as the Auditor General. We are pursuing a couple of matters on mental health that he has raised in those two reports. I invite you to make an opening statement.

Mr Wilson: I thought I would begin by indicating that my approach to the Auditor General's report has been one in a total context that takes into account the developing information that is available to us on the incidence of suicide, particularly in the age group that is encompassed in the Auditor General's report, although I am not sure that young people are defined. These days we talk about the age group between 14 and 25 years as young people in terms of mental health considerations. That cuts across the normal divisions within mental health services and other government department definitions, because normally the strata of consideration are infant mental health, child and adolescent mental health and then adult mental health. The feeling these days is that that does not take into full account the crucially significant years of 14 to 25 as an area in which there is the greatest incidence of first episode of severe mental illness. It is said that 75 per cent of people have their first episode of mental illness between the ages of 14 and 25, so it is a crucially significant part of a person's life for those general factors. I am starting by talking about the mental health context, because of the obvious connections between mental health conditions, particularly depression and suicide attempts or suicide being accomplished. I do not have available to me useful figures available on the current rates, because, as others will probably tell you, these statistics are always years behind. The published figures that are usually made available to people on youth suicide take us up to 1997. I understand from a very recent conversation that new figures will be available soon, but they will not bring us up to date, in the sense that we normally understand that.

Certainly, suicidal behaviours are a serious problem for Australia. We know in the broad term that each year between 2 300 hundred and 2 500 people take their lives; that a further unknown number, probably no fewer than 100 000 it is estimated, attempt suicide; and that for each person who

engages in suicidal behaviour, a further four or six will be associated with them in some way. These make a conservative total of about half a million Australians who are affected each year by suicide. From that point of view, this is obviously an extremely crucial area of concern.

[11.40 am]

The Australian Institute of Criminology has estimated that it costs Australia more than $100 million per annum. That is a significant economic impact. We often forget the economic and social impacts of these conditions. That is a very significant economic impact. I have already referred to the widespread social impacts on families and friends whose family members have survived a suicide attempt. Therefore, I place my comments on the Auditor General's report in that context and also in the context of the situation that faces us regarding the treatment of young people who present with cases of attempted self-harm in emergency departments. That is the specific area of concern for this committee. I will do that as I proceed with my more detailed comments.

The CHAIRMAN: Thank you for that. You may have covered some of this question. In the recently released report of the Mental Health Council of Australia "Not for Service", which points to systemic problems with mental health care in Australia, voicing the concerns of those who have recently sought primary or specialist mental health care, perhaps you could provide the committee with an overview of the report's findings and, in particular, explain how well mental health services in Western Australia meet the needs of patients and their families?

Mr Wilson: I have a vested interest in this report. The report deals with that and other issues by attempting to analyse the submissions received from the public about mental health services in Australia state by state, and in Western Australia in particular. This report makes its findings also on the data obtained at the public forums that were held in Western Australia in Bunbury, Perth and Geraldton. As I said, the report did that by analysing these submissions and the information provided at the forums against the national standards for mental health services. The national standards for mental health services are part of the National Mental Health Strategy, which has been agreed to by all Australian Governments. Those standards are many and cover a huge range of areas. The title of the report is "Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia". It is an unusual report because it puts together a view about the state of mental health services in Australia, including Western Australia, from the point of view of people who have received those services and from the families who are caring for people who have received those services, as well as from the health professionals and NGOs at the ground level who deliver those services. It is not the usual sort of report. It is not based on government department findings; it is from the community's point of view. In part 6 of the report on pages 663 to 668 is section 6.5.11.5, which is headed "planning for exit". That is a rather ambiguous term, unfortunately, but it is largely concerned with discharge of patients from acute care; that is, it deals with the discharge of patients, discharge planning and the links between emergency departments and community based services. It refers also to patients being discharged without the involvement of family carers prior to the patient's exit; the lack of follow-up; and the lack of individual care plans being appropriately reviewed. It instances some stories that were told by people who made these public submissions. Much of the material contained in the report is pertinent to the Auditor General's report and recommendations. Unfortunately, in the main, patients who have self-harmed or attempted suicide remain, to put it kindly, inadequately attended to.

The CHAIRMAN: I will ask from the chair and then other members may focus on some specific points. Given the shortage of mental health care, and indeed health professionals in general, are there alternative models of care that might better cater for deliberate self-harm and other mental health patients in an emergency setting? For example, the "Mental Health Strategy 2004-07" relies largely on the recruitment of mental health nurses and psychiatric registrars. Are there other health professionals who might be equally suitable to fill these rolls?

Mr Wilson: From the point of view of the analysis of the information that the Mental Health Council received, there is no doubt that there is a great deal of feeling and concern in the community sector that the treatment across the system, and particularly in an emergency situation such as this, must be multidisciplinary. Therefore, the emphasis on medical personnel such as mental health nurses and psychiatric registrars, does not do justice to the needs of those people who present with these conditions. There is a much greater need for the recruitment and involvement of social workers, psychologists and occupational therapists. The whole range of mental health professional expertise is required. These types of professionals are often more attuned to working in the community, to working in prevention services and to working with families in conjunction with carers of people who present with these types of problems. In a sense, an overmedicalised approach is taken both to mental health and the provision of services for those who present with evidence of self-harm. The point of concentrating on the services available in emergency departments is obviously a symptom of failings in others parts of the service, and particularly in the provision of community centred forms of rehabilitation and accommodation assistance.

The CHAIRMAN: Focussing on the quality of the service from a consumer perspective, has there been any tangible improvement in the quality of services received by deliberate self-harm patients in the four and a half years since the Auditor General first released his findings and recommendations?

Mr Wilson: I have read through the Auditor General's report. It is interesting to compare it with the Victorian Auditor General's report, which has followed a similar course, although that is a more general report. The Victorian Auditor General also reported in 2001, and has recently released a follow-up report. He has found that little has changed, even in Victoria, which probably has in some respects the best mental health services in Australia.

[11.50 am]

However, I think I would say that the recommendations out of the AG's report on the management of youth self harm in EDs have not been universally adopted and neither have, for instance, the Australasian College for Emergency Medicine and the Royal Australian and New Zealand College of Psychiatrists joint guidelines for management of deliberate self harm in young people been adopted as a mandatory requirement. There are few risk assessment standards in place and clinicians seem to resist the suggestion that they should comply with minimum assessment standards on the basis that it is their professional judgment and it is a matter between them and their patient, rather than complying with those sorts of mandatory standards. There is a risk assessment form that was issued last year through the Department of Health, but I am not at all certain what happened with this. I do know, however, that some action has been taken by the department through the Office of Mental Health in terms of clinical risk assessment and management. I happen to be a member of a working group, so-called, which is currently a project under what is called initiative five of the work force and strategy initiatives of the mental health strategy 04-07 aimed at supporting implementation of the national practice standards in clinical risk assessment and management. The work of this project is also supported by the national safety priorities for mental health 2005 and clinical risk management guidelines for the Western Australian health system under the Office of Safety and Quality in Health Care 2005. That is progressing. It is trying to work collaboratively with staff in public mental health services. I am not sure that they are working with staff in emergency departments for some sort of general acceptance of an across-service standard for clinical risk assessment and management. However, I would have to say that at this stage there is no indication that these will be mandatory. Therefore, it will continue to be left to the service providers to decide whether or not they adopt them. Although that could change, that currently is my understanding of the intention of these guidelines, but there is some attempt being made. I can table that document.

The CHAIRMAN: With regard to systems, policies and resources - you have touched on some of this already - how well do you think health professionals in emergency departments, and for that matter other hospital departments, and community-based mental health services communicate to ensure there is a continuum of care for deliberate self-harm patients?

Mr Wilson: I think it is not a question, Mr Chair, of how well; it is a question of it does not happen at all. The whole thrust of the discussions that are being held currently under the auspices of COAG to develop new initiatives for national mental health reform instance integration of services as one of the highest needs. Currently there is little integration. There is very little or no connection between what happens in an emergency department and what happens in a public psychiatric clinic or in other areas of non-government or public service provision of service. I think that is one of the worst problems that consumers face in accessing services, because the much-vaunted continuum of care does not exist. The resourcing for that to occur does not exist either, because if we are going to leave, for instance, the management of the ongoing care of a young person who presents with attempted self harm at an emergency department to them contacting mental health services, it will never happen. Therefore, there is an urgent need for the integration of the care of that person in an ongoing sense. The frameworks are not there to allow that to happen or to resource that to happen. It is a very fragmented system. If you have ever been in an emergency department, you will know that at peak times it seems like chaos. I think often a judgment is made about people presenting in those instances, which is that they have virtually caused their own problems and they have a lesser priority than other patients presenting for urgent attention. So I think there are a lot of attitudes, there is a lot of culture and there is an enormous lack of resources which just do not allow that to happen.

The CHAIRMAN: What strategies then need to be put in place to prevent these people falling through the gaps?

Mr Wilson: I guess the government would say that it is handling some of that, and under the strategy that some of those matters are being addressed. I think that, for instance, one way of coping with that situation, which is partly about resources and partly about how these connections are more effectively made, is that I would see that there a role for a resourced NGO to provide that service; that is, to be the link between a young person presenting with attempted self harm and being assessed and treated, in whatever way, in an emergency department, and the assertive follow-up of their ongoing care; and also addressing the needs of the family from whom that person comes, because often they are left feeling abandoned and completely bemused by that experience, particularly if it is a first experience. I know the Ministerial Council for Suicide Prevention is involved in work on bereavement services; that is, in the case, of course, of a suicide actually taking place. However, there is also need for that follow-up work with families and carers, even when it is only an attempted suicide, quite often a very important part of equipping the carers of that person with the information and the skill to ensure that they are better prepared in the future and they are also better prepared to assist that person in accessing the sorts of counselling and care that they need to allow them to recover and lead a good life. One NGO that I have in mind is Lifeline. Lifeline is already providing a very valuable telephone counselling service to people. It tells us that 25 to 30 per cent of its calls are from people who actually have mental illness, but a higher proportion of its calls are about people with suicidal behaviour; and, of course, the Samaritans would be able to justify that as well. So it seems to me that it is an area in which an NGO that was properly resourced and given the right terms of service delivery could be very effective.

[12.00 noon]

Just like telephone services, none of these things will be much help if there is no agency or service provision to refer people to. That has been the problem with telephone advisory services. The awful disaster of South West 24 is an example of that. People could ring a phone number to get access to the care and talk to somebody on the phone who would give them good or not so good

advice. However, the follow-up counselling services were not available to the people who rang the number. That is why all the problems need to be progressively fixed across the board. There is no use of a person contacting someone for help if there is no hope of providing follow-up counselling and care. The existing NGOs such as Lifeline and the Samaritans are in a very good position to do that because they have excellent programs for training volunteers. They have established centres in the Pilbara in which 40 trained councillors operate a telephone service in that region. They can do that work. They also provide follow-up counselling for people whom they determine are in need of it. A hands-on and proactive follow-up approach must be a dedicated part of the provision of care from the point when a person presents at an emergency department.

The CHAIRMAN: Access to mental health treatment close to home is an important consideration. Mental health personnel recruitment and retention difficulties can make the provision of services in regional areas particularly difficult. Given the higher suicide and deliberate self-harm rates in regional areas, must additional strategies be put in place or should alternative models of service delivery be considered for regional areas?

Mr Wilson: Certainly. This is probably one of the big holes in the provision of service and support for people living in rural and remote parts of the state. Even in regional centres and in the second-most populous region of Western Australia, the south west, the service delivery level is deplorable. One reason is that a population-based funding model is not used to resource rural and remote services. It is my view that they get what is left over. No real consideration is given to the special needs of those populations. They are, in the main, small and scattered populations, particularly in the north, in the goldfields and in places such as Esperance, which stands out on its own and does not rationally relate to any other major centre. These populations are not given any rational consideration in the allocation of resources. A few years ago the Mental Health Council of Australia conducted an estimate of the way in which funds were allocated around Australia. It found that in the south metropolitan region of Perth, the allocation of mental health funding was then something like $120 per head of population. It was about $50 per head in the central wheatbelt and in the south west it was more like $64 per head. We did not have figures for either the Kimberley or the Pilbara. They would have been much further down the scale. That is a particular problem. We still do not have an appropriate funding model in spite of the strategy. The allocation of funds under the strategy have been random. We have found money for a few Aboriginal mental health workers in one place and one child and adolescent worker in another place. These types of appointments are absolutely useless. They have no meaning because the people working in that type of isolated situation cannot provide much of a service. Eventually they leave because their work is so demanding and unsatisfying in terms of accomplishment. We have not put enough consideration into how to address the needs of regional, rural and remote Western Australia. The current problem is that everybody says it is too hard and they do not apply any careful research or thought into how the situation might be improved. People talk about telepsychiatry. People have told me that that is not a good experience for a person to look into a camera and talk to a psychiatrist who is thousands of kilometres away. That is not a very good way of diagnosing a person's problems and it is very impersonal. Sufficient effort and thought has not been applied to this. Generally, it has been fitful, subject to funding cuts, and the work force recruitment problems are almost self-defeating. People cannot be offered a reasonable lifestyle in these positions in many parts of the state. Nobody could possibly be attracted to work in those situations given that the conditions under which the jobs are offered are not only inadequate but also the collegiality of working with multidisciplinary teams does not exist. Therefore, the morale is soon shot.

We are still looking at mental health and situations such as EDs and people presenting with suicide and suicide prevention from a very metropolitan-centric point of view. I understand why. There are all sorts of political and service barrier reasons why it is easier to try to achieve success in an area of denser population. However, I cannot use that excuse for the south west of Western Australia. I cannot believe that it is not possible to provide attractive positions for people to work

in Margaret River, Busselton and other parts of the south west of Western Australia. I am sure some people would choose to live there if the jobs were made interesting, attractive and worthwhile. There are not many excuses for this situation; it is just a matter of absolute negligence in putting any thought, research and effort into doing something about it.

The CHAIRMAN: Some of us who represent those areas are very familiar with those types of sentiments. The Auditor General observed in 2001 that although most hospitals had the services of an Aboriginal liaison officer available, these officers were not specifically trained to deal with deliberate self-harm patients. Following up on what you said a while ago, could you prioritise the areas of specific need within the system? For example, young people, Aboriginal people, people living in regional areas or people with a history of substance abuse. Is there a hierarchy or priority that could be followed?

[12.10 pm]

Mr Wilson: It is not one that I could determine. I accept the point and I think they are priority areas. When you have a presentation from the ministerial advisory council for suicide prevention you will see that it is treating those areas as priority areas in its advice to government. However, of course its funding is a bit stalled at the moment. Its capacity to deliver in some of those areas is very stunted by a lack of resources also.

There is no doubt for instance, that the impact on the Aboriginal community - indigenous community - is very marked. All the obvious reasons for that have come through in inquiries such as the Gordon inquiry and all those inquiries that have been undertaken. I think that Aboriginal liaison officers in hospitals must have a terrible job because they are dogsbodies who have to do everything. It is true that many of them would not have been trained in mental health or suicide prevention, although some would have been. Conscientious efforts are being made to improve that situation. However, they are the thin edge of the wedge.

Certainly, suicide behaviour, drug addiction and alcohol addiction are well known to be matters of priority. Quite often when a person presents to established services with an alcohol or drug problem, they will be told, "Your problem is a mental illness. You should see mental health services." Those two areas, for instance, mental health services and drug and alcohol services, have no links, no integration, so people go backwards and forwards between them. Even a private psychiatrist would say to a person, "You go and deal with your alcohol problem and then I will treat your mental health problem." People are in limbo; there is nowhere for them to go.

People who have been diagnosed with conditions such as personality disorder are probably the worst placed, because that is such an imprecise diagnosis that everybody has been hands off about dealing with it. We have no designated service in Western Australia to treat these people. They are very troubled people - I can only imagine. They are also people who would be priority considerations in terms of suicide prevention. However, all these areas are very thinly resourced and even in mental health that condition is often used as a grab bag of people who are just hard cases who nobody wants to deal with. I would not like to rank them because I think they are all of crucial priority. Those with more professional expertise may be able to do so.

The CHAIRMAN: Thank you very much for your responses. I am sure that they have raised a lot of questions for members.

Hon ED DERMER: I am getting the general impression that a central issue is the matter of continuous care. Someone comes along to the emergency department and is dealt with by a psychiatric nurse or registrar -

Mr Wilson: The psychiatric nurse is called a liaison mental health nurse. It is said that they are all seen by a psychiatric registrar. I have been told that that is not necessarily so.

Hon ED DERMER: The nurse and the psychiatric registrar, one or the other or both, will be present in the emergency department. When people are regarded as no longer needing that type of

service immediately - they have gone through that acute phase - it appears that then the issue is how is their care planned and essentially handed over to community-based services.

Mr Wilson: It would depend on how they are assessed. Some would be assessed as requiring to be admitted to hospital for diagnosis and, maybe, treatment. Because there would be no beds available, some would go into these new observation beds that are attached to EDs and under this new strategy there is a segregated number of beds for people presenting with mental health problems who are awaiting a bed in hospital. That is the pure explanation; it does not actually work like that. For instance, people stay in those originally called holding beds for up to many days. There was a recent incident where a young woman, who had been in one of those beds awaiting treatment for eight days, just discharged herself, walked out of the hospital, collided with a car and ended up with a broken leg. The person driving the car ended up being totally traumatised by the event. That young woman was obviously very ill. There were obvious signs on her arms of self-mutilation and self-harm. Some attempts are being made, but some people would be assessed as not requiring hospital care and they would be discharged into the community.

Hon ED DERMER: If I understand correctly, and it is important to us in relation to what you are telling us today, it is important to have an appropriate strategy whereby those who are not assessed as requiring further acute care are then handed onto what has been referred to as community-based care.

Mr Wilson: Yes.

Hon ED DERMER: If I understand correctly that community-based care is a style of care that would normally be provided by a social worker or an occupational therapist, and there are a couple of other categories.

Mr Wilson: No. What would happen under the current arrangements is that if the person was referred for ongoing care, that person would normally be referred for an appointment at a public mental health clinic, such as exists in the metropolitan area and in Bunbury and Geraldton and I am not sure about Kalgoorlie, but not many other places. Then it would be whether the public mental health clinic was able to take them on or whether they had to wait an unknown period before they could be seen.

Hon ED DERMER: You referred earlier to occupational therapists and social workers. Where do they fit into this package?

Mr Wilson: The ongoing care of people once they have had an episode of trauma like that is often best coordinated by a social worker who works in a different way; who works by linking people with services, who works by following up people and who works with their families. That is the sort of community support that a person needs. They may also need ongoing clinical care which could be provided by the mental health clinic, but really they have a greater need for that sort of coordinating care, which does not wait for people to call you but is there proactively ensuring that you are progressing satisfactorily from the episode that you had.

Hon ED DERMER: In one part of the mental health service you have the psychiatric nurses and the registrars.

Mr Wilson: There are social workers and other OTs as well, but as far as mental health goes they are very limited in supply.

[12.20 pm]

Hon ED DERMER: Is what you referred to as community based - the clinic coupled with the social workers and occupational therapists?

Mr Wilson: The way it works is there are public mental health clinics like that, for example, in Mirrabooka, Armadale, Fremantle, Joondalup, Clarkson, and Swan. They are the clinics that are what might be called outpatient clinics in other areas of health care. People who live in the

community can go there for ongoing needs for medication, counselling or whatever. The other provisions of care that are important are good supported accommodation. Some people who attend emergency departments may be homeless, they may be in conflict with their family, or they may have had a flat that they have not cared for properly and have been evicted. Those types of people are at risk because they do not have a stable home to go to. If a person is discharged from an emergency department into the ether without anybody finding out whether the person has somewhere to live and is provided with a bed and food and so on, that is what we call a lack of integration of care. Nobody is then responsible for the ongoing care of that person.

Hon ED DERMER: Am I correct in understanding that you see it as a highly urgent need to provide an improved integration from the emergency departments to community based care?

Mr Wilson: Indeed. Commonwealth and state governments, Premiers and the Prime Minister have determined that as one of their priorities in thinking of new initiatives. It has been recognised at that level.

Hon ED DERMER: If someone goes from hospital care, the care of psych nurses and registrars into community based care, and one of the most urgent needs is to provide a plan that ensures continuity of service between those two different types of service, what is the biggest problem? Is it the quality of service provided by the psych nurses and the registrar? Is it the availability of the types of services that a person would receive from a social worker or an occupational therapist, or is it a failure of communication between the two?

Mr Wilson: It is probably a bit of all those things. Probably the real problem is the lack of community based services; that is, the lack of supported accommodation options for people, the lack of rehabilitation services so that people can get their lives back together, and the lack of vocational advice services and help that would put them in line to get back into the work force. All those things are necessary to overcome the type of social exclusion that is suffered by a person with a mental illness or a person who is known to have attempted suicide. They are seen as people who cannot deal with life. They already believe that themselves and for other people to believe it as well adds another burden on them. That umbrella-type of service provision will make a difference. Not only do we need better coordination and integration, but also an interagency approach to these issues. The education, the employment, justice and other agencies must work together with the health agencies to ensure that that range of services is available. Currently the Western Australian Premier's department has brought together an interdepartmental committee to guide its thinking on what it will propose in Canberra in July for the new COAG-sponsored mental health reform measures. It is hard for these things to work, but that is what is needed. If a person is transferred from an emergency department to a care provider in the community, that care provider encompasses the entire spectrum of care.

Hon ED DERMER: This might be a difficult question to answer, but I will ask it anyway. If sufficient funding were made available to enhance the type of community service delivery that you believe is necessary, do you believe - this may be almost an anecdotal rather than a quantitative judgment that I am asking for - that there are sufficient people who would be prepared to undertake the vocation of social work or other type of service providers that are required?

Mr Wilson: That is largely dependent on how those positions are described, how they are offered to potential candidates and how the work settings are made interesting and sustainable for the employees. I do not think we have looked at that. We have looked at employing people from the UK under the "Mental Health Strategy 2004-07". It was said that nearly 400 FTEs were needed in the mental health services. We are yet to be told the net gain. We were told recently that 74 additional mental health nurses were being employed, but we were not told how many left the service or how many transferred from existing services to take up positions in the new initiative services. Unless we have a net figure, we do not know whether or not we are making progress. There is no doubt that the work force issues are lesion and that innovatory ways of addressing that

must be considered. One way of doing that is to increase the involvement of NGOs with a proven track record who can provide auxiliary workers and mentors who can work alongside people and give them the support they need on a day-to-day basis. Some people just need support to manage their money or to look after their house without it getting into a mess. They are very basic levels of support, but they can be very important to people as they begin their recovery. That is a problem, but I think there are answers to it. For instance, there are workers in other states of Australia who are former patients. I have seen them in operation. They are people who have attempted suicide or who have had a mental illness and have been helped to make a recovery and who are now acting as consumer advisory assistants and work with patients. They are very effective because they have been through the experience themselves and they know what help is most effective. All these issues are being broached, but there is not the sense of urgency that one would hope for.

Hon ED DERMER: The 2001 Auditor General's report focused on the lack of integration of services. Notwithstanding the further needs you have articulated today, do you believe that that there has been an improvement since 2001?

[12.30 pm]

Mr Wilson: Not much because there are such hard and fast barriers that get in the way. It is hard to believe sometimes, but I know in the central west region in Geraldton that there was a problem because once a person with a mental health problem was admitted to hospital, the people who had been working with them in the community were not allowed to see that person in hospital. That is really quite ridiculous, but that was a barrier to integration. Hopefully that has been overcome since; I am not sure. You get these hard and fast barriers between people who work in community health services, people who work in prevention services in the community and people in hospital settings. And never the twain shall meet.

Hon ED DERMER: Is there any improvement that you can identify?

Mr Wilson: No.

Hon HELEN MORTON: I will ask you about one area that I am particularly interested in. It is a little about the hard and fast barriers that you have been talking about. In the past six months I have probably had a dozen families make contact with me about the culture that they come up against in the mental health system, a culture of intimidation of them being appropriately demanding to get better services for their family member.

Mr Wilson: If they dare.

Hon HELEN MORTON: If they dare; that is exactly it. And the treatment that they subsequently get from the system for daring to make that demand. They also get ostracised and are not allowed to be involved. I had one situation in the past couple of months in which I was the advocate for a parent of a mental health patient in a hospital. I demanded that we have the family conference and all these external agencies be brought into the hospital so they could all get to hear what was going to happen to this young chap when he was discharged. On the way out the psychiatric registrar said to me, "I'll be glad to get rid of this family." Am I seeing something that is a bit atypical or is this what you were talking about when you referred to the culture and how does that affect families?

Mr Wilson: In general, it means that families become the pseudo mental health workers, and so do the police. I have a lot of sympathy for the police, because often when people telephone in an emergency, say, to the psychiatric emergency team, which is under-resourced, they will be told to telephone the police in a crisis situation. The police have to go and they do the best they can. A lot of the police are very caring. There is a special section in this book about the police. The police who make submissions say, "We weren't trained to be health workers. These people need a health service, not the police." It is similar with families. Families were not trained to provide these services, but often they are the fallback service for the lack of service and an intimidating attitude of service. Some of that attitude is due to the pressure under which people operate and their low

morale. If they see somebody coming back again and again, they attribute blame to that person but of course the blame is not on that person; it is that they are not being adequately treated. Unfortunately, that is very common. There are a lot of judgments made about people - that they are manipulative and they are always complaining. I had an instance of that recently. The Department of Health has employed a consultant to build this communications program to work with communities where new mental health service facilities will be located. I saw the brief from the consultant. One area at the top was predictable barriers. One of the predictable barriers was probably aimed at me. It was that mental health advocates and peak bodies have now politicised mental health, which makes it very difficult for the Department of Health and its employees to operate. From my point of view they should see that as a plus, because if mental health advocates had not politicised the issue, it would still not be attended to so they should treat that as a plus and work with it. That defensiveness is very strong. Saying "I will be glad to be rid of that person" is part of it, instead of being able to say, "That person had some rehabilitation and job training and they are getting on with their life", so being glad to be rid of them in that sense not in a negative sense.

Hon HELEN MORTON: From your experience as the chair of the Mental Health Council of Australia and dealing with the families that would have made contact with you, can you give us an overview of the lengths people go to to get appropriate treatment for their sons or daughters or wives or husbands?

Mr Wilson: This book is full of them.

The CHAIRMAN: Mr Wilson is referring to the report "Not for service".

Mr Wilson: Yes. It is subtitled "Experiences of injustice and despair in mental health care in Australia; they're in the community living like ghosts - they are dying alone". They are quotes from people who made presentations. There were many tragic stories told by carers in this report. Some of them would make you weep. Having attended 20 of those forums around Australia and having listened to those sorts of stories over and again, I was just about a cot case. That is why I was so determined to release this report and convince the federal and state political leaders to do something about it. They are all there. They are tragic stories of preventable deaths and preventable self-harm attempts, because a lot of these tragedies end in suicide. People are still coping with the grief that that brought on them. That is why bereavement services are so important. Sometimes they are not bereavements for a death; they are bereavements for the experience of somebody being so desperate that they have made an attempt on their life or they have no hope because they have bipolar disorder or clinical depression. Again, it is most common in the non-metropolitan parts of Australia that you get that lack of attention to need at the time when the need is greatest.

Hon VINCENT CATANIA: You mentioned that once mental health patients leave hospitals, often there are limited places where they can go to be looked after, whether they be homeless or find it hard to go through the normal avenues of rental properties, getting leases and so forth. Do you feel there is a reluctance to accept mental health facilities or crisis accommodation in the community? Do you believe that there should be crisis accommodation where perhaps up to 20 mental health patients live together or should they be sporadically placed throughout the community? There is a reluctance of communities to accept mental health patients in the community perhaps because possibly dangerous people who have disorders can be a threat to the community. Do you believe that there is a reluctance to accept that sort of housing?

[12.40 pm.]

Mr Wilson: Yes. Obviously. It is a very difficult issue to come to terms with because on the one hand communities can be easily castigated for taking that attitude; however, on the other hand, there must be a recognition of the fact that a stigma is attached to mental illness and other strange behaviours. Therefore, there is a lot of ignorance and fear about them. That has been passed down

from generation to generation, so everybody thinks that someone who has that kind of label is a dangerous axe murderer and they do not want them living nearby because their children will be at risk of harm. We can easily castigate people for that attitude, but it is not helpful to do so. If people are placed in a community in which they are not welcome, that is not a good place for them to be. There are two answers to that. The first is that governments are now talking about the need to provide a range of accommodation options for people who leave hospital, for whatever reason, to do with mental health or suicide problems. The first of those is what is called step-down facilities. That is a terrible phrase. It refers to a facility in the community that provides 24-hour clinical care and some rehabilitation. I understand that the theory is that people stay in those facilities for six weeks and then they will be all right.

Hon VINCENT CATANIA: Is that on-site care?

Mr Wilson: Yes. It is on-site care, 24 hours a day. That is a better environment for the patient and it is also a cheaper option for the state, because the cost of a hospital bed is so much more. That is supposed to be part of the continuous treatment. Once a person has been stabilised in the community, he moves on to another spectrum of supported accommodation that does not involve so much intensive clinical support. However, he is given support for living requirements, such as shopping, budgets, meals and so on. However, it is no use having one of those services in place if the other services are not in place. If they are not, the families will continue to be the next port of call. The patient will go from a step-down facility to no supported accommodation, so he will have to go back to his family if his family will have him; sometimes they do not want them, and that is the problem. Unless all the services are in place so that the ongoing whole-of-care approach that a person needs is there, to provide just part of the service is not making much progress. We have one of those facilities in South Fremantle. That service provides eight beds. The government is proposing to build two more - one north and one south.

The CHAIRMAN: One in Busselton?

Mr Wilson: The one in Busselton is part of the next phase, which is supported accommodation but at a lesser intensity. Those people will get living support. Otherwise, they will be able to live independent lives.

Hon MATT BENSON-LIDHOLM: What is the plan for Albany Regional Hospital? I attended a meeting there late last year. When there are health problems in a family with ageing parents, they find it nigh on impossible -

Mr Wilson: You are looking at one!

Hon MATT BENSON-LIDHOLM: As an aside, a staggering thing that came out of this is that we had a community meeting at which 100 people turned up. Everybody was in favour of it, but there was this NIMBY thing - not in my backyard. The locals whose real estate fronts the site where the proposal would be built came up with the idea that their real estate values, because they had invested there a year or two ago, and had gone through the roof and that they would, in turn, plummet.

Mr Wilson: They were the ones who wanted an access road.

Hon MATT BENSON-LIDHOLM: They are exactly the ones. You know obviously know the story.

Mr Wilson: The thinking was that because hospital land would be used, there would not be a problem. That is not good thinking. There will always be a problem. That is what we must understand. There will always be people who are opposed to that type of service and who will make a lot of noise. We must try to pre-empt that. On the other hand, it is not good for a government agency to say that it will provide the service on a hospital site and that no matter what the locals do, it will be rammed through. That is exactly what has happened. It happened at Hawthorn House and all over the place. We cannot expect to ram these ideas through if they are

dropped on people without due notice and consultation. The Albany service is going ahead. It is one of the clusters of supported accommodation, but it will not provide an intensive level of support. It will be near the hospital.

Hon MATT BENSON-LIDHOLM: The proposal certainly looks very good.

I am very interested in your comment about Victoria. Having spoken to mental health experts in Victoria, they are rather envious of the sheer dollar allocation that comes forth per capita in Western Australia. You said that in terms of mental health services, Victoria has the best in Australia. Victoria is quite envious of the sheer amount of money that is spent on health services in Western Australia. Apart from the geographical differences between Western Australia and Victoria, which perhaps causes the latter to have a more centralised approach, can we take anything from the Victorian model that will improve the provision of mental health services in Western Australia? I see it as huge issue. What can we take from the Victorian example?

Mr Wilson: It may be that those people are concerned about the allocation to services in hospitals. Western Australia has a much greater proportion of mental health funding allocated to hospital services than community services and NGOs. The big strength about the Victorian model, apart from the smallness of the state - the people of Warrnambool told me they were regarded as a remote area in Victoria - is that the Victorian government has poured a lot more money into community-supported services; that is, supported accommodation, psychosocial counselling and rehabilitation. It is the only state that has a specialised service for people with a personality disorder. That is where the Victorians are at the fore. Other people in Victoria will say that it is as bad there as it is anywhere. The name of the report - "Not for service" - came from a consumer in Victoria who rang one of the phone lines and asked to make an appointment for care, but who was told that he was not sick enough anymore and that he had been categorised as "not for service". I heard that person say that, and that is why we chose that title. That is symbolic of people being told they are not sick enough. You can have depression or panic disorder, and the public mental health services will not treat you because you are not sick enough.

[12.50 pm]

Hon HELEN MORTON: They have 25 beds per 100 000 people for community supported accommodation; we have four per 100 000.

Hon MATT BENSON-LIDHOLM: That is a compelling figure.

Hon HELEN MORTON: Just backing up what Keith was saying, that is a significant difference.

Hon MATT BENSON-LIDHOLM: Obviously, the geography and the sheer size of Western Australia come into it.. I take on board the point you made about the south west. I am a south west MLC. However, to my way of thinking, it is the immediacy of these sorts of issues. When they come up, someone gets on a telephone and cries out for help, and that person might be talking to someone in Melbourne or somewhere else. Those sorts of issues decree that something needs to be done to address that issue. It does not matter to me whether it is in Mandurah, Mukinbudin or up at the top end somewhere; it is still an issue. If the geography of this state precludes us from adopting models that are successful in other states, we just have to find a better model or develop a model. That is my understanding of it.

Mr Wilson: I do not think we have put nearly enough effort into doing that, because we are stuck on the point that it is too hard and it will cost too much. However, we are spending all the money in one part of the state and giving the scraps to the rest; that is about it.

The CHAIRMAN: Can you give us an idea of the numerical scale of the issue? You may or may not be able to. How many, overall, are we talking about with mental health disorders, or what percentage of the population has mental health disorders that are curable, permanently or temporarily; how many require constant management; and how many are incurable? Do we have that sort of general information?

Mr Wilson: Serious mental illness is often incurable but it is highly treatable. Normally, what would be said would be that three per cent of the population has psychotic disorders. In the main, these are not curable, but they are treatable to varying degrees. The usual figure given for the proportion of the population that has experienced a serious mental illness within the past 12 months is 20 per cent of the population. Certainly, we know from our surveys that 62 per cent of people with a diagnosable mental illness get no care at all, and there are various reasons for that. Some of the reasons are that people are afraid to get into the hands of the mental health system, and some of the treatments they have heard about have terrible side effects. You cannot blame people for that. Other people just do not believe they have an illness at all, and they are very difficult to get to treatment, particularly if it is a 20-year-old son of a single parent mother. Those sorts of situations are very common. I think we can really say that what is called the disease burden of serious mental illness in terms of its disablement of people's lives is around 15 per cent of the total disease burden. It is moving close to second to heart disease in that regard. The World Health Organisation says that disablement due to schizophrenia is equivalent to disablement due to quadriplegia, and disablement due to clinical depression is equivalent to paraplegia. That is the level of disablement that people suffer through probably the biochemical make-up of their brain.

These are almost daunting figures, but they do present options for governments developing targets around them. What we do not have really in mental health services are good targets to work towards. For instance, in EDs, we should be able to have realistic targets that are based on good data - we do not have the data to start with - which would show that by providing follow-up care, the levels of young people presenting with self harm are reduced to a certain degree over five years. We need those sorts of hard targets to work towards, otherwise we will not achieve anything. We have a disease burden of 15 per cent. However, the Western Australian government says that it is now spending 10 per cent of the health budget on mental health. It has never shown me how it works that out, nor has anyone else. I doubt whether it is 10 per cent, but even if it is, the disease burden is 15 per cent. Why are we not working towards 15 per cent of the health budge in five years? At least we would then be matching the funding with some rational level of concern. It is the same with regional and rural services. Why are we not setting targets? We are not setting targets, so we are not making progress with on-the-ground services. I am not talking about telephone services or anything like that; I am talking about on-the-ground services, which are the only services, ultimately, that people benefit from.

The Auditor General has attempted to set some targets, but I think these targets need to be much harder targets, without being able to wriggle out of them. I understand that the minister will talk about some new health targets in a parliamentary statement some time this week, but I have not heard about any detail yet. That will depend on how hard the targets are and how easy it is for the departments to wriggle out of them and so on. For instance, I heard that one potential target for mental health in terms of Treasury funding would be that each person being discharged from an intensive care unit would have to be contacted within three days of discharge. That sounds good, but when you analyse it, what does contact mean? Does that mean a phone call, and if the person is not there, they just write down "could not be contacted"? What is it worth? Certainly we need those sorts of targets about people being discharged from emergency departments. What is the target date by which they have a follow-up episode of care, and what is the outcome of that and so on? If you do not have those targets - I know that departments and governments are loath to set them because they are scared that they will never meet them - I do not think you really know where you stand from year to year; so you have 2001 to 2005, and you really cannot point to much progress through the lack of data and the lack of the establishment of hard targets.

Hon ED DERMER: If progress had occurred in that period, are you suggesting that the data is not there to measure that progress?

[1.00 pm.]

Mr Wilson: The data is not there to measure the outcomes of service delivery. The best indication of progress is the degree to which you measure it. If you cannot measure it, you really cannot say what is being achieved. You have to have these measurable targets set so that there can be a real measure of any improvement or deterioration. Then there is some accountability. I pointed out that in the "Not for Service" report and other reports the two great things that are lacking in the mental health services are leadership and accountability. It stands to reason that if neither of those exists, not much of a service is being provided.

Hon ED DERMER: I was momentarily distracted by your last comment. From what you have said today, I understand that the "Not for Service" report is based on a compilation of reports from consumers.

Mr Wilson: Twenty public forums were held and were attended by many people. Some 100 people attended the Bunbury forum, 120 people attended the Perth forum and 80 people attended the forum in Geraldton. We replicated that all around Australia. The doors to the building at the forum in Melbourne had to be closed because the maximum number of people permitted by health regulations had been breached.

Hon ED DERMER: We have heard a lot today about the number of unsatisfactory reports that the consumers of the mental health services have reported through that process. Can you point to any positive reports from consumers that might be instructive to policy makers and people who deliver mental health services?

Mr Wilson: All the reports to which I have referred contain some quite positive proposals; not all the proposals are critical. However, not much positive input was provided from all the information that was gathered.

Hon ED DERMER: Were there any positive experiences?

Mr Wilson: Not that I heard. There are two different perceptions about the provision of mental health services. There is the perception from within the bureaucracy and the service providers, who argue that they are not doing a bad job when everything is considered. The other perception is that of the people who have tried to access and receive the services and who know from their own experiences that that is not true. It is not a good service. Part of the problem of dealing with the issue is the lack of convergence of perceptions about the type of care that is provided. No blame is attached to it. I do not blame the people who deliver the service and who believe they are doing a good job. I have no doubt that in many cases they are doing a good job. However, what can one think about a young suicidal person who is taken to an ED and is assessed as not needing further care?

Hon ED DERMER: You have relayed those points to the committee a number of times today. I find it extraordinary that not one of the consumers who reported through the forums provided a positive experience.

Mr Wilson: Prior to finalising this report, we contacted all the Premiers and health ministers in Australia, gave them a draft copy of the report and asked them to comment on it. The first comment we got back from WA was in the vein that the forum gathered together the usual lot of whingers and that government surveys show that 80 per cent of people think that what we had to say was not credible. The minister later withdrew that report - quite wisely - and submitted a two-page response that he had written in his office, whereas the original response was about 20 pages long and contained more generalised comments. That is contained in the report. Some states agreed with the report's findings and said that they must do better. People on both sides of the argument must have the confidence to stand their ground. If people who provide the services stand their ground with reasonable data and evidence, there is no reason to doubt that what they are saying is right. However, they are not in that position.

Hon MATT BENSON-LIDHOLM: I looked through the legal and human rights and work force recommendations contained in the summary of the "Not for Service" report. Recently there was a case at the Swan District Hospital involving an occupational safety and health issue. Did the Mental Health Council grapple with that occupational safety and health issue regarding recruitment? That is an example of the negative feedback that exists in Western Australia through the various forms of media. If I were a mental health nurse or was thinking about becoming one and that issue had not been addressed, there is no way I would put up my hand to train to become a mental health nurse. I did not see that issue referred to in the report.

Mr Wilson: There is a section in the report on national standards headed "safety". The member may find something of interest there. What the member said is true. I cannot imagine a young person or a parent of a young person wanting his or her child to do that type work in view of that type of report. After the report was released, the government said it would put in place safety measures in all the clinics. Recently I received information from someone who works in the industry that some of the safety measures such as call alarms have not been installed in some centres. WorkSafe followed up that matter and has said it is giving the centres some leeway because of particular problems. It seems to me that something could have and should have been done. It would not guarantee the safety of the workers, but it would give them some assurance.

Hon HELEN MORTON: I asked either a question on notice or a question without notice about that. I asked specifically about areas that have been identified but have not been addressed. I asked for time frames to be put in place to respond to those matters, and those time frames are noted in Hansard.

Hon MATT BENSON-LIDHOLM: How long ago was that?

Hon HELEN MORTON: It was in the past month.

The CHAIRMAN: We have covered a lot of ground. Mr Wilson, would you like to say anything in conclusion?

Mr Wilson: I failed to bring a matter to the attention of the committee, although the committee is probably aware of it. I refer to the report titled "A National Approach to Mental Health - From Crisis to Community" by the Senate Select Committee on Mental Health. The first report was released in March.

The CHAIRMAN: Was that March 2006?

Mr Wilson: Yes. The "Not for Service" report was released in October last year and the Senate's report was released this year. A particular section in the Senate's report deals with emergency departments and what the committee proposed. I will table that section of the report.

The CHAIRMAN: Thank you very much. This committee has taken up the role of investigating certain aspects of parliamentary officer's reports to Parliament and of providing a parliamentary follow-up of some of these issues. This is the first report we have attempted to get our teeth into, and it is proving to be a big, very interesting and important topic. The committee has a good deal more work to do before it reports.

Mr Wilson: I am glad that a parliamentary officer's report is being taken seriously, because often they are not. The same applies to the coroner's reports. The coroner is currently investigating about five cases of mental health patients who have committed suicide. There is no mandate for either the government or its departments to implement the coroner's recommendations. That is a serious issue because previously the coroner has made some very sensible recommendations about improvements in care that have been forgotten. The committee might like to pick up on that. I know that the Coroner's Court is sacrosanct and it may not be possible to do much. However, an inquiry into suicides is a significant factor in the circumstances into which people take their own lives. It is the ultimate in our community, but it is often done so far and so long after the incident or

is of concern only to family members and journalists that, in my view, it does not get sufficiently noticed.

The CHAIRMAN: One coroner's report about a suicide in the south west has come to the attention of the committee.

Mr Wilson: I can imagine that it has. There was another one in the Swan area. It is not only suicides that must be taken notice of, but also acts of violence and homicide. The government of New South legislated for and set up a special committee that released a report called "Tracking Tragedy". The committee reports to the minister and it analyses the findings of the coroner and reports of suicide and homicide. In many cases acts of homicide are a clear indication of a lack of the provision of appropriate mental health care. People go off the rails because they have stopped taking their medication or they are not getting the care they need. All those matters are associated issues. The Chief Psychiatrist's office is putting together a proposal to establish something like that. However, I know it will be another of those mickey mouse things that is not established under legislation and does not require anybody to act, but which looks good. That often happens.

Hon ED DERMER: How do you know that, Keith?

The CHAIRMAN: Thank you very much. The committee appreciates your input and will be in touch by way of the report at some stage.

Hearing concluded at 1.12 pm