STANDING COMMITTEE ON PUBLIC ADMINISTRATION

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
WEDNESDAY, 16 NOVEMBER 2005

Members

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

Hearing commenced at 11.20 am

PEARSON, MR DESMOND
Auditor General, Office of the Auditor General,
4/2 Havelock Street,
West Perth, examined:

WILKINS, DR PETER
Executive Director, Performance Review,
Office of the Auditor General,
4/2 Havelock Street,
West Perth 6005, examined:

The CHAIRMAN: On behalf of the committee, I welcome you to the meeting. You will have signed a document entitled "Information for Witnesses". Have you read and understood that document?

Mr Pearson: I have.

Dr Wilkins: I have.

The CHAIRMAN: These proceedings are being recorded by Hansard. The transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document that 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. 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 any public evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Would you like to make an opening statement to the committee which may summarise some of the major questions that I have for you on behalf of the committee?

Mr Pearson: At the outset I welcome this opportunity to discuss this report with the committee. From my perspective it comes down to the issue of why do we pick such an issue on which to do a performance examination, and why do we follow it up. In that respect, as you would appreciate, we have limited resources, and the public sector is quite large and complex, so how we topic-select is not an inexact science. We are forever scanning the sector for priority issues or sensitive issues in which I feel audit review would add value to the quality of administration of it. In a couple of respects the health sector always comes up. It is very large in terms of expenditure of more than $2 billion. It always comes up in the sensitive area of public interest, because people's health is important in the mind of the community. This particular area, deliberate self-harm to youth, is a area of community concern. There is quite a bit of concern about the incidence of youth suicide. Related to that, the mental health division of the health system is an area that gets some attention. Therefore, in a number of respects that is how the topic came up in about 1999-2000, when we commenced the initial audit. We tabled that report in 2001, if I recall correctly.

Just to take it to the next step, as the Auditor General I am charged with being independent and objective. I interpret that as meaning that we look at things analytically, form an opinion and report to the Parliament on what we think of the quality of efficiency and effectiveness of whatever program is being implemented that we have looked at. In the course of our reports we also make recommendations on what should happen in the future. It is in that context that, for over a decade, we have adopted a practice of two to three years after tabling an initial report, where warranted, we undertake a follow-up examination. That is what we have done in this particular case with the report that was tabled in October.

The purpose of our follow-up is not to pursue or advocate for the conclusions or recommendations that we made. To me it is an acquittal in as much as we made a judgment that the topic was of such significance that we should look into it and report to the Parliament,. We owe it to the Parliament to look at what has happened in the intervening period, and again give a relatively objective acquittal of what has happened in relation to our recommendations. That is our position with this report. We have made a report, and the overview is best summarised by saying that we have concluded that there has been limited progress in dealing with its recommendations.

The CHAIRMAN: From the committee's point of view, this is the first of what we hope to be a series of formal hearings with parliamentary officers such as yourselves relating to reports that you have made to the Parliament, and the follow-up reports. In a sense, it is a pilot at the end of this year, and we will be doing more in future years. Perhaps we should identify for the record exactly what the reports are and exactly what the issues are. I will then ask you to elaborate on the findings.

Dr Wilkins: The title of the report, which was tabled in the Parliament in November 2001, was "Life Matters: Management of Deliberate Self-Harm in Young People". In October this year, the follow-up report was tabled as part of the second public sector performance report, and that was titled "Follow-Up Performance Examination - Life Matters: Management of Deliberate Self-Harm in Young People".

The CHAIRMAN: What was the impetus for the 2001 "Life Matters" performance examination in the first place?

Dr Wilkins: I will take you back to the beginning of that 2001 report, or early in the second half of 1999, when we were looking at a range of topics in the health sector and elsewhere. It was identified at that time that one of the key indicators was the high rate of youth suicide in Western Australia compared with other Australian jurisdictions and overseas information. That was one of those alert signs. It was known in the community. It was reported in the media. The question then was: what is known about the causes of suicide and prevention strategies, and what sorts of initiatives were already under way in this state and elsewhere that we could look at to see whether there was a basis upon which things could be done differently? A particular opportunity emerged that new national quality standards and protocols were being finalised. That meant that in this particular area of mental health there was a baseline of standards, both professionally and in the health sector generally, about what would be good practice in addressing people who arrive at hospital emergency departments because they have exhibited signs of deliberate self-harm. There was also the context that the Health Department of Western Australia at that time had a number of clear outcome statements, goals and administrative targets related to youth suicide, so it was something that was already on its radar. Therefore, with those sorts of elements coming together, the decision was made to proceed. It is normally a two-stage process, at least, where we would have an initial look at what is happening in the department to form a view about whether there is a worthwhile project and a worthwhile report to the Parliament. The initial look at what the health department was doing indicated that a number of areas warranted further consideration. It appeared at that early stage that there was a considerable degree of variability in the way in which hospital emergency departments were providing the services, and the quality of those services.

[11.30 am]

Similarly, concerns were expressed about the quality and variability of post-discharge services. Those were two key elements of the study. We also received some information on consumer concerns and complaints about the sorts of services provided. That was really the starting point and usefully covers that aspect. If anyone wants to ask any questions about that stage, they are welcome to do so.

The CHAIRMAN: I will perhaps run through some summaries. I am sure individual members will then have specific questions they wish to ask. Can you summarise what you found in 2001 and what you found in the follow-up report this year? That will get to the nub of the issue.

Dr Wilkins: It is always a question of how you look at it. We undertook a detailed study of case files in 2001, because the information was not available in an aggregated level in the department to understand what the practices were. This work was done by professionals in the field under our instructions, so we had a clinical perspective as well as meeting the audit requirements. The positive side was that three out of four were getting an adequate level of service in the way they were being processed through the emergency departments. However, the concern was that, at this critical point in people's lives, because of the way in which the health service is able to provide services to them, deliberate self-harm patients were not always treated consistently in terms of urgency. They would face waiting times. There were also questions about the consistency and reliability of the psychiatric assessments that would be available to guide their treatment. A particular concern the report identified was the potential for patients to slip through gaps in the system; from arriving at the hospital emergency department, during the waiting periods, in the transition between services, when discharged back into the community and then through the follow-up they received through community services.

Some other procedural elements are detailed in the report. I will not go through all those findings, but they were the key elements of the initial report in 2001. Perhaps the most important one was that the Department of Health committed to adopt the national guidelines and promulgate them throughout the health system, as that would affect health services and hospital emergency departments. There is perhaps an intermediate step. Immediately after the tabling of that report in Parliament, the Department of Health agreed and responded to us that it would adopt those guidelines. If it is appropriate, I will move on to the follow-up report. Given the criteria the Auditor General mentioned, this was an appropriate topic to be followed up. We do not do follow-ups on all our examinations, but this was an appropriate one given the concerns raised in the original report and the information we had to hand on how well things were going. The 2005 follow-up report essentially raised the concern that limited progress had been made overall when we looked at what was happening. That is not to underplay what is recorded in the report as significant measures that have been undertaken by the department. As I indicated, the department adopted the guidelines immediately following the first report. However, in looking at current practice in 2005, we still saw that not all patients who were presenting as deliberate self-harm patients were receiving appropriate psychiatric attention in accordance with the guidelines that had been adopted.

There has been a government commitment to resource additional mental health nurses. Not all those positions have been filled but a substantial proportion has been. That appeared to be part of the reason for a comprehensive service not yet being in place. The Department of Health still did not have in place an active monitoring of compliance with the standards, so it could not be assured that the national mental health standards were being complied with. Again, when we start one of these follow-ups, one of the first steps is to find out what the department knows and whether it can give us an assurance that the system is running as it should be. We saw evidence of different referral and care protocols across individual health services. That is a worry in the sense that we want them all to operate at a better practice level. The guidelines clearly indicate what better practice is. There was also the issue of people in the community who might deal with more than one health service or hospital. We put them in the position of almost having to recalibrate the information they are getting; that is, because it has come from this service, they must look at it in a

particular light. A consistent approach across the state's health system would ensure consistency of understanding in the community organisations to which people are discharged and which have a role in providing follow-up services. A new computer support information system had been implemented but a number of features of the rollout were of concern; that is, they were still not getting the real benefits that the system was intended to deliver.

Perhaps to round out the comment, I will go back to what I said earlier about always trying to find out what assurance the department can give on how well a system is working. At the time, the department did not have an evaluation framework that it could use to look across this area to clearly establish what it was trying to achieve and a point and a process by which it would be established. We have been advised that the department is developing that evaluation framework, which will be linked to the overall state mental health strategy objectives. That is a picture of what we found through the 2005 follow-up, balanced by recognising that the Department of Health has undertaken a range of initiatives. However, there has been limited progress in getting a consistent and reliable service across the state.

The CHAIRMAN: You stated that WA has one of the highest rates of youth suicide in Australia. A couple of figures you quoted were 47 deaths in 1999 and 65 deaths in 1998. Did you obtain any statistics for the years 2000 to 2004?

Dr Wilkins: During the follow-up, we asked the Department of Health whether it now had information of that kind. It could not provide any more recent consolidated information on the issues contained in the original report. We would still refer to the data in that report. A number of steps are being put in place to try to provide that sort of information; for instance, the number of deliberate self-harm cases arriving at hospital emergency departments cannot yet be collected, but we are told that it will be collected in the future.

The CHAIRMAN: Were you offered an opinion by the Department of Health on why it did not have those statistics?

Dr Wilkins: I was advised that it related to categories. There is a health morbidity information system, but appropriate fields were not in place at the time. Changes are being implemented to make sure that the appropriate fields are available in the database so that that data can be presented in the future.

The CHAIRMAN: Just to explore that issue a little further, if you had those statistics of 47 deaths in 1999 and 65 in 1998 when you did your initial report in 2001, why were figures not available from the Department of Health for, say, 2000 and 2004 when you did the follow-up report in 2005?

Dr Wilkins: The specific figures you are referring to, from the very beginning of the 2001 report, were sourced from the Australian Bureau of Statistics. I understand that that information is fed through from the health services to the Australian Bureau of Statistics. In terms of the scope of our study, by trying to balance the amount of resources we spent in revisiting areas, we did not go back and do a comprehensive review of this sort of information from the Bureau of Statistics. For the initial study, a reference group of experts advised us on the interpretation of such statistics. The follow-up does not have that wider scope. The same question could be asked of the Department of Health, which may be able to provide, in those high-level aggregate statistics, more up-to-date information and the trends therein.

The CHAIRMAN: We will follow up this hearing with a hearing with the Department of Health to hear its views and explanations. Given that your general conclusion is that limited progress has been made, what do you think has contributed to this lack of progress?

Mr Pearson: That is a question I would prefer you to address in some detail with the Department of Health. My conclusion is based on a situation in 2001 when we did the detailed work and then on assessing what had happened four years later.

[11.40 am]

For instance, in terms of the recruitment of the clinicians, in the follow-up review, the health department had recruited about 70 per cent of its target. However, in other areas, such as monitoring compliance of service standards, in the follow-up, it appeared that that one was not clearly assigned within the department. My information is that monitoring compliance comes under the direct jurisdiction of health service management, not the department. Further information revealed that the Chief Psychiatrist regularly carries out reviews of mental health services. They seem to be components. However, from our review it was not evident that they were being drawn together and distilled into meaningful information that could then be used to trigger interventions or action to address issues. That is a long way of saying that I really see it as a health department management issue. As Auditor General, I see my key responsibility stopping at saying this is what we recommend, and looking at the extent to which it has been addressed.

Hon ED DERMER: One of the areas that you referred to as difficult was that the various emergency services have different referral and collaborative protocols. I have no experience whatsoever in understanding how this works in practice, but I am interested in your view about whether there may be differences in circumstances that would make it appropriate to have differences in referral and collaborative protocols between the particular emergency services to which a patient may present and the community-based health services to which the patient may be referred for further assistance. I think you were saying that the collaborative protocols vary or are inconsistent. I understand that is a problem, but I wonder whether you have explored the possibility that such a variation may be appropriate.

Dr Wilkins: From the audit perspective, our view is certainly not that there is always a one-size-fits-all solution. However, where there are these sorts of recommended guidelines that have been adopted and that have come from a national framework, if there are variations, we want to know whether they have been thought through and that the pros and cons of varying from the standard practice are clear. However, when we asked about the reasons behind it, because that is the sort of information that was collected at the preliminary level, no clear reasons were given that this was a conscious effort. It was more that the different areas and services had interpreted the guidelines differently and there was no central cohesion to ensure that variations were consciously being made for known reasons and that sort of variation could then be communicated to the community organisations so they understood why area A did something and area B did something different. However, again you could also ask the health department whether it has any views on an analysis of that kind. Certainly, it was not presented to us when we asked for that sort of explanation.

Hon HELEN MORTON: I am interested in knowing what month in 2001 the initial report was undertaken. There is a reason for asking that question. Was it early in the year or late in the year?

Mr Pearson: The report was tabled in November 2001. I would need to check the specifics, but these reports normally have an elapsed time of six to nine months, so the examination field work would have occurred between February or March, and September.

Hon HELEN MORTON: I ask that question because in that year there was a significant change to the way in which mental health services in the state were managed. This is focused on the response to people who present in emergency departments with deliberate self-harm. The mental health services on a general hospital site were separately managed from the rest of the hospital site. So an emergency department in a hospital site was not managed by the same part of the system that managed the mental health services. That means that there may have been some difficulties in an emergency department treating mental health patients with the same level of urgency as an acute patient because the emergency department was not being managed by the same people as the people to whom the mental health patients were accountable.

Mr Pearson: I accept that. The point I draw attention to is that, as part of finalising these reports, we go through a process of what we call procedural fairness. Given that the report was tabled in November, it would have been probably in September or early October, we would share with the

agencies that we are reviewing, what we call our draft summary of findings, to confirm that we have not misrepresented facts or context, and to provide assurance that what we think are logical recommendations are soundly based. The issue that you raise I do not recall being specifically raised, so by deduction I am assuming that the health system - we would have gone into a number of levels - did not raise that with us as an issue that should influence the facts or context on which we were drawing or the recommendations that we were making.

Hon HELEN MORTON: You spoke in your introductory comments about the Chief Psychiatrist undertaking reviews of mental health services etc, and whether they meet the national mental health standards. Perhaps it would be better to ask this question of the health department, but I wonder whether that includes reviewing the emergency departments, because the emergency departments are not a mental health service.

Mr Pearson: That is true, and the cross-over is important. Again, I suppose we need to be careful not to draw an audit conclusion based on facts that we are discussing here. My point in raising the issue about the monitoring and compliance is that it appeared to me in lay terms that there was a bit of bureaucratic blame sharing when one centre says it is not its responsibility, it is someone else's responsibility, and it does the circle within the system.

Hon HELEN MORTON: In some respects that is the issue I am raising. Mental health services could possibly be a bit fragmented on the basis that the emergency department, where a lot of these people turn up, is not managed under a mental health service framework. It is managed under a different framework.

Mr Pearson: That is right. It is not unusual in the public sector, and it is an area in which the audit involvement from time to time results in the matter being resolved to a degree, but given this has been raised in the follow-up, and this is where I am encouraged by the fact that the committee is looking at it, it might be a further impetus for the system to decide who is responsible, because at the end of the day, shared responsibility is generally relatively ineffective. At the end of the day, we need to have a position where the buck stops and people can be held accountable.

Hon MATTHEW BENSON-LIDHOLM: I am not sure that this fits into the discussion right here, but being a representative of the South West Region, I am particularly concerned about what I read in the executive summary and also the follow-up examination in respect of an obvious bias that is understandable towards the metropolitan area. Very little seems to be specific to some of the big regional centres. As all of us would appreciate, mental health issues across the board stem particularly from stress in relation to family and income. When you are talking about the south west, and indeed the agricultural region - we have a member from the Mining and Pastoral Region here - I am sure the same sorts of issues prevail, particularly in the Kimberley region. I am a bit concerned about the fact that the key findings in your follow-up performance action, and the what should be done section, focus very little on non-metropolitan issues.

[11.50 am]

I know that some aspects were mentioned, but the provision of mental health services in regional and rural areas is a significant issue, as you would appreciate. It is certainly an issue in the Agricultural and the South West Regions. One comment in relation to question 12 is that most staff in regional hospitals who were reviewed were unaware of the guidelines of 2000, for instance. There seem to be huge issues with regional and rural areas, which are not encompassed in either of the two comments I looked at. Could you comment on that aspect?

Mr Pearson: I accept your point. Peter might be able to answer more quickly in terms of whether that was specifically covered in this report. I accept that it is an ongoing challenge. To the extent that we can, we try to include regional areas in our fieldwork. However, it is a judgment call. At the other extreme, as auditors, we seek to look at enough information to form a reliable conclusion

and we then focus the recommendations on a systemic approach. It is implicit in our intention that a systemic approach includes regional as well as metropolitan areas.

Hon MATTHEW BENSON-LIDHOLM: Do you not think that there are specific issues with the significant differences in approach taken in regional and rural areas as opposed to the metropolitan area, given the nature of the mental health issues that prevail in the bush? Is that a fair comment, Peter?

Dr Wilkins: Perhaps I could step back. The 2001 report involved a very large study that included regional hospitals. We did not get out into the bush and to some of the primary care services where many people would arrive, given all the jurisdictional issues. Certainly there are differences in state services and as people arrive at emergency departments. Given the early comments I made about the scope of the follow-up and the relative resources we put into revisiting areas compared with going into new territory, the interviews and case information in the follow-up report is based on metropolitan sites only. We have not extended to new information about non-metropolitan areas. If the results had quickly provided an assurance that everything was fixed and running smoothly in the metropolitan area, that might have been a further question. However, given that the finding has been that limited progress has been made in terms of the metropolitan sites, it leaves open the concern about what would happen if the information were collected in non-metropolitan areas from regional hospitals. The wider question is how our whole mental health service applies throughout the state, beyond people arriving at a regional hospital. That is an even bigger question of looking at the operation of the mental health service and health services generally throughout the state.

Mr Pearson: I will make an additional comment and draw it back to the issue Mr Dermer and Peter discussed previously about our concern about the consistent application of the guidelines. I stress the point that Peter was making that we are not talking about a one-size-fits-all solution. There is a framework that people reconcile with. When you depart from that, you do that for particular reasons. That is an area that I could well anticipate. In some regional centres a conscious decision might be made to take a different approach, but that needs to be articulated and shared. On the other side, the patient could be presenting in a regional area and then in the metropolitan area. We have to take into account the patient's interaction with the system as well.

The CHAIRMAN: A recent coroner's inquiry exposed a situation that led to the suicide of a lady in Busselton. She presented to the Bunbury mental health unit and was refused entry on the basis that there was a lack of resources and staffing. She then went to Bentley and spent four days there before being discharged without any communication or consultation with her primary carers in the regional area. Two days later, she committed suicide. There is a significant overlap between the metropolitan area and the regions.

Mr Pearson: That is a graphic and tragic consequence of the sort of issue we are raising in theory.

Hon ED DERMER: I refer to the headings relating to risk assessment and psychiatric review in the follow-up performance examination, because they strike me as being two common factors. Reference is made to the Department of Health's endeavouring to recruit mental health nurses and the difficulties it has been experiencing with that. Similar problems seem to be faced when recruiting psychiatric registrars. I am interested in your opinion, if you have one. In those two instances, is a significant part of the reason for the Department of Health's not addressing the concerns to your 100 per cent satisfaction the fact that mental health nurses and psychiatric registrars are just not available?

Dr Wilkins: I will first provide some context for that issue. National reports talk about shortages in the health professions. That is the context; that is, health services must compete to attract people. We have not done an exact cause and effect analysis to assure ourselves that that is the predominant factor, but it has some face-value plausibility in that when a position is unfilled, there will clearly be problems. This problem will be faced across many professions as there will be skills shortages into the future. The question for management is how long a department should continue with a strategy

when it knows that it will be unlikely to fill positions. Should they revisit the strategy as they may not be able to get all the people they need in the current environment, or should they consider another couple of strategies to help meet that need? In the inquiries we made during the follow-up process, we were not given any indication of an option B, other than trying to get the positions filled.

Hon ED DERMER: If you asked people from a body such as the Royal Australian and New Zealand College of Psychiatrists to write guidelines, those honest and hard working professionals would write a set of guidelines that would highlight what they would like to see happen for every patient. The risk assessment and psychiatric review I referred to from your report are two areas that are pretty important parts of what you are suggesting needs attention. The guidelines need to match the reality when you are restrained by a lack of available mental health nurses and psychiatric registrars. It is a problem to which I cannot really see an answer, other than training.

Mr Pearson: We are perhaps being too subtle. That is where we are saying that that is the strategy, but if the strategy is not working, there comes a point when we must revisit the strategy.

Hon ED DERMER: The only other variable I can see is to ask why there is a shortage of these professionals. Is it because of their level of remuneration or training? It opens up a host of other questions that we have not really addressed.

Hon MATTHEW BENSON-LIDHOLM: A group of us recently spent some time in the eastern states and were briefed on the Victorian model. Helen would know only too well the situation that prevails there. The situation in Melbourne is critical. This is interesting, given the size of Victoria relative to the size of Western Australia. There has been a concentration of psychiatric services in Melbourne. Is that the sort of thing that will continue to happen in Western Australia? Three members of the committee represent regional and rural areas. We know that the centralisation of services would pose problems. Given the sheer size of Western Australia, it would only exacerbate the problems. Structures need to be put in place. This is a policy area, I know, and we do not want to go down that path; however, there are implications in terms of being able to get people to the more centralised services.

[12 noon]

As alluded to by Hon Ed Dermer, the necessary people are not available. I am reliably informed that the funding per capita is greater in Western Australia than is the case in all the other states and territories, so the situation is not looking good in relation to what you say.

Hon ED DERMER: I imagine that for both those types of professionals - the psychiatric nurses and the registered nurses - a fair element of vocation is required in the individuals who chose to take up those professions, so it may well not be an issue of remuneration or the availability of training. The problem may be that only a limited number of the population is drawn to that type of work.

Mr Pearson: But the issue for the community that the Department of Health is charged with managing is that while there may be a problem with the supply side - or the professionals - irrespective of how difficult that problem is, we have a very real need that needs to be addressed. It is not for me to think of alternative ways of doing it. We have mentioned that centralisation is one strategy. However, the point we are raising is that the timeliness of addressing this matter, and the element of whether it will ever be successful, in my mind requires a management decision. It is clearly acceptable to wait three months or six months to fill a position. However, if you have tried earnestly for six months and you cannot fill it, you are probably better off looking for another option than placing another ad. We have come back four years after the event, and I do not think anyone would disagree that it is a pretty fundamentally serious community issue.

Hon HELEN MORTON: In either your initial or subsequent report did you look at the number of people presenting at the various emergency departments with a mental health diagnosis, and can you break that down to deliberate self-arm? They are all registered on the emergency department

information system. The report talks about the department increasing the number of mental health nurses to make sure that there is 24-hour coverage at Sir Charles Gairdner, Royal Perth and Fremantle Hospitals, and after-hours support - so it is not on site - at Armadale and Swan District Hospitals. I am interested to know whether you have figures to indicate the number of people who presented at those various emergency departments with a mental health problem.

Dr Wilkins: I do not believe from the data systems that were available to us in our work for the 2001 report that we could get that information. Certainly there were aggregate numbers about people presenting at emergency departments, and the subclassification of the types. I may get that confirmed to see whether there was any other information.

Hon HELEN MORTON: That would be worthwhile, because emergency departments have that information.

Dr Wilkins: That is why we primarily went to a case file analysis. We had to get a random sample from files across the various centres to get our own picture of what was going on.

Hon HELEN MORTON: The other part of it that would be worthwhile to know - I do not think you have done it, so we will not be able to get it from you - is the number of psychiatric registrars or mental health nurses available at the respective hospitals, versus the number of others, on a basis of presentations. An example would be that Sir Charles Gairdner and Royal Perth Hospitals do not have an approved mental health unit within their facilities, so they cannot take people who need to be approved to go into a secure mental health facility; however, Swan District, Armadale and Fremantle Hospitals do. Nevertheless, the majority of the psychiatrists are working at Royal Perth and Sir Charles Gairdner Hospitals. We have been talking about not being able to get the services out to the regional areas. However, we actually have a difficulty in being able to get some of the psychiatrists and the resources out to the approved mental health hospitals from these teaching hospitals.

Mr Pearson: Again, that is an issue that I would encourage you to pursue with the department, because it is primarily responsible for the management and hopefully can provide you with the answers. The challenge for us as an auditor is that we are looking at a snapshot in time, and we are trying to look at what we think are the key issues.

Hon HELEN MORTON: I am really surprised about your inability to get the information that you wanted from the emergency department information system.

Mr Pearson: I do recall that from the audit. Unfortunately, health is not alone in that. When we come in, the first thing we look at is the integrity of the information. The level of integrity of the information for audit reliability was just not there, and that is why we had to go back to the case files and work through them.

Dr Wilkins: Perhaps to provide a bit of background context, we have talked about the mental health service changes that have occurred over time. The other fundamental change to observe from the audit perspective is the role and status of emergency departments. In the 1990s we did a report on hospital emergency departments. At that time, they were seen as a bit of a backroom rather the front door of hospitals. I remember doing some of that work myself, and the head of the department said it will be quite a surprise for me when the CEO actually visits this emergency department. One CEO had never been to the emergency department. He said perhaps the tabling of our report will lead to that. I did not follow it up to find out whether it did have that effect. Clearly the emergency departments have changed their role, and the separate profession of emergency medicine now has a much stronger role to play in ensuring that the services are well structured and in increasing the coordination to other parts of the health system.

The CHAIRMAN: One area of your recommendations related to the clinical information system. Why is that system not fully implemented and available for community mental health services personnel to access?

Dr Wilkins: There were a number of issues there. Some were as simple as the fact that having implemented the system, the hardware was not available, so the community health services did not have the computer hardware that would run the software that had been generated. There were also issues about the data entry load, or what was involved in actually entering the data into the system. We have just been talking about staff shortages. Typically in information systems there is a problem where, at least at the time when it is unfolding, the staff do not see any immediate benefit out of it. They are obligated to input data. However, rather than see the benefits in it, they see it as a one-way process. It also has to do with the skills and back-up support that are needed to make the system work. The follow-up report identifies that they are doing further work on the system. Obviously it is to be hoped that it becomes fully operational and provides good information across the state system.

The CHAIRMAN: Do you accept that those explanations or excuses are reasonable?

Mr Pearson: It is not really an auditor's role to be the judge of that. We are the informant. No system is ever going to be perfect. However, these issues were raised four years ago. It is interesting, because I notice that one of the responses is we are expecting full implementation by the end of 2006. Five years have gone by. From a governance perspective, and as an auditor, we always look at prioritisation, timeliness and delivery. It is not a perfect world, and allowances have to be made, but what we are really looking for is whether people are actively and purposefully driving the system to optimise the benefits from the available resources.

Hon HELEN MORTON: Was the online clinical information system known as the PSOLIS intended to be available to emergency departments as well as mental health services? Would that system be available to a registrar or mental health nurse who was working in an emergency department?

Dr Wilkins: My understanding is, yes, it was to be across the system - both the mental health services and the emergency departments - but I will clarify that.

[12.10 pm]

Hon HELEN MORTON: And non-mental health services as well. As I said before, an emergency department is not part of the mental health system. If this is being rolled out across mental health services, it may not be available to people who work in an emergency department.

Mr Pearson: We can seek to clarify that and will let the secretary know. Again, that is a test of effectiveness. If the emergency department is involved in providing initial treatment and is then excluded, I would have thought that would be a deficiency.

Dr Wilkins: The main purpose of the system was to give the mental health services the information they needed. Clearly, from the findings, that has not been achieved.

Hon HELEN MORTON: That is the case within the mental health system.

Dr Wilkins: Yes.

Hon HELEN MORTON: So community mental health people and acute and aged care mental health services - all the things that are designated as being mental health services - would have it.

Mr Pearson: Maybe I am being too idealistic, but my objective in looking at a holistic system is that there should be a capacity for entry from emergency departments, because that is where people present. You want them to be put into the record at the first opportunity.

Hon HELEN MORTON: Those same people turn up in the operating theatres, medical wards and surgical wards of hospitals. You might be being idealistic. This is not run across the entire health system; it is being confined to mental health services. I do not know the answer to that.

Mr Pearson: We will seek to clarify it. I think in principle you would expect the professionals to have access to the whole picture of any patient.

Hon HELEN MORTON: Was the issue of confidentiality raised at all through that process? One of the issues about making mental health records -

Mr Pearson: Yes; more broadly available -

Hon HELEN MORTON: - is that there are often issues about confidentiality.

Mr Pearson: When I was dealing with the last issue, I covered the privacy considerations mentally but not verbally. That is clearly a consideration. In principle, a clinician needs to know the full picture, whether he specialises in mental health or another complaint.

Dr Wilkins: A key issue that came through our inquiries is the need for the timely movement of information; that is, it is critical in some cases that a community health service is able to follow up a person immediately on being discharged from hospital. We were given examples. Again, it was not consistent across all hospitals. There were cases of best practice when information was transmitted that day. In those instances, the community health service knew that if a person did not arrive in a certain number of hours, it could take proactive steps to locate that person. That information needs to go in a timely way and by whatever channel from the hospitals to the community health organisations.

The CHAIRMAN: The coroner's inquiry I referred to exposed that need very tragically.

Hon ED DERMER: I note that your follow-up examination refers to the Department of Health advising that an evaluation framework for the state mental health strategy is under development. Can you shed any light on the progress of that development?

Dr Wilkins: Not at this stage. We have not seen any details. Again, that is a question you might ask of the department.

Hon ED DERMER: Would you have received the advice that it is under development during the early part of this year?

Mr Pearson: I would have thought about August.

Hon MATTHEW BENSON-LIDHOLM: I refer to your follow-up performance examination. Obviously, if it is part of a cohesive evaluation process, it is fairly important that that sort of thing gets up and going ASAP. Maybe that is something you could get back to the committee on to inform us of its likelihood.

Mr Pearson: We receive an update through our working papers. Equally, I encourage the committee to pursue that matter with the department, because we raised that issue in 2001. From an auditor's perspective, the department has had four years.

Hon MATTHEW BENSON-LIDHOLM: That is something we should take up.

Mr Pearson: I might be too hasty in judging the department, but we raised the issue in 2001 and it is under development in 2005. I would have expected it to be 80 per cent complete and for the department to be doing some refinements. In that instance we would have said that it was substantially in place and being developed. Without weighing up the priorities, I would expect that as a minimum after four years.

Hon ED DERMER: That is why I asked for further information.

Mr Pearson: We will confirm the facts on that. My recollection is that it was raised as an issue in the original report. In one sense it is a bit theoretical, but unless you have a cohesive approach to watching and monitoring what is going on, how do you know how well you are going and the extent to which you are achieving your outcomes, and how are you prompted to change your strategies?

The CHAIRMAN: You mentioned the word "priority". Of your 2005 findings, have you attached any priority to their implementation; that is, are some more urgent than others?

Mr Pearson: The honest answer is no. As an auditor, we generally provide our recommendations in descending order of implied priority. On the basis that the department accepted the findings of the initial report and indicated it would act on them, our thinking did not go any further. In the follow-up, we said that these are the recommendations we made, and that this is the extent of the progress. That comes back to my audit role. There is no executive authority. Impartiality and independence is a fine balance to manage, but in a sense you need to have a firm enough view to reach an opinion or conclusion and to report on it. However, I do not see the role as extending to prosecuting the acceptance and implementation of it. It is for executive government to respond and report, and for the Parliament to hold the executive to account when it considers that to be warranted.

Hon HELEN MORTON: You commented about the department reviewing discrete suicide prevention programs and trialling key performance indicators. Did you have access to any of the key performance indicators that the department is trialling; and, if so, what is your view of the usefulness of those key performance indicators?

Dr Wilkins: Again, I believe that we had an indication that this work was under way. We have not drilled down to do an assessment of the quality of the work. We acknowledge that the work is under way and have left it open to ask in due course what results have come from that work and whether something useful has been implemented.

Mr Pearson: As the auditor, we have done a substantive review and report. This is a high-level review of what has happened against what we said. That reflects an indication of positive action by the department, which we are relaying.

Hon HELEN MORTON: But you didn't see them?

Mr Pearson: No.

The CHAIRMAN: Do you have any closing remarks that you would like to make to the committee?

Mr Pearson: I express my appreciation for the opportunity to discuss the report, because it has been very fruitful feedback for us in terms of the topic and also helps us in drafting future reports and being a bit more sensitive to nuances and things like that. It completes the two-way feedback loop and is very helpful.

The CHAIRMAN: Thank you. As I indicated, we will be doing more of this next year in terms of following up reports from you, the Ombudsman and other parliamentary officers. We hope we can contribute to better public administration. That is the end goal.

Mr Pearson: My feeling is that it is sure to do so. While we approach our work in a responsible way, this adds another level of rigour to it and provides us with valuable feedback. Simply sending off reports and not getting any indication of what they mean to people or what use they are is to be avoided.

The CHAIRMAN: We have a public hearing planned with the Department of Health in two weeks' time to follow up today's proceedings. We will see what comes out of that. Thanks very much for your time this morning.

Hearing concluded at 12.18 pm