THE PARLIAMENTARY JOINT STANDING COMMITTEE ON COMMUNITY DEVELOPMENT MET IN COMMITTEE ROOM 2 ON TUESDAY, 8 NOVEMBER 2005

INQUIRY INTO STRATEGIES FOR THE PREVENTION OF SUICIDE

Dr ASHLEY ASHLEY, DIRECTOR, PSYCHOLOGICAL MEDICINE, ROYAL HOBART HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Thorp) - Perhaps you would like to speak to your statement.

Dr ASHLEY - I'm not sure whether the figures on suicide are decreasing or increasing. I think it involves extremely complex behaviour; it's just part of living. There are all sorts of opinions about suicide; you are merely getting a little of my opinion today.

Suicidal behaviour involves world views, the nature of the universe, the nature of man, what the problems and solutions are, and your hermeneutic approach to all of this. Something might look like a solution, but there is always something behind it. Then you have the problem with the history of ideas: Popper and Eccles, who won the Nobel Prize, talk about world 1, 2 and 3. World 1 is the world of science; it's falsifiable. World 2 is the world of the mind and its products. World 3 is the world of history, religion and ideas. Trying to approach a suicidal patient with all of that is difficult.

Then there is the whole question of therapy. What, how, who, where, when and why are you treating or intervening. All therapies have biological, psychological, social, environmental and spiritual aspects. I am not going to be the world 100-meter sprint champion no matter how hard I try, and there are some people who are simply going to commit suicide no matter what happens. Therapy is interpersonal, intersubjective, interrelational and, in the end, medical. Therapy requires a model of brain and mind; to change one's mind requires something. You are attempting to change people's environment, jobs, houses, relationships etc. The whole question is problematical.

I will give you some anecdotal comments about the Royal Hobart Hospital. I graduated in 1971 and I have been doing psychiatry since 1973. I direct the ship by default because Professor Pridmore left; I have been doing so for about three years. That has been about enough; it has been a pretty difficult few years. What I am saying is not hypothesis-driven or particularly rigorous. People are brought to, or come to, the RHH, in and out of office hours. There is only DEM and the RHH; there are no other options for whatever has happened. A person was discharged and they punched someone; another acted funny, like acting-out; or there is something defective. They are ill. By illness I mean that if I go to a doctor and complain about being ill, the doctor may or may not say I am sick. If I have some bad results from pathology then I may have a disease. All sorts of different things are going on. People have disturbed affect, behaviours, cognitions, self elatedness and so on. They may or may not have a recognisable mental illness. There are all sorts of arguments about what is or is not a mental illness. For a lot of folk it occurs in the presence or absence of something, or

they have little family, or overwhelmed family and friends, or no GP or private insurance or accommodation. They might or might not have committed a crime. There may be other services that are not functioning at that time. Often after hours there is nothing else available, so it all collapses at the Royal. I guess that is why you have asked me to come, because it all collapses on us.

In the first instance, they are triaged by the nursing staff and then by doctors of varying experience. Most of us doctors are a pretty mean bunch. We attempt to be good enough doctors within our associated legal, ethical and humanitarian considerations. Most of us have a paranoid stance: is the minister is coming the next day; will the family thank you in three days' time; will we be slaughtered by the Coroner in two years time? The questions I ask when I see patients include: are they psychotic or non-psychotic; do they have a medical condition; are they certifiable or not; can they give consent; are they treatable or is it just a matter of containment? The assumption for most of us is the worst-case scenario, requiring low risk and maximum impact.

I'm a bit of a fan of Steven Seagal. Remember when he is on the train and they think they have killed him? The chief baddie asks, 'Did you see the body?' The reply was, 'I assumed he was dead.' He replied, 'Assumption is the mother of all fuckups.'

Laughter

Dr ASHLEY - I wrote that to Mr Parker after Martin Bryant came to casualty. Any of us could have seen him or someone like him the day before. There would not have been any hole small enough or remote enough to hide in. Your career would have been over. That is the risk that we take all the time. We take a paranoid stance so that we err on the side of caution.

Consequently, these people are then referred to psychiatry. In terms of diagnosis and causation and what you are going to do, it's all a bit unclear. There is the tip of the iceberg, but what is beneath. Not to refer people is too hazardous for the clinician, the hospital, society and, in particular, for the patient. In the RHH, the assessment is generally done by me or a colleague - we are psychiatrists - or occasionally by the registrar and the nurse. In general, two people see a patient. It's just too dangerous; two brains are better than one. The clinical assessment is like a man going to a party and seeing a cute chick. Within about five milliseconds the brain has registered that there is someone over there who attractive. Similarly, if you are wondering through the jungle and you see a snake, the first thing you do is jump six feet in the air and then a half second later the brain tells you that it's a snake. If you go into casualty and attempt to engage with or talk to the person who has been brought in, you attempt to track their emotional experience while remaining attuned to everything else. You attempt to validate or contain the patient. You attempt to understand what is going on. You attempt to understand the diagnosis, if there is one, what the causation is, what the problems are, what strengths people bring with them, what you have to clarify, and management. In the end, all I have is my brain, my experience.

A long time ago I tried to construct instruments so that everyone could get standard information, but it is just a bearpit down there. The phone is ringing; someone wants to punch your lights out - whatever.

Mr WHITELEY - And that's just the staff!

Dr ASHLEY - It must be just like being in the House; you can't control it. I say to my younger colleagues, 'These are the principles and important things you need to think about.' They may or may not do so. We now formalise the clinical risk and try to be clear about what the person's clinical risk is at that time. There is a fair bit of acting-out in the unit, so we have a conduct code, which you can read. It says that it is the policy of the DPM that it does not tolerate abuse, violence, drug and alcohol abuse, sexual misconduct, absconding and self-harm, and if you do any of these you will be thrown out unless there is an absolute psychiatric need to be in the DPM. It's very unusual for us to throw people out because it is so risky. If people really play up they go to PICU and it is reviewed over a matter of hours. Some people are so dangerous to us and to other patients that they must be 'black-flagged'; they would only be seen in the hospital if they were bleeding to death, out on the footpath, in handcuffs, with armed police present. There are some extremely dangerous people who we are not going to see unless there is an extremely good reason to do so.

Mr WILKINSON - Has that increased over recent years? It seems that more people are being affected by their intake of drugs; therefore they become more unpredictable.

Dr ASHLEY - I think it has increased, but there is a category of people who are simply too dangerous for us. I don't think that has changed. There are one or two people around all the time whom you don't want to see, whom you don't want your daughters going out with. They are too dangerous for anyone who wants to help.

Mr WILKINSON - They are walking on the street?

Dr ASHLEY - You bet.

Mr WILKINSON - They come to see you?

Dr ASHLEY - Occasionally.

Mr WILKINSON - And you just say you can't see them for whatever reason; you don't tell them why.

Dr ASHLEY - We have had lots of these people in the unit and it has been a disaster. They say' I'm going to kill you if I see you on the street', or take a shot at you or whatever. By and large the police don't particularly want them because they haven't committed a crime. It is a very small group.

To continue, once you get into the unit all these forms are filled out. Risks are assessed, categories are changed and so on. If there has been an incident you try to understand what the incident was about. We would all agree that prediction is difficult. Heisenberg said that if you know where an electron is then you don't know how fast it's going. Bohr, who won the Nobel Prize for discovering the atom, said that forecasting is difficult, particularly predicting the future.

Laughter

Dr ASHLEY - Life is too short, and I don't want me, my staff or my patients to take unnecessary risks. One wrong decision can ruin the rest of your life, and others around you. The question in casualty is, are you looking at a reptile? All of us have seen reptiles. If you had a few beers and some drugs and you poked somebody on the nose then you would be a reptile. That is the basic level of brain organisation. Then there is the level of the mammal - caring or playing. Then there is the rational you and I. Rational people can sit down and so on but a lot of what we do is not rational.

Generally, people are admitted. If I don't know someone, I will generally admit them. It's too risky not to. The 24 hours of admittance is a very short time in a person's life, and often it is much clearer. The difference between a successful and unsuccessful suicide may be just two glasses of beer, or a girlfriend ringing up and saying that it's over. They may or may not be admitted in the presence or absence of formal mental illness. Fortunately, mental health legislation does not define it so a lot of the time we act illegally. However, I'd rather be thanked in three days' time and sued for caring or being overzealous or whatever, than be seen as cavalier and dodgy. It is our professional responsibility to care for the suffering, and these people suffer. Also, we admit because at the time we think it is going to be helpful. Occasionally, we accept a dangerous patient whom I would not normally admit.

The relationship between the presence or absence of mental illness and suicide is complex. Psychiatry is a traumatic profession. No-one runs around town saying, 'Psychiatrists are fine people, I want one to join my family'.

CHAIR - You ought to try being a politician.

Dr ASHLEY - Oh, I'm not far above you guys. We suffer from the disruption to our stream of consciousness, so it is really is clinicians and doctors. We spend most of our miserable lives worrying about our patients. We're nuts, and trauma just damages you, it robs you of your sense of agency that you can actually do something. It's something to do with burnout, as a politician or anyone know. What can I do in the face of everything, all the traumas and misery and whatever. By continuing involvement in the management of human suffering, especially at the toxic coalface of the Royal Hobart Hospital, over the years there has been the steady attrition of psychiatrists, registrars, nurses. We often struggle to provide a place of safety in which we can make some assessment dealing with broken down people.

I need to say to the committee, clearly most patients are not toxic; lots of people in the Royal Hobart Hospital are ordinary suffering people. They are not all horrible, but it's the one or two that can just ruin it all. Generally I think it's a bit like a balloon. If you squeeze the number of hospital beds, it pops out in jail, or if you squeeze the jail part then it all pops in lack of follow-up services or it pops out elsewhere.

I think there is increasing demand.

I remember being here in 1973 and being outraged one Saturday morning when I had two patients to see in DEM. I had never heard of it and never seen it and wondered why it happened. The other morning we had seven at 9 o'clock in the morning. A long time ago we were taught to inquire very discreetly about suicide or homicide. You might be half an hour into the interview and you would say vaguely, 'Have you ever thought life's

not worth living?'. Now it's about the second or third question if they haven't told you or haven't come in because they've punched someone or threatened to kill themselves.

Mr MORRIS - Do you think that's partly because it's more acceptable to talk about that now in the community as a whole?

Dr ASHLEY - I think so, but this is not academic; I think it's just changed. There is the increasing toxicity; I think it's a more aggressive society. I think domestic violence is perhaps more prevalent. There are much more drugs; THC and amphetamines are real problems in this town. When I came through it was barbiturates and narcotics and bromides. There is this whole question of sexual abuse in childhood, and all these abused people that we see. I am not sure that families are any less or more supportive than they once were, but I seem to think and in fact we see there is less support.

Unemployment is low at the moment, but lots of our clients haven't got jobs, and their relationships are a mess. I think once upon a time there were more resources in terms of this bottomless, expensive Royal Derwent Hospital; there was always a bed up there. It has been reduced to DPM having 34 beds and PICU having eight beds and Mistral Place having ten beds. The problem with bed block, being on call as a consultant psychiatrist in this city in recent times, is really a worry. You go to the weekend with one or two beds and discharge, I think, unwell people.

CHAIR - To free beds up?

Dr ASHLEY - Yes.

CHAIR - To make sure you have some beds because they will be required over the weekend?

Dr ASHLEY - Yes, over the weekend. We have to park people in medical wards or occasionally park people in DEM. I don't think that gets to 24 hours, but I think it's changed over the years, and there are more likely to be people in DEM. But it's preferable to sending them home because it's too dangerous.

There is a failure to recruit and retain psychiatrists. I think perhaps, like politicians, there is this increasing mistrust, blaming and devaluation of what we do and perhaps also of the mentally ill. Suicide and homicide are a dreadful experience, but we do our best in their complex lives. I think the questions are, 'Am I my brother's keeper?" who's responsible for what? Like you guys, I have too many people coming to me saying, 'Actually, I've got a problem; what are you going to do about it?'. The big question is not why do people kill themselves; I think the question is, 'Why should I live?' But that's just what you think, not why you killed yourself.

I think the questions involve complex past, present and future biological, psychological, social and environmental factors. I guess blaming the politician and the mental health professional at the Royal Hobart Hospital, who has otherwise acted reasonably, safely, effectively and responsibly most of the time is not particularly helpful. I think what I have just said to you is all somewhat subjective but cold objectivity, in the cauldron of the department of psychiatry or DEM Royal Hobart Hospital it is difficult. It is a bit like

Mathew 9:37-38, which I was reading at the weekend; the harvest is ripe and ready but there are not many -

Mr WHITELEY - Not may to pick it.

Dr ASHLEY - to pick it.

Mr WILKINSON - You have painted a pretty bleak story as to what happens at the hospital and I obviously accept what you say. What can we do or what can you recommend to assist what is going on in the hospital, especially in the areas of suicide and psychiatry?

Mr WHITELEY - Can I pick up on that. You made an interesting comment about the past. I think you said 'You could always find a room at New Norfolk.' You did not pursue that much by stating a comparative solution. So with that in mind do you have any further comment to make about what was and what is, and where we need to go? I am not suggesting we go back to New Norfolk, but you made an interesting statement.

Dr ASHLEY - This is anecdotal. There are a lot of people who do not have homes, do not have accommodation, cannot organise themselves. They might by psychotic and/or on drugs but if someone just made sure they had their medication that night and they had somewhere to go, then they might continue to take their drugs but they would not be otherwise mad. That is part of the answer. So I think we do not have enough accommodation. I am not sure that the answer then is putting people in houses and saying, 'Look, as long as you take your medication we will look after you; do not work and otherwise have a great time'. I don't think that is particularly good for them. I have no answers. I say to the committee, all I am is a clinician. I see a lot of people and I attempt to work with them. I have them and I have no answer to those problems.

Mr WHITELEY - That blows your magic-wand question out of the water, Jim, because you are always asking, 'If you had a magic wand, what would you do?'

Mr WILKINSON - It seems like a story of hopelessness. In other words, you do what you can with the tools that you have. But the tools that you have, in the end, are not enough to do the work that you would like to do. So therefore what extra tools do you need?

Dr ASHLEY - Staff, accommodation, better drugs, people who take their pills, families that care more.

Mr WILKINSON - Yes.

Dr ASHLEY - In the end for a lot of people it is about experience-dependent brain maturation. People need some kind of therapist, like a mother or someone, who is going to help them to grow up if it is possible for them the change.

Mr WILKINSON - The people that you have spoken about have no homes and there is nobody there to ensure that they take their medication et cetera. Those people come to the Royal, get treated and the doctor gives what he or she believes is the most appropriate recommendation in relation to treatment. They say, 'Look, I do not think you have a problem. I know you don't have a house, I know you don't have anybody to care for you as far as your medication is concerned but we cannot help you here because we

do not believe anything is wrong.' It's a bit like what you were saying about Martin Bryant, that he might have come in the day before. Do you find many people in that situation, who then go out and commit suicide or attempt suicide?

CHAIR - Would you know?

Dr ASHLEY - I get to write one coronial submission probably every three or four months. They are all people who have had a suicidal thought, and even a smaller circle would have had an attempt, but there are very few who actually do it. I am not sure if I am answering your question, Jim.

Mr WILKINSON - You were saying that there is a lack of accommodation, a lack of people to care for those that need the care, so therefore you have got to put those people out on the street again. Have you found, as a result of doing that, those people have either attempted or been successful?

Dr ASHLEY - I think some of them do. In the end because life is just so hopeless. There is no one to go to, no place to go to, no medication has worked. Schizophrenia is a dreadful illness. It robs you of your frontal lobe.

Mr WILKINSON - We have had a lot of evidence in relation to the main causes of suicide, some that you have mentioned. Are there any others? Relationships, drugs, alcohol, nobody cares, no accommodation, hopelessness, no job -

Mr WHITELEY - Bipolar.

Mr WILKINSON - Yes. Mental disorder. Have I missed any?

Mr WHITELEY - You said there were a number of things to do with the sort of environment one is left in, whether there is a psychologist on board, for example a mother or a father, which, sadly, a lot do not have. They go back to nothing - 'nothingsville as we call it up our way, nothing to go home to. Some of those things must be in our control, though, as members of Parliament, such as the issues of resources. We would like to think that we can do something about that.

You then mentioned the issue of accommodation. I think there are some issues there that we can do something about. You then move onto some of the issues that start to move outside of our control, such as the sort of environment one is living in, the care in the environment or lack of it, the sort of hostility within a home or whatever.

So I suppose our job, Madam Chair, is to try and find the things that we can do something about and to make recommendations that would at least lead to two or three of the six fundamental issues being addressed. Some of these other things are scary and somewhat hopeless in a way because we cannot walk into peoples lounge rooms. We wish we could from time to time.

CHAIR - Yes. I suppose you could argue that as a society we can tackle some of the issues that make the families disfunctional.

Mr WHITELEY - I cannot disagree with that. But as far as some of these other issues within this report I am saying -

CHAIR - The more pragmatic issues.

Mr WHITELEY - Yes; within this report we can make recommendations in relation to two or three of the practical things .

CHAIR - We heard from the police that when they have someone that they think needs your help they arrive at the Royal with the patient or client and there is an inevitable wait, so that police resource is being tied up because they are waiting for someone. As you said, you need at least two. How many psychiatrists have you got in your unit and how many do you think you should have?

Dr ASHLEY - Shivers. I have relinquished the directorship because it has been the worst 33 months of my life. I do not mind whether that is on the tape or not, but I have been doing it for a long time. We got down to less than half the complement, so we had two-and-a-bit psychiatrists. I am too old for it. I am talking about my particular experience. I have not got the general answers that I guess you want. I know I can help a lot of people. There are some people that I cannot help but I think with them more therapists around and more resources we could help more.

CHAIR - So what you need is that when you are confronted with an individual, you need to be able to send them somewhere secure, to ensure that they have someone with them to make sure that they are taking their medication, to make sure that they are sleeping well, eating well. Then you see them in a week and see what you can do. But you have not got that.

Dr ASHLEY - No. Years ago, when I was here in DEM, someone would come in depressed but we had a functioning community health centre so I could get them an appointment tomorrow. Now, I am not bagging the people in the community health centre because I think they are under-resourced and overwhelmed and they cannot see people for three months.

By and large you and I are pretty hopeful creatures, otherwise we all would have shot ourselves weeks ago. Often does not take very much to keep people going.

Mr WHITELEY - You have a really difficult job and I commend you. We all play a different role and we have all got our talents and gifts that are all different. You have a very good understanding of what you do and why you do it. However, if someone was to pick up a transcript of today and they were looking for a career, then I am not sure there would be too many backing it up at the university. So what is happening there? It is all very well to say we need another three or four psychs. Are they there? Are they coming through? Is there an interest across the nation to fill these positions or not?

Dr ASHLEY - There is a international and national shortage of psychiatrists. But Hobart is particularly blessed because for some peculiar reason. There have been changes. It is not all gloom and people can get through here. I think on the mainland half the training positions are vacant.

CHAIR - Is that right?

Mr WHITELEY - That is what I am leading to. It is all very well to say we need more of them but where do we get them?

Dr ASHLEY - We will have to grow them locally and keep them local.

Mr WHITELEY - So we have to be six years ahead of ourselves?

Dr ASHLEY - Yes. It is not the money. I get paid adequately. I could be paid more but that is not the reason I stay.

CHAIR - What about nursing staff? Are there enough nurses taking up psychiatry as an option?

Dr ASHLEY - I would probably say no. The more senior nurses are just burnt out and lots of them have gone elsewhere. It is exhausting.

Mr WILKINSON - Do you think there is any part to play in schools in relation to letting children know the danger signs? We've heard of an instance where a young fellow was walking home. He had gone and packed up all his bags, packed up all his books from his locker, and was walking home. These bullies who were bullying him did it again and his books fell all over the ground. A fellow who was one of the more senior members of the class helped him pack his books up and walked home with him and they finished up being best friends. But it came out later that this fellow was going home to commit suicide. He cleared his locker because he didn't want his parents to do it over the weekend after he committed suicide. That person obviously did not know he was stopping a suicide. Just realising there was somebody there for assistance, somebody there he could call a friend, I suppose, that is what saved him. People at a younger age are aware of what is going on, and bullying in schools is probably is a start which makes people depressed. I do not know, but it seems to be an area that needs to be addressed. There are telltale signs of people at risk. If we know more about them, educate the school more and have people who can tell those telltale signs, that might be of assistance.

Dr ASHLEY - I think that is true and I think we save hundreds of potential suicides here. It's just what you say; in the first 10 microseconds with someone you know that person is going to kill themselves that afternoon if you send them out. The police do have to wait sometimes. But I tell you what, if it is a big bloke and there are 55 police, it is a very brave doctor who says to the police, 'Don't hang around'.

Laughter.

CHAIR - They were not being critical of the service. They were basically saying that if there were more staff at the Royal they would be handing people over quicker and looking after other things.

Mr MORRIS - I will come back to quite practical matters if I can. You have just shown us the number of forms that have been developed and are used there. Firstly, with records of the patient, we saw in the report that was released earlier this year that there is not an

interchange of reports or medical records of patients to the community sector outside. Can you tell us whether that is a problem for you? Conversely, when someone comes in do you have any access to any existing records that might exist for that person? How do you go about finding out what records might exist to help you at least understand their history?

Dr ASHLEY - I think communication is a problem and we are forever asking registrars to make sure that the discharge summaries get out and that they have rung the doctor or whatever. It does fall down sometimes. I think most of us assume that if people are going to kill themselves, whatever the worst case scenario additional information, although useful, is not as important as just the assumption. So you do try to get information, but it is not perfect.

Mr MORRIS - Do you think that it is possible that an electronic record system that might operate through the hospitals or throughout Tasmania might help you in accessing information on a patient's history, perhaps?

Dr ASHLEY - I would have thought so, yes. Information is power

Mr MORRIS - Are there moves at the moment to provide electronic recording systems?

Dr ASHLEY - I think so. We are trying to standardise our procedures around the State.

Mr MORRIS - With the release of a patient, you obviously do not want to release them until you feel comfortable that they are stable and so forth. Do you ask patients what their wishes are for when they are released? Do you explore that with them, especially if they are homeless, unemployed and whatever? Do you explore, firstly, what their wishes are and then do you try and match them up to services? Is there a way that you can match them up to services that might fulfill or help to fulfill those wishes?

Dr ASHLEY - I think most of the time we try to arrange accommodation, follow-up, GP, mental health and whatever.

Mr MORRIS - Do you have a priority in terms of accessing those services? Do you ring up and say, 'I am from DPM I have someone here that needs accommodation. We need to discharge them and they are ready to be discharged', or 'We need to discharge them because we have someone more urgent coming in'. Do you have any priority to access accommodation for those people that you need to discharge?

Dr ASHLEY - I think so. We were talking about it today. We have sort of 'political prisoners', like the woman who has been with us for four years in Mistral Place. We have a man on the ward who has been with us a year and a half. We have another girl who has been there most of this year because we can do nothing else.

CHAIR - Do you think that is bed-blocking?

Dr ASHLEY - Well, I think so because there is no other containing, holding environment.

CHAIR - They do not need to be with you?

Dr ASHLEY - We are an acute unit and we lack the next level. I think we would have enough acute beds if they were just used for acute patients. But most people do not want to be in our place for all that long.

Mr MORRIS - I am not surprised; I have been there myself to visit.

Dr ASHLEY - The unit could be more therapeutic or healing, or less toxic.

Mr MORRIS - It is virtually in the bowels of the city.

Mr WILKINSON - What would you do to make it better?

Dr ASHLEY - You could send me on a round the world trip to see other good units, but I think a lot of psychiatric units are pretty dreadful around the country.

Mr WHITELEY - You have only to use a comparison of what used to be the case with aged care facilities, say thirty years ago when I used to visit my grandmother. That is not a bad comparison; there is just no comparison with now. It has actually got some life in it, some colour and some music and some softness.

Dr ASHLEY - PICU is a great unit; it is probably the beast PICU unit in the country. You might think it is dreadful but it is a pretty great unit.

Mr MORRIS - It is the setting in a sense that is not ideal, isn't it?

CHAIR - But you have got good people, I gather?

Dr ASHLEY - We have got good people. It is just that the harvest is full and there are not many labourers and there is no easy solution.

Mr FINCH - You mentioned that about half the training positions for psychiatrists are vacant.

Dr ASHLEY - Yes.

Mr FINCH - Why do you think that is? Why are the young students not being attracted to that course of learning?

Dr ASHLEY - I think I was saying that there were not enough consultants in Hobart in the public system. In the country there are not enough trainees. It is a toxic, dangerous, difficult job. Things go wrong; you get into trouble. There is the aggression, the drugs, the lack of compliance, the family breakdowns. Those are the reasons, I think.

CHAIR - It is not an attractive career option.

Dr ASHLEY - I am not sure that medicine is particularly attractive.

CHAIR - I talked my son out of it.

Dr ASHLEY - None of my daughters did medicine. It is a good thing. Medicine is a terrible mistress. I am not sure what politics is like, but it dominates your consciousness for the rest of your life. You are always behind; you are never up to date; there is the explosion of knowledge and so on.

Mr FINCH - Can it be made more attractive? Are there ways?

Dr ASHLEY - I cannot answer that.

Mr WILKINSON - Even though the Royal Derwent was not the answer, there appears to be a need for some type of facility like the Royal Derwent, updated for the 2000-10 era, built in Hobart or Launceston or wherever in order to place people that there is nowhere else to go.

Dr ASHLEY - I think that you are right. I am not an academic. I went to New South Wales in 1974 after a year of psychiatry here. I was trying to work out why at Morisset, which was just below Newcastle, there was this great big bin. All these people were coming up from Sydney in buses from the Blue Mountains, all these psychiatric patients, and Sydney was in the process of emptying their institutions. They all came to us because they were not containable in the Blue Mountains. I think that there has been a trend in the last 25-30 years for governments and everyone to appreciate that shutting down these institutions has been a mistake. I am not saying go back to it to get other opinions. At Morisset it was wonderful; the alcoholics went on strike so they paralysed the transport system in the hospital because that is what their job was, to move stuff around the hospital. They paid all the mentally retarded girls for their sexual services so there was this wonderful little community cash economy. It is true. You know that some people really long for the days of the Royal Derwent. That is all there was; it was as good as it was going to get.

Mr WILKINSON - But it was a community, wasn't it? It gave a person a reason for being. They had acquaintances there with the same or allied problems that they could discuss them with. It gave them that support that they did not get once they closed those places down.

Dr ASHLEY - I think so, because I hour with your community case worker every two months or so is not much.

CHAIR - Thank you very much for your time. You have been really very helpful.

THE WITNESS WITHDREW.