DEPARTMENT OF HEALTH
DIVISION OF MENTAL HEALTH

SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

Overview of Mental Health Policy and Reform 1990-2005

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1. Introduction

The purpose of this paper is to provide information to the Senate Select Committee on Mental Health of Western Australia's progress in implementing the National Mental Health Policy. It includes the current issues facing mental health service delivery in Western Australia.

The past century has witnessed extraordinary progress in improvement of the public health through medical science and innovative approaches to health care services. Through much of this era of great achievement, concerns regarding mental illness and mental health too often were relegated to the bottom of the health care system. A range of mental disorders affects one in five Australians, yet the stigma of mental illness remains to a large extent.

2. National Mental Health Policy Context

The 1980s was a decade characterised by significant adverse publicity and a series of public inquiries that centred on human rights abuses and inadequate levels of care in Australian Mental Health Services. As a consequence, in 1991, Australian Health Ministers signed the Mental Health Statement of Rights and Responsibilities the first step in a series of events that was designed to make mental health a national health priority.

The following year all Australian Governments agreed to adopt a National Mental Health Policy, which together with the Statement of Rights and Responsibilities and the series of five year National Mental Health Plans has become known as the National Mental Health Strategy.

The Strategy set out to achieve four aims:

- To promote mental health.
- To, where possible, prevent mental illness.
- To reduce the burden of disability for those people with a mental illness, their family, carers and the community.
- To assure the rights of those with a mental illness.

The First National Mental Health Plan was developed to guide implementation of the strategy over the following five years. The First National Mental Health Plan, which addressed 12 priority areas, focused on State-Territory-based public sector, specialist mental health services with an emphasis on community-based care, decreased reliance on stand-alone psychiatric hospitals, and 'mainstreaming' of acute psychiatric beds into general hospitals. The importance of integrating mental health in the overall health system was a major reform of the sector and had been recognised as a priority in Australia for over a decade.

In 1997, the Australian Health Ministers endorsed the Second National Mental Health Plan, which was designed to consolidate ongoing reform activities and expand into additional areas of focus. It built on the progress made during the First Plan by adding a focus on mental illness prevention, addressing ways in which the mental health sector could be integrated with other sectors (e.g. private psychiatrists, general practitioners, emergency services, non-government organisations and the general health sector) to maximize treatment outcomes and opportunities for recovery. Whereas the First Plan focussed largely on severe and disabling low-prevalence illnesses, particularly psychoses, the Second Plan expanded the emphasis to include high-prevalence illnesses such as depression and anxiety disorders.

During the period of the First and Second National Mental Health Plans, the mental health system strengthened its capacity to respond to the needs of people with mental illness through major shifts in the settings and workforce that provide care. Significant efforts were made to combine mental health services within the general health system and a community-based system of treatment and support.

The Evaluation of the Second National Mental Health Plan conducted in 2003, concluded that Australia had continued to pursue and make progress implementing the objectives of the National Mental Health Strategy, and that progress had been made in implementing the additional priority themes identified in the Second Plan. However, the Evaluation concluded that the extent and pace of progress was not satisfactory and that the failures were not due to a lack of clear and appropriate direction, but rather to failures in investment and commitment. The Evaluation made a number of recommendations regarding future directions for mental health reform, these were predominantly around improving population health, improving service responsiveness, strengthening quality and safety, and fostering innovation and ensuring sustainability.

The National Mental Health Plan 2003-2008 consolidates the achievements of the First and Second National Mental Health Plans and will attempt to address the gaps identified in the first two plans. The Plan identifies a number of priority themes for mental health sector development across Australia, these are:

- Promoting mental health and preventing mental health problems and mental illness.
- Increasing service responsiveness.
- Strengthening quality.
- Fostering research, innovation and sustainability.

The National Mental Health Plan 2003-08 contains 113 Key directions designed to achieve 34 different Outcomes to improve Mental Health Services. The plan also outlines the roles and responsibilities of the Australian Government, State and Territory Governments and other agencies that promote human rights. In addition, the plan outlines the accountabilities for resource usage, mental health expenditure and service quality as well as the process for national monitoring through national reporting, public reporting of performance indicators and finally through independent evaluation of the plan. The National Survey of Mental Health Services was designed to fulfil the reporting requirements under the Strategy. It requires states and territories to coordinate the collection of information relating to publicly funded mental health services within their jurisdiction. The most recent survey conducted throughout Australia collected information related to the 2003/04 financial year. The survey constructs the national picture from a 'bottom up' perspective by directly involving health service organisations in describing their mental health services according to a standard set of data categories and criteria. Information collected from the Survey is published in a series of National Mental Health Reports. The most recently published National Mental Health Report 2004 is the 8th report in the series and describes Australia's progress over the course of the National Mental Health Strategy between 1992 and 2002. The components of the Strategy that are monitored include:

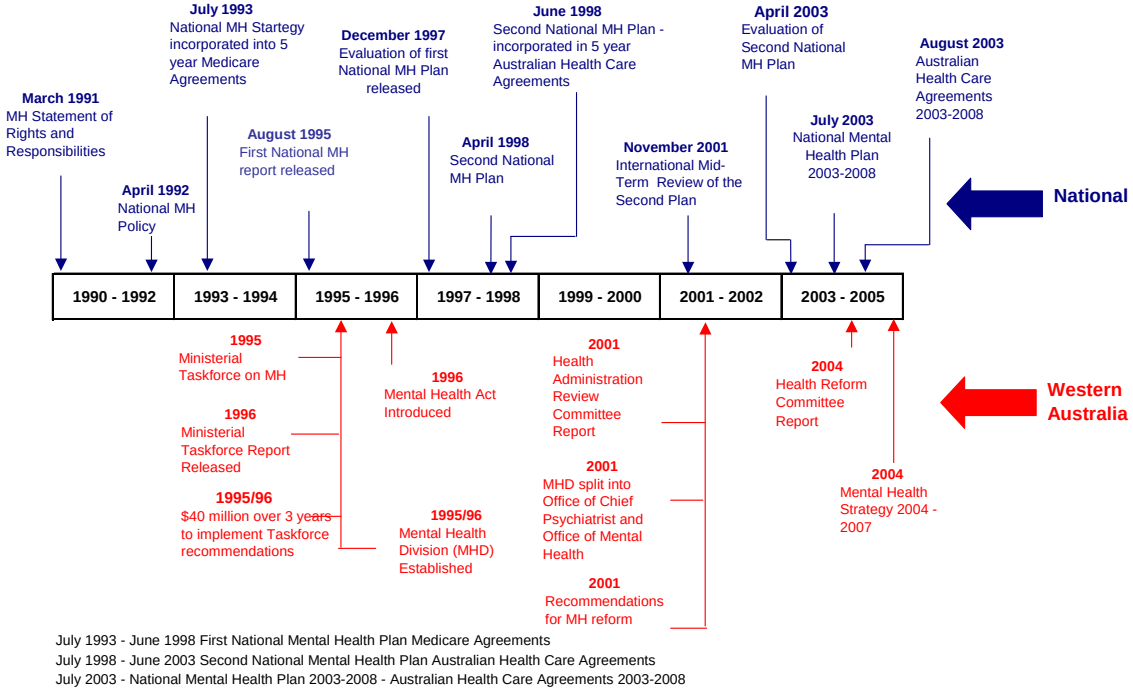
- Trends in government spending on mental health.
- Progress towards a community based system of care.
- Trends in the level and mix of psychiatric beds.
- Trends in transferring resources to new services.
- Consumer and carer participation in decision making.

In 2005, the National Mental Health Working Group of the Australian Health Ministers Advisory Committee agreed to an implementation plan for the National Mental Health Plan 2003-08.

3. *Key Mental Health Reforms in Western Australia*

Western Australia is committed to the ongoing reform and development of Mental Health Services and to meeting the changing needs and priorities of consumers and carers within the overall context of the National Mental Health Strategy. Figure 1 below depicts the major milestones of the National Mental Health Strategy at a national and state level and Table 1 below presents information on Western Australia's progress in key areas under the Strategy.

Figure 1: Milestones in Mental Health Reform - Australia and Western Australia



As can be seen from Table 1, Western Australia has made significant progress over the last ten years under the National Mental Health Strategy. Western Australia has the highest per capita mental health expenditure, the highest FTE equivalent in ambulatory mental health care services and apart from Level 1 consumer participation, progress has been made in all other areas in line with the directions of the Strategy.

Table 1: Progress under the National Mental Health Strategy

Key areas monitored under the NMH Strategy	Western Australia 1992/93	National 1992/93	Western Australia 2002/03	National 2002/03
Per capita expenditure on specialised mental health services	$72.7	$72.9	$119	$100
Full Time Equivalent staff (FTE) employed in ambulatory care mental heath services per 100,000 population	17	19	44	36
Ratio of percentage of inpatient and community expenditure (inpatient :community)	76:24	73:27	52:48	49:51
Psychiatric beds in stand alone hospitals as a percentage of total psychiatric inpatient beds	70%	76%	38%	39%
Percent of services that have level 1 consumer participation[1]	6%	17%	33%	55%

Source: 1992/93 data from the National Mental Health Reports 1993 and 2004
2002/03 data from the Report on Government Services 2005

[1] Level 1 consumer and carer participation requires that formal position(s) for mental health consumers exist on the organisation management committee for the appointment of person(s) to represent the interest of consumers

4. Reform and Policy Milestones in Western Australia

A brief synopsis of mental health reforms and key policy directions in Western Australia over the last fifteen years is provided below.

1990-1994

In the early 1990's, dissatisfaction had been expressed about the organisation and adequacy of mental health services provided by the State. Criticisms were directed towards the inadequate resourcing of Mental Health Services in relation to the rest of the health field and the inadequate numbers of practitioners to meet the needs that were becoming increasingly apparent. This was occurring in the context of a growing awareness of the enormous burden of ill health due to mental disorders. This increasing awareness was developing both as a result of the 1993 Human Rights and Equal Opportunity Report, the National Mental Health Strategy and also the interest of the media, who graphically described the consequences of inadequately funded and organised services.

1995-1998

Commencing in 1995/96, the WA Government initiated a review and reform of WA mental health care in line with the National Mental Health Strategy. In 1996, the Department of Health produced a plan consistent with recommendations from a Ministerial Taskforce on Mental Health to expand Mental Health Services. Reform of the Mental Health Act in 1996 and the creation of the Mental Health Division (MHD) established the structure necessary to undertake significant changes as part of the larger national agenda.

Over $40M of additional funds was targeted over a three year period to expand services consistent with the reform agenda. Investment began in the 1997/98 fiscal year and during this year, other sections within the Department of Health worked to identify and segregate existing funds for mainstream mental health services so that the MHD was aware of investment funds, specialised service funds and general facility mental health funds.

1999-2000

In January 2000, the first Integrated Clinical Stream was formed by the Metropolitan Health Services Board known as the Metropolitan Mental Health Services (MMHS). The MMHS was responsible for the provision of public mental health services to the Perth metropolitan area and specialist mental health services to the state of Western Australia. Its mission was to meet the needs of key stakeholders - consumers, carers, staff, funders and other service providers by providing an integrated, safe, reliable and effective mental health service. In June 2000, the Mental Health Reform 2000 Plus project commenced in order to achieve the aims and objectives of the MMHS. This project set about continuing the reform of metropolitan Mental Health Services that started with the First National Mental Health Plan and focussed on service enhancement and significant capital works for the benefit of consumers and carers, mainstreaming of services, care closer to home where appropriate, greater reliance on community based services and destigmatisation of mental illness.

2001-2002

In 2001, key recommendations of the Health Administrative Review Committee (HARC) report included that the Office of Chief Psychiatrist and the Mental Health Division should be two separate entities incorporating the coordinating functions of the Metropolitan Mental Health Services. The new Office of Mental Health continued with the reforms commenced in 1995/96 in close collaboration with key stakeholders.

2003-2004

While the evaluation of the Second Mental Health Plan conducted in 2003 concluded that all states and territories had made progress in implementing the objectives of the Strategy, it was clear that the pace and progress was not satisfactory. Conclusions reached indicated that these failures were due to failures in investment and commitment. In the same year, a nationwide review of the experiences of those who use and

provide mental health services, conducted by the Mental Health Council of Australia, documented that, at the time, community-based systems were failing to provide adequate services. The resulting report Out of Hospital Out of Mind 2003 states that these services were characterised by restricted access, variable quality, poor continuity, lack of support for recovery from illness, and protection against human rights abuses. The Report called for greater investment of financial and infrastructure resources, greater transparency and accountability, clear deadlines for key outcomes, a focus on quality service provision, reduction of human rights abuses and neglect, and genuine investment in service innovation, evaluation and associated aetiological and treatment research.

Continuous Quality Improvement

In progressing the continuous quality improvement reforms under the Strategy, by June 2003, all public Mental Health Services in Western Australia were registered with an external accreditation agency to undergo a review against the National Standards for Mental Health Services and as at April 2005, 84% of services had completed the review. As the National Standards have limited relevance to the non-government mental health sector, the Division of Mental Health developed a set of standards tailored to the needs of this sector in 2004. The Service Standards for NGO providers of community mental health services comprise of 8 standards as follows: Standard 1: Rights and Responsibilities

- Standard 2: Safety
- Standard 3: Privacy and Confidentiality
- Standard 4: Consumer Participation
- Standard 5: Participation of Carers and Significant Others
- Standard 6: Organisational Governance and Management
- Standard 7: accessible, Inclusive Service Provision
- Standard 8: Delivery of Services

The Division has two key strategies to ensure the standards are well integrated into its funded mental health non-government sector:

1. An implementation kit has been developed and distributed to all funded mental health non-government organisations; and
2. The Mental Health Strategy 2004-2007 includes an initiative to develop and implement the statewide strategy to support the non-government services to align their policies and procedures with the Standards, and to commence implementation. Once the standards have been implemented a process to monitor and report compliance will be developed.

Addressing the needs of homeless people with a mental illness

Both nationally and at the state level it is recognised that there is a significant problem in meeting the needs of homeless people who have a mental illness. The Division of Mental Health has participated in various processes to determine the quantum and type of service needs of this population.

Three statewide in-patient surveys (2003, 2003, 2004) have been undertaken to determine how many patients could be discharged if there were sufficient community supports, including supported accommodation, available. The last survey was undertaken as part of a national survey in December 2004, facilitated by the Homeless and Housing Taskforce, a sub-working group of the National Mental Health Working Group. On the survey collection day, 555 patients in 14 mental health inpatient units in Western Australia were surveyed.

The key findings from the 2004 national survey are consistent with the earlier two state surveys and include:

- 53% of patients could have been discharged if appropriate alternative services were available and, of these patients, 56% required both appropriate intermediate treatment/rehabilitation, support and accommodation services.
- 51% could have been discharged if appropriate support and accommodation services were available

Note: People remaining in in-patient services because there are insufficient community services are considered to be secondary level homeless.

In addition to the above surveys, the Division has also completed two state surveys of people who have primary (living on the streets) or secondary homelessness. Of the 126 people surveyed the key findings are that the population is predominantly male (75%), that there three distinct location clusters; Perth, Fremantle and Armadale/Gosnells and that the biggest age cluster is the 26 to 45 years age range, accounting for 50% of the groups surveyed. It was not possible to survey Aboriginal people who were homeless and have a mental illness. The Division is planning to address the needs of this group as part of its five year planning process, commencing in 2006.

In conclusion the data collected indicates that while it is difficult to count the number of people who require support, the current estimate, excluding Aboriginal people, is 400.

Current strategies being developed include a service for youth at risk of homelessness and developing a mental illness and a transition service to assist people discharged from hospital to supported accommodation. Thirty homes for people in the community will be established through the Community Options 100 project and the Independent Living Program that provides accommodation and community support for 570 people continue to be developed. Another strategy that will have a significant impact is the Community Supported Accommodation Units development that will provide an additional 200 places (permanent homes).

Information priority reforms

In progressing the information priority reforms under the Strategy, by the end of 2004, all public Mental Health Services in Western Australia had implemented the routine collection of consumer outcome measures. Clinicians and key administrative staff received training in the use of nationally agreed consumer outcome measures, including a consumer self report tool and the National Outcome and Casemix Collection protocols. These measures, together with demographic information, referrals, admissions, discharges, transfers, diagnoses and service events related to client activity are collected and stored in a centralised clinical information system, known as PSOLIS. The functionality in PSOLIS includes enhanced search functions, which allow a client to be tracked across community-based and inpatient services to assist in providing continuity of care.

Health Reform Committee

In 2004, the Western Australian Government commissioned a review of the whole health system and the Report of the Health Reform Committee – A Healthy Future for Western Australia highlights the need for increased emphasis on mental health promotion and early intervention strategies and community mental health services whilst recognising the need for increased inpatient facilities over the next decade. Community mental health services are cost effective and reduce both initial admission and readmissions to the acute inpatient sector. Specific recommendations of the Committee relating to mental health include:

- Recommendation 12: recognising the importance of mental health and the projected growth in mental illness, a whole of government approach is needed to provide a framework for action by government departments, the non-government sector and the community.

- Recommendation 13: A major focus in the treatment of mental health should be in prevention and early intervention programs and services.

- Recommendation 14: Recognising the need for coordination to improve child and maternal health, an interagency working group should be established to drive a new approach.

5. Future Directions in Western Australia – The Mental Health Strategy 2004-2007

In recognition of the shortcomings still apparent in the mental health system, the state Government has allocated $173.4M in additional funding over the next three years to enable the implementation of the comprehensive mental health reform initiatives identified in the Mental Health Strategy 2004-2007. Table 2 below provides details of the funding.

The Mental Health Strategy 2004-2007 is the culmination of an extensive consultation process and reflects the significant consideration the mental health sector has given to developing better services for mental health consumers. The Government recognises that more needs to be done in mental health to achieve the aim of a high quality, effective and efficient mental health system in Western Australia. Implementation of mental health reform and the provision of significant funding for initiatives under the Mental Health Strategy 2004-2007 provide a comprehensive approach to better meet community need for mental health services in Western Australia. The Government is in the process of developing a five year Action Plan for Mental Health that will outline the continued commitment to providing mental health services that are among the best in this country. Initial consultations have been held to inform the development of the Action Plan.

Dr Neale Fong, Acting Director General, Department of Health, Western Australia and Executive Chairman of the Health Reform Implementation Taskforce, is leading the implementation of the Mental Health Strategy 2004-2007, in partnership with the Department of Health's Division of Mental Health.

Table 2: Western Australia's Mental Health Strategy 2004-07 funding

Source of Funds	Value
Department of Health	$131,265,000
Operating	$ 93,115,000
Capital	$ 15,700,000
Land value for Housing	$ 22,450,000
Department of Housing and Works	$ 42,140,000
TOTAL	$173,405,000

The objectives of the WA Strategy are:

- To expand statewide mental health emergency services to meet the demand for services within emergency departments.
- To increase access to adult inpatient beds for people with severe metal illness.
- To improve clinical outcomes for people with a mental illness through provision of accessible community services which encourage early identification, intervention and recovery.
- To enhance service coverage and accessibility and provide a whole of service/government approach to ensure that young people with a mental health problem are given the best opportunity for early intervention.
- To expand community supported accommodation services for people with severe mental illness.
- To ensure services are adequately staffed with the appropriate skills and discipline mix and that Mental Health Services are safe places where innovative clinical practice is fostered.

The Mental Health Strategy consists of five key initiatives:

- Key Initiative 1 - Mental Health Emergency Services
- Key Initiative 2 - Adult Inpatient Services

- Key Initiative 3 - Community Mental Health
- Key Initiative 4 - Supported Community Accommodation
- Key Initiative 5 - Workforce and Safety Initiatives

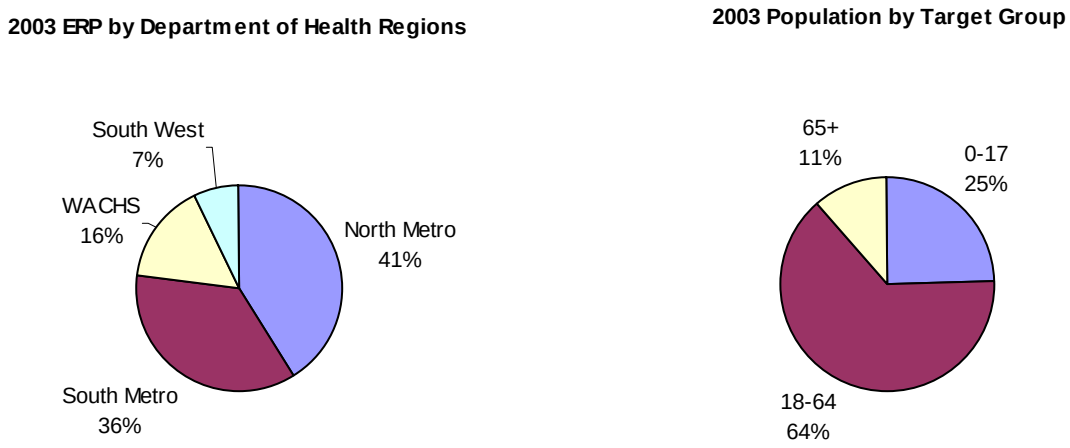
Further details of the Mental Health Strategy 2004-2007 can be found at Appendix 1.

6. Western Australian Context

Population

Western Australia's Estimated Residential Population (ERP) in 2003 was 1,952,238, which is approximately 10% of the total population in Australia. This is an increase of 21% from 1990. The population in 2008 is projected to be approximately 2,163,643, an increase of 10%. The graphs in Figure 2 below provide a breakdown of the 2003 ERP by health regions and sex.

Figure 2: Western Australia – 2003 ERP by Health Region and Age Group



WACHS: WA Country Health Services

Prevalence of mental disorders

Findings from the Survey of Mental Health and Wellbeing of Adults conducted by the Australian Bureau of Statistics in 1997-1998 found that almost one in five (19.2%) adults in Western Australia had experienced one or more mental disorders during the year prior to the survey[2]. While men and women had similar overall prevalence rates, there were differences by type of disorder. Males were much more likely to have a substance abuse disorder and females were more likely to have anxiety and affective disorders.

Burden of disease and disability

Mental disorders are now the third greatest contributor to the burden of disease in Western Australia. The WA Burden of Disease Study[3]estimates that by 2016, mental disorders will become the major cause of disease burden for females and the second highest cause of disease burden for males.

The WA Burden of Disease Study indicates that a large proportion of the disability burden among males (29%) and females (30%) was accounted for by mental disorders. Mental disorders account for the majority of the disability burden from the ages of 15 to 44 years, with a higher mental health burden among females. In addition, of the leading 20 specific causes of disability burden for each gender, mental disorders accounted for

[2] Australian Bureau of Statistics (1999) Mental Health and Wellbeing: Profile of Adults Western Australia 1997-98.
[3] Department of Health Western Australia (2004) WA Burden of Disease Study.

nine among males and six among females. Depression contributes more of the total disability burden than any other cause among both males and females with a greater burden among females. In relation to total burden, only the mortality burden contributed by ischaemic heart disease (8%) was greater than the disability burden contributed by depression (4%).

Suicide rates

The Standardised Mortality Rate (the ratio of the actual number of deaths in the population under study and the number of deaths which would have occurred if the population under study had experienced the age-specific death rates of the standard population) for Western Australia due to suicide from 1993-2003 is slightly higher than the national average (1.06 compared to 1.00)[4].

7. Snapshot of Mental Health Services in Western Australia

Services in the Public Mental Health Sector

Public mental health programs are divided into the following streams:

- Adult
- Child and Adolescent
- Elderly
- Forensic and
- Statewide Services.

There is a mix of community and inpatient services within these programs. Community mental health services consist of: medical staff including psychiatrists, mental health nurses, clinical psychologists, social workers, and occupational therapists who provide direct clinical services to the local community. They liaise directly with other health staff including general practitioners, the local hospital and other service providers. They also provide support to the families and carers of people with serious mental illness who access the services in their area.

Health regions include the North and South Metropolitan Area Health Services, the WA Country Health Services and the South West Area Health Service.

Mental Health inpatient services are provided in all metropolitan mental health areas and some regional areas, and Graylands Hosptial at present carrying particular statewide and tertiary service responsibilities.

There are also statewide services including:

- Women's and Children's mental health services provided through King Edward Memorial Hospital (KEMH) and Princess Margaret Hospital (PMH).
- The Psychiatric Emergency Team (PET).
- Transcultural Mental Health Unit.
- Youthlink.
- Neurosciences.

The WA Country Health Services (WACHS) and the South West Area Health Service comprise:

- Northwest Mental Health Service (divided into Kimberley and Pilbara areas).
- Central West Mental Health Service.
- Wheatbelt Mental Health Service.

[4] Australian Bureau of Statistics (2004). Suicides: Recent Trends, Australia. Catalogue Number 3309.0.55.001

- Great Southern Mental Health Service.
- Goldfields and South East Coastal Mental Health Service.
- South West Area Health Service

North Metropolitan Area Health Service

Adult inpatient services are provided in Joondalup, Mercy, Royal Perth, Sir Charles Gairdner and Swan Districts Hospitals and older adult inpatient services are provided in Osborne and Selby Lodges with a total of 203 beds.

Community based services for adults, children and adolescents and older adults are provided in clinics located in Clarkson, Hillarys, Subiaco, Joondalup, Mirrabooka, Osborne Park, Warwick, Perth, Midland, Morley, Kalamunda and Shenton Park.

South Metropolitan Area Health Service

Adult and older adult inpatient services are provided in Fremantle, Bentley and Armadale Hospitals with a total of 166 beds.

Community residential services for adults are provided in the Armadale and Fremantle areas with a total of 17 beds.

Community based services for adults, children and adolescents and older adults are provided in clinics located in Bentley, Fremantle, Rockingham, Mandurah and Armadale.

Statewide Services

Adult and forensic inpatient services are provided in Graylands Hospital with a total of 205 beds and Child and adolescent inpatient services are provided in Princess Margaret and Bentley Hospitals with a total of 28 beds.

Community based transcultural services for adults are provided at the Graylands campus, the Psychiatric Emergency Team and specific community services for youth are based in the Perth metropolitan area.

WA Country Health Services and the South West Area Health Service

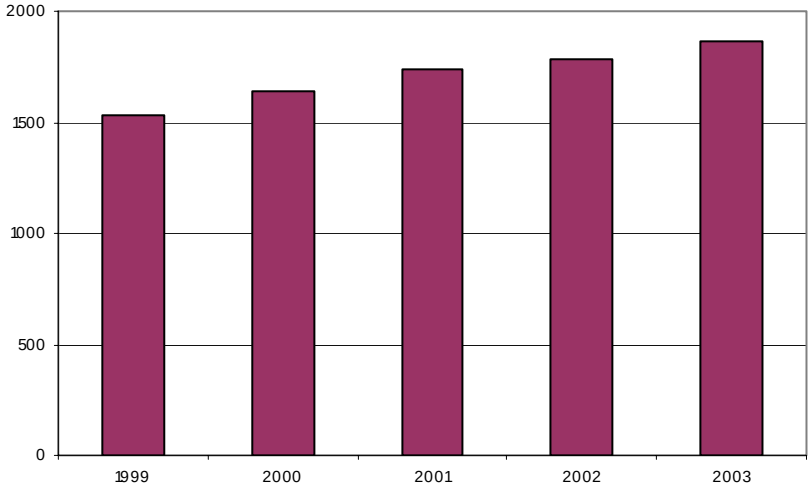
Adult inpatient services are provided in Albany, Bunbury and Kalgoorlie Hospitals with a total of 31 beds.

Community based services for adults, children and adolescents and older persons are provided in the larger regional towns of Albany, Northam, Narrogin, Merredin, Katanning, Geraldton, Bunbury, Carnarvon, Busselton, Port Hedland, Bridgetown, Karratha, Kalgoorlie, Broome, Esperance, and Derby. Visiting services are also provided to many of the smaller towns across the state.

Service utilisation in the public Mental Health Sector

Individuals with severe mental illness, often complicated by physical diseases or addictions, are high users of community and inpatient mental health services. As a result of the limited service options, such as intermediate care and non-acute rehabilitation units, they are admitted to acute inpatient units. Upon discharge, these individuals often do not manage living in the community and as a consequence have extensive re-admission rates to acute inpatient services. On average over the past five years, 32,604 people per annum receive treatment in public Mental Health Services (22% in inpatient services, 58% in community-based services and 20% received both types of service). Figure 3 below provides a snapshot of service utilisation in public Mental Health Services over the last five years and indicates that service provision increased from 1553 per 100,000 of the population in 1999 to 1865 per 100,000 of the population in 2003, an increase of 20%.

Figure 3: Service utilisation in public Mental Health Services (per 100,000) of the population.



Non Government Sector

The Division of Mental Health funds over 70 non-government organisations (NGOs) around the State to provide mental health. Of this total, 21 NGOs provide support in regional Western Australia. There are also metropolitan-based services that provide services across the state. The services are available for:

- Individuals affected by a mental illness and/or their carer/family.
- Individual and population groups within the community who may be potentially at risk of developing a mental illness.
- People working in, or directly affiliated with, the mental health sector

Funding to NGOs to provide mental health support totalled $19.3M in 2004/05 and Table 3 below provides details of the funding to NGOs by service type.

Table 3: Breakdown of funding to NGOs by type of service provided 2004/05

Service Description	Funding
Advocacy, self help and representation	$704,053
Carer Support	$1,263,406
Community Support	$5,486,282
Counselling	$649,165
Prevention and Promotion	$825,602
Research and Evaluation	$2,075,276
Supported Accommodation	$3,565,255
Licensed Psychiatric Hostels	$1,654,599
Inpatient Care	$2,841,969
Nursing home program	$182,616
Workforce Development	$80,477
TOTAL	$19,359,399

Recently the Division of Mental Health conducted a comprehensive review of existing NGO service types and descriptors with a view to implementing a performance and reporting framework. Service types and descriptors have been classified under ten key categories and these have been grouped according to the current Whole of Health Output Based Management (OBM) framework of Prevention and Promotion, Diagnosis and Treatment and Continuing Care. Table 4 below outlines the framework of Outputs and service categories. Consultations have taken place with representatives of NGOs and there is support in principle that these service types and descriptors will assist in standardising the performance monitoring and reporting processes for NGO activity commencing in 2005/06.

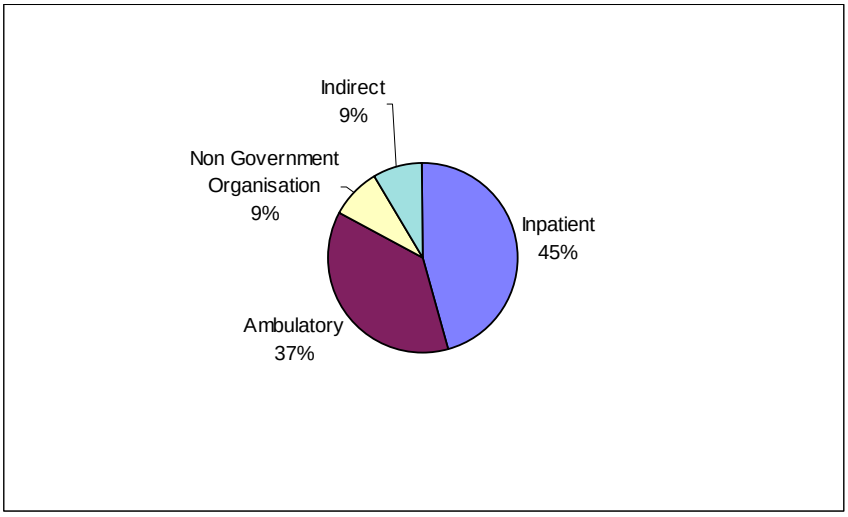
Table 4: Output based management framework for funding NGOs from 2005/06

Output 1: Prevention and Promotion	Output Two: Diagnosis and Treatment	Output Three: Continuing Care
1 Mental health promotion 2 Mental illness prevention 3 Research and evaluation 4 Workforce development	5 Clinical treatment and care 6 Early intervention 7 Safety and Quality	8 Accommodation 8.1 Crisis/respite accommodation 8.2 Intermediate care accommodation (transitional supported accommodation) 8.3 Supportive landlord services 8.4 Long-term supported accommodation 8.5 Supported community residential units (inc licensed psychiatric hostels) 8.6 Specialist residential services 9 Advocacy 9.1 Individual advocacy 9.2 Systemic advocacy 10 Community support 10.1 Independent living skills support 10.2 Psychosocial support 10.3 Recreation 10.4 Pre-vocational training 10.5 Carer/family support, Education/information and skill development, Respite

State expenditure on publicly funded mental health services

In 2003/04 expenditure on publicly funded Mental Health Services by the state government was approximately $260M[5]. Figure 4 below outlines the proportion of expenditure by inpatient services, ambulatory or community-based services, non-government organisations and indirect expenditure. Non-government organisation expenditure includes publicly funded inpatient, community residential and community support services.

Figure 4: Proportion of expenditure in publicly funded Mental Health Services in Western Australia 2003/04.



[5] National Survey of Mental Health Services 2003-04 (unpublished)

Private Psychiatrist Consultations

Western Australia has the second lowest rate of MBS funded private psychiatrist consultations per 100,000 population. In 2001-2002, WA had 5.3 providers per 100,000 population compared with an Australian average of 9.4. Only the Northern Territory with 3 providers per 100,000 population had a lower number of providers[6].

8. The Human Rights and Equal Opportunities Commission Report on Mental Health Services

In March 2005, the Human Rights and Equal Opportunities Commission in conjunction with the Mental Health Council of Australia and the Brain Mind Institute forwarded the draft report of their investigations into Mental Health Services to the Western Australian Government for comment and response.

The Western Australian Department of Health (DOH) is concerned that this draft Report is not representative of the views of the majority of the community or of those working in the mental health service system. The DOH has major concerns about the methodology utilised, particularly given the small number of respondents. The DOH does not believe the draft Report reflects the reality of the mental health system in Western Australia. We strongly disagree with the portrayal of the mental health system as one in continual crises and believe that promoting this message will not be of benefit for people with mental illness in Western Australia.

The DOH recognises that there are shortcomings in the mental health system in Western Australia. However we do not agree with the sentiment in the report that; 'experiences of injustice and despair' characterise our services. The DOH is committed to ongoing processes of reform and quality improvement and is pursuing a number of mechanisms to promote this.

The DOH has provided to the investigators a substantial amount of background information that we believe goes some way to accurately portraying a balanced view of the issues raised in their draft report.

It is a particular concern to the DOH that the methodology adopted in the review does not enable a balanced assessment of mental health services at a systemic level. Individual experiences of the system are valuable insights into where the system is or is not operating optimally. They can provide important indicators of where the system does not meet needs of mental health consumers in general as well as in specific cases. However, in order to draw conclusions at a systematic level, an accumulation of experiences is required. We do not believe that the methodology enables such conclusions to be made, especially given the small number of respondents.

The draft report seemed to make no attempt to determine whether the concerns that are raised occurred recently or many years ago. Some of the examples referenced within the draft report appear to have occurred more than a decade ago.

Furthermore, the "findings" in some cases appear to relate to experiences, as described by consumers who have complained about their care previously to various independent authorities in Western Australia. There does not appear to have been any attempt taken by the authors to determine whether serious allegations had any substance to them prior to documenting them in their draft report as examples of areas where standards were breached.

In addition, the methodology design cannot measure improvements that result from the implementation of the *National Standards for Mental Health Services (NSMHS),* nor can its design adequately reflect significant improvements in care. It does not balance the experiences of adverse care outcomes with unreported experiences of acceptable outcomes. Whilst the forums requested attendees give examples of improved services or positive responses a balanced response was unlikely given the methodology.

[6] National Mental Health Report 2004

In addition, no attempt was made to establish whether the *NSMHS* were actually achieved, as evaluated by an independent body. All mental health services are required to be reviewed and all have commenced the process of review with 84% being completed by April 2005. Those services that have not as yet undergone the review have been registered to have a review carried out by the Australian Council for Health Care Standards (ACHS).

The methodology did not include any specific consultation with key stakeholders or Statutory Bodies that are in a position to comment on the degree to which services meet the NSMHS. For instance, no formal process was established for a separate forum with the Division of Mental Health, the Chief Psychiatrist, the Council of Official Visitors or Area Directors of Mental Health Services. Such a process could have explored whether information was available that put the findings into an objective perspective based on the considerable evidence gathered through comprehensive reviews undertaken by independent bodies charged with the responsibility of either ensuring rights or standards of care are met. This would appear to be a major shortcoming of the draft report, and means that all of the findings are strongly disputed by the DOH.

Finally, the Government recognises that not all services are at the same level of development against the standards. It appears that comments that characterise services that need the greatest improvement have been generalised to describe all services in a way that does not recognise the better services.

9. Australian Government Funding in Western Australia

One of the critical issues that need to be addressed to improve the provision of Mental Health Services to Western Australians is the relationship between mental health services that are provided by the State Government Health System and those that are provided through funding by the Australian Government.

A recent examination of National Mental Health Expenditure, based on the most recent published data by Whiteford and Buckingham was reported in the Medical Journal of Australia in April 2005[7]. They reported an increase in total mental health spending of 65% in real terms between 1993 and 2002. However this growth is consistent with the overall growth in government health spending which was 65% during that time.

When this increase is further examined it is found that the overall increase in Federal expenditure was 128% whilst that of the States/Territories was only 40%. In Western Australia, the increase in mental health expenditure during this time was 106% and represents the greatest increase in mental health expenditure by any state jurisdiction[8].

A further exploration of the Federal expenditure reveals that in constant prices the major area of growth is in Pharmaceuticals provided under the PBS. The increase in expenditure for psychiatric drugs is nearly 600% during this time period and accounts for nearly two thirds of all of the growth in Federal mental health expenditure.

In contrast the number of private psychiatrists and the number of consultations they provide has remained reasonably stable over the past few years, and has shown an actual decline Nationally since 1996-97. This means that the increase in Commonwealth expenditure is almost entirely explained by the cost of pharmaceuticals and does not represent increased service provision through the private specialists sector. Figure 5 below provides a breakdown by various categories of this expenditure.

This issue is of vital importance to Western Australia. This state has the lowest number of Private Psychiatrists of the larger mainland jurisdictions (only NT has less per population), and the inability of the Private sector to

[7] Whiteford H A & Buckingham W J (2005). Ten years of mental health reform in Australia: are we getting in right. Medical Journal of Australia Volume 182 Number 8 pp 396-400.
[8] National Mental Health Report 2004

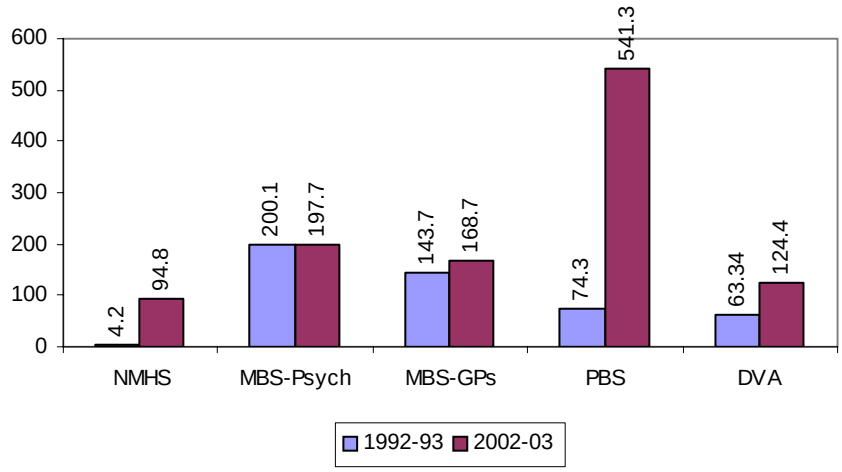
deal with the demand for mental health care results in the burden to provide care shifting to the State Government. This accounts in large part for the significant increase in funding by the State Government to Mental Health Services during the life of the National Mental Health Strategy, as private services have been significantly underdeveloped.

In addition, the initiatives that the Australian Government has instituted in the part five years, notably the Better Outcomes in Mental Health Care initiative need to be considered. This project has seen the training in identification of mental illness and also the understanding of mental illness in primary care raised to a significant extent.

Despite this, the Australian Institute of Health and Welfare 2002/03 report on Mental Health Services in Australia[9], showed that there was less mental health related GP encounters in 2003-04 than in 1998 before the initiative started. In 2004, Western Australia had the greatest number of General Practitioners who had completed phase 1 training through the "Better Outcomes". However general practitioners who provide the bulk of mental health service provision in this state regularly need the support of the specialist system. This cannot be provided by the underdeveloped Private specialist system and the result is that the burden of care again falls to the State Government system.

In essence, giving greater capacity for primary care to detect mental illness places greater expectation on the State Government system to support primary care without the links between the two systems having been formally developed.

Figure 5: Australian Government expenditure on mental health services 1992/93 to 2002/03 in $ millions – Constant prices



NMHS: National Mental Health Strategy
MBS-Psych: Medicare funded Consultant Psychiatrists
MBS-GPs: Medicare funded General Practitioners
PBS: Pharmaceutical Benefits Scheme
DVA: Department of Veterans' Affairs

The Western Australian Department of Health is concerned that mental health demand in this state is the fastest growing area of demand in health. In addition, the 1997 ABS National Survey of Mental Health and Wellbeing which showed that 62% of people with mental illness are not receiving treatment and this significant unmet need is now starting to come to the attention of not only primary care but also specialist care in this state. The Australian Government should consider how it allocates its funding to primary care and strongly consider shared care projects with the State Government in order to more effectively provide care to a greater number of people in a more coordinated fashion in order to address this unmet need.

[9] Australian Institute of Health and Welfare (2005). Mental health services in Australia 2002-03

10. Concluding Remarks

It is clear that significant gains have been made in Western Australia over the past 10 to 15 years, however:

- The escalating demand for mental health services is not being met through the provision of a range of service delivery options.
- There is a need to ensure that consumer and carer involvement in all levels of service delivery is further developed and maintained.
- There is a need for genuine leadership and commitment by a range of political leaders to continue the reforms in mental health.
- A range of accountability measures and systematic monitoring systems need to be developed and/or refined to ensure that mental health consumers and their carers receive a high quality of care.
- There is a lack of coordination of the main contributors to Western Australia's mental health sector (general practitioners, private psychiatrists, private psychologists, private hospitals, public inpatient and community-based services and non-government organisations).

Appendix 1 - The Mental Health Strategy 2004-2007

The mental health reform initiatives outlined in the *Mental Health Strategy 2004-2007* aim to increase the capacity of mental health services to meet the increase in demand.

The focus will be on relieving pressures in the mental health system, especially where this impacts on other parts of the health system such as Emergency Departments, increasing access to appropriate inpatient services and addressing the lack of intermediate care treatment options and community support services.

During the past few years a number of reports have been generated to plan for the delivery of mental health care in Western Australia. These include:

- *Western Australia's Mental Plan* (previously the Draft State Mental Health Strategic Plan);
- *A Healthy Future for Western Australians – Report of the Health Reform Committee*; and
- *Enhancing the Capacity of Mental Health Services*.

Specifically, the *Mental Health Strategy 2004-2007* addresses five main areas in the health system where targeted interventions have the capacity to immediately and significantly increase access to mental health services and reduce demand on acute hospital beds. The five strategy areas are:

- Mental health emergency services
- Adult inpatient services
- Community mental health services (Adult & Young people)
- Supported community accommodation
- Workforce and safety initiatives

These strategies are aligned with the innovative and longer term plans outlined in the Health Reform Committee's final report, which is being rolled out by the Health Reform Implementation Taskforce.

The development of these individual strategies is the culmination of a significant amount of consultation involving consumers, carers, mental health professionals, government and non-government mental health bodies and peak industry organisations.

To assist with the implementation of major reforms to mental health services in Western Australia, a Mental Health Advisory Group has been established. The Advisory Group of mental health specialists will oversee implementation of the *Mental Health Strategy 2004-2007* and play an integral role in the development and monitoring of activities. The Advisory Group will also be involved in engaging consumers, carers, community bodies and other stakeholders in the provision of advice and feedback and assist with communicating information out to the community.

Key Initiative 1 - Mental Health Emergency Services

Objective

To expand statewide mental health emergency services to meet the demand for services within Emergency departments.

Actions

1. Increasing the number of specialist mental health nurses within hospital emergency departments. The service ill provide 24-hour coverage for people presenting with mental health problems. An additional 42 (FTE) mental health nurses will be employed to provide specialised mental health triaging and clinical support within emergency departments across the metropolitan area.
2. Expansion of the Psychiatric Emergency Team (PET) to ensure comprehensive cover across the metropolitan area. This service will provide dedicated emergency coverage north and south of the river.
3. Increasing the number of On Duty Psychiatric Registrars for after hours cover across the metropolitan area, to provide psychiatric assessment, treatment and support for mental health patients in the Emergency Department.
4. Establishing 19 new mental health beds consisting of five-bed admission holding units at Sir Charles Gairdner Hospital, Fremantle Hospital and Royal Perth Hospital and a four-bed admissions unit at Graylands Hospital. These units will provide a safe and secure environment for both patients and staff.

Key Initiative 2: Adult Inpatient services

Objective

To increase access to adult inpatient beds for people with severe mental illness.

Actions

1. Provision of an additional 113 beds in the following locations:
    a. *Graylands Hospital* – conversion of an existing facility (the Fitzroy Administration complex) to provide 12 new acute secure beds.
    b. *Armadale Hospital* – creation of 8 new beds within the current facility.

c. *Bentley Hospital* – provision of an additional 20 beds through the reconfiguration of inpatient services.
d. *Mother and Baby Unit* – the mother and baby unit at Graylands Hospital will be transferred to King Edward Memorial Hospital for the establishment of an 8 bed authorised unit.
e. *Bunbury Regional Hospital* – expansion of the acute psychiatric unit to provide an additional 18 beds.
f. *Intermediate Care* – establishment of 47 new intermediate care beds, 22 beds in the north and 25 beds in the south metropolitan areas, to provide rehabilitation, disability and clinical support services.

2. Provision of additional psychiatrist cover in Albany, Bunbury and Geraldton to ensure inpatient services in these rural areas are maintained.

Key Initiative 3 Community Mental Health Services

a) ADULTS

Objective

To improve clinical outcomes for people with a mental illness through provision of accessible community services which encourage early identification, intervention and recovery.

Actions

1. Expansion of community mental health clinical services, through an assertive case management approach. These services will be undertaken by multidisciplinary community teams.
2. Establishment of day therapy services to individuals with a major mental illness. The services will provide structured individual and group based clinical programs. Therapy services may include intensive rehabilitation and be provided in the person's own home or in a community facility.
3. Extension of the statewide Post Natal Depression (PND) services for mothers with babies through the statewide expansion of non-government community services, particularly in areas with a high number and projected growth of young families. Research will also be undertaken to inform the development PND services for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

b) YOUNG PEOPLE

Objective

To enhance service coverage and accessibility and provide a whole of service/government approach to ensure that young people with a mental health problem are given the best opportunities for early intervention.

Actions

1. Development of two Multi Systemic Therapy (MST) teams for young people aged 12-16 years at risk of developing mental illness in the south and the north metropolitan areas.
2. Establishment of the Intensive Community Youth Service to provide intensive counselling, access to stable accommodation, education and employment access for homeless youth at risk of mental illness, with little family or guardian support, in the south metropolitan area.
3. Expansion of the Bentley Child and Adolescent Mental Health Service's transition unit for its Day Treatment Program, to support 10 extra children and treat others at home to prevent unnecessary hospital admission.
4. Recruitment of additional clinical staff to expand existing Child and Adolescent Mental Health Services into areas of rapid youth population growth to provide services to young people with severe and complex mental disorders.
5. Development of a service to assess and treat people with an eating disorder, particularly young adults. The service will have strong links with regional and rural services.

Key Initiative 4 Supported Community Accommodation

Objective

To expand community supported accommodation services for people with severe mental illness.

Action

1. Creation of 420 community beds statewide through the following programs:
    a. *Supported Community Residential Units* – provision of 200 beds in cluster accommodation for up to 25 people with 24 hour on-site staff support in locations including the metropolitan area, Albany, Bunbury and Geraldton.
    b. *Licensed Psychiatric Hostels* – increase in the personal care subsidy to improve service quality to hostel residents.
    c. *Specialist Residential Services* – development and construction of an extended care service at Graylands Hospital to provide rehabilitation and a home-like environment for 20 people with chronic mental illness and severe disability, currently in acute inpatient beds.
    d. *Community Options 100* – transition of 30 people with long-term support needs from Graylands Hospital to community living with associated support services in the metropolitan area.

e. *Psychosocial Support Services* – expansion of statewide non-clinical psychosocial/disability support services to assist people to live in their own homes. This includes the construction of 120 housing units for the Independent Living Program.
f. *Supported Accommodation* – establishment of non-government services in Perth inner city, Fremantle and Armadale to support 50 homeless people with a mental illness. The services will provide 24 hour support, 'drop in' services and community outreach.

Key Initiative 5 Workforce And Safety Initiatives

Objective

To ensure services are adequately staffed with the appropriate skills and discipline mix and that Mental Health Services are safe places where innovative clinical practice is fostered.

Actions

1. Recruitment and retention of 425 staff through the following:
    a. A major recruitment drive in Australia and overseas. Mental health staff including psychiatrists, nurses, social workers and occupational therapists will be recruited.
    b. Provision of incentives to practice in areas of greatest need and workforce shortage to ensure adequate staff coverage in rural and remote areas.
    c. Improvement of workforce re-entry processes for staff that have left the workforce. Education and training will be tailored to address the projected workforce requirements. Innovative education and training models will equip the workforce with the skills, knowledge and attitudes to competently do their work.
    d. Improvement of workplace safety through convening a statewide safety working group that will make recommendations for many current complex safety issues. The safety working group will address issues such as the use and availability of duress alarms, communication (including mobile phones), the safe transportation of patients and safe, flexible working environments. Mental health staff will be provided with improved education and training in key areas of practice such as assessment, risk assessment and dealing with aggression.
    e. Expansion of the electronic mental health clinical information system PSOLIS to provide intermediate information to all clinicians to assist them with day to day clinical decision making.