NSW HEALTH
DEPARTMENT
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Senator Allison
Chair
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
CANBERRA ACT 2600

H05/10323

Dear Senator

Please find attached the NSW Department of Health's answers to the Senate Select Committee on Mental Health. The delay in replying is regretted.

Yours sincerly

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Senate Select Committee on Mental Health

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Questions on Notice
to
NSW Health

Questions from Senator Allison
Hansard pp. 90-91.

1. ***To pick up on previous witnesses—Senator Humphries went to this point, but if I can just make it more acutely—it was said that acute beds were being contracted from the community base and were being picked up within hospital psych wards. This is, as I understand it, for acute beds for crises as well as crisis services in the community. There were some six centres that had closed their crisis service after 5 pm. Can you confirm that that is the case or not, and if so, why that policy has been adopted?***

   Consistent with the principle of mainstreaming, NSW Health has made significant investments and initiatives to improve access to Mental Health services at hospital Emergency Departments (EDs), the site where people usually go or are taken (by relatives, Police, or Ambulance) in the event of any health crisis.

   The first initiative was to place mental health CNC nurses in the EDs during working hours to support. There are now over 100 Mental Health CNCs working in hospital EDs in NSW.

   Following successful trials at Nepean and Liverpool hospitals EDs, NSW Health is now implementing on going Psychiatric Emergency Care Centres (PECC) at 9 metropolitan hospital ED sites (Nepean, Liverpool, St Vincent's, St George, Wyong, Hornsby, Blacktown, Campbelltown, and Wollongong). These will be 4 or 6 bed units providing a total of 40 additional short stay / observation beds for those in Mental Health crisis.

   Whilst the PECC facilities are being constructed, all sites have been funded to provide 24/7 mental health nursing cover in the hospital ED. Following a successful trial of a rural Mental Health critical care service to improve access to specialised mental health care for people presenting to hospital ED and for those requiring transfer to a gazetted MHIU, NSW Health has funded the expansion of similar services across rural NSW. Full recurrent funding commences at the beginning of 2006.

In addition to the implementation of the PECCs and rural emergency care program that is being co-ordinated as a statewide NSW Mental Health Emergency Care program (NSW MHEC), the program will fund an audit and further refinement of the current Mental Health telephone access line services which provide universal telephone access to Mental Health triage, advice, and referral.

2. ***It was said that every night in New South Wales 700 people are turned away from crisis accommodation. Can you confirm that and advise whether the proposals that you are putting together now will alleviate that problem and to what extent? I think it was Professor Puplick who said that prisoners are more likely to reoffend because of a lack of housing. Do you expect that the extra accommodation that you have outlined will alleviate that problem, and what effect do you think it will have on recidivism?***

NSW Health is not in a position to comment on the number of requests for emergency or crisis accommodation in NSW. Crisis accommodation is the responsibility of the Supported Accommodation Assistance Program (SAAP), funded primarily through five-year bilateral agreements by the Australian Government with the states and territories. SAAP services in NSW are auspiced and administered through the Department of Community Services.

Not all people who request emergency accommodation are people with mental illness or mental health problems. However, it is acknowledged that people with a mental illness make up a large number of the homeless population in NSW. Across NSW there is an interagency approach to homelessness and NSW Health works in collaboration with other key human service agencies to increase access to health services and improve their responsiveness to the needs of mentally ill homeless people in the community.

Assisting people with mental illness to access and maintain appropriate accommodation and support services is part of the core service delivery of NSW Health through inter-agency partnerships. NSW Health is a key partner in the *Joint Guarantee of Service for People with a Mental Illness Living Aboriginal, Community and Public Housing* (JGOS) and the Housing and Accommodation Support Initiative (HASI).

Under the *JGOS*, clinical mental health services work in partnership with officers of the Department of Housing to support people with mental illness who are at risk of homelessness or require assistance to maintain tenancies.

The JGOS provides a clear outline of the roles and responsibilities of the participating agencies, including protocols for communication and referrals between agencies. Under the JGOS, agencies meet regularly to address issues affecting their clients, to maintain and develop

effective working relationships, exchange information and plan joint strategies. Liaison officers are identified by each agency to assist clients, including clients on Community Treatment Orders and clients with behavioural problems.

3. ***You say that you are increasing spending by 140 per cent, but we were given this afternoon a graph that shows that admissions have risen by somewhere between 300 and 400 per cent and that this is partly due to the dual diagnosis—the extra complication of drugs. In arriving at that figure of a 140 per cent increase, was that taken into account or not? What was the policy rationale for that increase as opposed to a 300 per cent increase? Following on from Senator Humphries's questions about the relativity of New South Wales spending, where does that place New South Wales in terms of the overall national picture per capita?***

Inpatient services represent only one component of a comprehensive range of specialist mental health services provided by NSW Health. While it is valid to base the allocation and use of resources on the need for services, this estimation of need must take into account the complete spectrum of need across the population. It must include the need for prevention services to reduce the future need for inpatient services for example. It must also include the need for acute community services which can maintain clients without the need for inpatient admission.

NSW policy in relation to resourcing for mental health services is based on the population based Mental Health Clinical Care and Prevention (MHCCP) service planning model which determines need for mental health services based on epidemiologically determined proportions of the population with a particular level of acuity. Clinically determined 'packages' of care are matched to each severity group, the resource implications for these packages determined and then the whole matrix is costed.

A comprehensive description of this process and copies of the model and its user guide are attached. This response also includes an analysis of NSW national position for per capita spending.

Separate Document attached: H05 10323 QON 3 Separate document_GS.doc

4. ***The committee has been impressed with a couple of services it saw in Victoria—Victoria gets a bit of a gong for having some innovative work being done on mental health services. My question to you is: have you taken into account the Thomas Embling centre and will your new forensic centre have the step-down arrangements, for instance, that Thomas Embling does? What have you rejected, if anything, of that approach? Will it be the same and as good as Thomas Embling?***

The Thomas Embling staff have visited Sydney to have discussions and teach several times this year. The Chief Executive and staff of Justice Health have visited Thomas Embling for tours of the hospital and discussions with their Chief Executive and senior staff. All the best points identified by the Thomas Embling staff are incorporated in the Forensic and Prison Hospitals. The Forensic Hospital gatehouse/entry is the area most different to the Thomas Embling as they have had problems there and modified it twice since building it.

5. ***The same applies to ORYGEN Youth Health mental health services. Will you have youth mental health services around this state which will be equivalent and if not why not?***

There are a number of models internationally for delivering mental health services to young people. ORYGEN Youth Health Service targets young people from the ages of 15 to 24 years across adolescence into early adulthood. Although there are continuity advantages for this model, there are also child protection issues to be considered and concerns about some more vulnerable adolescents being treated in programs with young adults.

In NSW, specialist child and adolescent mental health services generally provide treatment for children and adolescents up until the age of 18 and their families. The aim is to provide treatment that best fits with the young person's developmental needs, including interagency collaboration with other service partners for this age-group, such as the Departments of Community Services, Education and Training and Juvenile Justice. The age of 18 is not an absolute service criterion and there is capacity for graded transitions according to need, for example for young people who are still attending school after they turn 18.

NSW Health recognises the growing need for mental health services for children and adolescents, with earlier age of onset of mental disorders and greater complexity. This is an international phenomenon.

Since 2001/2, acute specialist child and adolescent mental health inpatient programs have been established at Campbelltown, John Hunter and Sydney Children's Hospital and at the Children's Hospital at Westmead. These have advanced capacity beyond the 9-bed Acute Adolescent Unit at Redbank House, Westmead Hospital. Programs at Sydney Children's Hospital and Campbelltown will be enhanced to safely deliver care to young people with more severe problems.

During 2002/3 to 2004/5, the focus of the Child and Adolescent Mental Health Statewide Network (CAMHSNET) was on inpatient child and adolescent mental health care, with placement of nurses in regional locations to improve assessment and care planning for children and

adolescents admitted to paediatric wards and/or general (adult) psychiatry units in those sites.

A key feature of the CAMHSNET nurse consultation and supported unit program has been an extensive education, training and supervision component. This has made the challenges of such an innovation more attractive for nursing staff and has been an incentive in recruitment and retention to date. The CAMHSNET nurses have come from a diversity of backgrounds, consequently their training needs have been varied and packages have been tailored to ensure appropriate clinical skills development. Over 20 CAMHSNET nurses were placed in rural and regional centres, supported by a Clinical Nurse Consultant and a child and adolescent psychiatrist Network Director in each of three geographical networks (Northern, Western and Southern) covering NSW. During this start-up phase, CAMHSNET staff have been employed centrally by Hunter New England Area Health Service.

There has also been an initial recruitment and training of 10 psychologists for the Northern network in high priority clinical work, demonstrating the feasibility of repeating this approach in allied health.

During 2005/6, employment of CAMHSNET staff in supported units will be devolved to local Area Health Services.

NSW Health is reviewing the role of the Child and Adolescent Mental Health Statewide Network (CAMHSNET) and will be expanding clinical skills-focussed child and adolescent mental health education and training. This will build upon the successful CAMHSNET nurse education program, enabling skills-focussed programs to be provided for existing and new staff in child and adolescent mental health services.

NSW Health is committed to enhancing comprehensive child and adolescent mental health care by improving access with family-oriented service delivery as close to home as possible across the spectrum of promotion, prevention, early intervention and treatment programs. This will involve a major 5-10 year program, with service development, staff recruitment and training addressing population needs.

Beginning with day patient programs, integrated day patient and inpatient units will be established across Area Health Services in a staged program that will also increase provision of comprehensive community-based care. New day programs in metropolitan and regional centres will complement existing day programs at Rivendell, Redbank House, Gna Ka Lun and Coral Tree Family Service in metropolitan Sydney and will improve care pathways by expanding options for young people who require more intensive community based treatment but may not need full inpatient care. Area Health Services will move towards self-sufficiency in child and adolescent mental health

care, with network linkages for more specialised supra-Area services, such as intensive inpatient care and specialist forensic inpatient care.

Work has begun on the development of a day program and the regional Nexus Western network hub at Orange. A site has been identified in the Illawarra for development of a day program and work is progressing to identify a site for a day program in Lismore.

All rural Area Health Services have extensive experience in child and adolescent telepsychiatry services complemented by outreach visits from the Children's Hospital at Westmead through the Child and Adolescent Psychological Telemedicine Outreach Service (CAPTOS) for rural NSW. The three geographical networks will use modes such as telepsychiatry to strengthen network linkages, consultation and care pathways.

6. ***Criticism has been levelled at New South Wales—and other states, I might say—for lack of data on prisoner health. In fact, it has been said that there has been a contraction—that New South Wales is providing less data even than it did before and that this is making it difficult to understand what happens after prisoners come out of prison for a whole range of measures I am sure you are familiar with, including suicide rates. Can you comment on that?***

The prison health data in New South Wales is extensive – "The 2001 New South Wales Inmate Health Survey" Tony Butler and Lucas Milner 2001 NSW Inmate Health Survey

"Mental Illness Among New South Wales Prisoners" Tony Butler and Stephen Allnutt August 2003 Mental Illness Among NSW Prisoners

There are also other papers that can be provided by the Centre for Health Research in Criminal Justice, Westfield Office Tower, Eastgardens, Maroubra. New South Wales.

There is extensive work on viral illnesses – Hep B, Hep C and influenza and chicken pox.

With regard to discharge research is underway and quite advanced, on deaths after discharge.

Suicides in prison are studies jointly by Justice Health and the Department of Corrective Services and statistics are available. Further preventive Work has been done recently and a research project comparing suicide rates in correctional establishments in New South Wales and England will be underway this year.

7. ***Professor Puplick says that the 12-month prevalence of serious mental illness is 30 times—in fact, 'psychotic' I think he said—that of the general population. Do you agree with that and, if so, on what basis? You are nodding, Dr Basson. What plans does the government have to deal with that?***

The statistics for mental health problems in jails are higher than for the general public by a considerable factor. If we look at women with psychosis in jail this is thirty times what it is in the community. We have different occurrences of other diagnoses, and in men though they are all greater.

Justice Health has psychiatrists visiting twenty-one of thirty adult jails in New South Wales and there are mental health nurses in eleven out of the twenty-one.

We have been looking at the ambulatory service as Justice Health calls it, and this month we will open the Mental Health Screening Unit at Silverwater, forty cells for men, to see one thousand, eight hundred inmates/year. Early next year we will open ten cells for women.

8. ***I wonder if there is a view from the state government about whether Medicare should cover health services in prison populations? Has this been discussed by the New South Wales government and do you think that it is a good idea?***

The following response is the current opinion within NSW Health. It is not officially approved by the NSW Government.

"Section 120 of the Australian Constitution notes that States have responsibility for prisoners. It states that "every State shall make provision for the detention in its prisons of persons accused or convicted of offences against the laws of the Commonwealth....."

The Health Insurance Commission has determined that as a result of Section 120, inmates have been excluded from access to Medicare. However NSW would contend that the intent of section 120 in itself does not necessarily imply that prisoners do not have access to Medicare benefits.

Changes would need to occur with the Health Insurance Commission's legislation in order to provide access to Medicare for prisoners.

It should be noted that the majority of services provided to inmates of NSW Correctional Centres are provided by registered nurses or public hospitals, neither of which requires access to Medicare. However inmates would have increased access to a range of specialist medical services and allied health services through an opportunity to access Medicare, particularly in rural areas."

9. ***Does the New South Wales government have a position as to whether the proportion of spending on mental health should roughly represent the disease burden? Have you had that debate? If it does not, how do you justify that? Do you have more information on measurements of unmet need that your departments may have with respect to those issues? We have had from numerous sources evidence that community care and supported accommodation lack adequate resources. Do you agree with that? Is there a plan to correct it? This was pretty much my question a little earlier. What does New South Wales Health believe needs to be spent from all sources to largely eliminate the shortfall in their services? Your submission says:***

Commonwealth/ State divisions in policy and funding for public housing ... have a large impact on mental health costs.

We are quite sure that they do as well, but what you propose to do about that?

This question is similar to question 3. NSW has a very well defined position on the determination of spending for mental health services which is based on disease burden across the population. The planning model used by NSW Health can also inform about unmet need by determining the gap between current service provision and the ideal situation recommended by the model.
To enlarge on this, a section of the NSW Health submission to the Select Committee is reproduced here. The comprehensive response to question 3 is also applicable here.

'**Adequacy of resources:** To address the first aim, within the existing division of clinical health services across public and private, specialist and general, NSW Health developed a planning model in 1999-2000, known as the Mental Health-Clinical Care and Prevention (MH-CCP) model. It is a quantitative model, based on existing epidemiological data and service models, and in essence it shows that an adequate clinical service is feasible at a level of expenditure that would have the following effects:

- The mental health share of Australian health expenditure would rise from the current 6.5% to about 9%.
- The relative position of Australia within the OECD countries on per capita mental health expenditure would rise from 27th to about the same level (12th) as we occupy on general health expenditure: alongside Sweden (13th), a little below Canada (5th), above the United Kingdom (17th) and New Zealand (20th).
- There are many gaps in the information base needed to build such a model, but they can and have been addressed in various ways.

MH-CCP then serves to define, for a population, the quantity of standard resources (acute and non-acute/ transitional beds, ambulatory care clinical staff) needed to provide care for each age group; the outputs to be expected from the system; and – after application of standard resource unit costs – how much funding is needed. This then allows the gap between "met need" and "need" to be expressed as a percentage of funding, or beds, or staff, or service outputs.

The "gap analyses" from the model have been used since 2000 to guide the allocation of an 18% increase in real per capita funding over the three years 2000-01 to 2003-04, and a further increase of about 13% per capita over the four years 2004-05 to 2007-08. Subsequently, a number of other jurisdictions have used the model for planning (NT, ACT, SA, Tasmania) and have found it useful.

NSW Health has always regarded the quantification of "need" for particular levels and types of services as essential before it is possible to have a constructive debate about the adequacy of resources. In the absence of a national approach to this, we have taken the initiative with the MH-CCP model, and, as already noted, other jurisdictions have independently chosen to follow this approach.

Division of responsibility: In broad terms the MH-CCP model accepts the current division in which specialist public mental health services operated by States and Territories provide the vast majority of care for people with severe illness, and especially those who currently consume 50% of state resources, namely people who are so ill that they must be treated under the involuntary care provisions of mental health legislation. The other 50% of State services extend as far towards moderate and mild levels of illness as resources permit. The "care packages" in the model assume an increasing role for non-specialist clinical services, especially in primary care, for the high prevalence by lower severity illnesses. Most of these would be expected to be provided under Medicare, though generalist community health services would also be involved, especially in rural and regional areas where – for example – private psychiatry is either non-existent or extremely scarce.

As it currently stands, MH-CCP does not model non-State services in detail. However, we are currently revising the model to take account of new epidemiological data and to make it somewhat easier to apply with other populations and types of services. '

Work is proceeding to enhance the model to better define the need for community beds and accommodation support places.

It is estimated both for NSW and Nationally that an increase of at least 50% on current funding levels is needed to provide an 'adequate' level of mental health service.

Housing Issues

In general it is not the role of NSW Health to provide housing for clients. However, the fundamental need for people to be housed in order to maintain physical and mental health, highlights the responsibility of NSW Health to work in close partnership with housing providers. The provision of secure, affordable housing for people with mental illnesses depends on the funding available outside the health portfolio, especially for public housing. This is not considered "mental health" expenditure, but nevertheless, Commonwealth/ State divisions in policy and funding for public housing could have an impact on mental health costs.

Details of the impact of the Commonwealth and State divisions in policy and funding for public housing on the accessibility of housing for people with mental illness should be sought from the Department of Housing.

10. Does New South Wales support a review of the National Mental Health Strategy, which tackles the resourcing question and benchmarks and objectives that have time lines associated with them?

Yes NSW would support such a review.

There have been a number of formal reviews and evaluations of the National Mental Health Strategy since it began, including those commissioned under the Strategy itself (Fig 1). However, these have not explicitly addressed the issue of adequacy of overall resources for implementation.

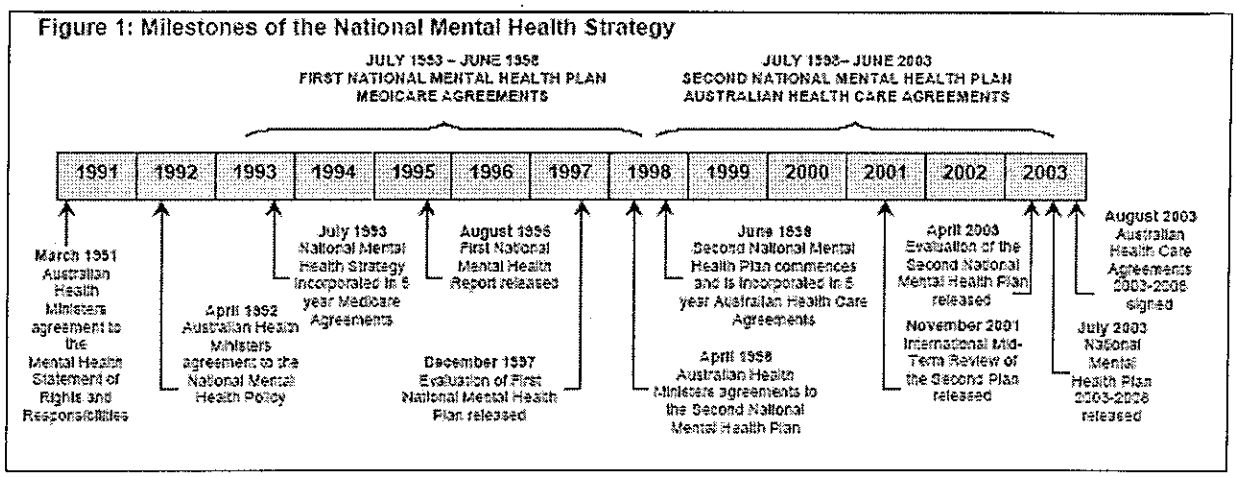


Figure 1: Reviews of the National Mental Health Strategy.

The annual National Mental Health Reports present comparative data across State-Territory jurisdictions, and present Commonwealth expenditures; but they do not relate these to any objective benchmarks. The results are always presented with the qualification:

- *"It is not known how much spending on mental health services is required to meet the priority needs of the Australian population. However, surveys conducted of the extent of mental illness in the community have highlighted a high level of unmet need. Similar findings have been reported in other countries." (National Mental Health Report 2004: Emphasis added)*

By contrast, funding is a major focus of criticism by the Mental Health Council of Australia. Professor Patrick McGorry's foreword to one of these reports identifies the problem as "trying to deliver mental health services on the cheap" and "totally inadequate funding". (Fig 2). It also refers to "cosy bipartisan neglect of mental health by both sides of politics" and "lack of political will", which may reasonably be taken as a commentary on the division of responsibility between Governments.

Despite its demonstrated capacity for innovation, Australia has not translated recent advances into better mental health care. The report demonstrates that this is primarily a matter of lack of political will and totally inadequate funding. The expertise and effective models of care are readily available but are not supported. Australia is still trying to deliver mental health services on the cheap. In the more visible post-institutional era, this is now having serious consequences for our community as a whole. Only the cosy bipartisan neglect of mental health by both sides of politics, and the lack of effective mobilisation of the population, enables this to persist. Other societies would not tolerate this.

Figure 2: Foreword to Out of Hospital Out of Mind report (Extract).

Likewise, the submission of the Australian Medical Association to the present Committee lists overall funding as the first of its seven key issues (Figure 3):

- **Mental health services get low funding priority:** In Australia, the provision of mental health services receives an inappropriately low priority having regard to the large number of people affected, the high burden of disability, the untoward impact on service-deprived sub-groups within the community and the missed potential for the cost-effective achievement of better health outcomes. International comparisons of mental health spending are dated (circa 1993) but suggest a spending shortfall in Australia compared to Canada, the US and the Netherlands.
- **Existing resources are not being used as well as they could or should:** Governments decry and undervalue the large contribution of the private psychiatric sector. The separation of some services results in significant inefficiency eg between mental health, drug and alcohol services, and there is scope to improve patient outcomes by integrating these services. Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.
- **Access to hospital services is increasingly problematical** for public mental health patients. The AMA does not believe that there is consistency between the National Mental Health Strategy and the resources applied to mental health in the public hospital sector.

Figure 3: Executive summary to Submission to the Senate Select Committee on Mental Health (Canberra: Australian Medical Association, 2005).

The evidence in the National Mental Health Report 2004 is that mental health expenditure to 2001-02 had been substantially increased in real per capita

terms since 1992-93, but had not been increased by more than the general increase in health expenditure over the same period (Fig 4):

"Growth in mental health spending by governments paralleled growth in the overall health sector. Although significant, the implication is that the mental health sector has maintained its position, but not increased its share of the health dollar." (National Mental Health Report 2004).

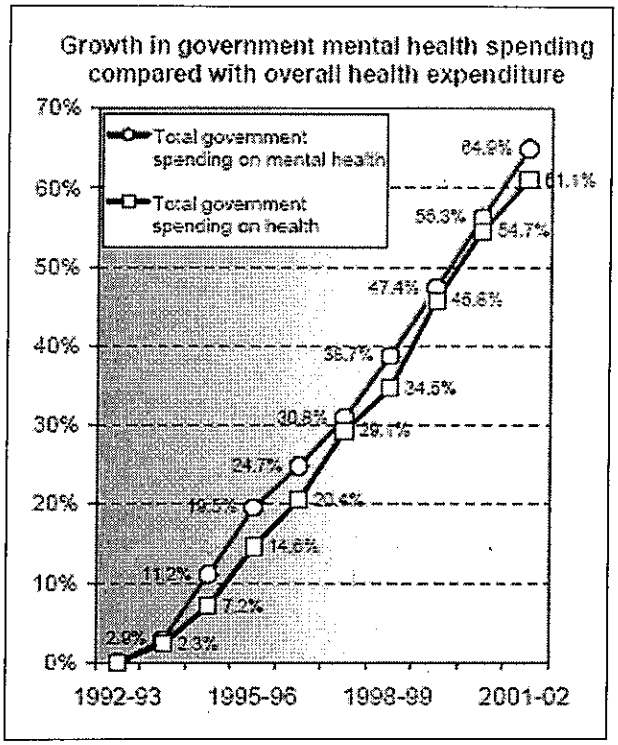


Figure 4: The National Mental Health Strategy has not increased the mental health share of the health dollar, overall, in Australia [Source: National Mental Health Report 2004].

Clearly, unless we have a clear definition of what we mean by "the priority needs of the Australian population" in relation to mental health services, and community agreement about what they are and how to meet them, these comparative analyses of health expenditures are of limited use. Unfortunately, the Strategy as it currently exists has not progressed past the point of relative statements about need.

Of the 38 specific Objectives of the Strategy, there are several relating to the issues of the adequacy of funding, and the way in which Governments in Australia were to collaborate, but two can represent the whole:

Objective 8: To develop formalised policy and planning arrangements at Commonwealth, State, Territory and Area/ regional levels to ensure that all programs relevant to those with severe mental health problems and mental disorders adequately address their needs.

Objective 15: To identify areas where the separation of Commonwealth and State funding for mental health treatment services compromises the targeting, integration and distribution of mental health services and to introduce measures to overcome this.

Considered against those global objectives, the Strategy has failed to do a number of essential things:

- o It has never explicitly defined the target population whose needs were to be addressed: that is, while objective 8 limits the scope to "those with severe mental health problems and mental disorders", the group is undefined.
- o It has never defined what was meant by "all programs relevant" to the target population: that is, the scope of the programs needed, and the scope of "health" programs within that.
- o It has never defined the "needs" of the target population, or what level of service would be consistent with "adequately" addressing them
- o It has not recognised that limiting Objective 15 to "mental health treatment services" is inconsistent with the reference to "all programs" in Objective 8, because the move to community-based care means that many human service agencies need to be involved in providing programs for people with mental illnesses, and the separation of Commonwealth and State responsibility for funding programs can either assist or compromise care delivery.

Some of these defects were noted by Dr Ron Manderscheid from the US Centre for Mental Health Services, in his 1997 review[1] of the Strategy in relation to the "appropriateness of national mental health policy settings from an international perspective". Manderscheid concluded that " [Australia] ...needs to develop a framework or map that disaggregates the Australian population into subgroups (perhaps by age, diagnosis and disability, e.g., adults with severe mental illness, adults with serious mental illness, adults with other mental illnesses, adults with risk factors, remaining adults) to examine current and needed insurance coverage, current and needed services, major gaps, and strategic actions that could be planned to remedy deficits. Such a strategy could also have the benefit of developing a common vision of mental health for the entire population of Australia. This work could provide an excellent transition toward a population focus." [underlining added].

The consequence of having an informally defined scope for the Strategy has meant that it is liable to criticism for failing to address needs in any area that anyone regards as relevant to mental illness. This has been exacerbated by the expanded scope of the National Survey of Mental Health and Wellbeing (SMHWB) in 1997, which included substance use disorders within the scope of "mental illness", and (for technical reasons) concentrated on the high prevalence disorders of anxiety and depression. Thus the "prevalence of mental illness" of 18% includes substance use disorders, even though services for these disorders are not funded out of mental health budgets in Australia. Moreover, the conclusions about the main sources of treatment services from the SMHWB only apply to the high prevalence disorders, but have been widely (mis)interpreted as evidence about mental health services in general.

The fact is that the SMHWB has very little to say about the treatment population of people served by State and Territory Mental Health services, and nothing at all to say about those who consume about half those services, namely those who are so ill that they require involuntary treatment under

Mental Health legislation. The separate "Low Prevalence" component of the SMHWB dealt with this group, but was confined to 3800 people already receiving care within the urban areas of Australian Capital Territory, Queensland, Victoria and Western Australia.

At the same time, the de facto scope of the Strategy had to be "historical", simply because there was no requirement to do more than maintain the historical scope (and funding) of specialist public sector mental health treatment services in States and Territories, Medicare-funded services of the Commonwealth, and a small volume of privately insured care.

In addition, there has been very little examination of how Commonwealth/ State responsibilities across the human services (general community services, housing, income support, residential aged care, family allowances, employment policies, etc) can compromise or improve the "targeting, integration and distribution of mental health services" and the ability to meet need.

[1]Evaluation of the National Mental Health Strategy: Research Components. Mental Health Branch, Commonwealth Department of Health and Family Services, December 1997 (p. 5). The reviewer, Dr Ron Manderscheid, is the Chief, Survey and Analysis Branch, Division of State and Community Systems Development, in the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services, and formerly (1981-92) Chief, Statistical Research Branch, (US) National Institute for Mental Health. Dr. Manderscheid has been the one of the principal editors of the series, Mental Health, United States since its inception 1983.

11. We have heard a lot of criticism of references in the Mental Health Strategy to serious mental illness. That, I think, is generally accepted to be a focus which it is now time to move on from, if that makes sense. We need to tackle prevention and early intervention now, having had a focus on acute. Does New South Wales agree with that?

For the past ten years New South Wales Health has focused on prevention and early intervention as well as all other modes across the spectrum of care required by mental health clients, providing funding for mental health programs in the framework of population mental health.

This model takes into account the epidemiology of mental health problems and disorders for each age group, the spectrum of interventions that may be provided and the evidence base supporting the effectiveness of these. It also acknowledges the different levels of service provision from primary care to secondary and tertiary specialised services. The population approach to mental health services as outlined in the National and NSW policies emphasizes both the provision of continuous service across the lifespan as well as a spectrum of interventions from health promotion, prevention, early intervention, treatment and continuity of care.

There is a range of prevention and early intervention initiatives in place in NSW which are based on available evidence of need and effectiveness for different age groups and risk groups. They emphasise

the use of evidence based tools and programs which have been evaluated and have been found to be effective (for example, Positive Parenting Program, Adolescents Coping with Emotions). However, at this stage there have been no large-scale evaluations of these initiatives, although there have been evaluations of local initiatives and a review of School-Link is currently underway.

Considerable progress has been made in the field of prevention and early intervention, but there still remains significant reforms to be undertaken to enhance awareness of mental health and mental illness across the community and all stakeholder groups and service networks and enhance their capacity to deal with mental health issues.

One of the major barriers appears to be the general lack of understanding of how to apply the Population Health model when there are competing priorities concerning lack of community care, particularly for people in crisis.

There is a need for good evidence based models to illustrate the medium and long terms outcomes for prevention and early intervention initiatives and their effects on the need for specialist mental health services. This may be achieved by putting aside specific Commonwealth funding for evaluation.

Section C of the NSW Submission to the Senate Committee lists some of the prevention and early intervention programs developed in NSW.

Health funding agreements between Commonwealth and States need to consider ongoing funding for Promotion, Prevention and Early Intervention to build on the evidence base.

12. ***With respect to the housing and support initiatives that you mentioned, Ms Murray, a bit earlier, could you just give us an estimate of the total number of the people in the state who will benefit from this program. Are the same criteria going to be used as were used in the trial in relation to that work? Are there plans to ultimately extend the initiative to all regions? How will you evaluate it if that is the expectation?***

The Housing and Accommodation Support Initiative (HASI) operates under three stages, when all three stages are fully operational there will be over 700 HASI places covering all Area Health Services in NSW.

HASI Stage One (high support)
Services under the first stage of HASI commenced in 2002/03 with NSW Health and the NSW Department of Housing jointly funding housing and accommodation support for over 100 people with complex mental health problems and disorders. The Department of Housing contributed appropriate housing and NSW Health provides $5million recurrently for NGOs to provide high-level accommodation support services.

HASI Stage Two (low support outreach)
Under HASI Stage Two, NSW Health is providing funding for 460 packages of care for low-level outreach, accommodation support for people who have a mental illness and reside in public housing and community housing. Services commenced in late 2005. HASI Two is funded for three years.

HASI Stage Three (high support)
Under HASI Stage Three, NSW Health are providing $6.3million recurrently for 126 places of high support and the Department of Housing are contributing housing stock. Services will commence from February 2006 and expected to be fully operational by mid 2006.

HASI Evaluation: The Social Policy Research Centre, University of New South Wales, has been contracted by NSW Health to conduct a formal 2-year longitudinal evaluation of HASI Stage One. The evaluation funded by NSW Health and the Department of Housing. Indications from HASI Stage One are that, for people with mental health problems and disorders, the HASI model can lead to stable, long term tenancies, reduced homelessness and reduced frequency and duration of hospitalisation.

There will also be a formal evaluation conducted of HASI Stage Two.

HASI is not a trial; it is a current NSW Health partnership initiative. The same criteria have been used in identifying HASI clients for Stage One and Three and have not been varied since the initial implementation of the program.

To be eligible for High Support HASI, applicants must meet the following criteria:

1) Be aged between 16 to 65 years.
2) Have a diagnosed severe mental disorder such as schizophrenia, schizoaffective disorder or bipolar disorder.
3) Be experiencing moderate to severe level of psychiatric disability.
4) Be eligible for community housing.
5) Have the ability and desire to live in the community.
6) Be capable of benefiting from the provision of accommodation support services.
7) Have completed and lodged the appropriate documentation with a nominated HASI accommodation support provider.
8) Have provided informed consent to participate in the Initiative. (Where appropriate, the client's guardian may need to provide the consent).

In addition to the above criteria, a relative needs assessment process is applied. 'Relative Need' is a concept that ranks potential clients based on greatest unmet need and the benefits they would gain from

the Initiative. High Support HASI will specifically prioritise applicants who are:

a) Residing in a hospital bed because it has been difficult to access high levels of accommodation support;
b) Homeless, at risk of homelessness or inappropriately housed individuals. This may include clients whose current housing is at risk due to the lack of care and support; and
c) Unlikely to be able to maintain a mainstream tenancy agreement without HASI type support.

The criteria for HASI Stage Two differ primarily according to the target group; clients eligible for HASI Two must be current public housing residents and have lower level support needs. The program principles remain the same.

13. ***We have received evidence, from not just New South Wales of course but right around the country, that carers are being discouraged from making complaints, that there are also consumer complaints that are not being taken seriously and that even employees are discouraged from reporting errors and making complaints. Is this just about perceptions? Perhaps you can tell us what you are doing about that or whether there are some significant policy changes that we can expect in terms of complaints mechanisms.***

Current State level complaint mechanisms include the Health Care Complaints Commission, the Official Visitors Program and the Sentinel Events Review Committee.

Since the restructuring of Area Health Services in NSW, the variety of complaint mechanisms which exist in Areas are now the responsibility of the Director of Clinical Governance who reports directly to the Chief Executive in each Area. Areas employ consumer advocates as well as a patient representative in each hospital or institution.

Documentation about patient rights exists in the form of booklets given to all mental health patients on admission.

To ensure that there is an independent and ongoing monitor of consumer opinion, NSW initiated the **MH-CoPES (Mental Health Consumer Perception and Experience of Services)** project in partnership with the NSW Consumer Advisory Group (NSW CAG)

It commenced in January 2004 and stage 1 has reported to NSW Health in 2005. MH- CoPES aims to develop a state wide approach for mental health services in NSW to hear and respond to consumers' views about services as part of their continuing improvement processes.

The vision of the project is:

- To develop a formal mechanism for consumers' voices to be recognised in practice – and recognised as essential to guiding services;
- To develop tools and processes which assist services to become more responsive and accountable to consumers;
- To augment existing quality processes in NSW by developing a mechanism whereby consumers' views contribute to continuous service improvement; and
- To establish a formal mechanism that builds dialogue and partnership within NSW Mental Health services around issues that are important to consumers.
- Mental Health First Aid courses

By April 2005, a process of consumer involvement and a survey tool had been developed. This project has been proposed for National development by the National Mental Health Information Strategy Committee.The NSW Minister for Health has approved $600K over 3 years to develop an implementation process for the tool developed by stage 1 of the project.

Question from Senator Humphries

14. ***Senator HUMPHRIES—The criticism has also been made that, while as you pointed out in your submission there is an opening of new acute care beds, the real crisis is coming about because community based beds are not only not being increased but are being reduced in number. Is there a policy on the part of the New South Wales government about those beds? Are they decreasing in number?***

Mr McGarrell—The short answer is no. There is a plan to increase community based beds. When we say community based beds we are talking about subacute beds, we are talking about community care beds and we are also talking about supported housing beds. There is a plan to increase the community care and non-acute beds over the next three years, I think—but I will have to check that, because we are building new units. We also have the HASI program which identifies a number of places. We are putting in 118 under HASI1.

Senator HUMPHRIES—What is HASI?

Ms Murray—I might assist with some information. HASI is the Housing and Accommodation Support Initiative. I used to

pronounce it 'hussy' but it is actually 'hassy'! As a result of a policy decision in New South Wales, with this policy we have worked towards implementing this program across New South Wales.

CHAIR—Can you give its full name?

Ms Murray—It is called the 'Framework for housing and accommodation support for people with mental health problems and disorders'. We have been working with the Department of Housing, through Mental Health and also through the NGO sector, to establish a program of high-level accommodation support as well as low-level outreach support. The first monies came through in 2002. Through that, we have delivered over 100 high-level accommodation support places across nine of the former area health services. That went to places like Broken Hill that had never had any kind of accommodation support or NGO sector involvement. The second stage of HASI is 460 low outreach places. That is across all areas in New South Wales. There we have targeted people already living in social housing—people in public housing as well as community housing. We are working with the Department of Housing and NGOs supplying accommodation support to provide outreach to these people to help them sustain tenancy. The third stage of HASI is currently under tender. Tenders closed last week. That will be added an additional 126 places.

Senator HUMPHRIES—I am pleased to see that that is happening, but I think the comment that was made by other witnesses was that in the past there has been a decline in either the actual number or the proportion of such beds available in the community. Has there been a decline and are you compensating for that now, or has it always been static or rising?

Mr McGarrell—I think we need to be clear about what we mean by community beds. There has been decrease in beds, as you all know, and now there is a U-turn in the number of beds right across the mental health system that is currently provided in New South Wales. We can provide you with the figures. But, when we are talking about community care beds, there is again an increase there. I do not think we have actually reduced community care beds.

Ms Murray—No. In fact, in 2001 we did a survey of what is called supported accommodation places in the community and the HASI beds are additional to that. We are taking a very strong line across the state that they are not to replace existing places—they are additional, extra support.

Senator HUMPHRIES—There is certainly evidence that there has been a reduction in bed numbers, so perhaps you might take on notice that question and give us the figures for 10 years of what beds have been like. Obviously there are acute, subacute and other sorts of beds, including crisis beds. However, you might want to define them; we would be very happy to get that information.

NSW Health does not have a stated policy about community based beds except that Areas have been advised that there is to be no reduction in beds funded by the department for mental health clients

The most comprehensive and comparable data about 'community beds' comes from the National Survey of Mental Health Services.

Prior to 1999-2000, community residential services were defined as 24 hour staffed residential units in community settings (external to the campus of a general hospital or psychiatric institution) and funded by government. From 1999-2000, the definition has been broadened to incorporate all staffed community based units, regardless of the number of hours that staff are present.

These beds will include those provided by both government and non government sources where government funds were allocated.
While the numbers show an overall increase in beds, there was some reduction in the number of beds staffed for 24 hrs a day and an increase in the number with less staffed hours.

Since 2002, under HASI more than 100 housing and accommodation support places have been created for people with mental illness across NSW. By mid 2006 an additional 500 housing and accommodation support places will be available through HASI.

Community Mental Health Beds (all support levels) and Supported Accommodation Places

	Community Beds	Supported Accommodation HASI places
June 1993	283	
June 1994	268	
June 1995	333	
June 1996	306	
June 1997	325	
June 1998	293	
June 1999	317	
June 2000	474	
June 2001	530	
June 2002	530	
June 2003	532	100
June 2004	na	100

June 2005	na	100
June 2006		600

Source: National Mental Health Report 2004 Figures for June 2003 approved for unpublished NMHR 2006
HASI – Centre for Mental Health

To form an accurate impression on how mental health services are meeting predicted need in the community and to answer the rest of this question, the attached annual report appendix (attached as part of response to Q3, needs to be considered with the table of community bed numbers above. This attachment also illustrates the changes in mental health acute and non acute bed numbers from 2003/04 to 2004/05.

Question from Senator Forshaw

15. ***Mr McGarrell—As you know, there were 120 recommendations made by the upper house inquiry. Some of those recommendations can be chunked together. So, for example, there was a view that mental health services should be working with other departments, and one of the outcomes of our work has been to develop an interagency or cross-departmental strategy for better mental health services. For example, I have here a document, signed off on by the Premier a couple of weeks ago, which is a document that has been agreed—***

Another big chunk of work is the Mental Health Act review, and that is something that the parliamentary secretary, Cherie Burton, has taken on board. She has gone around the state talking to consumers, carers, stakeholders, NGOs, staff, clinicians—

Senator FORSHAW—Is that the draft exposure?

Mr McGarrell—Yes. But there have been two discussion papers that went out last year to stimulate debate and discussion. A whole range of new ideas have come back through that process. I have been going with the parliamentary secretary on those visits and picking that up. So that is another tranche.

Senator FORSHAW—Is there a timeframe that the government has in mind as to when that might actually come before the parliament in New South Wales?

Mr McGarrell—Before the Premier resigned, the timeline for a draft exposure bill to be ready was September. I am not sure whether that timeline is still written in concrete or not. I do know that that the parliamentary secretary was very keen. She would rather do this properly than do it quickly. It is something that we are very keen to do, because it is a piece of legislation that is really

important. We are also looking at how we are going to consult with the Indigenous population and with people from culturally and linguistically diverse backgrounds. So there are a whole range of things that we still need to do, but we are very close to the draft exposure bill.

Senator FORSHAW—I would be interested, and I think the committee would be interested, in getting some further detail on that, if it is possible for it to be given to us.

Mr McGarrell—There is an up-to-date progress report, which is going to the committee next week, which gives updates on each of those 120 recommendations and where they have got to. It has gone to the committee to test that what we say is happening is what stakeholders see happening on the ground. I know that Dr Pezzutti is very keen to listen to what the community is saying, and not just to the bureaucrats.

REVIEW OF THE NSW MENTAL HEALTH ACT

Two discussion papers were released in 2004 to encourage community participation in the reform of mental health laws. More than 200 submissions were received.

During 2005 wide-ranging consultations were undertaken across urban and rural NSW. These meetings included key stakeholders in mental health, including NGOs, carers, consumers, and staff. The issues raised in these public meetings have been useful in further developing and finetuning the proposals.

In 2006, an Exposure Draft Bill will be prepared and released for further community consultation. To meet the needs of interested stakeholders, it is proposed to allow at least three months for feedback of comments on the exposure draft. A final Bill will then be developed for consideration of Parliament. The timing of this final draft will largely depend on the nature and scope of issues raised in the consultation period.

As the review is at a 'Cabinet-in-confidence stage' it is not possible to release details before the release of the next Exposure Draft Bill.

Question/s from Senator Allison

You say that you are increasing spending by 140 per cent, but we were given this afternoon a graph that shows that admissions have risen by somewhere between 300 and 400 per cent and that this is partly due to the dual diagnosis—the extra complication of drugs.

In arriving at that figure of a 140 per cent increase, was that taken into account or not? What was the policy rationale for that increase as opposed to a 300 per cent increase?

Following on from Senator Humphries's questions about the relativity of New South Wales spending, where does that place New South Wales in terms of the overall national picture per capita?

Answer

The question concerns the method used by NSW Health to identify the funding needed for a comprehensive mental health service. The NSW planning model was described in our submission to the Senate Inquiry, and is now attached. It is a complex model, and it is certainly not based on trying to match dollars with percentage increases in a single statistic. For that reason the discussion is postponed until the statistics cited in the question have been explained more fully.

- As stated in our submission to the Inquiry, the NSW mental health budget has increased by 140 per cent since 1994/1995 - from $355 million in that year to $854 million in 2005-06. It is intended only as a simple concrete statement of what has been achieved since Labor came to office in NSW. It is not intended to imply that the 140 percent increase on an inherited (and very low) baseline is sufficient, or that it was a planning target, or that it should bear any particular relation to other statistic, except for one: it disproves the false assertion that there has been "ten years of neglect" in NSW.

- The 140 per cent increase is simply based on mental health Program budgets in NSW, whereas for the national comparisons the scope of services included as "mental health" is broader (that is, it includes a small number of services that in NSW are funded by other programs within health). On the other hand, national comparisons exclude significant components of expenditure included in the NSW Mental Health program budget, such as depreciation, DVA payments for DVA patients treated in NSW, and a number of other things.

- Thus, to estimate where the NSW Mental Health program budget (when expended) would "place New South Wales in terms of the overall national picture per capita", we have to start from the latest national published data (in the *Report on Government Services 2005*). These data are supplied in

accordance with the *National Mental Health Report* definitions, but the *Report on Government Services* requires provisional data for the most recent reporting year available, even if it has not been validated by the processes agreed for reporting under the National Mental Health Strategy. Typically, therefore, there will be a few dollars per capita difference between provisional and final data.

- Figure 1 below is from a table (in the public domain) for the *Report on Government Services 2005*. It compares a particular set of expenditures "at the discretion of State and Territory governments", and it shows NSW at $93.60 per capita relative to an Australian average of $98.50, both being expressed in 2002/03 dollars. Previous expenditures back to 1998-99 are also given, and converted to 2002-03 dollars by means of a "deflator" that is different for each State and Territory (Fig 2).

Table 11A.24 **Real estimated recurrent expenditure at the discretion of State and Territory governments — excluding other revenue (2002-03 dollars) (a), (b), (c), (d), (e)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Real recurrent expenditure (excluding other revenue) ($'000)									
1998-99	517 318.2	411 984.3	282 591.9	191 719.7	134 187.5	39 798.6	21 140.9	15 821.7	1 614 562.9
1999-2000	537 020.3	433 246.4	303 752.2	198 521.6	140 513.9	37 729.9	22 573.8	15 761.8	1 689 120.0
2000-01	549 172.2	469 680.8	315 844.6	207 476.6	140 345.8	41 010.2	25 045.7	16 205.3	1 764 781.1
2001-02	568 764.8	484 975.5	318 898.4	218 612.3	147 253.4	43 309.2	27 794.6	17 578.6	1 827 186.7
2002-03	624 191.1	520 906.5	330 153.5	228 227.2	151 804.3	42 409.8	34 022.5	17 363.4	1 949 078.2
Real expenditure per person (excluding other revenue) ($)									
1998-99	81.2	88.4	81.4	104.4	89.8	84.3	68.1	82.7	85.8
1999-2000	83.3	91.9	86.0	106.6	93.5	80.0	72.0	81.1	88.7
2000-01	84.1	98.5	87.9	109.9	93.1	87.0	79.1	82.6	91.6
2001-02	86.1	100.3	87.0	114.2	97.1	91.7	86.8	89.0	93.6
2002-03	93.6	106.2	88.0	117.6	99.6	89.4	105.4	88.0	98.5

(a) 2002-03 data are preliminary only; final validation is ongoing prior to publication in the *National Mental Health Report 2005*.

(b) Constant price expenditure expressed in 2002-03 prices, using Government Final Consumption Expenditure on Hospital and Clinical Services as deflator. See table 11A.55 for details.

(c) Estimates of State and Territory government expenditure exclude all reported non-State revenue, including patient fees, reimbursement by third party compensation insurers, Australian Government funding provided under the NMHS funds and through the DVA and other Australian government funds. Revenue provided by the Australian Government under the Australian Health Care Agreement base grants is included. However, apart from NMHS and DVA funding, all other revenue categories are subject to minimal validation and may be inconsistently treated across jurisdictions. In addition, it is not possible to extract these amounts uniformly across time.

(d) Depreciation excluded for all years.

(e) See National Mental Health Report 2004 for full description of derivation of expenditure estimates.

Source: State and Territory governments.

Figure 1: Relative expenditure , Report on Government Services 2005.

- Figure 2 shows the conversion factors applied to bring expenditures in different years onto a common basis. ["Fixed Capital" in the footnote is presumably a mistake for "Final Consumption" – see Fig 1].

Table 11A.55 **Deflators used to calculate real state and territory mental health expenditure (a)**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1998-99	88.2	88.4	88.8	89.5	88.6	88.8	88.6	87.9
1999-2000	90.4	90.5	90.9	90.5	90.5	90.9	90.6	90.1
2000-01	93.4	93.5	93.9	93.7	93.5	93.8	93.4	93.2
2001-02	96.5	96.7	96.7	96.4	96.6	96.7	96.5	96.2
2002-03	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The deflators used are the State and Territory Implicit Price Deflators Gross Fixed Capital Expenditure hospital clinical services.

Source: ABS (unpublished).

Figure 2: Deflators for State/ Territory expenditure

- To carry per capita expenditure data forward, we would need to know many things that we do not, namely changes in expenditure in other States and Territories in 2003-04 and 2004-05, budget increases in 2005-06 and all the relevant deflators.

- However, we can at least calculate the NSW per capita expenditure in equivalent terms to Figure 1 – that is, in 2002-03 dollars - by adding in the known budget enhancements over the period (ignoring the NSW "escalation" factors for cost increases) and dividing by projected populations.

- On that basis we stated in the submission to the Inquiry that 'this additional funding will increase NSW per capita expenditure to about $109.30 in 2007-08 (in 2002-03 dollars)".

- If all other jurisdictions simply maintained their 2002-03 expenditures (in real terms) at the 2002-03 levels shown in Figure 1, NSW would be well above the national State/Territory per capita average, and second in relative expenditure behind Western Australia. But, since the general trend is upwards, the simplest way to express this is to say that in 2004-05 NSW was, and expected to remain, "at or about" the national average. [Remembering that every $3 per capita added by NSW increases the national average by $1 because we have a third of the national population, so we only "gain" $2.]

- That said, these relative comparisons are not relevant to NSW planning since 2000. It is just that there is a history of being judged by them, so that the calculations are necessary. For that reason we also draw the Inquiry's attention to the percentages in Figure 3 below:

	1992-93	2002-03	10 year impact
New South Wales	75.97	100.00	31.6%
Victoria	80.64	100.00	24.0%
Queensland	81.40	100.00	22.9%
Western Australia	81.87	100.00	22.1%
South Australia	80.34	100.00	24.5%
Tasmania	80.07	100.00	24.9%
Australian Capital Territory	76.86	100.00	30.1%
Northern Territory	79.62	100.00	25.6%

Figure 2: Deflators in Figure 2 compared over 10 years

- When jurisdictions are compared on their percentage expenditure increases since the start of the *National Mental Health Strategy*, this ignores the starting level (to the detriment of Victoria in particular), but it also ignores the estimated increase in relevant costs, as shown in Figure 3, which takes the deflators of Figure 2 back to 1992-93. This acts against NSW and the ACT, where costs (as estimated by the ABS by the "State and Local Government Final Consumption Expenditure - Hospital and Clinical Services") have risen much more than in other jurisdictions.

  The 31.2% "impact" in NSW means that increases in expenditure over the 10 years to 2002-03 (in "current dollars") have a 31.2% discount applied when expressed it in "constant dollars". By contrast, the discount was 22.1% in Western Australia. A <u>different</u> index is used to deflate Commonwealth expenditures (the "Implicit Price Deflator for Non-Farm GDP") and its "impact" is only 17.6% for the same period. These cost differentials are <u>not</u> recognised in the relevant Commonwealth-to-State funding formulae, but they <u>are</u> applied to State/Territory expenditure increases when reporting comparisons over time. They do not affect comparisons in the latest year, but they have to be considered when comparing increases.

- In summary, there are many complexities in comparing percentage changes in expenditure between places and over time. As we noted in our Submission to the Inquiry, these relative comparisons are of limited value, since they do not say what the right level of expenditure might be.

- Thus we appreciate the opportunity to explain in more detail the policy rationale for estimates of "appropriate" levels of expenditure that we explained at pages 12-23 of our submission.

- To summarise the key points of that part of the submission to the Inquiry, we estimated that an adequate expenditure to cover the need would be about 50% more than Australia currently spends: that is to say, about $2 Billion more, on a base of about $4 Billion. About half of this increase – under current divisions of responsibility for service provision – would need to be invested in State/ Territory services for severe/ low prevalence illnesses; and the other half in Commonwealth services for moderate-mild/ high prevalence illnesses. We note that this "bottom up" estimate is fairly consistent with "top down" estimates that can be derived from (problematic) international comparisons of mental health expenditure, in appropriately adjusted price terms. We also note that lack of clarity in defining "mental illnesses" and identifying the responsibilities and scope of different services and different levels of government has generated a confused, contentious and unhelpful debate on these matters.

- Subsequently, as we have seen from the transcripts of the Inquiry hearings, the scientific advisor to the Mental Health Council of Australia, Professor Hickie, has arrived at an estimate that +$2 Billion is needed, divided more or less equally between services provided by States and Territories and those (such as Medicare) funded directly by the

Commonwealth. The basis for this estimate is unknown, but judging by the author's previous publications, it appears to be a "top down" estimate based on un-adjusted international comparison data: in particular the 1997/98 percentages of health budgets expended on "mental health" as stated in the WHO "Project Atlas" report of 2001. [In this context we note that we have recently received the 2005 edition of that publication, but unfortunately, most of the relevant data have not been updated.]

- Subsequently, the Mental Health Council of Australia and the Brain and Mind Research Institute have produced the *Not for Service* report, which identifies the funding needs of NSW as below (MHCA media release, 19th October 2005):

> *Not For Service* calls on all Australian governments to increase expenditure on mental health care services by 1% per annum for each of the next five years, bringing expenditure by 2010 to 12% of total health care funding in real terms.
>
> The NSW Government must increase spending on mental health in 2006/7 by $100m based on their 2004/5 budget.

- It is clear from the context that the "1% per annum" should be read as "1% of the health budget per annum" so as to proceed from about 7% of the national health budget to 12% (of its current level) over the 5 years. The same conclusion follows from the particular statement for NSW, since the 2004-05 health budget was about $10 Bn, of which 1% is $100 million.

- This implies that the MHCA view of the "right" level of expenditure in NSW would be about $500 M per annum more than at present. The basis for the conclusion is unknown. It is not supported by any analysis in the report. There is no quantitative specification of the services that would be purchased with the money.

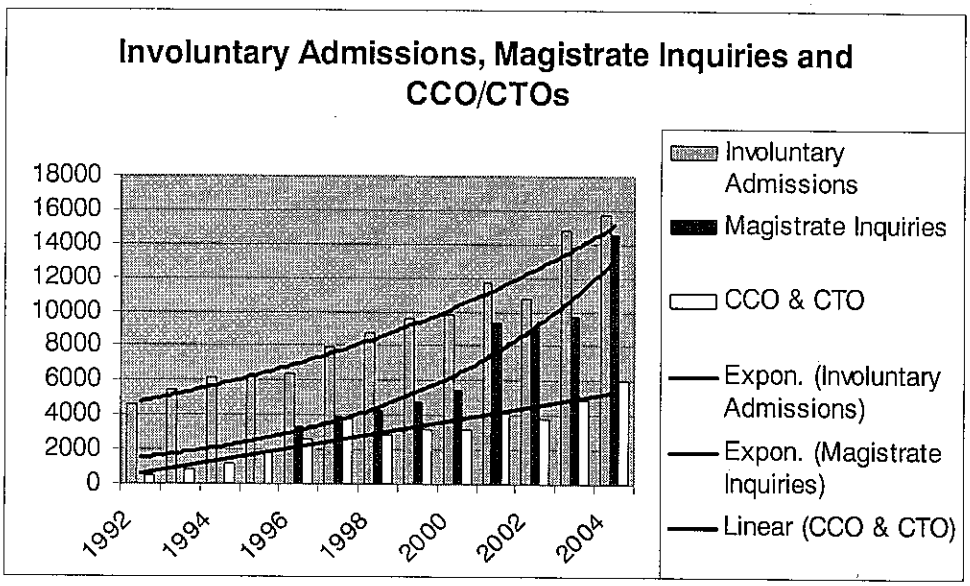
- This model was adopted in 2000-01, as part of the NSW Government Action Plan on Health. When combined with service development plans, it provides the "policy rationale" referred to in the question:

> *What was the policy rationale for that increase [of 140%] as opposed to a 300 per cent increase?*

- From that point of view, the budget of $854 million per annum in 2005-06 can be seen as a milestone along the way: the point at which NSW expenditure is "at or about" the national State/ Territory average. The issue of how Australia proceeds beyond this "average" level will no doubt be discussed at the special meeting of the Council of Australian Governments. It will no doubt be informed by the report of the current Senate Inquiry.

- For that reason, it is important to address the issue of the graph referred to in the question, because it is at best one of many factors underlying NSW planning, and at worst rather misleading.

- Dr Roger Gurr (Area Director of Mental Health, Sydney West Area Health Service) has kindly given us a copy of the spreadsheets underlying the graph that he supplied to the Inquiry. We assume that the question refers



to the graph above, since it shows a 3-fold or 4-fold increase on "involuntary admissions" between 1992 and 2004.

- Presented in that form, it might seem that a simple growth curve "explains" an increase in demand. However, as the examples below will show, reality is much more complicated than the curve suggests.

- These data come from the (calendar year) Annual Reports of the NSW Mental Health Review Tribunal. The database kept by the MHRT is based on paper notifications from hospitals. Electronic copies of the reports may be downloaded (from 1998) at: http://www.mhrt.nsw.gov.au/mhrt/mhrt_annual00.htm .

- The data refer to MHRT records that the person was presented involuntarily and "admitted" to the reporting hospital. The MHRT is an independent body and NSW Health does not have access to or manage the database in question. However, it is almost certain (see below) that some of the apparent increase reflects improved reporting to the MHRT rather than a real change. The period before 1996 is likely to be considerably under-reported, since the poor state of NSW mental health information was one of many aspects of the system that have had to be addressed over the last ten years.

- The following analysis looks at the effects in more detail, using the hospital-by-hospital data in the reports on the web site for 1997 and 2004.

- **Psychiatric Hospitals (overall):**

Major Psychiatric Hospitals	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Bloomfield	425	425	876	851	106%	100%
Cumberland	718	655	1321	1170	84%	79%
James Fletcher	578	575	1439	1256	149%	118%
Kenmore	263	263	424	423	61%	61%
Gladesville/Macquarie	155	155	312	303	101%	95%
Morisset			5	5		
Rozelle	913	849	1285	1285	41%	51%
SUB-TOTALS 1997 Vs 2004	3052	2922	5662	5293	86%	81%
Sub-Totals 1996 Vs 2003	2755	2665	5623	4990	104%	87%

This shows that psychiatric hospitals in general experienced a doubling of the number of attendances of persons taken involuntarily between 1997 and 2004. Since most of them were admitted in both years, there is a similar increase in "admissions" (as defined by the MHRT). However, there are quite a few complications in interpreting what this means. One of them is that multiple attendances by the same person are counted each time.

More important is the fact that most of the beds in psychiatric hospitals were non-acute in 2004. The clearest example is Kenmore Hospital at Goulburn, which had no acute beds at all in 2004, since a new co-located acute unit at Goulburn Base Hospital was built between 1997 and 2004. Thus a person could only be "taken involuntarily" to Kenmore if they were being transferred to the Kenmore Rehabilitation or Extended Care units from another setting. In such cases, it is likely that they would already have been an involuntary patient, and counted as such when they were admitted to the other setting. The obvious one would be the new 20 bed acute unit at Goulburn Base Hospital, but in fact that hospital reported zero attendances in 2004. This is extremely unlikely to be true, and it is much more likely that some of the attendances and admissions recorded as "Kenmore" should in fact be at Goulburn.

There are many reasons why transfer of involuntary patients between acute and sub-acute care may have increased over the period, without generating a "need" for more funding. The MHRT data cannot answer that question.

- **Co-located acute units in general hospitals (overall)**

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
SUB-TOTALS 1997 Vs 2004	5084	4990	10707	10433	111%	109%
Sub-Totals 1996 Vs 2003	3824	3780	10155	9772	166%	159%

The overall result from the dozens of units of this type in NSW is essentially the same as for psychiatric hospitals, namely a doubling of involuntary presentations, and of admissions. For these hospitals the complication of

transfers does not arise, or would be minimal. To ascertain why the increase may have occurred, it is useful to look at groups of units by type or within a region.

- **New Units**

During the period 1997-2004, a number of new units were opened in NSW, many in rural and regional areas. They can contribute to the total, but no specific increase can be identified for them.

Public Hospital Units	Persons taken Involv.	No. Involv. Admiss.	Persons taken Involv.	No. Involv. Admiss.	Persons taken Involv.	No. Involv. Admiss.
Armidale			1	1		
Goulburn			0	0		
Greenwich			42	42		
John-Hunter			36	36		
Maitland			723	706		
Queenbeyan			18	18		
Taree			238	238		
Tweed-heads			260	260		
Wollongong			209	209		
Wyong			346	340		

Collectively, these units account for 34% of the increase in involuntary admissions between 1997 and 2004 for co-located units as a whole, and 24% of the overall increase when psychiatric hospitals are included.

In theory, the availability of a new unit in a region should have no effect on whether a person would be admitted involuntarily, since patients with that level of need take precedence over voluntary admissions.

- **Northern Rivers:** In the former Northern Rivers AHS, a new unit at Tweed heads was added during the period to the long-established unit at Lismore.

Public Hospital Units	Persons taken Involv.	No. Involv. Admiss.	Persons taken Involv.	No. Involv. Admiss.	Persons taken Involv.	No. Involv. Admiss.
Lismore	392	384	472	472	20%	23%
Tweed-heads			260	260		
			732	732	87%	91%

There was only a small rise at Lismore during the period, presumably because the addition of a 25-bed unit at Tweed Heads was able to meet the need.

- **Greater Murray):** In the former Greater Murray AHS, the two existing units functioned through the period with minor changes:

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Albury	61	60	157	157	157%	162%
Wagga Wagga	175	175	187	187	7%	7%
	236	235	344	344	46%	46%

In this case, there was a large increase in Albury, and virtually none in Wagga, with a moderate increase overall. There may be many reasons for this, but the general point is that the increase is not uniform.

- **Wentworth:** In the former Wentworth AHS, a single unit operated through the period.

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Nepean	98	98	542	542	453%	453%

This makes it fairly clear why the Nepean unit has been enhanced with additional beds and a Psychiatric Emergency Care (PEC) centre, and a new unit is being added in the Blue Mountains.

- **Western Sydney :** In the former Western Sydney AHS the co-located acute units operate with a major psychiatric hospital (Cumberland Hospital), but the same overall result is found.

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Blacktown	181	181	356	329	97%	82%
St. Josephs	9	9	63	62	600%	589%
Westmead Acute Adol.	29	29	48	48	66%	66%
Westmead Adult psych	1	1	8	8	700%	700%
Westmead psychogeriatric	14	14	2	2	-86%	-86%
	234	234	477	449	104%	92%

There are two psychogeriatric acute units shown above (Westmead, St Joseph's), and also a gazetted adolescent unit. Clearly the adult psychiatric unit at a principal referral Hospital like Westmead – with Cumberland Hospital within a few hundred metres – is different from a "suburban" hospital unit like Blacktown.

- **Northern Sydney :** The former Northern Sydney AHS is generally regarded as better resourced than most in NSW, not only because it has Macquarie Hospital to call on, but also because of its community services.

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Greenwich			42	42		
Hornsby	271	271	350	315	29%	16%
Manly	222	222	292	292	32%	32%
Royal North Shore	299	299	210	210	-30%	-30%
	792	792	894	859	13%	8%

In that context, it is instructive to note that there has been hardly any increased in involuntary presentations or attendances at the general hospital units. On the other hand, as shown previously, the rates doubled at Macquarie Hospital. In any case, the effect of having a Psychiatric Hospital on hand was clearly quite different in Western Sydney and Northern Sydney.

- **Effect of reporting:** The former South Western Sydney AHS had three 30-bed units for most of the relevant period, and there is no obvious reason why their results would be as different as they appear below.

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Bankstown	28	28	838	838	2893%	2893%
Campbelltown	167	167	346	345	107%	107%
Liverpool	357	357	435	435	22%	22%
	552	552	1619	1618	193%	193%

The most likely explanation is that the Bankstown unit was under-reporting in 1997.

- **South Eastern Sydney:** To the extent that demand for non-acute admission is driven by substance use, the former South Eastern AHS might be expected to show it.

Public Hospital Units	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.	Persons taken Invol.	No. Invol. Admiss.
Prince Henry	173	173	0	0	-100%	-100%
Prince of Wales	372	305	721	643	94%	111%
St. George	96	96	330	330	244%	244%
St. Vincents	215	214	454	447	111%	109%
Sutherland	273	273	342	342	25%	25%
	1129	1061	1847	1762	64%	66%

The Prince Henry Hospital and Prince of Wales Hospital units were redeveloped into new units at POWH during this period. Since the increase in involuntary presentations and admissions is lower than average, there is no evidence for unusually high demand.

- **Summary of MHRT data:** When the overall increase of MHRT reports of involuntary presentations and admissions is broken down across various

regions of NSW, [remembering that many of these regions serve populations larger than the Territories or Tasmania], the plausibility of any single, simple explanation of the overall effects is greatly weakened.

- **Other "ecological" trends 1997-2004**

It is also necessary to relate these effects to some other observations of changes (or lack of change) during the period in question. The most striking one is that in 1997 the suicide rate in Australia, and in NSW, reached the highest levels since the so-called "barbiturate epidemic" of the early 1960s. In 2003, however, the suicide rate in NSW was the lowest for 20 years, and the lowest in Australia.

Secondly, NSW Health commenced a general population telephone survey in 1997, which in that year and the following surveyed 17,000 adults aged 16 and over, using the Kessler-10 measure of psychological distress, which was also used in the national Survey of Mental health and Wellbeing, and was thus calibrated against interview based diagnosis. Since 2002, the NSW Health Survey has run continuously and interviews about 12,000 people each year. Thus we have direct evidence of the rates of psychological distress in the NSW population over the period, and a very good proxy for the rates of anxiety and/or depression.

The results can be seen electronically at:
http://www.health.nsw.gov.au/public-health/survey/hs04/prodout/toc/toc.htm

Year	Males (95% CI)	Males (est. no.)	Females (95% CI)	Females (est. no.)	Persons (95% CI)	Persons (est. no.)
1997	9.2 (8.4-10.0)	220,400	13.0 (12.1-13.9)	319,600	11.1 (10.5-11.8)	539,900
1998	8.0 (8.1-9.9)	219,100	12.1 (11.2-12.9)	301,600	10.0 (10.0-11.2)	520,700
2002	10.5 (9.3-11.8)	261,800	14.2 (13.0-15.4)	362,100	12.4 (11.5-13.2)	623,800
2003	9.3 (8.2-10.4)	225,300	12.9 (11.8-13.9)	328,100	11.1 (10.3-11.8)	552,000
2004	11.7 (10.2-13.3)	288,900	14.7 (13.3-16.1)	375,000	13.2 (12.2-14.3)	664,900

Note: Estimates are based on the following numbers of respondents for NSW:
1997: 17,360; 1998: 17,376; 2002: 12,528; 2003: 12,852; 2004: 9,409.
The indicator includes those with a Kessler 10 (K10) score of 22 or above. The K10 is a 10-item questionnaire about the level of anxiety and depressive symptoms in the most recent 4-week period: K10 scores for respondents aged 65 years and over were derived using 8 questions from the K10 questionnaire.

Source: New South Wales Population Health Surveys 1997-1998, 2002-2004 (HOIST). Centre for Epidemiology and Research, NSW Department of Health.

As indicated in the table, there is no strong evidence of a trend in the levels of psychological distress in the NSW population.

The general point is that one could draw quite different conclusions from different single observations over time:

- the MHRT data on the most severe levels of mental illnesses (namely involuntary presentations and admissions) shows a 100% increase overall, with various sub-trends by various subdivisions.
- the suicide rate (which is frequently used as a proxy for mental illness) has decreased by about a third between 1997 and 2003;

- direct population measures [which are highly predictive of the same anxiety and depressive disorders that (with substance abuse) are called "prevalence of mental illness" by those who argue unmet need from the Survey of Mental Health and Wellbeing (1997)] suggest no change between 1997 and 2004.

The fact is that there are many mental illnesses, of many levels of severity, and there is a corresponding "service need" for each. There is no such thing as a single "unmet need" or a single measure of it. That is why NSW created the MH-CCP model in 2000.

The MH-CCP Model.

Since 2000 the funding requirements have been based on the resource requirements estimated from the population-based Mental Health-Clinical Care and Prevention (MH-CCP) model, version 1.11. The model is described in a document on the NSW Health Department web site:

www.health.nsw.gov.au/policy/cmh/publications/mh-ccp-v1-11.pdf

A copy is attached for the convenience of the Inquiry. Also attached is a copy of the user's guide for the model, which is not available on the web site.

This model is in the public domain, subject to acknowledgement, and it has been used by a number of other jurisdictions as a guide to planning.

The starting point for the model is estimates of the prevalence of mental illnesses, stratified across a spectrum of severity and service need. Put simply, people at one extreme need hospital care 365 days per year, and at the other extreme of the "treatment" spectrum, others need 1.5 hours of specialist assessment, and half an hour of specialist consultation-liaison to support the primary health care professionals who would provide the bulk of their care. The cost differential between these two groups "with mental illness" is more than 1000-fold, but they both fall within the estimate that "one person in six has a mental illness." To argue about a general "need" for "mental health services" is simply nonsense.

The most readable reference on the (non-)relation between "prevalence" and expenditure is by the eminent medical sociologist Professor David Mechanic. [Mechanic D. Is The Prevalence Of Mental Disorders A Good Measure Of The Need For Services? *Health Affairs*, September/October 2003; 22(5): 8-20]. He concludes:

"Mental disorders are highly prevalent, but prevalence is different from need for treatment. Some mental disorders are a major source of distress, disability, and social burden, and many people who could benefit from treatment do not receive it. Need is typically self-defined or defined by clinicians who are motivated to bring treatment to those who could benefit. Defining need appropriately requires consideration of the duration and reoccurrence of

disorder, associated distress and disability, and the likelihood that treatment will be beneficial. Demand may be promoted inappropriately by clinicians and drug manufacturers who profit from expansion of demand. Future assessments of need must be based on evidence and take into account priorities for care and cost-effectiveness."

A large part of the "policy rationale" behind recent increases in NSW expenditure on specialist mental health services was stated (very briefly) in section 1.4 of the NSW Health submission to the Inquiry. The planning model that underlies that paragraph is based on about three person-years of work by staff of the NSW Centre for Mental Health, and by many other NSW health staff who provided information during the "exposure draft" stage of the modelling between April and November 2000. The document describing the model has been on the Department's web site since July 2001, and it is 158 pages long, so we did not include it as part of our submission. We did note that it has been used by a number of other States and Territories as a guide to their own resource requirements.

Given the amount of epidemiological and clinical expertise that has been invested by the NSW Health system in developing the Mental Health – Clinical Care and Prevention (MH-CCP) model, Version 1.11, and in its subsequent application, we call the Inquiry's attention to various documents on the Internet that refer to it:

NSW references

www.health.nsw.gov.au/policy/cmh/mhccp.html

- This is a brief descriptive reference to the model

www.aph.gov.au/senate/committee/mentalhealth_ctte/submissions/sub415.pdf

- This is a submission to the Inquiry itself, which notes that the North Coast Area Health Service has used the model to identify gaps in its services. The submission, which seems to be from a consumer advocate, then goes on to argue for additional services in a sub-region of that Area Health Service.

www.callanpark.com/documents/alternativeplan.html

- This is a web document by "Jean Lennane, for Friends of Callan Park, September 2001", and presents an alternative plan for Rozelle Hospital. Its refers to MH-CCP in a way that is not entirely unfavourable:

> The NSW Health Department, rather surprisingly, has recently produced a document - the 'Mental Health Clinical Care and Prevention Model: a population mental health model' (MHCCPM) - which actually details the bed and staff requirements for the various services on a per 100,000 population basis. Recommended bed numbers are still far too low, at less than half the OECD average. This is no doubt an attempt to come up with figures that have at least some chance of gaining government acceptance: doubling current figures rather than recommending the four-fold increase that is really required.
>
> The model includes a number of justified caveats about the complications of applying the figures to a particular health Area. NSW is divided into 17 geographical Areas, all very different in some important respects; hence the difficulty of a uniform plan.

www.icms.com.au/ephm2005/session/352.htm

- This refers to a presentation at the World Psychiatric Association (Public Health & Epidemiology Section) in July 2005, aimed at seeking input from experts on the further development of the model.

www.nsh.nsw.gov.au/services/amh/planning/003683819.pdf

- This is an example of an Area Health Service in NSW (the former Northern Sydney AHS) using the model as a reference point in planning, with the aid of consultants.

6.4.2 Length of Stay

Table 11 shows the average length of stay by facility by age group and compares it to length of stay for each age group as shown in the Mental Health Clinical Care & Prevention Model, Version 1.11 (MH-CCP). The MH-CCP model (refer Section 6.7 for more detail) assumes all other service components are in place to support the continuum of care. If this is not the case then the length of stay increases. Most of the stays in the acute units appear reasonable and comparable, with only Cummins Unit having a longer than expected length of stay for adults. Length of admission of children and adolescents are much shorter than envisaged in the MH-CCP model.

Table 11: Average Length of Stay by Age Group – 2001/02

Facility	Age Group – Beddays		
	Child & Adolescent	Adult	Psychogeriatric
MH-CCP – model	14	14	28
Parkview - Macquarie Hospital (formerly Ward 13A)	4.6	14.3	6.0
Lindsay Madew Unit – HIK Hospital	5.9	13.5	29.2
East Wing – Manly Hospital	9.8	13.9	26.3
Cummins Unit – Royal North Shore Hospital	9.4	18.8	7.8
Riverglen – Greenwich Hospital	-	26.8	30.6
Coral Tree Family Service[1]	3.8	4.1	3.0
MH-CCP – model	14	10	17
General Wards – Hornsby Hospital	5.1	1.4	7.1
General Wards – Mona Vale Hospital	2.3	2.6	3.4
General Wards – Manly Hospital	1.0	1.4	9.9
General Wards – Royal North Shore Hospital	10.8	2.3	7.9
General Wards – Ryde Hospital		1.4	13.2

Note
1. Family admissions

Australian Capital Territory

www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1107901492&sid=

- This (PDF) file is an "options paper" for the ACT Health mental health services feasibility study 2004-05. It treats MH-CCP as follows:

6.2. Mental Health Problems - Prevalence Estimations

Two common methods to determine the prevalence of mental health problems are:

- Using current levels and projecting forward (using future populations as a guide) to demonstrate the number of people who will have a mental health problem;
- Using a reliable population-based model to predict future levels of mental health problems.

6.2.1. Mental Health Problems – Past (2002) & Projected Using MH-CCP

With reference to the second method, a current population-based model developed in NSW has gained credibility as being reliable and is seen to provide a certain degree of insight into future trends that can be used to determine future service demand. This population-based method is the *Mental Health Clinical Care and Prevention Model*

(MH-CCP)[1]. This model uses future population projections to determine bed-based and ambulatory services that are required to deliver a significant number of mental health services.

It should be noted that MH-CCP does not predict the need for some categories of care that are current in popular use:

- Mental Health Intensive Care Inpatient Services;
- Supported accommodation;
- High Security Inpatient Services (also referred to as Forensic Services).

It is also considered that MH-CCP underestimates the demand for Psychogeriatric Inpatient and Outpatient Services.

A further version of the model is currently being developed by the NSW Department of Health to address these underestimations and exclusions.

Using the MH-CCP methodology and population projections for the ACT, the following table demonstrates the numbers of particular age groups who will suffer from or be at risk of mental health problems and a broad definition of the services they will require in 2014.

Northern Territory

http://www.nt.gov.au/health/comm_svs/mental_health/Mental_Health_Final_Report.pdf

- This is a planning document prepared for the Northern Territory Government Department of Health and Community Services, by consultants. They note:

> 2.4 EPIDEMIOLOGICAL DATA
>
> In the course of undertaking consultations, reviewing available data and considering the literature the most striking issue that arises is the relative lack of a coherent epidemiology of mental health in non-urban environments. The following section considers the available data and options for assessing need within the Northern Territory, as well as identifying difficulties in applying current data. It should be noted at the outset that a coherent epidemiology of mental health in remote and indigenous communities has yet to be developed.
>
> *2.4.1 Prevalence of mental illness*
>
> The National Survey of Mental Health and Well Being found that approximately 20% of the population experienced a mental disorder in the twelve months preceding the survey (Andrews et al (2001)). Fuller (et al (2000)) notes that comparisons between urban and rural populations present mixed results.
>
> The New South Wales Centre for Mental Health (2001) developed a comprehensive model for estimating the population likely to experience severe or moderate mental health problems in a 12 month period, as well as the number likely to require targeted prevention or early intervention. Whilst the parameters are likely to vary, given the different characteristics of the Northern Territory population the approach is useful, particularly in seeking to link the allocation of resources, based on evidence based models of care, to the potential population.

The document uses MH-CCP alongside other models to arrive at an approximation of the particular needs of the NT population.

SOUTH AUSTRALIA

www.mhca.org.au/notforservice/report/part8_4.html

- The response to the Not for Service report by the Department of Human Services in South Australia included the following:

A population based resource funding approach – the way forward

One of the key outcomes of SA's Generational Health Review was recognition that governance and funding arrangements were required to concentrate the health system 'towards improving the health of the population, enhance capacity to promote population health and meet the equity objectives of the South Australian Government'. A population approach to mental health provides a framework which can respond to identified problems; unmet need (disorders which could be effectively prevented or treated but which are currently not); and accountability in population terms for improving health and lessening disease prevalence, morbidity, disability and mortality.[Note]

The initial focus of the South Australian Reform Agenda is to reorientate the whole health system to a population health planning approach, achieving gains in population health outcomes and improving health status by moving emphasis towards a primary health care focussed system.

[Note] Planning in South Australia is premised on the Mental Health Clinical Care and Prevention Model (MH-CCP) as a mechanism for developing population based estimates of the level of resources required.

Conclusions

The "policy rationale" for increases in NSW expenditure on mental health services since 2000 is specified in the attached documents.

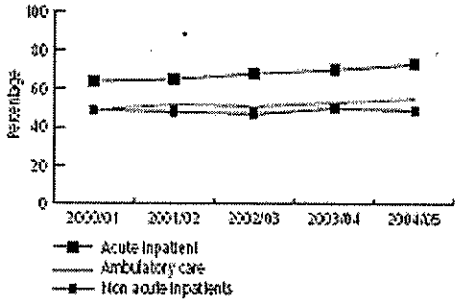
The planning model does not stand by itself. In many areas it needs better information than was available at the time when it was assembled, so NSW Mental Health Information Development strategies have been directed towards obtaining the necessary information, whether from population surveys or by improving service data. The model has also been built into the performance monitoring framework for the new Area health Services that commenced operation in 2004-05.

PERFORMANCE INDICATOR
Mental health needs met

Desired outcome
Improved mental health and well-being.

Context
Access to appropriate mental health services is an important part of NSW mental health strategies. The Need Met measure is an indicator of the level of services actually available compared to the theoretical need calculated for the population.

Mental health needs met



Source: DOHRS (Acute Inpatient, Non-acute Inpatient)
National Survey of Mental Health Services (Ambulatory Care)

Interpretation
These global indexes of service capacity are calculated with reference to the population need projections in the MH-CCP model (available on the Department's website). For indexes to increase, service capacity has to expand by more than population growth of 0.9 per cent per annum.

Acute Inpatient Beds: The index increased from 64 per cent to 74 per cent over the period, reflecting average availability of an additional 167 acute beds.

Non-acute Inpatient Beds: The index was the same (49 per cent) at the end of the period as at the beginning. This reflects maintenance of existing capacity levels in psychiatric hospitals.

Ambulatory Care Clinical Staff: The index increased from 49 per cent to 55 per cent over the period, with the 2004–05 level being 35.5 clinical FTE staff per 100,000 population as against 31.6 per 100,000 in 2000–01.

Strategies to achieve desired outcomes
- The increase in acute bed capacity is on track to achieve the target level of 80 per cent by 2007–08.
- Inclusion of 14 beds at prince of Wales Hospital and 100 sub-acute beds at other general hospitals will add about 7 per cent to the non-acute index by 2007–08.
- The provision of 226 High-support HASI beds is expected to meet some of the need for both acute and non-acute hospital beds, and this effect will be modelled when data are available.
- Ambulatory care enhancements in 2005–06 are expected to increase the index to 60 per cent.

The figures above come from page 40 of the *NSW Health Department Annual Report for 2004-05*, and shows how the indicators are used.

This is a completely transparent public statement of the best estimate we can make of the relationship between the services that were purchased with a budget of $763 Million in 2004-05, and the gap that remains to be filled. The numerators are what we have. The denominators are what MH-CCP states.

More detail on those services is provided in the attached material from the Annual Report, and more detail on "the theoretical need calculated for the population" is provided in the documentation of MH-CCP.

We appreciate the opportunity to explain the planning framework.

Encl: Annual Report 04/05 – Mental Health Section
MH-CCP V1.11 and User Guide